

**GROUP INSURANCE PLAN
FOR MEMBERS
of the
N.D.T. INDUSTRY
HEALTH BENEFIT PLAN**

Administered by:

D.A. TOWNLEY
& ASSOCIATES LTD.

Effective: February 1, 1977*

*with amendments to: January 1, 2009

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 Agreements between the Non-Destructive Testing Management Association and the Quality Control Council of Canada, a group insurance plan (the Plan) has been arranged by the Board of Trustees and is administered by D.A. Townley & Associates Ltd.

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

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

This booklet describes:

- The Full Benefit Plan (Page 1)
- The Mini Plan (Page 32)
- The Lay-off Plan (Page 3)

Please refer to the qualifications for coverage for each Plan.

PRIVACY POLICY

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

- Information about you and your communications with the Plan are kept confidential.
- Neither the Administrator, nor the Plan will sell your personal information.
- Information about you is gathered lawfully and fairly.
- Information about you is gathered, used, or disclosed only to provide you with benefits and services as outlined in your plan documents.
- We maintain appropriate procedures to ensure that personal information in our possession is accurate and, where necessary, kept up to date. You are entitled to seek 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 Members' 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 valuations, 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, or theft or accidental loss, the Plan will maintain appropriate security mechanisms.

– The Trustees

SCHEDULE OF BENEFITS

THE FULL BENEFIT PLAN

ALL ELIGIBLE EMPLOYEES:

LIFE INSURANCE (Policy #22565)

\$75,000

WAGE INDEMNITY (Policy #52565)

\$447* per week or the maximum payment provided under EI*, whichever is greater

*not to exceed 85% of pre-disability earnings

Benefit commences:

1st day for Accident

4th day for Illness

Maximum duration: 52 weeks for any one disability

LONG TERM DISABILITY (Policy #22565)

\$1,500 per month

Benefit commences:

After 52 weeks of continuous Total Disability

Maximum duration: to age 65

ALL ELIGIBLE EMPLOYEES and THEIR DEPENDENTS:

ACCIDENTAL DEATH & DISMEMBERMENT

(Policy #BSC9028472002)

Employees: \$75,000

Spouse: \$20,000

Each Dependent Child: \$5,000

EXTENDED HEALTH CARE (Policy #52565)

90% reimbursement

\$1,000,000 maximum per lifetime

\$25 (Single) \$50 (Family) calendar year deductible
(applies only to drugs)

Out of Country – 100% reimbursement

60 days out of country maximum

terminates at age 75

DENTAL CARE (Policy #52565)

100% reimbursement on Basic Services

100% reimbursement on Major Services

No deductible

\$2,000 Dental max. per family member per calendar year

ORTHODONTIA (Policy #52565)

50% reimbursement

No deductible

\$2,000 maximum every 24 months per eligible child

THE MINI PLAN (See page 32)

EXTENDED COVERAGE ON TERMINATION/LAY-OFF

(See page 3)

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

GENERAL INFORMATION

Eligibility:

Q.C.C.C. MEMBERS will initially become covered on the first day of the month following the month in which 120 hours are earned, provided the employer makes the appropriate contributions to the Plan. Example: 120 hours earned in April provide coverage for May. If an Employee working under the Q.C.C.C. Agreement earned less than 120 hours or is not a Union Member, and the employer has not contributed on his/her behalf for the Full Benefit Plan, please refer to the last section of this booklet regarding the Mini Plan. For continued coverage after initial qualification, the Employee must earn at least 90 hours per month. If a lapse in coverage occurs, the Employee must re-qualify with 120 hours.

NOTE: An enrolment card must be completed and forwarded to the Administrator's office before any claims payment will be made. If dependents or a beneficiary changes, a revised card must be completed.

Office Personnel will be initially covered the first of the month following the date of becoming a permanent employee*, provided he/she is actively at work on that day. 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.

*However, if the coverage is not requested on the eligible effective date, or if application for coverage has not been made within 31 days of that date, then any application for coverage will require submission of evidence of insurability. The Insurance Company will then determine the effective date of coverage and, if approved, Dental benefits will be limited during the first 12 months, as outlined in the group policy.

Dependent Eligibility

Eligible dependents are:

Spouse

- The person to whom the Employee is married or a person with whom they reside and who is represented as husband or wife. Only one person may qualify at any one time.

Children

- Unmarried children under 21 years of age.
- Unmarried children age 21 or over are also eligible provided they depend wholly upon the Employee for support and maintenance and are full-time students in an educational institution.

- Stepchildren, foster children and legally adopted children may be included the same as the Employee's own children, provided they depend upon the Employee for support and maintenance.
- A child who is physically or mentally incapable of self-support upon attaining age 21 may be continued under the Extended Health and Dental benefits while remaining incapacitated and unmarried, subject to the Employee's own coverage continuing in effect. This privilege also will apply to a child who has remained in the Plan beyond his or her twenty-first birthday if he or she later ceases to be a qualified dependent and is physically or mentally incapable of self-support and is not married. To continue coverage under this provision, proof of incapacity must be received by the Plan Administrator within 31 days after coverage would otherwise terminate. Additional proof will be required from time to time.

Children are eligible for the Health Insurance from birth. If a dependent, with the exception of a newborn child, is confined for medical care or treatment in any institution or at home when coverage would normally start, the dependent will not be covered until given a final release by the doctor from all such confinement.

Medical Examination

No medical examination will be required provided coverage commences on the eligibility date.

Termination of Dependent Insurance

Dependent coverage terminates the same day as the Employee's, **except in the event of the Employee's death while covered.** Upon the death of an Employee, Extended Health and Dental benefits will be continued for a period of twelve months for the spouse and eligible dependents of the deceased Employee.

