QUALITY CONTROL COUNCIL OF CANADA
NATIONAL POST RETIREMENT
BENEFIT PLAN

Life Insurance
Extended Health Care
Vision Care
Dental Care

Classes R1, R2, R3, R4 and R5
National Post Retirement Members
Policy No. 161133 & 52567

Administered by:

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Effective May 1, 2003 with amendments to January 2016
This Plan Document explains, in general terms, the plan of benefits and coverage in effect. It is not to be considered a contract of insurance. The complete terms of the Plan are set forth in the group policy.

**Eligibility**

Eligible Retired members will be covered immediately following normal retirement age, provided a Group Insurance Enrolment Card has been completed and submitted to the Administrator and the following requirements are met. A member must:

- retire and select an option under the NDT Pension Plan;
- must have uninterrupted service in the 10 years prior to retirement,
- have a minimum of 10,000 credited hours in the NDT Pension Plan, and in the 5 year period immediately preceding the retirement date have contributed 3,750 hours to the Plan through employment;
- be covered under the Full plan under the NDT Industry Health Benefit Plan, at the time of retirement (including Lay-off or Self-paid coverage);
- be a member in good standing of the UA or Boilermakers;
- have paid into the Retiree Fund; and
- be age 60 or over

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

**Eligibility For Continued Payment of Union Dues**

One of the Plan qualifications is that a retiring Member continues to be a Member in good standing of the either of the Participating Unions. To be eligible to continue to pay Union Dues while accessing the Retiree Plan, a Member must have maintained uninterrupted service through the Union prior to retirement.

Uninterrupted service is defined as at least 500 hours of work through the Quality Control Council of Canada in each of the 10 years immediately preceding the Member’s date of retirement.

Eligible dependents will be covered on the employee’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
- 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.

Attainment of the limiting age shall not terminate the 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.
**TERMINATION BY AGE**

Coverage terminates on the date you attain age 80 for the Life Insurance benefit, unless otherwise specified in the policy. There is no termination due to age for the Extended Health Care benefit.

Dependent coverage terminates on the date of your death, unless otherwise specified in the policy. Coverage for a Child (non-student) terminates at attained age 21. Coverage for a Child (student) terminates when full-time student status ceases.
LIFE INSURANCE

BENEFIT SUMMARY

| Amount of Insurance | $10,000 | Policy 161133 |

For Employees Only
Your Life Insurance is payable in the event of your death from any cause, at any time or place while you are insured. Payment will be made in a lump sum to the beneficiary designated by you. You may change your beneficiary at any time by written notice to the Administrator, subject to any legal restrictions.

EXTENDED HEALTH CARE

BENEFIT SUMMARY

<table>
<thead>
<tr>
<th>Percentage payable:</th>
<th>Policy 52567</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reimbursement: 90%</td>
<td></td>
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<tr>
<td>Deductible: $25/single $50/Family</td>
<td></td>
</tr>
<tr>
<td>Drug reimbursement: Maximum of $3,000.00 per calendar year</td>
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<tr>
<td>NO OUT OF COUNTRY COVERAGE</td>
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<tr>
<td>Overall maximum: $1,000,000 per lifetime</td>
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For Employees and Dependents

This Plan supplements provincial plans.

It is designed to provide valuable supplementary protection, but not to duplicate the provincial hospital and medical care plans under which an individual is or could be protected or benefits eligible under WCB. Therefore, Extended Health 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 sicknesses.

The Plan will pay 90% of all eligible expenses incurred by you or a covered dependent, up to a maximum of $1,000,000 per lifetime.

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

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.

- **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.

- **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., to a lifetime maximum of $25,000.

- **Services by a registered clinical psychologist** - Diagnosis and treatment of mental, nervous or emotional disorders.

- **Services of a licensed chiropractor, naturopath, registered massage therapist, osteopath or podiatrist** - the eligible expenses not to exceed $400 per calendar year, per practitioner.

- **Services of licensed physiotherapist**

- **Cost of Hearing Aids** for Retired 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 no 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 dispensed by a licensed pharmacist to a maximum of $3000.00 per calendar year. Lifestyle drugs such as weightloss, smoking cessation or erectile dysfunction are not eligible expenses unless there is an underlying medical condition. **Individuals are encouraged to avail themselves ofgeneric drugs wherever possible to help curtail the costs of the Plan.**

• **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** of wheel chair, hospital type bed, iron lung.

• **Casts; splints; braces; trusses; crutches; surgical dressings; electronic heart pacemaker.** Some maximums are applicable. Please contact your 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 orthopaedic 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, 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.

• **X-ray examinations and other diagnostic laboratory services.**
VISION CARE

$275 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.

EXPENSES INCURRED WHILE OUTSIDE CANADA

There is no out of country coverage on this plan.

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 you or a covered dependent are 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 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 a massage therapist or accupuncturist.

• 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 Insurer 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.

**DENTAL CARE**

<table>
<thead>
<tr>
<th>Percentage payable:</th>
<th>Maximum payable:</th>
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<tbody>
<tr>
<td>90% Basic Services</td>
<td>Annual Maximum of $2,000 per family</td>
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<tr>
<td>90% Major Services</td>
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**Deductible:**

- Single Nil
- Family Nil
**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 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-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 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.

*The following is an outline of the types of eligible expenses and the level of payment within the Plan:*
BASIC SERVICES – paid at 90%*

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 under 21 years of age.**

**General Anaesthesia (Only with oral surgery)**

**MAJOR SERVICES** – paid at 90%* 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
(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**
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.
NOW THAT YOU HAVE READ THIS BOOKLET

Remember - this is not the policy. The booklet is designed to tell you about 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 on the Plan, or if you would like to find out about any matter affecting your status in it, write to the administrator:

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