Manulife

Optional life insurance

Looking after your family's future

Your group benefits plan offers you easy and affordable life insurance options to help you better prepare for life's unpredictable moments, so you can focus on building unforgettable memories.

Group Benefits products are offered through Manulife (The Manufacturers Life Insurance Company).

Looking after your family's future

Life insurance can help your family deal with the financial impact that comes with a loss of life.

Basic life insurance
Your employer might offer you basic life insurance coverage at a lower cost, or no cost at all. This insurance typically pays up to the full amount of your annual salary. Make sure to check your benefit booklet for your coverage details.

Optional life insurance
You can buy this insurance on top of your basic life insurance as part of your group benefits plan. You can choose an amount that fits your family's needs. You can get the full details online in your benefits booklet. For questions about what your plan offers and how much it costs, ask your plan administrator or human resources (HR) team.

Why should I get added coverage?

Basic life insurance may not be enough. It may not meet all your family's needs if you die and they no longer have your income.

Optional life insurance is coverage you add on top of your basic coverage. It helps reduce the potentially devastating impact that the loss of your income could have on your family and their standard of living.

Here are a few other reasons why this coverage is worth it.

Flexible coverage – You choose the coverage you want.

Easy to pay for – The money comes off your pay and is sent to Manulife on your behalf.

Apply with no medical questionnaire – Your plan might allow you to get a fixed amount of coverage without a medical questionnaire when applying for optional life insurance.

Take it with you – If you change jobs and transfer some coverage to an individual policy, you can keep your coverage – with no medical questions asked when the transfer is requested.

Protection that makes sense

Because it's offered as a group benefit, optional life insurance is usually more affordable than other life insurance.

As well, your group benefits plan may include a premium waiver. That could cover your optional life premiums if you're disabled.

How much is enough?

Think about your annual income. Add up all the things it pays for - mortgage or rent, loans, regular household expenses, education, and other needs. Decide how long your family would need the replacement funds to last.

Then, add up how much coverage you already have. It may be through your employer, a personal insurance plan, or with a creditor like your mortgage company. Getting optional life insurance can help fill any gap.

How you pay

It's simple. Your employer will deduct the premium from your pay. Then, they'll send it to Manulife for you.

Take it with you

If you change jobs and transfer some coverage to an individual policy, you can keep your coverage – with no medical questions asked when transfer is requested. While you decide, your group coverage will stay in effect for 31 days at no charge. Your new premium will be based on your age and the type of plan you select.

Applying is easy

1. Decide how much insurance you want.
2. Check the cost and any coverage limits set for your plan.
3. Fill out and send us the application. You can find the forms to apply at manulife.ca/signin or through your plan administrator.

Once you're approved, your coverage starts.

Choosing a beneficiary

You'll need to choose a beneficiary. They'll receive the death benefit if you die. You can choose the same person you named for your basic life insurance or someone else. Either way, it's important to name a beneficiary for your optional life insurance.

If you add insurance on your spouse, you're automatically the beneficiary.

Coverage changes

- **Adding optional life insurance** - complete an application and provide proof of good health.
- **Increasing your insurance** - complete an application and provide proof of good health. On the application, state your original coverage amount, as well as the amount you'd like to add. (You can add up to the maximum allowed by your plan).
- **Changing your beneficiary** - contact your plan administrator or human resources. (In Quebec, spousal designations are irrevocable. So you must get their permission to change it.)
- **Cancelling or lowering your insurance** - give a written request to your plan administrator or human resources.

Frequently asked questions

Is there an age limit?

You can apply for optional life coverage any time before your 65th birthday. If your plan has spousal coverage, the same age limit applies to your spouse.

When does optional life coverage end?

Optional life coverage usually ends when the first of these happens:

- when you reach age 65
- when you leave your job
- when you retire
- if your employer cancels the group policy
- when you stop paying the premiums.

You can cancel your coverage at any time.

Is a medical exam required?

Not always. For some amounts, we'll need proof of good health. So, complete all the questions on the application. If our underwriters feel a medical or paramedical exam is necessary, we'll let you know. We'll pay for any cost.

Will you keep the information on my application and any test results confidential?

Manulife is committed to protecting the privacy and confidentiality of our customers' information. Keeping this sensitive information safe is very important to us. You can find more about our privacy policy at **manulife.ca/groupbenefits**.

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Questions?

