January 2017

Retiree FlexBenefits

Your options, your choice

Your retiree booklet

For Canadian employees who retire after January 1, 2010

What's inside

Note: To link to a topic, click anywhere on the table of contents, then press the control key and click on a specific topic.

This booklet is intended to provide a reasonable and easy-to-understand summary of the *Retiree FlexBenefits* program. In no way does it create or confer to you any contractual rights or obligations. All of the programs outlined in this booklet are governed by separate contracts and/or policy documents published by RBC. Where the information provided by this booklet, RBC, or any other source differs from the approved plan documents and insurance policies that govern your RBC programs, the approved documents and the governing policies will rule.

RBC and its subsidiaries reserve the unilateral right to change, amend or terminate the contracts, plans and/or policy documents covering retirees and/or their dependents and survivors, at any time, including after employees' retirement, and may be required to do so because of changes to legislation. In addition, RBC reserves the right to change or amend the terms and conditions of the various coverages, as well as the amount charged to the individual, at any time, including after employees' retirement.

Introduction

When you retire, you may be eligible for retiree benefits under the *RBC Retiree FlexBenefits Program* in addition to a retirement income from RBC's Retirement Program. The *Retiree FlexBenefits Program* offers you choice and flexibility, much like the *RBC FlexBenefits Program* for active employees. Under *Retiree FlexBenefits* you can use an annual *flex credit* allotment, which is based on your length of service, to purchase healthcare coverage.

You will simply use your *flex credits* – together with personal payments, where necessary – to purchase your preferred healthcare coverage option from four benefit options[1]:

- **Option 1: Basic**,
- **Option 2: Enhanced**,
- **Option 3: Catastrophic**, or
- **Option 4: Opt-out.**

You can also select a level of coverage to suit your needs – *Retiree only, Retiree plus one dependent*, or *Retiree plus two or more dependents.* Once you've chosen the coverage you need, any excess *flex credits* will be deposited to your Health Spending Account where they can be used to pay eligible out-of-pocket healthcare expenses that are either not fully covered by the healthcare plan or are outside of the healthcare plan's coverage.

You may be required to pay for a portion of your benefits, depending on the amount of your *flex credits* and the benefit selections you make. Any additional payments that are required to purchase your desired level of coverage after your *flex credits* have been applied will be deducted from your Monthly Pension Payment (DB pension members), or bank account (DC pension members).

There are a few key differences between the *Retiree FlexBenefits Program* and the *FlexBenefits Program* for active RBC employees. Under the *Retiree FlexBenefits Program*:

- The number of *flex credits* you receive will be based on your years of service, rather than *basic flex credit* allotment plus *dependent flex credits.*
- The *benefit period* is from January 1 to December 31, rather than July 1 to June 30.
- Your Retiree Basic Life Insurance is $10,000.
- The Optional Retiree Life Insurance is based on your *benefit base* immediately prior to retirement instead of benefit earnings.
- Optional Retiree Life Insurance coverage levels under age 65 may be the same as your pre-retirement coverage (although may not exceed your pre-retirement coverage), and reduces to 100% of your benefit base at age 65 and then again reduces to 50% of your benefit base at age 70.
- Optional Spousal Life coverage under age 65 may be the same as your pre-retirement coverage (although may not exceed your pre-retirement coverage), and reduces at age 65.
- Optional Accidental Death and Dismemberment (AD&D) coverage levels:
  - under age 65 – may be the same as your pre-retirement coverage (although may not exceed your pre-retirement coverage),
  - from age 65 on – may be reduced to set maximums, and
  - ends at age 70.

  Remember, coverage for your *spouse/partner* and/or *dependent child(ren)* cannot exceed your coverage.
- There are no work-related benefits, such as disability benefits or business travel accident insurance, and no critical illness insurance.

From time to time, RBC will review your *flex credit* allotment and the benefit price tags. RBC reserves the right to adjust both the annual *flex credit* allotment you receive and the benefit price tags at any time, including after your retirement.

[1]You have a one-time opportunity prior to your retirement to select your retiree healthcare option under the Retiree FlexBenefits Program.

Provincial healthcare plans

The *Retiree FlexBenefits Program* is designed to supplement your provincial healthcare plan, providing a level of coverage for many healthcare expenses that are outside of your provincial plan coverage.

Provincial healthcare plans typically cover a range of medical items, services and supplies, which may include:

- doctors' and surgeons' fees;
- specialists' fees when referred by a general practitioner;
- diagnostic procedures, including X-rays and lab tests;
- standard ward hospital accommodation;
- out-patient treatment; and
- other services not mentioned above.

As the consumer of the service, it remains your responsibility, in consultation with the healthcare professional providing the service, to ensure you are aware of applicable provincial limitations.

Your provincial healthcare plan is first payer

Any services that are covered by your provincial healthcare plan must first be submitted to that plan. Any unpaid portion may then be payable from the *Retiree FlexBenefits Program* in accordance with the provisions of the program. Only eligible expenses are reimbursed in accordance with the provisions of the *Retiree FlexBenefits Program.*

Under no circumstances, including any misunderstanding of what is an eligible expense, will the administrator reimburse an ineligible expense. In cases where a portion of an expense is reimbursed by the provincial healthcare plan, provincial legislation may exist that prohibits a private plan from covering the portion paid by the individual.

Changes to provincial healthcare plans, the introduction of new medical and dental services, or the development of new prescription drugs will not result in automatic adjustments to the *Retiree FlexBenefits Program*. RBC continually monitors the *Retiree FlexBenefits Program* to determine what, if any, adjustments are required.

RBC reserves the right to amend the *Retiree FlexBenefits Program* in any respect at any time, including the benefits payable to retirees. RBC also reserves the right to terminate the *Retiree FlexBenefits Program* in whole or in part at any time.

Residents of British Columbia see page 43 for details about the British Columbia Medical Services Plan.

Our starting points

The RBC Retiree FlexBenefits Program gives you a one-time opportunity prior to your retirement to select your preferred healthcare benefits from a range of four options. Here's how it works:

You receive *Retiree FlexBenefits* flex credits
As an eligible retiree, each *benefit period* you will receive an annual *flex credit* allotment – currently $50 for each year of service, to a maximum of 35 years. You will use these *flex credits* – together with personal payments, if necessary – to purchase your preferred healthcare benefit option and level of coverage. Excess annual *flex credits*, if any, will be deposited into your Health Spending Account (HSA). In addition, remaining *flex credits*, if any, will be prorated based on your date of retirement or eligible change event and the number of days remaining in the *benefit period*, and deposited into your HSA. If you have worked on an intermittent (part-time) basis from January 1, 2010 onwards, your annual *flex credit* allotment will be adjusted to reflect your reduced work arrangement.

You choose your preferred healthcare benefit options
You can use your *flex credit* – together with personal payments, if necessary – to purchase your preferred benefit option:

- **Basic:** Supplementary Medical, Emergency Out-Of-Province/Country Medical and Travel Assistance, Prescription Drug, Dental
- **Enhanced:** Supplementary Medical, Emergency Out-Of-Province/Country Medical and Travel Assistance, Prescription Drug, Dental
- **Catastrophic:** Supplementary Medical, Prescription Drug
- **Opt-out:** all *flex credits* are directed to your Health Spending Account

You must also choose your preferred coverage level:

- ***Retiree only***
- ***Retiree + one dependent***
- ***Retiree + two or more dependents***

All remaining *flex credits* will be directed automatically to your Health Spending Account
These *flex credits* are used to reimburse eligible medical, drug and dental expenses not covered by the benefit option you choose. Remaining *flex credits*, if any, will be prorated based on your date of retirement or eligible change event and the number of days remaining in the *benefit period*, and deposited into your Health Spending Account (HSA).

Basic Life Insurance benefit
In addition to the healthcare options, the *Retiree FlexBenefits Program* includes company-paid Retiree Basic Life insurance in the amount of $10,000.

Optional Life Insurance
You may purchase additional retiree-paid insurance at preferred rates. At the time of your retirement, you may continue your *FlexBenefits* optional life and AD&D coverage for you, your *spouse/partner* and *dependent children* into the *Retiree FlexBenefits Program*. This coverage may be at your existing level, or a reduced level.

Your additional retiree-paid coverage options include:

- **Optional Life Insurance**
- **Optional Accidental Death & Dismemberment (AD&D) Insurance**

Access to additional coverage at discounted rates
You will have access to additional Travel Medical Insurance coverage at discounted rates through RBC Insurance. This additional retiree-paid plan is available on an individual policy basis.

Important information

This booklet contains important information regarding your *Retiree FlexBenefits Program* coverage and should be kept in a safe place.

Eligibility

You are eligible to participate in the *Retiree FlexBenefits Program* provided you meet **all** of the following criteria:

- formally retire from RBC on or after January 1, 2010;
- are at least 55 years of age;
- are a resident of Canada;
- you must have five years of *benefit eligibility* in the last 10 years[1,2];
- have completed at least 10 years of *pensionable service* immediately prior to your retirement date[3]; and
- are accruing pensionable service in one of RBC's Canadian pension plans immediately prior to your retirement.

[1] **Benefits eligibility:** *Your most recent period of continuous service in which you qualified for employee benefits. If you were an intermittent employee, this is the period of continuous service in which you met the minimum earnings requirement for eligibility.*
[2] *Criteria changed effective July 1, 2011.*
[3] **Pensionable service:** *Your total years of membership in the RBC Retirement Program, prorated if you work part-time, up to a maximum of 35 years in the defined benefit (DB) and defined contribution (DC) options combined.*

Flex credits

As an eligible retiree, each *benefit period* you will receive an annual *flex credit* allotment – currently $50 for each full *year of service*, to a maximum of 35 years. You will use these *flex credits* – together with personal payments, if necessary – to purchase your preferred healthcare benefit option and level of coverage. Excess annual *flex credits*, if any, will be deposited into your Health Spending Account (HSA). In addition, remaining *flex credits*, if any, will be prorated based on your date of retirement or eligible change event and the number of days remaining in the plan year, and deposited into your HSA. If you have worked on an intermittent (part-time) basis from January 1, 2010 onwards, your annual *flex credit* allotment will be adjusted to reflect your reduced work arrangement.

At retirement, any remaining balance in your HSA under the *FlexBenefits Program* for active employees may **not** be carried over to the *Retiree FlexBenefits Program*. However, you will have up to 90 days after your retirement date to file any eligible claims that you incurred prior to your retirement.

If you die, your *surviving spouse/partner/eligible dependents* will remain eligible to receive a continuing *flex credit* allotment – currently $25 per year of your service, to a maximum of 35 years.

For more information on *Retiree FlexBenefits Program* coverage for Quebec residents, see page 41.

Making your choices

Prior to your retirement, you will be required to enroll in the *Retiree FlexBenefits Program.* You will choose one of the four healthcare benefit options available to you and your preferred level of coverage. You cannot elect a different coverage option for each plan, nor can you increase coverage after you make your election. Once made, your choice will be locked in for the duration of your retirement. However, you can make certain changes should you have an eligible change event and reduce/cancel your coverage at any time. You will not be able to reinstate coverage at a later date. Therefore, please consider your choices carefully. Refer to your retirement letter for instructions on how to enroll.

The effective date of coverage is the date your retirement benefits commence, provided you complete the online enrollment process by the enrollment deadline stated in your retirement information package. Regular monthly premiums will be deducted from your bank account through pre-authorized debit and/or from your Monthly Pension Payment if you are a member of the Defined Benefit (DB) option of the RBC Retirement Program. Coverage is at risk of being cancelled for non-payment of premiums and might not be reinstated at a later date.

For more information on *Retiree FlexBenefits Program* coverage for Quebec residents, see page 41.

If you don't enroll

You must enroll by the enrollment deadline stated in your retirement information package. If you fail to do so after 31 days after the enrollment deadline, you will be enrolled automatically in the *Opt-out* option retroactive to your date of retirement. If you are a Quebec resident and are under age 65 and fail to enroll, you will be enrolled

automatically in the *Basic* option. This default coverage will remain in effect for the duration of your retirement. Any excess *flex credits* will be deposited in your Health Spending Account.

Price tags

The price tags for coverage under the *Retiree FlexBenefits Program* vary by region:

- **Atlantic** – New Brunswick, Newfoundland and Labrador, Nova Scotia and Prince Edward Island;
- **Central** – Ontario and Quebec;
- **Western** – Manitoba, Alberta, British Columbia as well as Yukon, Northwest Territories, and Nunavut; and
- **Saskatchewan**.

This regional pricing structure is based on the integration of *Retiree FlexBenefits Program* coverage with the provincial healthcare plans. The provincial plans provide different levels of coverage that impact the supplementary coverage provided under *Retiree FlexBenefits Program.* Where applicable, the price tags reflect the fact that some provinces increase healthcare coverage at age 65. Refer to the *Retiree FlexBenefits Program* **Price Tags** document at **www.rbc.com/pensioners/** for the current monthly healthcare premiums.

