NDT Benefits

Career — Health — Security

NDT INDUSTRY HEALTH BENEFIT PLAN

THE PLAN ADMINISTRATION OFFICE

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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 (Canada) Association and the Quality Control Council of Canada, a group benefit plan (the Plan) has been arranged by the Board of Trustees and is administered by The McAteer Group of Companies.

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 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.

PRIVACY POLICY

We, the Trustees for the NDT 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

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SCHEDULE OF BENEFITS

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 Prescription Drug Prior Authorization Program Lifetime Maximum: $1,000,000 Calendar Year Deductible (applies only to drugs): $25 single and $50 family
Out of Province/ Canada Emergency Medical Travel Insurance	Reimbursement: 100% $5,000,000 maximum per coverage period Travel Duration: 60 days Terminates at age 75

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
Employee and Family Assistance Program	See this Section of the booklet for details
TELUS Health Virtual Care	See this Section of the booklet for details

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:

QCCC Members in good standing with one of the Affiliated Unions listed in the Quality Control Council of Canada Agreement must accumulate 180 hours of work within a 12-month period. Coverage will commence on the 1st day of the month following the month (lag) in which sufficient hours are reported and paid to the Plan by their employer(s).

EXAMPLE:

	Hours Worked		
MONTH	**MEMBER A**	**MEMBER B**	**MEMBER C**
May	50 hours	120 hours	200 hours
June	70 hours	150 hours	lag
July	45 hours	lag	qualified
August	100 hours	qualified	
September	lag		
October	qualified		

90 hours will be withdrawn each month from the Member's Hour Bank. A maximum of six months coverage (540 hours) can be accumulated in the Hour Bank, which will be drawn upon during a period of low employment, lengthy illness or extended vacation.

Upon qualifying for coverage, the Member will be provided with the required enrolment forms to complete and return to the Plan Administrator. Once these forms are completed and received by the Plan Administrator, the Member will be sent a pay-direct card (one for single coverage and two cards for dependent coverage - both will be in the Member's name). Once coverage starts, it will continue as long as the Hour Bank contains sufficient hours for the monthly 90-hour charge.

If a lapse in coverage occurs, the Member must requalify with 180 hours.

If a Member is found to be no longer in good standing of the QCCC - in particular, if they are found to be performing QCCC scope work for a non-union employer, coverage will be suspended and hours accumulated in the Member's Hour Bank may be forfeited.

Office Personnel who are full-time employees (30 hours per week) will be covered on the first day of the month following the date they become a permanent employee, provided they are actively at work on that day. If the coverage is not requested on the eligible effective date, or if application for coverage is not made within 31 days of that 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

The Hour Bank will not accumulate hours on behalf of someone who is not yet initiated with a QCCC-Affiliated Union Local/Lodge (Probationary Employees) 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.

Temporary Foreign Workers are not eligible for any benefits under the Plan.

If an Employee becomes disabled, they must have been covered under the Plan benefits for at least three consecutive months immediately preceding the month in which the disability was incurred (disability month makes four months) or have had a minimum of 1,000 reported hours within the 12 months immediately preceding (not including the disability month).

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.

Maternity / Parental Leave - Continuation of Benefits

For eligible Members on approved Maternity / Parental Leave, the Plan will credit the Member's Hour Bank with 90 hours for each month of approved Leave, up to a maximum of 12 consecutive months, to offset the Hour Bank charge of 90 hours. The Member must contact the Plan Administrator in advance of such Leave to confirm eligibility requirements for such continuation of coverage.

Absence Due to Disability

- If an Employee is approved for a Weekly Indemnity claim, the Plan will continue to provide coverage until their Weekly Indemnity claim ends, (or in the case of a QCCC Member who is in receipt of benefits under any Worker's Compensation Act or similar law - when the Weekly Indemnity benefits would have expired) at which time they will be provided an opportunity to continue their coverage, either through hours reported to the Plan and banked in their Hour Bank or by self-pay for up to a maximum of six consecutive months.
- QCCC Members who remain totally disabled, as determined by the Plan, may self-pay until the earlier of (i) the date the QCCC Member ceases to be totally disabled or (ii) the QCCC Member's attainment of age 65.
- A self-pay notice will be mailed to the address on file with the Plan Administrator. Payment must be arranged with the Plan Administrator via automatic monthly withdrawal. Do not ignore the self-pay notice. If payment is NOT arranged / received, a second notice will not be mailed the following month.

