EMPLOYEE BOOKLET

Group Benefit Solutions

CRAWFORD SMITH & SWALLOW CHARTERED PROFESSIONAL ACCOUNTANTS LLP
Policy No. RBC00003662
All Eligible Employees - Enhanced

RBC Insurance

Insurance

GROUP INSURANCE FOR EMPLOYEES OF:

CRAWFORD SMITH & SWALLOW CHARTERED PROFESSIONAL ACCOUNTANTS LLP

The policy contains a provision removing or restricting the right of the group life insured to designate persons to whom or for whose benefit insurance money is to be payable.

Policy No.:	**RBC00003662**
Policy Effective Date:	**January 1, 2024**
Policy Enrolment Date:	**January 1** and the same day of every second subsequent year.
Revision Date:	**October 1, 2024**
Issue Date:	**October 17, 2024**

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TABLE OF CONTENTS

THIS IS AN IMPORTANT DOCUMENT

AND SHOULD BE READ CAREFULLY AND KEPT IN A SAFE PLACE.

This booklet/certificate gives a brief outline of the plan for which a group policy was issued to the employer. This booklet/certificate does not create nor confer any rights. The exact terms of the benefit plan are described in the more detailed provisions of the group policy. In the event of a discrepancy between this booklet/certificate and the group policy, the terms of the group policy will govern.

The **employee's** coverage may be cancelled or changed in whole or in part under the terms and provisions of the policy.

RBC Life Insurance Company is the insurer of the coverage, unless otherwise specified. If there are any questions about any terms or provisions, please consult our claims paying office. We will assist the **employees** in any way to help them understand their benefits.

The **employer** has appointed a plan administrator who looks after the insurance under this plan. The administrator may arrange for items such as enrolment in the benefit plan, changes in insurance, termination from the benefit plan and any **beneficiary** designations, as applicable.

The policy may contain a provision removing or restricting the right of the group life insured to designate persons to whom or for whose benefit insurance money is to be payable.

BENEFIT SUMMARIES

GROUP INSURANCE BENEFIT SUMMARY - GENERAL

The following is only a summary of the insurance provided under this policy and must be read in context with the rest of the provisions, terms and conditions of the policy.

Insurance Under the Policy:

Insurance Benefit

- Employee Basic Term Life
- Employee Basic Accidental Death and Dismemberment (AD&D)
- Extended Health Care (EHC)
- Dental Care (DTL)

Description of Eligible Class of Employees:

2. All Eligible **Employees -** Enhanced

Eligibility Requirements Under the Policy:

An **employee** must:

- Be a **resident** in Canada;
- Hold current and valid **provincial or territorial health care plan** coverage in the province or territory where they reside or a health insurance policy from an insurer that provides for emergency medical coverage in the event of an injury or sickness;
- Be a permanent or contractual **full - time employee**;
- For **contractual employees**, must be working solely for the **employer;**
- Be in **active employment** in Canada with the **employer** for at least 25 hours per week each week;
- Have completed a written enrolment card for this group insurance (if applicable or by providing appropriate enrolment information); and
- Be in an Eligible Class of **employees** insured.

In addition to the above items, the **employee** must complete the **waiting period**.

Waiting Period Under the Policy:

For an eligible **employee** in **active employment** on or before the **Effective Date**:
3 months of continuous **active employment.**

For an eligible **employee** in **active employment** after the **Effective Date**: 3 months of continuous **active employment.**

GROUP BASIC TERM LIFE INSURANCE – EMPLOYEE – BENEFIT SUMMARY

Eligible Class(es):	2. All Eligible **Employees** - Enhanced
Definition of Disability:	Total **Disability**
Amount of Insurance:	$25,000
No-Evidence Maximum:	$25,000 Coverage above the No-evidence maximum is subject to satisfactory evidence of insurability.
Reduction:	The amount of insurance in force immediately prior to age 65 will reduce by 50% when the **employee** turns 65, rounded to the next higher $1,000. Any reduction in the amount of insurance will also apply to any insurance extended under the Waiver of Premium. The reduction applicable to any scheduled amount will also be used to determine the amount of insurance for an **employee** when they first become eligible.
Terminal Illness Disability Benefit:	The lesser of: ▪ 50% of the **employee's** AMOUNT OF INSURANCE; or ▪ $100,000. The above amount will be less any reductions that would occur within 12 months of the date the **employee** requests the TERMINAL **ILLNESS** DISABILITY BENEFIT. The TERMINAL **ILLNESS** DISABILITY BENEFIT is payable only once during the **employee's** lifetime.
Waiver of Premium Elimination Period:	The **employee** must be continuously **disabled** for at least 180 days.
Cost Contribution:	The **employer** pays the full cost of the insurance.
Termination of Coverage:	The earlier of the date the **employee** retires or turns 70.

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT SUMMARY

Eligible Class(es): 2. All Eligible **Employees** - Enhanced

Definition of Disability: Total **Disability**

Principal Sum: $25,000

No-Evidence Maximum: $25,000

Coverage above the No-evidence maximum is subject to satisfactory evidence of insurability.

Paralysis Limitation: For **paralysis** (quadriplegia, paraplegia, or hemiplegia, as described in the benefit provision under Schedule of Specific Losses) sustained by the **employee** as a result of any one accident, will not exceed $1,000,000.

Reduction: The **employee's principal sum** in force immediately prior to age 65 will reduce by 50% when the **employee** turns 65, rounded to the next higher $1,000.

Any reduction in the **principal sum amount** of insurance will also apply to any AD&D insurance extended under the WAIVER OF PREMIUM.

The reduction applicable to any scheduled principal sum will also be applied in the determination of the principal sum for an **employee** when he first becomes eligible.

Other Standard Features:
NOTE: Please refer to the specific benefit provisions for exact details.

As described in the benefit provisions, benefits provided under this policy include the following based on eligibility:

(also see Schedule of Specific Losses for various percentages of the Principal Sum applicable to covered losses)

Other Standard Features:	**Included / Maximum:**
Schedule of Specific Losses	Yes
Day Care Benefit	Payment will be equal to the lesser of: ▪ 5% of the **employee's principal sum** per year; or ▪ a maximum of $5,000 per year. The Day Care Benefit will be paid each year for 4 consecutive years. The maximum benefit payable is $20,000.
Education Benefit	Payment will be equal to the lesser of: ▪ 5% of the **employee's principal sum** per year; or ▪ $5,000 per year.

		The Education Benefit will be paid each year for 4 consecutive years if the covered **child** remains enrolled as a **full-time student**.
	Exposure and Disappearance Benefit	The **employee's principal sum** for Loss of Life
	Family Transportation Benefit	Up to $5,000 (subject to submission of proof of eligible expenses incurred)
	Funeral Expense Benefit	$3,000
	Home Alteration and Vehicle Modification	$20,000
	In-Hospital Indemnity Benefit	$12,000
	Rehabilitative Physical Therapy Benefit	Payment will be equal to the lesser of: ▪ 10% of the **employee's principal sum** or ▪ $10,000
	Repatriation and Identification Benefit	$10,000
	Seat Belt and Air Bag Benefit	Seat belt - additional 10% of the **employee's principal sum** and air bag - $5,000
	Spousal Retraining Benefit	Up to $10,000 (subject to submission of proof of eligible expenses incurred)
	Waiver of Premium Benefit ▪ **Waiver of Premium Elimination Period:**	The **employee** must be continuously **disabled** for at least 180 days.
Cost Contribution:	The **employer** and the **employee** share the cost of the insurance.	
Termination of Coverage:	The earlier of the date the **employee** retires or turns 70.	

GROUP EXTENDED HEALTH CARE (EHC) BENEFIT SUMMARY

Eligible Class(es): 2. All Eligible **Employees -** Enhanced

Flex Enrolment Period On the date that **you** first enroll, **you** may select one of the EHC Option classes offered above. **You** can change **your** EHC Option prior to the enrolment date of January 1 every 2nd subsequent year. If **you** do not change **your** EHC Option by the policy enrolment date, **you** will remain enrolled in **your** current Option. If **you** are new to the plan and a selection is not made, **you** will be placed in the EHC Option class with the lowest level of coverage. When a **life event** occurs a defined in Section A-SPECIFIC GROUP EHC DEFINITIONS, **you** may change **your** EHC Option selection within 60 days of the eligible **life event**.

Deductible Amount:

Single: Nil per **benefit period**
Combined with the Drug Single Deductible.

Family: Nil per **benefit period**
Combined with the Drug Family Deductible.

EHC Benefit Period: **Benefit period** is a calendar year as defined in the benefit.

Deductible Amount Not Applicable to:

Hospital Benefit
Private Duty Nursing
Ambulance
Out-of-Province/Country Travel Emergency Medical Coverage
Out-of-Province/Canada Referral
Accidental Dental Injury Services
Vision Care Benefit

Drug Benefit: *(Formulary, Deductible, Reimbursement Percentage And Dispensing Fee Cap If Applicable)*

Reimbursement Method: Pay Direct Drug Card

Prescription Drugs Deductible Amount:

Single: Nil per **benefit period**
Combined with the Medical Services and Supplies Deductible.

Family: Nil per **benefit period**
Combined with the Medical Services and Supplies Deductible.

Prescription Drugs – Per Prescription Deductible Amount:
Equal to the Dispensing Fee

Prescription Drugs - Dispensing Fee Cap: Nil

Basis Of Drug Formulary: Preferred Drug Formulary

Prescription Drugs Reimbursement Percentage: 70% after the **deductible**
90% after the **deductible** for Pocketpills;
80% after the **deductible** for all other pharmacies

Drug Plan Type: Generic Mandatory

Overall Drug Maximum: Unlimited per insured per benefit period.

Lifestyle Drugs:

Deductibles are not applicable to this coverage

This includes:

- treatment of obesity up to a **benefit period** maximum of $1,800 for each **insured**.

Preventative Vaccines: Included

EHC Reimbursement Percentage/Benefit Description:

In-Province Hospital Benefit:	100%, without a **deductible**, of the difference between the cost of a ward and a semi-private hospital room and board accommodation.
Convalescent Hospital Benefit:	100%, without a **deductible**, of the difference between the cost of a ward and a semi-private hospital room and board accommodation.
Out-Of-Province/Canada Referral Expenses:	Referred services: 100% without a **deductible** Covered charges incurred for pre-approved referral for medical services outside the insured's province of residence or Canada are subject to a lifetime maximum of $10,000 per **insured**.
Out-of-Province/Country Travel Emergency Medical Coverage: *(Underwritten By RBC Insurance Company Of Canada)*	100% without deductible Covered charges incurred for emergency services while the **insured** is outside their normal province of residence or Canada for up to 60 consecutive days are subject to an unlimited lifetime maximum per **insured.**
Medical Services And Supplies:	80% after the deductible. This also includes: - laboratory tests, ultrasounds, MRI (magnetic resonance imaging), CT (computed tomography) scans and other medical imaging services, up to a combined maximum of $2,500 per **insured** per **benefit period**, (Quebec residents only);

- services of an ophthalmologist or licenced optometrist, up to a **reasonable and customary** maximum per **insured** (age 18 or over) one every 24 months (for a **child** under age 18, once every 12 months);
- contact lenses or intraocular lenses following cataract surgery, limited to a lifetime maximum of one lens per eye;

- wigs following chemotherapy, up to a maximum of $300 per **insured** in a **benefit period**. Wigs do not require a **physician's** order;
- breast prostheses required as a result of surgery, up to a maximum of $200 per **insured** in a **benefit period**;
- surgical brassieres required as a result of surgery, up to a maximum of 2 brassieres per **insured** in a **benefit period**;
- viscosupplementation treatment up to a maximum of $500 per **insured** in a **benefit period;**
- stump socks, up to a maximum of 4 pairs per **insured** in a **benefit period**;
- elastic support stockings, including pressure gradient hose, up to a maximum of 4 pairs per **insured** in a **benefit period**;
- custom-made orthotic inserts for shoes when prescribed by a **physician**, **podiatrist** or **chiropodist**, and dispensed by a **podiatrist, chiropodist**, **pedorthist**, **orthotist** or **chiropractor**, up to a maximum of $150 per **insured** in a **benefit period**;
- custom-made orthopaedic shoes or modifications to orthopaedic shoes when prescribed by a **physician**, **podiatrist** or **chiropodist**, and dispensed by a **podiatrist, chiropodist**, **pedorthist, orthotist** or **chiropractor,** up to a maximum of $250 per **insured** in a **benefit period;**
- hearing aids prescribed by an ear, nose and throat specialist, up to a maximum of $500 per **insured** over a period of 5 consecutive **benefit periods**. Repairs are included in this maximum;
- diabetic blood glucose monitoring equipment (BGM machines), including transmitters, receivers, sensors, and supplies, prescribed by a **physician** up to $4,000 per **insured** per **benefit period**.

Private Duty Nursing: 100% without a **deductible**, up to a maximum of $10,000 per **insured** per **benefit period**.

Ambulance Services: Land and air service - 100% without a **deductible.**

Accidental Dental Injury Services: 100% without a **deductible.**

Paramedical Services:	Any per visit maximum will be reimbursed up to the **reasonable and customary** level per practitioner (unless otherwise noted). 90% after the **deductible**. A maximum of $500 per **insured** per **benefit period** per practitioner will be applicable to the following Paramedical Services: Paramedical practitioners are: **Acupuncturists** **Athletic therapists** **Audiologists** **Chiropractors**, including a maximum of one x-ray examination each **benefit period** **Dieticians** **Homeopaths** **Massage therapists** **Naturopaths** **Occupational therapists** **Osteopaths**, including a maximum of one x-ray examination each **benefit period** **Physiotherapists** **Podiatrists** or **chiropodists**, including a maximum of one x-ray examination each **benefit period** **Speech therapists** 100% after the **deductible**. A maximum of $1,500 per **insured** per **benefit period** per practitioner will be applicable to the following Paramedical Services: Paramedical practitioners are: **Mental Health Services**, (includes psychologists, psychotherapists, master of social work, counsellor social worker, behavioural therapist)
Vision Care Benefit:	100% without a deductible, up to a maximum of $300 per **insured** in any 12 consecutive month period for an insured person under age 18 or in any 24 consecutive month period for an insured person age 18 and over
Survivor Benefit:	Up to a maximum of 24 consecutive months without premium payment.
Work Life Assistance Program:	Yes

	Teladoc Medical Experts: Yes
Cost Contribution:	The **employer** and the **employee** share the cost of the insurance.
Termination of Coverage:	The earlier of the date the **employee** retires or turns 75.
Provincial Public Drug Plans - Mandatory Requirements:	If a province has enacted a public drug plan that establishes mandatory requirements for private drug plans, then drug claims for an **employee** or **dependent** who resides in that province will be administered in accordance with the mandatory requirements of that province.

GROUP DENTAL CARE (DTL) BENEFIT SUMMARY

Eligible Class(es):	2. All Eligible **Employees -** Enhanced
Flex Enrolment Period	On the date that **you** first enroll, **you** may select one of the DTL Option classes offered above. **You** can change **your** DTL Option prior to the enrolment date of January 1 every 2nd subsequent year. If **you** do not change **your** DTL Option by the policy enrolment date, **you** will remain enrolled in **your** current Option. If **you** are new to the plan and a selection is not made, **you** will be placed in the DTL Option class with the lowest level of coverage. When a **life event** occurs a defined in Section A-SPECIFIC GROUP DTL DEFINITIONS, **you** may change **your** DTL Option selection within 60 days of the eligible **life event**.
DTL Deductible Amount:	Single: Nil per **benefit period** Family: Nil per **benefit period**
DTL Benefit Period:	**Benefit period** is a calendar year as defined in the benefit.
Basis of Benefit: (Provincial Fee Schedule and Year in effect on the date treatment is rendered)	For General Practitioners Current, province of residence
DTL Reimbursement percentage/Benefit Description:	**Basic Dental Services:** 80% after **deductible.** **Endodontic/Periodontic Services:** 80% after **deductible.**
DTL Recall Period:	Every 9 consecutive months. **Children** under 19, every 6 consecutive months.
DTL Scaling Units:	10 Units per 12 consecutive months
DTL Benefit Period Maximum:	**Basic Dental Services:** $1,500 per **insured.**
Survivor Benefit:	Up to a maximum of 24 consecutive months without premium payment.
Cost Contribution:	The **employer** and the **employee** share the cost of the insurance.
Termination of Coverage:	The earlier of the date the **employee** retires or turns 75.

GENERAL DEFINITIONS

The following definitions are used throughout the entire policy. Definitions that are specific to a particular benefit are listed in that benefit section.

NOTE: In this booklet reference to the masculine gender will be deemed to include all gender identities, as well as any individual(s) that do not fully or partially identify with a particular gender.

Active employment means **you** are:
- working for **your employer** on a permanent or on a **contractual employee full-time** basis in Canada for earnings that are paid regularly;
- performing the **material and substantial duties** of **your regular occupation**; and
- working for at least the minimum number of hours per week each and every week* shown in the Group Insurance Benefit Summary – General; and
- for **contractual employees**, working solely for the **employer.**

*****If the minimum number of hours worked is other than each and every week, **we** must be informed by **your employer** prior to the policy coming into effect. Otherwise **we** reserve the right to deny insurance to **employee**s working on such a non-standard basis.

Normal vacation is considered **active employment**.

Your work site must be:
- **your employer's** usual place of business in Canada;
- an alternative work site in Canada at the direction of **your employer**, including **your** home in Canada; or
- a location outside Canada, at the direction of **your employer**, provided **you** do not work at this location for more than 12 months and provided the location is not in any country of concern, as determined and published by **us** from time to time. Any work site located in a country of concern, as determined and published by **us** from time to time, must be pre-approved in writing by **us.**

Certificate means **you** and **your dependent**s.

Child or children means, if insured under this policy, a **resident** who is **yours** or **your spouse's** own natural offspring, lawfully adopted **child**, step**child**, or other **child** who is dependent on **you** for financial support and are living with you in a regular pare-child relationship.

A **child** must be:
- at least
  - (i) with respect to Group Dependent Life Insurance (if insured under this policy), from live birth but not yet attained age 21; or
  - (ii) with respect to Group Extended Health Care Insurance or Group Dental Care Insurance (if insured under this policy), live birth but not yet attained age 21; or
  - age 21 but not yet attained age 26 and be attending an accredited educational institution, college or university recognized by the Canada Revenue Agency on a full-time basis. Satisfactory proof of full-time student attendance must be submitted to **us**; and
- not married or in any other formal union recognized by law; and
- dependent on **you** for financial support.

A **child** insured under the policy, who is incapacitated due to a mental or physical disability on the date they reach the age when they would otherwise cease to be an eligible **dependent**, will continue to be an eligible **dependent** under the policy.

A **child** is considered incapacitated if they are incapable of supporting themselves or engaging in any substantially gainful activity, and is dependent on **you** for financial support, maintenance and care, within the terms of the Income Tax Act, due to a mental or physical disability.

We may require written proof of the **child's** condition as often as may reasonably be necessary.

Claimant means **you** or a **beneficiary** who has submitted a claim for benefits under the policy to **us**. Claimant will also include the legal representative of an **insured** who is incapacitated, incompetent or a minor.

Where allowed by law, the term will mean any person who submitted a claim for benefits under the policy to **us**.

Compassionate care leave of absence means a period of absence allowed by federal or provincial law for **you** to care for a family member (as defined in the law) who has a serious medical condition which has significant risk of death.

Contractual Employee means a person hired by the **employer** for certain specified work for a specific or open ended period of time. Contractual **employees** must work at least the minimum number of hours per week, each and every week as shown in the GROUP INSURANCE BENEFIT SUMMARY – GENERAL and must do so consistently week over week for the duration of their contract. Contractual **employees** are not considered permanent **employees** of the **employer**. Casual **employees** whose work is scheduled only on an as needed basis are not considered contractual **employees** under this definition. Seasonal **employees** who work only during specified months out of the year are also not considered to be contractual **employees** under this definition.

Crime includes any actions which would be an offence under the Criminal Code or the Controlled Drugs and Substances Act, whether or not the actions occurred in Canada.

Dependent means, if insured under this policy, a **resident** who is **your spouse** and a **resident** who is **your**s and/or **your spouse's child**.

Any **child** who is insured under the policy as an **employee** is not a **dependent**. When two **spouses** are both insured as **employees** under the policy, both may cover **children** for Dependent Term Life insurance (if insured under this policy).

Employee means a person who is:

- in **active employment i**n Canada with the **employer;** and
- domiciled in Canada and is a **resident** in Canada and who is legally entitled to work for wages in Canada; and
- insured under a Canadian **provincial or territorial health care plan** (including any extension) of their province/territory of residence or insured under a health insurance policy that provides for emergency medical coverage in the event of injury or sickness.

An **employee** is also deemed to include a partner, sole proprietor or a teacher, if insured under this policy.

Casual temporary and seasonal workers are excluded from insurance. No coverage will be extended to a person who is not an **employee** unless an exception is applied for and approved in writing by the Company.

Employer means the **policyholder**, and includes any division, subsidiary or affiliated company named in the Group Insurance Benefit Summary - General.

Evidence of insurability means a statement of a person's medical history and/or health or dental state which **we** will use to determine if the person is approved for insurance. In addition to the information the person supplies on the application or other required documentation, **we** may require other proof of the person's medical history and/or health or dental state which includes but is not limited to test results, medical examinations and **physician** statements. **We** may also require that an insurability assessment be performed. **Evidence of insurability** must be provided at the person's own expense.

Full-time means a normal work schedule of at least the minimum number of hours per week each week as shown in the Group Insurance Benefit Summary - General for 52 weeks per year including paid vacation.

Grace period means the 31 days following the **Premium Due Date** during which premium and any applicable tax payment may be made. Insurance will continue in force during the **grace period**. If the full premium and tax due is not paid within the **grace period**, the policy will terminate for non-payment of premium at the end of the 31 days. The full premium and tax for the **grace period** will nevertheless be due and payable.

Hospital or institution means an accredited facility licenced to provide care and treatment for the condition causing the **disability**, loss, injury or sickness.

Insured means **you**, **your spouse** or **child** who is insured under the policy.

Late entrant means a person (including **you**) for whom **you**:
- apply for insurance after the person has been eligible for more than 61 days ; or
- re-apply for insurance after that person's insurance had earlier been cancelled.

It also means **you**, after having previously waived benefits under the policy because **you** were covered for similar benefits under **your spouse's** plan:
- apply for insurance more than 61 days after **your** benefits terminated under **your spouse's** plan; or
- apply for insurance even though benefits under **your spouse's** plan have not terminated.

Legislation, plan or act means the original enactments of the legislation, plan or act and all amendments.

Layoff or **leave of absence** means **you** are, for non-medical reasons, temporarily absent from **active employment** for a period of time that has been agreed to in advance in writing by **your employer**.

Your normal vacation time, **statutory leave** or any period of **disability** is not considered a temporary **layoff** or **leave of absence**.

Maximum benefit means the maximum amount payable under the policy for a valid claim for a particular benefit.

Payable claim means a valid claim for which **we** are liable under the terms of the policy. The actual submission of a claim for benefits does not, in itself, constitute a **payable claim** under the policy. Each claim for benefits is adjudicated on an individual basis.

Physician means:
- a person who is licenced to practice medicine, to prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients.

The **physician** must be performing tasks that are within the limits of their medical licence. **We** will not recognize **you** or **your spouse**, **child**, parent or sibling as a **physician** for a claim that the **insured** submits to **us**.

Policyholder means the **employer** or legal entity to whom the policy is issued.

Pregnancy leave of absence or **parental leave of absence** means:
- a period of time no longer than federally or provincially required that is agreed to between **you** and **your employer** prior to the actual absence or as defined by **your employer's** pregnancy leave of absence policy and/or parental leave of absence policy;
- any period of formal pregnancy and/or parental leave **you** are entitled to under federal or provincial legislation governing **your employer**; or
- any period during which **you** receive pregnancy leave benefits, parental leave benefits, and pregnancy-related sickness benefits, or any combination of these benefits under the Employment Insurance Act or the Quebec Parental Insurance Plan.

For the purposes of **parental leave of absence**, a parent includes natural and adoptive parents, as well as the person in a relationship of some permanence with a natural or adoptive parent of the **child** who intends to treat the **child** as their own.

Provincial or territorial health care plan means the body of provincially/territorially enacted laws, as amended from time to time, governing provincial or territorial health insurance plans which provide health insurance to residents of Canada.

Resident means a person who:

- is legally entitled to be or to remain in Canada;
- makes their home in, and is ordinarily present in, a province or territory of Canada (a foreign **employee** who is living and working in Canada for the **employer** and the foreign **employee's** spouse and any other dependents who are also living in Canada will be considered to have met the provisions in this clause); and
- satisfies the requirements for Canadian **provincial or territorial health care plan** coverage or insured under a health insurance policy that provides for emergency medical coverage in the event of injury or sickness.