- Check out your employee booklet at **manulife.ca/planmember**, under My benefits and click View benefits booklet.
- Contact your human resources (HR) team for more information.
- Learn more at **www.manulife.ca/optionallifeinsurance**

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Manulife

Group critical illness

Optional Group Critical Illness Insurance

Added protection for you and your family – group benefits

Make recovery your priority

It can begin in an instant – a diagnosis. Then shock – deafening in its disbelief – and suddenly life starts to spin out of control.

Most of us know someone who's been diagnosed with or suffered from a critical illness. The effects can be far-reaching – worry, treatments, time away from work and the financial burden of unexpected expenses.

That's where your Optional Group Critical Illness benefit comes into focus. It supplements the coverage provided through your health, life and disability plans – giving an extra layer of financial protection should you, your spouse or dependent children become critically ill.

With Optional Group Critical Illness, you may decide the coverage amount that is right for your family.

If you, your spouse or your dependent children are medically diagnosed with a covered condition defined within your plan, your Optional Group Critical Illness benefit will pay a one-time, lump-sum cash benefit that you can use in any manner you wish, for example: seeking other treatment options, making mortgage or credit card payments, hiring a caregiver, buying specialized equipment, or taking time for family or other interests.

Optional Group Critical Illness Insurance offers:

- **affordable** group rates;
- flexibility – you **choose the amount** of coverage that's right for you;
- convenient **payroll deduction** for premium payments;
- optional coverage for your **spouse** and **dependent children**;
- a one-time, **lump-sum benefit** you can use in any way you wish; and
- access to valuable **health information** and **navigation services** through Health Service Navigator®.

Why purchase Optional Group Critical Illness Insurance?

Critical Illness Insurance was developed more than 20 years ago by a South African physician to help heart patients avoid financial hardship after surgery.

The risk of experiencing a serious illness is high and many serious illnesses are already considered or may become critical illnesses:

- 1 in 2.6 Canadian women and 2 in 5 men will develop some form of cancer during their lifetimes.
- More than 140,000 new cases of cancer occur each year.
- About 300,000 Canadians are living with the effects of stroke.
- More than 75,000 heart attacks occur every year.
- Canadians have one of the highest rates of multiple sclerosis in the world.

Group Critical Illness Insurance is generally more affordable than individual coverage.

Covered conditions:

Coverage for a critical illness applies only to those conditions that are defined within the terms of the group benefits contract.

Definitions for covered conditions are available on Manulife's plan member site at **manulife.ca/planmember**, under **Tools and Resources**, select **Covered conditions for your critical illness** or by contacting our Customer Service Centre.

Health statistics courtesy of the following websites: Canadian Cancer Society, Heart and Stroke Foundation, The Multiple Sclerosis Society of Canada. The statistics quoted reflect broad-based incidence and do not reflect the specific incidence rates associated with the specific covered conditions.

The specific covered conditions are recognized within the medical profession as being critical in nature. As medical advances and treatment of critical illnesses evolve, the contract definitions for conditions covered under this benefit may change.

Your Optional Group Critical Illness benefit currently provides coverage for the following conditions:

Group Critical Illness covered conditions	You and your spouse	Your child
Alzheimer's Disease	✓	✓
Aortic Surgery	✓	✓
Benign Brain Tumour	✓	✓
Blindness	✓	✓
Cancer (Life-Threatening)	✓	✓
Coma	✓	✓
Coronary Artery Bypass Surgery	✓	✓
Deafness	✓	✓
Heart Attack (Myocardial Infarction)	✓	✓
Heart Valve Replacement	✓	✓
Kidney Failure	✓	✓
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	✓	✓
Severe Burns	✓	✓
Stroke (Cerebrovascular Accident)	✓	✓
Autism		✓
Cerebral Palsy		✓
Congenital Heart Disease (for which corrective surgery has been performed)		✓
Cystic Fibrosis		✓
Down Syndrome		✓
Muscular Dystrophy		✓
Type 1 Diabetes Mellitus		✓

As with most insurance, a few conditions apply:

