



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 dependents, when insured) under Group Policy no. 100006151V issued to the University of Alberta by Industrial Alliance Insurance and Financial Services Inc. (the **Company**) which is available to you upon request. This Group Policy contains a provision removing or restricting the right of the Insured Person to designate persons to whom or for whose benefit insurance money is payable. 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.*

BENEFIT SCHEDULE

You and your Spouse are insured for benefits indicated on your Group Insurance Certificate.

PLAN DESCRIPTION

Covered Condition Benefit

If an Insured Eligible Participant or Insured Spouse is diagnosed by a Specialist with a Covered Condition while 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 Person the Voluntary Group Critical Illness Insurance Benefit Amount in force (the **Covered Condition Benefit**), subject to the terms and conditions of the Group Policy. 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 Covered Condition Benefit will be paid to the Insured Person's estate. In the event an Insured Person receives a simultaneous Diagnosis of multiple Covered Conditions, the Company will pay the Covered Condition Benefit for one Covered Condition only. The Covered Condition for which the Covered Condition Benefit is paid will be the Covered Condition which first appears in the lowest Multiple Event Coverage Benefit grouping (**MEC Grouping**) shown in the **Multiple Event Coverage Benefit** section, starting with MEC Grouping Group 1.

Cancer Recurrence Benefit

If an Insured Eligible Participant or Insured Spouse receives a Diagnosis of Cancer under the Group Policy, and thereafter the Insured Person is diagnosed with Cancer again only as described below, the Company will pay the Insured Person the Benefit Amount in force (the **Cancer Recurrence Benefit**) subject to the terms and conditions of the Group Policy. **Cancer Recurrence** means an Insured Person receives a subsequent Diagnosis of Cancer, provided that:

- a) more than 60 months have passed between the previous Cancer Date of Diagnosis and the date of the subsequent Diagnosis;
- b) the Insured Person has not received any treatment relating directly or indirectly to the previous cancer within a continuous 60-month period prior to the subsequent Diagnosis;
- c) the Insured Person does not have any new signs, symptoms or deliberate or incidental findings, during a continuous 60-month period prior to the subsequent Diagnosis, for which they sought medical investigation, consultation to investigate and/or diagnose, Diagnosis, treatment, care, medication or medical advice, or for which there were symptoms that would have caused an individual to seek the same relating to a Diagnosis of any cancer covered or excluded under the Group Policy; and
- d) both the first and subsequent diagnoses are made subsequent to the effective date of coverage under the Group Policy and prior to the termination date of coverage under the Group Policy.

Multiple Event Coverage Benefit

If an Insured Eligible Participant or Insured Spouse receives a Covered Condition Benefit under the Group Policy, and thereafter the Insured Person is diagnosed with a different Covered Condition in a different Multiple Event Coverage Benefit grouping (**MEC Grouping**), the Company will pay such Insured Person the Voluntary Group Critical Illness Insurance Benefit Amount in force (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 survival period as described in certain Covered Conditions to qualify for this benefit. If an Insured Person dies before the approved Multiple Event Coverage Benefit is paid, the Multiple Event Coverage Benefit will be paid to such Insured Person's estate.

<u>MEC Grouping</u>	<u>Covered Condition</u>
Group 1	Cancer
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

AdvanceCare Benefit

If an Insured Eligible Participant or Insured Spouse is diagnosed by a Specialist with an AdvanceCare Benefit Condition while Voluntary Group Critical Illness Insurance is in force, the Company will pay such Insured Person a benefit equivalent to 10% of the Benefit Amount in force (the **AdvanceCare Benefit**), subject to the terms and conditions of the Group Policy. The Date of Diagnosis 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 such Insured Person's estate. The AdvanceCare Benefit is a one-time benefit for which the Company will pay for one AdvanceCare Benefit Condition only. Payment of the AdvanceCare Benefit will not affect the amount of benefit payment under a Covered Condition Benefit or a Multiple Event Coverage Benefit. Voluntary Group Critical Illness Insurance 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.