Covering your family

Benefit plans are not just about you; they are also about your family. That's why the *Retiree FlexBenefits Program* allows you to extend coverage to your eligible family members (see below) under the available healthcare benefit options. There are three levels of coverage:

- **Retiree only** – only you will be covered.
- **Retiree + one dependent** – you and your *spouse/partner* or eligible *dependent child* will be covered.
- **Retiree + two or more dependents** – you, your *spouse/partner* and/or eligible *dependent children* will be covered.

The level of coverage you select will apply to each of the available plans – Supplementary Medical, Emergency Out-of-Province/Country Medical and Travel Assistance, Prescription Drug and Dental Plans. You may **not** elect a different level of coverage for each plan.

As you might expect, the annual cost for *Retiree + one* coverage will be higher than *Retiree only* coverage. Likewise, the annual cost of *Retiree + two or more* coverage will be higher than *Retiree + one* coverage.

Eligible dependents

An eligible dependent is any person who qualifies as a retiree's *spouse/partner* or *dependent child(ren)* as outlined in the Glossary of Terms (see page 39).

Note: You must advise the **Human Resources Service Centre** if and when you no longer have a *spouse/partner* or when your child is no longer an *eligible dependent* so that your coverage and premiums can be adjusted accordingly. Premiums will continue to be collected until you advise us of a change.

Quebec residents

For retirees living in Quebec, and below age 65, the law requires that you select a minimum level of drug coverage for you and your eligible dependents (i.e., coverage that is compliant with the Régie de l'assurance-maladie du Québec (RAMQ)), unless you have comparable coverage under another plan. Your healthcare benefit options are therefore limited to **Basic** *or* **Enhanced** *coverage. Please see page 41 for more information.*

Eligible change event

You may change your level of coverage, up or down (e.g., from *Retiree + one* down to *Retiree only,* or *Retiree + one* up to *Retiree + two or more*), only under the following circumstances:

- a legal separation or divorce;
- disqualification of a *spouse/partner* or *dependent child*;
- the death of a *spouse/partner* or *dependent child*;
- birth, adoption, or accepting legal guardianship of a child; or
- a *dependent child* over age 21 returning to school full-time.

The circumstances noted above allow you to change the level of coverage; however, you may **not** select a new healthcare benefit option.

Marriage after retirement
If you should marry, remarry, or acquire a new partner after your retirement, your new *spouse/partner* is not eligible for benefits[1]. In the event you subsequently die and are survived by your new *spouse/partner*, he or she is still not eligible for benefits.

[1]For more information on *Retiree FlexBenefits Program* coverage for Quebec residents, see page 41.

Beneficiaries

The person or persons you name as your beneficiary (using the *Beneficiary Designation form*) will receive your Basic Life Insurance, Optional Retiree Life Insurance, as well as any Accidental Death & Dismemberment Insurance (AD&D) if you die as a result of a covered accident. If you have not named a beneficiary using the Beneficiary Designation form, the benefit will be paid to your estate.

You are automatically the beneficiary of any Optional Spousal Life Insurance or Optional Child(ren) Life Insurance payable under the *Retiree FlexBenefits Program* as well as any Accidental Death & Dismemberment (AD&D) Insurance paid on behalf of a covered family member.

A *Beneficiary Designation form* is available at **www.rbc.com/pensioners/**. You can update your beneficiaries at any time by completing a new *Beneficiary Designation form*.

When designating your beneficiary(ies), keep in mind the following:

If you appoint multiple beneficiaries…

If you appoint more than one person as beneficiary for the same benefit, you can specify what percentage of the benefit each will receive; however, the total must add up to 100%. The Beneficiary Designation Form allows you to designate a beneficiary as revocable or irrevocable.

If you want to appoint minor beneficiaries…

If you name a minor beneficiary, they will not have access to any insurance payout until reaching the age of majority – unless you take the necessary legal steps before your death, such as appointing a trustee (except in Quebec) to receive any payment on behalf of any beneficiary during his or her minority for support, maintenance, education and benefit of the minor beneficiary at the discretion of the trustee. Those steps vary from province to province.

In Quebec, when a death benefit under a life insurance policy is payable to a minor beneficiary, it must be paid to the parent(s) (or a tutor or curator as defined by the Quebec Civil Code, if applicable), and not to anyone else who might be named as administrator/trustee of the proceeds. Before naming a minor beneficiary, you may wish to seek legal advice.

If you live in Quebec and designate your legally married or civil union spouse/partner…

Under Quebec law, if you designate your legally married or civil union *spouse/partner* as beneficiary, this designation will be irrevocable unless you specify that it is revocable on the form. If you specify that a designation is revocable, then you can change your beneficiary at any time without the consent of your *spouse/partner*. To change an irrevocable designation, you will need the written consent of your *spouse/partner*.

Co-ordinating claims

If you, your *spouse/partner*, or an eligible *dependent child* are covered under the *Retiree FlexBenefits Program* and are also covered for similar benefits under another group plan, your expense claims may be co-ordinated under both plans. Keep in mind, payment from all sources cannot exceed the total of all eligible expenses incurred. Co-ordination of benefits claims will be adjudicated to the eligible (reasonable and customary) amount of the expense and not necessarily the full amount submitted.

Co-ordination of benefits can also apply in situations where your *spouse/partner* works for, or has retired from RBC. This includes initial expenses that involve the use of a pay-direct drug code under the *FlexBenefits Program* for active employees, or the *Retiree FlexBenefits Program.* In these situations, Sun Life will automatically co-ordinate the claim based on the information provided.

To ensure prompt processing of claims, you are required to comply with the following industry procedures:

- You must submit claims for yourself through the *Retiree FlexBenefits Program* first. Any unpaid personal claims can then be submitted through your *spouse/partner's* plan.
- Your *spouse/partner* must submit personal claims through his or her benefit plan first. If that plan doesn't cover the full cost of the service or procedure, you can claim the remaining expense through the *Retiree FlexBenefits Program*.
- Claims for *dependent children* are to be submitted first to the plan of the parent whose birthday falls earlier in the year. If you were born in March, for example, and your *spouse/partner* was born in July, you would submit claims for *dependent children* to the *Retiree FlexBenefits Program* first. Again, any uncovered expenses could, in turn, be submitted to your *spouse/partner's* plan as a secondary payer.
- If you are actively employed (other than at RBC), you must first submit claims for you and your covered dependents to your employer's service provider(s). Any unpaid claims can then be submitted through the *Retiree FlexBenefits Program*.

Claim payments and explanation of benefits

Reimbursement of claims is credited directly to the bank account to which your pre-authorized regular monthly premiums are deducted and/or your pension payments are made. An Explanation of Benefits (EOB) will be provided, reflecting both the amount eligible and the amount reimbursed.

If you prefer, a "paperless" EOB may be e-mailed to you once your claim has been processed. You can register for paperless EOBs from Sun Life Member Services, Paperless Payments at: **www.mysunlife.ca**. If you do not register for the paperless option, an EOB will be mailed to the home address on your claim form.

Premium deductions

Under the *Retiree FlexBenefits Program* regular monthly premiums will be deducted from your bank account through pre-authorized debit and/or your Monthly Pension Payment if you are a member of the Defined Benefit option of the RBC Retirement Program. Healthcare and insurance premiums are based on the coverage selected and the rates in effect. Funds for these deductions must be in your bank account in order for coverage to be effective. Should no funds be available in your bank account, coverage is at risk of being terminated.

Retail sales tax

In certain provinces (currently Ontario, Québec and Manitoba), retail sales tax will be added to premiums paid for insurance plans (Optional Life Insurance and Accidental Death & Dismemberment) and deducted from your bank account through pre-authorized debit and/or Monthly Pension Payment if you are a member of the Defined Benefit option of the RBC Retirement Program. Furthermore, if you are a resident of Ontario or Quebec, retail sales tax will also be added to premiums paid for the Healthcare coverage and deducted from your bank account through pre-authorized debit and/or your Monthly Pension Payment.

Tax treatment

Current legislation requires that you pay income tax on the premiums and retail sales tax (if applicable) that RBC pays to provide you with coverage under the Basic Life Insurance Plan. Your total taxable amount for this benefit appears each year on your T4A slip.

Quebec residents: Refer to page 41 for additional tax treatment information.

Survivor benefits

The *Retiree FlexBenefits Program* healthcare plans, (e.g., Supplementary Medical, Emergency Out-of-Province/Country Medical and Travel Assistance Plan, Prescription Drug and Dental Plans) include the following survivor benefits.

If, at the time of your death, you are participating in the *Retiree FlexBenefits Program*:

- your surviving *spouse/partner*, if already covered under the program, will continue to be eligible for coverage; and
- your surviving *dependent children*, if already covered under the program, will continue to be eligible for coverage, until such time as they no longer qualify as a dependent *(see the Glossary of terms*, page 39, *for a definition of dependent child)*.

Your surviving *spouse/partner/dependent child(ren)* will remain eligible to receive a continuing *flex credit* allotment, currently $25 per year of your service to a maximum of 35 years – but only if your *spouse/partner/ dependent* is covered under the *Retiree FlexBenefits Program* at the time of your death. If coverage costs more

than the available *flex credits*, your *spouse/partner/dependent child(ren)* will be responsible for paying any difference in the cost of coverage. Any remaining *flex credits* will be deposited into an HSA, and can be used to pay for eligible medical and dental expenses that are not covered, or not fully covered under *Retiree FlexBenefits Program.*

For more information on *Retiree FlexBenefits Program* coverage for Quebec residents, see page 41.

When coverage ends

Under the *Retiree FlexBenefits Program*, your coverage under the healthcare plans will end upon your death. Coverage for your *spouse/partner* (if covered) will end upon his or her death. Coverage for eligible *dependent children* will end when they no longer qualify as *dependent children*.

In the case of the Emergency Out-of-Province/Country Medical and Travel Assistance Plan, coverage will also end on the earliest of:

- the end of the 31st day of any out-of-province/country trip,
- your return to your province of residence following a trip,
- you no longer qualifying for benefit coverage, or
- the termination of your coverage under a provincial healthcare plan.

Should your coverage end, you may wish to contact **RBC Insurance** or **Sun Life** to see what individual policy options may be available.

Amendment and termination

RBC and its subsidiaries reserve the unilateral right to change, amend or terminate the contracts, plan and/or policy documents covering retirees and/or their dependents and survivors, at any time, including after employees' retirement, and may be required to do so because of changes to legislation. In addition, RBC reserves the right to change or amend the terms and conditions of the various coverages, as well as the amount charged to the individual, at any time, including after employees' retirement.

Your healthcare options

The *Retiree FlexBenefits Program* offers four important benefit options that give you the flexibility to choose the healthcare coverage you need and want. Your choices are as follows:

- **Option 1: Basic** – covers a broad range of healthcare needs at a 70% reimbursement level (subject to a lifetime maximum of $250,000 per insured individual).
- **Option 2: Enhanced** – covers a broad range of healthcare needs at an 80% (90% for hospital expenses) reimbursement level (subject to a lifetime maximum of $400,000 per insured individual).
- **Option 3: Catastrophic** – covers your prescription drug expenses, plus some medical and hospital expenses, at a 100% reimbursement level after your annual out-of pocket expenses reach a $5,000 deductible (subject to an annual maximum of $250,000, up to a lifetime maximum of $600,000 per insured individual).
- **Option 4: Opt-out** – places all your *flex credits* in your Health Spending Account (HSA).

If you are a Quebec resident, the *catastrophic* and *opt-out* options are available only if you have existing healthcare coverage elsewhere. Quebec residents, see page 41 for more details.

Keep in mind that you may choose only one benefit option, which will apply across all healthcare plans available under that option. For example, if you choose the *Basic* option, you will be enrolled for *Basic* coverage under the Supplementary Medical, Emergency Out-of-Province/Country Medical and Travel Assistance, Prescription Drug, and Dental Plans. You may **not** make multiple elections (for example, you cannot choose *Basic* Supplementary Medical and *Enhanced* Prescription Drug coverage).

If you elect to *Opt-out*, you will not have coverage under any of the Supplementary Medical, Emergency Out-of-Province/Country Medical and Travel Assistance Plan, Prescription Drug or Dental Plans. However, your *flex credits* will be deposited to your Health Spending Account where they can be used to pay for eligible medical and dental expenses as defined by the Canada Revenue Agency.

You may choose only one level of coverage (i.e., *Retiree only, Retiree + one,* or *Retiree + two or more*) which will apply to all plans available under that option. For example, if you elect *Retiree only*, this level of coverage will apply across all the plans.

Activation of your healthcare coverage

Please note that it may take up to three weeks following submission of your online *Retiree FlexBenefits Program* enrollment for your plan to be activated with Sun Life. Consider filling any prescriptions prior to your retirement or paying for your prescriptions upfront and then submit for payment using a *Retiree FlexBenefits* claim form once your coverage has been activated.

Supplementary Medical Plan

Coverage under the Supplementary Medical Plan is summarized in the following table.