- You must survive at least 30 days following the diagnosis of a covered condition in order to receive the benefit.
- A **pre-existing medical conditions** exclusion applies to coverage that is provided without completion of a detailed medical questionnaire. If you are diagnosed with a condition for which you have exhibited signs or symptoms, received or should have received medical treatment, consulted a physician, or been prescribed medication during the **24 months prior** to the effective date of coverage then during the **first 24 months** of coverage, no benefit is payable for a condition that is directly or indirectly related to a **pre-existing condition**.
- Within the **first 90 days of coverage** no benefit will be paid for cancer or benign brain tumour if the insured exhibits or receives any of the following:
  - signs or symptoms that lead to a diagnosis of cancer or benign brain tumour, regardless of the date when the diagnosis is made; or
  - medical consultations, tests or any form of clinical evaluation, that lead to a diagnosis of cancer or benign brain tumour, regardless of when the diagnosis is made; or
  - a diagnosis of cancer or benign brain tumour.
- Benefits are payable for the first diagnosis only and coverage terminates once a claim has been paid.

See your benefits booklet or plan contract for a complete list of exclusions.

Health Service Navigator®

In addition to financial support, your Optional Group Critical Illness benefit also provides you with access to valuable health information and health care navigation services.

Health Service Navigator is a phone and web-based health resource centre that is designed to help you find the best medical, treatment and therapeutic information available for your health situation – whether it is a covered critical illness or not.

Health Service Navigator connects you to:

- a world-class medical second opinion service;
- health, nutrition, drug and fitness information;
- detailed information for newly diagnosed conditions; and
- searchable databases to help you locate doctors, clinics and hospitals throughout Canada.

Our second opinion service and all of the other features available through Health Service Navigator are provided to both you and your immediate family members at any time, not just when you have been diagnosed with a critical illness.

Through this service, you may even obtain referrals to specialized treatment facilities outside of Canada where you can get help managing a covered condition.

There is no charge to you for using this health information, second opinion and referral service. However, fees for treatments, services or facilities that you choose to access through Health Service Navigator are your responsibility and may not be covered under your group benefits plan.

You'll receive more details about Health Service Navigator in a separate brochure.

Applying for coverage is easy:

We've done our best to make applying for Optional Group Critical Illness Insurance as convenient as possible:

1. Decide how much coverage you want to purchase (see rate sheet for details).
2. Check the cost (plus, any minimums or maximums that may apply under your plan).
3. Complete and return an application form (Evidence of Insurability may be required for Optional Group Critical Illness Insurance).

You will receive notice from Manulife regarding approval of coverage and when it begins. Premiums for Optional Group Critical Illness Insurance are paid by you, the plan member.

To cancel or reduce coverage, you will need to advise your plan administrator or Human Resources department in writing.

Questions?

Claim forms, application forms and contract definitions for covered conditions are available on the plan member site at **manulife.ca**.

Not registered yet? Follow these easy steps:

- Go to **manulife.ca**, hover over the sign in button located at the top of the screen, and select **Plan member** under **Group benefits** from the drop down menu.
- Follow the simple onscreen prompts to register your account.
- Once logged in, application forms and a claims guide are available under **Plan member brochures** in the **Forms** menu, and the claim form is available under **Claim forms** in the **Forms** menu.

Covered Critical Illness Conditions Appendix

Effective Date: February 1, 2010

This Appendix contains definitions for those Conditions that are covered under the Manulife Group Critical Illness plan.

Covered Conditions are those recognized within the medical profession as being of a critical nature. Advances in the medical knowledge and treatment of critical illnesses will evolve, and accordingly Manulife reserves the right to change the contract definitions for Conditions covered under any given Plan. All claims under this Policy shall be adjudicated using the definition of any Condition(s) that is in effect at the time the claim is incurred.

If you have any questions about any of the Conditions listed, please consult your doctor or call Manulife's Customer Service Centre at 1-800-268-6195.

Adult Covered Conditions definitions

Alzheimer's Disease is defined as a definitive clinical diagnosis by a specialist in the diagnosis and treatment of Alzheimer's Disease, which is a progressive degenerative disease of the brain. The Insured must exhibit the loss of intellectual capacity involving impairment of memory and judgment, which results in a significant reduction in mental and social functioning, as to require continuous daily supervision.

Exclusion: All other organic brain disorders and psychiatric illnesses that result in dementia are specifically excluded.

Aortic Surgery is defined as the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches.

Exclusion: Surgery for the diseases of the branches of the thoracic aorta or abdominal aorta is specifically excluded.

Benign Brain Tumour is defined as a non-malignant tumour arising from the brain or meninges. The histologic nature of the tumour must be confirmed by examination of tissue (biopsy or surgical excision).