When a QCCC Member is Unemployed

The Plan will continue to provide full coverage through periods of unemployment, provided there are sufficient hours in the QCCC Member's Hour Bank to be withdrawn to fund full coverage (90 hours per month).

Self-Pay: Once the Hour Bank falls below 90 hours, the Member will be provided with an opportunity to self-pay for their coverage for up to a maximum of six consecutive months, provided they remain a QCCC Member in good standing. Coverage under self-pay includes all benefits except Weekly Indemnity and Long Term Disability.

A self-pay notice will be mailed to the address on file with the Plan Administrator. If payment is received, subsequent notices will be sent on a monthly basis. Payment is due on the 15th day of the month. Do not ignore the self-pay notice. If payment is NOT received, a notice will not be mailed the following month.

If a QCCC Member incurs a claim prior to the Plan's receipt of a self-payment, the claim will be considered eligible, provided the self-payment is received within the time-frame given.

Reinstatement

If a QCCC Member in good standing returns to work, either with a previous employer or a new employer, before their coverage terminates, coverage will continue provided their Hour Bank has not dropped below 90 hours. If a QCCC Member in good standing returns to work and there are less than 90 hours in their Hour Bank, they must requalify for full coverage by accumulating 180 hours in their Hour Bank within a 12-month period. Coverage will commence on the 1st day of the month following the month (lag) in which sufficient hours are reported and paid to the Plan by their employer(s).

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 their 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 ..... Four-Fifths of The Principal Sum
Loss of One Leg ..... Four-Fifths of The Principal Sum
Loss of One Hand ..... Three-Quarters of The Principal Sum

Loss of One Foot .....Three-Quarters of The Principal Sum
Loss of the Entire Sight
of One Eye.....Three-Quarters of The Principal Sum
Loss of Thumb and Index Finger
of the Same Hand..... One-Third of The Principal Sum
Loss of Speech or Hearing ... Three-Quarters of The Principal Sum
Loss of Speech and Hearing.....The Principal Sum
Loss of Hearing in One Ear .....Two-Thirds of The Principal Sum
Quadriplegia (total paralysis of both
upper and lower limbs)..... Two Times The Principal Sum
Paraplegia (total paralysis of
both lower limbs) ..... Two Times The Principal Sum
Hemiplegia (total paralysis of
upper and lower limbs of one
side of the body) ..... Two 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 .....Three-Quarters of The Principal Sum
Loss of Use of One Arm
or One Leg..... Four-Fifths of The Principal Sum
Loss of Four Fingers of
One Hand ..... One-Third of The Principal Sum
Loss of All Toes of One Foot..... One-Quarter 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 total and irrecoverable loss of sight such that corrected visual acuity must be 20/200 or less in such eye.

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

Loss of the Entire Sight of Both Eyes means the total and irrecoverable Loss of sight in both eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than twenty (20) degrees in both eyes. A Physician certified in Ophthalmology must clinically confirm the diagnosis in writing. Loss of Hearing in One (1) Ear means the

diagnosis of permanent Loss of Hearing in one (1) ear, with an auditory threshold of more than ninety (90) decibels. A Physician certified in Otolaryngology must confirm the diagnosis in writing. Loss of Hearing means the diagnosis of permanent Loss of Hearing in Both Ears, with an auditory threshold of more than ninety (90) decibels an ear. A Physician certified in Otolaryngology must confirm the diagnosis in writing.

"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 Blue Cross Life "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.

Disappearance

If the body of an Insured Member 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 Member 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 Member 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 Member.

All other benefits shall be payable to the Insured Member.

Repatriation Benefit

When Injuries covered by this policy result in loss of life of an Insured Member 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

If an Insured Member suffers an Injury which results 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 Member provided:

a) Such training is required because of such Injuries and in order for the Insured Member to be qualified to engage in an occupation in which they 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 Member being confined to a hospital, outside 100 Km from their 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 reasonable and necessary expenses incurred by the immediate family member for transportation by the most direct route by a licensed common carrier to the confined Insured Member but not to exceed the amount $15,000.00.

