COVERED CONDITIONS AND SURGERIES

Category 1 – Covered Conditions and Surgeries

Cancer

Cancer means a definite Diagnosis of a malignant 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.

For payment to be made under this benefit, the Diagnosis of Cancer must be made by a Specialist and must be confirmed by a pathology report.

For purposes of this benefit,

a) **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.

b) The term **Gastrointestinal Stromal Tumours (GIST) Classified as AJCC Stage 1** means:

   i) Gastric and omental GISTs that are less than or equal to 10 cm in greatest dimension with five or fewer mitoses per 5 mm^2, or 50 per HPF; or

   ii) 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 mm^2, or 50 per HPF;

c) The terms "Tis, Ta, T1a, T1b, T1 and AJCC Stage 1" are to be applied as defined in the American Joint Committee on Cancer (AJCC) Cancer Staging Manual, 8th Edition, 2018.

d) The term Rai stage 0 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 payment will be made under this benefit if, within the first 90 Days following the later of the date the Participant became insured under this benefit or the last reinstatement date of a Participant's coverage, such Participant has any of the following:

a) Signs, symptoms or investigations that lead directly or indirectly to a Diagnosis of any Cancer (covered or excluded under this benefit), regardless of when the Diagnosis is made; or

b) A Diagnosis of any Cancer (covered or excluded under this benefit).

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the insurer within 6 months of the Date of Diagnosis. If this information is not provided within this period, the insurer has the right to deny any claim for Cancer or any critical illness caused by any Cancer or its treatment.

No payment will be made under this benefit for the following:

a) Lesions described as benign, non-invasive, pre-malignant, of low and/or uncertain malignant potential, borderline, carcinoma in-situ, or tumours classified as Tis or Ta;

b) Malignant melanoma skin Cancer that is less than or equal to 1 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;

c) Any non-melanoma skin Cancer, without lymph node or distant metastasis, including but not limited to cutaneous T cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma;

d) Prostate Cancer classified as T1a or T1b, without lymph node or distant metastasis;

e) Papillary thyroid Cancer or follicular thyroid Cancer, or both, that is less than or equal to 2 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;

f) 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;

g) Gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1;

h) 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

i) Thymomas (stage 1) confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus.

Limitation for Category 1 – Covered Conditions and Surgeries

Once a benefit has become payable for a covered condition or Surgery covered under Category 1, the Participant will not be insured under this benefit for any future covered conditions or Surgeries specified under Category 1.

Category 2 – Covered Conditions and Surgeries

Aortic Surgery

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.

For payment to be made under this benefit, the Surgery must be determined to be Medically Required by a Specialist.

Exclusions

No payment will be made under this benefit for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Coronary Artery Bypass Surgery

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).

For payment to be made under this benefit, the Surgery must be determined to be Medically Required by a Specialist.

Exclusions

No payment will be made under this benefit for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Heart Attack

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 cardiac biomarkers to levels considered diagnostic of myocardial infarction, with at least one of the following:

a) Heart Attack symptoms;

b) New electrocardiogram (ECG) changes consistent with a Heart Attack;

c) Development of new pathological Q waves on ECG following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and Coronary Angioplasty.

For payment to be made under this benefit, the Diagnosis of Heart Attack must be made by a Specialist.

Exclusions

No payment will be made under this benefit for:

a) ECG changes suggesting a prior myocardial infarction; or

b) Other acute coronary syndromes, including angina pectoris and unstable angina; or

c) Elevated cardiac biomarkers and/or symptoms that are due to medical procedures or diagnoses other than Heart Attack.

Heart Valve Replacement or Repair

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.

For payment to be made under this benefit, the Surgery must be determined to be Medically Required by a Specialist.

Exclusions

No payment will be made under this benefit for angioplasty, inter-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Limitation for Category 2 – Covered Conditions and Surgeries

Once a benefit has become payable for a covered condition or Surgery covered under Category 2, the Participant will not be insured under this benefit for any future covered conditions or Surgeries specified under Category 2.

