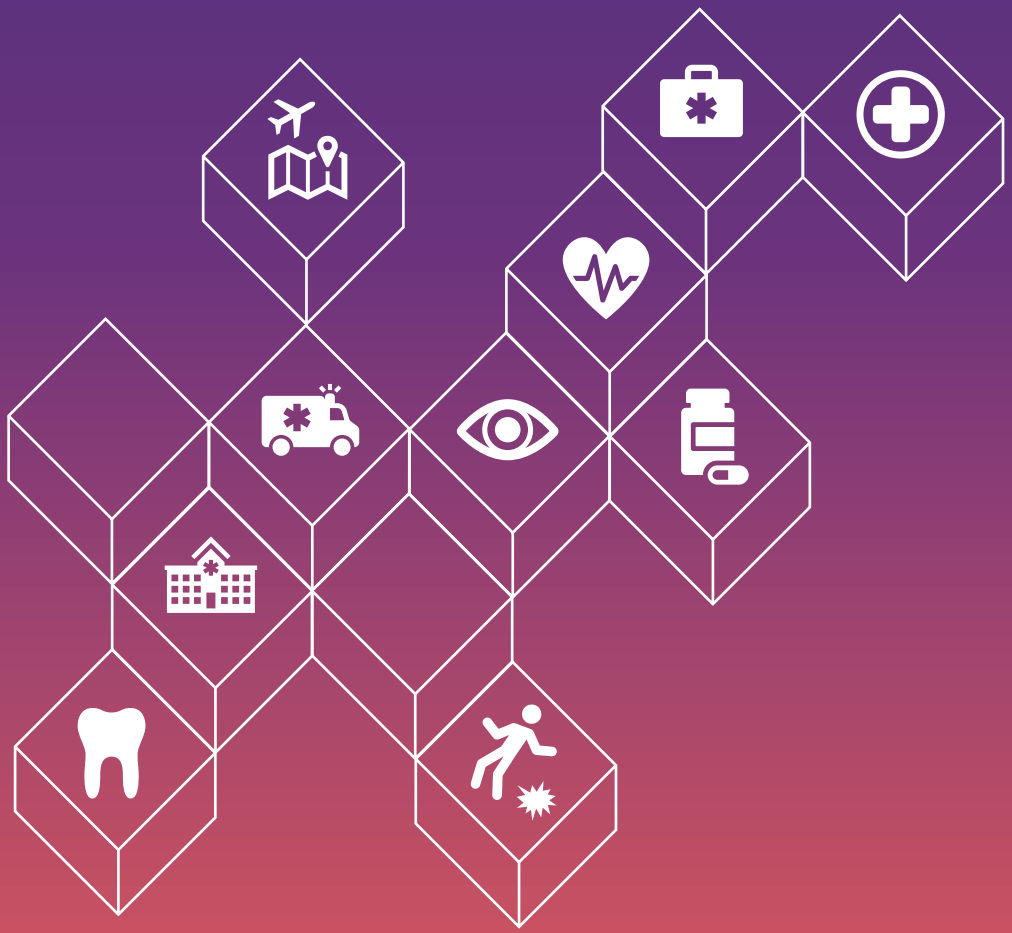
arc
Group Benefits Inc.
Financial Services Firm

Group Insurance Benefits Booklet



Latecoere Aerostructures Canada

F, F1 – Union employees

Group # 61027

Everything You Need to Know About Your Group Plan

Your employer has set up a group insurance plan to provide you and your family with peace of mind to overcome the unpredictability of life and thus contribute to your well-being.

They retained the services of *ARC Group Benefits Inc*. for the establishment of the plan and the administration of claims for Extended Healthcare and Dental. *ARC Group Benefits Inc*., hereafter referred to as *ARC* for simplicity, is not an insurance company, but a provider of third-party administrative services. For each of the benefits insured under this plan, you will find the name of the insurer under the heading.

This booklet and your drug card contain important information about your group insurance coverage. You should keep them in a safe place known to other family members for future reference.

The benefits can be modified after the establishment of this booklet. You will be notified in writing of any changes to your plan and an updated booklet will be provided to you.

We have prepared this booklet with the goal of clearly summarizing your coverage and answering the most frequently asked questions. However, if you do have any questions, we will be happy to answer them!

We are dedicated to providing you with unparalleled customer service.

- *The support team at ARC Group Benefits*

Latecoere Aerostructures Canada

F, F1 – Union Employees

Effective date: August 1st, 2023

Production date: November 24th, 2023

LATECOERE

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Benefit Summary

Extended Healthcare

This section is only an overview of what is covered and should be read together with the benefit details section in the booklet in order to fully understand the coverage, including exclusions, restrictions and other conditions.

General conditions

Benefit year	Calendar year		
Deductible	Amount		Applicable to
	Individual:	$25	Paramedical services, Medical supplies and services
	Family:	$25	
	Maximum per person:	$25	
	Drugs: $2 per prescription		
Termination of coverage	Upon your retirement or on your 85th birthday, whichever is earlier		
Survivor benefit	24 months		

Drugs

Reimbursement	100 %
List of covered drugs	Drugs and items that require a prescription by law as described in the benefit details
Reimbursement method	Direct payment card
Substitution clause for a lowest price equivalent drug	Non-mandatory
Coverage for residents of BC, Manitoba and Saskatchewan	Expenses for prescribed drugs must not exceed the Deductible and Co-insurance percentage prescribed from time to time under the British Columbia or Manitoba Pharmacare program, or under the Saskatchewan Prescribed Drug Plan.
Vaccines and allergy serums	$100 per calendar year for vaccines
Smoking cessation products	$500 lifetime
Diabetic supplies	Refer to the Benefit details

Benefit Summary

Hospitalization

	Reimbursement	Maximum
Hospital room	100 %	Semi-private room
Convalescent / rehabilitation home	100 %	$40 / day up to 120 days / calendar year

Paramedical services

	Reimbursement	Maximum
Acupuncture	80 %	$100 / calendar year
Audiologist	80 %	$100 / calendar year
Chiropractor	80 %	$500 / calendar year
X-rays for the chiropractor	80 %	$40 / calendar year
Dietitian	80 %	$100 / calendar year *medical recommendation required
Occupational therapist	80 %	$100 / calendar year
Homeopath	80 %	$100 / calendar year
Kinesitherapist	Not covered	n/a
Massage therapist	80 %	$500 / calendar year
Naturopath	80 %	$200 / calendar year
Speech Therapist	80 %	$100 / calendar year
Orthotherapist	80 %	Combined with massage therapist
Osteopath	80 %	$100 / calendar year
X-rays for the osteopath	80 %	$40 / calendar year
Physiotherapist	80 %	$500 / calendar year
Podiatrist / chiropodist	80 %	$100 / calendar year
X-rays for the podiatrist / chiropodist	80 %	$40 / calendar year
Psychoanalyst	80 %	Combined with psychologist
Psychologist	80 %	$100 / calendar year
Psychotherapist	80 %	Not covered
Physical Rehabilitation Specialist	80 %	Combined with physiotherapist
Athletic therapist	80 %	Combined with physiotherapist
Social worker	80 %	Combined with psychologist
Guidance counselor	80 %	Combined with psychologist

Medical supplies and services

	Reimbursement	Maximum
Dental services following an accident	80 %	
Diagnostic services	80 %	$500 / calendar year
Substance abuse rehabilitation	Not covered	n/a
External prostheses	80 %	Refer to the benefit details
Hearing aids	80 %	$400 / 60 months, batteries excluded, repairs included
Hair prostheses	80 %	$200 lifetime
Post-mastectomy bras	80 %	2 units per 24 months
Orthopedic supplies	80 %	Refer to the benefit details
Custom-made orthopedic shoes	80 %	Adult: $400 / 1 year Child: $200 / 1 year
Deep shoes	80 %	Not covered
Custom-made plantar orthotics	80 %	Combined with orthopedic shoes
Diabetic supplies	80 %	Refer to the benefit details
Therapeutic devices / medical equipment	80 %	Total lifetime maximum of $10,000, see the benefit details
Other medical supplies and services	80 %	Refer to the benefit details
Stockings for varicose veins, including regressive compression stockings	80 %	$500 / calendar year

To benefit from this coverage, you must be covered by a provincial health insurance plan or by a federal plan with similar benefits.

Vision care

	Reimbursement	Maximum
Eye exam	100 %	Adult: $110 / 24 months Child: $110 / 12 months
Glasses / contact lenses / lenses / laser surgery	100 %	Adult: $450 / 24 months Child: $450 / 12 months

Dental Care

This section is only an overview of what is covered and should be read together with the benefit details section in the booklet in order to fully understand the coverage, including exclusions, restrictions and other conditions.

General conditions

Deductible	None	
Benefit year	Calendar year	
Fee guide	Generalist, for the current year, in province where the participant resides	
	Reimbursement	Maximums
Preventive care	100 %	
Recall exams	100 %	1 exam / 6 months
Complete exams and panoramic x-rays	100 %	1 / 24 months
	Reimbursement	Maximums
Basic care	100 %	Scaling units : 12 units / year
Endodontics	100 %	
Periodontics	100 %	
	Reimbursement	Maximums
Major care	50 %	
	Reimbursement	Maximums
Orthodontic care	50 %	$2,200 lifetime
Termination of coverage	Upon your retirement or on your 85th birthday, whichever is earlier	
Survivor benefit	24 months	

Avoid surprises!

Before starting your treatment, ask your dentist if they base their fees on the fee guide mentioned in the *Benefit Summary*. It is important to take this into account because it can directly influence what you pay out of your pocket.

Global Medical Assistance and Out-of-Country Emergency Care

Insurer: Canada Life
Policy number: 178213

General Conditions

Deductible	None
Reimbursement level	100 %
Out-of-country emergency care maximums	$5,000,000 per person per trip
Benefit maximum	
• if you are under age 70	First 60 days
• if you are age 70 or over	First 60 days
Trip cancellation and trip interruption	$5,000 per person per trip. The cancellation or interruption must be for medical reasons only.
Lifetime maximum	Unlimited
Termination of coverage	Last day before your 85th birthday, or upon your retirement, whichever comes first
Survivor benefit	24 months

You must be covered under the employer's Extended Healthcare coverage plan in order to be covered under this benefit. You must also be covered by your provincial health insurance plan.

Life Insurance

Insurer : RBC Life Insurance Company
Policy number: RBC00003484

Employee basic life insurance

Amount of insurance	1 times your annual earnings rounded to the next higher $1,000
Minimum	$25,000
Maximum	$100,000
Non-evidence maximum	$100,000
Reduction	50% at age 65 50% at age 70, maximum $25,000
Waiver of premium elimination period	The employee must be continuously disabled for at least 47 weeks
Termination	When you retire or reach age 85, whichever is earlier

Dependent basic life insurance

Amount of insurance	Spouse	$5,000
	Child	$2,500
Effective date of insurance for a new-born	24 hours	
Survivor benefit	Not covered	
Termination	When you retire or reach age 85, whichever is earlier, based on the age of the employee	

Optional life insurance

Amount of insurance	Employee	Amounts in $10,000 units as applied for by the employee and approved by the Company, up to a maximum of $400,000.
	Spouse	Amounts in $5,000 units as applied for by the employee and approved by the Company, up to a maximum of $400,000.
	Child	Not covered
Termination of coverage	Employee	When you retire or reach age 65, whichever is earlier
	Spouse	Insurance for a spouse will terminate on the earlier of: • When the employee retires or reaches age 65, whichever is earlier • The date the employee is no longer insured for Basic Life insurance under the policy. Where an employee is not insured for Optional Life insurance, insurance for a spouse will terminate on the earlier of: • When the employee retires or reaches age 65, whichever is earlier • The date the employee is no longer insured for Basic Life insurance under the policy.
	Child	N/A

Proof of good health will be required from the first dollar of coverage for this benefit.

Accidental Death and Dismemberment (ADD)

Insurer : Solutions for Special Markets, a division of Industrial Alliance Insurance and Financial Services Inc.

Policy number: 100012326

Basic ADD insurance for the employee

Amount of insurance	1 times your annual salary, rounded off to the next multiple of $1,000
Minimum	$25,000
Critical illness benefit	Not covered
Maximum	$100,000
Non-evidence maximum	$100,000
Reduction	50% at age 65 50% at age 70, maximum $25,000
Termination of coverage	Upon your retirement or on your 75th birthday, if this birthday is earlier

Optional AD&D insurance

Amount of insurance	Employee	Amounts in $10,000 units as applied for by the employee and approved by the Company, up to a maximum of $500,000.
	Spouse	- Spouse only: 60% of the Employee's Opt. AD&D benefit. - With children: 50% of the Employee's Opt. AD&D benefit.
	Child	- Child only: 20% of the Employee Optional AD&D Benefit (per child). Maximum $50,000 - With spouse: 15% of the Employee Optional AD&D Benefit (per child). Maximum $50,000
Reduction	None	
Termination of coverage	For all coverage	When you retire or reach age 70, whichever is earlier

Employee Assistance Program (EAP)

Counselling Services

From time to time, we all need support to deal with an issue or challenge. If you could benefit from professional help to proactively address a personal or work-related concern, you can turn to TELUS Health.

