Critical Illness Recovery Plan

Insurance Advisor Guide

RBC Insurance

FOR ADVISOR USE ONLY

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Objective

The purpose of this document is to ensure that the advisors are provided clear knowledge of the listed products in the plan code to be able to educate our clients.

Plan code

10-year term, renewable to age 75, convertible to age 65 – T10NC

Level premiums to age 65 (guaranteed renewable) – T65GR

Level premiums to age 75 (guaranteed renewable) – T75GR

Level premiums to age 75 (non-cancellable) – T75NC

Product type

Individual lifestyle protection

Purpose and market

The RBC Insurance® Critical Illness Recovery Plan™ is designed as a perfect complement to income protection coverage. It can be used to cover additional expenses your client may face if they suffer from a catastrophic illness, such as Cancer (Life Threatening), a heart attack or a stroke. Income protection coverage, on the other hand, is designed to protect everyday living expenses.

Note: Please refer to policy language for a complete list of covered conditions and their definitions.

Critical Illness Recovery Plan policies provide a one-time lump-sum benefit to your clients who are diagnosed with and survive a covered critical illness. This benefit will assist your clients in making meaningful decisions about their physical and financial recovery and will help protect their standard of living. They may use the benefit in any manner they choose, such as:

- To make payments for a mortgage, business loans or other debts;
- To make alterations to a home or automobile to accommodate any special needs;
- To protect retirement savings;
- To supplement income protection coverage;
- To obtain specialized medical treatment, private nursing or child care; and
- To obtain out-of-country or non-government covered treatments.

The Critical Illness Recovery Plan policy isn't just about financial help. By including Assistance Services, the policy provides more than a claim cheque. These valuable services are designed to assist your clients in their recovery by addressing a range of common needs among critical illness survivors. Two separate services are built into all of our plan types:

- Teladoc Medical Experts‡
- Healing the Whole Person

The Critical Illness Recovery Plan policy is available to a wide range of individuals, including those who already have or are applying for income protection coverage. As well, it is available to many individuals who are traditionally unable to qualify for income protection coverage due to their level of income (including non-working spouses), occupation, type of employment or even certain non-critical-illness-related medical histories.

Plan type

The Critical Illness Recovery Plan policy is available in multiple versions:

Non-cancellable until age 75 (Term 10 or level premiums to age 75 policies). We cannot change the plan provisions or premiums from those stated in the policy.

Guaranteed renewable until age 65 or until age 75. We cannot change the plan provisions, but the premiums may be subject to change. However, we cannot change the premium unless we do so for an entire group of policyholders sharing similar characteristics.

The policy will be terminated at the earliest of:

- Termination by the owner;
- Death of the insured;
- Lapse of the policy;
- Conversion of the policy;
- Payment in full of the critical illness benefit; or
- Expiry date, or if the insured is satisfying a survival period, then the day after such survival period.

Underwriting guidelines

Occupational classes: The Critical Illness Recovery Plan policy is not class specific. There are restrictions on some hazardous occupations, such as hazardous waste handlers, explosives handlers or deepsea commercial divers.

Minimum lump sum benefit: $25,000 (increments of $1,000)

Maximum lump sum benefit: $2,000,000 (increments of $1,000)

Participation limit: $2,000,000

Base Plan Issue Ages Chart		
Level premiums to age 75 (non-cancellable)	T75NC	18 to 65
10-year term renewable to age 75, convertible to age 65 (non-cancellable)	T10NC	18 to 64
Level premiums to age 65 (guaranteed renewable)	T65GR	18 to 60
Level premiums to age 75 (guaranteed renewable)	T75GR	18 to 65

Riders Issue Ages Chart	
Disability waiver of premium rider	18 to 55
Return of premium on death rider	Same as base plan
Scheduled increase benefit (SIB) rider	18 to 45

Payment modes

- Annual (pre-authorized chequing and direct billing)
- Monthly (pre-authorized chequing)

Applications for critical illness coverage

Critical illness coverage may be applied for by completing one of the following two applications:

- The standalone Critical Illness Recovery Plan Application (83550 – English; 83551 – French)
- The Disability and/or Critical Illness Insurance Application as directed for critical illness (83530 – English; 83531 – French)

Critical Illness AAR Chart			
	Age 18 – 40	Age 41 – 50	Over 50
Up to $100,000	Non-Medical	Non-Medical	Blood, Urine, Vitals
$100,001 – $249,999	Non-Medical	Blood, Urine, Vitals	Blood, Urine, Vitals
$250,000 – $500,000	Blood, Urine, Vitals	Blood, Urine, Vitals	Blood, Urine, Vitals
Over $500,000	Paramedical*, Blood, Urine	Paramedical*, Blood, Urine	Paramedical*, Blood, Urine, ECG

PSA testing is obtained for all males above age 50.
* A teleinterview and vitals are acceptable in lieu of a paramedical exam.

