NDT Benefits

Career — Health — Security

NDT INDUSTRY HEALTH BENEFIT PLAN

POST-RETIREMENT BENEFITS

Address all inquiries to:

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*Including amendments to: January 1, 2024

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 D.A. Townley.

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

The Trustees are constantly attempting to provide benefits to the Retired Members in the most cost-effective manner. For some benefits such as Dental and the Extended Health Benefit, it is not always necessary to use the services of an insurance company. Consequently, some benefits provided 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 Retired 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 a Retired 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 the Retired 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

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

RETIRED MEMBERS:

Life Insurance	$10,000

RETIRED MEMBERS AND THEIR DEPENDENTS:

TELUS Health Virtual Care	See this Section of the booklet for details
Extended Health Benefits	Reimbursement: 90% of eligible expenses Dispensing fee limited to $8.00 per prescription Prescription Drug Maximum of $5,000 per person per calendar year Lifetime Maximum: $1,000,000 Calendar Year Deductible: $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 80 Pre-Existing Medical Condition Stability Period: 180 days
Vision	$350 per 24 consecutive month period includes eye examinations
Dental	Calendar Year Deductible: Nil Reimbursement: 100% Basic Services 100% Major Services Combined Annual Maximum: $2,000 per family, per calendar year

ELIGIBILITY

Retired Members will be eligible for coverage immediately following Normal Retirement Age, provided the following eligibility requirements are met. A Member must:

- retire and select an option under the NDT Industry Pension Plan;
- must have uninterrupted service in the 10 years prior to retirement;
- have a minimum of 10,000 credited hours in the NDT Industry Pension Plan, and in the 5-year period immediately preceding the retirement date have contributed 3,750 hours to the Retiree Plan through employment with a signatory employer;
- be covered under the NDT Industry Health Benefit Plan, at the time of retirement (including self-paid coverage);
- be age 60 or over; and
- be a Member in Good Standing of the Quality Control Council of Canada (QCCC) at the time of retirement and remain a Member in Good Standing, during retirement, as deemed by the QCCC and not engage in any work under the scope or jurisdiction of the QCCC with a non-signatory employer.

Members who were on Long Term Disability or Workers Compensation Benefits immediately preceding retirement will be eligible for coverage provided the following requirements are met. A Member must:

- retire and select an option under the NDT Industry Pension Plan;
- have a minimum of 10,000 credited hours in the NDT Industry Pension Plan, and in the 5-year period immediately preceding the disability date have contributed 3,750 hours to the Retiree Plan through employment with a signatory employer;
- be covered under the NDT Industry Health Benefit Plan, at the time of retirement (including self-paid coverage);
- be age 60 or over; and
- be a Member in Good Standing of the QCCC at the time of retirement and remain a Member in Good Standing, during retirement, as deemed by the

QCCC and not engage in any work under the scope or jurisdiction of the QCCC with a non-signatory employer.

Members retiring early, who are age 55 or over, may also be entitled to coverage by self-paying the premiums until age 60 – the Member must contact the Administrator for details. Coverage on a self-pay basis must be continuous.

Members Wishing to Transition to a Management Role

Members wishing to transition to a management role and remain eligible for Post-Retirement Benefits when they retire, at the time they make the transition to the management role, they must contact the Administrator to indicate they wish to participate in the Plan when they retire. The Administrator will confirm whether they meet the following criteria and make a note on system to that affect.

Eligibility Criteria:

At the time of making the transition to a management role

- they must have 10,000 credited hours in the NDT Industry Pension Plan;
- they must have 10 years uninterrupted service immediately prior to the transition;
- they must be a Member of the NDT Industry Health Benefit Plan and remain a Member of the NDT Industry Health Benefit Plan;
- they must be a Member in Good Standing of the QCCC and remain a Member in Good Standing and not engage in any work under the scope or jurisdiction of the QCCC with a non-signatory employer; and
- they must continue to have a minimum of 173 hours credited monthly on their behalf to the NDT Industry Pension Plan and the Post-Retirement Benefit Plan.

Dependent Eligibility

Eligible Dependents will be covered on the Retired Member's effective date, provided dependent coverage is applied for. Newly acquired Dependents must be enrolled within 31 days of becoming eligible.

Eligible Dependents are:

- Your legal spouse

- Your common-law spouse (The common-law spouse is a person with whom you have 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 *Post-Retirement Benefit Plan Application for Enrolment and Beneficiary Designation Form* must be completed and submitted to the Plan Administrator.)
- Your unmarried children to age 21, who are dependent upon you
- Your unmarried children age 21 or over, who are in full-time attendance at a recognized college or university and depend wholly on you for support and maintenance.