Supplementary Medical Plan

Your coverage	Basic	Enhanced	Catastrophic[1]	Opt-out[1]
Reimbursement level	• 70% • Subject to a lifetime maximum (Supplementary Medical Plan & Prescription Drug Plan combined)	• 80% (90% for hospital) • Subject to a lifetime maximum (Supplementary Medical Plan & Prescription Drug Plan combined)	• 100% after $5,000 annual deductible per insured • Subject to annual and lifetime maximums (Supplementary Medical Plan & Prescription Drug Plan combined)	Not covered
Hospital	Semi-private room	Semi-private room	Semi-private room	
Private duty nursing	$25,000 lifetime	$25,000 lifetime	$25,000 lifetime	
Convalescent/Nursing home	$25,000 lifetime	$25,000 lifetime	Not covered	
Dental accident	70%	80%		
Paramedical (including physiotherapy)	$500 combined per *benefit period*	$800 combined per *benefit period*		
Hearing aids, molds, Cochlear device, or hearing aid batteries	$300 every four years	$500 every four years		
Vision care	Not covered	$150 once in any 24-month period (12 month period for dependent children age 16 and under)		
Medical equipment & supplies	70%	80%		
Annual & lifetime maximums • Applies to eligible medical and prescription drug expenses incurred after retirement.	$250,000 lifetime per Insured	$400,000 lifetime per insured	$250,000 annual maximum, to a lifetime maximum of $600,000 per insured	

[1]Quebec residents: If you retire before age 65, you are required to choose RAMQ-compliant coverage. This means your choices are limited to the Basic and Enhanced options, unless you have comparable RAMQ coverage elsewhere. If you retire from age 65 on, you will be permitted to select the Catastrophic or the Opt-out option only if you have RAMQ coverage or alternative coverage under another healthcare plan.

Eligible expenses

The following is a summary of the eligible expenses that will be covered, at the set reimbursement rate, under each healthcare option selection up to the lifetime maximums and in the case of *Catastrophic*, annual and lifetime maximums. These expenses are eligible provided they are:

- medically necessary,
- *reasonable and customary*,
- recommended by a *qualified physician*, and
- covered under the option you select.

Reasonable and customary amounts

The program will reimburse the cost of eligible services or supplies (subject to the terms and limits of your coverage) up to the *reasonable and customary amounts* at the time of purchase including frequency limits and amount charged, in the province where you live. The program will not pay for costs that exceed these *reasonable and customary amounts*. For current *reasonable and customary amounts* please contact Sun Life at 1-800-305-5905.

Hospital – covers the difference between the public ward allowance under your provincial healthcare plan and the cost of semi-private accommodation in a Canadian *hospital*. Coverage is from the first day of your *hospital* stay. Expenses are deemed eligible provided that *hospital* accommodation is medically necessary. Should you no longer need to remain in the *hospital* but require an Alternate Level of Care (ALC), these charges are not eligible under the provincial healthcare plan nor are they eligible under RBC's plan. ALC is for chronic care when a

patient is placed in a chronic ward while waiting for a room in a *nursing home* (or to go home and be cared for by family members).

A *hospital* is a facility licensed to provide care and treatment for sick or injured patients, primarily while they are acutely ill. It must have facilities for diagnostic treatment and major surgery. Nursing care must be available 24 hours a day. It does not include a *nursing home*, rest home, home for the aged or chronically ill, sanatorium, *convalescent hospital* or a facility for treating alcohol or drug abuse or beds set aside for any of these purposes in a hospital.

Private duty nursing – covers care provided in the home (excluding custodial care) by a provincially licensed registered nurse or nursing assistant, who is not a member of your family, and does not normally live in your home. Coverage is subject to a *qualified physician's* written recommendation, and is limited to a lifetime maximum of $25,000 per person under the *Basic, Enhanced* and *Catastrophic* options. The medical necessity must be established to the satisfaction of the plan administrator and, benefits are not payable if rendered in a *hospital*.

Convalescent Hospital / Nursing Home – covers semi-private room accommodation in a qualified *convalescent hospital*, or *nursing home* for up to 180 days, provided such:

- is ordered by a *qualified physician*,
- begins within 14 days of release from the *hospital*,
- is primarily for rehabilitation and not custodial care[1], and,
- for a *nursing home*, the provincial healthcare plan pays for a daily allowance for your accommodation.

Coverage is limited to a lifetime maximum of $25,000 per person. Coverage is not provided under the *Catastrophic* option.

A *convalescent hospital* is a facility licensed to provide convalescent care and treatment for sick or injured patients on an in-patient basis. Nursing and medical care must be available 24 hours a day. It does not include a *nursing home*, rest home, home for the aged or chronically ill, sanatorium or a facility for treatment alcohol or drug abuse.

A *nursing home* is a facility licensed to provide care for patients who require assistance with daily living activities, who cannot be cared for at home and who require regular medical supervision and skilled nursing care on a 24-hour basis. It does not include a rest home, home for the aged, chronic care hospital, sanatorium, *convalescent hospital* or a facility for treatment of alcohol or drug abuse.

[1]Custodial Care is non-medical care that means you require assistance with activities of daily living such as dressing, bathing and using the bathroom.

Ambulance – covers the use of a licensed ambulance for transportation to and from a hospital, if medically necessary, that takes you to and from the nearest hospital that is able to provide the necessary medical services. Only those expenses not covered by your provincial healthcare plan will be reimbursed. Coverage is not provided under the *Catastrophic* option.

Dental accident – reimburses eligible expenses for dental services to repair damage to natural teeth caused by an accidental blow. Treatment within 12 months of the accident will be covered. Coverage is not provided under the *Catastrophic* option. The plan provides *reasonable and customary* charges up to the amounts specified in the current fee schedule for general dental practitioners, as approved in your province of residence and the least expensive alternative service or material that is consistent with normal dental care. The guide must be the current guide at the time that treatment is received.

Paramedical – covers the services of the following licensed practitioners: physiotherapists, psychologists or social workers, chiropractors[2], osteopaths or osteopathic practitioners[2], naturopaths, podiatrists or chiropodists[2], acupuncturists, massage therapists, orthotherapists, occupational therapists, visual therapists, speech therapists and audiologists. Paramedical services must be provided by a licensed practitioner to qualify for reimbursement. You do not, however, need to be referred for treatment by a physician. Only those expenses not covered by your provincial healthcare plan will be reimbursed. Coverage is subject to the applicable maximums of $500 combined per *benefit period* under the *Basic* option, and $800 combined per *benefit period* under the *Enhanced* option. Coverage is not provided under the *Catastrophic* option.

[2] including X-ray examinations.

Diagnostic tests and X-ray services – covers laboratory tests and diagnostic services done in a commercial laboratory, provided reimbursement is not prohibited under your provincial healthcare plan. Coverage includes:

- blood tests;
- echography (e.g., ultrasound) other than for pregnancy;
- X-rays; and
- thermograms and mammograms.

Coverage is not provided under the *Catastrophic* option.

Eye examinations – eye examination by a qualified ophthalmologist or optometrist, once every 24 months (12 months for dependent children age 16 and under). Eye examinations are not part of the vision care benefit maximum. Coverage is not provided under the *Basic* or *Catastrophic* options.

Vision care (including intraocular lenses) – covers the cost of eyeglasses or contact lenses prescribed by an ophthalmologist or optometrist, or laser eye surgery performed by an ophthalmologist, up to the applicable maximums of $150 once in any 24-month period (12 month period for *dependent children* age 16 and under). It is important to note that your vision care claim is adjudicated based on the purchase date and not on the date of your eye exam or the date of your prescription. The purchase date is the date in which you paid for your eye glasses/contact lenses in full. Coverage is not provided under the *Basic* or *Catastrophic* options. Eligible expenses reimbursed are not part of the lifetime maximum under the Healthcare *Enhanced* option.

Hearing aids, molds, Cochlear device, or hearing aid batteries – covers hearing aids prescribed by an ear, nose and throat specialist, and hearing aid batteries and/or molds, subject to the plan maximums of $300 under the *Basic* option, and $500 under the *Enhanced* option, every four years. It is important to note that a hearing-aid claim will be reviewed based on your purchase date, and not on the date of your examination or prescription. Coverage is not provided under the *Catastrophic* option.

Medical equipment & supplies[1] – on a *qualified physician's* written recommendation, the plan coverage includes (but is not limited to):

- Administration of oxygen, plasma and blood transfusions.
- Wheelchairs – coverage is limited to the use of a manual wheelchair except if the person's medical condition warrants the use of an electric wheelchair. The plan will reimburse based on the *reasonable and customary* amount in effect at the time of purchase.
- Hospital bed, or other durable equipment rented for temporary therapeutic use, casts, splints, trusses, braces and crutches, and the initial issue or replacement of artificial limbs or eyes to replace natural limbs or eyes lost, but excluding myoelectric appliances. Sales tax and delivery charges will be considered eligible expenses.
- Charges for a dextrometer, a glucometer or a medi-jector rented (or purchased at Sun Life's option), provided only for an insulin-dependent diabetic whose control is difficult to maintain with conventional methods, and if recommended in writing by a specialist in internal medical or a diabetologist. Charges must be prescribed in writing by a diabetologist or a specialist in internal medicine. Charges for the repair of a dextrometer or a glucometer, due to medical necessity, or for its replacement, provided at least five years have elapsed since the equipment being acquired.
- Charges for a continuous positive airway pressure (CPAP) machine and mask.
- Charges for a transcutaneous electronic nerve stimulation (TENS) machine for the control of chronic pain, up to $500 per lifetime.
- Charges for breast prostheses and surgical brassieres required as a result of surgery, up to three brassieres and a combined maximum benefit payable of $1,000 per person, per *benefit period*.
- Wigs – reimbursement (under the *Enhanced* option only), for the cost of wigs when your loss of hair is due to unnatural causes, such as post-chemotherapy hair loss, to a maximum benefit of $200 every 24 months (includes alopecia). Wigs do not require a physician's order.
- Orthopedic shoes – reimbursement (under the *Enhanced* option only), for custom-made or modifications to orthopedic shoes, when prescribed by a *qualified physician*, podiatrist or chiropodist; limit of one pair up to a maximum of $200 per person, per *benefit period*.

[1] (Coverage is not provided under the **Catastrophic** plan option)

- Orthotic inserts – reimbursement (under the *Enhanced* option only), for custom-made orthotic inserts for shoes, when prescribed by a *qualified physician*, podiatrist, or chiropodist, up to a maximum of two pairs per *benefit period*.
- Stump socks – a maximum of five pairs per person, per *benefit period*.
- Elastic support stockings (including pressure gradient hose) – up to two pairs and a maximum of $100 per person, per *benefit period*.
- Home care equipment/Living Aid equipment – reimbursement of the cost for medically-required home care equipment, up to $1,000 lifetime maximum, subject to a *qualified physician's* written recommendation. Percentage coverage and the lifetime maximum differ by plan option. Refer to Sun Life for details and prior approval. Items considered eligible for reimbursement are: bathroom safety items (for disabled persons) and wheelchair ramps. Not eligible are items such as: air filters for furnaces, and Obus Forme backrest supports.

What's not covered

Regardless of the benefit option you select, the *Retiree FlexBenefits Program,* Supplementary Medical Plan does not pay any benefit, or accept liability for claims relating to:

- Services or supplies payable or available (regardless of any waiting list) under any government sponsored plan or program, except as described below under *Integration with government programs*.
- Expenses for the portion of services covered under your provincial healthcare plan. Expenses for these services can be claimed only after your provincial plan has paid out the annual maximum benefit allowed under that plan.
- Charges for any illness or injury for which compensation is provided under a Workers' Compensation Act, Criminal Injuries Compensation Act, or similar legislation.
- Any services or supplies that are not usually provided to treat an illness, including experimental treatments.
- Charges above what is considered *reasonable and customary*.
- Expenses that you are not legally obligated to pay.
- Any illness or injury that is the result of:
  - committing or attempting to commit an unlawful act;
  - insurrection or war (declared or not); or
  - participation in any riot, civil commotion or any other act of aggression.
- Charges by a physician for travel time, cancelled appointments, advice given over the phone, completion of forms, or preparation of a letter.
- Charges for equipment considered by the plan administrator to be ineligible, such as insulin pumps.
- Equipment that Sun Life considers ineligible (examples of this equipment are orthopaedic mattresses, exercise equipment, air-conditioning or air-purifying equipment, whirlpools, humidifiers, and equipment used to treat seasonal affective disorders).
- Services or supplies that do not qualify as medical expenses under the *Income Tax Act (Canada)*.

In many cases, excluded expenses may be claimed through your Health Spending Account (HSA), subject to eligibility under tax rules and the available balance in your HSA. *See page 27 for details.*

Integration with government programs

The Supplementary Medical Plan will integrate with benefits payable or available under the government-sponsored plan or program (the government program).

The covered expense under this plan is that portion of the expense that is not payable or available under the government program, regardless of:

- whether you have made an application to the government program,
- whether coverage under this plan affects your eligibility or entitlement to any benefits under the government program, or
- any waiting lists.

Emergency Out-of-Province/Country Medical and Travel Assistance Plan

The *Basic* and *Enhanced* options include coverage under the *Retiree FlexBenefits Program's* Emergency Out-of-Province/Country Medical and Travel Assistance Plan. This plan provides both assistance and financial protection if you have a medical emergency during the *first 31 days* of a trip outside your province of residence. If you elect *Retiree + one*, or *Retiree + two or more* coverage, your *spouse/partner* and/or *dependent child(ren*) will also qualify for coverage.

