



VOLUNTARY GROUP CRITICAL ILLNESS INSURANCE INSURANCE BENEFITS SUMMARY

This Insurance Benefits Summary is designed to outline the Voluntary Group Critical Illness Insurance benefits which are available to you and your spouse under Group Policy 100006151V issued to the University of Alberta by Industrial Alliance Insurance and Financial Services Inc. ("the Company") and is available to you upon request. In the event of any variation between the Group Insurance Certificate, this document and the provisions of the Group Policy, the latter will prevail. All rights with respect to the benefits of an Insured Person will be governed solely by the Group Policy which may be amended from time to time.

PLAN DESCRIPTION

Covered Condition Benefit

If an Insured Eligible Participant or Insured Spouse is diagnosed by a Specialist with a Covered Condition while his Voluntary Group Critical Illness Insurance is in force and survives for 30 days following the Date of Diagnosis or such longer period as described in certain Covered Conditions, the Company will pay such Insured Eligible Participant or Insured Spouse the Benefit Amount in force with respect to such Insured Person (the "Covered Condition Benefit"). The Date of Diagnosis must be later than the effective date of coverage. If the Insured Person dies before the approved Covered Condition Benefit is paid, the Company will pay the Covered Condition Benefit to the Insured Person's estate.

Payment of the Covered Condition Benefit for Voluntary Group Critical Illness Insurance is limited to only the first Covered Condition to occur.

AdvanceCare Benefit

If an Insured Eligible Participant or Insured Spouse is diagnosed by a Specialist with an AdvanceCare Benefit Condition while his Voluntary Group Critical Illness Insurance is in force, the Company will pay to such Insured Eligible Participant or Insured Spouse a benefit equivalent to 10% of the Benefit Amount in force with respect to such Insured Person (the "AdvanceCare Benefit"). The Date of Diagnosis of the AdvanceCare Benefit Condition must be later than the effective date of coverage. If the Insured Person dies before the approved AdvanceCare Benefit is paid, the AdvanceCare Benefit will be paid to the estate of such Insured Person. The AdvanceCare Benefit is a one-time benefit which the Company will pay for one AdvanceCare Benefit Condition only.

Payment of the AdvanceCare Benefit in respect of an Insured Person will not affect the amount of benefit payment under a subsequent Covered Condition Benefit for such person.

Voluntary Group Critical Illness Insurance for an Insured Person will continue in force during the adjudication of an AdvanceCare Benefit and following the payment of an AdvanceCare Benefit providing premiums continue to be paid as required.

Multiple Event Coverage Benefit

If an Insured Eligible Participant or Insured Spouse receives a Covered Condition Benefit under the Group Policy, and then diagnosed with a different Covered Condition in a different Multiple Event Coverage Benefit grouping ("MEC Grouping") the Company will pay to such Eligible Participant or Spouse the Benefit Amount in force with respect to such Eligible Participant or Spouse (the "Multiple Event Coverage Benefit"), subject to the terms and conditions of the Group Policy. The Insured Person must survive for 30 days following the Date of Diagnosis or such longer period as described in certain Covered Conditions to qualify for this benefit. If the Eligible Participant or Spouse dies before the approved Multiple Event Coverage Benefit is paid, the Multiple Event Coverage Benefit will be paid to the estate of such Eligible Participant or Spouse.

<u>MEC Grouping</u>	<u>Covered Condition</u>
Group 1	Cancer (Life-Threatening)
Group 2	Aortic Surgery, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement or Repair, Stroke
Group 3	Bacterial Meningitis, Benign Brain Tumour, Coma, Dementia including Alzheimer's Disease, Loss of Independent Existence, Loss of Speech, Motor Neuron Disease, Multiple Sclerosis, Paralysis, Parkinson's Disease and Specified Atypical Parkinsonian Disorders,, Stroke
Group 4	Aplastic Anemia, Kidney Failure, Major Organ Failure On Waiting List, Major Organ Transplant
Group 5	Blindness
Group 6	Deafness
Group 7	Severe Burns
Group 8	Loss of Limbs
Group 9	Occupational HIV Infection