Coverage for a child who is incapable of self-support as a result of mental or physical handicap and who is dependent upon you for support and maintenance, will not terminate based on their attaining the maximum age, provided you make application to the Plan Administrator for continued coverage and provide evidence satisfactory to the Plan.

Termination by Age

Coverage terminates on the date you attain age 80 for the Life Insurance benefit, the Medical Referral benefit, and the Out of Province/Canada Emergency Medical Travel Insurance coverage, unless otherwise specified in the policy. There is no termination due to age for the Extended Health Care and Dental benefits.

Dependent coverage for a Child (non-student) terminates upon attaining age 21. Coverage for a Child (full-time student age 21 or older) terminates when the full-time student and/or Dependent status ceases.

Survivor Benefits

When a Retired Member dies, dependent coverage under this Plan will continue until the earliest of the following:

- 24 months from the date of the Retired Member's death;
- the date the person ceases to be a Dependent other than as a result of the Retired Member's death; or
- the date the Plan is terminated.

DESCRIPTION OF BENEFITS
LIFE INSURANCE

For Retired Members Only

Each eligible Retired Member 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.

You may change your beneficiary at any time by written notice to the Administrator, along with a newly completed *Post-Retirement Benefit Application for Enrolment and Beneficiary Designation Form.*

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

Life Insurance coverage terminates on the date you attain age 80.

TELUS HEALTH VIRTUAL CARE

For Retired Members and Eligible Dependents

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

This care is intended to provide you with added convenience and is not intended to replace emergency care provided by a hospital or ambulance, nor is it intended to replace your family physician.

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 wallet 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.

EXTENDED HEALTH BENEFITS

For Retired Members and Eligible Dependents

Eligible in-Canada expenses will be reimbursed at 90%, up to a maximum of $1,000,000 per lifetime, except as where otherwise specified.

Out of Province/Canada Emergency Medical Travel Insurance and Medical Referral coverage are provided to eligible Retired Members and their dependents under age 80 up to a maximum of $5,000,000 per coverage period.

Prescription Drugs are reimbursed up to a maximum of $5,000 per person per calendar year.

There is a calendar year deductible of $25 per individual or $50 per family. 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 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.

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) Drugs and medicines (including oral contraceptives) which require a prescription by law and are dispensed by a licensed pharmacist, up to a maximum of $5,000.00 per calendar year.

Reimbursement of prescription drugs is based on the cost of the lowest priced generic equivalent drug. 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.

Dispensing fees over $8.00 per prescription are not covered by the Plan. The difference in the charged dispensing fee and the $8.00 dispensing fee cap, is the responsibility of the insured.

- Lifestyle drugs such as weight loss, smoking cessation or erectile dysfunction are not eligible expenses unless there is an underlying medical condition.
- Drugs and medicines that can normally be purchased "over the counter" are excluded regardless of a prescription having been issued.

BC Residents must register for Fair PharmaCare. Fair PharmaCare covers a comprehensive list of drugs and medical supplies and, once registered, all Fair PharmaCare eligible drugs and supplies that your family is prescribed and fills are applied toward your family's annual Fair PharaCare deductible. Once the deductible is met, Fair PharmaCare will reduce up to 70% of the cost of eligible drugs and medical supplies for your family for the balance of the year. 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.

2) Hospital charges made by an approved acute general hospital in your province of residence, for the difference between ward cost and semiprivate room. For a semiprivate 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 by a physician, for private accommodation (not including rental of telephone, T.V. etc.).

3) Out-Patient hospital charges. Any hospital charge made for co-insurance and short-stay charges in any province where they are made and permitted by law.

4) 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.

5) 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, to a lifetime maximum of $25,000.

6) Services of a Licensed Chiropractor, Speech Therapist, Naturopath, Registered Massage Therapist, Osteopath, Podiatrist, Psychologist or Physiotherapist - the eligible expenses not to exceed $400 per calendar year, per practitioner type, provided the practitioner is registered and legally practicing within the scope of their license. Psychology services must be provided by a Registered Psychologist, Registered Clinical Counselor or a Licensed Social Worker.

7) Cost of Hearing Aids for Retired Members only, 6 to a maximum of $500 in a 5-year period. Repairs, maintenance, batteries or other accessories will not be considered an eligible expense.

8) 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.

9) Vaccinations and Immunizations for preventive treatment of communicable diseases.

10) Treatment by x-ray or radioactive substances

11) Anesthesia.

12) Blood and blood plasma.

13) Artificial limbs and eyes and under certain conditions artificial larynx.

14) Oxygen and rental of equipment for its use.

15) Rental of wheelchair, hospital type bed, iron lung.

16) Casts; splints; braces; trusses; crutches; surgical dressings; electronic heart pacemaker. Some

maximums are applicable. Please contact your Plan Administrator for policy details.