Notes regarding critical illness insurance medical requirements

If the insured is between the ages of 18 and 40 and applying for less than or equal to $249,000, there are no medical requirements.

Otherwise, the following applies:

- Urine/HIV, electrocardiograph (ECG), blood profile, hepatitis screen, paramedical, exam by an MD are considered current for 12 months.
- Total amount of critical illness insurance coverage includes:
  – Current amount of critical illness insurance applied for;
  – Current amount of scheduled increase benefit rider applied for; and
  – Any previous amount of critical illness coverage issued, including any scheduled increase benefit rider amount and Guarantee Standard Issue® offering (also known as GSI®), since medical requirements were last satisfied.
- If applying for the scheduled increase benefit rider, the sum of all future increases must be added to the base critical illness indemnity to calculate the total amount of coverage for the purpose of determining the medical requirements.

Each time the applicant has completed the automatic medical requirements, resulting in our issuing standard coverage, eligibility for non-medical insurance is renewed. The next time the applicant applies for coverage, the in-force coverage issued as a result of the automatic medical requirements is disregarded for the purpose of determining medical requirements. Only the current amount of coverage being applied for is used to determine requirements.

Example:

A 45-year-old has $200,000 of critical illness insurance coverage in force with the scheduled increase benefit rider, issued standard. At the time of application, a blood profile, urine profile, paramedical and ECG were submitted. He is now applying for an additional $100,000 of critical illness insurance coverage. Current medical requirements: none.

- If applying for critical illness insurance, along with individual or business disability coverage, please consult the medical requirements for both critical illness insurance and individual disability coverage to determine the overall medical requirements. The highest level of automatic requirements will apply.
- Testing for hepatitis is not a routine requirement for critical illness insurance unless applying in conjunction with a request for individual or business disability coverage, where a hepatitis screen is an automatic requirement.

Family history

Due to the strong statistical correlation between family history and the risk of other family members developing some of the same critical illness conditions, family history is an important aspect of critical illness insurance underwriting. The impact of family history on underwriting varies based on the specific medical condition of the family member, the age of onset in the family member, the age of the applicant and the overall medical history of the applicant. Due to these variables, it is not possible to create simple guidelines in regard to family history. Examples of family histories that are of particular concern are early onset cardiovascular disease, early onset diabetes, early onset cancer, any history of Motor Neuron Disease and any strong family incidence or death from the same medical cause or an unusually early onset of some conditions such as Alzheimer's disease.

Financial underwriting

There are no routine financial requirements. The underwriter reserves the right to request income documentation depending on the specifics of the case. Any request for coverage in excess of $1,000,000 will require income documentation and an Inspection Report.

Individual coverage

1. **Individual coverage:**
   - Up to age 50 – we allow up to nine times the net earned income*;
   - Age 51 to 59 – we allow up to seven times the net earned income*;
   - Age 60 to 65 – we allow up to five times the net earned income* at age 60, decreasing yearly by one multiple (20%) to a minimum amount of not less than $100,000.

   * Plus the amount of personal mortgage on the house and/or cottage (if applicable).

2. **Non-working spouse coverage:** We allow 50% of the income multiple amount* on the wage earner, plus the mortgage on the house and/or cottage (if applicable). Confirmation of the amount of critical illness coverage, in force or applied for on the wage earner, is required. The amount of critical illness coverage on the non-working spouse's life generally should not exceed the spouse's coverage.

   * The income multiple amount on the wage earner is the net earned income of the wage earner multiplied by the factor (one to nine) used in determining the amount of critical illness coverage in number 1. For example: an individual age 30 earning a net income of $50,000. $50,000 x 9 = $450,000. Plus the amount of mortgage if applicable.

3. **Farm owners:** We allow up to 10 times the net earned income. Farm owners with annual earned income of $0 to $9,999 are allowed up to $100,000; farmers with a net earned loss are ineligible for coverage.

4. **Medical doctors, lawyers, notaries (Quebec) and dentists** starting in practice are allowed up to $500,000. Other new professionals (see occupations listed under Student Limits in our published Underwriting Guidelines) are allowed up to $250,000.

5. **University students** are allowed up to $250,000 coverage.

6. **Applicants on welfare or social assistance** are not eligible for coverage.

7. **Unemployed applicants or those on disability** are likely uninsurable, but individual consideration is available. Please submit a trial application.

Note: The amount of coverage is based on an applicant's actual net income, after expenses but before taxes, earned in the previous calendar year. Perk allowances are not available. For employees, the income figure is based on their salary or hourly wages.