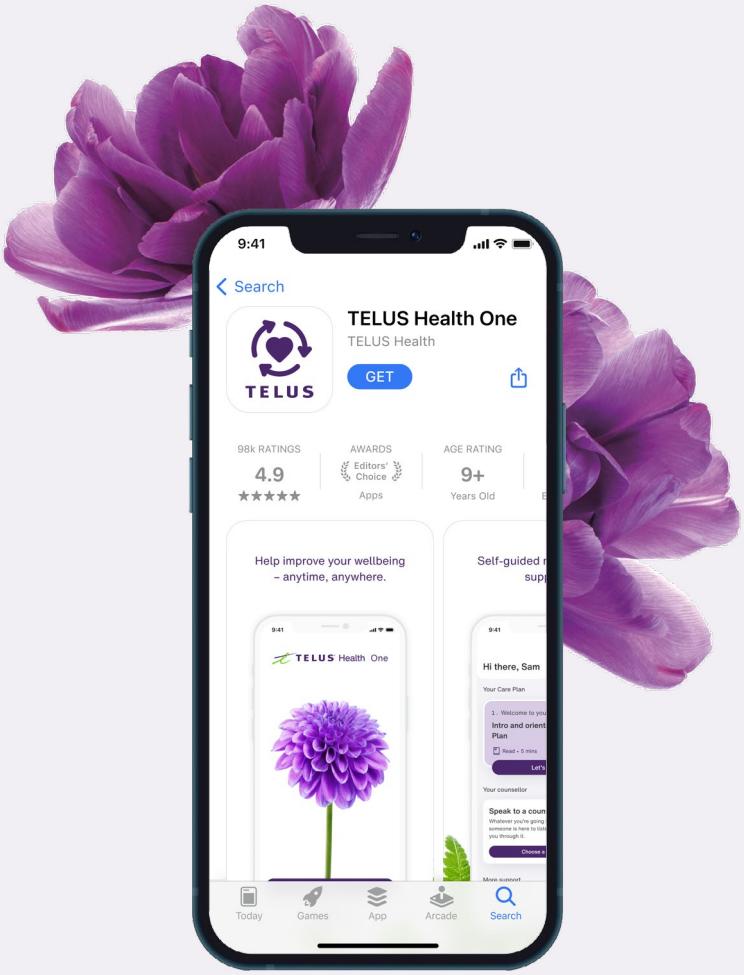
The Employee Assistance Program (EAP) is available to you and your dependents at no additional cost (as defined your benefits plan) and includes access to confidential counseling. Here are just some of the ways that EAP counseling can help:

- You're dealing with conflict or changes at work and it's affecting your productivity.
- You'd like to learn to better control anger or manage stress.
- You recently learned you have a chronic illness or disability.
- You're going through a separation or divorce.
- You're concerned about an addicted spouse or family member.
- You're struggling with self-esteem or communication issues; parenting challenges; midlife concerns; sexual orientation or gender identity, or other personal issues.

To get started, contact us toll-free anytime, 24/7, to speak with a caring advisor for guidance, resources, and a referral to a counsellor for face-to-face, telephonic, or video sessions for short-term, solution-focused counselling. All our counsellors are experienced therapists with a minimum Master's degree in psychology, social work, educational counselling, or other social services field.

Phone EN:* 1-844-671-3327
Phone FR:* 1-855-360-5485

TELUS Health



TELUS Health

Download the TELUS Health One app.

Feel supported and connected wherever you are.

With the TELUS Health One app, you can access your employee assistance program (EAP), which includes qualified support for your mental, physical, social and financial health.

- Search for resources and tools on topics ranging from **family and life to health, money and work**
- Stay connected to your organization through the **News Feed**
- Receive support on your own schedule with **CareNow**
- Access the **Total Wellbeing Assessment** to help identify your wellbeing strengths and opportunities for improvement

What's more, the app acts like your digital wallet card. You can call an EAP advisor with just one tap – toll-free, 24/7 – for expert advice, resources and referrals.

Download the TELUS Health One app today for convenient access to wellbeing support.

1. Download the free app on Android or iOS – simply search for 'TELUS Health One'.
2. Open the app, click on 'Log in' and enter your shared log-in credentials.

Download on the App Store | GET IT ON Google Play

Username: avcorpsi

Password: eap

Call us, 24/7: EN:* 1-844-671-3327/ FR:* 1-855-360-5485

How to Submit a Claim

For Extended Healthcare and Dental

Important

Your claims must be submitted electronically. Do not mail paper claims to *ARC;* they will be returned to you.

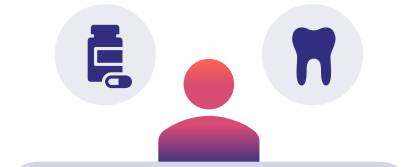
How do I submit a claim electronically?

1

The payment card

Obtain it:

- ✓ in your welcome package
- ✓ through your employer
- ✓ online on the employee portal
- ✓ via the mobile application



Present it:

- ✓ at your pharmacy
- ✓ at your dentist

Your participating health care provider will have all the information required to submit a claim for your prescription medications and dental care services online from the point of sale. You will only have to pay the amount not covered under the plan, if that is the case.

2

The employee portal

Visit it:
www.arcsupport.ca/en/arc-sante

3

The mobile application

Download it:
www.arcsupport.ca/en/arc-sante

You will need to keep all your original receipts for a period of 12 months following the date of service. At all times, *ARC Group Benefits Inc.* reserves the right to examine or verify the claim file of an insured person in connection with a claim.

Any claim, accompanied by appropriate supporting documents, must be submitted to *ARC Group Benefits Inc*. within 12 months of the date the expenses are incurred.

In the event that the plan or your coverage is terminated, all claims and proof must be submitted within 31 days of the date of termination. The date the expenses were incurred must be earlier than the date of termination.

How will I receive my refund?

For claims submitted via the employee portal or the mobile application, all benefits are paid to the participant. You must register for **direct deposit** on the employee portal or on the mobile app. The reimbursement of your claims for Extended Healthcare and Dental will only be made by direct deposit to your bank account. **We do not send checks.**

Why is it entirely digital, without paper claim forms?

- Limited environnemental impact
- Reduction of human error and document loss
- Quick turnaround time for claim reimbursements
- Best service! Business continuity guaranteed in the event of a pandemic and extra security

*How do I know if a medicine that I am taking—or that my doctor wants to prescribe for me—**requires a prior authorization**?*

Certain eligible drugs require prior authorization in order to be subject to reimbursement. The criteria are established by the insurer.

Contact *ARC Group Benefits* by phone at 514 397-0767 (1 888 589-0767) or visit our TELUS partner's website at https://www.telus.com/en/health/prior-authorization-forms for the list of medications and the Prior Authorization Form to be completed by you and your attending physician.

What is the prior authorization process?

If the medication you are prescribed requires special authorization in order to be reimbursed, you must obtain the specific Prior Authorization form from our TELUS partner website at https://www.telus.com/en/health/prior-authorization-forms or by calling *ARC Group Benefits at* 514 397-0767 or 1 888 589-0767.

The form must be completed by both the patient AND the attending physician. Instructions for completing the form are clearly listed on the first page of the form. All fields are mandatory and must be completed. Incomplete forms may result in your application being declined.

The completed form must be returned to Pharmacy Services at TELUS Health by fax at the number appearing on the form.

If you have any questions on the application process of this program or the reimbursement decision, or to inquire on the status of your Prior Authorization Form, please contact ARC at 514-397-0767 (1 888 589-0767) or by email at service@arcsupport.ca.

Please retain a copy of the completed form for your records.

Once a decision is made, it will be communicated to you by the preferred method of contact that you indicated on the form.

What supporting documents can we ask you to provide to determine if your dental expenses are covered?

- X-rays, complete dental record indicating any treatment prior to that which is the subject of the reimbursement, including extractions, fillings or other dental procedures;
- Detailed notes from the dentist or any other person who provided care or treatment; and
- Laboratory or hospital reports, models, molds or study casts, or any other evidence of treatment performed or of the condition of the teeth or mouth.

Coordination of Benefits

What happens if you are covered elsewhere?

You may have similar coverage under different plans. The coordination process ensures you get the most out of your coverage and receive reimbursement for your eligible expenses for up to 100%.

Government Health Care Coverage

The Extended Healthcare and Dental plans offered by your employer do not cover any health care services or supplies eligible under government healthcare coverage or administered by a government hospital, agency or provider. Your plan only considers eligible expenses in excess of those covered by government healthcare coverage.

Other Health Care Plans

Other plans that may be subject to coordination of benefits include any form of group, individual, family, creditor and savers insurance plan that provides benefits for medical treatment, services and supplies.

We coordinate benefits in accordance with the guidelines of the Canadian Life and Health Insurance Association (CLHIA). Here are the general rules :

Your incurred expenses

A. You must first submit the costs incurred under this plan for which you are covered as a participant. If you are covered as a participant under more than one group plan, the following order prevails:

1. the plan that covers you as an **active full-time** employee
2. the plan that covers you as an **active part-time** employee
3. the plan that covers you as a **retiree**

However, if you are covered in the same way by more than one plan, the plan that has covered you the longest pays your claim first.

B. The amount not reimbursed by this plan (if applicable) may be subject to another plan under which you are covered as a dependent (for example, your spouse's plan).

Expenses incurred by your spouse

A. Your spouse must first submit their expenses to their own group plan (if applicable).

B. The remaining amount that is not reimbursed by your spouse's plan (if applicable) may be subject to this plan.

Expenses incurred by a child

When a child is covered as a dependent under your plan and that of your spouse (it is the same in the case of shared custody):

A. you must submit their claims to the plan of the parent who has their birthday the earliest in the year; and

B. subsequently to the other parent's plan.

In the event of divorce or separation and in a case of sole custody:

A. The plan of the parent with whom the child resides (having custody) pays first.

B. The plan of the spouse of the custodial parent pays second.

C. The non-custodial parent's plan pays third.

Getting Help or Additional Information

You will find a lot of useful information in this booklet. However, please do not hesitate to contact us if you have any concerns or questions.

More specifically, here's where you can get more information on the following matters:

	Employee Portal	Mobile Application	ARC by Phone	Your Employer
Confirm if a medical or dental service or device is covered by your group insurance	X	X	X	
Confirm the status of a claim	X	X	X	
Confirm if your medications require prior authorization			X	
Help finding your payment card	X	X	X	X
Answer all your questions about the secure site for participants			X	
Report a change to your coverage or a life event				X
Add or update your banking information	X	X		

To contact ARC Group Benefits Inc.

Have your group plan number and participant number ready when you contact us by phone, and to access the employee portal, or the mobile application.

514 397-0767
1 888 589-0767

service@arcsupport.ca

For a medical emergency while traveling

To obtain the forms you must complete in order to request reimbursement of the costs incurred in case of emergency, either before receiving treatment or upon return, call:

Within Canada or the United States: 1 866 530-6024
Everywhere else: 1 905 816-1901 (collect call)

Your Eligibility and That of Your Dependents

Eligible employee

- You live and work in Canada.
- You are covered by the government public plan in your province of residence.
- You belong to a class eligible for insurance.
- You are actively at work, on a **permanent and full-time basis**.
- You are at work for a minimum of **35 hours** a week.
- You have completed the probation period of **The first day of the month coincident with or next following 3 months of continuous, active employment.**

An employee who is eligible for coverage is a ***Participant***.

Eligible dependent

An eligible dependent is a spouse or child residing in Canada. However, a dependent who is temporarily residing in the United States may be insured under the Dependent Life Insurance.

Spouse

- Meets one of the following criteria:
  1. is your lawful spouse—the person to whom you are legally married or in a civil union in accordance with provincial legislation; or
  2. is your common-law partner—the person who has lived with you and whose relationship with you has been conjugal in nature, for at least **12 months** and from whom you have not been separated for 90 days or more because of your relationship breakdown. However, the aforementioned period is not applicable if a child is born from this union.

At any time, only one person can be covered as the spouse of the participant.

Child

- is a natural or adopted child of the participant or their spouse, or is a child of which the participant or their spouse is the legal guardian with parental authority;
- depends on the financial support of the participant or the participant's spouse to meet their needs;
- is single; and
- meets one of the following criteria:
  1. is under 21;
  2. is under 26 years of age and a full-time student attending a recognized educational institution, college or university; or
  3. has reached the maximum age and is incapacitated due to a physical or mental disability occurring when they meet either of the definitions given in paragraphs 1. or 2. above.