17) 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 orthopaedic shoes that are not part of a brace or splint are prescribed by a doctor, 50% of their cost will be eligible.

18) Convalescent Home Care: Room and board charges for a maximum of 120 days during any one continuous period of confinement in a convalescent home, to a lifetime maximum of $25,000, 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 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.

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

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.
- Physiotherapy, Massage Therapy or Chiropractor expenses incurred as a result of a motor vehicle accident.
- Medical Marijuana, in any and all of its forms.
- 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 yourself, spouse, or a child, brother, sister, or a parent of yourself 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 covered Individual.

- 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 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.

Medical Referral Benefit

(Termination Age: 80)

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 Retired Members 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.

Termination Age: 80

Pre-Existing Medical Condition Stability Period: 180 days

Coverage Period: 60 days per trip

Policy Number: DAT00013354

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**

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.

VISION CARE

For Retired Members and Eligible Dependents

$350 for any one pair of eyeglasses in any 24 consecutive month period, including charges for examinations (when not covered by your 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.

DENTAL

For Retired Members 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.

Percentage payable:

100% Basic Services
100% Major Services
Deductible: Nil
Combined Calendar Year Maximum: $2,000/family

Definition of a Dentist
The term "Dentist" means a legally qualified Dentist, practicing within the scope of their 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, Denturist, Licensed Dental Hygienist or Dental Mechanic, practicing within the scope of their 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 a 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-Treatment Estimate of Major Restorative 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.

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 a Retired Member or a covered Dependent, provided the service:

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

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.

BASIC SERVICES – paid at 100% (up to the Plan maximum)

Visits and Examinations

- Standard or recall examinations (limited to one per calendar year, two per calendar year for children up to their 13th birthday)
- Visit 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 less than 21 years of age.*

General Anesthesia *(Only with oral surgery)*

MAJOR SERVICES – paid at 100% with the exception of (a), (b), and (c) below (up to the Plan maximum)

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 a natural tooth or teeth;

(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 family per calendar year.

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

Receipts for Extended Health and Vision expenses can be submitted for reimbursement directly (does not apply to Dental claims) through the **D.A. Townley** *My Claims* portal or mobile app (see page 23 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, D.A. Townley will comply with the Canadian Life and Health Insurance Association (CLHIA) guidelines in effect on the date the Eligible Expense was incurred.

2) If the Retired Member 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 Retired Member 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 Retired Member will provide the information required to implement this provision. It is the Retired Member'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 Number (found on your wallet card)

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

* the D.A. Townley ***My Claims*** portal or mobile app
* by email to **health@datownley.com**
* by fax to (604) 299-8136
* mail to: **NDT Industry Health Benefit Plan**
  4250 Canada Way
  Burnaby BC V5G 4W6

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 on the D.A. Townley website at **www.ndtbenefits.org.**

You can also use the **D.A. Townley *My Claims*** portal or mobile app - click on the Person icon on the top navigation. Go to Update Direct Deposit and enter your banking information (this can be found on the bottom of a personal cheque, from your online banking app or by calling your financial institution directly.)

D.A. TOWNLEY MY CLAIMS PORTAL and MOBILE APP

Go to: **www.datownley.com/myclaims/** and look for Online Registration in the resources section on the right side of the page. Click on the link. Complete all the required fields and acknowledge that you have read the terms and conditions.

Click on the Submit button and it will automatically direct you to the ***My Claims*** portal. Set up your account on the ***My Claims*** portal by clicking on Register Account. Enter your group number (52567) and your Client ID number from your wallet card, along with your postal code and date of birth. Then click Next. Set up your username and password.

Please note: you can only create one username and password for the same coverage. Then click Sign Up and accept the terms and conditions. Now you can download the free **D.A. Townley *My Claims*** app by visiting the App Store for IOS devices or Google Play for Android devices. Once downloaded, register your account on the portal and app, then you are ready to sign in using your username and password that you assigned.

RIGHTS TO INFORMATION

Under insurance standards regulation, such as the *Insurance Act* (BC), employees are entitled to request certain information regarding insured benefits (Life Insurance and 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 D.A. Townley.

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
#177272
Life Insurance

NDT Industry Health Benefit Plan
#52567
Extended Health Benefits
Vision Care
Dental

Manulife Group Travel Insurance
 # DAT00013354
Global Excel Management Inc.
Out of Province/Canada Emergency
Medical Travel Insurance
Medical Referral Benefit

TELUS Health
#4242
TELUS Health Virtual Care

THE ADMINISTRATOR

D.A. Townley

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4250 Canada Way
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Email: health@datownley.com (Claims)
Email: ndt@datownley.com (Administration)
www.ndtbenefits.org