Extended Coverage on Termination/Lay-off

Any Q.C.C.C. Member who has been in the employ of a Participating Employer and who was on the Full Benefit Plan, shall receive upon lay-off, one month's coverage for each 520 earned pension contribution hours, up to a maximum of six months' coverage, provided the Member is registered and available for work under the Q.C.C.C. Agreement. The Lay-off Plan will not include Wage Indemnity.

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

Absence Due to Disability

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

When the Employee is Unemployed

Self-pay: The Plan includes a six-month self-pay provision* for an Employee who is a Member in good standing of Q.C.C.C. (for all benefits except Wage Indemnity and Long Term Disability) effective on the first of the month coinciding with or next following:

- cessation of the extended coverage allowed after coverage provided by the employer terminates, as above.
- expiry of an Employee's Wage Indemnity benefits.
- when Wage Indemnity benefits would have expired had the Employee not been in receipt of Worker's Compensation benefits.

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

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

PAYMENT IS DUE ON THE 15TH OF THE MONTH.

Reinstatement

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

If an Employee should incur a claim prior to the receipt of a self-pay contribution, the claim will be considered eligible, provided the self-pay contribution is received within the time limit given. In the event of a Life Insurance claim, prior to the receipt of the self-pay contribution, the required self-pay premium is automatically deducted from the Death Benefit.

DESCRIPTION OF BENEFITS

Life Insurance

For Employees Only

A Life Insurance benefit of \$75,000 is payable in the event of the Employee's death from any cause, at any time or place while insured. Payment will be made in a lump sum to the designated beneficiary. The beneficiary may be changed at any time by giving written notice to the Administrator, subject to any legal restrictions.

Insurance during periods of Total Disability

If an Employee becomes totally disabled prior to reaching age 65, Life Insurance can be continued at no cost while the Employee remains totally disabled, but not beyond age 65. Proof of disability must be furnished between 6 and 12 months after total disability starts, and as required thereafter. Should death occur during the first 12 months of disability, a claim will be paid even if proof of disability had not yet been furnished, or premiums had not been continued.

Conversion to an Individual Policy

If the Life Insurance should terminate on or prior to the Employee's 65th birthday, during the 31 days following the termination, the Employee will be able to convert the Life Insurance, without a medical examination, to one of a number of individual Life Insurance policies. The policy will be effective at the end of the 31-day period, and the premiums will be the same as would have been paid if application had been made for an individual policy at that time. If death occurs during the 31-day period, the Life Insurance will be paid whether or not application had been made for an individual policy.

Living Benefits

If an Employee becomes terminally ill while covered under this coverage, they may elect to have a one-time lump sum payment equal to 50% of the total amount of Life Insurance coverage, up to a maximum of \$25,000. Terminally ill means the life expectancy is 12 months or less. In the event of death, the Life Insurance benefit payable will be the Life Insurance proceeds LESS the Living Benefit amount paid, plus interest on that amount, from the date the Living Benefit amount was paid.

How to File a Claim

The Administrator should be advised when a death occurs. The Administrator will then send the beneficiary the proper claim forms for completion. A death certificate will be required.

Accidental Death & Dismemberment

For Employees and Dependents

The Accidental Death and Dismemberment benefit provides coverage 24 hours per day, anywhere in the world, for specified accidental losses occurring on or off the job. If any of the losses outlined below are suffered as the result of an accidental injury which result 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 who are under age 80.	\$75,000
Spouses under age 70.	\$20,000
All eligible Dependent Children.	\$5,000

Schedule of Losses

Loss of Life	The Principal Sum
Loss of Both Hands	The Principal Sum
Loss of Both Feet	The Principal Sum
Loss of Entire Sight of Both Eyes	The Principal Sum
Loss of One Hand and One Foot	The Principal Sum
Loss of One Hand and the Entire Sight of One Eye	The Principal Sum
Loss of One Foot and the Entire Sight of One Eye	The Principal Sum
Loss of One Arm	3/4 of The Principal Sum
Loss of One Leg	3/4 of The Principal Sum
Loss of One Hand	2/3 of The Principal Sum
Loss of One Foot	2/3 of The Principal Sum
Loss of Entire Sight of One Eye	2/3 of The Principal Sum
Loss of Thumb and Index Finger of the Same Hand	1/3 of The Principal Sum
Loss of Speech and Hearing	The Principal Sum
Loss of Speech or Hearing	2/3 of The Principal Sum
Loss of Hearing in One Ear	1/3 of The Principal Sum
Quadriplegia (total paralysis of both upper and lower limbs)	2 Times The Principal Sum
Paraplegia (total paralysis of both lower limbs)	2 Times The Principal Sum
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	2 Times The Principal Sum
Loss of Use of Both Arms or Both Hands	The Principal Sum
Loss of Use of One Hand or One Foot	2/3 of The Principal Sum
Loss of Use of One Arm or One Leg	3/4 of The Principal Sum
Loss of Four Fingers of One Hand	1/3 of The Principal Sum
Loss of All Toes of One Foot	1/4 of The Principal Sum

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

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

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

All claims submitted under this policy for Loss of Use must be verified by agreement between a licensed practicing physician appointed by the N.D.T. Industry Health Benefit Plan “the Plan” and a licensed practicing physician appointed by American Home Assurance Company “the Company”, or in the event that the two physicians so appointed cannot arrive at an agreement, a third licensed practicing physician shall be selected by the first two physicians and the majority decision of the three physicians shall be binding on the Plan and the Company. This procedure may be waived by the Company at its sole discretion.

Exposure and Disappearance

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

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

Beneficiary Designation

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

All other benefits shall be payable to the Insured Person.

Rehabilitation Benefit

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

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

- such training is required because of such injuries and in order for the Insured Person to be qualified to engage in an occupation in which he/she would not have been engaged except for such injuries,
- expenses be incurred within three years from the date of the accident,
- no payment shall be made for ordinary living, travelling or clothing expenses.