Spouse means, if insured under the policy, a **resident** and:

- is legally married to **you**; or
- if **you** are not married, is a person whom **you** are publicly representing as **your** spouse and with whom **you** are residing in a conjugal-like relationship or adult interdependent relationship and who is:
    - at least 18 years of age or of legal age to marry;
    - competent to contract; and
    - not related by blood closer than would legally bar marriage.

Only one **spouse** will be eligible for insurance under this policy, and will be as indicated by the **employee** on their application for insurance under this policy. Where this information is not contained on their application, the person who qualifies last under this policy's definition of **spouse** will be the eligible **spouse**.

Statutory Leave means any specified period of leave during which **you** are entitled to be absent from work in accordance with federal or provincial **legislation**, and it includes **compassionate care leave of absence** and **pregnancy leave of absence** or **parental leave of absence**.

Waiting period means the continuous period of time that **you** must be in **active employment** in an Eligible Class before **you** are eligible for insurance under the policy.

We, us, our or the Company means RBC Life Insurance Company.

You and **your** means a person who is eligible for RBC Insurance coverage.

GENERAL INFORMATION

Employee Eligibility

You are eligible for insurance under the policy if **you**:

- are a member of an ELIGIBLE CLASS OF EMPLOYEES defined in the GROUP INSURANCE BENEFIT SUMMARY - GENERAL;
- have completed the applicable WAITING PERIOD UNDER THE POLICY specified in the GROUP INSURANCE BENEFIT SUMMARY - GENERAL;
- meet all other eligibility requirements as outlined in the GROUP INSURANCE BENEFIT SUMMARY - GENERAL; and
- meet any eligibility requirements outlined in this section.

You must request insurance in writing by supplying the required enrolment information, such as but not limited to, **employee** census data or an enrolment card (if applicable) to **us**.

Employees of any corporation or other business formally associated or affiliated with the **employer** as a subsidiary or otherwise are eligible for insurance, provided that such an organization is on record with **us** as being eligible for insurance under the policy.

Dependent Eligibility

If insured under the policy, **you** will become eligible for **dependent** insurance on the later of:

- the date **your** insurance begins; or
- the date **you** first acquire a **dependent**.

You must submit a written application and **evidence of insurability** (if required) for the **dependent** insurance.

Each additional **dependent** will become insured on the date the **dependent** becomes eligible for insurance.

In no event will **your dependent** be insured before **you** are insured.

Refusal of Extended Health Care or Dental Care insurance

You refuse Extended Health Care insurance and/or Dental Care insurance (if insured under the policy) for **your**self or a **dependent** only if comparable coverage is provided under this or another group insurance policy.

When Insurance Begins

Your insurance (subject to premium payment) begins at 12:01 a.m. on the latest of:

- the date **you** become eligible for the insurance, if **you** applied for insurance on or before that date;
- the date **we** receive enrolment/application information for **your** insurance; or
- the date **we** approve **your evidence of insurability**, if required.

Dependent insurance if insured under the policy (subject to premium payment) begins at 12:01 a.m. on the latest of:

- the date the **dependent** becomes eligible for insurance, if **you** applied for group dependent insurance on or before that date;
- the date **we** receive enrolment/application information for the **dependent's** insurance; or
- the date **we** approve the **dependent's evidence of insurability**, if required.

Absent When Insurance Would Normally Begin: Leave of Absence, Temporary Layoff, Strike, Lockout

If, on the date insurance would normally begin, **you** are absent from **active employment** due to **leave of absence**, temporary **layoff** or lawful strike or lockout, and **you** return to **active employment** within 6 months of the date insurance would normally begin, **your** insurance will begin on the date **you** return to **active employmen**t. However, if **you** return to **active employment** more than 6 months after **your** insurance would normally begin, **your** insurance will begin after **you** have again been in **active employment** for a period equal to **your** WAITING PERIOD UNDER THE POLICY.

Absent When Insurance Would Normally Begin: Statutory Leave

If, on the date insurance would normally begin, **you** are absent from **active employment** due to **statutory leave, your** insurance will still begin if **you** have decided to maintain insurance and if premiums are paid during **your statutory leave. You** may maintain insurance until 61 days after the date that **your statutory leave** ended. If **you** do not return to **active employment** within 61 days after the date that **your statutory leave** ended**, your** insurance will end.

However, if **you** have decided not to maintain insurance during **your statutory leave**, **your** insurance will begin on the date **you** return to **active employment,** provided that **you** return to **active employment** within 61 days of the date that **your statutory leave** ended.

Absent When Insurance Would Normally Begin: Sickness or Injury

If, on the date insurance would normally begin, **you** are absent from **active employment** due to **sickness** or **injury**, then:

- **you** and **your dependents** may be enrolled for Group Extended Health Care Insurance, unless extended health care insurance has been maintained under a previous group insurance policy;
- **you** and **your dependents** may be enrolled for Group Dental Care Insurance, unless extended dental care insurance has been maintained under a previous group insurance policy;
- **you** may be enrolled for Group Basic Term Life Insurance, subject to the Continuity of Coverage provision;
- **you** and **your dependents** may be enrolled for Group Optional Term Life Insurance, subject to the Continuity of Coverage provision;
- **you** may be enrolled for Group Accidental Death and Dismemberment Insurance, subject to the Continuity of Coverage provision;
- **your** Group Short Term Disability Insurance will begin on the date that **you** return to **active employment**; provided that **you** return to **active employment** within 6 months of the date insurance would normally begin. However, if **you** return to **active employment** more than 6 months after **your** insurance would normally begin, **your** Group Short Term Disability Insurance will begin after **you** have again been in **active employment** for a period equal to **your** WAITING PERIOD UNDER THE POLICY; and
- **you** may be enrolled for Group Long Term Disability Insurance, subject to the Continuity of Coverage provision.

If **your** insurance is subject to **evidence of insurability**, **you** will be deemed to be a **late entrant** if **we** approve any **evidence of insurability** previously submitted by **you** but **you** do not return to **active employment** within the time required by **our** guidelines in effect on the date **we** approved the **evidence of insurability**. In such event, **we** reserve the right to require **you** to resubmit current **evidence of insurability**.

If a **dependent** (if insured under this policy) is hospitalized on the date insurance (initial, additional or any increase) would normally begin, the **dependent's** insurance or any additional or increase in insurance for that **dependent** will begin on the date they are discharged from hospital. This is not applicable to a newborn **child**.

Late Entrants

We reserve the right to deem **you** a **late entrant** if **you** were absent from **active employment** on the date **your** coverage would normally begin as specified in the sections above.

All premiums and applicable tax payments are due and payable as of **your** effective date of insurance.

Late Entrants And Dental Care Limitation

If Group Dental Care Insurance is provided under the policy, an **insured** who is a **late entrant** will be restricted to a maximum Dental Benefit of $200 for all dental covered charges (except for Orthodontic Services), incurred during the initial 12 month period from the date they became an **insured.** Thereafter such covered charges will be subject to the maximum amount indicated in the GROUP DENTAL CARE (DTL) BENEFIT SUMMARY.

If Group Dental Care Insurance is provided under the policy, Orthodontic Services for an **insured** who is a **late entrant** will be restricted to a maximum Orthodontic Benefit of $300 for all such orthodontic covered charges incurred during the initial 12 month period from the date they became an **insured.** Thereafter such covered charges will be subject to the maximum amount indicated in the GROUP DENTAL CARE (DTL) BENEFIT SUMMARY.

Changes In Insurance

Changes in the amount of insurance or benefits may occur as the result of an employment status change, the addition of a benefit or a change to a benefit. Any resulting changes take effect on the date of the change in status or benefits.

The following exceptions apply if the result of the change is an increase in insurance:
- if **evidence of insurability** is required, the increase cannot take effect before **we** approve the **evidence of insurability**; and/or
- if **you** are not in **active employment** when the change occurs or when **we** approve the **evidence of insurability**, the increase will not take effect until **you** return to **active employment**.

If **you** are not in **active employment** due to **injury**, **sickness**, temporary **layoff** or **leave of absence**, or lawful strike or lockout, any increased or additional insurance will take effect the later of:
- the date **you** return to **active employment**; or
- the date **we** approve **your evidence of insurability** form, if **evidence of insurability** is required.

Any decrease in insurance will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

Evidence of Insurability

We require **evidence of insurability** when **you**:
- are a **late entrant**;
- are eligible and apply for insurance or an increase in insurance above any **no-evidence maximum**;
- voluntarily cancelled insurance and are re-applying for insurance; or
- were previously eligible for insurance but waived coverage under the policy but is now applying for the insurance.

If such benefits are insured under the policy, **we** also require **evidence of insurability** when **you**:
- apply for any Group Optional Term Life insurance coverage, (initial, increased or additional) for **your dependents**;
- make written application for **dependent** insurance (Group Basic Term Life, Group Optional Term Life, Group Extended Health Care or Group Dental Care*****) more than 61 days after the date the **dependent** becomes eligible;
- voluntarily cancel the Group Basic Term Life insurance for **your dependent** while **your dependent** remains eligible for the insurance, and then reapply for the insurance at a later date; or
- waive the Group Basic Term Life insurance for **your** eligible **dependent** and then apply for the insurance at a later date.

*see Late Entrant and Dental Care Limitation above

When Your Insurance Ends

Your insurance ends on the earliest of the following dates:
- the date **your active employment** ends;
- the date **you** are no longer in **active employment** except as set out in the continued insurance provisions for:
    - Leave of Absence, Temporary Layoff, Strike or Lockout;
    - Statutory Leave;
    - Sickness or Injury;
- the date **you** are no longer in an Eligible Class;
- the date **you** no longer meet the eligibility requirements as specified in the Group Insurance Benefit Summary - General;
- the end of the period for which premiums have been paid to **us** for **your** insurance; or
- the date the policy ends.

However, the ending of **your** insurance will not prevent a **payable claim** for:
- **your** death or other loss that is caused by an accident that occurred before the end of **your** insurance; or
- **your disability** that commenced before the end of **your** insurance.

Any benefit may end on an earlier or later date as specified in the applicable Benefit Summary.

Your dependent insurance (if insured under this policy) ends on the earlier of the following dates:
- the date **your active employment** ends;
- the date **you** are no longer in **active employment** except as set out in the continued insurance provisions for:
    - Leave of Absence, Temporary Layoff, Strike or Lockout;
    - Statutory Leave;
    - Sickness or Injury;
- the date **you** are no longer in an Eligible Class for dependent insurance;
- the date **you** and/or **your dependent** no longer meets the eligibility requirements as specified in the GROUP INSURANCE BENEFIT SUMMARY - GENERAL;
- the date **you** no longer have any **dependents** or the date the **dependent** loses their status as a **dependent**;
- the end of the period for which premiums have been paid to **us** for **your** dependent insurance; or
- the date the policy ends.

However, the ending of **your** dependent insurance will not prevent a **payable claim** for a **dependent**'s death if it is caused by an accident that occurred before the end of **your** dependent insurance.

Any benefit may end on an earlier or later date as specified in the applicable BENEFIT SUMMARY.

You may terminate Extended Health Care insurance or Dental Care insurance (if insured under the policy) for **your**self or a **dependent** only if comparable coverage is provided under this or another group policy. In these cases, insurance under the policy ends on the date **you** choose.

Continued Insurance - Leave of Absence**,** Temporary Layoff, Strike or Lockout

Once **your** insurance begins, if **you** cease to be in **active employment** due to a **leave of absence,** temporary **layoff**, strike or lockout, **your** Group Short Term Disability Insurance (if provided under this policy) and Group Long Term Disability Insurance (if provided under this policy) may be continued on a premium paying basis for up to 90 days after **your leave of absence,** temporary **layoff**, strike or lockout begins, and **your** other insurance may be continued on a premium paying basis for up to 180 days after **your leave of absence,** temporary **layoff**, strike or lockout begins.

Continued Insurance – Statutory Leave

Once **your** insurance begins, if **you** cease to be in **active employment** due to a **statutory leave**, **you** may continue all insurance on a premium paying basis for the duration of the **statutory leave**. If **you** do not continue **your** insurance on a premium paying basis, **your** insurance will end.

If **your** insurance ends because **you** do not continue **your** insurance on a premium paying basis during **your statutory leave**, **your** insurance may begin again on the date **you** return to **active employment** if **you** return to **active employment** within 61 days of the date that **your statutory leave** ended. **Your** previous service while in an ELIGIBLE CLASS will be credited toward the Pre-Existing Condition Limitation. If **you** return to **active employment** more than 61 days after the date that **your statutory leave** ended, **you** will be treated as a new **employee** and will be subject to all requirements applicable to new **employees**.

If **you** have continued insurance on a premium paying basis during **your statutory leave**, **you** must return to **active employment** within 61 days of the date that **your statutory leave** ended in order for insurance to continue. If **you** do not return to **active employment** within 61 days of the date that **your statutory leave** ended**, your** insurance will end.

Continued Insurance - Sickness or Injury

Once insurance begins, if **you** cease to be in **active employment** due to sickness or injury, the following provisions will apply to **your** insurance:

Your Extended Health Care Insurance and Dental Care Insurance may be continued on a premium paying basis until the date **your employer** terminates **your** employment.

Your Basic Life Insurance, Optional Life Insurance, and Accidental Death & Dismemberment Insurance may be continued on a premium paying basis until the date **your employer** terminates **your** employment. **You** may also submit a claim for Waiver of Premium. If **we** approve **your** claim, **your** Basic Life Insurance, Optional Life Insurance, and Accidental Death & Dismemberment Insurance will be continued as described in the Waiver of Premium provisions.

Your Short Term Disability Insurance and Long Term Disability Insurance may be continued on a premium paying basis for a period of time that is equal to the longer of:

- the length of the Maximum Period of Payment for **your** Short Term Disability Insurance; or
- the length of the **elimination period** for **your** Long Term Disability Insurance.

If **you** become **disabled** after the date **your** Short Term Disability Insurance and Long Term Disability Insurance end, no benefits will be payable. **We** will refund any premiums that were paid for **your** Short Term Disability Insurance or Group Long Term Disability Insurance after the date **your** insurance ended.

If **you** submit a claim under **your** Long Term Disability Insurance and **we** approve **your** claim, **your** Long Term Disability Insurance will be continued as described in the Waiver of Premium provision.

A type of insurance may be continued only if that type of insurance is identified in the BENEFIT SUMMARY.

Employment / Labour Standards Extension Of Insurance

All of **your** insurance under the policy will terminate when **your** employment terminates. However, if **your employer** has terminated **your** employment and **your employer** is required to extend insurance coverage or benefits to **you** during a termination notice period prescribed by any federal or provincial employment or labour standards legislation, the insurance under the policy may be extended for such period. In order to extend insurance under the policy beyond such period, **your employer** must request the continuation of insurance in writing and advise **us** of the date to which the insurance must be continued and continue to remit the required premium. **Your** insurance will not extend beyond the date that the policy terminates.

Return to Active Employment After Insurance Ends

If **your** insurance ends and **you** return to **active employment, your** insurance may begin again on the date **you** return to **active employment** if:

- **you** return to **active employment** within 180 days after the date **your active employment** ended; and
- **you** had already completed **your** Waiting Period Under the Policy before the date **your active employment** ended.

Your previous **active employment** while in an Eligible Class will be credited toward the Pre-Existing Condition Limitation (if any). All other policy provisions will apply.

The amounts of **your** insurance will be determined by **your** earnings and Eligible Class at the time that **your** insurance begins again. If **your** earnings at the time **your** insurance begins again are lower than **your** earnings were at the time **your** insurance ended, the amounts of **your** insurance coverage will relate to **your** lower earnings. However, if **your** earnings at the time **your** insurance begins again are greater than **your** earnings were at the time **your** insurance ended, the amounts of **your** insurance coverage may be subject to **evidence of insurability**, if **we** require it.

If **your** insurance ends and **you** return to **active employment, you** will be treated as a new **employee** and will be subject to all requirements applicable to new **employees** if:

- **you** return to **active employment** more than 180 days after the date **your active employment** ended; or
- **you** had not completed **your** Waiting Period Under the Policy before the date **your active employment** ended.

If **your** insurance ends because **you** do not continue **your** insurance during a **statutory leave**, the provisions regarding continued insurance during a **statutory leave** will apply instead of this section.

Fraud

The Company will deny all fraudulent claims. The Company also reserves the right to deny coverage to any **employee** who presents a fraudulent claim. **We** will pursue appropriate legal remedies in the event of fraud.

Incontestability:

Any person required to provide **evidence of insurability** shall disclose, within the **evidence of insurability**, every known fact that is material to the insurance applied for. If such person misrepresents or fails to disclose any such fact, the insurance in respect of such person will be voidable by **us**. However, where the insurance in respect of such person has been in effect continuously for two years, such insurance will not, except in the case of fraud, be voidable by **us** on the basis of the misrepresentation or failure to disclose.

Except for fraud, no statements made by **your employer** or by **you** at the time of the application for the policy will be used in defence of a claim under the policy unless it is contained in a written application or any other written documentation to secure insurance.

Receiving And Releasing Data:

We will comply with all relevant legislation protecting personal information. Any person claiming benefits under the policy must give **us** all necessary information and authorization needed for underwriting, administering and paying claims.

Where allowed by law, on written request, **we** will provide **you** (or a **claimant** - to the extent that information is relevant to a claim or denial of a claim) with a copy of **your** application for insurance and any record or written document that **you** provided under the group policy as **evidence of insurability**. A reasonable fee will be charged for each copy after the first if more than one copy of each document is requested.

Where allowed by law, on written request and with reasonable notice, **we** will provide **you** (or to a **claimant** as specified above) with, or allow to be examined, a copy of the group policy. A reasonable fee will be charged for each copy after the first if more than one copy of the group policy is requested.

You or a **claimant** will not be provided with any information contained in any document about any individual (other than **your**self or the **claimant**) insured under the group policy.

Limitation of Legal Action:

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in:

- the Insurance Act (for actions or proceedings governed by the laws of Alberta and British Columbia);
- the Insurance Act (for actions or proceedings governed by the laws of Manitoba);
- the Limitations Act, 2002 (for actions or proceedings governed by the laws of Ontario);
- the Quebec civil Code (for actions or proceedings governed by the laws of Quebec);
- other applicable legislation; or
- the time period set out below, whichever is later.

A legal action for money payable in the event of a person's death may not be commenced against **us** after the later of

1. 2 years after proof of claim has been provided; or
2. 6 years after the date of the death.

A legal action for payments under the Short Term Disability, Long Term Disability, if such benefits are insured under the policy, may not be commenced against **us**

1. more than 2 years after the date that the first payment became due, if **we** made no payments; or
2. more than 2 years after the date the next payment would have become due, if **we** began making payments and then stopped.

A legal action for money payable for a loss other than death, Short Term Disability, Long Term Disability, if such benefits are insured under the policy, may not be commenced against **us**

1. less than 60 days after the date that the money became payable or would have become payable if it had been a valid claim; or
2. more than 2 years after the date the money became payable or would have become payable if it had been a valid claim.

Complaints:

The complete process to file a complaint with RBC Life Insurance Company can be accessed on the RBC Life Insurance Company public website at https://www.rbcinsurance.com under "Make a Complaint."

CLAIMS INFORMATION

We encourage **you** or **your beneficiary** (if applicable) to notify **us** of any claim as soon as possible, so that a claim decision can be made in a timely manner.

Claims Adjudication:

Green Shield Canada is used by RBC Life Insurance Company as the adjudicator of all Extended Health Care and/or Dental Care claims under the policy (other than OUT-OF-PROVINCE/COUNTRY TRAVEL EMERGENCY MEDICAL COVERAGE which is underwritten and issued by RBC Insurance Company of Canada).

RBC Insurance Company of Canada will adjudicate claims for any OUT-OF-PROVINCE/COUNTRY TRAVEL EMERGENCY MEDICAL COVERAGE.

RBC Life Insurance Company will adjudicate all other claims for benefits under the policy (Life, AD&D, STD and LTD).

Requesting A Claim Form:

The claim form is available from **your employer**, or the **claimant** can request a claim form from **us**. If the **claimant** does not receive the claim form from **us** within 15 days of their request, they should send **us** written proof of claim without waiting for the form.

Written Notice Of Claim:

STD or LTD:
Written notice of a Short Term Disability (if insured under the policy) or Long Term Disability claim (if insured under the policy) should be sent to **us** within 30 days after the date the **disability** begins.

LIFE or AD&D:
Written notice of a Life or AD&D claim (if insured under the policy) should be sent to **us** within 30 days after the date the **loss** or death occurs.

LIFE or AD&D Waiver Of Premium:
Written notice of a Waiver of Premium claim for Life (Basic and Optional, if insured under the policy) or AD&D (if insured under the policy) should be sent to **us** within 12 months after the date the **disability** begins.

EHC or DTL:
Written notice of an Extended Health Care or Dental claim (if insured under this policy) should be sent to the Company within 30 days of becoming aware of the claim.

Written Proof Of Claim:

LIFE or AD&D Waiver Of Premium:
For a Life or AD&D (if insured under the policy) Waiver of Premium claim, **you** must send **us** first written proof of claim between the end of the Waiver of Premium Elimination Period as shown in the applicable Benefit Summary and the 365th day after the date the **disability** begins. If it is not possible to give proof of claim within such time period, it must be given no later than 1 year after the **disability** begins, except in the absence of legal capacity.

STD or LTD:
For a Short Term Disability (if insured under the policy) or Long Term Disability claim (if insured under the policy), **you** must send **us** written proof of claim no later than 90 days after the date the **disability** begins. If it is not possible to give proof of claim within 90 days, it must be given no later than 1 year after the **disability** begins, except in the absence of legal capacity.

LIFE or AD&D:
For a Life or AD&D claim (if insured under the policy), the **claimant** must send **us** written proof of claim no later than 90 days after the date the **loss** or death occurs. If it is not possible to give proof of claim within 90 days, it must be given no later than 1 year after the **loss** or death occurs, except in the absence of legal capacity.

EHC:
Extended Health Care benefits (if insured under the policy); will only be paid for covered charges for which **we** have received satisfactory proof that payment is due.

For an Extended Health Care claim, the **claimant** must send **us** written proof of claim no later than the earlier of:
- 12 months from the date on which the **insured** incurs the covered charges.
- 90 days after the end of the **insured's** Extended Health Care insurance.

A covered charge must be claimed for the **benefit period** in which the covered charge was incurred.

DTL:
Dental Care benefits (if insured under the policy), will only be paid for covered charges for which **we** have received satisfactory proof that payment is due. Proof must include pre-treatment radiographs and study models when required by **us**.

For a Dental Care claim, the **claimant** must send **us** written proof of claim no later than the earlier of:
- 12 months from the date on which an **insured** incurs the covered charges.
- 90 days after the end of the **insured's** Dental Care insurance.

An **insured** may be required to submit to **us** the dentist's statement of the treatment received, pre-treatment x-rays and any additional information that **we** consider necessary.

Cost of Proof of Claim:

Costs incurred for proof of claim will be at **your** own expense.

Proof of Continuing Disability:

Under a Short Term Disability or Long Term Disability claim (if insured under the policy), **we** may request that **you** send proof of continuing **disability** and proof that **you** are under **appropriate care**. This proof must be received within 30 days of a request by **us**.

Additional Information:

We may require the **claimant** to provide appropriate consent to obtain additional medical information and to provide non-medical information as part of the **claimant's** proof of claim or proof of continuing **disability**.

If the appropriate information is not submitted, **we** may not be able to properly adjudicate the claim and may deny the claim or stop sending payments.

Type Of Claim Information Required:

Depending on the type of claim being submitted, the type of information that **we** will require from the **claimant** may include, but is not limited to:
- proof the **claimant** is or was under **appropriate care**;
- appropriate documentation of earnings;
- appropriate documentation of the covered charge actually being incurred by an **insured**;
- the cause of **disability**, **loss**, or death;

- the date of **disability**, **loss,** death, or covered charge incurred;
- proof of death;
- the extent of **disability** or **loss**, including restrictions and limitations; and
- the name and address of any **hospital** or institution where treatment is received, including the names of all attending **physicians**.

Proof Of Age:

We may require proof of age for each **insured**.

If the appropriate information is not submitted, **we** may not be able to properly adjudicate the claim and may deny the claim or stop sending payments.

If an incorrect age is given, **we** may adjust benefits and premiums based on the true age.

Return To Work Notification:

Under a Short Term Disability or Long Term Disability claim (if insured under the policy), **you** must immediately notify **us** when **you** return to work in any capacity.

We Reserve The Right To Deny Claim Payment:

We reserve the further right to deny any claim if premiums were not paid in respect of the **claimant**.