A **medical emergency** is a sudden, unforeseen injury or acute episode which commences during the period of coverage and which results in a **medical condition** requiring immediate treatment from a licensed physician or immediate hospitalization.

If you are travelling outside of Canada or the United States, it is recommended that in advance of your trip, you obtain the Canada Direct telephone number for the country you are travelling to in order to make it easier to contact Assured Assistance Inc. in the event of an emergency. These access numbers are available by going to **www.infocanadadirect.com**.

Medical condition

A **medical condition** is accidental bodily injury or sickness (or a condition related to that accidental bodily injury or sickness) including disease, acute psychoses and complications of pregnancy occurring within the first 31 weeks of pregnancy.

Eligible expenses

The plan covers reasonable and customary expenses in excess of the amount covered by your provincial healthcare plan or other source of similar coverage for:

- hospital room and board in a ward or semi-private room;
- hospital services and supplies;
- the services of a *qualified physician*;
- diagnostic services;
- out-patient services;
- ground ambulance transportation to and from a hospital when medically necessary, and
- air ambulance transportation when medically necessary and pre-approved by Assured Assistance Inc.

The plan will reimburse 100% of eligible expenses not covered or in excess of coverage under your provincial healthcare plan or other sources of similar coverage. In all cases, treatment must be the result of a medical emergency that occurs while you and/or your covered family members are temporarily outside of your province of residence or Canada, and within the first 31 days of your departure. Any eligible expenses are not counted towards the lifetime maximum under the Healthcare *Basic* or *Enhanced* option.

Travel medical & claim assistance

The plan provides emergency medical and claim assistance through a worldwide communications network that operates 24 hours a day, seven days a week. The network locates medical services and obtains insurer approval for covered services.

If you, your *spouse/partner* or *dependent children* experience an unexpected **medical emergency** that requires immediate treatment while travelling, you should contact Assured Assistance Inc. before seeking medical attention when possible at:

- Canada and the U.S.: 1-866-496-5254 (toll-free)
- Worldwide: 1-905-816-1202 (collect)
- Fax: 1-905-813-4719 (outside North America)
- Fax: 1-888-298-6340 (toll-free in North America)

Travel assistance card

A travel assistance card with the contact information listed above can be found on page 44.

Medical assistance services
Assured Assistance Inc. provides a number of important medical services:

- Emergency response in many different languages.
- Referral to a certified medical facility.
- Arrangement of direct payment, whenever possible, to the provider for reasonable and customary expenses for the treatment of an unexpected **medical emergency** not covered by your provincial healthcare plan. Coverage includes:
  - hospital room and board in a ward or semi-private room,
  - hospital services and supplies,
  - diagnosis and treatment by a licensed physician,
  - out-patient services, and
  - arranging billing for medical treatment.
- Emergency transportation to a facility that is equipped to provide the necessary treatment.
- Contacting and updating your family, place of business or family physician.
- Monitoring of the medical treatment with the medical professionals treating you.

Non-medical assistance services
The plan also covers a number of non-medical services:

- Subsistence allowance that covers reimbursement for the covered person's commercial accommodations and meals, essential telephone calls and taxi fares, if, upon physician's advice:
  - the covered person, or the covered person's travelling companion (who must be covered under this plan), are relocated to receive medical attention; or
  - the covered person is delayed beyond his/her return date in order to receive emergency treatment for an emergency covered under this insurance.

  The benefit is up to C$150 per day to a maximum of C$1,500 per family. This benefit is subject to the pre-authorization of Assured Assistance Inc.
- Return transportation (via economy class) for insured children left unattended due to the death or hospitalization of a covered person. Where necessary, a qualified attendant will be provided.
- Economy-fare transportation for one family member to join a covered person who, while travelling alone, has been hospitalized for more than four consecutive days. No coverage under this plan is extended to the family member unless considered a covered person under this plan.
- The extra cost of a one-way economy-class ticket home for covered persons who miss their originally scheduled flight due to an accident or illness.
- If the covered person is unable to drive for medical reasons, and no one else is available to drive, the plan will pay up to $1,000 towards returning the covered person's vehicle to his or her home, or the nearest rental agency.
- If deceased, preparation of a covered person's remains, to a maximum of $3,500, and transportation to his or her hometown in Canada provided the return transportation is pre-approved by Assured Assistance Inc. Coverage does not include the cost of cremation or burial.

Emergency Out-of-Province/Country Medical and Travel Assistance Plan

Your coverage	Basic	Enhanced	Catastrophic	Opt-out
Coverage for the first 31 days of a trip	100%	100%	Not covered	Not covered

What's not covered

The following expenses will not be covered:

- Any illness or injury that occurs beyond the 31st day of your trip outside of your province of residence or Canada.
- Treatment for any **medical condition** that:
  - is not considered a **medical emergency**;
  - prior to your trip, it was reasonable to expect a covered person would require treatment or hospitalization during your trip;
  - prior to your trip, was identified as requiring immediate care or further investigation or treatment other than routine monitoring;
  - continues or recurs after you have been advised to return home or move to a different medical facility.
- Claims arising from pregnancy or childbirth after the 31st week of pregnancy (including care for a child born during your trip whether before or after the 31st week of pregnancy).
- Charges for treatment if you are medically able to return home or transfer to a medical facility that is part of the Assured Assistance Inc. medical network.

- Charges for invasive or aggressive investigation or surgery that is not pre-authorized by Assured Assistance Inc.
- Any illness or injury resulting from:
  - an intentionally self-inflicted bodily injury or sickness;
  - committing or attempting to commit an unlawful act;
  - insurrection or war (declared or not);
  - participation in any riot, civil commotion or any other act of aggression;
  - any occupation or paid employment;
  - an accident while operating a vehicle, vessel or aircraft while impaired by drugs or alcohol;
  - any medical condition arising from, or in any way related to, your chronic use of alcohol or drugs whether prior to or during your trip;
  - any medical condition arising from, or in any way related to, the abuse of alcohol during your trip;
  - any medical condition arising from, or in any way related to, the voluntary use, during your trip, of illegal drugs or prescription drugs not prescribed to you; or
  - your abuse of medication or deliberate non-compliance with prescribed medical therapy or treatment whether prior to or during your trip.
- Any medical treatment if you travelled to obtain medical treatment or advice.

Additional coverage for extended trips

- Beyond the first 31 days if you selected the *Basic* or *Enhanced* healthcare option, or
- From the first day of your trip if you selected the *Catastrophic* or *Opt-out* healthcare options

You may purchase travel medical insurance at discounted rates through *RBC Insurance*.

Under the *Basic* and *Enhanced* healthcare options – which include Emergency Out-of-Province/Country Medical and Travel Assistance coverage for the first 31 days of your trip – you may purchase travel medical coverage *beyond the first 31 days*.

Under the *Catastrophic* and *Opt out* benefit options – which *do not* include Emergency Out-of-Province/Country Medical and Travel Assistance coverage – you may purchase travel medical coverage *from the first day of your trip.*

Coverage must be in place prior to your trip.

You can apply for:

- single-trip coverage for one trip lasting up to 183 days, or
- multi-trip annual coverage of up to 365 days.

To obtain coverage or for more information call RBC Insurance at 1-800-769-2528, 6:00 a.m. to 12:00 a.m. ET, seven days a week.

You can find a full listing of RBC Insurance service centres and offices across Canada at: **www.rbcinsurance.com/contact_index.html**.

When coverage ends

Your coverage will end on the earliest of:

- the end of the 31st day of any out-of-province/country trip.
- your return to your province of residence following a trip,
- you no longer qualify for the benefit, or
- the termination of your coverage under a provincial healthcare plan.

Prescription Drug Plan

The cost of prescription drugs is typically the largest and fastest growing healthcare cost for Canadians. The *Retiree FlexBenefits Program* provides a range of coverage choices designed to assist in meeting your personal needs, and to supplement any coverage provided under provincial healthcare plans.

The Prescription Drug Plan's *Basic*, *Enhanced* and *Catastrophic* options provide prescription drug coverage under one of two drug formularies. A formulary is simply a list of eligible drugs covered by the plan.

- The *Basic* option covers drugs listed under Formulary A.
- The *Enhanced* and *Catastrophic* options cover drugs listed under Formulary B.

These two managed formularies are updated several times a year. Brand new drugs are reviewed 10 times each year. Generic drug and line extensions (excluding sustained release forms) of eligible brand name drugs are reviewed as they come on the Canadian market. Line extensions are simply a different dosage of the original drug (e.g., 10 mg versus 20 mg). Sustained release forms are forms of a drug that make it possible to reduce the number of daily doses (e.g., once a day instead of twice). As new drugs come available, they are assessed by ReVue, a consulting group of independent pharmacists, experts in drug research, and physicians. New drugs that receive a favourable assessment by ReVue are added to both Formulary A and B. You can review both formularies at **www.mysunlife.ca**.

Under the *Opt-out* option, prescription drug costs can be covered using the *flex credits* deposited to your Health Spending Account.

Prescription Drug Plan

Your coverage	Basic	Enhanced	Catastrophic	Opt-out
Reimbursement level	• 70% • Formulary A • Subject to a lifetime maximum (Supplementary Medical Plan & Prescription Drug Plan combined)	• 80% • Formulary B • Subject to a lifetime maximum (Supplementary Medical Plan & Prescription Drug Plan combined)	• 100% • Formulary B • Subject to annual and lifetime maximums (Supplementary Medical Plan & Prescription Drug Plan combined)	Not covered
Annual deductible	$0	$0	$5,000	
Lifetime maximum • Apply to eligible medical and prescription drug expenses incurred after retirement.	$250,000 lifetime per Insured	$400,000 lifetime per insured	$250,000 annual maximum, to a lifetime maximum of $600,000 per insured	

Reimbursement at Generic Equivalent Cost

The Prescription Drug Plan includes a *Generic Equivalent Drug* provision. This means that when a brand name drug is purchased when there is a generic substitution available, the drug plan will reimburse eligible drugs only up to the *generic equivalent drug* cost.

A *generic equivalent drug* is a drug with the same active ingredients at the same doses as the brand name original of the drug, but is normally available at a lower cost without the brand name attachment. Generic equivalents are introduced into the market only when the patent protection on brand name drugs expires.

Certain restrictions and exceptions may exist under this provision. For example, if a generic equivalent is not available, or if the prescribing physician indicates that no substitutions are to be made for the brand name drug, then the brand name cost may be eligible for reimbursement.

Drug Formularies

You can review and compare both Formularies A and B by linking to Sun Life's member website at **www.mysunlife.ca**. You'll need your access ID and password. If you don't have an access ID, or forgot your ID or password, call Sun Life Financial's Customer Care Centre at 1-800-305-5905.

Pay-direct drug code
A pay-direct drug (PDD) code is provided under the *Basic*, *Enhanced*, and *Catastrophic* options. Under the *Catastrophic* option, you should use your PDD code for all claims at the pharmacy, however, claims are only considered eligible for reimbursement under the plan once you reach the $5,000 *benefit period* deductible.

To obtain your PDD code, either:

- print a copy from the Sun Life website at **www.mysunlife.ca**, or
- call Sun Life at 1-800-305-5905 to request your code. You will need to provide the first eight digits of your retiree (employee) number (as found on your pension statement), and your policy number (14178).

A pay-direct drug code allows your pharmacist to verify your coverage and process drug claims instantly, billing the plan directly for all eligible expenses. You pay only the portion of your drug expense that isn't covered. Keep in mind that not all drug expenses can be processed with your PDD code. If you need to submit a paper-based claim, you will need to include the policy number (14178).

To be considered eligible for reimbursement, expense must be claimed within one year from the date incurred.

Prior Authorization program
Pre-approval is required for certain drugs before they are covered under the Prescription Drug Plan. Advance approval by Sun Life's pharmacy benefit manager is required for drugs classified as specialty drug categories. The specialty drug categories are Biologics[1], Blood Disorders, Rare Disease, Multiple Sclerosis, Muscle-Nerve Disorders, Osteoporosis, Pulmonary Arterial Hypertension, Cancer (drugs administered orally), and Hepatitis.

To obtain a list of impacted Prior Authorization drugs, as well as the application form, simply visit **www.mysunlife.ca/priorauthorization**. You will be prompted for your prescription drug contract number (14178).

Sun Life and its pharmacy benefit management provider regularly review the Prior Authorization drug list to see if new drugs should be added or if some drugs should be removed. Based on these reviews, the drugs in the Prior Authorization program may change from time to time.

If you are prescribed one of the drugs on the list, you and your doctor must complete and submit a **Prior Authorization form**[2] – details are included on the form. All requests are processed within five business days when your form is completed in full and received by Sun Life. Sun Life will notify you, in writing, regarding the approval status.

If your request is approved, your drug will be paid for under your plan option as usual.