Family Transportation

When injuries covered by the policy result in an Insured Person being confined to a hospital, outside 100km from his/her permanent city of residence, within 365 days of the accident and the attending physician recommends the personal attendance of a member of the immediate family, the Company shall pay the actual expenses incurred by the immediate family member for transportation by the most direct route by a licensed common carrier to the confined Insured Person but not to exceed the amount of \$15,000.

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

Conversion Privilege

On the date of termination of coverage or during the 60-day period following termination of coverage, you may change your insurance to the American Home Assurance Company'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 policy 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 of an individual policy may be made at any office of the American Home Assurance Company. The amount of insurance benefit converted to shall not exceed that amount issued during employment.

Continuance of Coverage

In the case of Members of the Plan who are:

- laid-off on a temporary basis,
- temporarily absent from work due to short-term disability,
- on leave of absence, or
- on maternity leave,

Coverage shall be extended for a period of twelve (12) months, subject to payment of premium.

If a Member of the Plan assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of this occupation.

Waiver of Premium

In the event an Insured Person becomes totally and permanently disabled and his/her waiver of premium claim is accepted and approved under the Plan's current Group Life Policy, then the premiums payable under this policy are waived as of the same date the claim is accepted and approved by the Group Life Plan Underwriter until one of the following occurs, whichever is earlier.

- The date the Insured Person attains age 65.
- The date of the death or recovery of the Insured Person.
- The date the Master Policy is terminated.

Seat Belt Rider

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

Home Alteration and Vehicle Modification

If an Insured Person receives a payment for Quadriplegia, Hemiplegia or Paraplegia as outlined in the schedule of losses herein and was subsequently required (due to the cause for which payment under such 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 injured person's residence to make it wheelchair accessible and habitable; and
- B. The one-time cost of modifications, necessary to a motor vehicle owned by the injured person, to make the vehicle accessible or driveable for the Insured Person.

Benefit payments herein will not be paid unless:

- Home alterations are made on behalf of the Insured Person and carried out by an experienced individual in such alterations and recommended by a recognized organization providing support and assistance to wheelchair users; and
- Vehicle modifications are made on behalf of the Insured Person and carried out by an experienced individual in such matters and modifications are approved by the provincial vehicle licensing authorities.

The maximum payable under both Items A and B combined will not exceed \$15,000.

Educational Benefit

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

1. Pay the lesser of the following amounts to or on behalf of any dependent child who, at the date of accident, was enrolled as a full time student in any institution of higher learning beyond the 12th grade level:
 - The actual annual tuition, exclusive of room and board, charged by such institution per school year.
 - \$10,000 per school year.
 - 5% of the Insured Employee's Principal Sum.

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

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

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

2. Pay to or on behalf of the surviving spouse the actual cost incurred within 30 months from the date of death of the Insured Employee as payment for any professional or trades training program in which such spouse has enrolled for the purpose of obtaining an independent source of support and maintenance, but not to exceed a maximum total payment of \$10,000.

Day Care Benefits

If indemnity becomes payable under the policy for accidental loss of life of an Insured Employee, the Company will pay an amount equal to the lesser of the following amounts:

- The actual cost charged by such day care centre per year, or
- 3% of the Insured's Principal Sum, or
- \$5,000 per year,

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

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

In-Hospital Indemnity Benefit

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

- a monthly benefit of one (1) percent of the Insured's applicable Principal Sum; or
- for periods of less than one (1) month, one thirtieth (1/30) of the above monthly benefit per day.

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

This benefit is limited to:

- a monthly amount not to exceed \$1,000; and
- a total of twelve (12) months for any covered accident.

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

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

- holds a license as a hospital (if licensing is required in the province);
- operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;
- provides 24-hour-a-day nursing service by registered or graduate nurses;

- has a staff of one or more licensed physicians available at all times;
- provides organized facilities for diagnosis, and major medical surgical facilities; and
- is not primarily a clinic, nursing, rest or convalescent home or similar establishment nor is not, other than incidentally, a place for alcoholics or those addicted to drugs.

Permanent Total Disability Indemnity

When, as the result of injury and commencing within 365 days of the date of the accident, an Insured Person is totally and permanently disabled and prevented from engaging in each and every occupation or employment for compensation or profit for which he/she is reasonably qualified by reason of his/her education, training or experience, the Company shall pay, provided such disability has continued for a period of twelve consecutive months and is total, continuous and permanent at the end of this period, the Principal Sum less any other amount paid or payable under the Accidental Death and Dismemberment Indemnity Coverage of the policy as the result of the same accident.

Exclusions

The Accidental Death and Dismemberment benefit does not cover any loss resulting from:

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

How to file a claim

Contact the Administrator for the proper forms.

Wage Indemnity

For Employees Only

A benefit of \$447* per week or the maximum weekly payment provided under EI Sick benefits* whichever is greater, is payable if the Employee becomes unable to work while covered for this benefit, due to an accident, sickness or pregnancy, provided he/she is under the regular care of a doctor.

*The amount of benefit paid may not exceed 85% of the Employee's pre-disability earnings.

Accident

If the Employee becomes disabled due to an accident, benefits are payable from the 1st day of disability, provided he/she is under the regular care of a doctor.

Illness or Pregnancy

If the Employee becomes disabled due to illness or pregnancy, benefits are payable from the 4th day of disability provided he/she is under the regular care of a doctor.

Payments will continue as long as the Employee remains Totally Disabled, is under the regular care of a doctor, and is unable to perform any and every duty of his/her occupation, up to a maximum of 52 weeks from the date the benefits begin.