Overpayment Of A Claim

We have the right to recover any overpayments due to issues such as, but not limited to:
- fraud;
- negligence on the part of **your employer** or **claimant** or any agent thereof;
- any error **we** make in processing a claim;
- **your** receipt of **benefit offsets**; and
- any claim paid during the **grace period** and the policy or benefit subsequently terminates for non-payment of premium.

The **claimant** must reimburse **us** in full. **We** will determine the method by which the repayment is to be made. **We** may reduce or suspend payments which would otherwise be made to the **claimant** in order to recover the overpayment.

We will not recover more money than the amount paid to the **claimant**.

Coordination Of EHC / DTL Benefits:

If an **insured** incurs a covered charge under Extended Health Care insurance or Dental Care insurance coverage (if insured under this policy), that is also insured under any **other coverage** providing similar benefits, **we** will coordinate **our** benefit payments with the **other coverage**.

Coordination of benefits will be done in accordance with the guidelines of the Canadian Life and Health Insurance Association (CLHIA), as amended from time to time, so that the total payments under all plans do not exceed the **insured's** total eligible expenses.

Additional Information Applicable to Plan Members who are Residents of Quebec

For claims related to:
Basic Term Life, Basic Dependent Life, Optional Life, Optional Dependent Life, any benefit that is payable will be made by the Company within 30 days after receipt of the required proof of loss.

For claims related to:
Basic Life - Terminal **Illness**, Optional Life - Terminal **Illness**, Accidental Death and Dismemberment, and Long Term Disability Survivor Benefit, Extended Health Care and Dental, any benefit that is payable will be made by the Company within 60 days after receipt of the required proof of loss.

GROUP BASIC TERM LIFE INSURANCE BENEFIT

If **you** die while insured, **we** will pay to **your beneficiary your** amount of insurance as shown in the Group Basic Term Life Benefit Summary, less any amount already paid under the Terminal **Illness** Disability Benefit.

Benefit Specific Definitions:

The following definitions are applicable to this benefit in addition to certain definitions under the GENERAL DEFINITIONS section of this booklet.

Appropriate care means:
- **you** personally visit a **physician** as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat **your** condition(s) causing **disability**; and
- **you** are receiving and complying with the most appropriate treatment and care, which conforms with generally accepted medical standards, for **your** condition(s) causing **disability** by a **physician** whose specialty and experience is the most appropriate for the condition(s) causing **disability** according to generally accepted medical standards.

Appropriate care must not be limited solely to examinations or testing. Where, according to generally accepted medical standards, the appropriate form of treatment for **your** condition(s) causing **disability** is surgery, hospitalization, in-patient treatment, hospital day treatment, or individual or group addiction support therapy, **you** must comply with such form of treatment.

Beneficiary means the person or persons designated by **you** in writing to receive **your** Group **Employee** Basic Term Life insurance upon **your** death.

You are considered to be the **beneficiary** of any Group **Dependent** Basic Term Life insurance (if included) under the policy.

Disability and **disabled** means that, due to **sickness** or **injury you**:
- are unable to perform the duties of any **gainful occupation** for which **you** are reasonably fitted by education, training, or experience**;** and
- are not working in any occupation.

You must be under **appropriate care** in order to be considered **disabled**. **Your disability** must commence while **you** are insured under the policy.

The unavailability of employment in an occupation does not, in itself, constitute **disability**.

The loss of a professional or occupational licence or certification does not, in itself, constitute **disability**.

Gainful occupation has the meaning as set out in SPECIFIC GROUP LTD DEFINITIONS, if Group LTD insurance is provided under the policy.

If Group LTD Insurance is <u>not</u> provided under this policy, means an occupation that provides or can be expected to provide **you** with an income that exceeds 60% of **your annual earnings** within 12 months of **your** return to work.

Injury means a bodily injury that is the direct result of an accident and not related to any other cause.

No-evidence maximum means the amount of insurance **you** may obtain without providing **evidence of insurability**. The **no-evidence maximum**, until further written notice, is shown in the GROUP BASIC TERM LIFE INSURANCE – EMPLOYEE - BENEFIT SUMMARY. On any Policy Anniversary the Company may establish a new **no-evidence maximum**.

Previous group policy means a policy of group insurance issued to the **employer** by another insurance company or by the Company which provided group basic term life insurance to the same group, or part of the group, insured under the policy, and which terminated less than 31 days before this policy became effective.

Recurrent disability means a period of **disability** which is:
- caused by a worsening in **your** condition(s); and
- due to the same condition(s) as **your** prior period of **disability** for which premiums were waived.

Retirement date means the first of the following to occur:
- the effective date of **your** retirement benefits under:
  - any plan of a federal, a provincial, a municipal or an association retirement system for which **you** are eligible as a result of employment with **your employer**;
  - any plan **your employer** sponsors; or
  - any plan for which **your employer**:
    - makes contributions; or
    - has made contributions.

or

- the effective date of **your** retirement benefits under the Canada Pension Plan/Quebec Pension Plan or any similar plan or act.

But if **you** are in **active employment** and receiving retirement benefits under the Canada Pension Plan/Quebec Pension Plan or any similar plan or act **you** will not be considered retired.

Sickness means an **illness** or disease.

Beneficiary

Designating

Your beneficiary will be as designated by **you**, subject to applicable law. If no **beneficiary** has been designated, payment will be made to **your** estate. If a designated **beneficiary** disclaims their right to receive insurance money or is disentitled by law to receive insurance money and there is no other designated **beneficiary**, payment will be made to **your** estate.

You may designate a **beneficiary** in writing, on a form acceptable to **us** that is signed by **you**. The **beneficiary** designation must be signed by **you** and filed with **your employer**. The **beneficiary** designation will take effect on the date it is filed with **your employer**.

NOTE: If **your employer** has requested, **we** will maintain **your** current **beneficiary** designations as specified on the prior carrier's enrolment cards at the time the policy was transferred.

The **beneficiary** designation listed on **your** prior carrier's enrolment card will be used by **us** in order to pay benefits under the policy unless **you** specifically request a change of **beneficiary** under the policy.

It is strongly suggested that **you** review the existing designation to ensure it reflects **your** current intentions.

Changing or revoking a beneficiary

You may change or revoke a **beneficiary** designation, in writing, on a form acceptable to **us**. The change to or revocation of the **beneficiary** designation must be signed by **you** and filed with **your employer**. The change to or revocation of the **beneficiary** designation will take effect on the date it is filed with **your employer**. **We** may pay insurance money in accordance with the **beneficiary** designation that **your employer** provides to **us**.

If **we** pay insurance money before receiving a change to or revocation of the **beneficiary** designation, **we** shall be fully discharged for the amount of insurance money paid in accordance with the previous **beneficiary** designation.

The consent of the **beneficiary** will not be required to change any **beneficiary** unless the **beneficiary** is an irrevocable **beneficiary**, as defined by provincial law.

Payment for loss of dependent life

Amounts of insurance for a **dependent's** loss of life (if insured under this benefit) are payable in one lump sum to **you**. Any such amounts unpaid at **your** death will be payable to **your** estate.

Payment to a beneficiary

If more than one **beneficiary** is designated on the same form and **you** do not designate their order of rights, the **beneficiaries** will share equally.

If more than one **beneficiary** is designated on the same form and a **beneficiary** predeceases **you**, then unless the **beneficiary** designation states otherwise, the share of a deceased **beneficiary** will be paid to the surviving **beneficiary**, or, if more than one, to the surviving **beneficiaries** in equal shares.

If any **beneficiary** is a minor and there is no other person capable of giving proper discharge, **we** reserve the right to pay the death payment to the relevant provincial trustee for the benefit of the minor or to a legal representative of the minor **beneficiary** living in another jurisdiction. If **we** pay benefits in good faith to such person or trustee, **we** will be fully discharged to the extent of the payment.

In the event of the simultaneous death of **you** and the named **beneficiary**, the death benefit will be paid as if the **beneficiary** predeceased **you**.

Payment Of Discretionary Amounts

If the person to whom any amount of insurance is payable is not able to give a valid discharge, **we** may pay up to $10,000 (subject to the maximum applicable amount of insurance) to any person or institution **we** consider appropriate, such as but not limited to, a living relative of that person or any person or institution incurring expenses for the care or maintenance of that person. As long as this payment is made in good faith, **we** will be fully discharged to the extent of the payment.

Optional Modes Of Settlement

Unless otherwise elected, payment for loss of life will be made in one lump sum.

You may elect to have all or any part of **your** benefits for loss of life paid under any other option offered by **us**. If **you** have not made such election, the **beneficiary**, after **your** death, may do so. At the death of any payee receiving installment payments, the remaining balance of the benefits with any accumulated interest will be paid in one sum to the payee's estate.

Medical Examinations And Autopsy

At **our** own expense and discretion, **we** will have the right and opportunity to have an **insured**, whose claim is pending, examined by a **physician** of its choice. This right may be used as often as reasonably required.

We will also have the right and opportunity, in case of death, to request an autopsy where not prohibited by law.

Continuity of Coverage

If **you** are employed by **your employer** and are not in **active employment** on the Policy Effective Date due to **sickness** or **injury**, **you** are still eligible to be enrolled for Group Basic Term Life Insurance under the policy if:

- **you** were properly insured for basic term life insurance under a **previous group policy** when that **previous group policy** terminated;
- **your** insurance under that **previous group policy** terminated solely because of the termination of that **previous group policy**; and
- **you** would be otherwise eligible under this policy if **you** were in **active employment**.

Continuity of Coverage Limitation

Premiums must be paid if **you** are enrolled under this Continuity of Coverage provision, and premiums will not be waived during:

- any period of **disability** which commenced prior to the Policy Effective Date; or
- any periods of **disability**, which commence after the Policy Effective Date, but which would qualify as a recurrent disability under the terms of the **previous group policy**.

Subject to a change in Quebec law, premiums must be paid for a person who is resident in the province of Quebec and who is enrolled under this Continuity of Coverage provision and premiums will not be waived during:

- any period of **disability** which commenced prior to the Policy Effective Date, unless the **disability** was not reported to the insurer of the **previous group policy** until more than 180 days after the Policy Effective Date; or
- any periods of **disability**, which commence after the Policy Effective Date, but which would qualify as a recurrent disability under the terms of the **previous group policy**, unless the person has been in **active employment** under this policy for at least 30 days.

No amount will be payable under this policy for a death if the death occurs while premiums are being waived under, or should have been waived under, the **previous group policy.**

Waiver Of Premium

If **you** become **disabled** (while insured under the policy) before retirement or age 65, whichever is earlier, **we** will continue **your** life insurance as long as **you** are **disabled**. This continued insurance is subject to the terms of the policy which were in effect on the date **you** became **disabled**, including reductions and terminations.

Disability must be continuous for an uninterrupted period equal to the Waiver of Premium Elimination Period as shown in the Group Basic Term Life BENEFIT SUMMARY. Premium payments must be continued during this period.

Once **your** Waiver of Premium claim has been approved, this insurance will continue without payment of premiums until the earliest of the following:

- the date **you** turn 65;
- the date **you** cease to be **disabled** as defined;
- the date **you** retire;
- the date **you** fail to give **us** proof of **your** continued **disability**; or
- the date **you** refuse to be examined as required.

Premium payment for any **dependent** insurance, if insured under the benefit, (which is considered to be **your** insurance) will also be waived when **your** premium payments are waived.

Recurrent Disability within 180 days

If, after a period of **disability** for which premiums have been waived, and **you** experience a **recurrent disability**, the Company will treat this **recurrent disability** as a continuation of **your** previous period of **disability** and a new Waiver of Premium Elimination Period will not have to be completed if:

- **you** return to continuous **active employment** for the period between the last date for which premiums were waived under **your** prior claim and the commencement of the **recurrent disability**
- **you** were continuously insured between the last date for which premiums were waived under **your** prior claim and the commencement of the **recurrent disability**;
- **your recurrent disability** commences within 180 days from the last date for which premiums were waived under **your** prior claim.

Recurrent Disability if more Than 180 days

Your recurrent disability will not be considered to be a continuation of a prior period of **disability** if the **recurrent disability** commences more than 180 days after the last date for which premiums were waived under **your** prior claim. In such case, the **recurrent disability** will be treated as a new claim. The new claim will be subject to all of the policy provisions, including the Waiver of Premium Elimination Period, in force at the commencement of the new claim.

If **your recurrent disability** is considered to be a continuation of a prior period of **disability**, **your recurrent disability** will be subject to the same policy terms as **your** prior claim. The commencement date of the **recurrent disability** will be deemed to be the original date of **disability** from the prior period(s) of **disability.**

Terminal Illness Disability Benefit:

We will pay a Terminal **Illness** Disability Benefit to **you** if **you** are less than 64 years of age, become **disabled** and have a life expectancy of 12 months or less due to a terminal **illness**.

In order to be considered for the Terminal **Illness** Disability Benefit, **you** must:

- be less than 64 years of age;
- be approved by **us** for Waiver of Premium;
- request this benefit, in writing, on a form acceptable to **us**; and
- submit to **us** written certification from a **physician**, that **you:**
  - are **disabled**;
  - are terminally ill; and
  - have a medical prognosis of 12 months or less to live.

The amount of the Terminal **Illness** Disability Benefit will be the lesser of:

- 50% of the amount of insurance on **your** life; and
- $100,000.

We will pay the Terminal **Illness** Disability Benefit to **you** in one lump sum. The Terminal **Illness** Disability Benefit is payable only once during **your** lifetime.

After a Terminal **Illness** Disability Benefit has been paid to **you**, the amount of insurance on **your** life will be reduced by the amount of the payment. The remaining amount of insurance on **your** life will be paid according to the terms of the policy, subject to any reduction or termination provision. Any amount that **you** could otherwise convert under the Conversion Privilege will also be reduced by the amount of the Terminal **Illness** Disability Benefit payment.

The Terminal **Illness** Disability Benefit payment is not available to **you** if **you** would be otherwise required by law to use this benefit to meet the claims of creditors, whether in bankruptcy, bankruptcy protection or otherwise.

Any payment made under this benefit will fully discharge **our** liability to the extent of the amount paid.

Conversion

You are entitled to obtain an individual life insurance policy without **evidence of insurability** if **you** meet the following conditions:

- All or part of **your** Group Basic Term Life insurance under the policy terminates prior to the earlier of retirement or the date **you** turn 65. This includes reductions or terminations of coverage which become effective at specified ages or on retirement which are specified in the policy. In addition, **your** death prior to age 65 will be considered termination of the Group **Dependent** Basic Term Life insurance amount and conversion of **your spouse's** insurance will be allowed within 31 days of **your** death.
- All of the Group Basic Term Life insurance for **you** under the policy terminates because **you** turn 65 while **your** premiums are being waived under the Waiver of Premium provision.

You must apply for the individual policy in writing and pay the first premium within 31 days after the insurance terminates. In the case of insurance for **your dependent**, either **you** or **your spouse** may apply for conversion of a **spouse's** insurance.

Exception

The Conversion Privilege is not available if insurance terminates because **you** and/or **your employer** stop making required premium contributions.

Policy Form

The individual policy may be in any one of **our** then standard life insurance conversion forms. Term insurance is only available in the following forms:

- a non-convertible term insurance policy to age 65; or
- a 1 year non-renewable term insurance policy. This type of policy can be converted to any other form of conversion policy being offered, without **evidence of insurability**, if the change is made before the end of the 1-year term.

No disability or accidental death benefit will be offered with the individual policy.

Premium

The premium for the individual policy will be based on the person's age, sex, and class of risk, and on the type and amount of policy being issued.

Maximum individual policy amount (other than for a resident in Quebec)

If **you** reside outside of Quebec, the amount of the individual policy will not exceed the lesser of:

- the amount of terminated insurance less the amount of any group term life insurance for which **you** or **your spouse** becomes eligible within the 31 days allowed for conversion; or
- $200,000.

This amount is **yours,** or the **spouse's,** combined maximum that can be converted under all group life policies issued to **your employer** by **us**.

An individual can convert less than the maximum individual policy amount but cannot convert an amount less than the minimum amount then issued by **us** for the type of policy chosen.

Maximum individual policy amount for a resident in Quebec

If **you** reside in Quebec, the amount of the individual policy will be:

1. **If you alone are converting:**
   the amount must be at least $10,000 and cannot exceed the lesser of all amounts of **your** group life coverages on the date of conversion or $400,000.

2. **If you alone are converting, and you have been insured under the policy for at least 5 years, the master policy is now terminating and not being replaced or is being replaced but with a lesser amount of insurance:**
   the amount must be at least $10,000 or 25% of the amount of **your** life insurance on the date the master policy terminates, whichever is greater.

3. **If your dependent is converting:**
   the amount must be at least $5,000, without exceeding the amount of insurance in force on the **dependent's** life under the policy on the date of conversion.

This amount is the maximum that can be converted under all group life policies issued to **your employer** by **us**.

An individual can convert less than the maximum individual policy amount but cannot convert an amount less than the minimum amount then issued by **us** for the type of policy chosen.

Conversion policy effective date

The individual policy will take effect at the end of the 31 days allowed for conversion.

Death during the conversion period

If an individual dies within the 31 days allowed for conversion, the total amount of terminated or reduced Group Basic Term Life insurance that the individual was entitled to convert is payable under the policy's Group Basic Term Life insurance benefit as if the death occurred while the Group Basic Term Life insurance benefit was still in force.

Cancellation:

If **you** are approved for the policy's Group Basic Term Life insurance Waiver of Premium benefit after **you** or **your dependent** have been issued an individual life insurance conversion policy, the individual policies will be cancelled and the premiums paid on the individual policies refunded to **you**.

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE BENEFIT

If **you** die or suffer a covered loss as specified in the Schedule of Specific Losses, while **you** are insured under the policy, **we** will pay the applicable percentage of the **principal sum** shown in the Schedule of Specific Losses to **you**, or to the designated **beneficiary** then on record (for benefits for loss of life).

Benefit Specific Definitions

The following definitions are applicable to this benefit in addition to certain definitions under the GENERAL DEFINITIONS section of this booklet.

Accidental injury means a bodily injury caused directly and in**dependent**ly of all other causes by an unexpected, unforeseen, external, violent and purely accidental means or event. It does not include a **sickness**.

Appropriate care means:
- **you** personally visit a **physician** as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat **your** condition(s) causing **disability**; and
- **you** are receiving and complying with the most appropriate treatment and care, which conforms with generally accepted medical standards, for **your** condition(s) causing **disability** by a **physician** whose specialty and experience is the most appropriate for the condition(s) causing **disability** according to generally accepted medical standards.

Appropriate care must not be limited solely to examinations or testing. Where, according to generally accepted medical standards, the appropriate form of treatment for **your** condition(s) causing **disability** is surgery, hospitalization, in-patient treatment, hospital day treatment, or individual or group addiction support therapy, **you** must comply with such form of treatment.

Beneficiary means, with respect to **your** Group AD&D insurance for loss of life by **accidental injury**, the person or persons designated by **you** in writing to receive **your** Group **Employee** Basic Term Life Insurance unless otherwise designated in writing and filed with **your employer**.

Child or children means, with respect to the Day Care Benefit, **your** or the **spouse's** own natural offspring, lawfully adopted **child**ren, step**child**ren, or other **child**ren who are **residents** and dependent on **you** for financial support and are living with **you** in a regular parent-**child** relationship.

A **child** must be:
- at least 24 hours old but not yet attained age 12; and
- dependent on **you** for financial support.

A **child** insured under the policy, who is incapacitated due to a mental or physical disability, will continue to be an eligible **dependent** under this policy until they turn 12.

We may require written proof of the **child's** condition as often as may reasonably be necessary.

Child or children means, with respect to the Education Benefit, **your** or the **spouse's** own natural offspring, lawfully adopted children, stepchildren, or other children who are **residents** and dependent on **you** for financial support and are living with **you** in a regular parent-child relationship.

A **child** must be:
- at least 24 hours old but not yet attained age 26;
- unmarried or not in any other formal union recognized by law; and
- dependent on **you** for financial support.

A **child** insured under the policy, who is incapacitated due to a mental or physical disability on the date they reach the age when they would otherwise cease to be a **child**, will continue to be an eligible **child** under the policy.

A **child** is considered incapacitated if, due to a mental or physical disability, they are incapable of supporting themselves or engaging in any substantially gainful activity, and is dependent on **you** for financial support, maintenance and care, within the terms of the Income Tax Act.

We may require written proof of the **child's** condition as often as may reasonably be necessary.

Commercial aircraft means a certified passenger aircraft that is provided by a commercial airline, operated by a properly certified pilot, and travelling on a regularly scheduled or chartered flight.

Disability and **disabled** means that due to **your sickness** or **injury you:**

- are unable to perform the duties of any **gainful occupation** for which **you** are reasonably fitted by education, training or experience; and
- are not working in any occupation.

You must be under **appropriate care** in order to be considered **disabled**. **Your disability** must commence while **you** are insured under the policy.

The unavailability of employment in an occupation does not, in itself, constitute **disability**.

The loss of a professional or occupational licence or certification does not, in itself, constitute **disability**.

Experimental or investigational medical procedures means any procedures not approved or not broadly accepted and recognized by the Canadian medical profession, as an effective, appropriate and essential form of treatment according to Canadian medical standards.

Full-time student means a student with a full course load as defined by the **institute of higher learning**.

Gainful occupation has the meaning as set out in SPECIFIC GROUP LTD DEFINITIONS, if Group LTD insurance is provided under the policy.

If Group LTD Insurance is <u>not</u> provided under this policy, means an occupation that provides or can be expected to provide **you** with an income that exceeds 60% of **your annual earnings** within 12 months of **your** return to work.

Hospital means an institution licensed as a hospital, which is open at all times for the care and treatment of sick or injured persons, with organized facilities for diagnosis, major surgery and with 24-hour nursing services. Hospital will not include a facility or part of a facility primarily used for the aged, the treatment of drug addiction or alcoholism, rehabilitative care, custodial or educational care, or a rest home, nursing home, or convalescent hospital.

Injury means a bodily injury that is the direct result of an accident and not related to any other cause.

Institute of higher learning means any institute of higher learning above the 12th grade level and includes any university, CEGEP (Collège d'enseignement général et professionnel), trade school or college, as defined where **you** reside.

Intoxicated means **your** blood alcohol level equals or exceeds .08.

Licenced day care facility means a facility which is operated according to laws and regulations applicable to day care facilities, and which provides care and supervision for **children** in a group setting on a regular basis. Day care facility will include neither a hospital, the **child's** home, care provided during school hours while a **child** is attending grades 1 through 12 nor any other day care facility which does not charge a fee for services rendered.

We will not recognize **you** or **your spouse**, **children**, parents or siblings as part of such a facility unless they are hired by or own and operate such a facility.

Member of the immediate family means **your spouse**, parents, grandparents, **children** over age 18, brother or sister.

Motorized vehicle means any land, water or air conveyance which is moved or operated by means other than muscular power.

No-evidence maximum means the amount of insurance **you** may obtain without providing **evidence of insurability**. The **no-evidence maximum**, until further written notice, is shown in the GROUP ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) - BENEFIT SUMMARY. On any Policy Anniversary the Company may establish a new **no-evidence maximum**.

Previous group policy means a policy of group insurance issued to the **employer** by another insurance company or by the Company which provided group basic term life insurance to the same group, or part of the group, insured under the policy, and which terminated less than 31 days before this policy became effective.

Principal sum means the amount which applies to **you** under the Group Accidental Death and Dismemberment (AD&D) BENEFIT SUMMARY at the time of the **accidental injury**.

Private passenger car means a validly registered four-wheel private passenger car (including **employer**-owned cars), station wagons, jeeps, pick-up trucks and vans that are used only as private passenger cars.

Reasonable and customary expenses means reasonable and customary charges made by the provider of care, treatment, services or supplies to **you**. Such charges will be considered reasonable and customary if they do not exceed the general level of charges made by other providers of similar standing in the province or territory of **your** residence, when furnishing comparable treatments, services or supplies for a similar injury, or condition.

Recurrent disability means a period of **disability** which is:
- caused by a worsening in **your** condition(s); and
- due to the same condition(s) as **your** prior period of **disability** for which premiums were waived.

Regular care and attendance means observation and treatment to the extent necessary under existing standards of medical practice for the condition causing the confinement.

Retirement date means the first of the following to occur:
- the effective date of **your** retirement benefits under:
  - any plan of a federal, a provincial, a municipal or an association retirement system for which **you** are eligible as a result of employment with **your employer**;
  - any plan **your employer** sponsors; or
  - any plan for which **your employer**:
    - makes contributions; or
    - has made contributions.

or

- the effective date of **your** retirement benefits under the Canada Pension Plan/Quebec Pension Plan or any similar plan or act.

But if **you** are in **active employment** and receiving retirement benefits under the Canada Pension Plan/Quebec Pension Plan or any similar plan or act **you** will not be considered retired.