Conversion Privilege

On the date of termination of coverage or during the 90-day period following termination of coverage, you may change your insurance to the Blue Cross Life's 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 Blue Cross Life. The amount of insurance benefit converted to shall not exceed that amount issued under this Plan.

Continuance of Coverage

In the case Members 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 a Member 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 Member becomes totally and permanently disabled and their 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 Member attains age 65.

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

c) The date the Insured Member is no longer eligible for total disability waiver of premium under the Policyholder's group life policy; and

d) The date the Master Policy is terminated

Seat Belt Rider

Benefits under the policy shall be increased by 10% if the Insured Member's Injury or death results while they are a passenger or driver of a private passenger type automobile and their 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 Member 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 Member's residence to make it wheel-chair accessible and habitable; and

b) The lesser of:

   i) the one-time cost of modifications necessary to a motor vehicle, owned by the Injured Insured

Member, to make the vehicle accessible or drivable for the Insured Member; and

ii) the one-time cost to purchase a wheelchair accessible specially modified vehicle, with the prior approval of the Company.

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

Benefit payments herein will not be paid unless:

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

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

Dependent Child Educational Benefit

If an Insured Member suffers Injury resulting in Loss of Life, for which the Company has paid the benefit set out in the Table of Losses, the Company will reimburse the annual tuition, not including room and board, charged by an Institution of Higher Learning per school year for each Dependent Child of such Insured Member up to the lesser of the following amounts:

a) ten thousand dollars ($10,000.00) per school year; or

b) 5% of such Insured Member's Principal Sum.

This benefit is payable annually up to a maximum of four (4) consecutive payments per Dependent Child:

c) only for such Dependent Child who is, at the time of such Insured Member's Loss of Life, enrolled as a full-time student in an Institution of Higher Learning beyond the twelfth (12^{th}) grade level; and

d) only while such Dependent Child continues their continuous enrollment in an Institution of Higher Learning.

The Company will reimburse the person who incurred the actual tuition expenses.

Spousal Educational Benefit

If an Insured Member suffers Injury resulting in Loss of Life, for which the Company has paid the benefit set out in the Table of Losses, the Company will pay to the Insured Member's Spouse the actual cost incurred for

a professional or trades training program in which such Spouse enrolls for the purpose of obtaining an independent source of support and maintenance provided such cost is incurred not later than thirty (30) months after the Insured Member's Loss of Life.

The maximum amount payable for this benefit is fifteen thousand dollars ($15,000.00) per Insured Member.

"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 post secondary college or trade school, and any College of General and Vocational Education/Collège d'enseignement général et professionnel (CÉGEP).

Day Care Benefit

If an Insured Member suffers Injury resulting in Loss of Life for which the Company has paid the benefit set out in the Table of Losses, the Company will pay to the legal guardian of any surviving Dependent Child of the Insured Member, an amount equal to the lesser of the following:

a) the actual annual cost charged by a commercial and licenced day care centre; or

b) 5% of the Insured Member's Principal Sum; or

c) five thousand dollars ($5,000.00) per year.

This benefit is payable annually for a maximum of four (4) consecutive payments per Dependent Child:

a) and only for such Dependent Child who at the date of the Insured Member's Loss of Life is under age thirteen (13);

b) provided such Dependent Child is enrolled in commercial and licenced day care centre no later than ninety (90) days following the Insured Member's Loss of Life; and

c) provided that the Dependent Child continues their enrollment in a commercial and licenced day care centre.

In-Hospital Benefit

If an Insured Member suffers injury resulting in a Loss (other than Loss of Life) for which the Company has paid a benefit set out in the Table of Losses, and as a consequence of such Loss the Insured Member is, pursuant to the instructions of a Physician, confined to

a Hospital for more than five (5) consecutive overnight stays, the Company will pay:

a) for a period of confinement in Hospital of more than thirty (30) consecutive overnight stays, 1% of the Insured Member's Principal Sum; or

b) for a period of confinement of thirty (30) consecutive overnight stays or less, one thirtieth (1/30) of the amount determined for each overnight stay in Hospital.

The Company will pay this benefit monthly, retroactive to the first (1st) overnight stay of confinement in Hospital.

The maximum amount payable for this benefit for all injuries resulting from any one (1) accident per insured is two thousand five hundred dollars ($2,500.00) per month.

Benefits are not payable for more than a total of twelve (12) months of confinement for any one (1) accident causing Injury.