Notwithstanding the above, once a benefit has become payable for a Stroke, the Participant will not be insured under this benefit for any future covered conditions or Surgeries specified under Category 2 or Category 3.

Category 3 – Covered Conditions and Surgeries

Bacterial Meningitis

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.

For payment to be made under this benefit, the Diagnosis of Bacterial Meningitis must be made by a Specialist.

For the purposes of this benefit, 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 payment will be made under this benefit for viral meningitis.

Benign Brain Tumour

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 Participant must have undergone Surgery or radiation treatment, or the tumour must have caused Irreversible objective neurological deficits.

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

For payment to be made under this benefit, the Diagnosis of Benign Brain Tumour must be made by a Specialist.

For the purposes of this benefit, 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 payment will be made under this benefit if, within the first 90 Days following the later of the date the Participant became insured under this benefit or the last reinstatement date of a Participant's coverage, such Participant has any of the following:

a) Signs, symptoms or investigations that lead directly or indirectly to a Diagnosis of any Benign Brain Tumour (covered or excluded under this benefit), regardless of when the Diagnosis is made; or

b) A Diagnosis of any Benign Brain Tumour (covered or excluded under this benefit).

Medical Information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the insurer within 6 months of the Date of Diagnosis. If this information is not provided within this period, the insurer 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 payment will be made under this benefit for pituitary adenomas less than 10 mm, vascular malformations, cholesteatomas or infectious or inflammatory tumours.

Coma

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.

For payment to be made under this benefit, the Diagnosis of Coma must be made by a Specialist.

Exclusions

No payment will be made under this benefit for:

a) A medically induced Coma; or

b) A Coma which results directly from alcohol or drug use; or

c) A Diagnosis of brain death.

Dementia, including Alzheimer's Disease

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:

a) Aphasia (a disorder of speech);

b) Apraxia (difficulty performing familiar tasks);

c) Agnosia (difficulty recognizing objects);

d) 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 Participant must exhibit:

a) 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

b) Evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6 month period.

For payment to be made under this benefit, the Diagnosis of Dementia, including Alzheimer's Disease must be made by a Specialist.

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

Exclusions

No payment will be made under this benefit for affective or schizophrenic disorders, or delirium.

Loss of Independent Existence

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 the following 6 Activities of Daily Living for a continuous period of at least 90 Days with no reasonable chance of recovery.

For payment to be made under this benefit, the Diagnosis of Loss of Independent Existence 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:

a) **Bathing:** the ability to wash oneself in a bathtub, shower or by sponge bath;

b) **Dressing:** the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances;

c) **Toileting:** the ability to get on and off the toilet and maintain personal hygiene;

d) **Bladder and bowel continence:** the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that hygiene is maintained;

e) **Transferring:** the ability to move in and out of a bed, chair or wheelchair;

f) **Feeding:** the ability to consume 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 Speech

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.

For payment to be made under this benefit, the Diagnosis of Loss of Speech must be made by a Specialist.

Exclusions

No payment will be made under this benefit for all psychiatric related causes.

Motor Neuron Disease

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.

For payment to be made under this benefit, the Diagnosis of Motor Neuron Disease must be made by a Specialist.

Multiple Sclerosis

Multiple Sclerosis means a definite Diagnosis of at least one of the following occurring after the later of the date the Participant became insured under this benefit, or the date of the last reinstatement of a Participant's coverage:

a) Two or more separate clinical attacks, confirmed by at least one magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or

b) 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

c) 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.

For payment to be made under this benefit, the Diagnosis of Multiple Sclerosis must be made by a Specialist.

For the purposes of this benefit, 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.

Exclusions

No payment will be made under this benefit if, within the first year following the later of the date the Participant became insured under this benefit or the last reinstatement date of a Participant's coverage, such Participant has any of the following:

a) Signs, symptoms or investigations that lead directly or indirectly to a Diagnosis of Multiple Sclerosis (covered or excluded under this benefit), regardless of when the Diagnosis is made; or

b) A Diagnosis of Multiple Sclerosis (covered or excluded under this benefit).

