



BASIC GROUP CRITICAL ILLNESS INSURANCE INSURANCE BENEFITS SUMMARY

This Insurance Benefits Summary is designed to outline the benefits for which you are eligible under Group Policy No. 100006151B 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 this document and the provisions of the Group Policy, the latter will prevail. All rights with respect to the benefits of an Insured Eligible Participant will be governed solely by the Group Policy which may be amended from time to time.

PLAN DESCRIPTION

Eligibility

Eligible Participants who meet the eligibility requirements defined in the Group Policy issued to the University of Alberta are eligible for coverage.

Benefit Amount

All Eligible Participants are insured for Basic Group Critical Illness Insurance in the amount of \$10,000.

Covered Condition Benefit

If an Insured Eligible Participant is diagnosed by a Specialist with a Covered Condition while his Basic 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 to such Insured Eligible Participant the Benefit Amount in force with respect to such Insured Eligible Participant (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 or latest reinstatement date of the coverage. If the Insured Eligible Participant dies before the approved Covered Condition Benefit is paid, the Covered Condition Benefit will be paid to the estate of such Insured Eligible Participant. In the event an Insured Eligible Participant 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.

Multiple Event Coverage Benefit

If an Insured Eligible Participant receives a Covered Condition Benefit under the Group Policy, and thereafter the Eligible Participant is diagnosed with a different Covered Condition in a different Multiple Event Coverage Benefit grouping ("**MEC Grouping**"), the Company will pay to such Insured Eligible Participant the Benefit Amount in force with respect to such Insured Eligible Participant (the "**Multiple Event Coverage Benefit**"), subject to the terms and conditions of the Group Policy. The Insured Eligible Participant 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 the Insured Eligible Participant dies before the approved Multiple Event Coverage Benefit is paid, the Multiple Event Coverage Benefit will be paid to the estate of such Insured Eligible Participant.

MEC Grouping

Covered Condition

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

AdvanceCare Benefit

If an Insured Eligible Participant is diagnosed by a Specialist with an AdvanceCare Benefit Condition while his Basic Group Critical Illness Insurance is in force, the Company will pay to such Insured Eligible Participant a benefit equivalent to 10% of the Benefit Amount in force with respect to such Insured Eligible Participant (the "**AdvanceCare Benefit**"), subject to the terms and conditions of the Group Policy. The Date of Diagnosis must be later than the effective date or latest reinstatement date of the coverage. If the Insured Eligible Participant dies before the approved AdvanceCare Benefit is paid, the AdvanceCare Benefit will be paid to the estate of such Insured Eligible Participant. 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. Basic Group Critical Illness Insurance for an Insured Eligible Participant 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

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

- Such Eligible Participant 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 Eligible Participant continues to satisfy the Eligibility provisions for coverage under the Policy, Basic Group Critical Illness Insurance will remain in force but Cancer (Life-Threatening) will no longer be considered a Covered Condition for such Eligible Participant.

An Insured Eligible Participant 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 Basic Group Critical Illness Insurance coverage:

- Such Eligible Participant 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 Eligible Participant continues to satisfy the Eligibility provisions for coverage under the Policy, Basic 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 Eligible Participant.

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

- Such Eligible Participant 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, Basic Group Critical Illness Insurance will remain in force but Early Stage Cancer will be removed as an AdvanceCare Benefit Condition for such Eligible Participant.

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 Basic 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 Basic 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;
 - 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 blood exceeds 80 milligrams; or
 - vii) intentionally self-inflicted injury, while sane or insane.

In addition, no benefit will be paid if the Insured Eligible Participant suffers Blindness, Coma, Deafness, Loss of Limb, 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.

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).

"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 Eligible Participant with one of the Covered Conditions or one of the AdvanceCare Benefit Conditions.

"Diagnosis" means the certified diagnosis of the Insured Eligible Participant with a Covered Condition or one of the AdvanceCare Benefit Conditions by a Specialist.

"Eligible Participant" means a person who is an Academic Staff member, Affiliate Member or Support Staff Employee.

"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 a person who is eligible and insured for Basic Group Critical Illness under the Group Policy.

"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 Eligible Participant, a relative or business associate of the Insured Eligible Participant.

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.

"Support Staff Employee" means a person who is on the support staff of the Employer in a benefit eligible appointment as outlined in the collective agreement between the Non-Academic Staff Association and the Governors of the University of Alberta.

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 transcatheter 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 coverage, or the last reinstatement date of coverage, the insured 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)
- aphraxia (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 Eligible Participant 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 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 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.

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 Eligible Participant 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 Eligible Participant'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 Eligible Participant 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 Eligible Participant's coverage, such Insured Eligible Participant 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 will apply.

GENERAL PROVISIONS

Termination of Insurance in Respect of an Insured Person

The Basic Group Critical Illness Insurance in respect of an Insured Eligible Participant 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 date on which the Insured Eligible Participant's employment terminates or changes so that he ceases to be eligible for insurance under the Group Policy;
- d) the date on which a paid sabbatical leave, paid special leave of absence, paid medical leave of absence, paid assisted leave of absence, paid professional or secondment leave of absence, paid compassionate leave of absence or a maternity and/or parental leave of absence has expired and the Insured Eligible Participant is not actively at work.

Conversion Privilege

If the Basic Group Critical Illness Insurance of an Insured Eligible Participant terminates as a result of such Insured Eligible Participant ceasing to be eligible for insurance under the Group Policy and the Insured Person is not in receipt of a Covered Condition Benefit or AdvanceCare Benefit from the Company, the Insured Eligible Participant may, on or before such Eligible Participant's 65th birthday and without evidence of insurability, convert such Eligible Participant's terminated Basic 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 Eligible Participant 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 Eligible Participant on the date of termination;
- c) the Insured Eligible Participant 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 Eligible Participant'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 Eligible Participant'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 Basic Group Critical Illness Insurance, then a comparable special provision, exclusion and/or limitation will be imposed on the Converted Policy.

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)
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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