Successive periods of confinement to Hospital for Injury resulting from the same accident, if separated by a period of less than three (3) months, are considered one (1) period of confinement to Hospital for the purposes of calculating this benefit.

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

If an Insured Member suffers Injury causing Permanent and Total Disability, the Company shall pay the amount which is 100% of the Principal Sum for the Insured Member less any amounts under the Table

of Losses which have been paid or which are payable by the Company for Losses of the Insured Member.

EXCLUSIONS

No coverage shall be provided under this contract and no payment shall be made for any Loss or claim resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks even if the proximate or precipitating cause of the Loss or claim is an accidental Injury:

a) suicide or any attempt thereat by the Insured Member while sane;

b) self inflicted Injury or any attempt thereat by the Insured Member while sane or insane;

c) declared or undeclared war or any act thereof;

d) sickness, disease, or bodily infirmity whether the Loss or claim results directly or indirectly from any of these;

e) mental incapacity whether the Loss or claim results directly or indirectly from any mental incapacity;

f) Injury sustained while the Insured Member is undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;

g) stroke or cerebrovascular accident or event, cardiovascular accident or event, myocardial infarction or heart attack, coronary thrombosis, aneurysm;

h) travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Insured Member is:

   i) riding as a passenger in any aircraft not intended or licenced for the transportation of passengers; or

   ii) performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or

   iii) riding as a passenger in an Owned Aircraft or Leased Aircraft operated by the Policyholder.

i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;

j) Injury or Loss sustained while the Insured Member is on full-time duty in the armed forces or organized reserve corps of any country or international

authority. (Unearned premium for any period for which the Insured Member is on full-time active duty shall, upon application to the Company by the Policyholder, be refunded);

k) Injury or Loss sustained while the Insured Member is under the influence of alcohol and operating any vehicle or means of transportation or conveyance while their blood alcohol is over eighty (80) milligrams in one hundred (100) millilitres of blood;

l) Injury or Loss sustained while the Insured Member is under the influence of a drug or substance which is controlled as specified under the Controlled Drug and Substances Act (Canada) unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licenced Physician;

m) the commission or attempted commission by an Insured Member or Injury incurred while an Insured Member is in the course of committing or attempting to commit any act which if adjudicated by a court would be an indictable offence under the laws of the jurisdiction where the act was committed; and

n) an act, attempted act or omission taken or made by the Insured Member, or an act, attempted act or omission taken or made with the Insured Member's consent, for the purposes of interrupting the blood flow to the Insured Member's brain or to cause asphyxiation to the Insured Member whether with intent to cause harm or not; and

o) natural causes.

WEEKLY INDEMNITY BENEFIT

For Employees 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 under the Plan benefits (including Weekly Indemnity) for at least three consecutive months immediately preceding the month in which the disability was incurred (disability month makes four months) or have had a minimum of 1,000 reported hours within the 12 months immediately preceding (not including the disability month). 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 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. 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

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.

If the Employee provides the Plan with evidence that a third party is not liable, in whole or in part, or evidence that a claim under workers compensation is denied, the Plan will require a Loan Agreement be signed by the Employee in order to receive benefits from the Plan. If financial relief is later paid to the Employee for such a claim by a third party or the workers compensation decision is overturned, the Employee must repay the Plan the amounts paid in respect of such claim.

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;
- where the Member is in receipt of income from other sources such as Employment Insurance or any other government issued benefits that are a source of income.
- 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.

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 their regular occupation; and
2. except for any employment under an approved rehabilitation plan, the Employee is not employed in any occupation that is providing them 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 they have at least the minimum qualifications
3. that provides income of at least 75% of their monthly earnings; and
4. that exist either in the province or territory where they worked when they became disabled or where they currently live.

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 Canada 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, Canada 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 their take-home pay. If it does, their income benefit is reduced by the amount in excess of 85%.

1. 92.5% of any disability benefit to which they are entitled on their 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 they are entitled on their 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 they or another member of their family is entitled on the basis of their 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, their income from this policy, and the income described under the all source maximum provision would exceed 100% of their take-home pay. If it does, their 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 Canada Life.

In considering whether to recommend or approve a rehabilitation proposal, Canada 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 Canada Life, they will no longer be entitled to income benefits.