However, no benefits will be paid during any of the following periods:

- for any period while on a pregnancy leave of absence;
- for any period while on a parental leave of absence;
- for any period while engaged in any business or occupation for wages or profit;
- for any period while eligible for receipt of E.I. maternity benefits; or
- for any period while eligible for receipt of benefits under WCB or other occupational disease law.

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.

Limitations

No weekly benefit will be payable for any disability that resulted either directly or indirectly from, or was in any manner or degree associated with or occasioned by:

- intentionally self-inflicted injury while sane or insane;
- any cause which entitles application for and receipt of indemnity or compensation under any Workers' Compensation Act;
- insurrection or war, declared or undeclared, whether or not there is actual participation therein;
- participation in any riot or civil commotion;
- committing or attempting to commit a criminal offense or provoking an assault excluding offenses related to the operation of a motor vehicle with a blood alcohol content in excess of the legal limit in the province of residence of the covered Employee.

How to File a Claim

SEND CLAIM TO THE ADMINISTRATOR, DO NOT SEND CLAIM TO THE INSURANCE COMPANY.

To claim for Wage Indemnity benefits, a special claim form is required.

This form consists of the following sections:

- (a) Attending Physician's Statement
- (b) Employer's Statement
- (c) Employee's Statement

The Physician should complete the "Attending Physician's Statement" portion of the form. He or she must clearly indicate his or her diagnosis, date(s) of service and type(s) of service rendered.

The "Employer's Statement" should be completed by the employer. The date the Employee last worked must be shown on this form.

Remember! The claimant must be under the continuous personal care of a medical doctor to qualify for Wage Indemnity benefits.

Long Term Disability (L.T.D.)

For Employees Only

The Long Term Disability benefit provides a monthly benefit of \$1,500 for eligible Employees who are Totally Disabled, as defined below, for a continuous period of time in excess of 52 weeks.

Elimination Period

L.T.D. benefits start after 52 consecutive weeks of Total Disability, provided the Employee is covered for this benefit at the commencement of his/her disability. This period may be reduced or increased to coincide with the date of the last payment under the Wage Indemnity benefit.

Benefit Duration

Benefits will be paid as long as the Employee remains Totally Disabled, but not beyond age 65. No benefits, however, will be paid for a Total Disability resulting from :

- any period during which the Employee is not under the regular care and attendance of a legally licensed physician, who is a registered specialist in the field of medicine which is applicable to the disability or the Employee is not undergoing a course of medical treatment or participating in a program of rehabilitation which, in the opinion of the Insurer, is medically required.
- any period while on a pregnancy leave of absence.
- any period while in receipt of pregnancy benefits, parental leave benefits, pregnancy related sickness benefits or any combination of such benefits under the Employment Insurance Act.
- any period while eligible to receive a benefit from WCB or other occupational disease law.

Reductions

The total amount of monthly income an Employee receives from this benefit shall be reduced so that the total benefit from all sources shall not exceed 85% of his/her indexed pre-disability monthly earnings (if the benefit is taxable) or 85% of his/her indexed net pre-disability monthly earnings (if the benefit is non-taxable). All sources, as used in the preceding sentence includes this benefit in addition to benefits received due to this disability from:

- The Canada Pension Plan, Quebec Pension Plan (but does not include any benefits which apply to the Employee's spouse and child(ren) as a result of this disability)
- Any Workers Compensation Law, provincial disability law or any similar law

- Any government legislated no-fault automobile insurance plan including the Quebec Automobile Insurance Act, but only to the extent permitted by such legislation
- A pension or retirement plan of his/her Participating Employer or of a related employer
- Any benefit plan provided to the Employee by or through or administered by his/her Participating Employer or related employer which has not been referred to elsewhere
- Any group, association or franchise insurance plan which has not been referred to elsewhere
- Any plan or program of any government or of any sub-division or agency thereof which has not yet been referred to elsewhere
- Any plan or arrangement resulting in the payment of any salary, wage or other payment by any employer during the Employee's disability, whether such payment involves the rendering of services by the Employee or not
- Damages received from a third party arising out of the same circumstances that caused the disability.

If the Employee receives a lump sum settlement from any of the sources described above, the Employee's monthly income benefit under this benefit will be reduced by the amount that he/she would have normally received if the payments were being made on a monthly basis.

“Total Disability” and “Totally Disabled” mean...

- During the qualifying disability period and the first 24 months of Total Disability in a continuous period of disability thereafter, the complete incapacity, as determined by the Insurer, due to a medically determinable physical or mental impairment, as prevents the Employee from performing substantially all of the essential duties of his/her own occupation.
- Thereafter, in the same period of disability, the complete incapacity, as determined by the Insurer, due to a medically determinable physical or mental impairment, to earn more than 75% of his/her indexed pre-disability monthly earnings.

However, if the Employee engages in any occupation or business except as specifically provided in this benefit, he/she will be deemed to be no longer Totally Disabled.

Successive Disabilities

If an Employee receives benefits for a disability, returns to work, and again becomes Totally Disabled while covered, the later disability will be regarded as a continuation of the prior one unless he/she has been

back to full-time work for at least 6 months. However, if the later absence is due to an unrelated cause and he/she had returned to full-time work, it will be considered a new disability.

Most Disabilities Covered

The Plan covers most types of disability. It does not cover disability resulting from an act of war, intentionally self-inflicted injury, attempted suicide whether sane or insane, disability during imprisonment, participating in any riot or civil commotion; commission of, or an attempt to commit, a criminal offense or provoking an assault excluding offenses related to the operation of a motor vehicle with a blood alcohol content in excess of the legal limit in the province of residence of the Employee.

To Help Get Back To Work...

“A rehabilitation program” means a training or work related activity that can be expected to facilitate the Employee’s return to gainful employment.

Once an Employee has completed the qualifying disability period, he/she will be eligible to enter a rehabilitation program, if approved in advance by the Insurer, without the Insurer deeming that he/she has ceased to be Totally Disabled.