Seat belt means those belts that form a restraint system and includes infant and **child** restraint systems when properly used with a seat belt.

Sickness means any sickness, **illness**, disease, internal pathological process or physical or mental infirmity.

Beneficiary

Designating

Your beneficiary will be as designated by **you**, subject to applicable law. If no **beneficiary** has been designated, payment will be made to **your** estate. If a designated **beneficiary** disclaims their right to receive insurance money or is disentitled by law to receive insurance money and there is no other designated **beneficiary**, payment will be made to **your** estate.

You may designate a **beneficiary** in writing, on a form acceptable to **us** that is signed by **you**. The **beneficiary** designation must be signed by **you** and filed with **your employer**. The **beneficiary** designation will take effect on the date it is filed with **your employer**.

NOTE: If **your employer** has requested, **we** will maintain **your** current **beneficiary** designations as specified on the prior carrier's enrolment cards at the time the policy was transferred.

The **beneficiary** designation listed on **your** prior carrier's enrolment card will be used by **us** in order to pay benefits under the policy unless **you** specifically request a change of **beneficiary** under the policy.

It is strongly suggested that **you** review the existing designation to ensure it reflects **your** current intentions.

Changing or revoking a beneficiary

You may change or revoke a **beneficiary** designation, in writing, on a form acceptable to **us**. The change to or revocation of the **beneficiary** designation must be signed by **you** and filed with **your employer**. The change to or revocation of the **beneficiary** designation will take effect on the date it is filed with **your employer**. **We** may pay insurance money in accordance with the **beneficiary** designation that **your employer** provides to **us**. If **we** pay insurance money before receiving a change to or revocation of the **beneficiary** designation, **we** shall be fully discharged for the amount of insurance money paid in accordance with the previous **beneficiary** designation.

The consent of the **beneficiary** will not be required to change any **beneficiary** unless the **beneficiary** is an irrevocable **beneficiary**, as defined by provincial law.

Payment to a beneficiary

If more than one **beneficiary** is designated on the same form and **you** do not designate their order of rights, the **beneficiaries** will share equally.

If more than one **beneficiary** is designated on the same form and a **beneficiary** predeceases **you**, then unless the **beneficiary** designation states otherwise, the share of a deceased **beneficiary** will be paid to the surviving **beneficiary**, or, if more than one, to the surviving **beneficiaries** in equal shares.

If any **beneficiary** is a minor and there is no other person capable of giving proper discharge, **we** reserve the right to pay the death payment to the relevant provincial trustee for the benefit of the minor or to a legal representative of the minor **beneficiary** living in another jurisdiction. If **we** pay benefits in good faith to such person or trustee, **we** will be fully discharged to the extent of the payment.

Any other AD&D insurance money (other than for loss of life) which remains payable after **your** death, will be paid to **your** estate, unless the benefit is payable to another individual as specified in the policy.

In the event of the simultaneous death of **you** and the named **beneficiary**, the death benefit will be paid as if the **beneficiary** predeceased **you**.

Paym.ent Of Discretionary Amounts

If the person to whom any amount of insurance is payable is not able to give a valid discharge, **we** may pay up to $10,000 (subject to the maximum applicable amount of insurance) to any person or institution **we** consider appropriate, such as but not limited to, a living relative of that person or any person or institution incurring expenses for the care or maintenance of that person. As long as this payment is made in good faith, **we** will be fully discharged to the extent of the payment.

Medical Examinations and Autopsy

At **our** own expense and discretion, **we** will have the right and opportunity to have an **insured**, whose claim is pending, examined by a **physician** of its choice. This right may be used as often as reasonably required.

We will also have the right and opportunity, in case of death, to request an autopsy where not prohibited by law.

Continuity of Coverage

If **you** are employed by **your employer** and are not in **active employment** on the Policy Effective Date due to **sickness** or **injury**, **you** are still eligible to be enrolled for Group Accidental Death and Dismemberment Insurance under the policy if:

- **you** were properly insured for accidental death and dismemberment insurance under a **previous group policy** when that **previous group policy** terminated;
- **your** insurance under that **previous group policy** terminated solely because of the termination of that **previous group policy**; and
- **you** would be otherwise eligible under this policy if **you** were in **active employment**.

Continuity of Coverage Limitation

Premiums must be paid if **you** are enrolled under this Continuity of Coverage provision, and premiums will not be waived during:

- any period of **disability** which commenced prior to the Policy Effective Date; or
- any periods of **disability**, which commence after the Policy Effective Date, but which would qualify as a recurrent disability under the terms of the **previous group policy**.

Subject to a change in Quebec law, premiums must be paid for a person who is resident in the province of Quebec and who is enrolled under this Continuity of Coverage provision, and premiums will not be waived during:

- any period of **disability** which commenced prior to the Policy Effective Date, unless the **disability** was not reported to the insurer of the **previous group policy** until more than 180 days after the Policy Effective Date; or
- any periods of **disability**, which commence after the Policy Effective Date, but which would qualify as a recurrent disability under the terms of the **previous group policy**, unless the person has been in **active employment** under this policy for at least 30 days.

No amount will be payable under this policy for a death if the death occurs while premiums are being waived under, or should have been waived under, the **previous group policy.**

Waiver Of Premium

If **you** become **disabled** (while insured under the policy) before retirement or age 65, whichever is earlier, **we** will continue **your** AD&D insurance as long as **you** remain **disabled**. This continued AD&D insurance is subject to the terms of the policy which were in effect on the date **you** became **disabled**, including reductions and terminations.

Disability must be continuous for an uninterrupted period equal to the Waiver of Premium Elimination Period as shown in the Group Accidental Death & Dismemberment (AD&D) Benefit Summary. Premiums payments must continue during this period.

Once **your** Waiver of Premium claim is approved, this insurance will continue without payment of premiums until the earliest of the following:

- the date **you** turn 65;
- the date **you** cease to be **disabled** as defined;
- the date **you** retire;
- the date the policy or benefit terminates (the policy in its entirety, or just the AD&D benefit itself);
- the date **you** fail to give **us** proof of **your** continued **disability**; or
- the date **you** refuse to be examined as required.

Recurrent Disability within 180 days

If, after a period of **disability** for which premiums have been waived, and **you** experience a **recurrent disability**, the Company will treat this **recurrent disability** as a continuation of **your** previous period of **disability** and a new Waiver of Premium Elimination Period will not have to be completed if:

- **you** return to continuous **active employment** for the period between the last date for which premiums were waived under **your** prior claim and the commencement of the **recurrent disability;**
- **you** were continuously insured between the last date for which premiums were waived under **your** prior claim and the commencement of the **recurrent disability**;
- **your recurrent disability** commences within 180 days from the last date for which premiums were waived under **your** prior claim.

Recurrent Disability if more Than 180 days

Your recurrent disability will not be considered to be a continuation of a prior period of **disability** if the **recurrent disability** commences more than 180 days after the last date for which premiums were waived under **your** prior claim. In such case, the **recurrent disability** will be treated as a new claim. The new claim will be subject to all of the policy provisions, including the Waiver of Premium Elimination Period, in force at the commencement of the new claim.

If **your recurrent disability** is considered to be a continuation of a prior period of **disability**, **your recurrent disability** will be subject to the same policy terms as **your** prior claim. The commencement date of the **recurrent disability** will be deemed to be the original date of **disability** from the prior period(s) of **disability.**

Schedule of Specific Losses

If as a direct result of an **accidental injury** and within 365 days after the date of such **accidental injury**, **you** suffer any of the following specific covered losses, **we** will pay the percentage of the **principal sum** set opposite such loss. The amount of the **principal sum** applicable to **you** is as shown in the Group Accidental Death and Dismemberment (AD&D) Benefit Summary. Only one (the larger) of such percentages will be paid if more than one specific covered loss results from the same **accidental injury**.

For Loss of:	**Percentage of Principal Sum**
Life	100%
Both **hands** or both **feet**	100%
Sight of both eyes	100%
One **hand** and one **foot**	100%
One **hand** and **sight** of one eye	100%
One **foot** and **sight** of one eye	100%
Speech and **hearing** in both ears	100%
One **leg** or one **arm**	75%
Either **hand** or **foot**	66 2/3%
Speech or **hearing** in both ears	66 2/3%
Sight of one eye	66 2/3%
Thumb and index **finger**	33 1/3%

Four **fingers** of the same hand	33 1/3%
Hearing in one ear	16 2/3%
All **toes** of one foot	12 1/2%
For Paralysis of:	
All four limbs (Quadriplegia)	200%
Both lower limbs (Paraplegia)	200%
One **arm** and one **leg** on the same side of the body (Hemiplegia)	200%
For Loss of Use of:	
Both **hands** or **arms**	100%
One **arm** or one leg	75%
One **hand** or one **foot**	66 2/3%

Loss means, with respect to:

hands and feet: Actual complete severance through or above the wrist or ankle joint.
eyes: Entire loss of sight that cannot be corrected. The corrected visual acuity in the affected eye must be worse than 20/200 or the field of vision must be less than 20 degrees.
leg or arm: Actual complete severance through or above the knee or elbow joint.
thumb and fingers: Actual complete severance through or above the metacarpophalangeal joints.
speech: Entire and irrecoverable loss of speech.
hearing: Entire and irrecoverable loss of hearing. The auditory threshold in the affected ear must be more than 90 decibels.
toes: Actual complete severance through or above the metatarsophalangeal joints.
paralysis: Complete, permanent and irreversible loss of all muscle power due to nerve damage.
Loss of Use means: Total and irrecoverable loss of use due to nerve damage. The loss of use must be continuous for 12 consecutive months after which the benefit for Loss of Use is payable, provided such nerve damage is permanent.

Day Care Expense Benefit

If an **accidental injury** sustained by **you** results in loss of life within 365 days of the date of the **accidental injury** and results in **our** making a payment under the Schedule of Specific Losses, **we** will also pay a Day Care Expense Benefit for each eligible **child**.

A **child** is eligible for this benefit until they turn 12 and is enrolled in a **licensed day care facility** within 90 continuous days from the date of the **accidental injury**. Proof of annual enrolment may be required.

Payment will be as shown in the Group Accidental Death and Dismemberment (AD&D) BENEFIT SUMMARY.

If, at the time of loss of life, **you** have no **dependent children** eligible for the Day Care Expense Benefit, **we** will pay a $1,000 additional benefit to **your** estate.

Education Benefit

If an **accidental injury** sustained by **you** results in loss of life within 365 days of the date of the **accidental injury** and results in **our** making a payment under the Schedule of Specific Losses, **we** will also pay an Education Benefit to an eligible **dependent child**.

An eligible **dependent child** is eligible for the Education Benefit if:

- they, at the time of the **accidental injury**, are enrolled as a **full-time student** in any **institution of higher learning**; or
- they are in the 12th grade level and enrolls within 365 days of the accident as a **full-time student** in an **institute of higher learning**.

Payment will be as shown in the Group Accidental Death and Dismemberment (AD&D) BENEFIT SUMMARY.

The first payment will be made when:

- the benefit for loss of life becomes payable; and
- **we** have received written proof that the **dependent child** is attending an **institute of higher learning** as a **full-time student**.

Future payments will be made for each following school year on the date **we** receive written proof that the **dependent child** is attending an **institute of higher learning** as a **full-time student**.

If, at the time of loss of life, **you** have **children** but none of the **children** are eligible for the Education Benefit, **we** will pay a lump sum of $1,000 additional benefit to **your** estate.

Exposure And Disappearance Benefit:

The Company will cover a loss as specified in the Schedule of Specific Losses that is the result of unavoidable exposure to the elements, to the extent of the benefits insured by the policy.

Subject to the terms of this policy, the Company will presume **your** accidental loss of life and will pay the **principal sum** if **your** body has not been found within 1 year after having been involved in the disappearance, sinking or wrecking of a vehicle in which **you** were an occupant at the time of the accident.

Family Transportation Benefit:

If an **accidental injury** sustained by **you** results in **our** making a payment under the Schedule of Specific Losses, **we** will also pay a family transportation benefit if that **accidental injury** requires **you** to be confined as an in-patient in a **hospital** which is more than 150 kilometres from **your** normal residence. This benefit will provide reimbursement for the expenses incurred by a **member of the immediate family** for transportation to the **hospital**. In order for this benefit to be payable, **you** must be under the **regular care and attendance** of a **physician** and that **physician** must recommend the personal attendance of a **member of the immediate family**. The immediate family member must actually incur the expenses. The amount of the expenses will be limited to the cost of a licenced common carrier travelling the most direct route to the **hospital**. The maximum amount that will be reimbursed is shown in the Group Accidental Death and Dismemberment (AD&D) Benefit Summary.

Payment will not be made for ordinary living, travelling or clothing expenses. If transportation occurs in a vehicle or device other than one operated under a licence for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited (subject to submission of proof of expenses incurred) to a maximum of $0.30 per kilometre travelled.

Funeral Expense Benefit:

If an **accidental injury** sustained by **you** results in loss of life and results in **our** making a payment under the Schedule of Specific Losses, **we** will also pay up to the amount shown in the Group Accidental Death and Dismemberment (AD&D) Benefit Summary for the services and/or materials provided by a mortician, undertaker, crematorium or funeral home, related to the burial or cremation of **your** body and charges for the purchase of a burial plot, gravesite or mausoleum for the interment of the remains thereof, including any markers or monuments.

Payment will only be made if the expenses are actually incurred as a result of an **accidental injury** and at the time of **your** death, and will not include any charges for preparation of the remains for travel if they are reimbursed under the Repatriation/Identification Benefit.

Home Alteration And Vehicle Modification Benefit:

When **you** receive a payment under the Schedule of Specific Losses, and are subsequently required (due to the cause for which payment under the Schedule of Specific Losses was made) to use a wheelchair to be ambulatory, then **we** will reimburse **you**, upon presentation of proof of payment for:

- the one-time cost of alterations to **your** residence to make it wheelchair accessible and habitable; and
- the one-time cost of modifications necessary to a motor vehicle, owned by **you**, to make the vehicle accessible for or driveable by **you**.

Benefit payments will not be paid unless:

- home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization providing support and assistance to wheelchair users; and
- vehicle modifications are carried out by a person or persons with experience in such matters and such modifications are subsequently approved by the vehicle licencing authorities in the province where **you** reside.

The maximum payable for both home alterations and vehicle modifications combined will not exceed the maximum amount shown in the Group Accidental Death and Dismemberment (AD&D) Benefit Summary.

In-Hospital Indemnity Benefit:

If a covered **accidental injury** requires that **you** be **hospital** confined for more than 7 consecutive days, we will pay for each day of continuous **hospital** confinement:

- a monthly benefit of 1% of **your** applicable **principal sum**; or
- for periods of less than 1 month, 1/30 of the above monthly benefit per day.

Benefits are retroactive to the 1st day of **hospital** confinement.

This benefit is limited to:

- a monthly amount not to exceed $1,000; and
- a total of 12 months for any covered **accidental injury**.

The maximum amount payable will be as shown in the Group Accidental Death and Dismemberment (AD&D) BENEFIT SUMMARY.

Successive periods of **hospital** confinement for loss from the same covered **accidental injury** separated by a period of less than 3 months will be considered as 1 period of **hospital** confinement. Total combined successive periods of **hospital** confinement for loss from the same covered **accidental injury** will not exceed 12 months.

Rehabilitative Physical Therapy Benefit:

When an **accidental injury** to **you** results in **our** making a payment under the Schedule of Specific Losses (other than for loss of life), **we** will also reimburse **you** for the **reasonable and customary** expenses actually incurred within 3 years from the date of the **accidental injury** for rehabilitative physical therapy as prescribed by **your physician.**

The maximum amount payable will be as shown in the Group Accidental Death and Dismemberment (AD&D) BENEFIT SUMMARY.

No payment will be made for ordinary living, travelling or clothing expenses.

Repatriation And Identification Benefit:

If an **accidental injury** causes **your** loss of life and results in **our** making a payment under the Schedule of Specific Losses, **we** will also pay, up to the amount shown in the Group Accidental Death and Dismemberment (AD&D) Benefit Summary for the identification, preparation and transportation of **your** body to **your** principal city of residence.

Seat Belt And Air Bag Benefit:

For Seat Belt:
When an **accidental injury** to **you** results in the Company making a payment under the Schedule of Specific Losses, the benefit amount payable will be increased by 10% of **your principal sum**, provided that:

- such loss occurs while **you** are a passenger or driver of a **private passenger car**;
- **you** were wearing a properly fastened **seat belt**; and
- verification of the actual use of the **seat belt** is part of the official report of the accident or certified by the investigating officer.

For Air Bag:
When an **accidental injury** to **you** results in **our** making a payment under the Schedule of Specific Losses, the benefit amount payable will be increased by the amount shown in the Group Accidental Death and Dismemberment (AD&D) Benefit Summary, provided that:

- such loss occurs while **you** are a passenger or driver of a **private passenger car** equipped with either a single air bag, air bags for both the driver and the front passenger seats, or air bags for the driver, front passenger and rear passenger seats; and
- the **seat belt** is in actual use and properly fastened at the time of the accident.

For Seat Belt and Air Bag:
The driver of the vehicle must hold a current and valid driver's licence of a rating authorizing them to operate such vehicle and neither be **intoxicated** nor under the influence of drugs, unless such drugs are taken as prescribed by a physician, at the time of the accident. "Under the influence of drugs" is as defined by the local jurisdiction where the accident occurs.

Spousal Retraining Benefit:

When an **accidental injury** to **you** results in **our** making a payment under the Schedule of Specific Losses, **we** will also reimburse **your spouse** for the expenses actually incurred by **your spouse**, within 3 years from the date of the **accidental injury**, for a formal occupational training program. The formal occupational training program must be designed to qualify **your spouse** to gain **active employment** in an occupation for which they would otherwise not have had sufficient qualifications and it must be mutually agreed upon and preapproved by **us**. The maximum amount that **we** will reimburse is shown in the Group Accidental Death and Dismemberment (AD&D) Benefit Summary.

General AD&D Limitations and Exclusions:

This Accidental Death and Dismemberment insurance does not insure any loss which results directly or indirectly from, or is in any manner or degree associated with or occasioned by:

- **your** intentionally self-inflicted injury or asphyxiation;
- **your** asphyxiation or self-inflicted injury, whether intentional or unintentional, sustained while **you**:
  - have a blood alcohol level of .08 or higher; or
  - are under the influence of any poison, fume or other chemical substance or any prescription or non-prescription drug, unless used according to the prescription or direction of **your physician**;
- war, declared or undeclared, or any act of war;
- **your** active participation in a riot;
- **your** attempt to commit or commission of a **crime**, whether or not **you** have been charged;
- any injury sustained by **you** while **you** were driving, using or operating any **motorized vehicle** while **you:**
  - have a blood alcohol level of .08 or higher; or

- are under the influence of any poison, fume or other chemical substance or any prescription or non-prescription drug, unless used according to the prescription or direction of **your physician**;
- **your** voluntary use, inhalation or ingestion of any poison, fume or other chemical substance or any prescription or non-prescription medication, unless used according to the prescription or direction of **your physician**;
- any **experimental or investigational procedures**;
- plastic surgery and cosmetic procedures, such as but not limited to injections and laser treatments, unless performed by or under the supervision of a **physician;**
- an infection (except a pyogenic infection arising from an **accidental injury**);
- any **sickness** or treatment of **sickness**;
- any injury sustained by **you** while **you** are serving on full-time active duty in the armed forces of any country or international authority (any premium paid to be returned by **us** pro-rata for any such period of full-time active duty);
- any injury sustained while **you** are flying or traveling in (including boarding and alighting from) any kind of flying device (including aeroplanes, ultra-light aeroplanes and hot air balloons), other than as a fare-paying passenger on a **commercial aircraft**.

We will not pay a benefit for a loss during any period which **you** are lawfully incarcerated, confined or imprisoned.

NOTE: **Other Exclusions or Limitations may be applicable as specified under each individual additional benefit provision.**

GROUP EXTENDED HEALTH CARE (EHC) INSURANCE BENEFIT

If an **insured** incurs covered charges as specified in this Benefit Provision for **medically necessary** care, treatment, services or supplies while under the care and attendance of a **physician, dentist** or **paramedical practitioner**, **we** will pay such covered charges after the satisfaction of the **deductible amount** (if any) and subject to the **reimbursement percentage**, exclusions, coordination of benefits and other applicable provisions of the policy.

Benefit Specific Definitions

The following definitions are applicable to this benefit in addition to certain definitions under the GENERAL DEFINITIONS section of this booklet.

Accidental dental injury means an unexpected and unforeseen **injury** to the dental and contiguous structures which is the result of an event that occurs by chance. The term is deemed to include **injury** or accidents of the "biting" type to **natural teeth**.

Benefit period means 12:01 a.m. January 1 to midnight December 31.

Convalescent hospital means a licenced, extended-care hospital facility or institution, regularly engaged in the care of patients who do not require active medical treatment but do require skilled nursing care by registered nurses and continued medical supervision of a **physician** in regular attendance for the acute or convalescent phase of their **sickness** or **injury**. The **convalescent hospital** must have patient transfer agreements with active treatment **hospitals** and must be qualified to participate in and be eligible for subsidy under the provincial hospital plan. It may be a sanatorium, skilled nursing care facility or a special ward of a **hospital** which provides 24 hour nursing service and regular medical supervision. **Convalescent hospital** does not include a nursing home, home for the aged, private rest home, chronic care facility, health spa or hotel, an establishment providing custodial care or an institution for the care and the treatment of drug addiction or alcoholism (unless the facility is provincially funded), tuberculosis or mental **illness**.

Convention means drugs which by law do not require a prescription but which would not be ethically dispensed by a **pharmacist** without a written prescription.

Deductible amount if applicable, means the total dollar amount of covered charges which must be paid by or on behalf of the **insured** during any one **benefit period** before benefits become payable by the Company. **You** (**employees** without insured **dependents**) will be subject to the single deductible amount; **you** and **your dependents** shall be subject to the family deductible amount as described in the Group Extended Health Care (EHC) Benefit Summary.

Dentist means a person who is duly qualified and legally licenced to practice dentistry by the province in which they practice. **We** will not recognize **you** or **your spouse**, **child**, parent or sibling as a dentist for a claim that the **insured** submits to **us**.

DIN means Drug Identification Number (DIN) issued by Health Canada to regulate therapeutic products in Canada.

Enrolment date means the date by which **you** must select your EHC Class.

Experimental or investigational treatment means treatment that is not approved by Health Canada or other government regulatory body for the general public.

Extemporaneous compound mean a drug or combination of drugs prepared or compounded in a pharmacy according to a prescription. In order for a compound to be considered a covered charge, the compound drug must have a **DIN** and be a covered charge under the policy.

In order to be eligible:

- for topical products, the compound must combine two or more ingredients that are covered charges under the policy; or
- for other compounds, the active ingredient must be a covered charge under the policy and must contain no ineligible ingredients.

Generic drug means a drug or medicine that is considered by Health Canada to be the pharmaceutical equivalent of a brand-name drug. To be a pharmaceutical equivalent, the generic drug must contain identical amounts of the identical medicinal ingredients, in comparable dosage forms as the brand-name drug, but it does not need to contain the same non-medicinal ingredients as the brand name drug.

Government health care means the body of federally or provincially enacted laws, as amended from time to time, governing provincial health insurance plans, provincial hospital insurance plans, provincial medicare plans, provincial dental care plans, federal or provincial medical or dental care and services Acts, the Hospital Insurance and Diagnostic Services Act (Canada) and any other federal or provincial government sponsored hospitalization, medicare, drug or dental insurance plan which provides health insurance to residents of Canada.

Hospital means an institution licensed as a hospital, which is open at all times for the care and treatment of sick or injured persons, with organized facilities for diagnosis, major surgery and with 24-hour nursing services. **Hospita**l will not include a facility or part of a facility primarily used for the aged, the treatment of drug addiction or alcoholism (unless the facility is provincially funded), rehabilitative care, custodial or educational care, or a rest home, nursing home, or **convalescent hospital**.

Injury means a bodily injury that is the direct result of an accident and not related to any other cause.

Life Event means you experience one of the following:

- loss of alternate coverage;
- qualifying as a **spouse** or partner/legal separation;
- birth/adoption/accepting legal guardianship of a **child**;
- death of a **dependent**;
- **dependent** no longer qualifies for coverage.

Medically necessary means generally recognized by the Canadian medical profession as effective, appropriate care and required in the treatment of a **sickness** or **injury** in accordance with Canadian medical standards.

Natural teeth means teeth, whether or not restored, but does not include removable or fixed prosthetic devices.

NPN means the Natural Drug Product Number (NPN) issued by Health Canada.

Ophthalmologist means a person who is a medical **physician** who is legally licenced to practise ophthalmology.