Time Commitment

The duration of a rehabilitation plan must be approved by Canada Life. Once approved, a person's benefit period is guaranteed for that duration so long as they continue 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 Canada Life at its discretion.

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

In considering whether to recommend or approve a medical coordination program, Canada 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 Canada Life, they will no longer be entitled to income benefits.

Expense Benefit

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

Expenses claimed under this provision must be pre-authorized by Canada 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. Canada Life will not cover medical coordination services after the person has returned to work, unless they are 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 Canada 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, their 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 Canada Life.

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

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

5. any period after the person fails to participate or cooperate in a medical or vocational assessment required by Canada 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 Canada Life pre-authorized 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.
one.telushealth.com
ENGLISH:
login username: ndt
password: eap

FRENCH:
login username: end
password: pae

or call **1-844-880-9137**

TELUS HEALTH VIRTUAL CARE

TELUS Health Virtual Care brings patient-first healthcare to you and your covered eligible dependents.

TELUS Health Virtual Care allows you and your eligible dependents to access the physical and mental health care you need as soon as you need it. No matter the time of day or where you are in Canada, service is available directly on your phone or computer, using encrypted text or video to address health questions and issues with friendly, knowledgeable clinicians.

This benefit provides you with on-line virtual access to:
Medical advice
Diagnosis
Mental health support
Referrals
Prescriptions and refills
Lab requisitions
Imaging requisitions
Nutrition consultations

It's complimentary access to virtual care 24/7, from anywhere in Canada. You can request that a copy of your consultation be shared with your family doctor.

If you haven't yet created your account, you can visit **http://virtualcare.telushealth.com/welcome/activation** using your group number ***4242*** and your **Client ID Number** found on your pay-direct card.

Once you have created an account, download the **TELUS Health Virtual Care** app from the App Store or Google Play and sign into your account.

SUBSTANCE ABUSE REHABILITATION ASSISTANCE (SARA)*

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. The Member must also have 500 hours reported to the NDT Industry Health Benefit Plan in the last 12-month period or have been covered under the Full Plan for 4-consecutive months prior to making application for SARA. If a Member is not in good standing at the time of applying for SARA, provided all other eligibility criteria is met, they may bring their union membership into good standing and reapply. 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.

*Members from the Central Region receive substance abuse rehabilitation services through De Novo Treatment Centre. De Novo is an alcohol and drug treatment service operated as a partnership between management and Unionized Members of Ontario's Construction Trades. De Novo provides free assessment, referral, residential treatment and recovery support for Quality Control Council Members that work in Ontario.

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.

Out of Province/Canada Emergency Medical Travel Insurance 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) – Present your pay-direct 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 pay-direct 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, 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
https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/who-we-cover/fair-pharmacare-plan

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

Prescription Drug Prior Authorization Program

There are a number of prescription drugs which will now require prior authorization before they can be determined eligible under the Plan. The complete Prior Authorization Listing of these drugs can be found online at:
https://www.telus.com/en/health/prior-authorization-forms

If your doctor prescribes a drug for you or one of your eligible dependents, that is on the Prior

Authorization Listing, when you take your prescription to the pharmacy, your pharmacist will be advised that you must obtain prior authorization first. You will then need to download the applicable Prior Authorization (PA) form for that drug from: **https://www.telus.com/en/health/prior-authorization-forms** and complete the patient section, have the prescribing physician complete their section of the form, and then send the completed form to where indicated. This information will be reviewed, and it will be determined whether the required eligibility criteria is met.

The decision will be communicated directly with the patient or individual indicated by the patient on the form. If deemed to be eligible, an exception will be added to that patient's Plan record so that the pay-direct card will accept that drug going forward according to the terms of the approval.

Important: *do not purchase your medication in advance of the completion of the Prior Authorization Process. Claims are not covered retroactively. Please wait to confirm criteria has been met before returning to your pharmacy to fill your prescription.*

It's recommended that you refer to the Prior Authorization Listing while you are with your doctor, so that if a drug they intend to prescribe is on the Listing, the applicable Prior Authorization form can be downloaded, printed, and completed before you leave your doctor's office. If you need assistance accessing a Prior Authorization form, you can contact health@ndtbenefits.org.

2) Vaccinations for preventative treatment of communicable diseases.