If your request is denied, the drug will not be paid for under the plan. However, you can choose to pay for the drug yourself, or through a spouse's or other benefit plan if such coverage is available. You may also ask your doctor about other drug treatment options.

If you submit a claim without prior approval, it will be declined and you will be advised to complete and submit the Prior Authorization form.

For Quebec residents, drugs included in the formulary and the *Retiree FlexBenefits* Prior Authorization program will be reimbursed at the RAMQ minimum with no pre-approval required. To claim the difference between the RAMQ minimum and your *Retiree FlexBenefits* coverage, you must submit the required form for approval.

Note, some doctors will charge a fee to complete your form. You're responsible for paying your doctor directly, but you can submit your doctor's fees to your HSA for reimbursement.

For more information about the Prior Authorization program, you can speak with a representative at the Sun Life Customer Care Centre at 1-800-305-5905.

[1]Biologic drugs are a specific class of drugs, made through biological processes (as opposed to chemical processes) and used primarily for the treatment of chronic conditions such as (but not limited to) rheumatoid arthritis, Crohn's disease, and plaque psoriasis.

[2]The Prior Authorization program applies to all claimants on or after January 1, 2014. However, if you were taking one of the drugs on the defined list and have submitted eligible claims for the drug through the Retiree FlexBenefits program before January 1, 2014, you will not be required to complete a Prior Authorization form for that specific drug.

Eligible expenses

The Prescription Drug Plan covers certain drugs prescribed by a physician, dentist or, where applicable under provincial law, other qualified health professionals. The plan covers the cost of prescription drugs up to the amount charged for a generic equivalent.

To be eligible for coverage, drugs must be:

- listed on the applicable managed formulary (i.e., Formulary A or B);
- listed in the federal or provincial drug schedules; and
- assigned a Canadian drug identification number (DIN).

The payment for a single eligible drug expense is limited to the cost of a 34-day supply from the date of purchase. To request reimbursement for a 100-day supply of a particular maintenance drug instead of the usual 34-day supply, refer to **www.rbc.com/pensioners** or the Sun Life website at **www.mysunlife.ca** to print the Prescription Drug Plan Maintenance Drug Request form.

The following items are covered under both Formularies and are available using your pay-direct drug code:

- medication listed in the Federal or Provincial Drug Schedules which has a Drug Identification Number (DIN) and requires a prescription;
- oral contraceptives;
- drugs for sexual dysfunction, up to $1,200 per person per *benefit period;*
- drugs for the treatment of infertility up to a lifetime maximum of $6,000 per person
- disposable needles, syringes, lancets and chemical reagent testing materials used to monitor diabetes;
- injectable drugs, vitamins and allergy extracts with a DIN (drug identification number);
- preparations and compounds for which the principal or active ingredient is an eligible drug under this benefit;
- extension devices for inhaled medications; and
- life-sustaining drugs (e.g., insulin).

The following items are covered, but are not available with your pay-direct drug code:

- compound serums that require a prescription;
- varicose vein injections, if medically necessary;
- vaccines used to prevent disease (for dependent children age 16 or under);
- diaphragms, intrauterine devices (IUDs), and contraceptive implants;
- colostomy supplies; and
- drugs for weight loss, provided:
  - they are prescribed for obesity or Type 2 diabetes,
  - a physician's written recommendation is submitted with your claim, and
  - the individual's body mass index is greater than 27 with co-morbidities, or greater than 30 if no co-morbidities.

Quebec residents

Retirees living in Quebec should be aware that some prescription and non-prescription drugs (and some dietary supplements) are covered by the Régie de l'assurance-maladie du Québec (RAMQ), except where covered by a group plan. As a result, the *Retiree FlexBenefits Program* is obligated to cover these expenses. These expenses can be submitted to Sun Life for approval and payment up to the RAMQ reimbursement level, subject to your option's lifetime maximum.

Consistent with Quebec legislation, if you are taking a brand-name drug on RAMQ's formulary (where a generic exists), the plan only covers the cost of this drug up to the amount charged for a generic equivalent (i.e., the reimbursement no longer corresponds to the cost of the brand-name drug times the RAMQ reimbursement level).

For more information on *Retiree FlexBenefits Program* coverage for Quebec residents, see page 41.

Special provincial drug programs are integrated

Some provinces have special disease-specific programs that cover drugs beyond the basic provincial drug program. To help you get the coverage you are entitled to, Sun Life has enhanced its drug claims process. The process will help ensure that you benefit from these provincial programs if you are eligible, while also managing future costs to our drug plan. Sun Life will help you with the claims process if you are eligible for special provincial coverage.

The process is initiated by Sun Life. If you submit a claim for an eligible drug, you will receive a letter from Sun Life notifying that you may be entitled to coverage under a provincial program and that you need to apply. The letter will provide you with the instructions on the application process.

What's not covered

- Non-prescription or over-the counter drugs (except life-sustaining drugs approved by the plan administrator).
- Any drug or item that does not have a drug identification number (DIN).
- Proprietary medicines bearing a GP (general product) number, as defined in Division 10 of the *Food and Drugs Act, Canada.*
- Homeopathic preparations.
- Drugs and treatments, and any services and supplies relating to the administration of the drug and treatment, administered in a hospital, on an in-patient or out-patient basis, or in a government-funded clinic or treatment facility.
- The cost of giving injections, serums and vaccines.
- Medicines dispensed directly by a doctor or dentist.
- Hair growth stimulants.
- Items deemed cosmetic, such as topical minoxidil or sunscreens (including those requiring a prescription), whether or not such items are prescribed for medical reasons.
- Any nicotine resin containing products to help a person quit smoking, whether or not they require a prescription.
- Natural health products, whether or not they have a Natural Product Number (NPN).
- Condoms or contraceptive applications (e.g., jellies, foams, sponges, suppositories, patches, etc.), whether or not prescribed for medical reasons.
- Oral vitamins, minerals, dietary supplements, infant formulas or injectable total parenteral nutrition (TPN) solutions.
- Atomizers, prosthetic devices, first-aid kits, electronic diagnostic, monitoring or testing equipment, reusable insulin delivery devices, and spring-loaded devices to hold lancets.
- Muscle relaxants that do not require a prescription.
- Charges covered under any provincial plan.
- Any charges stemming from an illness or injury that is the result of:
  - committing or attempting to commit an unlawful act;
  - insurrection or war (declared or not);
  - participation in any riot, civil commotion or any other act of aggression; or
  - any occupation or paid employment.

Note: This is not an all-inclusive list. **If you have questions about your coverage for an expense not listed, please call Sun Life at 1-800-305-5905.**

Dental Plan

Your *Retiree FlexBenefits Program* Dental Plan offers coverage for a range of preventive, routine and restorative procedures under the *Basic* and *Enhanced* benefit options. No coverage is provided under the *Catastrophic* or *Opt-out* options. You select the level of coverage that works best for your situation.

Under the *Opt-out* option, dental costs can be covered using *flex credits* deposited to your Health Spending Account.

Keep in mind that the Dental Plan will reimburse only:

- reasonable and customary charges in the amount which is the lessor of:
  - the fee guide for general practitioners which is current on the date of treatment for dental services or supplies approved by the provincial dental association in your province of residence; and
  - the current fee guide for general practitioners approved by the Dental Association in the province where treatment is received; and
- the least expensive service or supply that produces an adequate dental service.

Note: In Alberta, there is no fee schedule for general practitioners. Reimbursement rates for dental expenses are based on the fee schedule developed by the insurer.

Eligible expenses reimbursed under the Dental Plan are not counted towards the lifetime maximum available under the Healthcare *Basic* or *Enhanced* option.

Remember, you can use *flex credits* in your Health Spending Account to offset the cost of those services and procedures that are not covered (or not fully covered) under the option you select – as long as the expense qualifies as an eligible deduction under Canada Revenue Agency (CRA) tax rules. For more information, visit the CRA website at **www.cra-arc.gc.ca**.

Eligible expenses

Basic and Preventive services

Reimbursement (up to the rate specified in the *Specified Fee Guide* for the *Basic* and *Enhanced* options) for the following services:

- one recall oral exam per person, including teeth cleaning, every nine months (every six months for dependent children age 16 and under);
- one complete oral examination, one per person every 36 months;
- one complete series of X-rays or one panorex every 24 months
- fluoride treatments every nine months (every six months for dependent children age 16 and under);
- polishing every nine months (every six months for dependent children age 16 and under);
- routine scaling by a licensed dental hygienist;
- oral hygiene instruction every nine months (every six months for dependent children 16 and under);
- X-rays, bitewing X-rays every nine months (every six months for dependent children 16 and under);
- test and lab exams for basic services;
- fillings (amalgam or composite);
- extractions;
- space maintainers;
- pit and fissure sealants;
- repair, relining or rebasing of dentures (by a licensed denturist, denture therapist, technician or mechanic); and
- oral surgery, including removal of impacted wisdom teeth.

Specified fee guide

The fee guide for general practitioners that is current on the date of treatment for dental services or supplies, and approved by the provincial dental association in your province of residence. When a fee guide is not published for a given year, the term fee guide may also mean an adjusted fee guide established by Sun Life.

Treatment plan

If treatment under the Dental Plan is expected to cost more than $500, you should ask your dentist to submit a treatment plan to Sun Life before treatment begins. A treatment plan is simply a description of the proposed procedure and its related cost.

As plan administrator, Sun Life will review the treatment plan and report what portion of the cost (if any) is covered under the benefit option you have selected. This will allow you to determine how much reimbursement you can expect – before your treatment begins and provided you and/or your *eligible dependents* remain eligible when the treatment occurs. For more information, call the Sun Life Customer Care Centre at 1-800-305-5905, or go to the member website at **www.mysunlife.ca**.

Dental Plan

Your coverage	Basic	Enhanced	Catastrophic	Opt-out
Basic & Preventive	50%	70%	Not covered	Not covered
Endodontic / Periodontic	50%	70%		
Major restorative	50% for dentures only; $250 every 5 years	50%; Dentures $250 every 5 years		
Annual maximum	$1,000 per person, per *benefit period* including major restorative	$3,000 per person, per *benefit period* including major restorative		

Endodontic and periodontic services
Reimbursement (up to the rate specified in the *Specified Fee Guide* for each level) for the following services:
- endodontics – root canal therapy and root canal fillings and treatment of disease of the pulp tissue; and
- periodontics – treatment of disease of the gum and other supporting tissue, excluding treatment for temporomandibular joint dysfunction; and
- test and lab exams for endodontic and periodontic services.

Major restorative
Reimbursement (up to the rate specified in the *Specified Fee Guide* for each level) for the following services:
- the first installation, including adjustments, of a partial or full denture;
- replacement of a denture that is at least five years old and no longer serviceable;
- addition of teeth to an existing partial denture;
- first placement of inlays, onlays and crowns;
- veneers and veneer replacement (once every 36 months);
- replacement of inlays, onlays and crowns that are at least five years old and no longer serviceable;
- repair or re-cementing of bridge-work;
- the first installation of bridgework;
- replacement of bridgework that is at least five years old and no longer serviceable; and
- test and lab exams for major restorative.

Implants are not covered. However, for an implant-related crown or prosthesis, the plan will pay the benefit that would have been payable for a tooth-supported crown or a non-implant related prosthesis, respectively. Any limitations that would have applied if there had been no implant will be taken into account. All other expenses related to implants, including surgery charges, are not covered.

What's not covered

- Supplies usually related to sports (e.g., mouth guards).
- Expenses covered under another *Retiree FlexBenefits* plan (e.g., Supplementary Medical) or any other policy (e.g., under another group plan).
- Charges that exceed the *reasonable and customary amounts* for the least expensive alternative service or material that is consistent with normal dental care.
- Services or supplies that are considered by the plan administrator to be unreasonable under the terms of the contract.
- Procedures or supplies used in full mouth reconstruction (capping all of the teeth in the mouth), vertical dimension corrections (changing the way the teeth meet) including attrition (worn down teeth), alteration or restoration of occlusion (building up and restoring the bite), or for the purpose of prosthetic splinting (capping teeth and joining teeth together to provide additional support).
- Transplants, and repositioning of the jaw.
- Expenses you would not normally incur in the absence of this coverage.
- Cosmetic dental care.

- Services or supplies for implantology.
- Charges related to temporomandibular joint (TMJ) treatment.
- Dental services required due to congenital malformation.
- Charges for a missed appointment, counselling or completion of a claim form.
- Experimental treatment.
- Expenses for lost or stolen dentures.
- Expenses arising from:
  - committing or attempting to commit an unlawful act;
  - insurrection or war (declared or not);
  - participation in any riot, civil commotion or any other act of aggression; or
  - injury or illness arising out of any occupation.

Health Spending Account (HSA)

The Health Spending Account allows you to use excess *flex credits* to pay for a number of health-related expenses not covered, or only partly covered, under the *Retiree FlexBenefits Program* option you've selected, including the *Catastrophic* and *Opt-out* options.

The HSA may also help you to pay medical and dental related expenses for dependents who aren't covered (or aren't eligible for coverage) under your *Retiree FlexBenefits Program* healthcare plans, but who do qualify as dependents for tax purposes. This can include anyone who is recognized as your dependent under Canada Revenue Agency (CRA) tax rules – such as a *spouse/partner* acquired after your retirement, a parent, brother, sister, or grandchild.