Medical Information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the insurer within 6 months of the Date of Diagnosis. If this information is not provided within this period, the insurer has the right to deny any claim for Multiple Sclerosis or any critical illness caused by Multiple Sclerosis or its treatment.

No payment will be made under this benefit for:

a) Solitary sclerosis; or

b) Clinically isolated syndrome; or

c) Radiologically isolated syndrome; or

d) Neuromyelitis optica spectrum disorders; or

e) Suspected Multiple Sclerosis of probable Multiple Sclerosis.

Paralysis

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.

For payment to be made under this benefit, the Diagnosis of Paralysis must be made by a Specialist.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders

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 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 Parkinsonian Disorders means a definite Diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

For payment to be made under this benefit, the Diagnosis of Parkinson's Disease or a Specified Atypical Parkinsonian Disorder must be made by a Neurologist.

Exclusions

No payment will be made under this benefit if, within the first year following the later of the date the Participant became insured under this benefit or the last reinstatement date of a Participant's coverage, such Participant has any of the following:

a) Signs, symptoms or investigations that lead directly or indirectly 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

b) 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 insurer within 6 months of the Date of Diagnosis. If this information is not provided within this period, the insurer has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

No payment will be made under this benefit for any other type of parkinsonism.

Stroke

Stroke (cerebrovascular accident resulting in persistent neurological deficits) means a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism, with:

a) Acute onset of new neurological symptoms, and

b) 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.

For payment to be made under this benefit, the Diagnosis of Stroke must be made by a Specialist.

For the purposes of this benefit, 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.

Exclusions

No payment will be made under this benefit for:

a) Transient Ischaemic Attacks; or

b) Intracerebral vascular events due to trauma; or

c) Ischaemic disorders of the vestibular system; or

d) Death of tissue of the optic nerve or retina without total loss of vision of that eye; or

e) Lacunar infarcts which do not meet the definition of stroke as described above.

Limitation for Category 3 – Covered Conditions and Surgeries

Once a benefit has become payable for a covered condition or Surgery covered under Category 3, the Participant will not be insured under this benefit for any future covered conditions or Surgeries specified under Category 3.

Notwithstanding the above, once a benefit has become payable for a Stroke, the Participant will not be insured under this benefit for any future covered conditions or Surgeries specified under Category 2 or Category 3.

Category 4 – Covered Conditions and Surgeries

Aplastic Anemia

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:

a) Marrow stimulating agents; or

b) Immunosuppressive agents; or

c) Bone marrow transplantation.

For payment to be made under this benefit, the Diagnosis of Aplastic Anemia must be made by a Specialist.

Kidney Failure

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.

For payment to be made under this benefit, the Diagnosis of Kidney Failure must be made by a Specialist.

Major Organ Failure on Waiting List

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 Required. To qualify under Major Organ Failure on Waiting List, the Participant must become enrolled as the recipient in a recognized transplant center in Canada or the United States that performs the required form of transplant Surgery. For the purposes of the Survival Period, the Date of Diagnosis is the date of the Participant's enrollment in the transplant centre.

For payment to be made under this benefit, the Diagnosis of the major organ failure must be made by a Specialist.

Major Organ Transplant

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 Required. To qualify under Major Organ Transplant, the Participant must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

For payment to be made under this benefit, the Diagnosis of the major organ failure must be made by a Specialist.

Limitation for Category 4 – Covered Conditions and Surgeries

Once a benefit has become payable for a covered condition or Surgery covered under Category 4, the Participant will not be insured under this benefit for any future covered conditions or Surgeries specified under Category 4.

Category 5 – Covered Conditions and Surgeries

Blindness

Blindness means a definite Diagnosis of the total and Irreversible loss of vision in both eyes, evidenced by:

a) The corrected visual acuity being 20/200 or less in both eyes; or

b) The field of vision being less than 20 degrees in both eyes.