Limitations

An Insured Eligible Participant or Insured Spouse will not be entitled to a Covered Condition Benefit for Cancer (Life-Threatening) if, within 90 days following the issue date of such insured's Voluntary Group Critical Illness Insurance coverage:

- Such Insured Person has a diagnosis of Cancer (Life-Threatening), or has any signs, symptoms or investigations leading to the Diagnosis of Cancer (Life-Threatening), regardless of when the Diagnosis is actually made. In the event of any such Diagnosis, the Covered Condition Benefit will not be paid. If the Insured Person continues to satisfy the Eligibility provisions for coverage under the Policy, Voluntary Group Critical Illness Insurance will remain in force but Cancer (Life-Threatening) will no longer be considered a Covered Condition for such Insured Person.

An Insured Eligible Participant or Insured Spouse will not be entitled to a Covered Condition Benefit for Benign Brain Tumour if, within 90 days following the issue date of an insured's Voluntary Group Critical Illness Insurance coverage:

- Such Insured Person has a diagnosis of Benign Brain Tumour, or has any signs, symptoms or investigations leading to the diagnosis of Benign Brain Tumour, regardless of when the Diagnosis is made. In the event of any such Diagnosis, the Covered Condition Benefit will not be paid. If the Insured Person continues to satisfy the Eligibility provisions for coverage under the Policy, Voluntary Group Critical Illness Insurance will remain in force but Benign Brain Tumour and all other MEC Group 3 Covered Conditions will no longer be considered Covered Conditions for such Insured Person.

An Insured Eligible Participant or Insured Spouse will not be entitled to an AdvanceCare Benefit for Early Stage Cancer if, within 90 days following the issue date of such insured's Voluntary Group Critical Illness Insurance coverage:

- Such Insured Person has a diagnosis of Early Stage Cancer, or has any signs, symptoms or investigations leading to the diagnosis of Early Stage Cancer, regardless of when the Diagnosis is made. In the event of any such Diagnosis, Voluntary Group Critical Illness Insurance will remain in force but Early Stage Cancer will be removed as an AdvanceCare Benefit Condition for such Insured Person.

Exclusions

In addition to the exclusions included within the definition of certain Covered Conditions, the following exclusions also apply:

- a) No benefit will be paid if a Covered Condition results from any Covered Condition or AdvanceCare Benefit Condition diagnosed prior to the effective date of an Insured Eligible Participant's or Insured Spouse's Voluntary Group Critical Illness Insurance;
- b) No benefit will be paid if an AdvanceCare Benefit Condition results from any AdvanceCare Benefit Condition diagnosed prior to the effective date of an Insured Eligible Participant's or Insured Spouse's Voluntary Group Critical Illness Insurance;
- c) No benefit will be paid if a Covered Condition or AdvanceCare Benefit Condition results directly or indirectly from any one or more of the following:
 - i) attempted suicide;
 - ii) taking poison or inhaling gas, whether voluntarily or involuntarily, not connected with the employment of the Insured Eligible Participant or Insured Spouse;
 - iii) taking any drug other than as prescribed by a licensed physician;
 - iv) war or full-time active service in the armed forces of any country;
 - v) flying as a student pilot or flying as a privately licensed pilot for less than 25 hours or more than 400 hours per year;
 - vi) participation in a criminal act or any attempt to commit a criminal offense, including but not limited to operating a motor vehicle while the concentration of alcohol in 100 millilitres of the Insured Eligible Participant's or Insured Spouse's blood exceeds 80 milligrams; or
 - vii) intentionally self-inflicted injury, while sane or insane.
- d) with respect to Voluntary Group Critical Illness Insurance issued to an Eligible Participant or Spouse as a result of a Special Offer or New Eligible Participant Offer, in addition to the exclusions described above, no benefit will be paid if a Covered Condition or AdvanceCare Benefit Condition results directly or indirectly from any illness, disease, mental, nervous or psychiatric condition or disorder for which any one of medical advice, treatment, service, prescribed medication, diagnosis or consultation, including consultation to investigate and/or diagnose (where diagnosis has not yet been made) was received by the Insured Eligible Participant or Insured Spouse or would have been received by a prudent individual within the 24 months immediately preceding the effective date of such person's coverage. This exclusion applies for the 24 months following the effective date of the Insured Eligible Participant's or Insured Spouse's Voluntary Group Critical Illness Insurance coverage under the Special Offer and New Eligible Participant Offer.

