QCCC National Post-Retirement Benefit Plan

Life Insurance ***GWL Policy No. 177272***

Extended Health Care ***Policy No. 52567***

Out of Canada Emergency ***RSA Policy No. 1170150***

Vision Care ***Policy No. 52567***

Dental Care ***Policy No. 52567***

Administered by:

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This brochure 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

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 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 Retiree Plan through employment with a signatory employer;
- 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 age 60 or over;
- be a Member in Good Standing of the UA or Boilermakers at the time of retirement and remain a Member in Good Standing, during retirement, as deemed by their home UA or Boilermaker Local or Lodge and not engage in any work under the scope or jurisdiction of the QCCC with a non-signatory employer; and
- sign and return to the Administrator, the *Acceptance of the Terms of Plan Eligibility* form.

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 Pension Plan;
- have a minimum of 10,000 credited hours in the NDT 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 Full Plan under the NDT Industry Health Benefit Plan, at the time of retirement (including self-paid coverage);
- be age 60 or over;
- be a Member in Good Standing of the UA or Boilermakers at the time of retirement and remain a Member in Good Standing, during retirement, as deemed by their home UA or Boilermaker Local or Lodge and not engage in any work under the scope or jurisdiction of the QCCC with a non-signatory employer; and
- sign and return to the Administrator, the *Acceptance of the Terms of Plan Eligibility Form*.

Members retiring early, who are age 55 or over, may also be entitled to coverage by self-paying the premiums to 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 the QCCC National Post-Retirement Benefit Plan 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 Full Plan under the NDT Industry Health Benefit Plan and remain a Member of the Full Plan under the NDT Industry Health Benefit Plan;
- they must be a Member in Good Standing of the UA or Boilermakers 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 QCCC National Post-Retirement Benefit Plan.

Dependent Eligibility

Eligible Dependents will be covered on the 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 *Common-Law Spouse Declaration Form* must be completed and submitted to the Plan Administrator along with a completed *QCCC National Post-Retirement Benefit Plan Application for Enrolment and Beneficiary Designation Form*.
- 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 and the Emergency Out of Canada 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 at attained age 21. Coverage for a Child (full-time student age 21 or older) terminates when full-time student and/or Dependent status ceases.

Survivor Benefits

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

1) 24 months from the date the of the Member's death
2) the date the person ceases to be a Dependent other than as a result of the Member's death
3) the date the Plan is terminated.

LIFE INSURANCE

Benefit Summary

Amount of Insurance $10,000

For Members 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, along with a newly completed *QCCC National Post-Retirement Benefit Plan Application for Enrolment and Beneficiary Designation Form*.

EXTENDED HEALTH CARE

Benefit Summary

Percentage Payable:

Reimbursement: 90%

Deductible: $25/single $50/Family

Drug reimbursement: Maximum of $5,000.00 per person per calendar year

EMERGENCY OUT OF COUNTRY COVERAGE (See RSA / Viator benefit booklet)

Overall maximum: $1,000,000 per lifetime

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 Workers Compensation Benefits. 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 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 except as where specified.

Family Deductible Feature

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.

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 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, provided the practitioner is registered and legally practicing within the scope of his/her license. Psychology services must be provided by a Registered Psychologist, Registered Clinical Counselor or a Licensed Social Worker.
- Cost of Hearing Aids for Retired Members 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 (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 PharmaCare 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.

- Treatment by x-ray or radioactive substances
- Anesthesia.
- Blood and blood plasma.
- Artificial limbs and eyes and under certain conditions artificial larynx.
- 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** (with respect to residents of the Province of Quebec)

Vision Care

$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.

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 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

Benefit Summary

Percentage payable:

100% Basic Services

100% Major Services

Deductible: Nil

Combined Calendar Year Maximum: $2,000 per family

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, 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-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 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 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)
- 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) & (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 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

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 Member'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, please contact the Administrator:

The Administrator

D.A. Townley

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