Business coverage

1. **Business key person coverage:** We allow up to three times the net earned income of the key person. Critical illness coverage should be applied for or in force for all key persons of a firm. Individual consideration to exceed this amount is only available with full documentation on how the amount was calculated and subject to our approval. An explanation of the key person's value should be included.
2. **Business loan:** We allow coverage of up to 50% of an owner's share of a business loan, subject to our issue and participation limits. The loan must be a long term liability with a minimum five-year payback. All active owners must be insured or there must be a reasonable explanation as to why they are not. Full loan or financing details, including the reason for the loan, amount, name of lender and terms, must be provided.
3. **Line of credit:** Coverage for a line of credit, overdraft and partnership/shareholder buy sell is not available.

Note: Coverage in the amount of $500,000 or more will require financial documentation including the most recent financial statement of the business and likely an inspection and business beneficiary report.

Policy benefits

Lump sum critical illness benefit†

If after the effective date of coverage and while the policy is in force, the insured is given a diagnosis or undergoes surgery for one of the covered critical illnesses (excluding the conditions covered under the early assistance benefit) and satisfies the survival period, we will pay a lump sum critical illness benefit. Benefits are payable to the insured, unless the policyowner has declared otherwise. The minimum survival period for all covered conditions is 30 days; although some covered conditions require a period of longer than 30 days to be satisfied before benefits are payable.

The critical illnesses specifically covered by this policy are listed below. The definitions below are a summary only; for complete definitions refer to specimen policy wording available in the RBC Insurance Business Intelligence Centre.

Covered conditions

- Aortic Surgery
- Aplastic Anemia
- Bacterial Meningitis*
- Benign Brain Tumour
- Blindness
- Cancer (Life Threatening)
- Coma
- Coronary Angioplasty
- Coronary Artery Bypass Surgery
- Deafness
- Dementia including Alzheimer's Disease
- Early Breast Cancer
- Early Prostate Cancer
- Early Skin Cancer
- Early Stage Blood Cancer
- Early Stage Intestinal Cancer
- Early Thyroid Cancer
- Heart Attack
- Heart Valve Replacement or Repair
- Kidney Failure
- Loss of Independent Existence*
- Loss of Limbs
- Loss of Speech*
- Major Organ Failure on Waiting List
- Major Organ Transplant
- Motor Neuron Disease
- Multiple Sclerosis*
- Occupational HIV Infection*
- Paralysis*
- Parkinson's Disease and Specified Atypical Parkinsonian Disorders
- Severe Burns
- Stroke

* Bacterial Meningitis – 90 days; Loss of Independent Existence – 90 days; Loss of Speech – 180 days; Multiple Sclerosis – 180 days; Occupational HIV – a 30 day survival period following the diagnosis, which cannot be made until a minimum of 90 days after the accident causing the infection; Paralysis – a 30 day survival period following the diagnosis, which cannot be made until 90 days after the accidental injury.

To learn more about the covered illnesses, please contact your MGA or call your RBC Insurance Sales Consultants at 1-866-234-4332.

Note: Specialist means a licensed physician who has been trained in the specific area of medicine relevant to the covered critical illness condition and who has been certified by a specialty examining board in Canada, the United States of America or another jurisdiction as we may approve. Specialist is not you, the insured or the insured's relative or business associate. In the absence or unavailability of a Specialist, and as approved by us, a condition may be diagnosed by a qualified physician practicing in Canada, the United States of America or another jurisdiction as we may approve.

Aortic Surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a Specialist. No critical illness benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Aplastic Anemia means a definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, that results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion and treatment with at least one of the following:

- Marrow stimulating agents;
- Immunosuppressive agents;
- Bone marrow transplantation.

The diagnosis of Aplastic Anemia must be made by a Specialist.

Bacterial Meningitis means a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in a neurological deficit documented for at least 90 days from the date of diagnosis. The diagnosis of Bacterial Meningitis must be made by a Specialist. No critical illness benefit will be payable under this condition for viral meningitis.

Benign Brain Tumour means a definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause an irreversible objective neurological deficit(s). The diagnosis of Benign Brain Tumour must be made by a Specialist. No critical illness benefit will be payable under Benign Brain Tumour for pituitary adenomas less than 10 mm in thickness.

Benefits for this condition are subject to the Moratorium Period Exclusion for Benign Brain Tumour. Refer to Exclusions on page 13.

Blindness means the definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

- The corrected visual acuity being 20/200 or less in both eyes; or
- The field of vision being less than 20 degrees in both eyes.

The diagnosis of Blindness must be made by a Specialist.

Cancer (Life Threatening) means a definite diagnosis of a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of Cancer (Life Threatening) include carcinoma, melanoma, leukemia, lymphoma and sarcoma. The diagnosis of Cancer (Life Threatening) must be made by a Specialist.

The following forms of cancer are excluded:

- Lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis) or tumours classified as Ta;
- Malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- Any non-melanoma skin cancer, without lymph node or distant metastasis;
- Prostate cancer classified as T1A or T1B, without lymph node or distant metastasis;
- Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- Chronic lymphocytic leukemia classified less than Rai stage 1; or
- Malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC stage 2.