Optometrist means a member of the Canadian Association of Optometrists or of any provincial association affiliated therewith. **We** will not recognize **you** or **your spouse**, **child**, parent or sibling as an optometrist for a claim that the **insured** submits to **us**.

Orthotist means a person who designs and fits corrective braces, inserts and supports for body parts that need straightening or other curvative functions and who is certified by the Canadian Board for Certification of Prosthetists and Orthotists.

Other coverage means insurance or reimbursement provided for the **insured** under any insurance policy, plan or arrangement under which the **insured** is a participant, other than under the policy.

Paramedical practitioners means a person who is a member of the paramedical profession duly licenced, certified or registered to practice that profession in the province where they practice and a member of an association that is recognized by **us**.

Pedorthist means a person who specializes in the use of footwear and supportive devices to address conditions which affect the feet and lower limbs and who are certified by the College of Pedorthists of Canada.

Pharmacist means a person who is licenced to practise pharmacy and whose name is listed on the pharmacists' registry of the licencing body for the jurisdiction in which such person is practising.

Preventative vaccines means vaccines recommended for disease prevention, outbreak control and routine travel and include **routine immunization series vaccines.**

Prior Authorization Program means the Company`s administrative procedure for the prior approval of a limited number of drugs and medicines. If a drug or medicine is included in the prior authorization program, both the **insured** and the **insured`s physician** must complete and submit the Company`s prior authorization form. The Company will review the form to determine if the **insured** will be covered for the drug or medicine.

Reasonable and customary means reasonable and customary charges made by the provider of health care, treatment, services or supplies to the **insured**. Such charges shall be considered reasonable and customary if they do not exceed the general level of charges made by other providers of similar standing in the **insured's** province or territory of residence, when furnishing comparable care, treatment, services or supplies for a similar **sickness**, **injury** or condition.

Reimbursement percentage means the specified percentage of covered charges payable by **us**. The reimbursement percentage is applied after the **deductible amount**, if any, has been satisfied.

Routine immunization series vaccines means vaccines recommended in the routine immunization schedule for infants and children published in the Canadian Immunization Guide - Seventh Edition (2006) as amended from time to time.

Sickness means an **illness** or disease, or a medical condition requiring medical treatment.

No EHC Beneficiary Designation Allowed

No **beneficiary** designation for the Group Extended Health Care insurance under the policy shall be valid. **You** do not have the right to name a **beneficiary** for any amount of Extended Health Care insurance money payable under the policy.

No Waiver of Premium

Premium payments for Extended Health Care benefits must continue to maintain coverage if **you** become **disabled** while insured under the policy.

Covered Charges

Covered charges are charges incurred by an **insured** for **medically necessary** health care, treatment, services and supplies to the extent that the covered charges:

- are an eligible covered charge;
- are **reasonable and customary** as defined in the policy;
- are recommended, approved and/or prescribed by a **physician, dentist** or **paramedical practitioner** as **medically necessary**;

- exceed the amounts payable under any **government health care** plan, and in the case of an **insured** not covered under such a plan, to the extent that they exceed the amounts that would have been payable had such coverage been applicable;
- exceed (in the case of an **insured** with **other coverage** for the same benefit) the charges reimbursed from all other sources. Any benefit payable under any other insurance policy or plan that duplicates benefits payable under this Benefit Provision will be fully coordinated with this Benefit Provision so that the aggregate reimbursement from all benefits payable does not exceed the total covered charge incurred by the **insured**; and
- do not exceed any maximum or limit as specified in the Group Extended Health Care (EHC) Benefit Summary.

Benefit Determination

The **insured** will not be reimbursed for a covered charge under more than one of the applicable sections of the policy.

Survivor Benefit

Insurance under this Benefit Provision for a **dependent** may be continued, (without premium payment), after **your** death until the earliest of the following events has occurred:
- termination of the policy;
- 24 months from the date of **your** death;
- the date similar benefits are obtained elsewhere;
- remarriage of the **spouse**; or
- the date when **dependent** status under the policy would have ceased had **you** not died.

When insurance under this Benefit Provision is continued, it is subject to all other terms and conditions of the policy.

Benefit Payment

We will pay covered charges incurred by an **insured** during the **benefit period**, after satisfaction of the **deductible amount**, if any, and to the extent of the applicable **reimbursement percentage**.

Benefit Period

With respect to covered charges and for purposes of applying the deductible amount, the **benefit period** will be as specified in the Group Extended Health Care (EHC) Benefit Summary.

A covered charge will be deemed to have been incurred on the date the service is rendered or the purchase or rental is made.

Deductible Amount

The **deductible amount** is the amount of covered charges that an **insured** must incur and pay before benefits become payable by **us**. The **deductible amount**, if any, will apply to each **benefit period.**

The **deductible amount** applied to **you** (an **employee** without **dependents**) will be the single deductible.

The **deductible amount** applied to a family will be the family deductible. A family includes **you** and **your dependents**. During each **benefit period**, the maximum **deductible amount** applied to each **insured** in a family will be equal to the single deductible. Once the sum of the **deductible amounts** applied to several members of that family equals the family deductible, no further **deductible amounts** will be applied to any member of that family for the rest of that **benefit period**.

The single and family deductible amounts are shown in the Group Extended Health Care (EHC) Benefit Summary.

Carry Forward Deductible

Any amount of covered charges that an **insured** incurs during the last 3 months of a **benefit period** that is not reimbursed or used to satisfy the **deductible amount**, may be carried forward and applied to the **deductible amount** for the next **benefit period**.

Reimbursement Percentage

The **reimbursement percentage** will be the percentage of the covered charges payable by **us**. The **reimbursement percentage** is applied after the **deductible amount**, if any, has been satisfied. Where the **reimbursement percentage** is less than 100%, the **insured** is responsible for the balance of the covered charges.

The **reimbursement percentage** applicable to benefits under this benefit provision will be as specified in the Group Extended Health Care (EHC) Benefit Summary.

Maximum Benefit

There will be no overall lifetime EHC Benefit maximum amount applicable to the total covered charges incurred by an **insured** except as provided in the specific benefit provisions. Individual services, supplies or treatment limits will be applicable as shown in the Group Extended Health Care (EHC) Benefit Summary.

Benefit Payment After Insurance Ends

If the Extended Health Care insurance terminates, covered charges for dental services to repair **natural teeth** damaged by an **accidental dental injury** will continue, if the accident occurred while an **insured** was covered, and the procedure is performed within 6 months after the date of the accident.

When Insurance Ends

Insurance ends on the date specified in the Group Extended Health Care (EHC) Benefit Summary. In addition, insurance may end on an earlier date, as specified in General Eligibility For Insurance.

Hospital Covered Charges In The Province Where The Insured Lives

We will cover the cost of room and board and out-patient services in a **hospital** up to the limit specified in the Group Extended Health Care (EHC) Benefit Summary.

We will also cover the cost of room and board in a **convalescent hospita**l, up to the limit specified in the Group Extended Health Care (EHC) Benefit Summary, if this care has been ordered by a **physician** and as long as it is primarily for rehabilitation, and not for custodial care.

Covered Charges For Medical Referrals Outside Canada/The Province Where The Insured Lives

If an **insured** is referred for medical services outside of their province of residence, **we** will cover the cost of the following, up to the level specified in the Group Extended Health Care (EHC) Benefit Summary:

- a semi-private **hospital** room;
- other **hospital** services provided outside the province of residence;
- out-patient services in a **hospital**; and
- the services of a **physician**.

Referred services must be for the treatment of a **sickness** or **injury** and ordered in writing by a **physician** located in the **insured's** province of residence. The **insured's** provincial **government health care** plan must agree in writing to pay for the service that would normally be covered under a **government health care** plan.

All referred services must be:
- obtained in Canada, if available, regardless of any waiting lists, and
- covered by the provincial **government health care** plan in the **insured's** province of residence.

If referred services are not available in Canada, they may be obtained outside of Canada. Where possible, all referrals must be pre-approved by **us** and the **insured's** provincial **government health care** plan.

Pay Direct / Deferred Prescription Drugs

We will cover drugs and medicines, up to the limit specified in the Group Extended Health Care (EHC) Benefit SUMMARY, which:
- by law or **convention**, are only available with a prescription;
- are prescribed by a **physician** or **dentist;** and
- are obtained from a **pharmacist**.

The drug or medicine must have a Drug Identification Number (**DIN**) and be approved for sale in Canada.

The Company will cover certain drugs prescribed by other qualified health professionals the same way as if the drugs were prescribed by a **physician** or a **dentist** if the applicable provincial legislation permits them to prescribe those drugs.

Covered charges also include the following if they have been prescribed by a **physician**:
- insulin and diabetic supplies, such as needles and syringes;
- certain life-sustaining drugs or medicines which do not require a prescription by law or **convention;**
- injectable vitamins and allergy serums;
- **routine immunization series vaccines;**
- intrauterine devices;
- **extemporaneous compounds** prepared by the **pharmacist;**
- sclerosis injections.

We will not cover charges for items, such as, but not limited to, the following (even if they should appear on a written prescription):
- any drug or medicine used to treat sexual dysfunction, infertility, cessation of smoking, or obesity, except if described in the Group Extended Health Care (EHC) Benefit Summary as being a covered charge;
- **preventative vaccines**, except if described in the Group Extended Health Care (EHC) Benefit Summary as being a covered charge;
- any drug or medicine dispensed by a person not legally licenced to do so;
- vitamins, except injectables;
- first aid and surgical supplies;
- atomizers, vaporizers;
- salt and sugar substitutes;
- infant formula, dietary foods and aids;
- contact lens care products;
- lozenges, mouthwashes, toothpastes and cosmetics;
- non-medicated shampoos, skin-cleansers, skin protectors, emollients and soaps;
- drugs that are used to prevent baldness or promote hair growth;
- any drug or treatment, and any services or supplies relating to the administration of the drug or treatment, administered in a hospital on an in-patient or out-patient basis or in a government-funded clinic or treatment facility;
- any drug or medicine dispensed, in any one prescription, in excess of a 100-day supply;
- any drug or medicine assigned a Natural Health Product Number (NPN) by Health Canada;
- additional narcotic drugs or medicines for an **insured**, if charges already submitted for narcotic drugs or medicines exceed industry approved prescribing guidelines for treatment and management of pain, unless the **insured** provides written confirmation from a **physician** supporting continued use;

- additional oral triptans for an **insured**, if charges already submitted for oral triptans exceed Health Canada's and the pharmaceutical manufacturer's recommended dosing and duration of use guidelines, unless the **insured** provides written confirmation from a **physician** supporting continued use;
- any drug within the Company`s **prior authorization program**, unless the **insured** and the **insured`s physician** have completed and submitted the Company`s prior authorization form, and the Company has provided its authorization; or
- any drug or medicine that is available under any government-sponsored plan or program, except as described in the **Integration with Government Programs** section.

Generic Mandatory Drug Costs

When there is a generic version of the prescribed drug or medicine, the Company will limit coverage to that of the lowest available cost for the drug or medicine. In the event that the lowest cost drug is a brand-name drug, the Company will cover the cost for the brand drug.

Per Prescription Deductible or Dispensing Fee Cap

If applicable, any **deductible amount** or dispensing fee cap will be as shown in the Group Extended Health Care (EHC) Benefit Summary.

Deferred Payment

If **your employer** selects the deferred drug card reimbursement option **(**as shown in the Group Extended Health Care (EHC) Benefit Summary), then an **insured** must pay the full amount of the covered charge at the pharmacy. When the **insured** presents their drug **identification card**, the **pharmacist** will inform the **insured** of the portion of the total **covered charge** that is covered by the plan. The **pharmacist** will electronically submit the **covered charge** for payment. Alternatively, the **insured** may have to submit a claim form to **us** for the **covered charge**, and **we** will reimburse the **insured** for the eligible amount.

Integration With Government Programs

When a drug or medicine is available under a government-sponsored plan or program, the Company will cover only that portion of the charge that is not payable or available under the government-sponsored plan or program, regardless of:

- whether the **insured** has made an application to the government-sponsored plan or program;
- whether coverage under this policy affects the **insured`s** eligibility or entitlement to any benefits under the government-sponsored plan or program; or
- any waiting lists.

Medical Services And Supplies

We will cover the cost for the medical services listed below when ordered by a **physician** or other qualified health professionals who are permitted by legislation to prescribe such services (the services of a licenced **optometrist**, **ophthalmologist** or **dentist** do not require a **physician's** or other qualified health professional's order). Covered charges may be limited to the cost of the least expensive service or supply that meet the insured's basic medical needs:

- out-of-hospital private duty nurse services, when **medically necessary**, up to the limit specified in the Group Extended Health Care (EHC) Benefit Summary. Services must be for nursing care, and not for custodial care. The private duty nurse must be a registered graduate nurse or nursing assistant who is licenced, certified and registered in the province where the service is performed. The Company will not recognize **you** or **your spouse**, **child**, parent or sibling as a registered graduate nurse or nursing assistant. The services of a registered graduate nurse are eligible only when someone with lesser qualifications cannot perform the duties;

- transportation in a licenced ambulance, if **medically necessary,** to and from the nearest **hospital** that is able to provide the necessary medical services and appropriate care.

  Expenses incurred outside Canada for emergency services will be paid based on the conditions specified for emergency services in the Group Extended Health Care (EHC) Benefit Summary under Out-of-Province/Country Travel Emergency Medical Coverage;

- transportation in a licenced air ambulance, if **medically necessary**, to the nearest **hospita**l that is able to provide the necessary emergency services and appropriate care.

  Expenses incurred outside Canada for emergency services will be paid based on the conditions specified for emergency services in the Group Extended Health Care (EHC) Benefit Summary under Out-of-Province/Country Travel Emergency Medical;

- the following diagnostic services rendered outside of a **hospital**, in the province of Quebec:
  - laboratory tests;
  - Ultrasounds;
  - magnetic resonance imaging (MRI);
  - computerized axial tomography (CAT) scans; and
  - other medical imaging services;

  up to a combined maximum per **insured** as specified in the Group Extended Health Care (EHC) Benefit Summary;

- dental services, including braces and splints to repair damage to **natural teeth** caused by an **accidental dental injury** to the mouth that occurs while an **insured** is covered. These services must be received within 12 months of the accident. **We** will not cover more than the fee stated in the **Dental Association Fee Guide** for a general practitioner in the **insured's province of residence**;

- services of an **ophthalmologist** or licenced **optometrist**, up to a maximum as specified in the Group Extended Health Care (EHC) Benefit Summary;

- contact lenses or intraocular lenses following a cataract surgery, limited to a lifetime maximum of one lens per eye;

- wigs (capillary prosthesis) following chemotherapy, up to a maximum as specified in the Group Extended Health Care (EHC) Benefit Summary. Wigs (capillary prosthesis) do not require a **physician's** order;

- rental, or purchase at **our** request of **medically necessary** equipment, that meets the **insured's** basic medical needs.

  Covered charges include:
  - wheelchairs;
  - hospital beds;
  - diabetic administration equipment (insulin infusion pumps);
  - diabetic blood glucose monitoring equipment (BGM machines), including transmitters, receivers, sensors and supplies, prescribed by a physician, up to the maximum per **insured** per **benefit period** as specified in the Group Extended Health Care (EHC) Benefit Summary;
  - intermittent positive pressure breathing machine (IPPB);
  - continuous positive airway pressure machine (CPAP);
  - cervical collar;
  - mist tents and nebulizers (excluding humidifiers and vaporizers);
  - traction apparatus;
  - apnea monitor for respiratory dysrhythmia.

For wheelchairs, eligible expenses are limited to the cost of a manual wheelchair, except if the **insured's** medical condition requires the use of an electric wheelchair.

- casts, splints, trusses, braces, crutches, canes or walkers;
- colostomy and ileostomy supplies including irrigation sets, bags, catheters, catheterization supplies and urinary kits;
- breast prostheses required as a result of surgery, up to a maximum per **insured** as specified in the Group Extended Health Care (EHC) Benefit Summary;
- surgical brassieres required as a result of surgery, up to a maximum per **insured** as specified in the Group Extended Health Care (EHC) Benefit Summary;
- artificial limbs and eyes.
- viscosupplementation treatment up to a maximum per **insured** as specified in the GROUP EXTENDED HEALTH CARE (EHC) BENEFIT SUMMARY**;**
- stump socks, up to a maximum per **insured** as specified in the Group Extended Health Care (EHC) Benefit Summary;
- elastic support stockings, including pressure gradient hose, up to a maximum per **insured** as specified in the Group Extended Health Care (EHC) Benefit Summary;
- custom-made orthotic inserts for shoes, when prescribed by a **physician**, **podiatrist** or **chiropodist**, up to a maximum per **insured** as specified in the Group Extended Health Care (EHC) Benefit Summary;
- custom-made orthopaedic shoes or modifications to orthopaedic shoes when prescribed by a **physician**, **podiatrist** or **chiropodist**, up to a maximum per **insured** as specified in the Group Extended Health Care (EHC) Benefit Summary;
- hearing aids prescribed by an ear, nose and throat specialist or **audiologist**, up to a maximum per **insured** as specified in the Group Extended Health Care (EHC) Benefit Summary. Repairs are included in this maximum;
- radiotherapy or coagulotherapy;
- oxygen, plasma and blood transfusions.

Paramedical Services

We will cover, up to the limit specified in the Group Extended Health Care (EHC) Benefit Summary, the costs for the **paramedical practitioners** listed in the Group Extended Health Care (EHC) Benefit Summary.

Vision Care

We will cover, up to the limit specified in the Group Extended Health Care (EHC) Benefit Summary, the cost of contact lenses, eyeglasses or laser eye correction surgery. Contact lenses or eyeglasses must be prescribed by an **ophthalmologist** or licenced **optometrist** and obtained from an **ophthalmologist**, licenced **optometrist** or licenced optician. Laser eye correction surgery must be performed by an **ophthalmologist**.

We will not pay for sunglasses, magnifying glasses, or safety glasses of any kind, unless they are prescription glasses needed for the correction of vision.

Work Life Assistance Program

The policy provides **you** and **your dependents** access to a work life assistance program designed to assist them with problems of daily living.

You and/or **your dependents** can call and request assistance for virtually any personal or professional issue, from helping find a day care or transportation for an elderly parent, to researching possible colleges for a **child**, to helping to deal with the stress of the workplace. This work life program is available for everyday issues as well as crisis support.

This service is also available to the **employer**.

This program can be accessed by a 1-800 telephone number available 24 hours a day, 7 days a week.

Information about this program can be obtained through **your employer's** plan administrator.

NOTE: If such services or program are included under more than one of the applicable sections of the policy, they shall be deemed to be only one single benefit and not two benefits. Any limitations or restrictions on usage or payment (if applicable) of these services or program shall be deemed covered under one single benefit only.

Teladoc Medical Experts

Teladoc Medical Experts provides **you** and **your** eligible* **dependents** with a unique combination of information and access to the best medical care when it matters most.

Teladoc Medical Experts helps **you** navigate the healthcare system and confirm **your** diagnosis and treatment options, through convenient, responsive services that connect **you** to a global database of over 50,000 top peer-nominated specialists, including 2,000 in Canada. Refer to the Teladoc Medical Experts brochure for more information about the services available to **you**.

*eligible **dependents** are **spouse** and **dependent children**, under the age 21 or under age 26 if full time students.

NOTE: If such services or program are included under more than one of the applicable sections of this policy, they shall be deemed to be only one single benefit and not two benefits. Any limitations or restrictions on usage or payment (if applicable) of these services or program shall be deemed covered under one single benefit only.

General EHC Limitations And Exclusions

This policy does not cover any charges which result directly or indirectly from, or are in any manner or degree associated with or occasioned by:

- the **insured's** active participation in a riot, insurrection or civil commotion;
- the **insured's** service in the armed forces of any nation;
- the **insured's** attempt to commit or commission of a **crime**, or provoking an assault, whether or not the **insured** has been charged;
- war, declared or undeclared, or any act of war;
- any **sickness** or **injury** for which the charge is payable or reimbursable under any Workers' Compensation Act, or similar **legislation, plan or act** or would have been payable if a claim had been submitted.

In addition, this policy does not cover the following charges:

- charges that private insurers are not permitted to cover by law;
- care, treatment, services or supplies payable or available (regardless of any waiting list) under any **government health care** plan or program unless explicitly listed as covered under this benefit provision;
- cost of care, treatment, services or supplies that exceed the **reasonable and customary** rates in the **insured's** province or territory of residence;
- equipment and supplies for personal comfort, convenience, exercise, safety, self-help or environmental control or items which may be also used for non-medical reasons such as but not limited to, orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, heating pads, lamps, communication aids, air conditioners, whirlpools, saunas or humidifiers);
- any care, treatment, services or supplies that are not usually provided to treat a **sickness**, including **experimental or investigational treatments**;
- care, treatment, services or supplies for cosmetic purposes only;
- care, treatment, services or supplies which are provided in a **hospital** while an **insured** is confined on an in-patient basis;
- services or supplies used solely for recreation or sports (such as but not limited to sport mouth guards, helmets or chin guards) rather than with other regular daily living activities;
- the diagnosis or treatment of infertility, except as may be provided under the drug benefit provision (if included);
- treatment or supplies for contraception, other than oral contraceptives, except as may be provided under the drug benefit (if included);
- care, treatment, services or supplies that do not qualify as medical expenses under the Income Tax Act (Canada);
- care, treatment, services or supplies for which no charge would have been made in the absence of this coverage;
- charges for rest cures or travel for health reasons;
- charges for medical screening or examinations required by a third party;
- charges for broken appointments, transportation costs of a practitioner, advice received by telephone or other electronic communication, or for the completion of claim forms or reports;
- charges for any shipping and handling charges;
- charges for supplies that were ordered or charges for care, treatment or services rendered prior to the date a person became an **insured**;
- charges for the replacement of a medical appliance which has been lost, mislaid or stolen or to provide any duplicate medical appliance;
- services or supplies that are provided by **you** or **your spouse**, **child**, parent or sibling or by a person who normally resides in **your** home.

NOTE: **Other Exclusions or Limitations may be applicable as specified under each individual additional benefit provision.**

Your Out-of-Province/Country Travel Emergency Medical Insurance

Out of Province/Country Travel Emergency Medical Insurance covers **your emergency** medical expenses, incurred in the first 60 consecutive days of any trip by **you** while outside **your** Canadian province or territory of residence.

All **bolded** terms have the specific meaning explained in the "Definitions" section. This insurance is underwritten by RBC Insurance Company of Canada.

RBC Insurance Company of Canada has appointed AZGA Service Canada Inc. (operating as "Allianz Global Assistance") as the provider of all assistance and claims services under this certificate of insurance.

You have the right to request a copy of the application, a copy of the policy of group insurance and/or a written record as evidence of insurability of the group person insured under the contract.

Emergency Medical Assistance

Wherever you go, we are just a phone call away - 24 hours a day, 7 days a week.

If **you** require medical treatment during **your trip**, or for any other **emergency**, **you** must contact us:

Assistance:
- Canada and USA toll free: 1 855-603-5571
- Local: 905-608-8251 – collect from anywhere

Claims:
- Canada and USA toll free: 1 855-603-5574
- Local: 905-608-8254 – collect from anywhere

Fax Numbers
- 1-888-298-6340 (toll-free fax from the USA or Canada)
- 905 813-4719 (fax)

IMPORTANT NOTICE - READ CAREFULLY BEFORE YOU TRAVEL

We want **you** to understand (and it is in **your** best interests to know) what **your** certificate of insurance includes, what it excludes, and what is limited (payable but with limits). Please take time to read through **your** certificate of insurance before **you** travel. **Bold** terms are defined in **your** certificate of insurance. RBC Insurance Company of Canada has appointed AZGA Service Canada Inc. (operating as "Allianz Global Assistance") as the provider of all assistance and claims services under this certificate of insurance.

- Travel insurance covers claims arising from sudden and unexpected situations (i.e. accidents and emergencies) and typically not follow-up or recurrent care.
- To qualify for this insurance, **you** must meet all of the eligibility requirements.
- This insurance contains limitations and/or exclusions e.g.: **medical conditions** that are not **stable**, pregnancy, child born on **trip**.
- This insurance may not cover claims related to **pre-existing medical conditions**, whether disclosed or not.
- Contact **us** before seeking **treatment** or **your** benefits may be limited or denied.
- In the event of a claim **your** prior medical history may be reviewed.

IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR COVERAGE. IF YOU HAVE QUESTIONS, CALL 1-855-603-5571

Visit our website at www.rbcinsurance.com or contact us at
RBC Insurance Company of Canada Claims
c/o Allianz Global Assistance
P O Box 277
Waterloo, ON N2J 4A4

Summary of Insurance Coverage

OUT OF PROVINCE/COUNTRY TRAVEL EMERGENCY MEDICAL INSURANCE

Benefits	Maximum Sums Available
Emergency treatment	Combined Maximum for all Benefits: an unlimited lifetime maximum
Incidental Allowance while in **hospital** (telephone calls, television rental etc.)	$50 per day to a maximum of $500
Ground Ambulance	Local Ground Ambulance covered
Other **Emergency** Services (Chiropractor, Physiotherapist etc.)	$300 per profession
Out of Pocket Expenses	$175 per day to a maximum of $1,750
Return of Deceased	- Transportation: unlimited - On-site cremation or burial: $2,000 - Preparation of remains: $3,000 - Return **trip** by someone required to identify **your** remains: Return Economy Airfare & $300
Bedside Companion's travel to bedside *Please see coverage details for what this benefit covers.	Return Economy Airfare & $500
Return to **your** Province or Territory of Residence	via one-way economy airfare, or stretcher, or qualified medical attendant or air ambulance
Emergency Dental Treatment	$300 for **emergency treatment.** Accidental blow to the face-unlimited + $2,000 within 180 days of returning
Return of **Vehicle**	Reasonable costs
Return of **children**	One-way economy Airfare & escort if necessary
Return of one **travelling companion**	One-way economy airfare
Return of dog or cat	$500
Return of Excess Baggage	$500
24/7 Assistance Services	Included

Definitions

The following definitions apply when written in **bold**.

Children – dependent unmarried persons, who are **your** natural, adopted or step-children, and are:

a) under 21 years of age; or
b) under 26 years of age if full-time students; or
c) **you**r child of any age who is mentally or physically disabled.

Commercial rental agency - a car rental agency licensed under the law of its jurisdiction.

Contamination - the poisoning of people by nuclear, chemical and/or biological substances which causes **illness** and/or death.

Departure point - the place **you** depart from on the first day, and return to on the last day, of **your** intended travel period.

Dependent – means **your spouse** or **your children.**

Effective date –

a) for Travel Emergency Medical coverage; the date on which **you** are scheduled to leave **your departure point**.

Emergency - A sudden and unforeseen **medical condition** that requires immediate treatment. An **emergency** no longer exists when the evidence reviewed by **us** indicates that no further **treatment** is required at destination or **you** are able to return to **your** province/territory of residence for further **treatment**.

Expiry date - 11:59 p.m. on the 60th day of **your trip** as described on your confirmation of coverage as the length of your coverage period.

Government health insurance plan - the health insurance coverage that Canadian provincial and territorial governments provide for their residents.

Hospital - An institution that is licensed as an accredited **hospital** that is staffed and operated for the care and **treatment** of in-patients and out-patients. **Treatment** must be supervised by **physicians** and there must be registered nurses on duty 24 hours a day. Diagnostic and surgical capabilities must also exist on the premises or in facilities controlled by the establishment.

A **hospital** is not an establishment used mainly as a clinic, extended or palliative care facility, rehabilitation facility, addiction treatment centre, convalescent, rest or nursing home, home for the aged or health spa.

Immediate family - **spouse**, parent, legal guardian, legal ward, step-parent, grandparent, grandchild, in-law, natural or adopted child, step-child, brother, sister, step-brother, step-sister, aunt, uncle, niece, nephew.

Medical condition - Any disease, **illness** or injury (including symptoms of undiagnosed conditions).

Network - the **hospitals, physicians** and other medical service providers recognized by **us** at the time of the **Emergency.**

Period of insurance - the period of time between **your effective date** and **your return date.**

Physician - A person who is not **you** or a member of **your immediate family** or **your travelling companion**, licensed in the jurisdiction where the services are provided, to prescribe and administer medical **treatment**.

Pre-existing medical condition- Any **medical condition** that exists prior to **your effective date.**

Prescription drug - drug or medicine that can only be issued upon the prescription of a licensed physician or dentist and is dispensed by a licensed pharmacist. Prescription drug does not mean such drug or medicine, when **you** need (or renew) them to continue to stabilize a condition which **you** had before **your trip**, or a chronic condition. (Limited to a 30-day supply per prescription, unless you are hospitalized).

Reasonable and customary - Charges incurred for goods and services that are comparable to what other providers charge for similar goods and services in the same geographical area.

Return date – the earliest of 11:59 p.m. on the last date of **you**r scheduled **trip**, or **your expiry date.**

Spouse - the person who is married to **you,** or in any formal union recognized by law, either of the opposite sex or of the same sex who is publicly represented as **your spouse**. Only one **spouse** at a time can be covered under this insurance.

Stable -
A **medical condition** is considered **stable** when all of the following statements are true:

- there has not been any new **treatment** prescribed or recommended, or change(s) to existing **treatment** (including a stoppage in treatment), and
- there has not been any change to any existing prescribed drug (including an increase, decrease, or stoppage to prescribed dosage), or any recommendation or starting of a new **prescription drug**, and
- the **medical condition** has not become worse, and
- there has not been any new, more frequent or more severe symptoms, and
- there has been no hospitalization or referral to a specialist, and
- there have not been any tests, investigation or **treatment** recommended, but not yet completed, nor any outstanding test results, and
- there is no planned or pending **treatment.**

All of the above conditions must be met for a medical condition to be considered **stable**

Top-up means the additional travel insurance coverage **you** purchase from RBC Insurance Company of Canada to extend the coverage available to **you** under **your** Group Extended Health Care coverage. The terms, conditions, and exclusions of the additional insurance coverage **you** purchase apply to **you** during **your top-up** period.
Please call 1-855-516-6268 to purchase **your top-up** coverage.

Travelling companion - the person who is sharing travel arrangements with **you** and who is covered under this travel insurance.

Treat, Treated, Treatment- A procedure prescribed, performed or recommended by a physician for a medical condition. This includes but is not limited to prescribed medication, investigative testing and surgery.

Trip - the period of time between leaving **your departure point** up to and including **your return date**.

Vehicle - a private passenger automobile, minivan, mobile home, camper truck or trailer home, which **you** use during **your trip** exclusively for the transportation of passengers other than for hire. It can be either owned by you or leased by **you** from a **commercial rental agency**.

We, us and **our** refer to RBC Insurance Company of Canada and any services provided by Allianz Global Assistance.

You, yourself and **your** refers to the person who is entitled to travel insurance coverage under the accompanying Group Extended Health Care Insurance underwritten by RBC Life Insurance Company.

General Insurance Details

Who is eligible for coverage?

- To be eligible for insurance coverage **you** must be covered under the accompanying Group Extended Health Care Insurance issued by the **employer**.

When does **your** travel insurance start and end?

Your travel insurance begins on your **effective date** and ends on the earliest of:

a) the date **you** no longer meet the eligibility requirements for coverage;
b) the date **you** return to **your** province, territory or country of residence;
c) midnight of **your return date;**
d) midnight of **your expiry date.**

When does **your** travel insurance automatically extend?

1. If **you** cannot complete **your trip** by **your return date** because of the delay of a common carrier in which **you** are scheduled to travel, **your** coverage will automatically extend for the delay period to a maximum of 72 hours.
2. If **you** or **your travelling companion** are hospitalized on **your return date** or **expiry date, your** coverage will automatically extend for the period of hospitalization and up to an additional 5 days after discharge.
3. If **you** or **your travelling companion** are delayed beyond **your return date** because of a **medical condition** and are medically unable to travel, but are not ***hospitalized***, **your** coverage will automatically extend for the delay period to a maximum of 5 days after **your return date.**
4. Regardless of the automatic extensions above, coverage will not continue beyond 365 days from *your* latest date of departure from **your departure point.**

Need additional travel insurance coverage?

If **you** are travelling for more than the days covered under this travel insurance or require additional **trip** cancellation and **trip** interruption insurance coverage, **you** may be eligible to purchase travel insurance from us by calling 1-855-516-6268.

What if you decide to extend your trip?

If **you** decide to extend **your trip**, any extension of **you**r coverage is subject to the following conditions:

a) before **your effective date**, **you** may contact **us** by calling 1-855-516-6268 to purchase **top-up** coverage;
b) after **your effective date** and if **you** have not had a **medical condition** during **your trip, you** must contact **us** before **your** scheduled **return date** to purchase **top-up** coverage;
c) after **your effective date** and if **you** have had a **medical condition** during **your trip, you** must contact us before **your** scheduled **return date** to purchase **top-up coverage**. The issuance of the **top-up** coverage is subject to our approval;
d) the terms, conditions and exclusions of **our** new coverage issued as **top-up** apply to **you***;*
e) **you** must pay the required **top-up** premium on or before the **top-up** period.
f) any **top-up** coverage is subject to **our** approval and **we** reserve the right to decline the request.

Out of Province/County Travel Emergency Medical Insurance

What must you do in a medical **emergency?**

- **You** must contact **us** before seeking **emergency treatment.**
- In addition, all surgery and heart procedures, including heart catheterization, must be approved in advance by **us.**
- When you contact **us**, **we** will refer **you** or may transfer **you**, when medically appropriate, to one of the accredited medical service providers within the **network.**
- **We** will also request for the medical service provider within the network to bill the medical expenses covered under this insurance directly to **us** instead of to **you**.
- Failure to call may result in reduced benefits.

- If **your medical condition** prevents **you** from calling **us** before seeking **emergency treatment, you** must call **us**, as soon as medically possible. As an alternative, someone else (family member, friend, hospital or **physician's** office staff, etc.) may call on **your** behalf.
- **You** must repay **us** any amount paid or authorized by **us** on **your** behalf if **we** determine that the amount is not payable under **your** coverage**.**

Emergency Contact Numbers:
- Canada and USA toll free: 1-855-603-5571
- Local: 905-608-8251 – collect from anywhere

What coverage limitation applies?
- If **you** do not contact **us** at the time of **your** medical **emergency** or **you** choose to receive treatment from a medical service provider outside the **network**, **you** will be responsible for 25% (up to a maximum of $25,000) of **your** medical expenses covered under this insurance and in excess of **your** medical expenses paid by **your government health insurance plan**. If **your medical condition** prevents **you** from calling **us** before seeking **emergency treatment**, **you** must call **us** as soon as medically possible. As an alternative, someone else (family member, friend, **hospital** or **physician's** office staff, etc.) may call on **your** behalf.

What risks are insured?
This insurance covers the reasonable and customary medical expenses **you** actually incur once **you** have left **your departure point** for necessary medical care or surgery, as part of the **emergency treatment** arising from a **medical condition**. This insurance only covers expenses in excess of those covered under **your government health insurance plan** and by any other insurance or benefit plan under which **you** are covered.

What are the benefits?
Combined Maximum for all Benefits: an unlimited lifetime maximum.

1. **Emergency** medical expenses
   This insurance covers medical expenses related to the following when required as part of the **emergency treatment** and ordered by a licensed **physician** during **your trip**:
   a) **emergency treatment**, other than dental treatment;
   b) the services of a licensed private duty nurse while you are hospitalized;
   c) the lesser of the rental or purchase of a **hospital**-type bed, a wheelchair, brace, crutches and other medical appliances;
   d) diagnostic testing, when pre-authorized by us; and
   e) prescription drugs limited to a 30-day supply per prescription unless **you** are hospitalized.
2. Incidental allowance while in **hospital**
   This insurance covers **your** reimbursement up to $50 per day to a maximum of $500 for **your** incidental **hospital** expenses (telephone calls, television rental), while **you** are hospitalized for at least 48 hours.
3. Other **emergency** services
   This insurance covers expenses for **emergency treatment** by a licensed physiotherapist, chiropractor, chiropodist, podiatrist or osteopath, to a maximum of $300 per profession.
4. Ground ambulance
   This insurance covers **you** for local ground ambulance service to a **hospital, physician** or medical service provider in an **emergency**. **We** will pay for local taxi fare in lieu of local ground ambulance service, where an ambulance is medically required but not available.
5. Return of deceased
   If, during **your trip, you** die from a **medical condition** covered under this insurance, the insurance covers:
   a) the transportation of **your** remains in the common carrier's standard transportation container to *your* province or territory of residence, and up to $3,000 for the preparation of **your** remains and for the cost of the common carrier's standard transportation container; or
   b) the transportation of **your** remains to **your** province or territory of residence and up to $2,000 for the cremation of **your** remains at the location where **your** death occurred; or

c) up to $3,000 for the preparation of **your** remains and, the cost of a standard burial container and up to $2,000 for the burial of **your** remains at the location where **your** death occurred.

If someone is legally required to identify **your** remains, this insurance covers the cost of a return economy air fare on a commercial flight via the most cost effective route and up to $300 for commercial accommodations and meals for that person.

6. Return to **your** Province or Territory of Residence

If the **physician** treating **you** recommends to **us** in writing that **you** return to **your** province or territory of residence because of **your medical condition** in order to receive **emergency** medical attention, or if our medical advisors \ determine that **you** are able to and recommend that **you** return to **your** province or territory of residence following **your emergency treatment**, this insurance covers **you** for one or more of the following, when pre-authorized and arranged by us, when medically essential:

a) the extra cost of a one-way economy air fare on a commercial flight via the most cost effective route to **your** province or territory of residence to receive immediate **emergency** medical attention; or
b) the cost of a stretcher fare on a commercial flight via the most cost effective route to **your** province or territory of residence, if a stretcher is medically necessary; and
c) the cost of a return economy air fare on a commercial flight via the most cost effective route and the usual fees and expenses for a qualified medical attendant to accompany **you,** when the attendant is medically necessary or required by the airline; or
d) the cost of air ambulance transportation if it is medically essential.

7. Out of pocket expenses

a) **This benefit is subject to our pre-authorization.**
b) This insurance covers *your* reimbursement up to $175 per day to a maximum of $1,750 for *your* commercial accommodations and meals, essential telephone calls and taxi fares, if, upon **physician's** advice:
   - **you, your dependent(s) or your travelling companion**, are relocated to receive medical attention; or
   - **you** are delayed beyond **your return date** in order to receive **emergency treatment** or because **your dependent(s) or your travelling companion** requires **emergency treatment** for an **emergency medical condition** covered under this insurance.

8. Bedside companion's travel to your bedside

a) **This benefit is subject to our pre-authorization.**
b) If **you** are travelling alone and are expected to be hospitalized for more than 3 days during **your trip** and a **bedside companion** is required, this insurance covers:
   - the cost of a return economy air fare on a commercial flight via the most cost effective route;
   - up to $500 maximum for commercial accommodations and meals for the **bedside companion.**
c) If **you** are over age 20 and physically or mentally disabled, or under age 21 and dependent on **your bedside companion** for support, this insurance provides this benefit to **you** as soon as **you** are admitted to a **hospital.**

A bedside companion is a person of **your** choice who is required at **your** bedside while **you** are hospitalized during **your trip.**

9. **Emergency** dental treatment

This insurance covers the following dental expenses when required as **emergency treatment** and ordered by or received from a licensed dentist:

a) if **you** need dental treatment to repair or replace **your** natural or permanently attached artificial teeth because of an accidental blow to **your** face, **you** are covered for the **emergency** dental expenses **you** incur during **your trip** and **you** are also covered up to a maximum of $2,000 to continue necessary treatment after **your** return to Canada. However, this treatment must be completed within 180 days after the accident.
b) if **you** need other **emergency** dental treatment, **you** are covered for the **emergency** dental expenses **you** incur during **your trip**, up to a maximum of $300, and the complete cost of **prescription drugs**.

10. Return of vehicle

If, as a result of a medical **emergency** during **your trip, you** are unable to return a **vehicle** to its point of origin, this insurance covers the reasonable costs for a commercial agency to return the **vehicle** to **your departure point** or to a **commercial rental agency**, when pre-authorized by us.

11. Return of **children** and escort for **children** to **your** province or territory of residence

If **children** insured under ***your*** **emergency** medical insurance travel with **you** or joins **you** during **your trip** and **you** are hospitalized for more than 24 hours or **you** must return to Canada because of **your emergency medical condition** covered under this insurance, this insurance covers:

a) the extra cost of a one-way economy air fare on a commercial flight via the most cost-effective route for the return of those **children** to **your** province or territory of residence; and

b) the cost of a return economy air fare via the most cost effective route on a commercial flight for an escort, if the airline requires that the **children** be escorted.

12. Return of **travelling companion**

a) **This benefit is subject to our pre-authorization.**

b) If **you** are travelling with a **travelling companion,** this insurance covers one **travelling companion** for the extra cost of a one-way economy air fare on a commercial flight via the most cost effective route to **your** province or territory of residence, if **you** must return to Canada because of a **medical condition** covered under this insurance.

13. Return of **your** dog or cat

a) **This benefit is subject to our pre-authorization.**

b) If **your** domestic dog(s) or cat(s) travel with **you** during **your trip** and you must return to Canada because of **your emergency medical condition** covered under this insurance, this insurance covers the cost of one-way transportation up to a maximum of $500 to return **your** domestic dog(s) or cat(s) to **your** province or territory of residence.

14. Return of your excess baggage

a) **This benefit is subject to our pre-authorization.**

b) If **you** return to **your** province or territory of residence by air ambulance (pre-authorized by us) because of **your emergency medical condition**, this insurance covers the cost to return **your** excess baggage up to a maximum of $500.

What conditions apply?

You agree that **we** have:

a) **your** consent to verify **your** health card number and other information required to process **your** claim, with the relevant government and other authorities;

b) **your** authorization to **physicians**, **hospitals** and other medical providers to provide to **us** any and all information they have regarding **you,** while under observation or treatment, including **your** medical history, diagnoses and test results; and

c) **your** agreement to the disclosure of the information available under a) and b) above to other sources, as may be required for the processing of **your** claim for benefits obtainable from other sources.

Unstable Medical Conditions

Applicable to Out of Province/Country Travel **Emergency** Medical Insurance:

This insurance does not pay for any expenses incurred directly or indirectly as a result of:

1. **Your medical condition** or related condition (whether or not the diagnosis has been determined), if at any time in the ninety (90) days before **you** depart on **your trip**, **your medical condition** or related condition has not been **stable**.
2. **Your** heart condition (whether or not the diagnosis has been determined), if at any time in the ninety (90) days before **you** depart on **your trip**:
    a. any heart condition has not been **stable**; or
    b. **you** have taken nitroglycerin more than once per week specifically for the relief of angina pain.
3. **Your** lung condition (whether or not the diagnosis has been determined), if at any time in the ninety (90) days before **you** depart on **your trip**:
    a. any lung condition has not been **stable**; or
    b. **you** have been treated with home oxygen or taken oral steroids (prednisone or prednisolone) for any lung condition.

General Exclusions

This insurance does not cover any loss, claim or expense of any kind caused directly or indirectly from:

1. The continued **treatment**, recurrence or complication of a **medical condition** or related condition, following **emergency treatment** during **your trip,** if **our** medical advisors determine that **your emergency** has ended.
2. The treatment of any heart or lung condition, following **emergency treatment** for a related or unrelated heart or lung condition during **your** trip, if our medical advisors determine that **you** were medically able to return to **your** home country and **you** chose not to return.
3. Any claim that results from or is related to **your** involvement in the commission or attempted commission of a criminal offence or illegal act.
4. **We** will not pay a benefit with respect to non-emergency, experimental or elective **treatment** (e.g. cosmetic surgery, chronic care, rehabilitation including any expenses for directly or indirectly related complications.)
5. A **medical condition** for which future investigation or treatment (except routine monitoring) is planned before **your effective date**.
6. Any **medical condition** or symptoms for which it is reasonable to believe or expect that **treatment** will be required during **your trip.**
7. a) Any claim related to routine pre-natal or post-natal care, or
   b) Any claim related to pregnancy, delivery, or complications of either, arising 8 weeks before the expected date of delivery or 8 weeks after.
   c) A child born within 8 weeks of the expected date of delivery.
8. Any expenses incurred, if the reason for **your emergency** is associated in any way with an official travel advisory issued before **your effective date**, by the Canadian government stating "Avoid all travel" regarding the country, region or city of **your** destination. **To view the travel advisories, visit the Government of Canada Travel site. This exclusion does not apply to claims for an **emergency** or a **medical condition** unrelated to the travel advisory.
9. After **your** medical **emergency treatment** has started, **we** must assess and pre-approve additional medical **treatment.** If **you** undergo tests as part of a medical investigation, **treatment** or surgery, obtain **treatment** or undergo surgery that is not pre-approved, **your** claim will not be paid. This includes, but is not limited to, invasive testing, surgery, cardiac catheterization, other cardiac procedures, transplant, and MRI.
10. Any claim related to:
    an act of war whether declared or undeclared;
    rebellion;
    exposure to nuclear reaction or radiation;
    radioactive, biological or chemical contamination.

General Conditions

1. If **you** fail to meet the eligibility conditions as outlined under "Who is eligible for coverage?" **your** insurance coverage is void.
2. When making a claim under this insurance, **you** must provide the applicable documents **we** require. Failure to provide the applicable documentation will invalidate **your** claim.
3. If **you** are eligible, from any other insurance company, for benefits similar to the benefits provided under this insurance, the total benefits paid to **you** by all companies cannot exceed the actual expense that **you** have incurred. **We** will coordinate the payment of benefits with all companies from whom **you** are eligible for benefits similar to those provided under this insurance, to a maximum of the largest amount specified by each company.
4. Any of our coverages are excess insurance and are the last payors. All other sources of recovery, indemnity payments or insurance coverage must be exhausted before any payments will be made under any of **our** coverages.
5. **You** must repay to **us** any amount paid or authorized by **us** on **your** behalf if and when **we** determine that the amount is not payable under the terms of **your** coverage.
6. If **you** incur expenses covered under this insurance due to the fault of a third party, **we** may take action against the party at fault. **You** agree to cooperate fully with **us** and to allow **us**, at **our** own expense, to bring a law suit in **your** name against the third party. If **you** recover against a third party, **you** agree to hold in trust sufficient funds to reimburse **us** for the amounts paid under this coverage.

7. **We** will pay the expenses, covered under this insurance to **you** or to the provider of the service(s).
8. Payment, reimbursement and amounts shown throughout this contract are in Canadian dollars, unless otherwise stated. If currency conversion is necessary, **we** will use the exchange rate on the date the last service was rendered to **you**. This insurance will not pay for any interest.
9. During the processing of a claim under this insurance, **we** may require **you** to undergo a medical examination by one or more **physicians** selected by **us** and at **our** expense.
10. Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act (for actions or proceedings governed by the laws of Alberta and British Columbia). The Insurance Act (for action or proceedings governed by the laws of Manitoba). The *Limitations Act, 2002* (for actions or proceedings governed by the laws of Ontario), or in other applicable legislation in **your** province of residence. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec civil Code.
11. **You** may only commence a legal action in the province or territory where the insurance coverage was issued. **You**, **your** heirs and your assigns consent to the transfer of any legal action to the province or territory where the insurance coverage was issued.
12. **You** must be accurate and complete in **your** dealings with **us** at all times. **We** will not pay a claim if **you**, any person insured under this coverage or anyone acting on **your** behalf attempt to deceive **us** or makes a fraudulent, false or exaggerated statement or claim.
13. Throughout this document, any reference to age refers to **your** age on the **effective date**.
14. **We** and our agents are not responsible for the availability, quality or results of any medical treatment or of any transportation or of **your** failure to obtain medical treatment.
15. This policy contains all terms, conditions and exclusions of **your** travel insurance coverage. Despite any other provision of this contract, this contract is subject to the statutory conditions in the Insurance Act respecting contracts of accident and sickness insurance.

Access to Care

We will assist **you** to access care whenever possible; however, **we** are not responsible for the quality of care **you** receive.

How Do *You* Submit A Claim?

If **you** contacted **us** at the time of the medical **emergency**:
When **you** call **us** at the time of an **emergency** as shown under "What must **you** do in a medical **emergency***?*" **you** are given all the information required to file a claim.

If you did not contact **us** at the time of the medical **emergency**:
1. If **you** did not contact **us** at the time of **your** medical emergency or **you** chose to receive treatment from a medical service provider outside the network, **you** will be responsible for 25% (up to a maximum of $25,000) of **your** medical expenses covered under this insurance and in excess of **your** medical expenses paid by **your government health insurance plan**.
2. **We** do not cover fees charged for completing a medical certificate.
3. For an **Emergency** Medical Insurance claim , **you** must provide notice of **your** claim within thirty (30) days of the date the claim arises.

   You must submit the information required for **your** claim within ninety (90) days of the date of the claim arises. If it is not reasonably possible to provide such information within ninety (90) days, **you** must do so within one (1) year of the date the claim arises or such other time period as may be permitted by **your** applicable provincial legislation or **your** claim may not be reviewed.

   If **your** claim is approved, payment will be made within sixty (60) days of receipt of all of the required information.