NOTE 1: Exclusion d) applicable to the Special Offer and New Eligible Participant Offer coverages only, will be removed in the event that an Insured Eligible Participant or Insured Spouse applies for additional Voluntary Group Critical Illness Insurance coverage which is subject to evidence of insurability and such coverage is approved by the Company.

In addition, no benefit will be paid if the Insured Eligible Participant or Insured Spouse suffer Blindness, Coma, Deafness, Loss of Limbs, Paralysis, Severe Burns or Stroke as a result, directly or indirectly, from amateur or professional boxing, bungee jumping, B.A.S.E. jumping, cliff diving, mountain climbing, motor vehicle racing or speed competition on land and/or water, parachuting or underwater activities, including scuba diving and snuba diving.

Conversion Privilege

If the Voluntary Group Critical Illness Insurance of an Insured Eligible Participant or Insured Spouse terminates as a result of such Insured Person ceasing to be eligible for insurance under the Group Policy and the Insured is not in receipt of an AdvanceCare Benefit from the Company, the Insured Person may, on or before such Insured Person's 65th birthday and without evidence of insurability, convert their terminated Voluntary Group Critical Illness Insurance to a separate critical illness policy (the "**Converted Policy**"), issued by the Company subject to the following conditions:

- a) the minimum amount of insurance in force with respect to the Insured Person on the date of termination must be \$5,000;
- b) the maximum amount of insurance under the Converted Policy will be limited to \$100,000 and the amount of coverage in force with respect to the Insured Person on the date of termination;
- c) the Insured Person must reside in Canada at the time of application and submit a completed application and the first premium to the Company within 31 days of the date of termination of such Insured Person's insurance;
- d) the Converted Policy will be of a type then issued by the Company providing term insurance to age 75;
- e) the Converted Policy will be issued without waiver of premium benefit, return of premium benefit, paid-up benefit or guaranteed increase benefit;
- f) the premium rates for the Converted Policy will be those then in effect for such policy;
- g) the premium rates will be based on the Insured Person's gender, smoker status and age at the time of conversion; and
- h) if a special provision, exclusion and/or limitation had been imposed on the Voluntary Group Critical Illness Insurance, then a comparable special provision, exclusion and/or limitation will be imposed on the Converted Policy.

DEFINITIONS

POLICY DEFINITIONS

"Academic Staff" means a person who is on the academic staff of the Employer in a benefit-eligible appointment as outlined in the collective agreements between the Association of Academic Staff University of Alberta and the Governors of the University of Alberta

"AdvanceCare Benefit Conditions" are medical conditions for which an AdvanceCare Benefit is paid under the Group Policy. These are Coronary Angioplasty or Early Stage Cancer as defined in this document.

"Affiliate Member" means a person who is in the employ of an Affiliate of the Board of Governors and is a benefit-eligible participant of St. Joseph's College, the Non-Academic Staff Association (NASA) or the Association of Academic Staff University of Alberta (AASUA).

"Age" means the attained age of an Insured Eligible Participant or Insured Spouse on each and every Renewal Date as defined in the Group Policy.

"Benefit Amount" means the amount of Voluntary Group Critical Illness Insurance for which the Insured Person has been approved by the Company as indicated in the Group Insurance Certificate issued to the Eligible Participant.

"Covered Conditions" are Aortic Surgery, Aplastic Anemia, Bacterial Meningitis, Benign Brain Tumour, Blindness, Cancer (Life-Threatening), Coma, Coronary Artery Bypass Surgery, Deafness, Dementia including Alzheimer's Disease, 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 and Stroke, as defined in the section titled *Definitions of Covered Conditions*.