For payment to be made under this benefit, the Diagnosis of Blindness must be made by a Specialist.

Limitation for Category 5 – Covered Conditions and Surgeries

Once a benefit has become payable for a covered condition or Surgery covered under Category 5, the Participant will not be insured under this benefit for any future covered conditions or Surgeries specified under Category 5.

Category 6 – Covered Conditions and Surgeries

Deafness

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.

For payment to be made under this benefit, the Diagnosis of Deafness must be made by a Specialist.

Limitation for Category 6 – Covered Conditions and Surgeries

Once a benefit has become payable for a covered condition or Surgery covered under Category 6, the Participant will not be insured under this benefit for any future covered conditions or Surgeries specified under Category 6.

Category 7 – Covered Conditions and Surgeries

Severe Burns

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

For payment to be made under this benefit, the Diagnosis of Severe Burns must be made by a Specialist.

Limitation for Category 7 – Covered Conditions and Surgeries

Once a benefit has become payable for a covered condition or Surgery covered under Category 7, the Participant will not be insured under this benefit for any future covered conditions or Surgeries specified under Category 7.

Category 8 – Covered Conditions and Surgeries

Loss of Limbs

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.

For payment to be made under this benefit, the Diagnosis of Loss of Limbs must be made by a Specialist.

Limitation for Category 8 – Covered Conditions and Surgeries

Once a benefit has become payable for a covered condition or Surgery covered under Category 8, the Participant will not be insured under this benefit for any future covered conditions or Surgeries specified under Category 8.

Category 9 – Covered Conditions and Surgeries

Occupational HIV Infection

Occupational HIV Infection means a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Participant's normal occupation, which exposed the person to HIV contaminated body fluids.

The accidental injury leading to the infection must have occurred after the later of the date the Participant became insured under this benefit or the last reinstatement date of a Participant's coverage.

Payment under this Covered Condition or Surgery requires satisfaction of all of the following:

a) The accidental injury must be reported to the insurer within 14 Days of the accidental injury; and

b) A serum HIV test must be taken within 14 Days of the accidental injury and the result must be negative; and

c) A serum HIV test must be taken between 90 Days and 180 Days after the accidental injury and the result must be positive; and

d) All HIV tests must be performed by a duly licensed laboratory in Canada or the United States; and

e) The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

For payment to be made under this benefit, the Diagnosis of Occupational HIV Infection must be made by a Specialist.

Exclusions

No payment will be made under this benefit if:

a) The Participant has elected not to take any available licensed vaccine offering protection against HIV; or

b) A licensed cure for HIV infection has become available prior to the accidental injury; or

c) HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Limitation for Category 9 – Covered Conditions and Surgeries

Once a benefit has become payable for a covered condition or Surgery covered under Category 9, the Participant will not be insured under this benefit for any future covered conditions or Surgeries specified under Category 9.

Category 10 – Covered Conditions and Surgeries

Coronary Angioplasty

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.

For payment to be made under this benefit, the procedure must be determined to be Medically Required by a Specialist.

The benefit payable for a Coronary Angioplasty will be 10% of the sum insured as indicated in the Summary of Benefits.

Early Stage Cancer

Early Stage Cancer refers to one of the following conditions:

a) Malignant melanoma skin Cancer that is less than or equal to 1 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis; or

b) Prostate Cancer classified as T1a or T1b, without lymph node or distant metastasis; or

c) Papillary thyroid Cancer or follicular thyroid Cancer, or both, that is less than or equal to 2 cm in greatest diameter and classified as T1, without lymph node or distant metastasis; or

d) Chronic lymphocytic leukemia classified as Rai stage 0; or

e) Gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1; or

f) Ductal carcinoma in situ of the breast; or

g) 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.

For payment to be made under this benefit, the Diagnosis of an Early Stage Cancer must be made by a Specialist.

The benefit payable for an Early Stage Cancer will be 10% of the sum insured as indicated in the Summary of Benefits.