Exclusion for Certain Tumours: Tumours of the bony cranium and pituitary microadenomas (less than 10 mm in diameter) are excluded.

Moratorium Period Exclusion: No benefit under this condition will be payable in relation to this condition if, within the first 90 days following the later of:

a. the effective date of coverage, or

b. the effective date of last reinstatement of coverage,

The insured person has any of the following:

a. signs or symptoms that lead to a diagnosis of Benign Brain Tumour, regardless of the date when the diagnosis is made; or

b. medical consultations, tests or any form of clinical evaluation, that lead to a diagnosis of Benign Brain Tumour, regardless of when the diagnosis is made; or

c. a diagnosis of Benign Brain Tumour.

This information must be reported to Manulife within 6 months of the date of the first diagnosis. If this information is not so provided, Manulife has the right to deny any claim for Benign Brain Tumour or any critical illness caused by Benign Brain Tumour or its treatment.

Blindness is defined as the total and irreversible loss of vision in both eyes as confirmed by an ophthalmologist, with the corrected visual acuity being 20/200 or less in each eye or the field of vision is less than 20 degrees in both eyes.

Cancer is defined as a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

Exclusion for Certain Cancers: The following cancers are excluded from coverage:

a. carcinoma in situ

b. stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without level IV or V invasion)

c. any non-melanoma skin cancer that has not become metastatic (spread to distant organs)

d. stage A (T1a or T1b) prostate cancer

e. any tumour in the presence of any HIV

Moratorium Period Exclusion: No Benefit will be payable in relation to this condition if, within the first 90 days following the later of:

a. the effective date of coverage, or

b. the effective date of last reinstatement of coverage,

The insured person has any of the following:

a. signs or symptoms that lead to a diagnosis of cancer (covered or excluded under this Policy), regardless of the date when the diagnosis is made; or

b. medical consultations or tests that lead to a diagnosis of cancer (covered or excluded under this Policy), regardless of the date when the diagnosis is made; or

c. a diagnosis of cancer (covered or excluded under this Policy).

This information must be reported to Manulife within 6 months of the date of the first diagnosis. If this information is not so provided, Manulife has the right to deny any claim for cancer or, any critical illness caused by any cancer or its treatment.

Coma is defined as a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of four days. The Glasgow coma score must be four (4) or less, continuously during the four days.

Exclusions: Medically induced comas are specifically excluded.

Coronary Artery Bypass Surgery is defined as the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, excluding any non-surgical techniques such as balloon angioplasty or laser relief of an obstruction or other non-coronary artery bypass graft medical treatments.

Deafness is defined as 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 cycles per second.

Heart Attack (Myocardial Infarction) is defined as the death of a portion of heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis must be based on:

a. new electrocardiographic changes consisting of the development of Q waves and/or ST segment elevation not previously present or any other changes indicative of a myocardial infarction; and

b. elevation of cardiac biochemical markers to levels considered diagnostic for infarction.

Exclusion: Heart attack does not include and no Benefit shall be payable for an incidental finding of ECG changes suggesting a prior myocardial infarction, in the absence of a corroborating event.

Heart Valve Replacement is defined as the replacement of any heart valve with either a natural or mechanical valve.

Exclusion: Heart valve repair is specifically excluded.

Kidney Failure (End Stage Renal Disease) is defined as end stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular hemodialysis, peritoneal dialysis or renal transplantation is initiated.

Loss of Limbs is defined as the irreversible severance of two or more limbs above the wrist or ankle joint as the result of an accident or medically required amputation.

Loss of Speech is defined as the total and irreversible loss of the ability to speak as the result of physical injury or disease which must be established for a continuous period of at least 180 days.

Exclusion: All psychiatric related causes are specifically excluded.

Major Organ Failure on Waiting List is defined as the diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow as a result of which transplantation must be medically necessary.

To qualify under Major Organ or Bone Marrow Failure on Waiting List the Insured must become enrolled as the recipient in an approved government organ or bone marrow transplant program in Canada or the U.S., for one or more of the organs or bone marrow specified in this provision. For the purposes of the Survival Period, the date of diagnosis is the date your enrolment in such a transplant program takes effect.

Major Organ Transplant is defined as the diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow as a result of which transplantation is medically necessary.