Benefits for this condition are subject to the Moratorium Period Exclusion for Cancer. Refer to Exclusions on page 13.

Coma means the definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least ninety-six (96) hours, and for which period the Glasgow coma score must be four (4) or less. The diagnosis of Coma must be made by a Specialist.

No critical illness benefit will be payable under Coma for:

- A medically induced coma;
- A coma which results directly from alcohol or drug use; or
- A diagnosis of brain death.

Coronary Angioplasty means the undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be medically necessary by a Specialist.

Coronary Artery Bypass Surgery means the undergoing of heart surgery to correct a narrowing or blockage of one or more coronary arteries with a bypass graft(s). The surgery must be determined to be medically necessary by a Specialist. No critical illness benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Deafness means the definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of ninety (90) decibels or greater within the speech threshold of five hundred to three thousand (500 to 3,000) hertz. The diagnosis of Deafness must be made by a Specialist.

Dementia including Alzheimer's Disease means the definite diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

- Aphasia (a disorder of speech);
- Apraxia (difficulty performing familiar tasks);
- Agnosia (difficulty recognizing objects); or
- Disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor and stop complex behaviour) that is affecting daily life.

The Insured Person must exhibit:

- Dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or the equivalent score on another generally medically accepted test or tests of cognitive function; and
- Evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a six-month period.

The diagnosis of Dementia must be made by a Specialist. No critical illness benefit will be payable under this condition for affective or schizophrenic disorders or delirium.

Early Breast Cancer means ductal carcinoma in situ of the breast as confirmed by biopsy and diagnosed by a Specialist.

Early Prostate Cancer means prostate cancer that is either T1A or T1B, without lymph node or distant metastasis, as confirmed by biopsy and diagnosed by a Specialist.

Early Skin Cancer means malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis as confirmed by biopsy and diagnosed by a Specialist.

Early Stage Blood Cancer means chronic lymphocytic leukemia classified less than Rai stage 1, as confirmed by appropriate blood tests and diagnosed by a Specialist.

Early Stage Intestinal Cancer means malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC stage 2, as confirmed by biopsy and diagnosed by a Specialist.

Early Thyroid Cancer means papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis, as confirmed by biopsy and diagnosed by a Specialist.

Heart Attack means the definite diagnosis of the death of heart muscle due to obstruction of blood flow that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one (1) of the following:

- Heart attack symptoms;
- New electrocardiographic (ECG) changes consistent with a heart attack; or
- Development of new Q waves during or immediately

following an intra-arterial procedure such as coronary angiography and Coronary Angioplasty.

The diagnosis of Heart Attack must be made by a Specialist.

No critical illness benefit will be payable under Heart Attack for:

- Elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and Coronary Angioplasty in the absence of new Q waves; or
- ECG changes suggesting a prior myocardial infarction that do not meet the Heart Attack definition as described above.

Heart Valve Replacement or Repair means undergoing surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a Specialist. No critical illness benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Kidney Failure means the definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular hemodialysis, peritoneal dialysis or renal transplantation is initiated. The diagnosis of Kidney Failure must be made by a Specialist.

Loss of Independent Existence means the definite diagnosis of the total inability to perform, by oneself, at least two (2) of the following six (6) Activities of Daily Living (ADL) for a continuous period of at least ninety (90) days with no reasonable chance of recovery. The diagnosis of Loss of Independent Existence must be made by a Specialist.

Activities of Daily Living are:

- Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment;
- Dressing – the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances;
- Toileting – the ability to get on and off the toilet and maintain personal hygiene;
- Bladder and Bowel Continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;
- Transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment;
- Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

Loss of Limbs means the definite diagnosis of the complete severance of two (2) or more limbs at or above the wrist or ankle joint as the result of an accidental injury or medically required amputation. The diagnosis of Loss of Limbs must be made by a Specialist.

Loss of Speech means the definite diagnosis of the total and irreversible loss of the ability to speak as the result of an accidental injury or disease for a period of at least one hundred and eighty (180) days. The diagnosis of Loss of Speech must be made by a Specialist. No critical illness benefit will be payable under Loss of Speech for all psychiatric related causes.

Major Organ Failure on Waiting List means the definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List, the insured must become enrolled as the recipient in a recognized transplant centre in Canada or the United States of America that performs the required form of transplant surgery. For the purposes of the survival period, the date of diagnosis is the date of the insured's enrolment in the transplant centre. The diagnosis of major organ failure must be made by a Specialist.

Major Organ Transplant means the definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, the insured must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow and limited to these entities. The diagnosis of the major organ failure must be made by a Specialist.

Motor Neuron Disease means the definite diagnosis of one (1) of the following:

- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease);
- Primary lateral sclerosis;
- Progressive spinal muscular atrophy;
- Progressive bulbar palsy; or
- Pseudo bulbar palsy;

and is limited to these conditions. The diagnosis of Motor Neuron Disease must be made by a Specialist.