"Date of Diagnosis" means the date on which a Specialist diagnoses the Insured Person with one of the Covered Conditions or one of the AdvanceCare Benefit Conditions.

"Diagnosis" means the certified diagnosis of the Insured Person with a Covered Condition or AdvanceCare Benefit Condition by a Specialist.

"Eligible Participant" means a person who is an Academic Staff member, Affiliate Member or Support Staff Employee who is hired on a continuous basis, either full-time or part-time as designated by the Employer, or who is hired full-time for a specified term period where the appointment is not less than one year in duration.

"Employer" means the Governors of the University of Alberta and its affiliated college, St. Joseph's College, and its staff associations, Non-Academic Staff Association (NASA) and Association of Academic Staff University of Alberta (AASUA).

"Insured Eligible Participant" means an Insured Person who is an Eligible Participant.

"Insured Person" means a person who is eligible and insured under the Group Policy.

"Insured Spouse" means an Insured Person who is a Spouse.

"New Eligible Participant Offer" (when applicable) means Voluntary Group Critical Illness Insurance available to a new Eligible Participant and/or their Spouse on a guaranteed issue basis during a specified enrolment period following completion of any required eligibility waiting period.

"Special Offer" (when applicable) means Voluntary Group Critical Illness Insurance available to eligible Participants and/or their Spouses on a guaranteed issue basis during a specified open enrolment period.

"Specialist" means a licensed medical practitioner who

- has been trained in the specific area of medicine relevant to the Covered Condition or AdvanceCare Benefit Condition for which a benefit is being claimed;
- has been certified by a specialty examining board; and
- is currently practicing in their area of specialty in Canada or the United States of America

Specialist includes but is not limited to: cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist. The Specialist must not be the Insured Person, a relative or business associate of the Insured Person.

In the absence or unavailability of a Specialist, and as approved by the Company, a Covered Condition or AdvanceCare Benefit Condition may be diagnosed by a qualified medical practitioner practicing in Canada or the United States of America.

"Spouse" means the legal or common-law spouse of an Eligible Participant. Legal spouse is a person who is legally married and cohabiting with the Eligible Participant and with whom there is no formal or informal agreement of separation. Common-law spouse is a person who has been cohabiting in a marriage-like relationship with the Eligible Participant for a period of not less than twelve consecutive months.

"You or your" refers to the Insured Person.

DEFINITIONS OF COVERED CONDITIONS

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 refers to the thoracic and abdominal aorta but not its branches.

The surgery must be determined to be medically necessary by a Specialist.

Exclusion: No 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, which 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 neurological deficit documented for at least 90 days from the date of Diagnosis.

The Diagnosis of Bacterial Meningitis must be made by a Specialist.

Exclusion: No 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 irreversible objective neurological deficit(s).

The Diagnosis of Benign Brain Tumour must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition if, within the first 90 days following the later of the Issue Date of coverage, or the last reinstatement date of coverage, an insured has any of the following:

- *signs, symptoms or investigations that lead to a Diagnosis of Benign Brain Tumour (covered or excluded under the Policy), regardless of when the Diagnosis is made; or*
- *a Diagnosis of Benign Brain Tumour (covered or excluded under the Policy).*

Medical Information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Benign Brain Tumour or any Critical Illness caused by any Benign Brain Tumour or its treatment.

No benefit will be payable under this condition for pituitary adenomas less than 10mm.

Blindness means a 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 include carcinoma, melanoma, leukemia, lymphoma, and sarcoma. The Diagnosis of Cancer (Life Threatening) must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition if, within the first 90 days following the later of the Issue Date of an Insured Person's coverage, or the last Reinstatement Date of an Insured Person's coverage, such Insured Person has any of the following:

- *signs, symptoms or investigations that lead to a Diagnosis of cancer (covered or excluded under the Policy), regardless of when the Diagnosis is made; or*
- *a Diagnosis of cancer (covered or excluded under the Policy).*

Medical Information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Cancer (Life Threatening) or any Critical Illness caused by any cancer or its treatment.

No benefit will be payable for the following:

- 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.