To qualify under Major Organ or Bone Marrow Transplant the Insured must undergo surgery as the recipient for transplantation of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

Exclusion: A transplantation that is not medically necessary is specifically excluded.

Motor Neuron Disease is defined as a definitive 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 entities.

Multiple Sclerosis is defined as a diagnosis that is made in accordance with one of the two methods outlined below, either of which will be acceptable to Manulife:

c. A diagnosis by a neurologist of Multiple Sclerosis, characterized by well defined neurological abnormalities persisting for a continuous period of at least six months or with evidence of two separate clinically documented episodes. Multiple areas of demyelination must be confirmed by MRI scanning or imaging techniques generally used to diagnose multiple sclerosis
OR

d. A diagnosis of Multiple Sclerosis by a neurologist, in accordance with definitions established by the International Panel on MS Diagnostic Criteria in the following tables.

Table 1

International panel criteria (2005 revisions to the McDonald criteria) for diagnosis of MS

Clinical presentation	Additional data needed for MS diagnosis
Two or more attacks; objective clinical evidence of 2 or more lesions	None[a]
Two or more attacks; objective clinical evidence of 1 lesion	Dissemination in space, demonstrated by: • MRI[b], OR • 2 or more MRI-detected lesions consistent with MS plus positive CSF[c], OR • await further clinical attack implicating a different site
One attack; objective clinical evidence of 2 or more lesions	Dissemination in time, demonstrated by: • MRI[b], OR • Second clinical attack
One attack; objective clinical evidence of 1 lesion (monosymptomatic presentation; clinically isolated syndrome)	Dissemination in space, demonstrated by: • MRI[b], OR • 2 or more MRI-detected lesions consistent with MS plus positive CSF[c], AND Dissemination in time, demonstrated by: • MRI[b], OR • Second clinical attack
Insidious neurological progression suggestive of MS	One year of disease progression (retrospectively or prospectively determined), AND 2 out of the following 3: a. Positive brain MRI (9 T2 lesions or 4 or more T2 lesions with positive visual evoked potentials) b. Positive spinal cord MRI (2 or more focal T2 lesions) c. Positive CSF (isoelectric focusing evidence of OCB and/or elevated IgG index)

[a] Brain MRI is recommended to exclude other etiologies
[b] MRI criteria for dissemination in space or time are described in Table 2
[c] Positive CSF defined as oligoclonal bands different from those in serum, or raised IgG index

Table 2

Magnetic resonance imaging criteria for brain abnormality: space and time dissemination

Magnetic Resonance Imaging Criteria to Demonstrate Dissemination of Lesions in Time (DIT)

There are two ways to show DIT using imaging:

a. Detecting gadolinium enhancement at least 3 months after the onset of the initial clinical event, if not at the site corresponding to the initial event.

b. Detecting a NEW T2 lesion if it appears at any time compared to a reference scan done at least 30 days after the onset of the initial clinical event.

Magnetic Resonance Imaging Criteria to Demonstrate Brain Abnormality and Demonstration of Dissemination in Space (DIS)

Three out of four of the following:

1. One gadolinium-enhancing lesion or nine T2 hyperintense lesions if there is no gadolinium-enhancing lesion
2. At least one infratentorial lesion
3. At least one juxtacortical lesion
4. At least three periventricular lesions

NOTE: A spinal cord lesion can be considered equivalent to a brain infratentorial lesion: an enhancing spinal cord lesion is considered to be equivalent to an enhancing brain lesion, and individual spinal cord lesions can contribute along with individual brain lesions to reach the required number of T2 lesions.

Occupational HIV Infection is defined as the diagnosis of Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured's normal occupation, which exposed the person to HIV contaminated body fluids.

Payment of the Benefit in relation to this condition requires satisfaction of all of the following criteria:

a. The accidental injury must be reported to the Policyholder within fourteen (14) days of the accidental injury;

b. An HIV test must be taken within fourteen (14) days of the accidental injury and the result must be negative;

c. An HIV test must be taken between ninety (90) days and one hundred eighty days (180) after the accidental injury and the result must be positive;

d. All HIV tests must be performed by licensed HIV testing facilities and personnel;

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

Exclusions: No payment of this Benefit will be made if:

a. the Insured has elected not to take any available licensed vaccine or any other form of treatment offering protection against HIV;

b. a licensed cure for HIV infection has become available prior to the payment of the Benefit; or

c. HIV infection has occurred as a result of

d. non-accidental injury (including, but not limited to, sexual transmission or intravenous (IV) drug use).