During participation in a rehabilitation program, the Employee’s monthly income benefit will continue, but it will be reduced so that the total of the monthly income being received under this benefit and the sources described in the Reductions section does not exceed 100% of the indexed pre-disability monthly earnings (after tax earnings if the monthly income benefit is non-taxable).

If the Employee participates in a rehabilitation program, his/her monthly income benefit will not terminate until the earliest of:

- age 65.
- the end of any period deemed to be reasonable by the Insurer.
- the date on which the Employee would otherwise cease to be Totally Disabled as defined in this benefit.
- the date on which the Employee would otherwise cease to receive a monthly income benefit from the Insurer.

The Insurer may pay the expenses incurred by the Employee, other than usual employment expenses, which are associated with the rehabilitation program, provided the expenses have been approved, in writing, by the Insurer prior to being incurred.

How to File a Claim

SEND CLAIM TO THE ADMINISTRATOR, DO NOT SEND CLAIM TO THE INSURANCE COMPANY.

To claim for Long Term Disability benefits, a special claim form is required.

This form consists of the following sections:

- (a) Attending Physician's Statement
- (b) Employer's Statement
- (c) Employee's Statement

The Physician should complete the "Attending Physician's Statement" portion of the form. He or she must clearly indicate his or her diagnosis, date(s) of service and type(s) of service rendered.

The "Employer's Statement" should be completed by the employer. The date the Employee last worked must be shown on this form.

Extended Health Care

For Employees and Eligible Dependents

The Extended Health Care benefit is designed to provide valuable supplementary protection to the provincial hospital and medical care plans. It is not intended to duplicate them. Therefore, the Extended Health Care benefits exclude services and supplies to the extent benefits can be obtained under a provincial plan by fulfilling the requirements of that plan, or services and supplies where private insurance is prohibited.

Benefits Paid

The insurance applies to expenses for the treatment of pregnancies, non-occupational accidents and illnesses.

The Plan will pay 90% of all eligible expenses incurred by the Employee or covered dependent, up to a maximum of \$1,000,000 per lifetime. At the end of each year, up to \$1,000 of this maximum, that has been paid in benefits, will be restored automatically.

Eligible Out of Canada expenses will be reimbursed at 100% up to and included in the overall EHB lifetime maximum of \$1,000,000. Coverage is limited to 60 days outside of Canada for emergency services.

There is a calendar year deductible of \$25 per individual or \$50 per family, applied only to prescription drugs and oral contraceptives. This deductible is applied only once a year, even if the individual has several accidents or illnesses.

Family Deductible Feature

If the total of \$50 of eligible expenses is incurred collectively by the family members during the calendar year, no further deductibles will be required on any of the family members for the rest of the year. But, not more than \$25 of any one individual's expenses may be applied toward the family deductible.

Deductible Carry-Over Provision

Expenses incurred in the last three months of a calendar year, which are applied to that year's deductible, may also be applied to the deductible for the next calendar year.

ELIGIBLE EXPENSES

(To the extent of expenses not excluded on account of provincial plans or other exclusions described later.)

- **Hospital charges** - In excess of the provincial hospital plan coverage for room and board and other services and supplies needed for medical care, excluding professional services. For a semi-private room, the eligible expenses for room and

board will not exceed the hospital's standard semi-private room rate. Private rooms will be covered only when certified medically necessary. Any hospital charge made for co-insurance and short stay charges in any province - where they are made and permitted by law.

“Hospital”: means a legally operated institution providing in-patient care and treatment through medical, diagnostic and major surgical facilities on its premises under supervision of a staff of doctors, and with a 24-hour-a-day nursing service; or one accredited as a hospital by the Canadian Council on Hospital Accreditation. In any event, an institution approved for resident in-patient care under a provincial hospital services program is considered a “hospital”. The term does not include any other institution, or part of one, used mainly as a facility for convalescence, nursing, rest, the aged, or care of drug addicts or alcoholics.

“Doctor” means physician or surgeon licensed to practice medicine and perform surgery - also any of the following practicing within the scope of his or her profession: licensed chiropractor, dentist, denturist, naturopath, optometrist, osteopath, podiatrist or psychologist. A psychologist is considered licensed if certified or registered in the jurisdiction in which he/she practices.

- **Outpatient Hospital Charges** Any hospital charge made for co-insurance and short-stay charges in any province where they are made and permitted by law.
- **Ambulance Services** Charges for emergency transportation to and from a hospital, provided the trip is in a professional ambulance to the nearest hospital qualified to provide the necessary treatment.
- **Private Duty Nursing** by a registered graduate nurse, licensed practical nurse, registered nursing assistant or similarly licensed person provided service is rendered outside a hospital.
- **Services by a registered clinical psychologist** - Diagnosis and treatment of mental, nervous or emotional disorders.
- **Services of a licensed chiropractor, massage therapist, naturopath, osteopath or podiatrist** - the eligible expenses not to exceed \$300 per calendar year, per practitioner category.
- **Treatment by a physiotherapist.**
- **Costs of Hearing Aids** for Employees only, when prescribed by a certified Ear, Nose and Throat Specialist to a maximum of \$500 in a 5-year period. Repairs, maintenance, batteries or other accessories

will not be considered an eligible expense.