Multiple Sclerosis means the definite diagnosis of at least one (1) of the following:

- Two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system showing multiple lesions of demyelination;
- Well-defined neurological abnormalities lasting more than six (6) months confirmed by MRI of the nervous system showing multiple lesions of demyelination; or
- A single attack, confirmed by repeated MRI imaging of the nervous system that shows multiple lesions of demyelination which have developed at intervals at least one month apart.

A diagnosis of Multiple Sclerosis must be made by a Specialist.

Occupational HIV Infection means the definite diagnosis of infection with the human immunodeficiency virus (HIV) resulting from accidental injury during the course of the insured's normal occupation which exposed the person to HIV contaminated bodily fluids. The accidental injury leading to the infection must have occurred after the later of the effective date or the date of the last reinstatement of this policy.

Payment under this condition requires satisfaction of all of the following:

- The accidental injury must be reported to us in writing within fourteen (14) days of its occurrence;
- A serum HIV test must be taken within fourteen (14) days of the accidental injury and the result must be negative;
- A serum HIV test must be taken between ninety (90) and one hundred eighty (180) days after the accidental injury and the result must be positive;
- All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America; and
- The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

The diagnosis of Occupational HIV Infection must be made by a Specialist.

No critical illness benefit will be payable under Occupational HIV Infection if:

- The insured has elected not to take any available licensed vaccine offering protection against HIV; or
- A licensed cure for HIV infection has become available prior to the accidental injury; or
- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis means the definite diagnosis of the total loss of muscle function of two (2) or more limbs as a result of accidental injury or disease to the nerve supply of those limbs, for a period of at least ninety (90) days following the precipitating event. The diagnosis of Paralysis must be made by a Specialist.

Parkinson's Disease means the definite diagnosis of primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of muscular rigidity or rest tremor. The Insured Person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.

Specified Atypical Parkinsonian Disorders means the definite diagnosis of progressive supranuclear palsy, corticobasal degeneration or multiple system atrophy.

The diagnosis of Parkinson's Disease or a Specified Atypical Parkinsonian Disorder must be made by a neurologist. No critical illness benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of Parkinsonism.

Benefits for this condition are subject to the Moratorium Period Exclusion for Parkinson's Disease and Specified Atypical Parkinsonian Disorders. Refer to Exclusions on page 13.

Severe Burns means the definite diagnosis of third degree burns over at least twenty percent (20%) of the body surface. The diagnosis of Severe Burns must be made by a Specialist.

Stroke is defined as the definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or hemorrhage, or embolism from an extra-cranial source with:

- The acute onset of new neurological symptoms; and
- New objective neurological deficits on clinical examination, persisting for more than thirty (30) days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing.

The diagnosis of Stroke must be made by a Specialist.

No critical illness benefit will be payable under Stroke for:

- Transient ischemic attacks (TIAs);
- Intracerebral vascular events due to trauma; or
- Lacunar infarcts which do not meet the definition of Stroke as defined above.

Early assistance benefit

If while the policy is in force, the insured meets the specific definition of Early Prostate Cancer, Early Breast Cancer, Early Skin Cancer, Early Stage Blood Cancer, Early Stage Intestinal Cancer, Early Thyroid Cancer, Coronary Angioplasty and completes the survival period as defined in the policy, we will pay 10% of the lump-sum critical illness benefit to a maximum of $50,000. The lump-sum critical illness benefit is not reduced by the payment of the early assistance benefit.

The early assistance benefit is payable only once to the insured, regardless of the number of critical illnesses or policies the insured may have with us.

Critical illness while outside Canada

If the insured is given a diagnosis of a defined critical illness outside Canada, we will pay the critical illness benefit as long as the following conditions are met in addition to all other terms and conditions outlined in the policy.

- The insured's medical records are made available to us and:
  - The same diagnosis would have been made if the critical illness had occurred in Canada; and
  - Immediate treatment would have been indicated under Canadian standards; and
  - The same treatment involving the particular surgical procedure would have been advised if treatment had taken place in Canada.
- The insured must undergo an independent medical examination by a physician appointed by RBC Life Insurance Company if such a request is made. In the case of elective surgery, the insured must undergo such an examination before surgery occurs, unless RBC Insurance determines otherwise.

Long term care conversion option

Without any medical evidence, the owner can convert all of, or a portion of, their critical illness coverage to a long term care policy being offered by RBC Life Insurance Company at that time.

Conversion can be elected at the attained age of 55 and each policy anniversary thereafter until the attained age of 65. Conversion is available if the critical illness coverage has been in force for at least two years; premiums are not being

waived under the disability waiver of premium rider or under the provisions of an income replacement policy issued by RBC Life Insurance Company; the insured is not satisfying a survival period; a claim for the critical illness benefit is not pending or payable; or the insured is not already unable to perform two or more Activities of Daily Living or is cognitively impaired at the time of conversion.