3) Charges in excess of the amount payable under the covered 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) You can use your pay-direct card with participating paramedical practitioners. The Plan will recognize charges from a massage therapist, podiatrist/ chiropodist, chiropractor, naturopath or osteopath who is registered and legally practicing within the scope of their license. These charges will be reimbursed at 90% up to a calendar year maximum of $500 per covered person for each practitioner. For eligible QCCC Members and their eligible dependents, charges for speech therapist are limited to a calendar year maximum of $10,000* per person, charges for registered psychologist are limited to a calendar year maximum of $25,000* per person, and charges for physiotherapist are limited to a calendar year maximum of $15,000* per person. For eligible Office Personnel and their eligible dependents, charges for speech therapist, registered psychologist, and physiotherapist are limited to $500 per person per calendar year, per practitioner type. Registered clinical counsellors and licensed social workers are included under coverage for registered psychologist.

   *Effective January 1, 2025

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. 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 child in any 24 consecutive months is available.

You can use your pay-direct card for the purchase of the following eligible expenses:

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. You can use your pay-direct card when you visit a participating Licensed Optometrist or Ophthalmologist for your eye examination.

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. 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/Canada Emergency Medical Travel Insurance or if pre-approved under the Medical Referral Benefit as described herein;

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.

Medical Referral Benefit

The Medical Referral Benefit provides coverage for reasonable and customary charges for medical and transportation expenses in excess of those expenses covered by the covered person's government health insurance plan, Health Insurance Plan or EHC plan, for the covered person and an approved escort, up to a lifetime maximum of $75,000 per person, as a result of a pre-approved medical referral for treatment, subject to the following conditions:

a) the treatment must not be available within 500 kilometres from your residence; and

b) the medical referral service must be obtained in Canada, if available, regardless of any waiting lists; and

c) your attending Canadian physician and a qualified Canadian medical specialist from an appropriately related medical field must recommend the treatment; and

d) the referral service must be eligible for reimbursement and paid in whole or in part by your government health insurance plan or Health Insurance Plan (a written pre-authorization from your government health insurance plan or Health

Insurance Plan outlining their liability is required); and

e) if your government health insurance plan, Health Insurance Plan or EHC plan covers and reimburses the full medical referral expenses, no benefits are payable; and

f) the treatment must not be experimental or investigative in nature; and

g) medical services and travel must take place within 30 days of receiving approval from your government health insurance plan or Health Insurance Plan, unless the earliest possible treatment date exceeds 30 days from the date of approval; and

h) the medical referral must be pre-approved, following submission of a request for pre-approval in writing to Global Excel, along with supporting documentation.

Out of Province/Canada Emergency Medical Travel Insurance

Emergency Medical Travel Insurance provides coverage for eligible Employees and their eligible dependents for certain expenses incurred as a result of an emergency while travelling outside your province. This travel insurance is underwritten by the Manufacturers Life Insurance Company (Manulife). Manulife has appointed Global Excel Management (Global Excel) as the provider of all assistance and claims services under this policy.

Coverage Period: 60 days per trip

Policy Number: DAT00013353

Out of Province/Canada Emergency Medical Travel Insurance coverage has a maximum of $5 Million per coverage period.

IF YOU HAVE AN EMERGENCY, YOU MUST CALL GLOBAL EXCEL IMMEDIATELY BEFORE SEEKING TREATMENT. THEY ARE AVAILABLE 24 HOURS A DAY, 7 DAYS A WEEK AND CAN BE CONTACTED BY CALLING:

From Canada and the United States,
call TOLL FREE 1-833-685-2790

From anywhere else in the world,
call COLLECT + 519-735-9448

You must notify Global Excel before obtaining emergency treatment, so that they may:

- confirm coverage
- provide pre-approval of treatment

If it is medically impossible for you to call prior to obtaining emergency treatment, call or have someone call on your behalf as soon as possible.

If you fail to notify Global Excel, the Insurer reserves the right to limit your benefits as follows:

- The Insurer will not pay expenses for benefits that are not approved by Global Excel, if pre-approval is required; and
- In the event of hospitalization, 80% of eligible expenses, based on reasonable and customary charges, to a maximum of $25,000; and
- In the event of an outpatient medical consultation, a maximum of one visit per sickness or injury.

You will be responsible for payment of any remaining charges.