For more information, visit the CRA website at **www.cra-arc.gc.ca**.

How it works

As an eligible retiree each *benefit period* you will receive an annual *flex credit* allotment – currently equal to $50 for each *year of service*, to a maximum of 35 years. You will use these *flex credits* – together with personal payments, if necessary – to purchase your preferred benefit and level of coverage. Excess annual *flex credits*, if any, will be deposited to your Health Spending Account (HSA).

In addition, remaining *flex credits*, if any, will be prorated based on your date of retirement or eligible change event and the number of days remaining in the plan year, and deposited into your HSA. If you have worked on an intermittent (part-time) basis from January 1, 2010 onwards, your annual *flex credit* allotment will be adjusted to reflect your reduced work arrangement.

The money in your HSA can be used to reimburse any eligible medical, drug or dental expenses that are not covered (or not fully covered) by your *Retiree FlexBenefits* healthcare plans. The more *flex credits* that flow to your HSA, the more money you'll have available.

Say, for example, you elect the *Basic* option, which doesn't include vision care coverage, but you purchase a new pair of prescription eyeglasses. Your HSA can reimburse up to the full cost of your prescription eyeglasses, provided you have enough *flex credits* in your HSA.

Quebec residents

If you live in Quebec, any medical, prescription drug and dental expenses (including related retail sales tax and administration fees) paid with credits from your HSA will be considered a taxable benefit. You will not pay federal tax, but Quebec provincial tax will apply.

Eligible expenses

Your HSA covers all eligible expenses as defined in the Canada Revenue Agency (CRA) tax rules – but only to the extent that those expenses are not covered under a provincial or private healthcare plan.

There are literally hundreds of eligible expenses that are covered – everything from laser eye surgery to drugs not eligible under Formulary A or B. For a list of covered expenses refer to the Sun Life website at **www.mysunlife.ca**. Select *Health Spending Account*, then *Health Spending Account coverage* at the bottom of the screen.

To qualify as an eligible expense, the service, procedure or item must be provided or prescribed by a medical practitioner who is licensed in the province in which he or she is practising.

Your expense claims should first be submitted to the *Retiree FlexBenefits Program* for payment (unless you have chosen the *Opt-out* option), or any other benefit plan you are covered under, before you submit them to your HSA. Your HSA will cover only those expenses that aren't covered, or aren't fully covered, by any other plan you may be eligible for.

Use it or lose it

For the HSA to qualify as a tax-preferred program, the CRA requires your HSA to have an element of risk. This risk is what we call the "use-it-or-lose-it factor."

Based on current CRA provisions, if you have *flex credits* remaining in your account at the end of the *benefit period* (i.e., at December 31), you can carry forward your *flex credits* for one *benefit period* to cover any outstanding expenses incurred before the end of the original benefit period. If you do not use these *flex credits* before the end of the following *benefit period* (i.e., the following December 31), they will be forfeited. You can submit a claim for an eligible expense incurred in the same year as the *flex credits* were allotted, up to as late as December 31 of the following *benefit period.*

For example, *flex credits* provided for the *benefit period* January 1, 2016 to December 31, 2016, will be carried forward to the next *benefit period*, that is, January 1, 2017 to December 31, 2017. Any eligible expense incurred up to December 31, 2016, can be submitted up to one year from the date of the eligible expense, but no later than December 31, 2017.

Retiree Basic Life Insurance

As part of your *Retiree FlexBenefits* coverage, RBC provides you with $10,000 of Retiree Basic Life Insurance payable to your beneficiary upon your death for any cause. You are provided with this coverage even if you have chosen the *Opt-out* option.

Retiree Basic Life Insurance is payable to your *beneficiary* upon your death for any cause. No evidence of insurability is required.

Additional benefits

Optional Life Insurance

Life insurance is an important source of financial protection for your family. If your life insurance needs exceed the $10,000 coverage provided under the Retiree Basic Life Insurance Plan, you may continue your *FlexBenefits* optional life coverage for you, your *spouse/partner* and *dependent children*. As part of the *Retiree FlexBenefits Program*, you may be eligible to continue your coverage at your existing level, or a reduced level, in multiples of your *benefit base*.

Coverage cannot be increased once your retirement has occurred and any election to reduce coverage cannot be subsequently increased. Coverage can be further reduced or cancelled at any time after retirement. Please contact the **Human Resources Service Centre at 1-800-545-2555** for assistance.

*Note: because your Optional Retiree Life coverage is based on your **benefit base**, it will differ from your pre-retirement coverage, which is based on your* benefit earnings.

The Optional Life Insurance coverage is available as follows:

Optional Life Insurance

Offers continued optional life insurance coverage for you and/or your *spouse/partner* and *dependent child(ren).*
Optional Retiree Life Insurance • For retiree under age 65: continue coverage at existing or reduced level in multiples of 1 to 7 times your *benefit base* • For retiree age 65 to 70: maximum coverage reduces to 100% of your *benefit base* • For retiree age 70 and up: maximum coverage reduces to 50% of your *benefit base* The above coverage/maximums will change automatically on the day you reach age 65 or 70, as the case may be.
Optional Spousal Life Insurance • For *spouse/partner* under age 65: continue spousal coverage at existing or reduced level to a maximum of $90,000. • For *spouse/partner* age 65 and up: maximum coverage reduces to 50% of previous spousal coverage to a maximum of $45,000. Coverage will reduce on the day your spouse/partner turns age 65.
Optional Dependent Child(ren) Life Insurance Continue coverage of $10,000 until no longer an *eligible dependent.* If coverage prior to your retirement was $5,000, this level of coverage is not available under the *Retiree FlexBenefits Program*. Your continued coverage will be increased automatically to $10,000.

Premium deductions

How much you pay for Optional Life Insurance (retiree, *spouse/partner* and/or *dependent child(ren)*) will vary depending on your age and the amount of coverage you select. RBC reserves the right to adjust the premiums at any time.

Evidence of insurability

You and/or your *spouse/partner* will not be required to provide evidence of insurability (EOI) for continuing coverage into retirement.

Living death benefit

If you are diagnosed with a terminal illness and have a life expectancy of 12 months or less, you may receive an advance benefit. This benefit – payable while you are still alive – will equal 50% of your Optional Retiree Life Insurance amount to a maximum of $100,000.

Similarly, if you elect Optional Spousal Life coverage and your *spouse/partner* is diagnosed as terminally ill with a life expectancy of 12 months or less, you may receive an advance benefit. The living benefit will equal 50% of the insured amount, to a maximum of $45,000.

If you are within five years of a scheduled reduction of Optional Life Insurance coverage, the advance that you may receive cannot exceed 50% of the lowest reduced amount of the Optional Life Insurance coverage, to a maximum of $100,000.

If your *spouse/partner* is within five years of a scheduled reduction of Spousal Life Insurance coverage, the advance that you may receive cannot exceed 50% of the lowest reduced amount of the Spousal Optional Life Insurance coverage, to a maximum of $45,000.

The approval of a Living Benefits loan is at the discretion of Sun Life and is not part of the group insurance policy.

What's not covered

If an insured retiree or *spouse/partner* takes their own life within two years of starting or increasing their coverage, the benefit will be limited to:

- the insurance coverage that has been in place for more than two years, and
- the premiums paid (without interest) for insurance that has been in place for less than two years.

When coverage ends

Your Optional Retiree Life Insurance coverage will end when you die. Coverage for your *spouse/partner*, and/or *dependent children* will end when your coverage ends, when your *spouse/partner* and eligible children no longer qualify as a *spouse/partner* or *dependent child* or when your *spouse/partner* and/or eligible *dependent children* die, whichever comes first.

Optional Accidental Death & Dismemberment Insurance

The *Retiree FlexBenefits* program offers you retiree-paid Optional Accidental Death & Dismemberment (AD&D) Insurance. AD&D gives you an easy and affordable way to provide your family with additional financial protection. You can purchase coverage for yourself, your *spouse/partner*, and/ or your *dependent children.* Coverage for your *spouse/partner* and/or *dependent child(ren)* cannot exceed the coverage you have elected for yourself.

The AD&D Plan will provide you with a benefit if you suffer an accidental injury, as specified in the table of covered losses that follows.
Your loss must:

- be a direct result of an accidental injury,
- occur within 365 days from the date of the accidental injury, and
- be total and irreversible or irrecoverable.

Optional Accidental Death & Dismemberment (AD&D) Insurance

Offers continued coverage for accidental injury for yourself, your *spouse/partner*, and/or your *dependent children*.
Retiree AD&D • For retiree under age 65: continue coverage at existing or reduced level (in units of $50,000) to a maximum of $500,000. Coverage may not be increased beyond the amount in force before retirement, but you may reduce your coverage. If you reduce your coverage on or after retirement, this will be your new level of coverage and you may not increase your coverage at a later date. • For retiree age 65 to 69: maximum coverage reduces to $150,000 • Coverage ends when you reach age 70
Spousal AD&D • For your *spouse/partner* under age 65: continue spousal coverage at existing or reduced level (in units of $50,000) to a maximum of $500,000 or the amount of your Retiree AD&D coverage, whichever is lower • For your *spouse/partner* age 65 to 69: maximum spousal coverage reduces to $150,000 or the amount of your Retiree AD&D coverage, whichever is lower • Coverage ends when you or your *spouse/partner* reach age 70, whichever comes first
Dependent Child(ren) AD&D • For retiree under age 65: continue dependent coverage at existing or reduced level (in units of $25,000) to a maximum of $100,000 or the amount of your Retiree AD&D coverage, whichever is lower • Coverage ends when you reach age 70 or your covered child(ren) are no longer dependent, whichever comes first

Principal sum

The amount of coverage you select is known as the *principal sum*. For example, if you select five units of coverage for yourself, your *principal sum* would be $250,000 (5 x $50,000 = $250,000). Except where an accident results in irrevocable quadriplegia, paraplegia, hemiplegia, or the loss of sight in both eyes (see payment amounts on the next page), the maximum benefit payable is equal to the principal sum.

Premium deductions

How much you pay for AD&D coverage for yourself will vary depending on your age and the amount of coverage you select. The premiums for spousal coverage depend on the amount of spousal coverage and the age of your *spouse/partner*. RBC reserves the right to adjust the premiums at any time.

Covered loss

Life	100%
Both hands or both feet	100%
One hand and one foot	100%
One hand and entire loss of sight in one eye	100%
One foot and entire sight in one eye	100%
One arm or one leg	100%
One hand or one foot	100%
Entire sight in one eye	100%
Use of one hand	100%
Speech	100%
Hearing in both ears	100%
Hearing in one ear	50%
Thumb and finger on same hand	33⅓%
Four fingers of same hand	33⅓%
All toes of the same foot	25%
Permanent and total disability	100%
Speech and hearing in both ears	200%
Entire sight in both eyes	200%
Quadriplegia means paralysis of four limbs	200%
Paraplegia means paralysis of the lower portion of the body (including bowel and bladder) and both lower limbs due to injury of the spinal cord	200%
Hemiplegia means paralysis of one side of the body	200%

Loss means

For hand or foot	Complete severance at or above the wrist or ankle joint, but below the elbow or knee joint.
For arm or leg	Complete severance at or above the elbow or knee.
For thumb and fingers	Complete severance at or above the knuckles joining the fingers to the hand.
For toes	Complete severance at or above knuckles joining the toes to the foot.
For speech or hearing	The entire and irrevocable loss of speech which does not allow audible communication of any degree. Total and irrecoverable loss.
For loss of use that has been continuous for 12 months from the date of the accident	Permanent, total and irrecoverable loss of use.
For paralysis	Permanent and irrevocable paralysis

Payment amounts

Amounts payable under the plan will depend on the nature and extent of the injury. The *Covered loss* table above outlines the percentage of the *principal sum* that will be paid out, depending on the plan and injury.

Only one benefit – the largest amount – will be paid for all losses relating to the same accident. For example, if you permanently lost the use of an arm due to an injury, you would receive 100% of the *principal sum*. However, if in the same accident, you also lost all the toes on one foot, you would not be able to make a second claim for an additional benefit.

Exposure and disappearance

If you or a covered family member suffers a loss specified in the *Covered loss* table due to unavoidable exposure to the elements of nature after a conveyance in which you or a covered family member was travelling, sinks, makes a forced landing or is lost, wrecked or stranded, such loss will be deemed to have occurred as a result of an accidental injury. You or a covered family member is deemed to have suffered death by accidental injury if his/her body is not found within 365 days after a conveyance in which you or a covered family member was travelling, sinks, makes a forced landing or is lost, wrecked or stranded.

Common accident

If you and your *spouse/partner* die as a direct result of a common accident, the amount of benefit payable for loss of your *spouse's/partner's* life will increase to equal the amount payable for your loss of life provided spousal coverage was in place as of the date of the accident. However, in no event will the amount paid for both lives exceed the combined benefit maximum specified in the covered loss section, maximum $1,000,000.