Coma means a 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 96 hours and for which period the Glasgow coma score must be 4 or less. The Diagnosis of Coma must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for:

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

Coronary Artery Bypass Surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s).

The surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures

Deafness means a definite Diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

The Diagnosis of Deafness must be made by a Specialist.

Dementia, including Alzheimer's Disease means a 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 behavior), which 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 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 6 month period.

The Diagnosis of Dementia, including Alzheimer's Disease must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for affective or schizophrenic disorders, or delirium.

Heart Attack means a 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 of the following:

- heart attack symptoms
- new electrocardiogram (ECG) changes consistent with a heart attack
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

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

Exclusions: No benefit will be payable under this condition 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, which do not meet the Heart Attack definition as described above.*

Heart Valve Replacement or Repair means the undergoing of 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.

Exclusion: No benefit will be payable under this Covered Condition for angioplasty, inter-arterial procedures, percutaneous transcatheter procedures or non-surgical procedures.

Kidney Failure means a definite Diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

The Diagnosis of Kidney Failure must be made by a Specialist.

Loss of Independent Existence means a definite Diagnosis of the total inability to perform, by oneself, at least 2 of the following 6 Activities of Daily Living for a continuous period of at least 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 assistive devices;
- dressing – the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices;
- toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
- 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 aid of assistive devices; and
- feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

Cognitive Impairment means mental deterioration and loss of intellectual ability, evidenced by deterioration in memory, orientation and reasoning, which are measurable and result from demonstrable organic cause as diagnosed by a Specialist. The degree of cognitive impairment must be sufficiently severe as to require a minimum of 8 hours of daily supervision. Determination of a Cognitive Impairment will be made on the basis of clinical data and valid standardized measures of such impairments.

Exclusion: No benefit will be payable under this condition for any mental or nervous disorder without a demonstrable organic cause.

Loss of Limbs means a definite Diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

The Diagnosis of Loss of Limbs must be made by a Specialist.

Loss of Speech means a definite Diagnosis of the total and irreversible loss of the ability to speak as a result of physical injury or disease, for a period of at least 180 days.

The Diagnosis of Loss of Speech must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for all psychiatric related causes.

Major Organ Failure on Waiting List means a 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 Person must become enrolled as the recipient in a recognized transplant center in Canada or the United States of America that performs the required form of transplant surgery. For the purpose of the Survival Period, the Date of Diagnosis is the date of the Insured Person's enrolment in the transplant centre.

The Diagnosis of the major organ failure must be made by a Specialist.

Major Organ Transplant means a 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 Person 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 a definite Diagnosis of one 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 limited to these conditions.

The Diagnosis of Motor Neuron Disease must be made by a Specialist.

Multiple Sclerosis means a definite Diagnosis of at least one of the following:

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

The Diagnosis of Multiple Sclerosis must be made by a Specialist.

Occupational HIV Infection means a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the effective date of such Insured Person's insurance coverage.

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

- The accidental injury must be reported to the Company within 14 days of the accidental injury;
- A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
- A serum HIV test must be taken between 90 days and 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;
- 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.

Exclusion: No benefit will be payable under this condition if:

- *the Insured Person 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 a definite Diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

The Diagnosis of Paralysis must be made by a Specialist.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders means a definite Diagnosis of either a) Parkinson's Disease or b) Specified Atypical Parkinsonian Disorders, as defined below.

- a) **"Parkinson's Disease"** means a definite Diagnosis of primary Parkinson's disease, a permanent neurological condition which must be characterized by bradykinesia (slowness of movement) and at least one of the following: 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.
- b) **"Specified Atypical Parkinson's Disorders"** means a 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 Specialist.

Exclusions: No benefit will be payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if, within the first year following the later of the Issue Date or the latest Reinstatement Date of an Insured Person's coverage, such Insured has any of the following:

- 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 is made; or
- a Diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of Parkinsonism.

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

No benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of Parkinsonism.

Severe Burns means a definite Diagnosis of third-degree burns over at least 20% of the body surface.