Limitations

a) **Cancer**

An Insured Eligible Participant or Insured Spouse will not be entitled to a Covered Condition Benefit for Cancer if, within the first 90 days following the Issue Date of Voluntary Group Critical Illness Insurance coverage, such Insured Person has a Diagnosis of Cancer, or has any signs, symptoms or investigations leading to the Diagnosis of Cancer, regardless of when the Diagnosis is actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If the Insured Person continues to satisfy the eligibility provisions for coverage under the Group Policy, Voluntary Group Critical Illness Insurance will remain in force but Cancer in MEC Grouping 1 will no longer be considered a Covered Condition for such Insured Person.

b) **Benign Brain Tumour**

An Insured Eligible Participant or Insured Spouse will not be entitled to a Covered Condition Benefit for Benign Brain Tumour if, within the first 90 days following the Issue Date of 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 actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If the Insured Person continues to satisfy the eligibility provisions for coverage under the Group Policy, Voluntary Group Critical Illness Insurance will remain in force but Benign Brain Tumour and all Covered Conditions in MEC Grouping 3 will no longer be considered Covered Conditions for such Insured Person.

c) **Multiple Sclerosis**

An Insured Eligible Participant or Insured Spouse will not be entitled to a Covered Condition Benefit for Multiple Sclerosis if, within the first year following the Issue Date of Voluntary Group Critical Illness Insurance coverage, such Insured Person has a Diagnosis of Multiple Sclerosis, or has any signs, symptoms or investigations leading to the Diagnosis of Multiple Sclerosis, regardless of when the Diagnosis is actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If the Insured Person continues to satisfy the eligibility provisions for coverage under the Group Policy, Voluntary Group Critical Illness Insurance will remain in force but Multiple Sclerosis and all Covered Conditions in MEC Grouping 3 will no longer be considered Covered Conditions for such Insured Person.

d) **Parkinson's Disease and Specified Atypical Parkinsonian Disorders**

An Insured Eligible Participant or Insured Spouse will not be entitled to a Covered Condition Benefit for Parkinson's Disease and Specified Atypical Parkinsonian Disorders if, within the first year following the Issue Date of Voluntary Group Critical Illness Insurance coverage, such Insured Person has a Diagnosis of Parkinson's Disease and Specified Atypical Parkinsonian Disorders, or has any signs, symptoms or investigations leading to the Diagnosis of Parkinson's Disease and Specified Atypical Parkinsonian Disorders, regardless of when the Diagnosis is actually made. In the event of such Diagnosis, the Covered Condition Benefit will not be paid. If the Insured Person continues to satisfy the eligibility provisions for coverage under the Group Policy, Voluntary Group Critical Illness Insurance will remain in force but Parkinson's Disease and Specified Atypical Parkinsonian Disorders, and all Covered Conditions in MEC Grouping 3 will no longer be considered Covered Conditions for such Insured Person.

e) **AdvanceCare Benefit**

An Insured Eligible Participant or Insured Spouse will not be entitled to an AdvanceCare Benefit for Early Stage Cancer if, within the first 90 days following the Issue Date of 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 Person'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 Person'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 any drug other than as prescribed by a licensed physician;
 - iii) taking poison or inhaling gas, whether voluntarily or involuntarily, not connected with the Insured Person's employment;
 - 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 Person's blood exceeds 80 milligrams; or
 - vii) intentionally self-inflicted injury, regardless of any impairment, illness, or state of mind.
- d) with respect to Voluntary Group Critical Illness Insurance issued 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 a Pre-existing Condition. A **Pre-existing Condition** means any symptom, condition, disorder, illness, pre-disease or disease, or any 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 Person or would have been received by a prudent individual within the 24 months immediately preceding the effective date of such Insured Person's coverage. This exclusion applies for the 24 months following the effective date of the Insured Person's Voluntary Group Critical Illness Insurance coverage under the Special Offer or New Eligible Participant Offer.

NOTE: Exclusion d) applicable to the Special Offer and New Eligible Participant Offer coverages only, will be removed with respect to an Insured Eligible Participant or Insured Spouse in the event that such Insured Person 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 Person suffers 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 Person has not received a Covered Condition Benefit nor an AdvanceCare Benefit from the Company, the Insured Person may, before their 65th birthday and without evidence of insurability, convert their terminated Voluntary Group Critical Illness Insurance to a separate critical illness policy (the **Converted Coverage**), 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 Coverage will be limited to the lesser amount of \$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 Coverage will be of a type then issued by the Company providing term insurance to age 75;
- e) the Converted Coverage 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 Coverage 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 Coverage.

DEFINITIONS

POLICY DEFINITIONS

AdvanceCare Benefit Conditions are medical conditions for which an AdvanceCare Benefit is paid under the Group Policy with respect to an Insured Eligible Participant or Insured Spouse. These are Coronary Angioplasty or Early Stage Cancer as defined in this document.

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

Covered Conditions with respect to an Insured Eligible Participant and Insured Spouse are Aortic Surgery, Aplastic Anemia, Bacterial Meningitis, Benign Brain Tumour, Blindness, Cancer, 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, with Cancer Recurrence, or with one of the AdvanceCare Benefit Conditions.

Diagnosis means the certified Diagnosis of the Insured Person with a Covered Condition, with Cancer Recurrence or with one of the AdvanceCare Benefit Conditions by a Specialist.