Common accident means the same accident or separate accidents occurring within the same 24-hour period.

Permanent and total disability
If, as a direct result of an accidental injury, you or a covered family member becomes *permanently and totally disabled* while insured for this benefit, the insurer will pay the *permanent and total disability* benefit shown in the *Covered loss* table provided:

1. the person becomes *permanently and totally disabled* within 365 days after the date of the accidental injury; and
2. the person has been *permanently and totally disabled* for a continuous period of 12 months and remains so disabled at the end of such period.

The benefit is payable to the person in a single payment.

Permanent and total disability

Permanent and total disability is defined as: wholly and continuously disabled due to an accidental injury that is severe enough, in the insurer's opinion, to permanently prevent the person from working for pay or profit.

Additional coverage

In addition to the coverage outlined previously, the AD&D Plan provides you and your covered family members with a range of additional benefits. These valuable benefits are summarized below:

Rehabilitation
If you are injured in an accident, the plan will cover reasonable and necessary costs associated with retraining you for an occupation that you would otherwise not pursue. Expenses must be incurred within three years of the accident. The maximum benefit payable is $10,000. The plan does not cover room, board, ordinary living, travel or clothing expenses.

Spousal retraining benefit
If you die in an accident, the plan will cover the reasonable and necessary costs associated with your *spouse/partner* completing a formal occupational training program, provided your *spouse/partner* is covered under the plan. The training program must be to help your *spouse/partner* qualify for employment in an occupation for which he or she would otherwise not have sufficient qualifications. Expenses must be incurred within three years of the accident. The maximum benefit payable is $10,000. The plan does not cover room, board, ordinary living, travel or clothing expenses.

Repatriation benefit
If you (or a covered family member) die as the result of an accident that occurs while travelling 150 kilometres or more away from home, the plan will cover the costs related to preparing and shipping the body to your city of residence. The maximum benefit payable is $10,000.

Education benefit
If you die, the plan will provide a special education benefit on behalf of your *dependent children*. The plan will provide the lesser of $5,000 or 5% of the *principal sum* for the continuing education of any *dependent child* who, at the date of the accident:

- is enrolled as a full-time student in any institution of higher learning beyond the secondary school level, or
- is attending secondary school and subsequently enrolls as a full-time student in an institution of higher learning within 365 days of the date of the accident.

The special education benefit is paid annually for up to four consecutive years, but only if the *dependent child* continues his or her education as a full-time student in an institution of higher learning.

If you have *dependent children* who at the time of your death are not eligible for the education benefit, a lump sum of $1,500 will be paid to your *beneficiary*.

What's not covered

No benefit will be paid for any loss that is directly or indirectly related to:

- suicide or self-inflicted injury, whether the person is sane or insane;
- war, insurrection, the hostile actions of any armed forces, or participation in a riot or civil commotion;
- an infection (except pyogenic infections from an accidental cut or wound) illness or disease, or bodily or mental infirmity;
- the committing of, or attempt to commit an assault or criminal offence; or
- injuries sustained while operating a motor vehicle, either while under the influence of any intoxicant, or if the person's blood contained more than 80 milligrams of alcohol per 100 millilitres of blood at the time of injury.

Non-duplication of expenses
Expenses that are eligible under this benefit and that are also payable in part or in full under any other benefit, policy, or plan providing similar coverage issued by RBC, will be paid first under such other benefit, policy or plan. Any expenses not paid will then be considered under this benefit, subject to any stated maximum.

The total amount of payments from all coverages combined will not exceed 100% of the eligible expenses incurred.

When coverage ends

Your Optional AD&D coverage will end on the earlier of your reaching age 70 or your death. Coverage for your *spouse/partner*, and/or *dependent children* will end when your coverage ends, when your *spouse/partner* and/or *dependent children* no longer qualify as a *spouse/partner* or *dependent child* as the case may be, or when your *spouse/partner* and/or d*ependent children* die, whichever comes first.

EmployeeCare Program

RBC EmployeeCare is a confidential service provided by *Ceridian*. As well as offering free, in-person, confidential counselling services, RBC EmployeeCare provides access to information and resources that can help you in your everyday life.

The program can assist you with a variety of issues including but not limited to:

- Emotional well-being – Relationships, stress management, depression/anxiety;
- Elder care – Support in accessing care, housing, health/financial information;
- Financial – Credit and debt management, budgeting;
- Addiction and recovery – Resources/support for alcohol, drugs, gambling;
- Health and wellness – Free nutrition counselling, resources on fitness, diet, exercise;
- Everyday Issues – Time-saving research on any issue including home improvements, community resources and more;
- Legal – Consultation with lawyers on estate planning, civil issues, real estate and more.

To learn more, call 1-800-667-3400 or visit **www.lifeworks.com**.

- User ID: **rbc**
- Password: **rbccanada**

Submitting a claim

You and your covered family members should follow the procedures outlined below when making claims.

E-claims

Submit your **vision, some paramedical, dental** and **HSA** claims – such as physiotherapy, massage, chiropractic services and more – online using the E-claim process featured on the Sun Life website. You don't need a paper claim form – just fill in the information online.

Your claim will be adjudicated instantly and you can access your claim statement right away. The payment will be in your account within 24 to 48 hours.

To submit a **vision, paramedical, dental** and **HSA** claim online:

1. Visit **www.mysunlife.ca** and sign on using your Access ID and Password.
2. Select "Submit a Claim" under the "Take me to" menu on the right side of the screen, or select the type of claim from "Claims" on the blue menu bar.
3. You will be guided through the claiming process in a few easy steps.

Sun Life randomly audits claims submitted online, so please be sure to keep your original receipts and supporting documents for 12 months. If your claim is chosen for audit, Sun Life will ask you to mail your original receipts.

Paperless claim statements

Electronic delivery of your Explanation of Benefits (EOB) statements is easy to set up and environmentally friendly too. You receive statement of adjudicated claims by email rather than in the mail. For more details, refer to **www.mysunlife.ca**.

Supplementary Medical

(excluding Emergency Out-of-Province/Country Medical & Travel Assistance. Refer to page 17 for claims information)

You can submit vision and some paramedical claims directly to Sun Life electronically (see the instructions under E-claims). For other medical services and supplies, you can print out a personalized claim form from the Sun Life website, at **www.mysunlife.ca**.

Your form should be mailed directly to the Sun Life office on the claim form. Be sure to include your policy number (that number is 14178), and to save a copy of the claim form for your own files.

Claim payments will be deposited in your bank account. Sun Life will also send you an Explanation of Benefits (EOB) that you can use for co-ordination of benefits (see page 9).

Claims must be submitted within one year of the date the expense is incurred. Claims submitted beyond this one-year window will be considered ineligible for payment.

Custom-made orthotics and orthopaedic shoes

Claims for custom-made orthotics and orthopaedic shoes must include all of the following:

- A written recommendation (i.e., prescription) for the custom-made orthopaedic shoes or orthotics from an eligible prescribing healthcare practitioner *(note: a new written recommendation must be submitted with each claim and must include the diagnosis necessitating the custom-made orthopaedic shoes or orthotics)*;
- A detailed lab invoice which provides an itemized breakdown of the raw materials used, their cost, and any other associated costs incurred to manufacture the custom-made orthopaedic shoes or orthotics *(note: if there are costs related to shoe modifications, the details and cost of each modification must be included on the lab invoice)*; and
- A receipt showing full payment has been made, patient's name and date of service.

When purchasing your custom made orthopaedic shoes or orthotics, ask your provider for the items listed above at the same time you pick up and pay for your shoes or orthotics. Claims submitted without each item listed above will be declined.

Prescription Drugs

A pay-direct drug (PDD) code is provided for coverage under the *Basic*, *Enhanced* and *Catastrophic* benefit options. A PDD code enables your pharmacist to verify your coverage and process drug claims at the pharmacy. The pharmacist will bill the plan directly for all eligible expenses reimbursed. You pay only the portion of the drug expense that is not covered or not fully covered.

Keep in mind that not all drug expenses can be processed with your PDD code. If you need to submit a paper-based claim, you will need to include the policy number (14178).

To be eligible for reimbursement, claims must be submitted within one year of the date the expense is incurred. Claims submitted beyond this one-year window are ineligible for reimbursement.

Sun Life will email or mail you an Explanation of Benefits (EOB) that you can use for co-ordination of benefits (see page 9).

If you require additional PDD codes for *eligible dependents* (i.e., a *spouse/partner* or a *dependent child* who is studying outside your province of residence), you can either:

- call Sun Life at 1-800-305-5905 to request an additional PDD code, or
- print a copy from the Sun Life website at **www.mysunlife.ca**.

Activation of your healthcare coverage

Please note that it may take up to three weeks following submission of your online *Retiree FlexBenefits* enrollment for your plan to be activated with Sun Life. Consider filling any prescriptions prior to your retirement or paying for your prescriptions upfront and then submit for payment using a *Retiree FlexBenefits* claim form once your coverage has been activated.

Dental

Claims can be submitted either electronically or using paper-based forms.

Electronic claims:

- If your dentist has electronic access to the Sun Life claims system, he or she can submit a claim on your behalf. You will need to tell your dentist the plan policy number (14178) and your eight-digit retiree number.
- If your dentist submits the claim electronically, your reimbursement should be deposited in your bank account within a few days. You'll need to pay your dentist. Be sure to ask your dentist for a receipt for your records.

Paper-based claims:

If you wish to submit a paper-based form, you can print a personalized claim form available from Sun Life at: **www.mysunlife.ca** using your access ID and password.

- If your dentist prefers, a Standard Dental Claim Form can be used, but you must be sure to write the plan policy number (14178) and your retiree number on the form.
- Paper-based claim forms should be mailed directly to the Sun Life office as indicated on the claim form.
- Sun Life will not send the reimbursement to your dentist. You'll need to pay your dentist, and then file a claim for reimbursement.
- Your claim payment will be deposited in the bank account where your pension payments are deposited, or from where your benefit premiums are paid. Sun Life will email or mail you an Explanation of Benefits (EOB) that you can use for *co-ordination of benefits*.

Claims must be submitted within one year of the date the expense is incurred. Claims submitted beyond this one-year window are ineligible for reimbursement.

Health Spending Account

Claims can be submitted using a paper claim form. You can print out a personalized claim form from Sun Life Member Services, at **www.mysunlife.ca.**

Alternatively, you can submit your Health Spending Account claim directly to Sun Life using the Sun Life E-claim option. Simply go to the Sun Life website mentioned above and follow the instructions for E-claims under "My Claims." Remember to keep your receipts. You may be asked by Sun Life to provide receipts up to 12 months from the date of claim.

If you have access to coverage under other benefit plans, you must submit claims to those plans first. The remaining portion can be claimed under the Health Spending Account, subject to your account balance. If you don't have coverage under any other plans, simply tick the appropriate box on the claim form and the unpaid portion will be withdrawn from your HSA account and deposited in your bank account.

HSA claims must be submitted before the end of the plan year following the year the expense is incurred. Claims submitted beyond this date will be considered ineligible for payment.

Your form should be mailed directly to the Sun Life office as indicated on the claim form. Be sure to save a copy for your own files. Claim payments will be deposited in the bank account where your pension payments are deposited or from where your benefit premiums are paid. Sun Life will email or mail you an Explanation of Benefits (EOB) that reports the balance remaining in your HSA. You can elect a "paperless" EOB, which will be e-mailed to you once your claim has been processed. To request a paperless EOB, go to Sun Life Member Services, Paperless Payments at: **www.mysunlife.ca**.

Retiree Basic Life Optional Life and Optional AD&D

For claims under the Retiree Basic Life, Optional Life or Optional AD&D Insurance Plans please call the HR Service Centre at 1-800-545-2555. Claims should be initiated as soon as possible, but no later than **60 days** (for life insurance) and **90 days** (for AD&D) after the illness, injury or death for which a claim is being made.

For follow-up contact regarding claims, you may also write or send a fax to:

RBC - HRSC Benefits Administration
6880 Financial Dr., 2nd Floor, Tower 1
Mississauga, ON L5N 7Y5
Transit 6315

The fax number is 1-888-309-4999.

Glossary of terms

Beneficiary: The individual(s) you name to receive the death benefit from your Retiree Basic Life Insurance, your Optional Life Insurance or Optional AD&D Plans. If you do not have a beneficiary, benefits will be paid to your estate.

Benefit base: Your benefit base equals either your current salary or, if you were on an average earnings formula, the average of your eligible earnings for the two previous calendar years, including salary/draw and any regular, ongoing variable pay (e.g., commissions, IA bonus) as designated in your compensation structure/plan and approved by Corporate Compensation. Benefit base excludes any annual or yearend incentive(s)/bonus, or other specified incentives.

Benefit period: The *Retiree FlexBenefits Program* benefit period runs from January 1 to December 31.

Benefits eligibility date: The start of your most recent period of continuous service in which you qualified for employee benefits. If you were an intermittent employee, this is the date you first meet the minimum earnings requirement for eligibility.

Company: Refers to any Canadian member company of RBC.