The amount of long term care available is dependent on our issue and participation limits and the critical illness benefit in force at the time of conversion. See the table below for the maximum convertible amounts that can be applied for.

Long Term Care Conversion Option Amounts	
Amount of critical illness coverage in force	**Maximum amount of long term care coverage available**
$25,000 but not exceeding $99,000	$110 per day (or monthly equivalent)
$100,000 but not exceeding $249,000	$150 per day (or monthly equivalent)
$250,000 but not exceeding $2,000,000	$200 per day (or monthly equivalent)

Conversion privilege (built into Term T10NC)

Without any medical evidence, the insured can convert their 10-year term (T10NC) Critical Illness Recovery Plan policy to similar coverage under one of our then eligible level premium Critical Illness Recovery Plan policies provided the original policy is in force at the time of conversion, premiums are not being waived under the disability waiver of premium rider or under the provisions of an income replacement policy issued by RBC Life Insurance Company, and the insured is not satisfying a survival period, or a claim for the critical illness benefit is not pending or payable.

The maximum age for conversion is:

- The attained age of 60 (if converting to a level premium to age 65 plan); or
- The attained age of 65 (if converting to a level premium to age 75 plan).

Following conversion to a new critical illness policy:

- Any rider issued on the original T10NC plan may be carried forward provided the rider is still available at the time of application;
- Any extra premium ratings or exclusions in the original T10NC plan will apply to the converted policy;
- The premium for the new policy will be based on our rates in effect at the time of conversion, using the insured's attained age at the time of the application for conversion; and
- The option date to exercise an early return of premium on surrender will be reset and recalculated from the effective date of the new policy.

Partial conversions

The policyowner may apply for a partial or total conversion, but the total conversion amount cannot exceed the benefit amount of the original T10NC policy. Any amount of the T10NC plan that is not converted will terminate once a partial conversion is issued.

Credit for return of premium

We will carry forward any premiums (less any premiums previously waived) on the original policy for the purpose of determining the benefit amount for the return of premium on death benefit rider (if applicable) on the new policy if a rider providing return of premium benefits (whether on death, surrender or expiry) is available and requested by the owner at the time of the application for conversion. This amount will be added to the premiums paid (less any premiums previously waived) from the effective date of conversion to the date when a return of premium benefit is payable at the critical illness benefit amount in force at that time.

Exclusions

These exclusions are in addition to the specific exclusions set out in the "Covered conditions" section of the policy. Please refer to the policy for full details.

No benefit will be paid under the policy (including any riders), nor will premiums be refunded for any critical illness, death or other loss that results, directly or indirectly, from any of the following:

- The insured's suicide, attempted suicide or intentional self-inflicted injury, whether or not the insured was in possession of his or her mental faculties at the time; or
- The insured's intentional use or intake of any drug, intoxicant, narcotic or poisonous substance except as prescribed by a physician or as directed by the manufacturer in the case of non-prescribed medication; or
- The insured's attempt to commit or commission of a crime, whether charged or not; or

- The insured's participation in war (whether such war is declared or undeclared) or hostile action of the armed forces of any country, insurrection or civil commotion; or
- The insured's operation of any land, water or air conveyance that is moved or operated by any means other than muscular power while the insured's concentration of alcohol in 100 millilitres of blood exceeds 80 milligrams or while the insured is under the influence of any drug, intoxicant, narcotic or poisonous substance except as prescribed by a physician or as directed by the manufacturer in the case of non-prescribed medication.

No benefit will be paid under the policy (including any riders), nor will any premiums be refunded for any critical illness, death or other loss that results, directly or indirectly, from any condition(s) that we have excluded by name or specific description in an endorsement or amendment to the policy.

No critical illness benefit will be paid unless the insured survives the survival period.

Moratorium Period Exclusion for Benign Brain Tumour

No critical illness benefit will be payable if within the first 90 days following the later of the effective date of the policy and the date of the last reinstatement of the policy:

- The insured has any signs, symptoms or investigations that lead to a diagnosis of a Benign Brain Tumour, regardless of when the diagnosis was made; or
- The insured has a diagnosis of a Benign Brain Tumour.

Thereafter, Benign Brain Tumour will be deemed not to be a covered critical illness under the terms of the policy; and no benefit will be payable under the policy, nor will we refund any premiums paid for the policy, if the insured suffers a critical illness or death as a direct or indirect result of any type of Benign Brain Tumour.

This medical information as described above must be reported to us within six months of the date of the diagnosis. If this information is not provided, we have the right to deny any claim for Benign Brain Tumour or any critical illness caused by Benign Brain Tumour or its treatment.