Some treatments require pre-approval in order to be covered (for more details refer to the full Emergency Medical Travel Insurance Booklet). Ask the Plan Administrator for a copy or download from the Plan's website **www.ndtbenefits.org**

If you do not contact Global Excel prior to seeking treatment, the medical treatment you receive may not be covered by this insurance.

Global Excel can direct you to a medical facility or doctor in your area of travel. If you contact Global Excel at the time of your emergency, they will ensure that your covered expenses are paid directly to the hospital or medical facility, where possible.

Travel insurance is designed to cover losses arising from sudden and unforeseeable circumstances. It is important that you read and understand your coverage before you travel, as your coverage is subject to certain limitations and exclusions.

Pre-existing medical condition exclusions may apply to medical conditions and/or symptoms that existed before your trip. Refer to your Schedule of Benefits outlined above your Manulife/Global Excel Assistance Wallet Card to determine how these exclusions affect your coverage and how they relate to your departure date.

In the event of a claim, your medical history will be reviewed after a claim has been reported.

Your insurance provides travel assistance. You are required to contact Global Excel prior to treatment. Failure to do so limits benefits.

Coverage is for an unlimited number of trips up to the coverage period for each trip (60 days per trip); however, each trip must be separated by a return to your province.

Coverage must be in effect before you leave your province. You do not need to provide advance notice of your departure date and return date for each trip. However, you will be required to provide evidence of these dates when filing a claim, for example, an airline ticket or boarding pass.

A Manulife/Global Excel Assistance Wallet Card, with worldwide contact numbers, for the Emergency Medical Travel Insurance coverage should be carried by the Insured when travelling. These cards, along with the Schedule of Benefits and the full Emergency Medical Travel Insurance booklet can be obtained from the Plan Administrator or downloaded from the Plan's website **www.ndtbenefits.org**

Employees working outside of Canada must independently arrange for additional coverage.

Claims Procedures
(Out of Province/Canada Emergency)
You are responsible for providing all the documents outlined below and for any charges levied for these documents. To file a claim:

If in Canada or the United States,
call toll free at: 1-833-685-2790.

From anywhere else in the world,
call collect to: + 519-735-9448.

During your call, you will be given all the information required to file a claim.

You will be asked to substantiate your claim by providing all required documents. Failure to do so may result in non-payment of your claim. The Insurer is not responsible for fees charged in relation to any such documents. Incomplete documentation will be returned to you for completion.

When making a claim, you may be required to complete a Claim & Authorization Form along with providing supporting documentation such as:

- Complete original unused transportation tickets and vouchers if the Emergency Air Transportation or Return of Travel Companion benefit is used.
- All original itemized bills from the medical provider(s) stating the patient's name, diagnosis, all relevant dates and type of treatment, and the name of the hospital or medical facility and/or physician.
- All original prescription drug receipts (not cash receipts) from the pharmacist, physician, hospital or medical facility showing the name of the prescribing physician, prescription number, name of preparation, date, quantity and total cost.
- Proof of your departure date and return date. While boarding passes are preferred, airline tickets or other proof of departure date from your province, may be accepted, provided it contains your name and the location and date of your purchase.
- Any other additional documents pertinent to your claim, as may be required by Global Excel.

Failure to complete the required Claim & Authorization Form in full may delay the assessment of your claim.

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.

All pertinent documents should be sent to:

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

Online Claim Submission:
Visit **https://manulife.acmtravel.ca** to submit your claim online. For faster and easier submissions, have all your documents available in electronic format, such as a PDF or a JPEG.

DENTAL

For Employees and Eligible Dependents

The Dental Plan will cover you and your eligible dependents. You must be prepared to prove that persons claimed as dependents are actually dependent upon you. The Plan provides pay-direct

claims processing using your pay-direct card. Present your pay-direct card to the receptionist when you arrive at your dentist's office for your appointment.

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 preformed 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:

Use your pay-direct card when you fill a prescription, when you visit participating paramedical practitioners, when you have an eye examination, for dental visits and vision care purchases. If you do not use your pay-direct card, these expenses can be submitted for reimbursement directly (does not apply to Dental claims) through the **GreenShield+** portal or mobile app (see page 49 for details).