Limitation for Category 10 – Covered Conditions and Surgeries

Once a benefit has become payable for a covered condition or Surgery covered under Category 10, the Participant will not be insured under this benefit for any future covered conditions or Surgeries specified under Category 10.

PRE-EXISTING CONDITION EXCLUSION

As used in this provision, **Pre-existing Condition** means a covered condition or Surgery:

a) Which was sustained or contracted; or

b) For the signs and symptoms of which the Participant was under treatment by a Physician; or

c) For the signs and symptoms of which a Physician had undertaken an investigation or review of; or

d) For which the Participant was taking medication as prescribed by a Physician,

during the 24 months prior to the date the Participant became insured under this benefit.

No payment will be made under this benefit for a covered condition or Surgery:

a) That resulted either directly or indirectly from, or was in any manner or degree associated with or occasioned by a Pre-existing Condition; and

b) Which occurred during the first 24 months after the date the Participant became insured under this benefit.

Notwithstanding the above, with respect to a Participant who had his insurance reinstated under this benefit as described in the Reinstatement of Insurance provision, if the insurance provided to the Participant was not in force for the full period of 24 months at the termination date of insurance, the Participant will continue to satisfy the remainder of the Pre-existing Condition from the reinstatement date.

Exception to Pre-existing Condition

However, if the Participant's insurance under this benefit is replacing a critical illness benefit under a previous group policy, the Pre-existing Condition provision will not apply for a condition or Surgery which had been provided for under the critical illness benefit of the previous group policy and a benefit will be payable due to such condition or Surgery provided:

a) The Participant had been insured under the critical illness benefit under the previous group policy immediately prior to the date the benefit terminated under such policy; and

b) The Participant became insured under this benefit immediately following the date the critical illness benefit terminated under the previous group policy; and

c) The Participant had satisfied the Pre-existing Condition exclusion period that was specified under the critical illness benefit of the previous group policy or he has satisfied the Pre-existing Condition exclusion period under this benefit, giving consideration towards continuous time insured under this benefit and the critical illness benefit under the previous group policy.

The benefit that will be payable to the Participant for whom the Pre-existing Condition exclusion has been waived due to the preceding paragraph, will be determined in accordance with the critical illness benefit under the group policy, but in no case will it exceed the critical illness benefit that would have been payable under the previous group policy.

The Pre-existing Condition provision will apply to any condition or Surgery which had not been provided for under the critical illness benefit of the previous group policy with respect to a Participant whose benefit under the group policy is replacing a critical illness benefit that had been provided under a previous group policy.

This Pre-existing Condition exclusion will not apply to any coverage issued with evidence of insurability provided and approved for this benefit.

EXCLUSIONS

No payment will be made under this benefit if the covered condition or Surgery resulted directly or indirectly from any of the following causes:

a) Suicide, attempted suicide or self-inflicted injury, regardless of any impairment, Illness, or state of mind.

b) Committing or attempting to commit a criminal offense or provoking an assault.

c) Civil unrest, insurrection or war, whether war be declared or not, or participation in a riot.

d) Use of drugs, poisonous substances, intoxicants or narcotics, other than as prescribed and administered by or in accordance with the instructions of a legally licensed Physician.

e) Abuse of alcohol.

f) The operation of a motor vehicle, if the Participant at the time of the Accident had a blood alcohol concentration rate in excess of the limit permitted by law.

g) Flight in an aircraft, except as riding as a passenger and not as a pilot, operator or member of the crew, in or on any aircraft provided (i) the flight was a regularly scheduled flight, (ii) the aircraft has a current and valid certificate of air worthiness and is piloted by a person who holds a current and valid pilot's license of a rate authorizing him to pilot the aircraft and (iii) the aircraft is not owned, operated, chartered or licensed by the Policyholder or the Participant's Employer.

h) Participation, amateur or professional, in any of the following activities:

   i) Underwater activities, including but not limited to, scuba diving and scuba diving; or

   ii) Hang-gliding; or

   iii) Parachuting; or

   iv) Motor vehicle race or speed competition on land and/or water; or

   v) Boxing; or

   vi) Bungee jumping; or

   vii) BASE jumping; or

   viii) Cliff diving; or

   ix) Mountain climbing.