A child is considered to be incapacitated if they cannot be gainfully employed because of their physical or mental disability, and they depend entirely on the financial support of the participant or the participant's spouse to provide for their needs. The child must also live with the participant or the spouse of the participant who exercises parental authority or holds legal guardianship if the child is a minor.

You are responsible for enrolling your dependents as soon as they are eligible, and for unenrolling them when they no longer meet the criteria. Consult the "*Changes to Your Situation*" section and notify your employer within the prescribed time limits.

This booklet provides a brief overview of the eligibility criteria for the plan. This booklet does not create or confer any rights. The exact terms and definitions are those described in the detailed provisions of each group insurance policy in the plan. In the event of any discrepancy between this booklet and the group insurance policy, the terms of the group insurance policy will prevail.

Your Coverage

How to enroll

Your employer will give you an enrollment form to complete and provide you with the necessary information. Your enrollment must be made within 31 days of the date of your eligibility.

In what circumstance is evidence of insurability required?

- for a late application;
- for any optional coverage, unless otherwise specified in the *Benefit Summary*; and
- for any amount of coverage that exceeds the Maximum without proof of insurability mentioned in the *Benefit Summary*.

* If the group insurance policy includes special conditions, they will prevail

Is participation in the plan mandatory?

Enrollment in the group insurance plan is mandatory for all employees and their dependents who meet the eligibility criteria set out on the previous pages.

The **exceptions** are as follows:

- you have the choice to take advantage of optional benefits or not; and
- you and/or your dependents have the right to be exempt from the Extended Healthcare, Dental Plan, and Travel Insurance—if, and only if—you or your dependents already have **similar coverage under another private group insurance plan**.

When does your coverage take effect?

Your coverage takes effect on the later of the following dates:

- the date the contract comes into effect;
- the date you meet all the eligibility criteria; or
- the date the insurer approves your proof of insurability, if applicable.

If you are not actively at work on the date your coverage is due to take effect, it will take effect on the date you return to work.

* If the group insurance policy includes special conditions, they will prevail

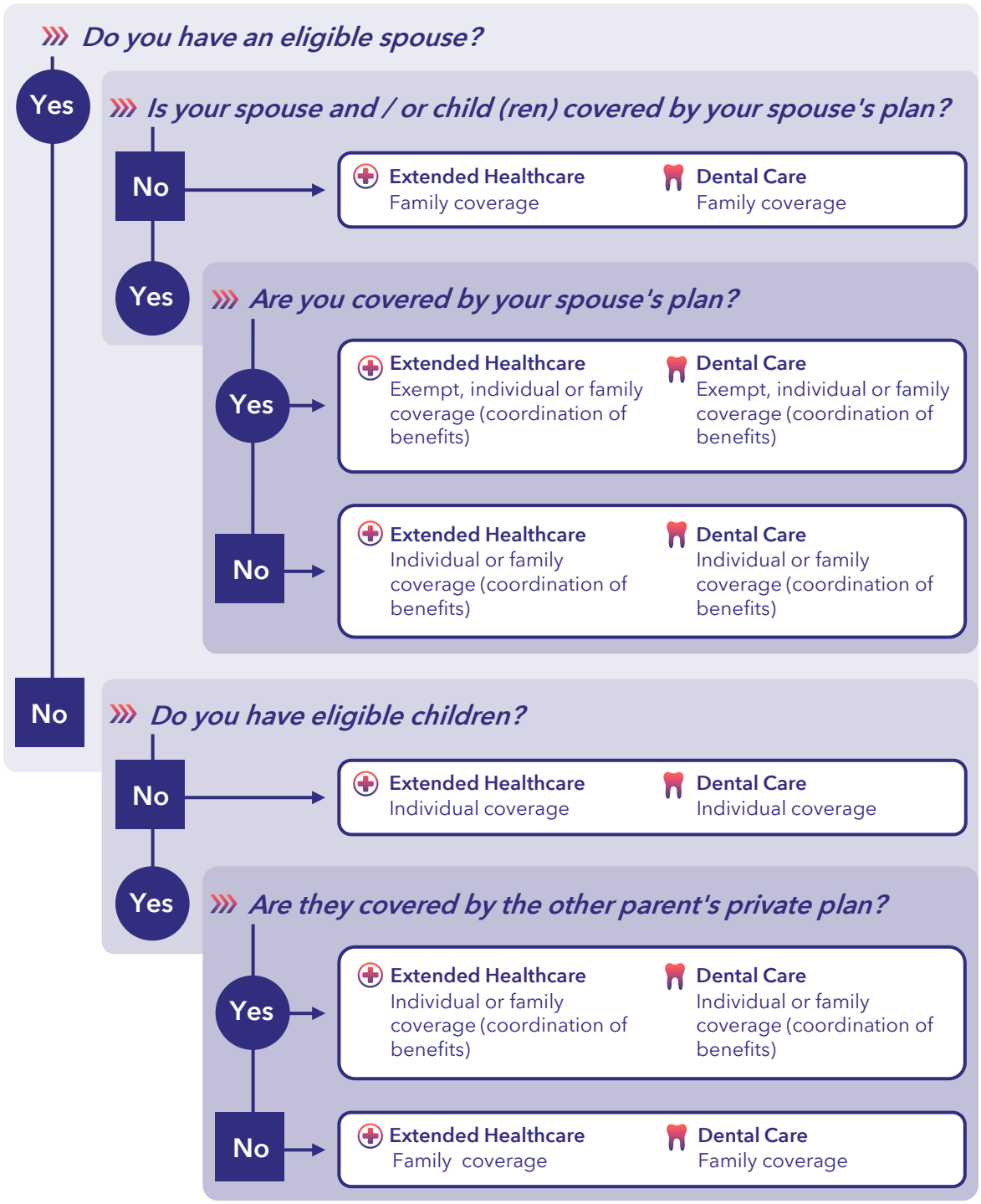
When does your dependents' coverage take effect?

Coverage for your dependents takes effect on the later of the following dates:

- the date you become eligible for coverage;
- the date they meet all the eligibility criteria; or
- the date the insurer approves their application for proof of insurability, if applicable.

How to choose your coverage

The type of coverage may be different for Healthcare and Dental coverage. The following diagram is intended to help you understand the choices available to you depending on your situation.



What happens to your coverage during an absence from work?

Absence due to illness or accident

When you take time off work due to illness or accident, your coverage continues. In these circumstances, please contact your employer to discuss the maximum period for which your coverage will be maintained.

Maternity leave, parental leave or other absences prescribed by law

If you stop working on a regular and continuous basis in order to take maternity leave, parental leave or other leave prescribed by law, all insurance benefits may be kept in effect during the period of leave that you are entitled to in accordance with the laws to which the employer is subject.

In jurisdictions where continued coverage is required by law, a copy of the notice prepared and signed by you to suspend payment of any mandatory premiums must also accompany the request for termination.

If you are an employee of Quebec, you must at least maintain Extended Healthcare coverage including drug coverage, unless you have drug coverage under another group plan.

Temporary layoff, leave of absence, disciplinary suspension, strike or lockout

In these circumstances, please contact your employer to discuss the coverages you must maintain during such an absence and the maximum period for which these coverages can be maintained.

When does your coverage end?

Your insurance coverage ends on the earliest of the following dates:

- the date you no longer meet the definition of employee;
- the date you leave the employer's service or retire;
- the date you stop working on a regular and continuous basis;
- the date the employer terminates your coverage;
- the date of termination of the contract or of termination of the insurance of the category to which you belong;
- the date you reach the age at which you are no longer entitled to the insurance provided for in the *Benefit Summary*; or
- the date of your death.

When does coverage for your dependents end?

Your dependent's insurance ends on the earliest of the following dates:

- the date your insurance ends;
- the date the dependent ceases to be eligible for insurance under the provisions of the group insurance plan;
- the date of receipt of a written notice from you requesting that the dependents' coverage be canceled because they are already insured under another insurance plan offering similar benefits for Extended Healthcare or Dental Care to those of this group insurance plan; or
- the date on which any mandatory contribution that is due remains unpaid.

When will a change take effect?

Any change to the amount of coverage or to a benefit takes effect on the later of the following dates, provided you are actively at work on that date:

- the date on which you first become eligible for such a change, provided a written request is received by *ARC* on or before that date; or
- the date on which the insurer approves your insurability:
    - if the new amount of coverage exceeds the maximum amount that the insurer grants without evidence of insurability; or
    - if the change request is received more than 31 days after your eligibility for the change.

If you are not at actively at work on the date your coverage would normally be changed, coverage is changed on the first day you return to work.

Changes to Your Situation?

Life event

A situation resulting from one of the following events will allow you to make changes to your coverage:

- marriage or common-law relationship
- birth or adoption of a child
- divorce or legal separation
- loss of coverage for you or a dependent with another insurer for reasons beyond their control
- death of a dependent

here are some examples:

Event	Possible modification of coverage
✓ New common-law partner (eligible following the 1-year cohabitation period) ✓ New spouse (married) (eligible from the date of marriage) ✓ Loss of group insurance coverage that covered the spouse ✓ Loss of group insurance coverage for a former spouse who covered dependent children ✓ Birth or adoption of a child	From individual coverage to coverage with dependents (family, couple or single parent, depending on the situation)
✓ You become eligible for coverage under another group insurance plan through a new spouse (marriage or de facto union)	From individual coverage to exempt or family coverage with coordination of benefits for the family
✓ Your spouse becomes eligible for a group insurance plan ✓ Separation or divorce ✓ You have no more eligible dependents	From coverage with dependents to individual coverage
✓ Your spouse becomes eligible for a group insurance plan and has family coverage	From family coverage to exempt or individual coverage, with coordination of benefits for the participant

A modification request for any other reason will be refused. Also, proof of insurability will be required for any request received more than 31 days after the date on which the life event occurred, except for:

- dental coverage (if applicable), for which the maximum reimbursement is then limited to $250 for the first 12 consecutive months for latecomers; and
- plan members in Quebec for whom no proof of insurability can be required for enrollment in prescription drug insurance.

Extended Healthcare

Benefit details

Your employer is responsible for the Extended Healthcare coverage described in this booklet. *ARC Group Benefits Inc.* is not an insurance company, but however handles the processing of claims:

Payment of benefits

The coverage provides for the payment of eligible expenses explicitly listed for each category in this section of the booklet, provided that they are validated by *ARC*'s due diligence process and that they are incurred during coverage by an eligible person.

Eligible expenses are reimbursed, subject to the following conditions :

- they are incurred in the province of residence of the participant;
- they are incurred outside the participant's province of residence, but in Canada, for a reason other than a medical emergency;
- reimbursement is limited to the reimbursement percentages and the maximums mentioned in this section or in the *Benefit Summary*;
- the participant must pay the amount of the Deductible, if applicable, mentioned in the *Benefit Summary*; and
- the coverage is subject to the *Restrictions, Limitations and Exclusions* clause of this benefit.

When the expense is incurred

Eligible expenses are considered to have been incurred on the date on which the service was rendered, or the products obtained.

Eligible expenses

Expenses incurred for the services and items indicated in this section which are medically necessary for the treatment of an illness, pregnancy or accident and which do not exceed the reasonable and customary fees usually charged for the services or items that are the subject of the claim.

Medically necessary

It is generally recognized by the Canadian medical profession as effective, appropriate and required to treat illness, pregnancy or accident according to Canadian medical standards. They cannot be omitted without harming the condition of the person or the quality of medical care.

By "reasonable and customary fees" we mean:

- fees and prices normally charged in the regional area where the services or supplies are provided, and
- charges for services and supplies that represent reasonable treatment, considering the duration of services and how frequently services and supplies are provided.

End of coverage

The coverage end date is indicated in the *Benefit Summary* at the beginning of this booklet.

Survivor benefit

If you die while your coverage is still in effect, the Extended Healthcare coverage for your dependents continues, without premium, until one of the following happens:

- the period indicated in the *Benefit Summary* following your death ends
- the dependent ceases to meet the eligibility criteria
- your coverage would have ended if you were still alive
- the benefit covering the dependent is canceled

Additional Definitions

Accident

Any bodily injury certified by a physician and arising directly and independently of all other causes, from the sudden and unforeseen action of an external cause and is unintentional on the part of the insured. This definition excludes any form of disease or degenerative process, or inguinal, femoral, umbilical or abdominal hernia, any infection other than infection from an apparent external cut or injury suffered by accident.

Illness

Any deterioration of health or disorder of the organism certified by a physician. Organ donation and related complications are also considered illnesses.