Moratorium Period Exclusion for Cancer

No critical illness benefit will be payable if within the first 90 days following the later of the effective date of the policy and the date of the last reinstatement of the policy:

- The insured has any signs, symptoms or investigations that lead to a diagnosis of cancer (covered or excluded under this policy), regardless of when the diagnosis is made; or
- The insured has a diagnosis of cancer (covered or excluded under this policy).

Thereafter, Cancer (Life Threatening), Early Breast Cancer, Early Prostate Cancer, Early Stage Blood Cancer, Early Stage Intestinal Cancer, Early Thyroid Cancer and Early Skin Cancer will be deemed not to be a critical illness under section 2.1 Covered Conditions; and no benefit will be payable under this policy, nor will we refund any premiums paid for this policy, if the insured suffers a critical illness or death as a direct or indirect result of any type of cancer including Cancer (Life Threatening), Early Breast Cancer, Early Prostate Cancer, Early Stage Intestinal Cancer, Early Thyroid Cancer or Early Skin Cancer (whether covered or excluded in this policy).

This medical information as described above must be reported to us within six months of the date of the diagnosis. If this information is not provided, we have the right to deny any claim for cancer or any critical illness caused by cancer or its treatment.

Moratorium Period Exclusion for Parkinson's Disease and Specified Atypical Parkinsonian Disorders

No critical illness benefit will be payable if within the first year following the later of the effective date of the policy and the date of the last reinstatement of the policy:

- The insured has any signs, symptoms or investigations that lead to a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of Parkinsonism, regardless of when the diagnosis was made; or
- The insured has a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of Parkinsonism.

Thereafter, Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of Parkinsonism will be deemed not to be a critical illness under section 2.1 Covered Conditions; and no benefit will be payable under this policy, nor will we refund any premiums paid for this policy, if the insured suffers a critical illness or death as a

direct or indirect result of any type of Parkinson's Disease or Specified Atypical Parkinsonian Disorders.

This medical information as described above must be reported to us within six months of the date of the diagnosis. If this information is not provided, we have the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or any critical illness caused by Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

Providing more than a claim cheque

If your client suffers a critical illness, it's understandable that their needs are not limited to financial assistance. RBC Insurance Critical Illness Recovery Plan allows you to provide a more holistic solution to their needs by including an array of Assistance Services. Assistance Services complement the RBC Insurance Critical Illness Recovery Plan policy. The program is currently provided by Teladoc Health, Ceridian Inc. and the Healing Journey/PMH Foundation. RBC Insurance does not guarantee the availability of this service before, after or at the time of claim. RBC Insurance may change or cancel access to this service at any time without notice. Assistance Services include:

- Teladoc Medical Experts‡;
- Healing the Whole Person.

Each service is designed to assist your client's recovery by addressing a common need among critical illness survivors. The policy provides more than just a claim cheque.

Having the proper resources to help your clients deal with their new reality may alleviate some of the additional stress that can keep them from focusing on their major priority – recovering from an illness. Financial security is a key component in recovering from a critical illness, but ask anyone who has been through it and many will tell you that there are less tangible feelings and challenges that are every bit as important to address.

Teladoc Medical Experts

To assist your clients in making choices about their medical treatment, RBC Insurance Critical Illness Recovery Plan policy includes a service provided by Teladoc Health – a world-leading provider specializing in medical information and services. This service can help your clients access the best possible medical experts, information and advice, without having to leave work or to travel.

While there is no obligation on their behalf, RBC Insurance Critical Illness Recovery Plan policyholders are entitled to unlimited access, and spouses and dependents can use the service once every three years – even if they do not submit a critical illness claim with the policyholder, the spouse and dependents can use the services as often as they need throughout the life of the policy. Any treatments resulting from this service will be the responsibility of the policyholder. As well, all dealings with Teladoc Medical Experts are the responsibility of the policyholder.

Services offered

There are four seamless components to the Teladoc services:

- **Expert Medical Opinion‡.** Teladoc provides your clients and their physician(s) with access to advanced, case-specific recommendations from world-renowned medical experts. More than just an expert opinion, Expert Medical Opinion complements the care your client receives from their treating physician by providing a second expert review, bringing greater certainty to the diagnosis and treatment plan. Teladoc Medical Specialists perform an in-depth analysis of medical records (including X-rays, test results, imaging scans and pathology samples) resulting in a detailed summary of findings that your clients can share with their treating physicians.
- **Find a Doctor‡.** Teladoc helps your clients find Specialists in Canada by taking into account their unique medical history and geographic location and matching them with the right doctor for their condition.
- **Care Finder‡.** If your client's medical condition requires treatment outside Canada, Care Finder will co-ordinate a search through its global database of over 50,000 medical experts from over 450 specialties and subspecialties of practice to find the expert(s) best suited to your client's needs.
- **Personal Health Navigator‡.** Teladoc can help your clients get the information, tools and resources they need when facing medical uncertainty, including condition-specific website links and articles, physician biographies, and contact information for Specialists, groups, associations and facilities that can assist your clients with their medical needs.