Co-ordination of benefits (COB): If you are covered under *Retiree FlexBenefits* and another group plan, the payment of eligible expenses can be shared by both plans. There are, however, standard industry procedures for submitting claims under more than one plan. For details, refer to page 9.

Dependent child: A natural, adopted or step-child of you and/or your spouse/partner who is:

- unmarried and dependent on you for support, and
- residing in Canada and has coverage under a provincial healthcare plan;

and is:

- under age 21; or
- under age 25, if attending school fulltime at a post-secondary institution, such as a college or university (under 26 for prescription drug coverage in Quebec); or
- any age, with pre-approval of the plan administrator, if the child:
  - is unmarried, unemployed, and financially dependent on you due to a mental or physical disability; and
  - was disabled before age 21; and
  - was covered under an RBC benefits plan prior to turning age 21.

If a child becomes disabled while a dependent, the age limit specified above does not apply, provided an extension of coverage beyond the limiting age has been applied for within 31 days and approved by the plan administrator.

In the case of a divorced retiree or a retiree with a common-law partner, only children actually dependent on the retiree are considered dependents.

Eligible dependent: Your spouse/partner and/or dependent child(ren).

Flex credits: A dollar amount credited to eligible retirees by RBC at the start of each benefit period to help you purchase healthcare plan coverage under the *Retiree FlexBenefits Program*.

Health Spending Account (HSA): An account containing credits that can be used on a tax-preferred basis to pay for eligible medical, prescription drug and dental expenses. Eligible expenses are defined by the Canada Revenue Agency. Credits in an HSA can be carried forward for one benefit period. Credits not used by December 31 of the second benefit period are forfeited. Note: Quebec residents, see page 37 for tax treatment of HSA.

Pensionable service: Your total years of membership in the RBC Retirement Program, pro-rated if you work part-time, up to a maximum of 35 years in the defined benefit (DB) and defined contribution (DC) options combined.

Qualified physician: A medical doctor who is licensed to practice medicine in the place services are provided.

Retiree: You are eligible to participate in the *Retiree FlexBenefits Program* provided that you meet **all** of the following criteria:

- are formally retired from RBC (on or after January 1, 2010);
- are at least 55 years of age,
- are residing in Canada,
- you must have five years of *benefits eligibility* in the last 10 years,[1, 2]
- have completed at least 10 years of pensionable service immediately prior to your retirement date[3], and
- are accruing pensionable service in one of RBC's Canadian Pension Plans immediately prior to retirement.

[1] **Benefits eligibility:** *Your most recent period of continuous service in which you qualified for employee benefits. If you were an intermittent employee, this is the period of continuous service in which you met the minimum earnings requirement for eligibility.*
[2] *Criteria changed effective July 1, 2011.*
[3] **Pensionable service:** *Your total years of membership in the RBC Retirement Program, pro-rated if you work part-time, up to a maximum of 35 years in the defined benefit (DB) and defined contribution (DC) options combined.*

Spouse/partner: The person of the same or opposite sex who, at the date of your retirement:

- is legally married to you; or
- has been living with you in a common law relationship for at least one year and whom you publicly represent as your spouse/partner, or has entered into a civil union with you pursuant to Quebec law;

and is:

- residing in Canada and has coverage under a provincial healthcare plan.

A divorced spouse is **not** eligible for coverage. You can qualify only one person as your *spouse/partner*. Also, a *spouse/partner* that you acquire **after the date of your retirement** is **not** eligible for coverage under the *Retiree FlexBenefits Program*. Quebec residents, see page 41 for more details.

Years of service: Up to a maximum of 35 years. For part-time employees, starting January 1, 2010 years of service is adjusted to reflect your reduced work arrangement.

Information for Quebec residents

Tax treatment of benefits

Quebec residents are subject to a provincial tax on company-paid medical, drug, and dental benefits. If you live in Quebec you will incur a taxable benefit, for provincial income tax purposes, for any benefits you buy using *Retiree FlexBenefits* credits, augmented by the insurance company administration fees plus Quebec Sales Tax including:

- Supplementary Medical, Prescription Drug and Dental, and
- Expenses paid out of your Health Spending Account.

Under current tax legislation, you will not pay federal tax, but Quebec provincial tax will apply.

RAMQ rules on basic prescription drug coverage

Retirement before age 65

Under Régie de l'assurance maladie du Québec (RAMQ) regulations, retirees below age 65 who have access to RAMQ-compliant coverage under a private prescription drug plan are required to participate in that plan. Therefore, if you retire before age 65, you must choose either *Basic* or *Enhanced* coverage under the *Retiree FlexBenefits* program. This is a **one-time** choice made at the time of your retirement; your choice will remain in effect for the duration of your retirement.

If you have existing RAMQ compliant coverage under another group plan – for example, through a *spouse/partner's* plan or another employer – you may choose to opt out of *Retiree FlexBenefits or elect the Catastrophic option*. If you lose access to this alternative coverage at a later date but before age 65, you will be permitted to enroll in the *Basic* option of the Prescription Drug Plan, including coverage for your *spouse/partner* and/or eligible *dependent child(ren)*.

If you enroll in the *Basic* or *Enhanced* option and gain access to alternative RAMQ-compliant coverage at a later date, you will not be permitted to change your *Retiree FlexBenefits* coverage.

Retirement at or after age 65 and when you reach age 65

From age 65, you are automatically enrolled in RAMQ's prescription drug program. If you retire at age 65 or later, you may choose to supplement your RAMQ coverage with *Retiree FlexBenefits* coverage.

Alternatively, you can choose *Retiree FlexBenefits Program* coverage and withdraw from the RAMQ coverage provided from age 65. If you withdraw from RAMQ coverage you will be charged an additional premium for your *Retiree FlexBenefits Program* coverage. You may also choose to opt out of *Retiree FlexBenefits Program* prescription drug coverage, and opt for RAMQ prescription drug coverage only. By doing so, neither you or your *spouse/partner*, irrespective of his or her age, will be covered under the *Retiree FlexBenefits* Healthcare which includes supplementary medical, prescription drug and dental plans.

If you have both RAMQ and *Retiree FlexBenefits* coverage, payment of your prescription drug claims can be coordinated under both plans. Your eligible prescription drug claims would be reimbursed by RAMQ as first payer. Any part of the claim that is not covered could be submitted to *Retiree FlexBenefits* plan for consideration and potential payment.

You must notify the Human Resources Service Centre of any changes to your RAMQ status so that your premiums may be adjusted accordingly.

RAMQ drug coverage

Drugs that are covered by RAMQ but not listed on the formulary for your level of coverage will be reimbursed at the rate set by RAMQ.

Note: Consistent with Quebec legislation, if you are taking a brand-name drug on RAMQ's formulary (where a generic exists), the plan only covers the cost of this drug up to the amount charged for a generic equivalent (i.e., the reimbursement no longer corresponds to the cost of the brand-name drug times the RAMQ reimbursement level).

Marriage after retirement
If you retire before age 65 with coverage under the *Basic*, or *Enhanced* options, and you marry or acquire a *spouse/partner* after retirement but before attaining age 65, your acquired *spouse/partner* and/or eligible *dependent child(ren*) must be added to your Prescription Drug coverage unless he or she is covered under another Group Plan as required under Quebec law. Your monthly premiums will be adjusted to the higher level of *Retiree plus one* or *Retiree plus two or more*.

Survivor benefits
If you die, your surviving *spouse/partner's Retiree FlexBenefits* coverage will continue; however, if your *spouse/partner* does not have RAMQ coverage, he or she must immediately apply for this coverage and the RBC Prescription Drug Plan will become second payer.

Spousal coverage ends on marriage breakdown
Your *spouse/partner's* coverage under the *Retiree FlexBenefits* program – including coverage under the Optional Spousal Life and Optional Spousal AD&D insurance plans – will end following a marriage breakdown. That is, as soon as the *spouse/partner* no longer qualifies as a *spouse/partner* under tax legislation.

For more information

Link to RAMQ at **www.ramq.gouv.qc.ca/en**. Alternatively, you can access RAMQ's Health Insurance Infoline, 24 hours a day, 7 days a week by calling:

- Quebec City: 418-646-4636,
- Montreal: 514-864-3411, or
- Elsewhere in Quebec, toll-free: 1-800-561-9749.

Information for British Columbia residents

All eligible retirees are entitled to participate in RBC's Group British Columbia Medical Services Plan. Once you have enrolled in this plan, RBC will pay 50% of monthly Medical Services Plan (MSP) premiums on your behalf. To register for RBC Group British Columbia Medical Services Plan complete the application form, found at **http://www2.gov.bc.ca/gov/content/health/**, and send it to:

Group Administrator, BC Health Plans
RBC - HRSC Benefits Administration
6880 Financial Dr., 2nd Floor, Tower 1
Mississauga, ON L5N 7Y5
Transit 6315

Please note that you do not need to apply to the RBC Group Plan if you have:

- coverage through your *spouse's/partner's* employer
- two places of employment and group coverage is provided by the other employer
- BC Medicare due to 100% government subsidy and you receive no Medicare billing.

RBC, as the employer, is only responsible for 50% of the MSP premiums when you enroll in the Group Plan. All premiums prior to enrollment in the RBC Group Plan are the responsibility of the retiree. Your RBC Group Plan coverage date commences the first day of the calendar month. Cancellations are made on the last day of the month. Deductions of 50% of your premiums will be made from your bank account through pre-authorized debit and/or your Monthly Pension Payment if you are a member of the Defined Benefit (DB) option of the RBC Retirement Program. RBC will only refund a maximum of two months premiums for cancellations and any changes.

All applications for BC Medicare – e.g. enrollments, changes (deletions/addition of dependents), cancellations and premium assistance – must come through RBC for authorization. The Group Administrator authorizes and processes these forms for payroll deductions before it is forwarded to BC Medicare.

Enrollments
Retirees must notify RBC if they are enrolling for coverage under another employer's group so that their deductions will stop within four to six weeks. RBC Group Plan can only backdate two months retroactive premiums, including the month the application is received. Retirees should notify RBC upon enrollment if they are on a government subsidy otherwise you will be charged the full rate.

Cancellations
Unless you have duplicate coverage or have left the province, cancellation of the plan should be submitted within 31 days so that two months premiums will be refunded.

Coverage
A new B.C. resident can only be added to the RBC Group Plan coverage three months after they have arrived in the province. A retiree transferring between provinces is covered by Medicare in their previous province of residence for the month, which they moved, plus two months.

For further details refer to the B.C. Health Ministry's website at **http://www2.gov.bc.ca/gov/content/health/**, or contact the Human Resources Service Centre at 1-800-545-2555. Please ensure that you advise the Human Resources Service Centre should you move into/out of British Columbia.

You may wish to consider printing a copy of this page for future reference.

Resources – Information

For more information about your *Retiree FlexBenefits* program, you can:

- Go to the website for retirees at: **www.rbc.com/pensioners**. The website includes a wide range of information and resources specifically for RBC retirees.
- Go to the Sun Life website at: **www.mysunlife.ca**. The website includes a wide range of information and resources about your healthcare plans. Alternatively, you can call Sun Life at **1-800-305-5905** for any specific questions about your coverage or a claim.
- Call the **Human Resources Service Centre** (HRSC) at **1-800-545-2555**. The HRSC has representatives available to answer questions on a wide range of issues.
  - Hearing impaired retirees may contact the HRSC via e-mail, or TTY users may utilize a Message Relay Service, provided by your local telecom by dialing 711.
  - Service in English and French is available 8 a.m. to 8 p.m. (EST).

The following table outlines the various carriers and the benefits they cover. Be sure to provide the applicable policy number, as well as your retiree (employee) number.

Benefit plan	Carriers	Policy number	Contact
Supplementary Medical	Sun Life Financial	14178	1-800-305-5905 **www.mysunlife.ca**
Prescription Drug	Sun Life Financial	14178	
Dental	Sun Life Financial	14178	
Emergency Out-of-Province/Country Medical	RBC Insurance / Assure Assistance Inc.	N/A	See wallet card below
Retiree Basic Life	RBC Insurance	800080	HRSC 1-800-545-2555
Optional Life Insurance	RBC Insurance	800082	
Optional AD&D	Manulife Financial	39150	
Travel Medical (beyond first 31 days)	RBC Insurance	N/A	1-800-769-2528

Additional Links

RBC quarterly pensioner publication – *Keeping in Touch*	**www.rbc.com/pensioners**
EmployeeCare Program	**www.lifeworks.com** • User ID: **rbc** • Password: **rbccanada**
Canada Revenue Agency (CRA)	**www.cra-arc.gc.ca**
RBC Insurance	**www.rbcinsurance.com**

Travel Assistance card

It is recommended that you keep the information card below with you at all times while traveling. You should write your member number on the card.

Retiree Benefits Program
Emergency Out-of-Province/Country Medical and Travel Assistance

Assured Assistance Inc.:

Canada & U.S.:	**1-866-496-5254** (toll-free in North America)
Worldwide:	**1-905-816-1202** (collect)
Fax:	**1-888-298-6340** (toll-free in North America)
Fax:	**1-905-813-4719** (outside North America)
Member N°.:	

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