Licensed health professional

Paramedical services must be provided by a Licensed Health Professional. They must be a member of the appropriate body governing the practice of their profession established by provincial government authorities or, in the absence of such body, be an active member of an association approved by *ARC*. They must hold a permit or be authorized to practice their profession, have undergone adequate training and have obtained the qualifications required for the practice of their profession. They must keep clinical records in accordance with the standards and practices dictated by their organization or association, collaborate with *ARC* when additional information is requested and not resort to practices that we deem unacceptable.

Important

To benefit from this coverage, you must be covered by a provincial health insurance plan or by a federal plan with similar benefits.

Drugs

ARC Group Benefits may determine that certain eligible drugs are subject to:

- maximum amounts, quantities and frequencies;
- special authorization; and
- coordination with patient support programs. Reimbursement for a high-priced specialty drug may be reduced depending on the amount of financial assistance offered under a patient support program.

Drugs	
Covered expenses	The following drugs and items that are dispensed by a pharmacist and prescribed by a doctor or dentist and that are approved in accordance with the section *Evaluation of covered drugs* below and approved for use by Health Canada: • drugs that carry a DIN (drug identification number); • drugs that legally require a prescription; • Life-sustaining drugs that may not legally require a prescription; • preparations and compounds, if their main ingredient is a qualifying drug and has a DIN number; • supplies for people with diabetes, including blood glucose test strips, lancets, needles, and syringes; • the costs used to cover the deductible and the coinsurance of the provincial drug insurance plan, for people covered by their provincial plan, unless otherwise stipulated in the *Benefit Summary*.

Evaluation of covered drugs

The drugs covered are those approved by the insurer of the insurance policy in excess of loss, in conjunction with Telus, the drug claims manager. Drug costs are eligible for reimbursement only if they were incurred from the date they were approved. The following factors are taken into consideration:

- comparative analysis of the cost of the drug and its clinical efficacy;
- recommendations made by provincial health technology assessment bodies;
- access to other medications that treat the same or similar conditions;
- the sustainability of the benefit plan.

Supply limit

Benefits paid for each purchase of items or drugs are limited to the cost of those that would be reasonable to use for a period of 34 days or, in the case of some maintenance drugs, for a period of 100 days, according to the doctor's prescription.

Substitution clause for a less expensive drug

ARC will reimburse the cost of the interchangeable drug with the lowest price, regardless of the interchangeable drug that was prescribed. The insured can purchase a higher cost interchangeable drug and then pay the price difference.

If it is mentioned in the *Benefit Summary* that the substitution clause is mandatory, *ARC* applies the *Substitution clause for a less expensive drug* even if the doctor indicates that the interchangeable drug cannot be substituted. If the insured cannot tolerate the interchangeable drug with the lowest cost, *ARC* may agree to reimburse the cost of another interchangeable drug, on a case-by-case basis, through the prior authorization program.

A generic drug and its branded equivalent are considered to be interchangeable drugs. Health Canada imposes the same standards and tests for generic drugs as those required for brand-name drugs. Generic drug are effective and safe, while being less expensive.

Prior authorization program

Certain eligible drugs as determined by *ARC* require prior authorization or authorization on a regular basis from *ARC* in order to be eligible for reimbursement. To ensure that the drugs prescribed meet the criteria for prior authorization, a form provided for this purpose must be used and completed by the physician. This allows *ARC* to confirm that the prescribed drugs:

- are used for an approved therapeutic purpose; and
- demonstrate satisfactory efficiency in relation to the associated costs.

Proof of efficacy or new results may be requested during treatment to determine whether the drug produces the expected effects and remains eligible for reimbursement.

ARC will reimburse an equivalent drug or a less expensive biosimilar drug if there is one on the market.

Your group plan gives you immediate access to most eligible drugs. Some eligible drugs require a prior authorization before your prescription is covered. See the "*How to Submit a Claim*" section in this booklet to understand the process for assessing a prior authorization request.

Patient support program

Some pharmaceutical manufacturers offer patient assistance programs. Through these programs, patients receive information, training, intravenous administration and, occasionally, financial assistance.

Exclusions and restrictions

Unless otherwise specified in the *Benefit Summary*, expenses for the following items are not eligible for reimbursement:

1. viscosupplementation injections;
2. sclerosing injections;
3. smoking cessation products;
4. vaccines and allergy serums;
5. bottle mixes (milk and milk substitutes), minerals, proteins, vitamins and collagen treatments;
6. medications related to the treatment of obesity, including medications, proteins, and food or dietary supplements;
7. natural health products, homeopathic and naturopathic products, herbal and traditional remedies, nutritional and dietary supplements;
8. fertility drugs;
9. drugs to treat sexual dysfunction;
10. hair growth stimulants;
11. drugs, services, treatments or supplies that:
    a. are not medically necessary;
    b. are given for cosmetic or preventive purposes only;
    c. are optional; or
    d. have a relative indication for experimental or research purposes.
12. procedures related to drugs injected by a health professional in a private clinic;
13. drugs which, in the opinion of *ARC*, are intended for hospital use, due to the route of administration and the condition for which the drug is used;
14. fees payable by any government healthcare plan or by virtue of any occupational health and safety commission, any automobile insurance company or other similar laws or plans;
15. services, treatments or supplies that the insured received free of charge;
16. costs that would not have been incurred in the absence of coverage; and
17. drugs that are eligible under the plan's *Global Medical Assistance and Out-of-Country Emergency Care*, if applicable.

Minimum requirements for drug coverage in Quebec (only applies to insureds in Quebec)

Prescription Drug Insurance Act

Any condition of this plan that does not comply with the requirements of the *Quebec Prescription Drug Insurance Plan* is automatically modified to meet these requirements.

Maximum out-of-pocket per calendar year

The expenses incurred for drugs covered and which are not reimbursed by this plan due to the application of the deductible or the reimbursement percentage, are limited, during each calendar year, to the maximum annual contribution established by the RAMQ for you and your children, and another maximum for your spouse.

For covered drugs, charges in excess of the price of the least expensive equivalent drug are not taken into account in the maximum contribution to costs, unless *ARC* has expressly approved reimbursement for the most expensive drug.

When the participant's contribution reaches the maximum annual contribution established by the RAMQ for the costs incurred for themselves and their dependent children, the percentage of reimbursement of the drugs covered for the participant and their children increases to 100% for the rest of the calendar year. When the contribution reaches the maximum annual contribution established by the RAMQ expenses incurred by the spouse of the participant, the reimbursement percentage of the drugs covered for the spouse increases to 100% for the remainder of the calendar year.

Pharmaceutical services (rendered by pharmacists)

Pharmaceutical services that are covered by the RAMQ according to its requirements.

Smoking cessation products

Smoking cessation products are covered as per the requirements of the RAMQ.

Quebec insureds aged 65 and over

What happens when you, the participant, turn 65?

When an insured in Quebec reaches the age of 65, they are automatically registered with the RAMQ Quebec Prescription Drug Insurance Plan. You will have a CHOICE to make as to which basic plan will reimburse your medications. Your two choices are:

1. Accept public drug insurance coverage (irrevocable choice).
2. Cancel your automatic enrollment in the public plan and maintain group plan coverage.

Your two choices are described on the next page.

Choice 1	Choice 2
Accept public drug insurance plan (irrevocable choice)	**Cancel your automatic enrollment in the public drug insurance plan and keep group plan coverage**
Coverage	
Drugs : First payer: The RAMQ will cover the prescription drugs from its list according to the conditions provided for in the public plan. Second payer: the group insurance plan offers additional coverage to that of the public plan. The eligible expenses will be as follows: 1. Deductible and coinsurance paid to the public plan; 2. Medicines not covered by the public plan but covered under this benefit subject to the conditions and termination age mentioned in this booklet.	**Drugs :** As the sole payer, the group insurance plan will continue to cover the drugs eligible under this benefit and under the conditions mentioned in this booklet.
Other extended healthcare: The other supplies and services covered under the extended healthcare benefit remain covered by the group insurance plan under the conditions and termination age mentioned in this booklet	**Other extended healthcare:** The other supplies and services covered under the extended healthcare benefit remain covered by the group insurance plan under the conditions and termination age mentioned in this booklet.
Actions to take	
For the participant: No action to take. At your 65th birthday, you are automatically enrolled in the RAMQ prescription drug insurance plan. **For the dependents:** Dependents must register for the RAMQ public drug insurance plan as of the participant's 65th birthday.	**For the participant:** Ask the RAMQ to cancel the automatic registration for the public drug insurance plan **by phone at 514-864-3411.** **For the dependents:** No action to take
Costs	
RAMQ : The annual contribution established for the current year will be payable for each adult. You must complete the appendix on your income statement. **Group insurance plan:** The participant remains in the same category and the current pricing for extended healthcare coverage remains the same depending on the type of protection (individual, family, etc.)	**RAMQ :** N/A **Group insurance plan:** The current pricing for extended healthcare coverage remains the same depending on the type of protection (individual, family, etc.) PLUS the applicable **MONTHLY** surcharge of: **$250.00 for an individual certificate** **$500.00 for a family or couple certificate** (the additional premium is subject to revision according to the pricing terms of the plan)

Hospitalization

Hospital	The occupancy of a room when the insured is admitted to a hospital as an inpatient for acute care in their province of residence. The eligible amount is the difference between the price of a standard room and that of the eligible room type mentioned in the *Benefit Summary*. Coverage under Hospitalization is limited to room and board. **Exclusion:** administrative and secondary costs (for example: television, telephone and parking). A long-term care facility, nursing home, care facility for the elderly or chronically ill, sanatorium, convalescent hospital or establishment for the treatment of alcoholism or drug addiction, as well as reserved beds for these purposes in a hospital are not eligible to be considered a hospital.
Convalescent home / physical rehabilitation	**Up to a maximum of $40 per day, for a period limited to 120 days per calendar year** The occupancy of a room when an insured person is admitted to a convalescent home or a physical rehabilitation establishment within 14 days of their discharge from the hospital where they were receiving acute care (and not supervision), on doctor's recommendation. **Exclusion:** a long-term care establishment, a nursing home, a care establishment for the elderly or chronically ill, a sanatorium, an establishment intended for the treatment of alcoholism or drug addiction are not considered to be a convalescent home.

Paramedical services

Paramedical services	Eligible expenses for treatment received from any Authorized Health Professional and mentioned in the *Benefit Summary*. The protection is limited to: • treatments provided by a health professional within the limits of their competence; and • 1 treatment per day per professional. Unless otherwise indicated in the *Benefit Summary*, a medical referral is not required for treatment to be eligible for coverage. **Exclusions:** • products supplied by a healthcare professional (except if they are covered under this contract); • comprehensive health checks; • charges for services obtained in a hospital; and • group treatment sessions.

Medical supplies and services

Ambulance services	**Reasonable and customary fees** In the event of an emergency, the cost of transporting a patient on a stretcher by ambulance to or from the nearest hospital that can provide the emergency care the insured person needs, including air transport or rail. Transport from a hospital to the person's home is covered only if their state of health does not allow the use of another means of transport. **Exclusion:** costs for transport between hospitals
Nursing care in private practice given outside the hospital	**$10,000 per calendar year** Charges for the services of a registered nurse or a nursing assistant when these services are provided at the home of the insured and are not primarily on-call or midwifery care. Nursing care may require prior approval from *ARC* to be reimbursed, in whole or in part. By nurses practicing in a private capacity, we mean nurses and nursing assistants, who are authorized to practice their profession in the province of the insured's domicile, who do not reside with you and who are not members of your family, nor by blood, nor by marriage. **Exclusion:** costs for custodial care, homemaking duties, shopping, transportation, respite care, foot care, samples, and services unrelated to activities of daily living.
Diagnostic services	**For all diagnostic services combined, up to the amount mentioned in the *Benefit Summary*** When recommended by a physician and provided by an *ARC* licensed and approved commercial laboratory: • laboratory analysis • prenatal screening tests • imaging techniques (MRI, computed tomography, ultrasounds, electrocardiograms, x-rays) **Exclusion:** fees for services for screening purposes (except prenatal tests), for health check-ups and services insured by the insured's government plan
Dental care following an accident	**Up to the amount mentioned in the *Benefit Summary*** The services of a dentist required to repair or replace healthy teeth as a result of an accidental direct external blow to the mouth that occurs during coverage. To be eligible for coverage, treatment must: • begin within 90 days of the accident or dislocation, or include a detailed treatment plan satisfactory to *ARC*, which must be submitted for approval within this period; and

Medical supplies and services (continued)

Dental care following an accident (continued)	• have been received within 12 months of the date of the accident. **Definition:** healthy tooth means a natural tooth that is not the subject of any pathological damage, either in its material or in the structures which are adjacent to it. **Exclusion:** any loss or breakage caused when the tooth was performing its main role (chewing)
Substance abuse rehabilitation	**$80 / day / maximum of $2,500 for life, if coverage elected in the *Benefit Summary*** Room and board costs for detoxification in a center recognized by the Ministry of Health of the province of residence of the insured and specializing in the treatment of alcoholism, drug addiction or gambling addiction. The person's condition must require care under the supervision and control of a doctor and the stay must be approved in advance by *ARC*.