4. If **you** need a claim form, or to submit a claim, please contact the Claims Department at:
   RBC Insurance Company of Canada - Claims
   c/o Allianz Global Assistance
   P.O. Box 277
   Waterloo, ON N2J 4A4
   1-855-603-5574 (toll-free from USA or Canada)
   905-608-8254 (collect call from anywhere)
   905-813-4701 (fax)

Out of Province/Country **Emergency** Medical Insurance Coverage:
We require the fully completed Claim & Authorization form, and where applicable:

- documentary evidence of **your** departure date;
- original of all bills, invoices and receipts;
- proof of payment by **your government health insurance plan** and payment from any other insurance company or benefit plan;
- the completed and signed government specific forms if **you** reside in Quebec, British Columbia or Newfoundland;
- a complete diagnosis from the **physician**(s) and/or hospital(s) who provided the treatment, including, where applicable, written verification from the **physician** who treated **you** during **your trip** that the expenses were medically necessary;
- for accidental dental expenses, **we** require proof of the accident.

How to file a Complaint

The complete process to file a complaint with RBC Insurance Company of Canada can be accessed on the RBC Insurance Company of Canada public website at https://www.rbcinsurance.com under "Make a Complaint" at https://www.rbc.com/customercare/index.html.

What can you do if your claim is not approved

If **your** claim is not approved and **you** disagree with **our** decision, **you** have the option to appeal. **You** can contact the RBC Client Complaints
Appeal Office for assistance at:

- ccao@rbc.com or 1-888-728-6666 or
  https://www.rbcinsurance.com/contact-us/personal-insurance/index.html

In order to submit the appeal, **you** will need to outline **your** concerns and resolution expectations. **You** will also need to send **us** the following:

- A copy of the final decision/proposal letter that **you** received
- Any new information or documentation that has not already been submitted to support **your** position

There is a limitation period for commencing an action in the Province of Quebec. If **you** decide to commence an action in court, we recommend **you** seek independent legal advice on **your** rights and the applicable limitation period. **You** may only commence a legal action in the province or territory where the insurance was issued.

What Assistance Services Are Available?

The following assistance services are available to **you**:

1. Medical Assistance & Consultation
   When **you** have a medical emergency and **you** call **us**, whenever possible **you** will be directed to one or more recommended medical service providers near **you**. In addition, whenever possible, **we** will:
   - provide confirmation of coverage and pay **your** eligible medical expenses directly to the recommended medical service provider;
   - consult with **your** attending physician to monitor **your** care; and
   - monitor the appropriateness, necessity and reasonableness of that care to ensure that **your** resulting eligible expenses will be covered by this insurance.

2. Payment Assistance
   Whenever possible, the payment of the eligible medical services **you** receive will be co-ordinated through **us**, communicated with **your** medical provider and billing arrangements will be discussed. Pay assistance may not be available from certain medical service providers for reasons beyond **our** control. **You** may be required to make payment up-front or to leave a deposit. If **you** are required to make payment up-front or leave a deposit, call **us** immediately.
3. Emergency Message Centre
   In case of a medical **emergency**, **we** will help exchange important messages with **your** family**,** business or **physician.**
4. Replacement Co-ordination
   Whenever possible, **we** will help co-ordinate the replacement of **your** prescription eyeglasses or essential prescription medication in the event these items need to be replaced during **your** trip.
5. Travel Services:
   If you require planning or assistance during your trip, please contact **us** at:

Canada and USA toll free: 1-855-603-5571
Local: 905-608-8251 – collect from anywhere

- Emergency Cash Services
- Emergency Messages
- Emergency Ticket Replacement
- Legal Services
- Bail Bond Services
- Passport and Visa Information
- Health hazards advisory
- Inoculation requirements
- Weather Info
- Currency Exchange info
- Consulate and Embassy location

Important Telephone Numbers

Assistance Centre
(For details, please see "What assistance services are available?")

- Canada and USA toll free: 1-855-603-5571
- Local: 905-608-8251 – collect from anywhere
- 905-813-4719 (fax)
- Medical assistance and consultation
- Payment assistance
- **Emergency** message centre

Claims Centre

- Canada and USA toll free: 1-855-603-5574
- Local: 905-608-8254 – collect from anywhere
- Claim filing after **your** return
- Claim enquiry after **your** return

GROUP DENTAL CARE (DTL) INSURANCE BENEFIT

If an **insured** incurs covered charges for dental care, treatment, services and supplies performed by a licenced **dentist**, **oral surgeon, denturist**, **denturologist,** or **dental technician** to prevent or correct dental disease, dental defect or **accidental dental injury**, **we** will pay such covered charges after the satisfaction of the **deductible amount** (if any) and subject to the **reimbursement percentage**, exclusions, coordination of benefits and other applicable provisions of the policy.

Benefit Specific Definitions

The following definitions are applicable to this benefit in addition to certain definitions under the GENERAL DEFINITIONS section of this booklet.

Abscess means pus enclosed in the tissues of the jaw bone at the tip of an infected tooth.

Accidental dental injury means an unexpected and unforeseen **injury** to the dental and contiguous structures which is the result of an event that occurs by chance. The term is deemed to include **injury** or accidents of the "biting" type to **natural teeth**.

Alveolar means the dental alveolus or the bony processes of the maxilla (upper jaw) or mandible (lower jaw) that may contain the teeth.

Alveoplasty means the surgical excision or revision of the **alveolar** process to restore a normal contour.

Anterior means the front position. These are the incisors and cuspids (canine) teeth.

Apexification means an **endodontic** procedure performed to induce tooth apex (tip) barrier development.

Apicoectomy Excision of the apical portion of a tooth through an opening made in the overlying labial, buccal, or palatal **alveolar** bone.

Benefit period means 12:01 a.m. January 1 to midnight December 31.

Bitewing means a kind of dental x-ray which is taken while the teeth bite together.

Caries means tooth decay.

Cephalogram means an X-ray photograph of the bones of the skull that assist in the evaluation of the patient's facial growth and development.

Crown *(porcelain/plastic/metal)* means a type of dental restoration which completely caps or encircles a tooth or dental implant.

Curettage means scraping or removal of diseased tissue with a 'curette' (a surgical instrument with a sharp spoon-shaped blade).

Deductible amount if applicable, means the total dollar amount of covered charges which must be paid by or on behalf of the **insured** during any one **benefit period** before benefits become payable by **us**. **Employees** without insured **dependents** will be subject to the single deductible amount; **employees** with insured **dependents** will be subject to the family deductible amount as described in the Group Dental Care (DTL) Benefit Summary.

Dental Association Fee Guide means the published fee guide for the dental services provided and approved by the applicable provincial dental association. The fee guide used will be based on the province of residence of the **insured**. The fee guide or guides applicable to this benefit are described in the Group Dental Care (DTL) Benefit Summary.

Dental technician means a dental mechanic, **denturologist**, denture therapist or **denturist** duly licensed by the province in which they practice and duly qualified to perform the services or covered charges rendered. The term dental technician includes a dental hygienist who has received a diploma from a recognized dental faculty and is qualified to practice dental hygiene and dental prophylaxis. **We** will not recognize **you** or **your spouse**, **child**, parent or sibling as a dental technician for a claim that the **insured** submits to **us**.

Dentist or **oral surgeon** means a person who is duly qualified and legally licenced to practice dentistry by the province in which they practice, when such person renders a covered charge within the scope of their licence. **We** will not recognize **you** or **your spouse**, **child**, parent or sibling as a dentist or oral surgeon for a claim that the **insured** submits to the Company.

Denturist or **denturologist** means a person licensed by the appropriate provincial regulatory authority to work as a direct practitioner supplying and fitting dentures to the public. **We** will not recognize **you** or **your spouse**, **child**, parent or sibling as a denturist or denturologist for a claim that the **insured** submits to the Company.

Endodontics means a department of dentistry which involves diagnosis, prevention and treatment of dental pulp (root canal specialization).

Enrolment date means the date by which **you** must select your DTL Class.

Equilibration means the study and achievement of equalized pressure. Balance of opposing forces, such as the maxilla with the mandible.

Extra oral x-ray means a film held outside the mouth and records larger areas than is possible with smaller films.

Frenectomy means the excision of the mucous membrane attaching the cheeks and lips to the mucosa of the maxilla and mandible.

Furca means the dividing point of the root.

General practitioner means a **dentist** who practices dentistry without specialization. **We** will not recognize **you** or **your spouse**, **child**, parent or sibling as a general practitioner dentist for a claim that the **insured** submits to the Company.

Gingivectomy means the excision of diseased or unsupported gingival tissue elimination of periodontal pockets and/or creation of a new gingival margin (gumline).

Gingivoplasty means the procedure by which gingival deformities are reshaped and reduced to create normal and functional form; surgical contouring of the gingival tissues.

Government health care means the body of federally or provincially enacted laws, as amended from time to time, governing provincial health insurance plans, provincial hospital insurance plans, provincial medicare plans, provincial dental care plans, federal or provincial medical or dental care and services Acts, the Hospital Insurance and Diagnostic Services Act (Canada) and any other federal or provincial government sponsored hospitalization, medicare, drug or dental insurance plan which provides health insurance to residents of Canada.

Hemisection means cutting a two rooted tooth in half; it frequently also involves extraction of one of the two separate roots.

Injury means a bodily injury that is the direct result of an accident and not related to any other cause.

Inlay means a restoration (usually gold, composite or porcelain ceramics) fabricated in the lab and cemented on a tooth like a missing puzzle.

Legislation, plan or act means the original enactments of the legislation, plan or act and all amendments.

Life Event means you experience one of the following:

- loss of alternate coverage;
- qualifying as a **spouse** or partner/legal separation;
- birth/adoption/accepting legal guardianship of a **child**;
- death of a **dependent**;
- **dependent** no longer qualifies for coverage.

Maxillo-facial deformities means deformities pertaining to the jaws and face.

Natural teeth means teeth, whether or not restored, but does not include removable or fixed prosthetic devices.

Occlusal means the biting surface of the back teeth. Occlusion, in a dental context, means simply the relationship of contact between teeth.

Occlusal equilibration means the correction of occlusion by selective grinding to equalize occlusal stress or for harmonizing cuspal relations; the removal of high spots and areas of interference.

Occlusal x-ray means an intra-oral film showing the lingual surfaces of the teeth and a portion of the hard palate.

Onlay means a restoration that covers the entire biting surface of a tooth. In dentistry, an inlay is an indirect restoration (filling) consisting of a solid substance (as gold, composite or porcelain ceramics) fitted to a cavity in a tooth and cemented into place.

Orthodontics means a special field in dentistry which involves diagnosis, prevention, and treatment of bite abnormalities or facial irregularities.

Other coverage means insurance or reimbursement provided for the **insured** under any insurance policy, plan or arrangement under which the **insured** is a participant, other than under this policy.

Panoramex / panoramic x-ray means an extra-oral film that provides a continuous view of the teeth and associated structures.

Periapical x-ray means an x-ray that records the entire tooth, including the apex (tip) of the root and some of the surrounding bony tissue.

Pericoronitis means inflammation of the gingiva surrounding the crown of a tooth.

Periodontics means a specialty of dentistry that studies supporting structures of teeth, diseases, and conditions that affect them.

Pontics means the false tooth in a bridge or denture to replace the missing tooth.

Pre-treatment plan means a written report, in a form approved by **us**, which is prepared by the attending **dentist** or **oral surgeon** following their examination of the **insured**, and which provides the following:

- a description of the recommended treatment necessary to prevent or correct the dental disease, dental defect or **accidental dental injury**, as well as any applicable dental X-rays;
- an estimate of the period of time during which such treatment is to be rendered; and
- the estimated cost of the recommended treatment and supplies (such as, but not limited to, dental appliances).

Prosthodontics means the dental specialty pertaining to the diagnosis, treatment planning, fabrication of artificial parts to replace missing teeth and their associated structures, rehabilitation and maintenance of the oral function, comfort, appearance and health of patients with clinical conditions associated with missing or deficient teeth and/or oral and maxillofacial tissues using biocompatible substitutes.

Pulpectomy means the removal of the whole pulp inside a tooth. Pulpectomy refers to a common **endodontic** procedure in which the dental pulp and root canal are completely removed.

Pulpotomy means the removal of the top part of the pulp inside a tooth. Pulpotomy refers to a common **endodontic** procedure in which dental pulp is removed from the pulp chamber.

Pulp vitality means the health of the pulp. When there is complete degeneration, or the pulp has been removed, the tooth is termed nonvital.

Reasonable and customary means reasonable and customary charges made by the provider of dental care, treatment, services or supplies to the **insured**. Such dental charges shall be considered reasonable and customary if they do not exceed the general level of charges made by other providers of similar standing in the **insured's** province or territory of residence, when furnishing comparable dental care treatment, services or supplies for a similar condition.

Reimbursement percentage means the specified percentage of covered charges payable by **us**. The reimbursement percentage is applied after the **deductible amount**, if any, has been satisfied.

Residual root means a root or part of a root remaining in the soft or hard tissues.

Root canal therapy means treatment of a tooth having a damaged pulp or associated with periapical disease. It is normally performed by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling with a sterilized sealing material.

Sickness means an **illness** or disease or a medical condition requiring medical treatment.

Splinting means stabilization or immobilization of periodontally involved teeth.

Stomatoplasty means reconstructive or plastic surgery of the mouth.

Supernumerary teeth means extra teeth in excess of the regular or normal number of teeth. Sometimes can show up as an extra row.

Temporomandibular joint dysfunction (TMJ) means Costen's Syndrome. The symptoms associated with malfunction of the temporomandibular joint (the joint between the skull and the lower jaw).

Veneer means a thin layer of tooth-colored restorative material (can be porcelain, composite or ceramics) placed over a tooth's front surface either to improve the aesthetics of a tooth, or to protect a damaged tooth surface.

Vertical dimension means the vertical height of the face with the teeth in **occlusion;** vertical relationship, the degree of jaw separation when the teeth are in contact. The measurement is usually made from the tip of the chin to the base of the nose.

Vestibuloplasty means a surgical procedure to restore alveolar ridge height by lowering muscles attaching to the buccal, labial, and lingual aspects of the jaws.

No DTL Beneficiary Designation Allowed

No **beneficiary** designation for the Group Dental Care insurance under this policy shall be valid. **You** do not have the right to name a **beneficiary** for any amount of Dental Care insurance money payable under the policy, other than as an assignment of benefits directly to the **dentist**, **oral surgeon, denturist**, **denturologist** or **dental technician**.

No Waiver of Premium

Premium payments must continue to maintain coverage if **you** become disabled while insured under the policy.

Covered Charges

Covered charges are charges incurred by an **insured** for necessary dental care, treatment, services and supplies to prevent or correct dental disease, dental defect or **accidental dental injury** to the extent that the covered charges:

- are an Eligible Covered Charge;
- are **reasonable and customary**;
- are recommended, approved and/or prescribed by a **dentist**, **oral surgeon, denturist**, **denturologist** or **dental technician**;
- exceed the amounts payable under any **government health care** plan, and in the case of an **insured** not covered under such a plan, to the extent that they exceed the amounts that would have been payable had such coverage been applicable, unless the payment of such charges is not prohibited by law;
- exceed (in the case of an **insured** with **other coverage** for the same benefit) the dental charges reimbursed from all other sources. Any benefit payable under any **other coverage** that duplicates benefits payable under this Benefit Provision will be fully coordinated with this Benefit Provision so that the aggregate reimbursement from all benefits payable does not exceed the total covered charge incurred by the **insured**;
- do not exceed any maximum or limit as specified in the Group Dental Care (DTL) Benefit Summary; and
- do not exceed the suggested fee listed in the **Dental Association Fee Guide** specified in the Group Dental Care (DTL) Benefit Summary, except that if the procedures are rendered by a **dental technician** who is a member of a provincial group of **dental technicians** which has its own official fee guide, then to the extent that the procedures do not to exceed the suggested fee listed in such fee guide.

NOTE:
In all cases where an **insured** knows or can reasonably be expected to know that the estimated cost of dental care, treatment, services or supplies will exceed $300 and such treatment is not being provided in an emergency situation, the **insured** or the attending **dentist, oral surgeon, denturist**, **denturologist,** or **dental technician** is strongly encouraged to submit a **pre-treatment plan** acceptable to **us** prior to the commencement of such treatment. **We** will review and assess the **pre-treatment plan** to determine the amount of the covered charges payable. This determination may be based on alternate dental procedures for treating the condition which would provide an adequate result in accordance with accepted professional standards of dental practice. **We** will thereby determine in advance its share of the cost of such treatment.

Unless a **pre-treatment plan** is filed with **us**, the charges incurred may not be considered covered charges or may be assessed in a lesser amount than would otherwise have been payable.

Date the Covered Charge was Incurred

If an **insured** remains continuously covered for the duration of a course of dental treatment, any eligible covered charge will be deemed to have been incurred as of the date the particular procedure is performed except that an eligible covered charge will be deemed to have occurred:

- with respect to treatment where an appliance or prosthetic device is inserted, on the date such appliance or prosthetic device was inserted;
- with respect to a crown, on the date such crown was placed; or
- with respect to a root canal treatment, on the date the canal was closed.

If an **insured** does not remain continuously covered for the duration of a course of dental treatment, the date the covered charge was incurred will be deemed to be the date the particular procedure is performed, subject to the Extension of Coverage provision.

Extension of Coverage

The following dental treatment for an **insured** will be considered a covered charge for a 90-day period immediately following an **insured's** termination of insurance provided the covered charge would have been considered an eligible covered charge had the insurance remained in force:

- Dental treatment following **accidental dental injury** to a **child**, which occurred while **child** was insured, will be considered a covered charge for such **child** during the 90-day period immediately following the termination of insurance of the **child** if the treatment was deferred on the recommendation of the **dentist** because of the age of the **child**; and
- Where a series of treatments with respect to **Orthodontic** Services (if insured under this policy) had commenced prior to the date of termination of an **insured's** insurance, the **orthodontic** treatments incurred during the 90 days following such termination will be considered covered charges.

Benefit Determination

The **insured** will not be reimbursed for a covered charge under more than one of the applicable sections of the policy.

Coverage Outside of Canada

If an **insured** incurs a covered charge for dental care, treatment, services or supplies outside of Canada as a result of an emergency due to **accidental dental injury** or dental complaint, **we** will insure such covered charges if:

- the covered charges are incurred while the **insured** is temporarily absent from their normal residence in Canada;
- the covered charges would otherwise be payable;
- the covered charges do not exceed any provincial **Dental Association Fee Guide** maximums and limitation; and
- the covered charges are the **reasonable and customary** fees usually charged for such dental care, treatment, services or supplies by the attending practitioner to all their private patients.

If an **insured** incurs a covered charge for dental care, treatment, services or supplies outside of Canada other than as a result of an emergency due to **accidental dental injury** or dental complaint, such covered charge will be subject to the terms and conditions of this benefit that would apply if such covered charge was incurred in the **insured's** province of residence.

Survivor Benefit

Insurance under this Benefit Provision for a **dependent** may be continued, (without premium payment), after **your** death until the earliest of the following events has occurred:

- termination of the policy;
- 24 months from the date of **your** death;
- the date similar benefits are obtained elsewhere;
- remarriage of the **spouse**; or
- the date when **dependent** status under the policy would have ceased had **you** not died.

When insurance under this Benefit Provision is continued, it is subject to all other terms and conditions of the policy.

Benefit Payment

Subject to the provisions of this policy, **we** will pay dental covered charges incurred by the **insured** during the **benefit period**, after satisfaction of the **deductible amount**, if any, and to the extent of the applicable **reimbursement percentage**.

Benefit Period

With respect to covered charges and for purposes of applying the deductible amount, the **benefit period** will be as specified in the Group Dental Care (DTL) Benefit Summary.

Deductible Amount

The **deductible amount** is the amount of covered charges that an **insured** must incur and pay before benefits become payable by **us**. The **deductible amount**, if any, will apply to each **benefit period.**

The **deductible amount** applied to **you** (an **employee** without **dependents**) will be the single deductible.

The **deductible amount** applied to a family will be the family deductible. A family includes **you** and **your dependents**. During each **benefit period**, the maximum **deductible amount** applied to each **insured** in a family will be equal to the single deductible. Once the sum of the **deductible amounts** applied to several members of that family equals the family deductible, no further **deductible amounts** will be applied to any member of that family for the rest of that **benefit period**.

The single and family deductible amounts are shown in the Group Dental Care (DTL) Benefit Summary.

Carry-Forward Deductible Amount

Any amount of covered charges that an **insured** incurs during the last 3 months of a **benefit period** that is not reimbursed or used to satisfy the **deductible amount**, may be carried forward and applied to the **deductible amount** for the next **benefit period**.

Reimbursement Percentage

The **reimbursement percentage** will be the percentage of the covered charges payable by **us**. The **reimbursement percentage** is applied after the **deductible amount**, if any, has been satisfied. Where the **reimbursement percentage** is less than 100%, the **insured** is responsible for the balance of the covered charges.

The **reimbursement percentage** applicable to benefits under this benefit provision will be as specified in the Group Dental Care (DTL) Benefit Summary.

Maximum Benefit

There will be no overall lifetime DTL Benefit maximum amount applicable to the total covered charges incurred by an **insured** except as provided in the specific benefit provisions. Individual services, supplies or treatment limits will be applicable as shown in the Group Dental Care (DTL) Benefit Summary.

Pre-Treatment Plan

When a proposed course of treatment is expected to cost more than $300, a treatment plan should be filed with **us** before treatment begins.

When **we** receive the **pre-treatment plan**, **we** will determine and pre-certify, in writing, **our** share of the cost of the anticipated course of dental treatment. This process will identify coverage and benefit limitations and clarify applicable policy specifications including **deductible amounts**, **reimbursement percentage** and maximum amounts.

If **we** pre-certify a pre-treatment plan, but the proposed course of dental treatment does not begin within 12 months of the date the pre-treatment plan was submitted, **we** will not be bound by its pre-certification.

When Insurance Ends

Insurance ends on the date specified in the Group Dental Care (DTL) Benefit Summary. In addition, insurance may end on an earlier date, as specified in General Eligibility For Insurance.

Basic Dental Services

Basic dental services consist of:
- preventive dental procedures; and
- basic dental procedures (including **endodontics** and **periodontics**).

Preventive Dental Procedures

Preventive dental procedures are:
- oral examinations:
  - complete examinations: 1 complete oral examination every 36 consecutive months. A complete examination includes complete examination and charting of the hard and soft structures, periodontal charting, **pulp vitality** tests, recording history, treatment planning, case presentation and consultation with the **insured**. A complete examination must be separated from any other complete, recall or specific examination by at least the recall period shown in the Group Dental Care (DTL) Benefit Summary.
  - recall or specific examinations: 1 recall or specific examination every recall period shown in the Group Dental Care (DTL) Benefit Summary. Recall and specific examinations include a complete examination of the hard and soft structures, checking occlusion, **pulp vitality** tests and consultation with the **insured**. A recall or specific examination must be separated from any other complete, recall or specific examination by at least the recall period shown in the Group Dental Care (DTL) Benefit Summary.
  - specialty examinations: 1 examination per specialty every 36 consecutive months. Specialty examinations include general or specific examinations for **periodontics**, oral surgery, **prosthodontics** and **endodontics**.
  - emergency examinations: An emergency examination includes an evaluation for acute pain or infection, and **pulp vitality** tests.

- x-rays:
  - 4 **bitewing** x-rays in any 12 consecutive month period. A **bitewing** x-ray is a routine check-up x-ray used to detect decay in molar teeth.
  - 1 complete series of x-rays or 1 **panorex** every 36 consecutive months. A complete series of x-rays is 10-14 individual x-rays, including **bitewings**, showing all the teeth in the mouth. A **panorex** is a large panoramic view of the entire mouth.
  - 4 single-teeth x-rays, called **periapical x-rays**, in any 60 consecutive day period.
  - 2 **occlusal x-rays** in any 12 consecutive month period.
  - 2 **extra oral x-rays** in any 12 consecutive month period.

- tests and lab examinations, including microbiological tests, histological tests and cytological tests.

- polishing (cleaning of teeth), limited to 1 unit of 15 minutes every recall period shown in the Group Dental Care (DTL) Benefit Summary.

- scaling and root planing (tartar removal), limit shown in the Group Dental Care (DTL) Benefit Summary. Scaling means removing calcium deposits above and below the gum line. Root planing is the final smoothing of rough tooth surfaces and removing any remaining calcium deposits.

- topical fluoride treatment once every DTL recall period shown in the Group Dental Care (DTL) Benefit Summary.

- oral hygiene instruction (instruction on how to brush and floss), limited to 1 unit of 15 minutes every 36 consecutive months.

- disking (filing or reshaping teeth), for **children** under 19 only.

- space maintainers and maintenance for **children** under 14 only, when a dentist has removed a primary tooth and an appliance is used to maintain the space for a permanent tooth. An **insured** can have only 1 appliance per quadrant unless another tooth in that quadrant is subsequently lost. Teeth are divided into 4 quadrants: upper right, upper left, lower right and lower left:
    - space maintainers include the design, separation, fabrication, insertion, cementation, removal and 6 month follow-up care; and
    - maintenance includes adjustments and recementation, addition of clasps or activating wires, repairs and recementation, and 6 month follow-up care.