The Diagnosis of Severe Burns must be made by a Specialist.

Stroke (Cerebrovascular Accident) means a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source with:

- acute onset of new neurological symptoms, and
- new objective neurological deficits on clinical examination, persisting for more than 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.

Exclusion: No benefit will be payable under this condition for:

- *Transient Ischaemic Attacks; or*
- *Intracerebral vascular events due to trauma; or*
- Lacunar infarcts which do not meet the definition of stroke as described above.

DEFINITIONS OF ADVANCECARE BENEFIT CONDITIONS

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.

Early Stage Cancer refers to one of the following conditions:

- 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.
- Ductal Carcinoma in situ of the Breast

The Diagnosis of an Early Stage Cancer must be made by a Specialist.

CLAIMS AT TUGO

As an insured person under a Company critical illness insurance plan, you are eligible to access **Claims at TuGo**. **Claims at TuGo** is a service that provides assistance in obtaining specialized, private medical treatment at claim time. With access to treatment centres around the world, **Claims at TuGo** coordinates medical appointments and procedures with specialists and surgeons, and arranges travel and lodging, if required, at special pricing discounts.

For assistance in accessing this service, please contact **Claims at TuGo** toll-free at: 1.800.663.0399, via e-mail: claims@tugo.com, or visit tugo.com/claims. Note that utilization fees may apply.

GENERAL PROVISIONS

Termination of Insurance in Respect of an Insured Person

An Insured Eligible Participant's insurance will terminate automatically on the earliest of the following dates:

- a) the termination date of the Group Policy;
- b) the date of death of the Insured Eligible Participant;
- c) the end of the policy month coincident with or next following the date on which the Eligible Participant's employment terminates or changes so that the Eligible Participant ceases to be eligible for insurance under the Group Policy;
- d) the end of the policy month coincident with or next following an Eligible Participant's 75th birthday;
- e) the due date of any unpaid premiums; and
- f) the date that the Company receives written notice from the Eligible Participant requesting cancellation of all or part of the insurance; and
- g) the end of the policy month coincident with or next following the date on which a paid or approved self-funded leave of absence, a medical leave of absence or a maternity and/or parental leave of absence has expired and the Eligible Participant is not actively at work.

An Insured Spouse's Insurance will terminate automatically on the earliest of the following dates:

- a) the termination date of the Group Policy;
- b) the date of death of the Eligible Participant or Insured Spouse;
- c) the end of the policy month coincident with or next following the date on which the Eligible Participant's employment terminates or changes so that the Eligible Participant ceases to be eligible for insurance under the Group Policy;
- d) the end of the policy month year coincident with or next following a Spouse's 75th birthday;
- e) the due date of any unpaid premiums;
- f) the date that the Company receives written notice from the Eligible Participant requesting cancellation of all or part of the Spouse's insurance;
- g) the end of the policy month coincident with or next following the date on which an Eligible Participant's paid or approved self-funded leave of absence, a medical leave of absence or a maternity and/or parental leave of absence has expired and the Eligible Participant is not actively at work;
- h) the end of the policy month coincident with or next following the date on which he/she no longer qualifies as a Spouse.

CLAIMS PROCEDURES

Before paying a benefit under the Group Policy, we will require our claims forms to be duly completed and sent to the Company's address below. Please call us toll-free at: 1.800.266.5667 to obtain the appropriate forms and for details on claims procedures.

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act. Insurance Act means the applicable insurance legislation in the applicable provincial jurisdiction.

Note: All claims will be adjudicated according to the definition at the time of Diagnosis of the Covered Condition or the applicable AdvanceCare Benefit Condition.

QUESTIONS? WE'RE HERE TO HELP.

Contact a Client Service Specialist at:

1.800.266.5667 (toll free)
604.737.3802 (Vancouver)
solutions@ia.ca
Monday to Friday 6:30 a.m. - 4:30 p.m. Pacific Time

Or write to:

Special Markets Solutions
Industrial Alliance Insurance and Financial Services Inc.
2165 Broadway W PO Box 5900
Vancouver, BC V6B 5H6



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