External prostheses

Hearing aids	**Up to the amount mentioned in the *Benefit Summary*** Hearing aid purchase and repair costs when prescribed by an otolaryngologist or otologist, or recommended by an audiologist, up to the overall maximum for both ears. **Exclusion:** replacement batteries and hearing test fees
Hair prostheses	**Up to the amount mentioned in the *Benefit Summary*** When hair loss is caused by chemotherapy or radiation therapy **Exclusions:** when hair loss is not caused by an underlying condition or its treatment, hair replacement therapy and other treatments for physiological hair loss (for example, alopecia)
Breast prostheses	**$200 per person per 24-month period** When required following a mastectomy
Post-mastectomy bras	**Up to the amount mentioned in the *Benefit Summary*** When required following a mastectomy

External prostheses (continued)

Prostheses and artificial limbs	**Up to 1 member and a maximum of $10,000 for life, unless otherwise indicated in the *Benefit Summary*** **Repair or adjustments of eligible prostheses are reimbursed up to a maximum of $300 per calendar year.** Fees for standard artificial limbs or myoelectric limbs Fee for artificial eyes (up to 1 per eye per lifetime) Costs for an artificial nose (up to a maximum of 1 nose per lifetime) Costs for an artificial larynx (up to 1 larynx per lifetime) **Exclusions:** • dental prosthesis • microprocessor knees • replacement of prostheses, unless required due to a pathological or physiological change

Orthopedic supplies

Custom-made orthopedic shoes	**Up to the amount mentioned in the *Benefit Summary***
	
	The costs for the purchase and repair of:
	• custom made orthopedic shoes;
	• Extra depth shoes or prefabricated orthopedic shoes that have been personalized through permanent modifications to accommodate, alleviate or correct a mechanical defect or abnormality of the foot, provided that:
	  ○ the shoes are prescribed by the attending physician, an orthopedic surgeon, a physiatrist, a rheumatologist, a chiropodist, or a podiatrist;
	  ○ the insured provides a copy of the biomechanical examination or gait analysis performed by the healthcare professional who prescribed the shoes; and
	  ○ the shoes are supplied by an approved supplier of orthopedic shoes.
	
	Exclusion: the purchase and repair of prefabricated orthopedic shoes without permanent modifications

Custom-made plantar orthotics	**Up to the amount mentioned in the *Benefit Summary*** Costs for the purchase of custom-made plantar orthotics to accommodate, relieve or correct a mechanical defect or anomaly of the foot, provided:

Orthopedic supplies (continued)

Custom-made plantar orthotics (continued)	• They are prescribed by an attending physician, an orthopedic surgeon, a physiatrist, a rheumatologist, a podiatrist, or a chiropodist; and • the insured provides a copy of the biomechanical examination or gait analysis performed by the health professional who prescribed the orthotics; and • they are supplied by an approved supplier of custom-made foot orthotics.
Rigid or semi-rigid splints, hernial bandage and casts	**Reasonable and customary fees** Purchase and repair on medical recommendation from the attending physician or any other therapist recognized by a professional order (for splints and casts)
Medical corsets	**Reasonable and customary fees** Purchase and repair

Diabetic Supplies

Blood glucose meters	**1 device per 36-month period, up to a maximum of $200**
Continuous glucose monitoring systems: receivers, transmitters or sensors	**Up to a maximum of $3,500 per calendar year** The equipment must be used for the treatment and control of diabetes and the insured must meet eligibility criteria established by *ARC*.
Pressure insulin injectors	**Reasonable and customary fees** **Exclusions:** Insulin pumps are eligible under the Medical Equipment category. Certain supplies for people with diabetes, such as strips, are eligible under the Drug Benefit.

Therapeutic devices / Medical equipment

Rental (or purchase at our request) of devices	**Reasonable and customary fees, lifetime maximum of $10,000** Medically necessary devices that meet your basic medical needs. If there is more than one device that meets your basic medical needs, the reimbursable expense is limited to the cost of the least expensive device. You must meet the criteria established by *ARC*.

Therapeutic devices / Medical equipment (continued)	
Rental (or purchase at our request) of devices (continued)	The purchase of medical equipment requires prior approval from *ARC*. Failure to obtain prior approval could mean that the purchase may not be eligible for a refund, in whole or in part. If, due to prolonged illness or disability, the medical equipment becomes the object of long-term use, *ARC* may, at its discretion, approve the purchase of such equipment. If such a purchase is approved, the rental or purchase of a second piece of similar equipment is limited to once in a 5-calendar year period. Two pieces of equipment are similar if they serve the same function (for example, to facilitate breathing, provide mobility, or distribute insulin). Manual or electric wheelchair only when the insured's state of health justifies its use (includes cushions and inserts) Manual hospital bed Traction apparatus Standing aids Sleep apnea devices **Exclusions:** Medical equipment provided by a hospital is not eligible as well as costs for special mattresses, air conditioning units or air purifiers and breast pumps.
Insulin pumps	**1 pump every 5 years, up to a maximum of $5,000** The equipment, including accessories, must be used for the treatment and control of type 1 diabetes and the insured must meet the eligibility criteria established by *ARC*.
Lymphedema pumps	**Reasonable and customary fees**
Chest percussion accessories	**Reasonable and customary fees**
Enuresis devices	**Reasonable and customary fees**
Oxygen and material necessary for its administration	**Reasonable and customary fees**
Aerosol therapy devices	**Reasonable and customary fees**
Bone stimulators	**Reasonable and customary fees**
TENS neurostimulators and its supplies	**Reasonable and customary fees**

Exclusions: Medical equipment supplied by a hospital is not eligible as well as costs for special mattresses, air conditioning units or air purifiers and breast pumps.

Other medical supplies and services	
Stockings with varicose veins, including receding compression stockings	**Up to the maximum indicated in the *Benefit Summary***
Stump covers	**5 pairs per 24-month period**
IUDs or diaphragms	**Up to a maximum of $75 per 2 calendar years**
Cautery catheters and supplies	**Reasonable and customary fees**
Supplies for people with ostomies	**Reasonable and customary fees**
Supplies for paraplegics	**Reasonable and customary fees**
Medical supplies following a tracheostomy	**Reasonable and customary fees**
Medical supplies for gavage	**Reasonable and customary fees**
Medicated dressings	**Reasonable and customary fees**
Compression garments for the treatment of severe burns	**Up to $500 per calendar year**
Sleeves for lymphedema	**Up to 2 per calendar year**
Intraocular lenses	**Up to $300 per 24 consecutive months** Required following cataract surgery, ulcerative keratitis, severe corneal scarring, keratoconus, aphakia or marginal corneal degeneration Contact lenses must restore visual acuity to at least 20/40 whereas this improvement would not be possible with corrective glasses.

Vision care	
Eye exams	**Up to the maximum mentioned in the *Benefit Summary***
Glasses, contact lenses and laser surgery	**Up to the maximum mentioned in the *Benefit Summary*** Eyeglasses and contact lenses should be prescribed by an ophthalmologist or optometrist and provided by an ophthalmologist, optometrist or optician, to correct vision. Laser surgery to correct eyesight **Definition:** For the purposes of vision care coverage, a child is an eligible dependent under the age of 18

Restrictions, Limitations and Exclusions

No benefit is payable (or benefits are reduced) for:

1. services, treatments, items or supplies that do not fall within the categories of eligible costs set out in this benefit;
2. implanted prostheses or medical devices (e.g. gastric rings, breast implants, spinal implants and hip prostheses)
3. services, treatments or supplies covered under any government healthcare plan or fees payable under any occupational health and safety commission, any auto insurance company or other similar laws or plans;
4. services, treatments or supplies that the insured received free of charge;
5. costs that would not have been incurred in the absence of coverage;
6. services, treatments or supplies that:
    a. are not medically necessary;
    b. are given for cosmetic or preventive purposes only;
    c. are optional; or
    d. are experimental or for research purposes;
7. services related to family planning (with the exception of the cost of IUDs or diaphragms), including artificial insemination and laboratory or other costs related to fertility treatments, whether or not infertility is considered a disease;
8. charges for services eligible under the plan's *Global Medical Assistance and Out-of-Country Emergency Care*, regardless if you are covered or not;
9. services or supplies normally intended for recreation or sport;
10. additional supplies, such as spare parts and substitutes;
11. fees for missed appointments or for filling out forms;
12. medical examinations or check-ups;
13. mileage or delivery costs from or to a hospital or to a healthcare professional;
14. services or costs incurred during imprisonment in a penal institution or in legal custody; or
15. services or costs incurred due to:
    a. insurrection, war (whether declared or not), hostility from the armed forces of any country or participation in a riot or public confrontation; or
    b. participation in or attempted commission of a criminal offense, even if no charges have been laid or a guilty verdict has not been entered.

Further Information on the Benefit

For more information about your plan

For information on filing claims or if you have any questions about your claims or your coverage, see the *"Submitting a Claim for Extended Healthcare and Dental"* and *"Communicate with ARC Group Benefits"* sections of this booklet.

Access to documents

The wording in this booklet regarding healthcare coverage constitutes all the terms of the healthcare plan offered by your employer. Subject to certain restrictions, you have the right, upon request, to obtain a copy of your insurance application or any written statements.

Legal actions

No legal action may be taken for the settlement of any uninsured benefits–Extended Healthcare and Dental benefits–under this plan before 60 days from the date the claim has been submitted, and no more than one year after the rejection of a claim.

Appeal procedure

You have the right to appeal against the employer's refusal to grant all or part of the coverage or benefits described in this plan within one year of the initial refusal. You must appeal in writing, specifying the reasons why you consider the refusal to be unjustified.

Suspension of benefits due to overpayment

If benefits that should not have been paid under this plan are paid, you are required to repay them within 60 days of *ARC Group Benefits* sending a notice of overpayment or within a longer period agreed in writing with the employer. If you fail to comply with this obligation, payment of benefits under the plan will be suspended until the overpayment is reimbursed. This action in no way limits your employer's right to recover overpayments by other legal means.

Dental Care

Benefit details

Your employer is responsible for the Dental care coverage described in this booklet. *ARC Group Benefits Inc.* is not an insurance company, but however handles the processing of claims on behalf of your employer:

Benefit payment

The Dental Care plan provides for the payment of eligible expenses incurred during coverage by an eligible person for care provided by an authorized dentist, denturist, dental hygienist or anesthesiologist and which exceed the deductible, subject to the percentage reimbursement and the maximums mentioned below or in the *Benefit Summary*.

Treatment date

Eligible expenses are deemed to have been incurred on the date the treatment is given, in the case that treatment requires a single appointment. For care or supplies requiring several appointments, the costs are deemed to have been incurred on the date when the whole procedure is completed or on which the device has been put in place.

Fee guide

Eligible expenses are based on the fee guide. The applicable guide and its year of publication are indicated in the *Benefit Summary*. Where a fee is not published for a given year or if the guide is not recognized by *ARC*, the eligible expenses are based on reasonable and customary charges. In any case, the eligible costs will never exceed the costs actually incurred by the member.

Prior authorization for requests over $500

When the total cost of any treatment is estimated at more than $500, the member is strongly advised to submit a detailed treatment plan to *ARC* before the start of treatment, specifying the type of care to be provided, the dates planned, and the fees required for each treatment.

Temporary treatment

This type of care is an integral part of the definitive treatment given to correct a problem and is not considered to be a separate type of care. Only the fees charged for permanent care will be used to determine the amount of reasonable and customary fees charged for the final dental treatment.

End of coverage

The end date of coverage is indicated in the *Benefit Summary* at the beginning of this booklet.