- **caries**, trauma and pain control (sedative fillings). An **insured** is covered for sedative fillings that are applied to very deep cavities to reduce pain. This procedure includes local anesthesia, removal of decay or removal of existing restoration, **occlusal** adjustment, pulp cap and placement of a sedative filling.

Basic Dental Procedures

Basic dental procedures are:
- fillings – amalgam fillings (silver) and composite or acrylic (white) fillings.
    - an amalgam filling procedure includes pulp cap, sedative base, local anesthesia, **occlusal** adjustment, removal of decay or existing restoration, placement of filling and finishing the restoration. Multiple restorations on one surface will be considered a single filling.
    - a composite or acrylic filling procedure includes pulp cap, sedative base, local anesthesia, **occlusal** adjustment, removal of decay or existing restoration, placement of filling and finishing the restoration. Multiple restorations on one surface will be considered a single filling. Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on **anterior** teeth will be considered single surface restorations.

- retentive pins (for amalgam and composite fillings), limited to 3 pins per tooth.

- prefabricated metal or plastic restorations (including stainless steel **crowns)**, when a permanent **crown** is not being installed. Replacements must be separated by at least 36 consecutive months. This procedure includes pulp cap, sedative base, local anesthesia, **occlusal** adjustment, removal of decay or existing restoration, and cementation of **crown**.

- pit and fissure sealants on permanent molar teeth, for **children** under 16. This is a coating put on top of any pits or cracks in teeth to prevent cavities from forming. Coverage is limited to 1 treatment per tooth.

- **endodontics** (**root canal therapy** and root canal fillings, and treatment of disease of the pulp tissue):
    - **root canal therapy**, limited to 1 standard treatment per tooth every 5 consecutive years. This procedure includes treatment plan, **pulp vitality** test, opening and drainage, local anesthesia, tooth isolation, clinical procedure with appropriate x-rays, relieving occlusion, smoothing tooth, and follow-up care. If **root canal therapy** is performed on the same tooth by the same **dentist** within 3 months of opening and drainage, **pulpotomy** or **pulpectomy**, the amount payable is reduced by the amount previously paid for such opening and drainage, **pulpotomy** or **pulpectomy**.
    - **apexification** on permanent teeth. This procedure includes treatment plan, local anesthesia, tooth isolation, clinical procedure with appropriate x-rays, placement of dentogenic media, and follow-up care.
    - **apicoectomy**. This procedure includes treatment plan, local anesthesia, clinical procedure with appropriate x-rays, root resection, apical **curettage**, and follow-up care.
    - retrofilling. This procedure includes **apicoectomy**, **curettage** and root-end filling.
    - root amputation. This procedure includes recontouring tooth and **furca**.
    - **hemisection**.
    - vital **pulpotomy**. This procedure includes treatment plan, local anesthesia, clinical procedure and appropriate x-rays, and follow-up care.

- **periodontics** (treatment of bone and gum disease):
  a. definitive periodontal surgery, once every 12 consecutive months on the same surgical site. If a person has surgery, coverage depends on how many teeth are involved. Definitive periodontal surgery includes local anesthesia, management of infection, surgical procedure, surgical dressing (packing), sutures, and post surgical care. A surgical site is considered a sextant. The mouth is divided in 6 sextants. The allowance for fewer teeth may be prorated. Definitive periodontal surgery includes the following procedures:
     i. gingival **curettage**, limited to 1 gingival **curettage** per site every 12 months. Definitive surgical procedure performed by the **dentist** under local anesthesia.
     ii. **gingivoplasty**, limited to 1 **gingivoplasty** per site every 12 consecutive months.
     iii. **gingivectomy**, limited to 1 **gingivectomy** per site every 12 consecutive months.
     iv. flap approach, limited to 1 flap approach surgery per site every 12 consecutive months.
     v. grafts – pedicle, free soft tissue, lateral sliding and rotated – limited to 1 graft per site every 12 consecutive months. This procedure includes local anesthesia, management of infection, surgical procedure, surgical dressing (packing), sutures, and post surgical care.

  b. additional periodontal surgery:
     i. distal wedge procedure, limited to 1 distal wedge procedure per site every 12 consecutive months. This procedure includes local anesthesia, management of infection, surgical procedure, surgical dressing (packing), sutures, and post surgical care. A surgical site is considered a sextant.
     ii. treatment of periodontal **abscess** or **pericoronitis**, limited to 1 unit of 15 minutes per treatment and 2 units of 15 minutes in any 12 consecutive month period. This procedure includes lancing, scaling, **curettage**, medication, or surgery.

  c. related periodontal services:
     i. provisional **splinting**, limited to 1 unit of 15 minutes per joint. Replacements must be separated by at least 24 consecutive months. This procedure includes tooth preparation, acid etch, wire replacement, acrylic or composite filling, **occlusal** adjustment, and 3 month follow-up care.
     ii. **occlusal** adjustment – treatments to adjust an **insured's** bite – limited to 1 unit of 15 minutes for each office visit and 2 units of 15 minutes in any 12 consecutive month period. This treatment is only available when an **insured** has gum surgery.
     iii. periodontal appliance. Replacements must be separated by at least 12 months. Includes impression, insertion and adjustments within 6 months of insertion. A periodontal appliance is used to treat gum disease.
     iv. periodontal appliance adjustment or reline, limited to 1 unit of 15 minutes in any 12 consecutive month period.

- oral surgery. Oral surgery includes local anesthesia, removal of excess gingival tissue, surgical service, control of hemorrhage, suturing, and post-operative treatment and evaluation. A surgical site will be considered a sextant unless specified as a quadrant.
  a. extraction of erupted tooth – uncomplicated. Limited if additional teeth extracted in the same quadrant.
  b. extraction of erupted tooth – complicated. Limited if additional teeth extracted in the same quadrant. Surgery requires surgical flap or sectioning of the tooth.
  c. extraction of impacted tooth – soft tissue impaction. Limited if additional teeth extracted in the same quadrant. Surgery requires removal of overlying soft tissue and extraction of impacted tooth.
  d. extraction of impacted tooth – partial bone impaction. Limited if additional teeth extracted in the same quadrant. Surgery requires removal of overlying soft tissue, evaluation of flap, and either removal of bone and tooth or sectioning and removal of tooth.
  e. extraction of impacted tooth – complete bone impaction. Limited if additional teeth extracted in the same quadrant. Surgery requires removal of overlying soft tissue, evaluation of flap, and removal of bone and sectioning and removal of tooth.
  f. extraction of **residual root**. Limited if additional teeth extracted in the same quadrant.
  g. surgical exposure of impacted tooth. Limited if additional teeth exposed in the same quadrant.
  h. **alveoloplasty**. This procedure includes remodelling, excision, removal and reduction of bone.

i. other procedures: **stomatoplasty**, remodelling mouth floor, **vestibuloplasty**, ridge reconstruction, and mucus fold extension; surgical excision of tumors; surgical excision of cysts; surgical incision and drainage; surgical removal of foreign body; repairs of lacerations; **frenectomy**; salivary gland treatment; and antral surgery.

- related surgical services, only when a person has eligible complicated oral surgery:
  a. anesthesia, including pre-anesthetic evaluation and post-anesthetic follow-up: general anesthesia; provision of dental and anesthetic facilities, equipment and supplies; and deep sedation.
  b. conscious sedation: inhalation technique; intravenous sedation; intramuscular injections of sedative drugs; and combined techniques of inhalation plus intravenous or intramuscular injections.
  c. therapeutic injections – administration of intramuscular drug injections.

- repairing (fixing broken or damaged dentures), including 6 month follow-up care.

- relining or rebasing dentures, limited to 1 reline or rebase in any 12 consecutive month period per denture. Relining dentures means adding material so that the dentures fit properly. Rebasing dentures means fitting dentures with a new base. These services include 6 month follow-up care.

Major Dental Services

Major dental services consist of the following major dental procedures:

- **inlays**, **onlays** and gold foil restorations. Replacements must be separated by at least 5 years. **Inlays** and **onlays** are metal or porcelain fillings placed on the surface of the tooth. **Inlays**, **onlays** or gold foil restorations are only covered for teeth that cannot be restored with a regular filling because of extensive incisal or cusp damage.
  - **inlays** and **onlays** include treatment planning, **occlusal** records, local anesthesia, removal of decay or old restoration, tooth preparation, pulp protection, impressions, temporary services, insertion, **occlusal** adjustments, and cementation. **Inlays** are only covered when x-rays indicate a **crown** will be required. **Onlays** are limited to teeth with extensive incisal or cusp damage;
  - gold foil restorations include treatment planning, local anesthesia, removal of decay or old restoration, tooth preparation, pulp protection, insertion, **occlusal** adjustments, and gold material.

- **crowns**: Replacements must be separated by at least 5 consecutive years. This procedure includes treatment planning, **occlusal** records, local anesthesia, subgingival preparation of the tooth and supporting structures, removal of decay or old restoration, tooth preparation, pulp protection, impressions, temporary services, insertion, **occlusal** adjustments, and cementation. It does not include porcelain or porcelain fused to metal for molar teeth. **Crowns** are only covered for teeth that cannot be restored with a regular filling because of extensive incisal or cusp damage.

- **veneers**: Replacements must be separated by at least 36 consecutive months. **Veneers** are white facings put on the front of the tooth's surface. **Veneers** are only covered for teeth that cannot be restored with a regular filling and as long as they are not used primarily to improve appearance.

- dentures:
  a. full dentures: Replacements must be separated by at least 5 consecutive years.
     i. standard dentures. This procedure includes treatment plan, initial and final impressions, jaw relations records, try-in insertion, **occlusal equilibration**, and follow-up care and adjustments for 6 months following insertion;
     ii. standard immediate dentures. This procedure includes treatment plan, impressions, jaw relations records, tissue conditioner, insertion, **occlusal equilibration**, and follow-up care and adjustments for 6 months following insertion.
  b. partial dentures: Replacements must be separated by at least 5 consecutive years. This procedure includes treatment plan, mouth preparation, initial and final impressions, jaw relations records, connectors, rests, clasps, and bases, framework try-in, try-in evaluation, insertion, **occlusal equilibration**, and follow-up care and adjustments for 6 months following insertion.
  c. remake, partial denture: An **insured** is only covered when a replacement partial denture would be covered.

- denture adjustments. This procedure includes 6 month follow-up care.

- tissue conditioning.

- fixed bridges: **We** will only pay for the least expensive alternate procedure when considering the cost of a bridge.
  a. initial bridges: Limited to teeth extracted while an **insured** is covered under this provision until the **insured** has been covered for 12 consecutive months.
  b. replacement bridges:
     i. limited to teeth extracted while an **insured** is covered under this provision until the **insured** has been covered for 12 consecutive months;
     ii. after the **insured** has been covered for 12 consecutive months, replacement bridges are covered provided the existing bridges are at least 10 years old.

  This procedure includes treatment planning, **occlusal** records, local anesthesia, subgingival preparation of the tooth and supporting structures, removal of decay or old restoration, tooth preparation, pulp protection, impressions, temporary services, **splinting** and intraoral indexing for soldering purposes, insertion, **occlusal** adjustments, and cementation. Does not include porcelain or porcelain fused to metal abutments or **pontics** for molar teeth.

- repairing fixed bridges.

- recementing fixed bridges.

- miscellaneous:
  a. diagnostic casts – unmounted for prosthetic dentistry – limited to 1 diagnostic cast every 36 consecutive months;
  b. retentive pins with **inlays**, **onlays** or **crowns**, limited to 3 pins per tooth. This procedure is for the retention and preservation of the tooth;
  c. retentive pins with fixed bridges, limited to 3 pins per tooth. This procedure is for the retention and preservation of the tooth;
  d. cast metal post and core – custom made casting includes cast core, limited to 1 post and core per tooth. This procedure is for teeth which have had **root canal therapy**;
  e. prefabricated post, prefabricated post and core – manufactured metal post – manufactured metal post and core – limited to 1 one post and core per tooth. This procedure is for teeth which have had **root canal therapy**;
  f. amalgam and pin **crown** build-up, composite and pin **crown** build-up. This procedure is for the retention and preservation of the tooth;
  g. repair of **inlays**, **onlays** or **crowns**. Recementing of **inlays**, **onlays** and **crowns**, limited to 1 unit of 15 minutes per tooth every 6 consecutive months.

General DTL Limitations And Exclusions

This policy does not cover any charges which result directly or indirectly from, or are in any manner or degree associated with or occasioned by:

- the **insured's** active participation in a riot, insurrection or civil commotion;

- the **insured's** service in the armed forces of any nation;

- the **insured's** attempt to commit or commission of a **crime,** or provoking an assault, whether or not the **insured** has been charged;

- war, declared or undeclared, or any act of war; or

- any **sickness** or **injury** for which the charge is payable or reimbursable under any Workers' Compensation Act or similar **legislation, plan or act**, or would have been payable if a claim had been submitted.

In addition, this policy does not cover the following charges:

- charges that private insurers are not permitted to cover by law;

- care, treatment, services or supplies payable or available (regardless of any waiting list) under any **government health care** plan or program;

- care, treatment, services or supplies to the extent that their costs exceed the **reasonable and customary** rates in the **insured's** province or territory of residence;

- dental screening or checkups required for the use of a third party, such as applications for employment, admission to camps or recreational activities, or research studies;

- cosmetic treatment, including dental care, treatment, services or supplies rendered to improve appearance, when the form and function of the teeth is satisfactory and no pathological condition exists. The following will always be considered cosmetic treatment:
    - porcelain or other **veneer** facings on **crowns** or **pontics** posterior to the second bicuspid;
    - alteration, extraction or replacement of sound **natural teeth** to change appearance;
    - treatment of teeth to remove discoloration, except in connection with **endodontic** treatment;
    - replacement of congenitally missing teeth and the removal of **supernumerary teeth**;
    - appliances and restorations for the purpose of **splinting** teeth, except in connection with periodontal surgery;
    - replacement of sound amalgams where there is no evidence of damage to the amalgam or evidence of further decay.

  We will review claims submitted for dental surgery or treatment that is wholly or partly cosmetic in nature, and **we** may consider the surgery or treatment to be a covered charge if it is as a result of an **accidental dental injury**.

- **accidental dental injury**:
    - unless dental treatment is rendered within 365 days following the date of the **accidental dental injury**; or
    - if the covered charge is an eligible expense under any extended health care policy or benefit provision of which the **insured** is a **covered person**;

- hospital charges for dental treatment or treatment of mouth conditions;

- dietary or nutritional counselling for the control of dental caries or for dental plaque control;

- charges for broken appointments, transportation costs of a **dentist, oral surgeon, denturist**, **denturologist,** or **dental technician**, advice received by telephone or other electronic communication or for completing claim forms or reports;

- protective athletic appliances;

- charges to replace an existing dental appliance, including removable partial or complete dentures, which has been lost, misplaced or stolen, or to provide any duplicate dental appliance;

- treatment, including restorations and appliances, to correct **vertical dimension**, **temporomandibular joint dysfunction**, **maxillo-facial deformities**, or congenital or developmental malformations, or full-mouth reconstructions;

- services furnished by a commercial laboratory, to the extent that they exceed **reasonable and customary** covered charges;

- implants and implant related services;

- dental treatment or a series of dental treatments received prior to the effective date of insurance under this Benefit Provision, both with or without a **pre-treatment plan** having been filed with the previous insurance carrier;

- dental treatment or a series of dental treatments which is rendered subsequent to the date of termination of the **insured's** dental coverage, except as provided under the Extension of Coverage provision;

- services or supplies for which no charge would have been made in the absence of this coverage; or

- services or supplies that are provided by the **employee** or their **spouse**, **child**, parent or sibling or by a person who normally resides in the **employee's** home.

NOTE: **Other Exclusions or Limitations may be applicable as specified under each individual additional benefit provision.**

GROUP HEALTH SPENDING ACCOUNT (HSA) BENEFIT

Your HSA is funded by your employer and can be used to pay for health and dental expenses that are not covered (or not fully covered) by your group health and dental benefit plan or your provincial health plan.

Eligibility
2. All Eligible **Employees** - Enhanced

Employees and their dependents who are eligible for Group benefits under Group Number RBC00003662 issued by RBC Life Insurance Company.

Eligibility Waiting Period

Employees become eligible for HSA coverage on the later of:
- the date they become eligible for Group benefits under Group Number RBC00003662, and
- the effective date of the HSA plan.

Amount of HSA Credits

*$*250 *per employee per* ***Plan year***

Plan year means 12:01 a.m. January 1 to midnight December 31. Thereafter, the Plan year will run from January 1st to December 31st.

Allocation of HSA Credits

HSA credits are distributed to employees on an annual basis.

The amount and allocation of Credits are as noted in this Agreement for the first Plan year and will remain so, unless The Company remits an Annual Allocation Form to The Service Provider which may amend the amount and/or allocation of Credits as set out in the Annual Allocation Form.

For employees in an eligible group on or before January 1, 2024**:**

For the first Plan year, full annual credits will be allocated, even if the Plan Year is less than 12 months.

For employees entering an eligible group after January 1, 2024**:**

Credits applicable to each employee will be allocated for the period that begins on the employee's date of eligibility and end at the end of the Plan year.

Carry Forward

HSA credits for a Plan year may only be used within the Plan year for which they were allocated. Expenses incurred during a Plan year can only be claimed within that Plan year. Any HSA credits that an employee has remaining at the end of the Plan year will be lost.

Eligible Expenses

Your HSA covers all eligible expenses as defined in the Canada Revenue Agency (CRA) tax rules – but only to the extent that those expenses are not covered under a provincial healthcare plan. For a complete list of covered expenses, link to the CRA's bulletin on medical expenses at:

http://www.cra-arc.gc.ca/medical

To qualify as an eligible expense, the service, procedure or item must be provided or prescribed by a medical practitioner who is licenced in the province in which they are practicing.

Claims

Claims for expenses should first be submitted to your Group plan for payment or any other benefit plan you are covered under, before you submit them to your HSA. Your HSA will cover only those expenses that aren't covered, or aren't fully covered, by any other plan you may be eligible for.

HSA benefits will only be paid for covered charges for which we have received satisfactory proof that payment is made.

The **claimant** must send **The Service Provider** written proof of claim no later than the earlier of:

- 12 months from the end of the plan year in which the claim was incurred, or
- 90 days from the date the plan member is terminated
- 0 days from the date the group's WSA coverage is terminated; WSA claims submission is terminated as of the group termination date

Auto Coordination of Claims

You can set up the auto-coordination functionality through the Group Benefit Solutions service for plan members or via the call centre. Additional funds put into the HSA will automatically be disbursed until the claim is paid in full. In the absence of auto-coordination, you will have to submit the proper form and Explanation of Benefits (EOB) in order to receive additional funds.

Other Coverage

If you or your eligible dependents have health or dental coverage under another plan, it is to your advantage to submit your claims to the other plan first. Once benefits have been determined under the other plan, you can submit a claim for reimbursement of any unpaid portion from your HSA.

Termination of Coverage:

Your coverage terminates on the earlier of the following dates:

1. the date **you** retire or turn 75.

2. the date the HSA Plan terminates;

3. the date you cease to be an eligible employee;

4. the date you cease to be eligible for Group benefits under Group Number RBC00003662.

Coverage for your dependents terminates when your coverage terminates or when your dependent ceases to qualify as an eligible dependent, whichever comes first.

GROUP WELLNESS SPENDING ACCOUNT (WSA) BENEFIT

Your WSA is funded by your employer and can be used to pay for wellness related expenses hat support your nutrition, physical activity, and mental health.

Eligibility
2. All Eligible **Employees** - Enhanced

Employees who are eligible under Group Number RBC00003662 issued by RBC Life Insurance Company.

Eligibility Waiting Period

Employees become eligible for WSA coverage on the later of:

- the date they become eligible under Group Plan Number RBC00003662, and
- the effective date of the WSA plan.

Amount of WSA Credits

*$*250 *per employee per* ***Plan year***

Plan year means 12:01 a.m. January 1 to midnight December 31. Thereafter, the Plan year will run from January 1st to December 31st.

Taxable Benefit

WSA is a taxable benefit. Any funds reimbursed under the WSA coverage are considered taxable as income.

Allocation of WSA Credits

WSA credits are distributed to employees on an annual basis.

The amount and allocation of Credits are as noted in this Agreement for the first Plan year and will remain so, unless The Company remits an Annual Allocation Form to The Service Provider which may amend the amount and/or allocation of Credits as set out in the Annual Allocation Form.

For employees in an eligible group on or before January 1, 2024**:**

For the first Plan year, full annual credits will be allocated, even if the Plan Year is less than 12 months.

For employees entering an eligible group after January 1, 2024**:**

Credits applicable to each employee will be allocated for the period that begins on the employee's date of eligibility and end at the end of the Plan year.

Carry Forward

WSA credits for a Plan year may only be used within the Plan year for which they were allocated. Expenses incurred during a Plan year can only be claimed within that Plan year. Any WSA credits that an employee has remaining at the end of the Plan year will be lost.

Eligible Expenses

Your WSA covers eligible expenses for products and services that support your nutrition, physical activity, and mental health. Eligible expenses include:

Education and Personal Development
Family Care
Fitness Equipment
Fitness/Sports Fees
Health and Dental Expenses (as defined by CRA guidelines)
Insurance Premiums
Non-Health Professional Services
Wellness Services

Claims

Your WSA will cover only those expenses that aren't covered, or aren't fully covered, by any other plan you may be eligible for.

WSA benefits will only be paid for covered charges for which we have received satisfactory proof that payment is made.

The claimant must send us written proof of claim no later than the earlier of:
- 12 months from the end of the plan year in which the claim was incurred, or
- 90 days from the date the WSA coverage terminates

Termination of Coverage:

Your coverage terminates on the earlier of the following dates:

1. the date **you** retire or turn 75.

2. the date the WSA Plan terminates;

3. the date you are no longer eligible for benefits under Group Number RBC00003662.

RBC Life Insurance Company
PO Box 1840, Mississauga, Ontario L5N 7Y5
1-855-264-2174
www.rbcinsurance.com

COLLECTION AND USE OF PERSONAL INFORMATION

Collecting your personal information

We (RBC Life Insurance Company) may from time to time collect information about you such as:

- information establishing your identity (for example, name, address, phone number, date of birth, etc.) and your personal background;
- information related to or arising from your relationship with and through us;
- information you provide through the application and claim process for any of our insurance products and services; and
- information for the provision of products and services.

We may collect information from you, either directly or through representatives. We may collect and confirm this information during the course of our relationship. We may also obtain this information from a variety of sources including hospitals, doctors and other health care providers, the MIB, Inc., the government (including government health insurance plans) and other governmental agencies, other insurance companies, financial institutions, motor vehicle reports, and your employer.

Using your personal information

This information may be used from time to time for the following purposes:

- to verify your identity and investigate your personal background;
- to issue and maintain insurance products and services you may request;
- to evaluate insurance risk and manage claims;
- to better understand your insurance situation;
- to determine your eligibility for insurance products and services we offer;
- to help us better understand the current and future needs of our clients;
- to communicate to you any benefit, feature and other information about products and services you have with us;
- to help us better manage our business and your relationship with us; and
- as required or permitted by law.

For these purposes, we may make this information available to our employees, our agents and service providers, and third parties, who are required to maintain the confidentiality of this information. If you are insured under a group insurance policy obtained through your employer, we may also share your information with your employer when necessary for the services we provide to you. Your health information will not be shared with your employer without your consent.

In the event our service provider is located outside of Canada, the service provider is bound by, and the information may be disclosed in accordance with, the laws of the jurisdiction in which the service provider is located. Third parties may include other insurance companies, the MIB, Inc. and financial institutions.

We may also use this information and share it with RBC® companies (i) to manage our risks and operations and those of RBC companies and (ii) to comply with valid requests for information about you from regulators, government agencies, public bodies or other entities who have a right to issue such requests.

If we have your social insurance number, we may use it for tax related purposes and share it with the appropriate government agencies.

Your right to access your personal information

You may obtain access to the information we hold about you at any time and review its content and accuracy, and have it amended as appropriate; however, access may be restricted as permitted or required by law. To request access to such information or to ask questions about our privacy policies, you may do so now or at any time in the future by contacting us at:

RBC Life Insurance Company
P.O. Box 515, Station A,
Mississauga, Ontario
L5A 4M3
Telephone: 1-800-663-0417
Facsimile: 905-813-4816

Our privacy policies

You may obtain more information about our privacy policies by asking for a copy of our “Financial fraud prevention and privacy protection” brochure, by calling us at the toll-free number shown above or by visiting our website at www.rbc.com/privacysecurity.