- **Dental treatment due to an accident** - The following Dental services received within 24 months of an accident are eligible: Treatment by a physician, dentist or dental surgeon of injuries to natural teeth including replacement of such teeth, treatment of a fractured jaw, and related x-rays.
- **Vaccinations and Immunizations** for preventive treatment of communicable diseases.
- **Drugs and medicines** which require a prescription by law and are dispensed and recorded by a licensed pharmacist. Lifestyle drugs such as weightloss, smoking cessation or erectile dysfunction are not eligible expenses unless there is an underlying medical condition. ***Employees are encouraged to avail themselves of generic drugs wherever possible to help curtail the costs of the Plan.***

Employees, who are residents of British Columbia, are required by the Plan to register for Fair PharmaCare and provide proof of such registration to the Administrator. If such proof is not provided, the Plan may reduce or suspend benefits that may have been the responsibility of PharmaCare, had the Employee been registered under the program. To register for Fair PharmaCare, call 1-800-387-4977 or visit the Government of BC Website and follow the links to the BC PharmaCare site. www.gov.bc.ca

- **Oral contraceptive pills** prescribed by a doctor.
- **Speech therapy** by a qualified speech therapist, under certain conditions; artificial larynx.
- **Treatment by x-ray** or radioactive substances.
- **Anaesthesia.**
- **Blood and blood plasma.**
- **Artificial limbs and eyes.** Some maximums are applicable. Please contact the Plan Administrator for policy details.
- **Oxygen and rental of equipment** for its use.
- **Rental or, at the discretion of the Plan, purchase** of wheel chair, hospital type bed, iron lung or other durable equipment up to a lifetime maximum of \$10,000. For items in excess of \$5,000, a pre-authorization from the Plan must be obtained in advance of purchase/rental.
- **Casts; splints; braces; trusses; crutches; surgical dressings; electronic heart pacemaker.** Some maximums are applicable. Please contact the Plan Administrator for policy details.

- **Orthopaedic 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.
- **Convalescent Home Care.** Room and board charges for a maximum of 120 days during any one continuous period of confinement in a convalescent home provided such confinement:
 - occurs within 48 hours following a hospital stay of at least 3 consecutive days,
 - is for the same cause or causes as the preceding hospital stay,
 - has been recommended and approved, in writing, by a physician, and
 - is primarily for rehabilitation or convalescent care and not primarily for custodial care.

“Convalescent home” means an extended care facility, such as a sanatorium or skilled nursing home or a special wing or ward of a hospital which is licensed by the appropriate licensing authority and which provides supervision by registered nurses 24 hours per day.

- **X-ray examinations and other diagnostic laboratory services.**

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

A benefit of \$400 per Employee/spouse and \$350 per eligible dependent child is available for reimbursement of any one pair of eyeglasses in any 24-consecutive month period, including charges for examinations (when not covered by the provincial plan), frames, lenses, and dispensing fees. This limit also applies to contact lenses purchased in lieu of eyeglasses unless the contact lenses are the only means available to restore the visual acuity of the better eye to at least 20/70 or are purchased following cataract surgery.

Please note that charges incurred in connection with sunglasses (whether or not prescription) or safety glasses are not a covered expense. However, prescription safety glasses are an eligible expense.

LASER EYE SURGERY EXPENSES

For Employee’s only, expenses for Laser Eye Surgery will be reimbursed at 100% to a lifetime maximum of \$1,500.

EXPENSES INCURRED WHILE OUTSIDE CANADA

Emergency hospital, medical, surgical, Dental and other similar expenses incurred by an Employee or

his/her eligible insured dependents while travelling on vacation or business outside of Canada will be eligible under this Plan, just as they are while in Canada. (Provided it is within 60 days of leaving Canada) This benefit is provided through Viator Out-of-Province/Canada Travel Medical Emergency Insurance Policy #32445291, through Expert Travel Financial Security (E.T.F.S.). In the event of an emergency the insured must immediately contact Global Excel (the company appointed to provide medical assistance and claims services). Global Excel will open a claim file, assist in locating proper medical care, verify coverage and assist in co-ordinating payment of the claim with the Provincial Medical Plan and the Plan's policy. A Medical Assistance Card, with worldwide contact numbers, for the Viator Emergency coverage should be carried by the Insured when travelling. These cards can be obtained from the employer or Administrator. Full details of the Out-Of-Province/Canada coverage can be obtained on the NDT Industry web-site www.ndtbenefits.org. Employees working outside of Canada must arrange for additional coverage.

Before submitting claims for such expenses, they must be submitted to the Provincial Medical Plan for payment. To the extent that expenses are reasonable and customary (relative to charges in the area in which they were incurred) and there remains a balance unpaid by the Provincial Medical Plan, it will be payable under the terms of this Plan, provided payment of the charges is allowed by law. Coverage for Out-Of-Country/Province terminates at age 75.

EXTENSION OF BENEFITS

Under certain circumstances, as described in the Group Policy, Extended Health benefits will be available for 3 months after the termination of insurance, if that Employee is Totally Disabled when the insurance terminates. This extension of benefits will apply only to expenses due to the sickness or injury which caused the Total Disability.

BENEFIT EXCLUSIONS

- Services or supplies to the extent benefits are provided under any provincial plan or other government plan or law under which the individual is or could be covered, or to the extent to which benefits would be provided had the individual met the requirements for having the care or services furnished under the plan or law.
- Services or supplies for which insurance benefits are prohibited by any provincial plan or other government plan or law.
- Charges incurred in connection with an injury or disease related to employment.

- Certain expenses, as described in the group policy, incurred for government furnished care or treatment.
- Anything not ordered by a doctor, or not necessary for medical or vision care.
- The portion of a charge in excess of the reasonable and customary charge (the usual charge when there is no insurance) not to exceed the prevailing charge in the area for a comparable service by a person of similar training and experience, or for a comparable supply.
- Expenses for cosmetic surgery unless due to an accident occurring while covered.
- Treatment of periodontal or periapical disease or any condition involving teeth, surrounding tissue or structure, except as described in "Dental treatment due to accident".
- Examinations in connection with glasses except as described in "Vision Care".
- Charges for "check-ups" (including screening, routine physical examinations, and research studies) unless part of an illness, injury or pregnancy (including pre- and post-natal care).
- Telephone consultations.
- Nursing, speech therapy, or physiotherapy rendered by the Employee, Spouse, or a child, brother, sister, or a parent of the Employee or Spouse.
- Vitamins, minerals, foods and dietary supplements whether or not a prescription is given for a medical reason.
- Services of an acupuncturist.
- Services/supplies received as a result of participation in a riot or civil commotion.
- Services/supplies received as a result of the commission of or attempted commission of a criminal offense or the provoking of an assault excluding charges in connection with offenses related to the operation of a motor vehicle with a blood alcohol content in excess of the legal limit in the province of residence of the Insured.
- Services/supplies received due to intentionally self-inflicted injury while sane or insane.
- Charges for which recipient is not required to make payment or where payment is received as a result of legal action or settlement.
- 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.