Survivor benefit

f you die while your coverage is still in effect, Dental Care coverage for your dependents continues, without premium, until one of the following situations occurs:

- the period indicated in the *Benefit Summary* following your death ends
- the dependent would cease to meet the definition
- your coverage would have ended if you were still alive
- the benefit covering the dependent is canceled

Your Coverage at a Glance

Preventive care	
Oral exams	1 complete oral examination every 36 months, unless stated otherwise in the *Benefit Summary* 1 periodic or recall examination according to the period mentioned in the *Benefit Summary* Emergency oral examination or specific orthodontic examination 1 specific aspect examination every 12 months 1 periodontal examination every 60 months 1 examination for stomatognathic dysfunctions every 60 months 1 prosthodontic examination every 36 months
X-rays	1 complete series of x-rays or 1 panoramic x-ray every 36 months, unless stated otherwise in the *Benefit Summary* Bitewing x-rays X-rays used to diagnose a symptom or to review progress on a particular treatment series
Laboratory tests and examinations	Microbiological cultures Biopsies Cytological examinations
Consultations	Oral hygiene instructions, once per lifetime Teeth polishing and topical fluoride application at the same interval as the periodic or recall exams listed in the *Benefit Summary* 1 unit of light scaling for preventive purposes at the same interval as the periodic or recall examinations listed in the *Benefit Summary* Pit and fissure sealants for children under 16 Space maintainers for missing primary teeth, only for children under 16 (devices fitted for orthodontic purposes are not covered)

Basic care	
Restorations	Amalgam (gray), acrylic, silicate or composite restoration of anterior and posterior teeth The cost of replacing fillings is covered only if: • the current filling is at least 12 months old and its replacement is necessary due to a major breakage of the current filling or recurrent tooth decay; or • the existing filling is amalgam and there is medical evidence that the patient is allergic to amalgam. Retentive pins Preformed stainless steel and polycarbonate crowns on primary teeth (only for children under 16)
Endodontics	Root canal treatments and root canal fillings, pulp disease treatments, root amputation, apexification and periapical treatments: • Root canal treatments and root canal fillings are covered subject to initial treatment and subsequent treatment per tooth for life. • Subsequent treatments are covered only if the costs are incurred more than 12 months after the initial treatment.
Periodontics	Periodontal surgery Treatment of diseases of the gums and other tissues that support the tooth, including: • scaling for therapeutic purposes not covered under preventive care and root planing, limited to a combined maximum of 8 units per calendar year for adults and a maximum of 4 units per calendar year for children under the age of 13 years old; unless stated otherwise in the *Benefit Summary* • curettage or root planing limited to a maximum of once in a period of 60 months; and • occlusal equilibration, limited to a maximum of 8 units per calendar year (s). Periodontal appliances, up to a maximum of 1 per 2 calendar years Device adjustments, up to 3 units per calendar year

Basic care (continued)	
Adjustment and maintenance of removable prostheses	Denture repairs, relining and rebasing of dentures (up to 1 per 2 calendar years), and prosthesis adjustments (only if the costs are incurred more than 3 months after the initial placement of the prosthesis)
Oral surgery	Removal of teeth and roots Surgical exposure and removal of teeth Incision, removal and drainage of tumors or cysts Frenectomy Removal, reduction or correction of bone and gum tissue Post-surgical care
Anesthesia	General anesthesia, constant sedation

Outside of Canada

To be eligible, expenses for dental treatment received outside of Canada must be:

- ✓ included in the list of eligible expenses in Canada; and
- ✓ submitted with an official translation of receipts

Reimbursement of eligible expenses is based on the fee guide indicated in the *Benefit Summary* and translation costs are at the expense of the insured.

Major care

Prosthodontics	Fabrication and insertion fees of standard fixed or removable prosthodontics are eligible when at least one natural tooth has been extracted while the insured was covered under this benefit, or a comparable benefit held by the policyholder in effect immediately before the effective date of this benefit. Replacement fees for a standard fixed or removable prosthodontics when the insertion is dated from at least five years (60 months). Replacement fees of a temporary prosthodontic with a permanent one when done within 12 months of the initial placement. The amount reimbursed for the permanent prosthodontic will be deducted from the amount already reimbursed by the plan for the temporary one. If the temporary prosthodontic is not replaced by a permanent one within 12 months of the initial placement, the temporary prosthodontic will be considered as a permanent one and its date of insertion will be used for the replacement clause. Removable prosthodontics, denture : • temporary, immediate or transitional • Partial, complete, immediate complete, complete overdenture standard Fixed prosthodontics : • Bridge (abutments and pontics) • Repairs, recementation or removal of bridge
Major restorations	Fabrication fees and insertion of major restorations when the loss of tooth structure does not allow amalgam or composite fillings Replacement fees when the insertion is dated from at least five years (60 months) Individual crown (excluding prefabricated stainless steel and polycarbonate crowns on primary teeth) Inlays Onlays Cast post Reconstruction, tooth in preparation for crown or bridge Prefabricated post Repairs, recementation or removal crown, inlay, onlay, prefabricated post and cast post

Orthodontic care	
Orthodontics	Expenses for dental care aimed at restoring and maintaining optimal occlusal relationships between craniofacial and dentofacial structures in children under 19 who meet the eligibility criteria, unless otherwise stipulated in the *Benefit Summary* A treatment plan is required prior care to determine the eligibility of the expenses and the terms of reimbursement. Orthodontic complete oral examination. Myofunctional evaluation and therapy. Major orthodontic treatment. Adjustments, alterations or recementation. Removable or fixed appliances : Space regaining, cross-bite correction, dental arch expansion, closure of diastemas, alignment, mechanical eruption of tooth. Removable or fixed retention appliances.
Reimbursement of costs relating to orthodontic treatment	Notwithstanding any provision to the contrary in this contract appearing in the section SUBMITTING A CLAIM for extended medical care and dental care, reimbursement of costs relating to orthodontic care takes place according to one of the following methods: 1) if a lump sum has been fixed for the entire series of treatment and the insured person pays this sum to the orthodontist in agreed installments, according to the duration of the treatment or in a single sum, the insurer will reimburse the member each time the latter presents a certificate, an invoice or a receipt specifying the amount of the charges charged, the date and the nature of the treatment received; 2) if, instead of a lump sum, the services are billed as they are provided, the insurer reimburses the participant each time he submits a claim for benefits.

Restrictions, Limitations and Exclusions

Late enrollment

In the case of late enrollment for the participant or their dependents, reimbursement is limited to $250 per covered person for the first 12 months.

Alternative treatments

Where one or more forms of treatment exist, payment is limited to the cheapest treatment cost which meets the basic needs of the insured person and which gives a professionally appropriate result.

Laboratory costs

Laboratory fees are limited to 60% of the amount indicated in the fee guide for the service provided.

General exclusions

No reimbursement is made for the following:

1. services or care that a public health insurance plan prohibits from paying in whole or in part, except to the extent that it allows an excess reimbursement
2. services, care or products that the person receives free of charge or that are reimbursable under any provincial or federal law applicable to the covered person, whether or not they are covered by these laws
3. dental treatment that is not yet approved by the Canadian Dental Association or that is for experimental purposes
4. services, care or products provided by the employer
5. fees charged by a dentist for missed appointments, for filling out claims for reimbursement or for telephone consultations
6. eligible expenses that arise directly or indirectly from the following:
    a. offense or attempted criminal offense, as provided for in the Criminal Code of Canada
    b. any cause for which the expenses are eligible for reimbursement under the Workmen's Compensation Act, similar legislation or any other public plan
    c. war, whether declared or not, active service in the armed forces of a country, or participation in a riot, insurrection or popular unrest
7. dental treatment received for cosmetic purposes when the shape and function of the teeth are satisfactory, and no pathological condition exists
8. charges for nutritional counselling
9. dental care and supplies, including x-rays, aimed at:
    a. Full mouth reconstruction;
    b. vertical dimension correction;
    c. correction of temporomandibular joint dysfunction; or
    d. permanent splinting of teeth.
10. bleaching
11. expenses incurred for implants

Restrictions, Limitations and Exclusions (continued)

12. electronic dental anesthesia, acupuncture or hypnosis anesthesia
13. dental services and supplies not included in the list of eligible expenses
14. expenses incurred after the insured's coverage end date, even if a detailed treatment plan has been submitted and approved by *ARC* before that date
15. replacement fees for lost, misplaced or stolen devices
16. fees for a dental appliance for the purpose of practicing a sport (custom-made mouthguard)
17. Dentition Breach Restriction: No amount will be paid for a prosthodontic that is only used to replace a missing natural tooth before the date the person became insured by this benefit under the group insurance policy
18. dental expenses incurred for a treatment related to a congenital malformation or acquired deformity
19. fees for prefabricated stainless steel or polycarbonate crowns, except for primary teeth

Further Information on the Benefit

For more information about your plan

For information on filing claims or if you have any questions about your claims or your coverage, see the *"Submitting a Claim for Extended Healthcare and Dental"* and *"Communicate with ARC Group Benefits"* sections of this booklet.

Access to documents

The wording in this booklet regarding dental coverage constitutes all the terms of the dental plan offered by your employer. Subject to certain restrictions, you have the right, upon request, to obtain a copy of your insurance application or any written statements.

Legal actions

No legal action may be taken for the settlement of any uninsured benefits–Extended Healthcare and Dental benefits–under this plan before 60 days from the date the claim has been submitted, and no more than one year after the rejection of a claim.

Appeal procedure

You have the right to appeal against the employer's refusal to grant all or part of the coverage or benefits described in this plan within one year of the initial refusal. You must appeal in writing, specifying the reasons why you consider the refusal to be unjustified.

Suspension of benefits due to overpayment

If benefits that should not have been paid under this plan are paid, you are required to repay them within 60 days of *ARC Group Benefits* sending a notice of overpayment or within a longer period agreed in writing with the employer. If you fail to comply with this obligation, payment of benefits under the plan will be suspended until the overpayment is reimbursed. This action in no way limits your employer's right to recover overpayments by other legal means.

Global Medical Assistance and Out-of-Country Emergency Care

Benefit details

Insurer: Canada Life
Policy number: 178213

The booklet summarizes the important features of your coverage. The exact terms and conditions are described in the group policy held by your employer. If there is a discrepancy in terms between the booklet and the group policy, the group policy will prevail.

Global Medical Assistance and Out-of-Country Emergency Care

A deductible may be applied before you are reimbursed. All expenses will be reimbursed at the level shown in the *Benefit Summary*. Benefits may be subject to plan maximums and frequency limits. Check the *Benefit Summary* for this information.

The plan covers customary charges for the following services and supplies. All covered services and supplies must represent reasonable treatment. Treatment is considered reasonable if it is accepted by the Canadian medical profession, it is proven to be effective, and it is of a form, intensity, frequency and duration essential to diagnosis or management of the disease or injury.

Global Medical Assistance Program (GMA)

This program provides medical assistance through a worldwide communications network which operates 24 hours a day. The network locates medical services and obtains *Canada Life*'s approval of covered services, when required as a result of a medical emergency arising while you or your dependent is travelling for vacation, business or education. Coverage for travel within Canada is limited to emergencies arising more than 500 kilometres from home. You must be covered by the government healthcare plan in your home province to be eligible for Global Medical Assistance benefits.

Services under this benefit are covered subject to *Canada Life*'s prior approval.

1. On-site hospital payment when required for admission, to a maximum of $1,000 per person per trip
2. If suitable local care is not available, medical evacuation to the nearest suitable hospital while travelling in Canada. If travel is outside Canada, transportation will be provided to a hospital in Canada or to the nearest hospital outside Canada equipped to provide treatment.

   When services are covered under this provision, they are not covered under other provisions described in this booklet.
3. Round trip economy class transportation and lodging for one family member joining a patient hospitalized for more than 7 days while travelling alone
4. If you or a dependent is hospitalized while travelling with a companion, extra costs for lodgings for the companion when the return trip is delayed due to your or your dependent's medical condition

   Limitation
   Benefits for lodging are limited to moderate quality accommodation for the area of hospitalization. Telephone expenses as well as taxicab and car rental charges are included. Meal expenses are also covered. The maximum amount payable is $150 per day to a maximum of $3,000 per family per trip.

5. The cost of comparable return transportation home for you or a dependent and one travelling companion if prearranged, prepaid return transportation is missed because you or your dependent is hospitalized. Coverage is provided only when the return fare is not refundable. A rental vehicle is not considered prearranged, prepaid return transportation.
6. In case of death, preparation and transportation of the deceased home, to a maximum of $5,000 per person
7. Return transportation home for minor children travelling with you or a dependent who are left unaccompanied because of your or your dependent's hospitalization or death. Return or round-trip transportation for an escort for the children is also covered when considered necessary
8. Costs of returning your or your dependent's vehicle home or to the nearest rental agency when illness or injury prevents you or your dependent from driving, to a maximum of $5,000 per trip

   Limitation
   Benefits will not be paid for vehicle return if transportation reimbursement benefits are paid for the cost of comparable return transportation home.
9. Incidental expenses including but not limited to telephone charges, television rental, and parking while the person is hospitalized for an emergency and the expenses are incurred as a direct result of such hospitalization. *Canada Life* will only reimburse covered expenses for which original receipts are submitted, to a maximum of $250 per confinement.
10. Prepaid travel expenses which are not refundable or recoverable from any other source if, prior to a scheduled departure, you or one of your dependents is required to cancel a trip due to:
    a. your death, the death of a dependent or the death of a member of your family, or of your dependent's family, occurring within 22 days of the scheduled departure date; or
    b. the disease or injury of a member of your family, or of your dependent's family, which required immediate hospitalization with an expected stay of at least three days and did not result from a medical condition that existed prior to booking the trip; or
    c. the disease or injury of you or of your dependent, which did not result from a medical condition that existed prior to booking the trip.