Alternatively, claim forms for Extended Health benefits can be obtained from the Plan Administrator or the Plan's website **www.ndtbenefits.org**

Standard Dental claim forms are usually provided by your dentist but if you require Dental claim forms, they can be obtained from the Plan Administrator.

All claims must be received by the Plan Administrator within 24 months from the date of purchase/service to be considered for payment.

COORDINATION OF BENEFITS:

1) When co-ordinating benefit payments, the Plan 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
- Client ID
- Your Local Union

All claims should be forwarded, along with applicable receipts, to the Plan Administrator via GreenShield+

DIRECT DEPOSIT

You can now arrange to have your claim reimbursements directly deposited into your bank account by completing the Direct Deposit Registration form, available at **www.ndtbenefits.org.**

You can also update your direct deposit information on **GreenShield+.**

GREENSHIELD+

If you need help using GreenShield+ visit ndtbenefits.org/gsc/. On that page you will see tutorial videos on;

- Registering for an account,

- Submitting a claim,
- Checking coverage,
- Viewing claims history.

If you need help using the GreenShield+ website or app, you can call GreenShield Canada at 1-888-711-1119.

To download the GreenShield+ mobile app:

Apple App Store Link Google Play Link

MEMBERXG - MY BENEFITS ONLINE ADMINISTRATION PORTAL

Upon qualifying for coverage, new Plan Members will receive a Plan Member ID number. Please note: this is not your Client ID that is found on your pay-direct card, which is specific to your claims. Please contact the Plan Administrator if you do not have your Plan Member ID number, which you will need in order to register and set up an account for access to **MemberXG**.

Once registered and once you have set up an account on **MemberXG - My Benefits,** you will be able to view, 24/7, from the convenience of your personal computer or Wi-Fi enabled smartphone or tablet:

* **Work History** – View the hours received on your behalf under both the Pension Plan or the Benefit Plan and from which Employer(s)
* **Pension Account Balances** – You can see a quick glance at your current balance along with the contributions that have been received on your behalf

  Please note: *the interest is only credited annually*
* **Benefit Plan Eligibility** – See whether you have benefit coverage and for how long based on the hours reported to the Plan
* **Member Demographics** – View your personal information and the information of your enrolled dependents

To access MemberXG, go to the Plan's website: **www.ndtbenefits.org** and click on the MemberXG link on the homepage.

RIGHTS TO COPIES OF INFORMATION

Under insurance standards regulation, such as the *Insurance Act* (BC), employees are entitled to request certain information regarding insured benefits (Life Insurance, Long Term Disability, Accidental Death and Dismemberment, Emergency Medical Travel

Insurance), including a copy of the insurance 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 the Plan Administration Office.

TIME LIMITS

Claims for certain benefits must be filed within the times set out in this Booklet or the relevant insurance policies and contracts. Failure to file a claim within those time limits could result in your claim being denied. Every action or proceeding against the Plan for payment of benefits must be commenced within the limitation periods provided by relevant insurance policies or contracts, the applicable limitations statute (e.g. Limitations Act (BC)) or the applicable insurance standards legislation (e.g. *Insurance Act* (BC)). Each employee is responsible for obtaining their own independent legal advice with respect to such limitation periods.

CONFLICT

To the extent that there is any conflict between the content of this Booklet and a provision of the Trust Agreement, an applicable insurance policy or benefit contract, or applicable legislation, the provision of the Trust Agreement, insurance policy, benefit contract or applicable legislation (as the case may be) will prevail.

NOT A CONTRACT OF INSURANCE

This booklet is not to be considered a contract or policy of insurance. The complete terms of any insured benefit are set forth in the group policies of insurance issued to the Trustees.

Benefits Provided By:

Canada Life
#161133
Life Insurance
Long Term Disability

NDT Industry Health Benefit Plan
Weekly Indemnity
Extended Health Benefits
Dental

Manulife Group Travel Insurance
 # DAT00013353
Global Excel Management Inc.
Out of Province/Canada Emergency
Medical Travel Insurance

TELUS Health
#7026
Employee and Family Assistance Program
#4242
TELUS Health Virtual Care

THE PLAN ADMINISTRATION OFFICE

The McAteer Group of Companies

45 McIntosh Drive
Markham, Ontario
L3R 8C7

Phone: 1-888-278-9003

Fax: 905-946-2535

Email: questions@ndtbenefits.org