Paralysis is defined as the complete and permanent loss of use of two or more limbs for a continuous period of 90 days following the precipitating event, during which time there has been no sign of improvement.

Exclusion: All psychiatric related causes for paralysis are specifically excluded.

Parkinson's Disease is defined as a definitive diagnosis by a specialist of primary idiopathic Parkinson's Disease, which is characterized by a minimum of two or more of the following clinical manifestations: muscle rigidity, tremor, or bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses). The Insured must require substantial physical assistance from another adult to perform at least 2 of the following 6 Activities of Daily Living:

a. Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.

b. Dressing – the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.

c. Toileting – the ability to get to and from 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 a reasonable level of hygiene is maintained.

e. Transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment.

f. Feeding – the ability to consume food or drink that already have been prepared and made available, with or without the use of adaptive utensils.

Exclusion: All types of Parkinsonism other than the type described in this section are specifically excluded.

Severe Burns is defined as third degree burns over at least 20% of the body surface.

Stroke (Cerebrovascular Accident) is defined as a cerebrovascular event producing neurological sequelae lasting more than 30 days and caused by intracranial thrombosis or hemorrhage, or embolism from an extra-cranial source. There must be evidence of measurable, objective neurological deficit.

Exclusion: Transient Ischemic Attacks are specifically excluded.

Child Covered Conditions Definitions

Includes all of the Adult Covered Conditions plus the following conditions:

Autism is defined as an organic defect in brain development characterized by failure to develop communicative language or other forms of social communication, with the diagnosis confirmed either by a pediatric psychiatrist or a pediatrician before the Child's third birthday.

Cerebral Palsy is defined as a definitive diagnosis of definite Cerebral Palsy, a non-progressive neurological defect characterized by spasticity and in coordination of movements.

Congenital Heart Disease is defined as any one or more diagnosis(es) from the following lists of heart conditions:

List A

a. Total Anomalous Pulmonary Venous Connection

b. Transposition of The Great Vessels

c. Atresia of any heart valve

d. Coarctation of The Aorta

e. Single Ventricle

f. Hypoplastic Left Heart Syndrome

g. Double Outlet Left Ventricle

h. Truncus Arteriosus

i. Tetralogy of Fallot

j. Eisenmenger Syndrome

k. Double Inlet Ventricle

l. Hypoplastic Right Ventricle

m. Ebstein's Anomaly

The foregoing conditions shall be covered following the expiry of a 30 day Survival Period, commencing from the date of diagnosis or birth, whichever is the later of the two. The diagnosis of any of the conditions in List A must be made by a qualified pediatric cardiologist, and supported by appropriate cardiac imaging.

List B

a. Pulmonary Stenosis

b. Aortic Stenosis

c. Discrete Subvalvular Aortic Stenosis

d. Ventricular Septal Defect

e. Atrial Septal Defect

The foregoing conditions shall be covered only when open heart surgery is performed for correction of the condition and following the expiry of a 30 day survival period from the date of diagnosis or birth, whichever is the later of the two. The diagnosis of any of the conditions in this List B must be made by a qualified pediatric cardiologist and supported by appropriate cardiac imaging. The surgery must be recommended by a qualified pediatric cardiologist and performed by a cardiac surgeon in Canada.

List B Exclusion: Trans-catheter procedures such as balloon valvuloplasty or percutaneous Atrial Septal Defect closure are excluded.

General Exclusions: All other congenital cardiac conditions, not specifically listed herein, are excluded.

Cystic Fibrosis is defined as a definitive diagnosis of Cystic Fibrosis with evidence of chronic lung disease and pancreatic insufficiency.

Down Syndrome is defined as a definitive diagnosis of Down Syndrome supported by chromosomal evidence of Trisomy 21.

Muscular Dystrophy is defined as a definitive diagnosis of Muscular Dystrophy, characterized by well defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

Type 1 Diabetes Mellitus (Juvenile Diabetes) is defined as a diagnosis of type 1 diabetes mellitus, characterized by absolute insulin deficiency and continuous dependence on exogenous insulin for survival. The diagnosis must be made by a qualified pediatrician or endocrinologist licensed and practicing in Canada, and there must be evidence of dependence on insulin for a minimum of three months.

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