    Limitation
    No benefits will be paid unless the attending physician states in writing that prior to the scheduled departure date, the physician advised the person to cancel the trip, or that the disease or injury made it impossible for the person to start the trip.

★ The maximum amount payable is $5,000 per person per trip.

11. Non-refundable prepaid travel expenses for yourself or one of your dependents and for each person insured under this plan travelling with them if they have to end a trip and return home because they experienced a medical emergency

    If a person does not return home and opts to continue travelling after the medical emergency has ended, *Canada Life* will cover the additional cost of travel for the person and for each person travelling with them, as long as they are insured under this plan.

    If required, *Canada Life* will cover the additional cost for hotel accommodation and meals incurred by yourself or a dependent travelling with the person on account of the interruption

★ The maximum amount payable is $5,000 per person per trip.

Out-Of-Country Emergency Care

The plan covers medical expenses incurred as a result of a medical emergency arising while you or your dependent is outside Canada for vacation, business or education purposes. To qualify for benefits, you must be covered by the government health plan in your home province.

By "medical emergency" we mean:

- a sudden, unexpected injury; or
- an acute episode of disease.

Limitation

If you are age 70 or over, no benefits will be paid for an emergency related to a pre-existing medical condition that was not stable and controlled for a period of at least 6 months immediately prior to your departure from Canada (If covered under your plan as indicated in the *Benefit Summary*).

Covered Services and Supplies

The following services and supplies are covered when related to the initial medical treatment:

1. treatment by a physician
2. diagnostic x-ray and laboratory services
3. hospital accommodation in a standard or semi-private ward or intensive care unit, if the confinement begins while you or your dependent is covered
4. medical supplies provided during a covered hospital confinement
5. paramedical services of chiropractors, physiotherapists, podiatrists and osteopaths, to a maximum of $250 per practitioner per trip
6. hospital out-patient services and supplies
7. medical supplies provided out-of-hospital
8. prescription drugs

   Limitation

   No benefits will be paid for any single purchase of a drug that would not reasonably be consumed or used within 30 days.
9. out-of-hospital services of a professional nurse, to a maximum of $5,000 per person per trip
10. ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available. If transportation is to a further centre, *Canada Life* will provide alternative benefits based on coverage for transportation to the nearest centre where essential treatment is available.
11. dental accident treatment to sound natural teeth to a maximum of $2,000 per person per trip

Restriction

If your medical condition permits you to return to Canada, benefits will be limited to the cost of return transportation. No further benefits will be paid under this provision.

If you are under age 85, no benefits are paid for expenses incurred more than 60 days after the date of departure from Canada. If you or your dependent is hospital confined at the end of the 60-day period, benefits will be extended to the end of the confinement.

Expenses not covered

Except to the extent otherwise required by law, no benefits are paid for:

1. Expenses private insurers are not permitted to cover by law
2. Services or supplies for which a charge is made only because you have insurance coverage
3. The portion of the expense for services or supplies that is payable by the government health plan in your home province, whether or not you are actually covered under the government health plan
4. Any portion of services or supplies which you are entitled to receive, or for which you are entitled to a benefit or reimbursement, by law or under a plan that is legislated, funded, or administered in whole or in part by a government ("government plan"), without regard to whether coverage would have otherwise been available under this plan

   In this limitation, government plan does not include a group plan for government employees
5. Services or supplies that do not represent reasonable treatment
6. Services or supplies associated with:
   a. treatment performed only for cosmetic purposes
   b. recreation or sports rather than with other daily living activities
   c. the diagnosis or treatment of infertility
   d. contraception
7. Services or supplies not listed as covered expenses
8. Extra medical supplies that are spares or alternates
9. Expenses arising from war, insurrection, or voluntary participation in a riot

Survivor Benefits

If you die while your coverage is still in effect, coverage under *Global Medical Assistance* and *Out-of-Country Emergency Care* for your dependents continues without premium, until one of the following situations occurs:

- the period indicated in the *Benefit Summary* following your death ends
- the dependent would cease to meet the definition
- your coverage would have ended if you were still alive
- the benefit covering the dependent is canceled

How to Make a Claim

Travel Emergency Medical claims

In a medical emergency, call the *Assistance Centre* immediately, prior to seeking medical treatment. If it is not reasonable to call prior to seeking medical treatment, call as soon as possible following the medical emergency:

Within Canada or United States: 1 866 530-6024
All other locations: 1 905 816-1901 (collect)

When you return home, contact *Global Excel Management Inc.* for the forms you need to submit a claim for reimbursement of expenses.

Submit the claim to the *Global Excel Management Inc.* along with your original receipts to:

Global Excel Management Inc.
3355 Munich Court
Windsor ON N8N 5G2
Téléphone : 1 866 530-6025 or 905 816-1990 (collect)

Travel Emergency Medical claims should be submitted to the *Assistance Centre* as soon as possible upon incurring the expense. It is very important that your claims are submitted promptly upon your return to Canada because your provincial health plan has very strict time limitations for submission. The provincial plan time limits apply to your group health plan claim as well. We suggest you contact your provincial health plan prior to leaving the country to determine the extent of your provincial health plan coverage. If your provincial health plan refuses payment, you may be asked to reimburse the *Assistance Centre* for any amount already paid on behalf of the provincial health plan.

No benefit is payable if the claim is submitted more than **15 months** after the date the insured received the services or supplies.

Trip Cancellation or Interruption claims

Call the *Assistance Centre's Claims Department* toll-free at 1-866-530-6025 or collect at 905-816-1990 for the forms you need to submit a claim.

Other Information on the benefit and Canada Life

Canada Life online

Visit our website at ***www.canadalife.com*** for :

- information and details on the Company's profile, our products and services;
- investor information;
- press releases; and
- the resource persons to contact.

For more information about your plan

If you have any questions about your claim or coverage, contact the *Claims Department* at the *Assistance Center* toll-free at 1-866-530-6025 or collect at 905-816-1990.

Access to Documents

You have the right, upon request, to obtain a copy of the policy, your application and any written statements or other records you have provided to *Canada Life* as evidence of insurability, subject to certain limitations.

Legal Actions

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), or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the *Quebec Civil Code*.

Appeals

You have the right to appeal a denial of all or part of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Benefit Limitation for Overpayment

If benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days after *Canada Life* sends you a notice of the overpayment, or within a longer period if agreed to in writing by *Canada Life*. If you fail to fulfil this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit *Canada Life*'s right to use other legal means to recover the overpayment.

Canada Life Privacy Policy

At *Canada Life*, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of *Canada Life* or the offices of an organization authorized by *Canada Life*. *Canada Life* may use service providers located within or outside Canada. We limit access to personal information in your file to *Canada Life* staff or persons authorized by *Canada Life* who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

We use the personal information to administer the group benefits plan under which you are covered. This includes many tasks, such as:

- determining your eligibility for coverage under the plan
- enrolling you for coverage
- investigating and assessing your claims and providing you with payment
- managing your claims
- verifying and auditing eligibility and claims
- creating and maintaining records concerning our relationship
- underwriting activities, such as determining the cost of the plan, and analyzing the design options of the plan
- *Canada Life*'s and its affiliates' internal data management and analytics
- preparing regulatory reports, such as tax slips

We may exchange personal information with your health care providers, your plan administrator, any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the plan.

As a plan member, you are responsible for the claims submitted. We may exchange personal information with you or a person acting on your behalf when relevant and necessary to confirm coverage and to manage the claims submitted.

You may request access or correction of the personal information in your file. A request for access or correction should be made in writing and may be sent to any of *Canada Life*'s offices or to our head office.

For a copy of our *Privacy Guidelines*, or if you have questions about our personal information policies and practices (including with respect to service providers), write to *Canada Life*'s Chief Compliance Officer or refer to *www.canadalife.com*.

Accidental Death and Dismemberment Insurance

Benefit details

Insurer : Industrial Alliance Insurance and Financial Services Inc.
Policy number: 100012326

The booklet summarizes the important features of your coverage. The exact terms and conditions are described in the group policy held by your employer. If there is a discrepancy in terms between the booklet and the group policy, the group policy will prevail.

Basic accidental death and dismemberment insurance

You are covered for any injury sustained as the result of an accident anywhere in the world - 24 hours per day - on or off the job. The principal sum is in the *Summary of Benefits*.

Accidental Death, Dismemberment and Specific Loss Indemnity

The "loss" or "loss of use" must occur within 365 days of the date of the accident. These benefits are payable on a lump sum basis and in addition to any other benefits you may receive.

Loss	% of Principal Sum
Life	100%
Both hands or both feet or entire sight of both eyes	100%
One hand and one foot or one hand and entire sight of one eye	100%
One foot and entire sight of one eye or speech and hearing in both ears	100%
One arm or one leg	75%
One hand or one foot or entire sight of one eye or speech or hearing in both ears	66 2/3%
Thumb and index finger of either hand or four fingers of either hand	33 1/3%
Hearing in one ear	33 1/3%
All toes of one foot	25%
Quadriplegia (total paralysis of all four limbs)	200%
Paraplegia (total paralysis of the lower limbs)	200%
Hemiplegia (total paralysis of one side of the body)	200%

Continuation of coverage

See the section *Your Coverage* for details.

Conversion option

Upon termination of active employment with the participating client of the Policyholder, an insured may convert their insurance to an individual accident insurance plan, with no evidence of insurability, for an amount of principal sum equal to or lower than the amount of principal sum in force at the time of termination. Application for conversion must be made within 31 days. Premiums become payable annually in advance. This benefit is restricted to Canadian residents only.

Day care benefit ($5,000)

If an injury results in loss of life, the Company will pay 5% of the principal sum for each year the dependent child is enrolled in a legally licensed day care (not to exceed 4 years) for each dependent child who is under 13 years of age and enrolled in the day care centre on the date of, or within 12 months following the accident.

Education benefit ($5,000)

If an injury results in loss of life, the Company will pay 5% of the principal sum for each year the dependent child continues education as a full-time student in an institution of higher learning beyond the secondary school level (not to exceed 4 years) for each dependent child who was enrolled as a full-time student in an institution of higher learning beyond the secondary school level, or at the secondary school level but enrolls in an institution of higher learning beyond the secondary school level within 12 months following the accident. If, at the time of loss, none of the dependent children are eligible for the Education Benefit, the Company shall pay an additional amount of $2,500 to the designated beneficiary.

Family transportation benefit ($15,000)

If an injury results in confinement as an inpatient in a hospital located at least 150 km from the insured's residence, and such injury results in a loss payable under the *Accidental Death, Dismemberment and Specific Loss Indemnity*, *Industrial Alliance* will pay the expenses actually incurred by a member of the immediate family for hotel accommodation and transportation by the most direct route to the confined insured. If transportation occurs in a private vehicle, then reimbursement of transportation expenses will be limited to a maximum of $0.20 per kilometre travelled.

Home alteration and vehicle modification benefit ($15,000)

If injury requires the use of a wheelchair to be ambulatory, *Industrial Alliance* will pay the cost of alterations to the insured's principal residence and/or the cost of modification to one motor vehicle utilized by the insured, provided such injury results in a loss payable under the *Accidental Death and Dismemberment and Specific Loss Indemnity*.

Identification benefit ($5,000)

If an injury results in loss of life, and requires body identification, *Industrial Alliance* will pay the expenses actually incurred by a member of the immediate family for lodging, board and transportation by the most direct route, provided the body is located not less than 150 kilometres from the member of the immediate family's residence and the identification of the body is required by the police or a similar law enforcement agency. If transportation occurs in a private vehicle, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometer travelled.

Rehabilitation benefit ($15,000)

If an injury results in a loss payable under the *Accidental Death, Dismemberment and Specific Loss Indemnity* and requires that the insured undergo special training in order to be qualified to engage in a special occupation in which the insured would not have engaged except for such injury, *Industrial Alliance* will pay the reasonable and necessary expenses incurred for such training within 3 years.

Repatriation benefit ($15,000)

If an injury results in loss of life, *Industrial Alliance* will pay the expense incurred for shipment of the body to the city of residence of the deceased.

Seat belt benefit

If an injury results in a loss payable under the *Accidental Death, Dismemberment and Specific Loss Indemnity*, the principal sum will be increased by 10% if, at the time of the accident, the insured was driving or riding in a vehicle and wearing a properly fastened seat belt.