Eligible Participant means a person who is a Non-Union Employee (Academic Administrators, Continuing or Temporary) as defined in the Group Policy.

Employer means the Governors of the University of Alberta.

Insured Eligible Participant means an Insured Person (you) who is an Eligible Participant.

Insured Person means an Eligible Participant 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 acceptance basis during a specified enrolment period following completion of any required eligibility waiting period.

Non-Union Employee (Academic Administrators, Continuing or Temporary) means a person who is a non-union employee of the Employer as defined in the Group Policy. The terms of employment for such a person are subject to the University of Alberta Handbook of Terms and Conditions for Employment for Non-Union Employees.

Special Offer (when applicable) means Voluntary Group Critical Illness Insurance available to Eligible Participants and/or their Spouse on a guaranteed acceptance 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 and any medical professional performing any tests or examinations required to satisfy the Covered Condition requirements 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 your legal or common-law spouse. Legal spouse is a person who is legally married and cohabiting with you 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 you for a period of not less than twelve consecutive months.

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 means 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; or
- 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 the presence of pathogenic bacteria. The presence of pathogenic bacteria must be confirmed by culture or other generally medically accepted microbiological testing. The Bacterial Meningitis must result in objective neurological deficits persisting for at least 90 days from the Date of Diagnosis.

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

For purposes of the Group Policy, neurological deficits must be detectable by the Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

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).

These deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location and timing with the neurological deficits.

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

For purposes of the Group Policy, neurological deficits must be detectable by the Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

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

- Pituitary adenomas less than 10 mm;
- Vascular malformations;
- Cholesteatomas; or
- Infectious or inflammatory tumours.

90-Day 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 Benign Brain Tumour (covered or excluded under the Group Policy), regardless of when the Diagnosis is made; or
- A Diagnosis of Benign Brain Tumour (covered or not covered under the Group 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.

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 means the definite Diagnosis of a malignant tumour. This tumour 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 must be made by a Specialist and must be confirmed by a pathology report.

For purposes of the Group Policy:

- T1a or T1b prostate cancer means a clinically inapparent tumour that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue.
- The term gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1 means:
 - Gastric and omental GISTs that are less than or equal to 10 cm in greatest dimension with five or fewer mitoses per 5 mm², or 50 per HPF; or
 - Small intestinal, esophageal, colorectal, mesenteric and peritoneal GISTs that are less than or equal to 5 cm in greatest dimension with 5 or fewer mitoses per 5 mm², or 50 per HPF;
- The terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 1 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018.
- The term Rai stage 0 is as defined in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219,1975.

Exclusions: No benefit will be payable under this Covered Condition for the following:

- Lesions described as benign, non-invasive, pre-malignant, of low and/or uncertain malignant potential, borderline, carcinoma in situ, or tumors classified as Tis or Ta;
- Malignant melanoma of skin that is less than or equal to 1.0mm 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. This includes but is not limited to, cutaneous T cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma;
- 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 2.0cm in greatest dimension and classified as T1, without lymph node or distant metastasis;

- *Chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;*
- *Gastro-intestinal stromal tumours classified as AJCC Stage 1;*
- *Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormonal oversecretion by the tumour; or*
- *Thymomas (stage 1) confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus.*

90-Day 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, the Insured Person has any of the following:

- *Signs, symptoms or investigations leading directly or indirectly to a diagnosis of any cancer (covered or not covered under the Group Policy), regardless of when the diagnosis is made; or*
- *A diagnosis of any cancer (covered or not covered under the Group 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 or any critical illness caused by any cancer or its treatment.

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.

For purposes of the Group Policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res. 1975;12(3):189.

Heart Attack (acute myocardial infarction) 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:

- *ECG changes suggestive of a prior myocardial infarction;*
- *Other acute coronary syndromes, including angina pectoris and unstable angina; or*
- *Elevated cardiac biomarkers and/or symptoms that are due to medical procedures or diagnoses other than heart attack.*

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 trans-catheter 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, due to disease or injury, to perform independently, with or without the aid of assistive devices, at least 3 of 6 Activities of Daily Living listed below for a continuous period of at least 90 days with no reasonable chance of recovery. The Diagnosis must be made by a physician and supported by an independent home care assessment made by an occupational therapist or equivalent.

Activities of Daily Living are as follows:

Bathing: washing oneself in a bathtub, shower or by sponge bath;

Dressing: putting on and removing necessary clothing, braces, artificial limbs or other surgical appliances;

Toileting: getting on and off the toilet and maintaining personal hygiene;

Bladder and bowel continence: managing one's bladder and bowel function with or without protective undergarments or surgical appliances so that hygiene is maintained;

Transferring: moving in and out of a bed, chair or wheelchair;

Feeding: consuming food or drink that already has been prepared and made available.