- Charges for, or in connection with, any services received or performed outside of Canada which (i) are due to a pregnancy (includes childbirth, miscarriage, or any complications incident to a pregnancy) and which are received or performed after the 32nd week of gestation or (ii) are due to the deliberate inducement of a miscarriage.

How to File a Claim

A claim form for Extended Health Benefits must be completed for each person in the family who has eligible expenses. Specify the dependent's name, the Employee's name, address, policy number, Social Insurance Number/certificate number and list receipts.

Both the original receipts and the forms should be sent to the Administrator. Although claims for Extended Health Benefits can be made at any time, it would be preferable if they were sent every two or three months. Only receipts for the current and previous calendar year are payable.

Dental Care

For Employees and Eligible Dependents

The Plan covers certain Dental expenses incurred by Employees and their eligible dependents, subject to the co-insurance arrangements described below. The schedule of fees to be used is that which is in effect in the Employee's province of residence on the date the service is rendered. The benefits are provided under three categories:

Basic Services	100% reimbursement
Major Services	100% reimbursement
Maximum of \$2,000 per person/calendar year for Basic and Major Services combined	
Orthodontia	50% reimbursement
Maximum of \$2,000/24 months per eligible dependent child	

Examples of each and the rules applying to each appear below.

Definition of a Dentist

The term "dentist" means a legally qualified dentist, practicing within the scope of his or her license. For the purposes of this Plan, the term "dentist" also includes a legally qualified physician authorized to perform the particular service rendered, a denture technician, denturologist, denturist, licensed dental hygienist or dental mechanic, practicing within the scope of his or her license.

Many Dental conditions can properly be treated in more than one way. This Plan is designed to help pay Dental expenses, but not on the basis of treatment that is more expensive than necessary for good Dental care.

Therefore, if the condition is being treated for, and two or more services included in the schedule are suitable under customary Dental practices, the benefit paid by the Plan will be based on the least expensive of services.

Pre-determination of Benefits

Pre-determination of benefits permits the review of the proposed treatment in advance and allows for resolution of any questions before, rather than after, the work has been done. Additionally, both the Insured and the dentist will know in advance what is covered and what the Plan will pay, assuming the Employee or the dependent remains covered.

If the treatment that the dentist is proposing will cost more than \$1,000, the dentist's Treatment Plan must be submitted to the Plan Administrator for prior review. No Treatment Plan is required if the proposed treatment is for emergency care. A Treatment Plan is required for all Major and Orthodontia services.

A "Treatment Plan" is the dentist's report that (a) details the recommended services, (b) shows the charge for each service, and (c) is accompanied by supporting x-rays.

What an "Eligible Charge" Is

An "eligible charge" is one the dentist makes to the Insured for a covered Basic or Major Dental service furnished to him or her or a covered dependent, provided the service:

- is in the applicable Fee Schedule;
- is part of a "Treatment Plan" as described above, and
- is not excluded by the section "Limitations" which follows.

The amount of the eligible charge for a covered service, with the exception of Orthodontia, is equal to the charge made by the dentist, but not to exceed the amount provided for that service in the applicable Fee Schedule.

A charge will be considered to be incurred on the date the service is received, rather than on the date the charge is made.

The following is an outline of the types of eligible expenses and the level of payment within the Plan:

BASIC SERVICES – paid at 100%*

Visits and Examinations

- Standard or recall examinations (limited to one per calendar year, two per calendar year for children up to their 13th birthday)
- Visits during office hours to treat injuries (other than for routine operative procedures)
- Prophylaxis - including scaling and polishing (limited to twice yearly)
- Topical application of fluorides (limited to twice yearly)
- Emergency palliative treatment
- Consultation by specialist when diagnosis has been made by general dentist

X-Rays and Pathology

- Single film
- Additional films (up to 12)
- Complete series - 14 or more films (limited to once every 3 years)
- Bitewings (limited to twice yearly)
- Biopsy and examination of oral tissue
- Microscopic examination

Restorations

Amalgam and composite restorations only if necessitated by decay or traumatic injury

Oral Surgery (including local anaesthesia and routine postoperative care)

- Extractions
 - Uncomplicated
 - Surgical removal of erupted and impacted teeth
 - Postoperative visits (sutures and complications) after multiple extractions and impaction
- Other Oral Surgery
 - Incision and drainage of abscess
 - Removal of cyst or tumor
 - surgical exposure of tooth
 - Alveoloplasty
 - Gingivoplasty and/or stomatoplasty
 - Osteoplasty
 - Frenectomy
 - Alveoplasty
 - Maxillary sinusotomy for removal of tooth fragment or foreign body
 - Suture, soft tissue injury

Periodontics

- Subgingival curettage, root planing (limited to 16 units per year)
- Gingivectomy

Endodontics

- Pulp capping
- Root canals (including necessary x-rays and cultures)
- Apicoectomy

Denture Repairs (Acrylic)

- Denture rebasing and relining (limited to once every two years)
- Adding teeth to partial denture to replace extracted natural teeth, only if teeth extracted while insured under this Plan.