LIMITATIONS

a) Cancer

   A Participant will not be entitled to a covered condition or Surgery benefit for Cancer if, within the first 90 Days following the date the Participant became insured under this benefit, the Participant has a Diagnosis of Cancer or any signs, symptoms or investigations that lead to a Diagnosis of Cancer, regardless of when the Diagnosis is actually made.

   In the event of any such Diagnosis of Cancer:

   i) The covered condition or Surgery benefit will not be payable; and

   ii) Cancer will no longer be considered a covered condition or Surgery for the Participant.

b) Benign Brain Tumour

   A Participant will not be entitled to a covered condition or Surgery benefit for Benign Brain Tumour if, within the first 90 Days following the date the Participant became insured under this benefit, the Participant has a Diagnosis of Benign Brain Tumour or any signs, symptoms or investigations that lead to a Diagnosis of Benign Brain Tumour, regardless of when the Diagnosis is actually made.

   In the event of any such Diagnosis of Benign Brain Tumour:

   i) The covered condition or Surgery benefit will not be payable; and

   ii) Benign Brain Tumour and any other covered condition or Surgery within the category 3 of covered conditions and Surgeries will no longer be considered a covered condition or Surgery for the Participant.

c) Early Stage Cancer

   A Participant is not entitled to a covered condition or Surgery benefit for Early Stage Cancer if, within 90 Days following the date the Participant became insured under this benefit, the Participant has a Diagnosis of an Early Stage Cancer or has any signs, symptoms or investigations that lead to a Diagnosis of Early Stage Cancer, regardless of when the Diagnosis is made.

In the event of any such Diagnosis of Early Stage Cancer, the covered condition and Surgery benefit will not be payable. Notwithstanding the foregoing, this benefit will remain in force, subject to the continued payment of the required premiums and other terms and conditions of the group policy, but Early Stage Cancer will no longer be considered a covered condition or Surgery for the Participant.

REDUCTIONS

The sum insured is reduced as indicated in the Summary of Benefits. The sum insured is also subject to any applicable reductions indicated in this benefit or in the General Provisions of the group policy.

TERMINATION

The insurance under this benefit terminates as indicated in the Summary of Benefits, or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

EFFECT OF TERMINATION OF INSURANCE ON CLAIMS

Termination of this benefit or the termination of the Participant's insurance will not prejudice any claim in connection with a covered condition or Surgery provided that:

a) The Date of Diagnosis is before the earlier of the termination date of this benefit or the termination date of the Participant's insurance.

b) The existence of the covered condition or Surgery is reported to the insurer within 30 Days of the earlier of the termination date of this benefit or the termination date of the Participant's insurance.

c) For Bacterial Meningitis, the documented 90 Day period of neurological deficit must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the Participant's insurance.

d) For Coma, the continuous 96 hour minimum period of unconsciousness must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the Participant's insurance.

e) For Loss of Independent Existence, the continuous 90 Day period of incapacity must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the Participant's insurance.

f) For Loss of Speech, the 180 Day period of total and Irreversible Loss of Speech must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the Participant's insurance.

g) For Major Organ Failure on Waiting List, the date the Participant is enrolled as a recipient in a recognized transplant centre must have occurred before the earlier of the termination date of this benefit or the termination date of the Participant's insurance.

h) For Multiple Sclerosis, the 6 month period of episodes of well-defined neurological abnormalities must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the Participant's insurance.

i) For Occupational HIV Infection, the 14 Day period during which a serum HIV test must be taken, must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the Participant's insurance.

j) For Paralysis, the 90 Day period of total loss of muscle function must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the Participant's insurance.

k) For Stroke, the 30 Day period of Paralysis or other measurable objective neurological deficit must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the Participant's insurance.