No additional survival period is required once the conditions described above are satisfied.

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;
- A single attack, with objective neurological deficits lasting more than 6 months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or,
- A single attack, confirmed by repeated MRI 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.

For purposes of the Group Policy, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable for the following:

- *Solitary sclerosis;*
- *Clinically isolated syndrome;*
- *Radiologically isolated syndrome;*
- *Neuromyelitis optica spectrum disorders; or*
- *Suspected multiple sclerosis or probable multiple sclerosis.*

1-Year Exclusion: No benefit will be payable under this Covered Condition if, within the first year following the later of the Issue Date of an Insured Person's coverage or the last reinstatement date of an Insured Person's coverage, the Insured Person has any of the following:

- *Signs, symptoms or investigations leading directly or indirectly to a diagnosis of multiple sclerosis (covered or not covered under the Group Policy) regardless of when the diagnosis is made; or*
- *A diagnosis of multiple sclerosis (covered or not covered under the Group 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 Multiple Sclerosis or, any critical illness caused by multiple sclerosis or its treatment.

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;*
- *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 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. Specified Atypical Parkinsonian Disorders are defined as 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.

1-Year Exclusion: 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 Person 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 resulting in persistent neurological deficits) means a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis, haemorrhage, or embolism 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 showing changes that are consistent in character, location and timing with the new neurological deficits.

The Diagnosis of Stroke must be made by a Specialist.

For purposes of the Group Policy, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

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

- *Transient Ischaemic Attacks;*
- *Intracerebral vascular events due to trauma;*
- *Ischaemic disorders of the vestibular syndrome;*
- *Death of tissue of the optic nerve or retina without total loss of vision of that eye; 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;
- 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 as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;
- Gastrointestinal stromal tumours classified as AJCC Stage 1;
- Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormone oversecretion by the tumour;
- Thymomas (Stage 1), confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus; or
- 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. **Claims at TuGo** coordinates medical appointments and procedures with specialists and surgeons at special pricing discounts.

For assistance in accessing this service, please visit www.tugo.com/tms.

Note that utilization fees may apply.

GENERAL PROVISIONS

Termination of Your Insurance

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 month coincident with or next following the date on which the Insured Eligible Participant's employment terminates or changes so that the Insured Eligible Participant ceases to be eligible for insurance under the Group Policy;
- d) the date an Insured Eligible Participant, under age 65 and residing in Québec, is no longer covered under a private drug plan provided by the Policyholder, as required by the Québec Act respecting prescription drug insurance;
- e) the end of the month coincident with or next following the Insured Eligible Participant's 75th birthday;
- f) the due date of any unpaid premiums;
- g) the end of the month coincident with or next following the date the Company receives written notice from the Insured Eligible Participant requesting cancellation of all or part of the insurance; and
- h) the end of the month coincident with or next following the date on which a leave of absence has expired, and the Insured 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 Insured Eligible Participant or Insured Spouse;
- c) the end of the month coincident with or next following the date on which the Insured Eligible Participant's employment terminates or changes so that the Insured Eligible Participant ceases to be eligible for insurance under the Group Policy;
- d) the end of the month coincident with or next following the Insured Spouse's 75th birthday;
- e) the due date of any unpaid premiums;
- f) the end of the month coincident with or next following the date the Company receives written notice from the Insured Eligible Participant requesting cancellation of all or part of the Spouse's insurance;
- g) the end of the month coincident with or next following the date on which a leave of absence has expired, and the Insured Eligible Participant is not actively at work; and
- h) the end of the month coincident with or next following the date on which they no longer qualify as a Spouse.

Important note regarding termination of your coverage:

You must advise our office in writing once you and/or your Insured Spouse are no longer eligible for coverage under the Group Policy, if applicable.

Depending on when the Company is advised, the premium payor may be eligible to receive a premium refund of up to 3 months, if applicable.

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 of the Covered Condition or the AdvanceCare Benefit Condition applicable at the time of Diagnosis.

QUESTIONS? WE'RE HERE TO HELP.

Contact a Client Service Specialist at:

1.800.266.5667 (toll free)

604.737.3802 (Vancouver)

SpecialMarkets@ia.ca

Monday to Friday 6:30 a.m. - 4:30 p.m. Pacific Time

Or write to:

iA Special Markets

Industrial Alliance Insurance and Financial Services Inc.

400 - 988 W Broadway PO Box 5900

Vancouver, BC V6B 5H6

Or visit our website at:

specialmarkets.ia.ca/uofaemployees



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