Space Maintainer, Fixed (Band Type) limited to children under 21 years of age.

General Anaesthesia (Only with oral surgery)

MAJOR SERVICES – paid at 100%* with the exception of (a), (b) & (c) below.

As an exception a maximum reimbursement not to exceed 70% of the amount shown in the Fee Schedule will apply if:

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

Inlays and Crowns – (Not covered if teeth can be restored with a filling material)

- Inlays and onlays
- Crowns - Acrylic, acrylic with metal, porcelain, porcelain with metal, gold, gold dowel pin, veneers and metal post and core.

Pontics (Artificial teeth)

Cast gold, porcelain fused to gold, plastic processed to gold.

Removable Bridge (Unilateral)

One piece casting, gold or chrome cobalt alloy clasp attachment (all types)

Dentures (Specialized techniques not eligible)

- Complete upper or lower
- Partial dentures
- Partial denture repairs limited to twice in a calendar year.

* **The maximum benefit payable for Basic and Major services (combined) is \$2,000 per Insured person per calendar year.**

ORTHODONTIA – paid at 50%

To be eligible for this benefit, the Employee must have been covered for at least 3 consecutive months. This benefit applies to Orthodontia (teeth straightening) treatment for an eligible dependent child who is under the age of 21.

Eligible expenses will be reimbursed up to 50% with a maximum benefit of \$2,000 per eligible dependent child, each 24-month period.

A “Treatment Plan” must be submitted, as outlined previously.

The Plan will not pay for a Treatment Plan for which an active appliance was installed before the patient becomes eligible for Orthodontia benefits.

Limitations:

Please note the following exclusions:

- Anything not furnished by a dentist, except x-rays ordered by a dentist. Anything not necessary or not customarily provided for Dental care.
- Services (a) furnished by or for any government unless payment is legally required, or (b) to the extent provided under any government program or law under which the individual is, or could be covered.
- A denture or fixed bridge involving replacement of teeth extracted before the individual was covered, unless it also replaces a tooth that is extracted while covered, and such tooth was not an abutment for a denture or fixed bridge installed during the preceding five years.
- Services due to an accident related to employment or disease covered under Workers' Compensation or similar law.
- Replacement of lost or stolen appliances or restorations for the purpose of splinting, or to increase vertical dimension or restore occlusion.
- Any portion of a charge for a service in excess of the applicable Provincial Dental Regulatory Authority Fee Schedule.
- Services for cosmetic purposes unless made necessary by an accident occurring while covered. (Facings on crowns or pontics, posterior to the second bicuspid, are always considered cosmetic, as are plastic, porcelain, or other materials fused to gold on molar crowns or pontics).
- Services due to war, insurrection, participation in a riot or civil commotion, commission of or attempted commission of, a criminal offense or provoking an assault excluding charges in connection with offenses related to the operation of a motor vehicle with a blood alcohol content in excess of the legal limit in the province of residence of the Insured, or a self-inflicted injury.
- Recent duplication of services by same or different dentist.
- Endodontics and coping with respect to over-denture.
- Treatment which was furnished or commenced prior to the date insured under the Plan.

If a particular charge is covered under the Dental Insurance and also under another part of the Plan, the Dental Insurance payment will be limited to the excess, of any of the amount normally paid by that insurance over the amount paid by the other benefit.

HOW TO FILE A CLAIM

A claim form for Dental expenses must be completed for each insured person in the family who has eligible expenses. Specify the dependent's name, the Employee's name, address, policy number and Social Insurance Number/certificate number.

Both the receipts and the forms should be sent to the Administrator. Claims should be submitted once the course of treatment has been completed.

COORDINATION OF BENEFITS

The purpose of Extended Health Care and Dental insurance is to help meet actual expenses. In line with that purpose, the Plan contains a non-profit provision. As a result, benefits under this Plan may be reduced so that benefits from all plans do not exceed the actual expenses. "Plans" includes medical and Dental care benefits under a law or government program, group insurance or other coverage for a group of individuals, including student coverage obtained through an educational institution above the high school level.

FORMS

All forms can be obtained from:

1. Your Employer
2. The Administrator:
D.A. Townley & Associates Ltd.
#101 - 4190 Lougheed Highway
Burnaby, B.C. V5C 6A8
Telephone: 604-299-7482
Toll Free: 1-800-663-1356
Facsimile: 604-299-8136
Email: NDTHealth@datownley.com
3. From the Plan's website:
www.NDTbenefits.org

THE MINI PLAN

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

Life Insurance

For Employees \$75,000

Accidental Death & Dismemberment

For Employees \$75,000

ELIGIBILITY

Q.C.C.C. Members will become covered as of the date he/she commences working for a Participating Employer, regardless of the number of hours worked, provided the employer makes the appropriate contributions to the Plan. Coverage will be provided until the end of the calendar month following the date of employment, provided he/she does not qualify for the Full Benefit Plan in the meantime.

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

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

NOTE: If the Employee earned fewer than 120 hours with one employer (Mini Plan), but 120 hours with 2 or more employers, he/she may be eligible for the Full Benefit Plan. Please contact the Administrator for details.

TERMINATION

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

DESCRIPTION OF BENEFITS

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

NOW THAT YOU HAVE READ THIS BOOKLET

REMEMBER – this is not the policy. The booklet is designed to explain the provisions of the Plan which are of most general interest. Not all of the Plan's details are included. The extent of the insurance for each individual is governed at all times by the master group insurance policies issued to the Trustees. If you have any questions regarding the Plan, or if you would like to find out about any matter affecting your status in it, write to the Administrator.

D.A. TOWNLEY & ASSOCIATES LTD.

Administrator
Suite 101 - 4190 Lougheed Highway
Burnaby, British Columbia
V5C 6A8

Telephone: 604-299-7482
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- Notes -

1M May/08