Spousal retraining benefit ($15,000)

If an injury results in loss of life, *Industrial Alliance* will reimburse the spouse for the reasonable and necessary expenses actually incurred for a formal occupational training program in order to become qualified for active employment in an occupation in which the spouse would not otherwise have sufficient qualifications.

Waiver of premium

In the event of total disability and waiver of premium has been approved and accepted by the participating client of the Policyholder's group life carrier, then premium under this plan will be waived until the earlier of: death, recovery, attainment of age 65, the date the participating client of the Policyholder is terminated under the policy or the date the policy is cancelled.

Limited air travel coverage

Coverage includes injury sustained in consequence of riding as a passenger and not as a pilot or member of the crew; in boarding or alighting from or being struck by; or making a forced landing with or from:

a) any aircraft having a current and valid airworthiness certificate, and which is operated by a person holding a current and valid pilot's license of a rating authorizing them to pilot such an aircraft, or

b) any transport-type aircraft operated by the Canadian Armed Forces or by the similar air transport service of any duly constituted governmental authority of the recognized government of any nation anywhere in the world, provided the aircraft is not being used for test or experimental purposes.

Notwithstanding (a) and (b) above, coverage excludes injury sustained while and in consequence of riding as a passenger, pilot, operator or member of the crew, in or on; boarding or alighting from; being struck by; or making a forced landing with or from any aircraft owned, operated or leased by the participating client of the policyholder.

Termination of insurance of an insured

Coverage will terminate immediately on the earliest of:

- the policy termination date;
- the premium due date if the Policyholder fails to pay the insured's premium, except as a result of an inadvertent error;
- the premium due date coinciding with or immediately following the termination age of the insured described under the participating client of the Policyholder's current Basic Group Life insurance policy, but not to exceed 85 years of age;
- the premium due date next following the date an insured ceases to be associated with the participating client of the Policyholder in a capacity making such person eligible for insurance hereunder, except as provided under the part titled "Continuation of Coverage".

When does this insurance not apply?

The policy does not cover loss, fatal or non-fatal, caused by or resulting from:

- declared or undeclared war or any act thereof;
- active full-time service in the armed forces of any country;

When does this insurance not apply? (continued)

- suicide or any attempt thereat or intentionally self-inflicted injury, while sane or insane;
- injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in the Limited Air Travel Coverage

Beneficiary

Indemnity payable in the event of the loss of life of an insured is payable in accordance with the beneficiary designation in effect under the participating client of the Policyholder's current Basic Group Life Insurance policy. Unless otherwise indicated and if there is no such designation, the indemnity is payable to the estate of the insured. All other indemnities are payable to the insured, with the exception of indemnities payable under the following parts:

- Day Care Benefit
- Education Benefit
- Family Transportation Benefit
- Identification Benefit
- Repatriation Benefit
- Spousal Retraining Benefit

In the situation where this policy replaces an existing policy issued to the participating client of the Policyholder, the designation recorded under the replaced policy will be deemed to be valid and of full force and effect under this policy until changed in writing by the insured.

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 or other applicable legislation.

This summary is for information purposes only. For further details, refer to the Master Policy which is on file with the Policyholder. This Master Policy sets forth in detail the terms and conditions of the plan and all rights and obligations are determined in accordance with the Master Policy issued by Special Markets Solutions, a division of Industrial Alliance Insurance and Financial Services Inc., not this summary.

How to Make a Claim

Requests must be submitted within the prescribed time limits. If you fail to submit your claims on time, you may not be entitled to some, or all, of the benefits.

To process a claim, the insurer may ask you to provide the following documents:

- medical records or reports
- satisfactory certificate on the cause or nature of the accident
- any other information the insurer needs

Contact **Arc Group Benefits Inc**. to obtain the claim forms:

514 397-0767
1888 589 0767

service@arcsupport.ca

Submission of a written claim notice

The notice must be given within **30 days** of the date of the accident or the date of the diagnosis.

Proof

All reasonably required proof of the accident, as well as the loss caused, must be provided within **90 days** of the date of the accident or diagnosis.

Definitions of Industrial Alliance Insurance and Financial Services Inc.

The definitions applicable under the terms of the *Accidental Death and Dismemberment* coverage are those appearing in the policy 100012326. This is available on request. Contact *ARC Group Benefits Inc*. for more details.

Other Information About Industrial Alliance

Physical examination and autopsy

Industrial Alliance at its own expense will have the right and opportunity to examine the person of any individual whose Injury is the basis of claim when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Inspection of records

The Policyholder will, from time to time, whenever requested by the *Industrial Alliance* during the term of this policy and for 12 months after its expiration, permit the *Industrial Alliance* to inspect all records of the Policyholder relating to this policy and all persons insured hereunder.

Legal action

No action at law or in equity will be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action will be brought after the expiration of 12 months (two years in Alberta and British Columbia, and three years in Quebec) after the time written proof of loss is required to be furnished.

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* or other applicable legislation.

Industrial Alliance Financial Group Privacy Policy

The privacy policy is described in the policy and is available on request. Contact *ARC Group Benefits Inc.* for more details.

Appendix A

RBC Booklet

- Life Insurance

EMPLOYEE BOOKLET

Group Benefit Solutions

LATECOERE AEROSTRUCTURES CANADA
Policy No. RBC00003484
All Eligible Union Employees

RBC Insurance

Insurance

GROUP INSURANCE FOR EMPLOYEES OF:

LATECOERE AEROSTRUCTURES CANADA

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.:	**RBC00003484**
Policy Effective Date:	**August 1, 2023**
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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
- Dependent Basic Term Life
- Optional Term Life

Description of Eligible Class of Employees:

F. All Eligible Union **Employees**

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 35 hours per week each week;
- Have completed a written enrollment 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**: first day of the month following or coincident with 3 months of continuous **active employment.**

For an eligible **employee** in **active employment** after the **Effective Date**: first day of the month following or coincident with 3 months of continuous **active employment.**

GROUP BASIC TERM LIFE INSURANCE – EMPLOYEE – BENEFIT SUMMARY

Eligible Class(es):	F. All Eligible Union **Employees**
Definition of Disability	Total **Disability**
Amount of Insurance:	The greater of $25,000 or an amount equal to 100% of the **employee's annual earnings**, rounded to the next higher $1,000, if not already a multiple of $1,000.
Maximum Amount of Insurance:	$100,000
No-Evidence Maximum:	$100,000 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. When the employee turns 70, the amount of insurance will reduce to $25,000. 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 47 weeks.
Cost Contribution:	The **employer** pays the full cost of the insurance.
Termination of Coverage:	The earlier of the date the **employee** retires or turns 85.

GROUP BASIC TERM LIFE INSURANCE – DEPENDENTS – BENEFIT SUMMARY

Eligible Class(es):	F. All Eligible Union **Employees**	
Maximum Amount of Insurance:	**Spouse:**	$5,000
	Each child:	$2,500
Termination of Coverage:	The earlier of the date the **employee** retires or turns 85.	

GROUP OPTIONAL TERM LIFE INSURANCE BENEFIT SUMMARY

Overall Participation Requirements:

An **employee** must be insured for Group Basic Term Life insurance in order for the **employee** to become insured for this benefit.

Eligible Class(es):

F. All Eligible Union **Employees**

Amount of Employee Insurance:

Amounts in $10,000 units as applied for by the **employee** and approved by the Company.

Maximum Amount of Employee Insurance:

$400,000

Amount of Dependent Insurance:

Spouse: Amounts in $5,000 units as applied for by the **employee** and approved by the Company.

Maximum Amount of Dependent Insurance:

Spouse: $400,000

Reduction:

None

No-Evidence Maximum:

All initial, increased or additional amounts of Group Optional Term Life insurance for any **insured** are subject to **evidence of insurability**.

Terminal Illness Disability Benefit : (Employee Only, if insured)

The lesser of:

- 50% of the **employee's** combined Optional and Life Insurance; or
- $100,000.

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 47 weeks.

Cost Contribution:

The **employee** pays the full cost of the insurance.

Termination of Coverage:

Where an employee is insured for Group Optional Term Life insurance:
Insurance for an **employee** will terminate on the earlier of the date the employee retires or turns 65.

Insurance for a spouse will terminate on the earlier of:

- The date the **spouse** turns 65; or
- The date the **employee** is no longer insured for Group Basic Term Life insurance under the policy.

Where an employee is not insured for Group Optional Term Life insurance:
Insurance for a **spouse** will terminate on the earlier of:

- The date the **spouse** turns 65; or
- The date the **employee** is no longer insured for Group Basic Term Life insurance under the policy.

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 or be scheduled to be 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.**

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.

A **child** must be:

- at least
    - (i) with respect to Group Dependent Life Insurance (if insured under this policy), from 24 hours old but not yet attained age 21; or
    - (ii) 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** have publicly represented as **your spouse** and with whom **you** have resided continuously for at least 12 months in a conjugal-like relationship, civil union, adult interdependent relationship, or any other formal union defined and recognized by law 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.

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** 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.

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) 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.

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.

Continued Insurance

Leave of Absence, Temporary Layoff:

Once **your** insurance begins, if **you** cease to be in **active employment** due to a **leave of absence** or temporary **layoff**, **your** Group Short Term Disability Insurance (if provided under this policy) and Group Long Term Disability Insurance (if provided under this policy) will terminate immediately, and **your** other insurance may be continued on a premium paying basis for up to 6 months after **your leave of absence** or temporary **layoff** begins.

Strike or Lockout:

Once **your** insurance begins, if **you** cease to be in **active employment** due to a **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) will terminate immediately. **Your** other insurance may be continued on a premium paying basis up to the minimum required by law after the **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 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:

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.

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.

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**.

Additional Information if a Resident 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, Long Term Disability Survivor Benefit, 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.

Annual earnings means the annual rate of pay received by the **employee** from the **employer** just prior to the date of loss or **disability** excluding commissions, bonuses, overtime pay, or any other extra compensation, or income received from sources other than the **employer**.

For any benefit calculation, **annual earnings** will not be more than the amount of **annual earnings** for which premiums have been paid.

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 **you**:
- are unable to perform the **material and substantial duties** of **your regular occupation** due to **your sickness** or **injury**; and
- are not working in any occupation.

After 24 months of Waiver of Premium, **disability** and **disabled** means that due to the same **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 not 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.

Material and substantial duties means duties that:
- are normally required for the performance of **your regular occupation**; and
- cannot be reasonably omitted or modified, except that if **you** are required to work on average in excess of 40 hours per week, **we** will consider **you** able to perform that requirement if **you** are working or have the capacity to work 40 hours per week.

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.

Regular occupation means the occupation **you** are routinely performing when **your disability** begins. **We** will look at **your** occupation as it is normally performed in Canada, instead of how the work tasks are performed for a specific **employer** or at a specific location.

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 enrollment cards at the time the policy was transferred.

The **beneficiary** designation listed on **your** prior carrier's enrollment 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 OPTIONAL TERM LIFE INSURANCE BENEFIT

If an **insured** dies while they are insured under the policy, **we** will pay to the **insured's beneficiary** the amount of insurance for the **insured** as shown in the Group Optional Term Life Benefit Summary, less any amount already paid under the Terminal Illness Disability Benefit.

Benefit Specific Definitions:

The same Benefit Specific Definitions used under GROUP BASIC TERM INSURANCE BENEFIT – **EMPLOYEE** will also be used in this benefit (except as specified below), in addition to certain definitions under the GENERAL DEFINITIONS section of this booklet.

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

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

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 enrollment cards at the time the policy was transferred.

The **beneficiary** designation listed on **your** prior carrier's enrollment 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 Optional Life Insurance under the policy if:

- **you** were properly insured for optional 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 Optional 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.

In the event that **you yours**elf are not insured under this benefit, premium payment for any **dependent** insurance, if insured under this benefit, (which is considered to be **your** insurance) will also be waived when **your** premium payments are waived under the Group Basic Term Life benefit contained in the policy.

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.

Suicide Exclusion:

Where the cause of death is suicide:

1. no benefits will be payable if death occurs within 24 months after the **insured's** initial effective date of insurance; and
2. no increased or additional insurance will be payable if death occurs within 24 months after the day such increased or additional insurance is effective.

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 Optional 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 Optional Term Life insurance amount for the **spouse** and conversion of a **spouse's** insurance will be allowed within 31 days of **your** death.
- **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 the **spouse**, either **you** or the **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 the **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 replace 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 Optional Term Life insurance that the individual was entitled to convert is payable under this policy's Group Optional Term Life insurance benefit as if the death occurred while the Group Optional Term Life insurance benefit was still in force.

Cancellation:

If **you** are approved for the policy's Group Optional Term Life insurance Waiver of Premium benefit after **you** or **your dependents** 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**.

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.