Healing the Whole Person

RBC Insurance will make a gift of membership in a powerful program of mental coping support to all claimants under the Critical Illness Recovery Plan policy. This program can help them successfully manage the stress associated with their illness.

Known as "The Healing Journey," this program has provided help to thousands of cancer survivors for over 20 years, and was developed by Dr. A.J. Cunningham while working at a large cancer research and treatment centre in Canada. The benefits of this program, however, are easily applied to any number of other critical illnesses.

A membership in The Healing Journey includes:

- *The Healing Journey*, a book by Dr. A.J. Cunningham – a cancer survivor himself; video tapes, focusing on different aspects of the journey; and interviews with program participants who share their experiences and reactions;
- Audio tapes for practicing the exercises;
- A workbook with a detailed written explanation of all aspects of the program; and
- Access to a website to facilitate interactions with other critical illness survivors and provide access to qualified professionals, such as Dr. A.J. Cunningham.

The program harnesses the power of the mind to help critical illness survivors deal proactively with their illness and enhance their mental and perhaps even their physical recovery. Its benefits range from overcoming fear, anxiety and depression to managing their thoughts and feelings to controlling symptoms and experiencing an improved quality of life through a positive outlook.

Optional benefits

Disability waiver of premium rider

Available with all plans.

After the insured has been disabled for 90 consecutive days, we will waive premiums that come due while the insured is disabled. We will also refund premiums paid during those first 90 days. Disabled means that, as a result of an illness or accidental injury that manifests itself after the effective date of this rider and while the policy and the rider are in force, the insured is unable to perform any occupation for which they are reasonably suited by education, training or experience.

However, if the insured owns any other RBC Insurance individual disability income protection policy, we will waive the critical illness premiums when the premiums under their individual disability income protection policy are being waived. This rider may be added to a policy up to two years after issue with appropriate medical requirements.

Return of premium on death rider

Available with all plans.

If the insured dies during the survival period or from a condition or event not defined as a critical illness, we will pay a return of premium on death benefit to the policyowner, or to the policyowner's estate in the event of the policyowner's death, as long as the Critical Illness Recovery Plan policy is in force and there is no critical illness benefit payable or pending. The return of premium on death benefit is equal to the lesser of:

- $2,000,000; and
- The sum of all premiums paid for the policy (including riders, ratings and modal loadings).

This benefit is payable to the policyowner only and cannot be assigned. It will be reduced by any premiums waived (if a disability waiver of premium rider is purchased). If death is a result of any exclusion listed in the policy, no return of premium on death benefit is payable.

Scheduled increase benefit rider

The scheduled increase benefit (SIB) rider pre-approves a future increase(s) in the critical illness benefit amount.

On every second policy anniversary and while the policy is in force, the critical illness benefit will be automatically increased by 20% of the original amount. These increases will occur over a period of 10 years. The increases cannot be declined; however, if increases are no longer required, the client may choose to terminate this rider.

The premium for each increase will be based on:

- The rate table used for the base policy and riders if the policy is non-cancellable; or the rate table in effect for the base policy and riders as of the increase date if the policy is guaranteed renewable;
- The insured's attained age; and
- The premium rate band applicable to the increased total benefit amount.

The total of the base critical illness benefit and all future SIBs cannot exceed the lesser of:

- Our published underwriting financial guidelines; and
- Our maximum issue limits.

Note:

- Any automatic increases that occur during the survival period for a critical illness or survival period for the Loss of Independent Existence condition will not apply to that claim.
- If a face amount decrease is requested prior to the first SIB increase, we will process the decrease and the SIB will be automatically recalculated based on the new face amount.
- If a face amount decrease is requested after a SIB has been processed, this rider will be removed and no further increases will be allowed.
- If premiums for the policy are being waived on any increase date, premiums for the increase will not become payable until the policy is removed from the waiver.

SIB rider is available with the following plans only:

Level premiums to age 65 (guaranteed renewable) – T65GR

Level premiums to age 75 (guaranteed renewable) – T75GR

Level premiums to age 75 (non-cancellable) – T75NC

For more information, please contact your MGA, call your **RBC Insurance Sales Consultant** at **1-866-234-4332** or visit **rbcinsurance.com/salesresourcecentre.**

RBC Insurance

This Insurance Advisor Guide is a summary only. For complete details, including terms and conditions, please refer to the policy contract.

Underwritten by RBC Life Insurance Company

† Please note that the assessment of a Critical Illness claim is often complex. As a result, until we are actually presented with a claim and given the opportunity to conduct a complete review of all the particular circumstances, the specific provisions of the particular policy in question, we are unable to determine whether or not benefits would be payable based on hypothetical circumstances. There simply are too many potential factual and contractual variations that cannot all be anticipated or taken into account in advance that may impact the assessment of a future claim.

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