Manulife

Group critical illness

Optional Group Critical Illness Insurance

Added protection for you and your family

Make recovery your priority

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.

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 non-taxable 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; typically, lower cost than individual coverage.
- 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 non-taxable lump-sum benefit you can use in any way you wish; and
- access to navigation services and the medical second opinion service

You're covered for multiple payments for critical illnesses

With Optional Group Critical Illness Insurance, you get longer term protection that extends beyond just one critical illness. Coverage continues in the event of another critical illness in the future. What's more important, this coverage applies to both you and your spouse. The multiple critical illness coverage includes a second cancer event five years following the initial cancer claim payout. Conditions apply.

Why purchase Optional Group Critical Illness Insurance?

Critical Illness Insurance was developed more than 35 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.

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.

Covered conditions*:

While there are a lot of critical illnesses, coverage under this benefit is limited to those defined conditions within the terms of the group benefits contract. Covered conditions are outlined below and grouped to demonstrate how the multiple critical illness coverage works:

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

Group Critical Illness Covered Conditions	You and your spouse	Your Child
Cancer Critical Illness conditions		
Cancer (Life-Threatening)	✓	✓
Cardiovascular Critical Illness conditions		
Aortic Surgery	✓	✓
Coronary Artery Bypass Surgery	✓	✓
Heart Attack (Myocardial Infarction)	✓	✓
Heart Valve Replacement	✓	✓
Congenital Heart Disease (for which corrective surgery has been performed)	✓	✓
Stroke (Cerebrovascular Accident)	✓	✓
Other Critical Illness conditions		
Alzheimer's Disease	✓	✓
Aplastic Anemia	✓	✓
Bacterial Meningitis	✓	✓
Benign Brain Tumour	✓	✓
Blindness	✓	✓
Coma	✓	✓
Deafness	✓	✓
Kidney Failure (End Stage Renal Disease)	✓	✓
Loss Of Independent Existence**	✓	✓
Loss Of Limbs	✓	✓
Loss Of Speech	✓	✓
Major Organ or Bone Marrow Failure and On Waiting List For Transplant	✓	✓
Major Organ or Bone Marrow Transplant	✓	✓
Motor Neuron Disease	✓	✓
Multiple Sclerosis	✓	✓
Occupational HIV Infection	✓	✓
Paralysis	✓	✓
Parkinson's Disease	✓	✓
Severe Burns	✓	✓
Autism		✓
Cerebral Palsy		✓
Cystic Fibrosis		✓
Down Syndrome		✓
Muscular Dystrophy		✓
Type 1 Diabetes Mellitus		✓

***** 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. 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.

As with most insurance, a few conditions apply:

You must survive at least 14 days, or as specified in the covered condition definition, 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.

A moratorium period exclusion applies within the first 90 days of coverage for certain conditions. During this time, if there are signs, symptoms, or investigations such as medical consultations, tests or any form of clinical evaluation that could be related to the eventual diagnosis of benign brain tumour cancer, or specified atypical parkinsonian disorders, regardless of the date of when the diagnosis is made, then no benefits will be payable for that claim.

Multiple critical illness coverage is limited to one benefit payment in each condition category. The categories include cancer, cardiovascular conditions, and other conditions. In addition, a subsequent cancer benefit could be eligible under the second event cancer coverage. Coverage will be maintained until all benefit payments have been exhausted to a maximum of 4 claims.

**As an exception to the multiple critical illness coverage, any claim for loss of independent living will be limited to only one benefit payment and no additional claims for any subsequent covered conditions will be eligible. Also, once a critical illness claim is paid for cancer or a cardiovascular condition, any future claim for loss of independent existence will not be covered.

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

Medical Second Opinion

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

Medical Second Opinion 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.

Our second opinion service and health navigation features are provided to both you and your immediate family members.

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 Medical Second Opinion are your responsibility and may not be covered under your group benefits plan.

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/planmember.

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: January 1, 2022

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

Aortic Surgery is defined as 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 payment of this Benefit will be made under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Aplastic Anemia is defined as 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 is defined as 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 payment of this Benefit will be made under this condition for viral meningitis.

Benign Brain Tumour is defined as a definite Diagnosis of a non-malignant 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.

*Exclusions***:** No payment of this Benefit will be made under this condition for pituitary adenomas less than 10 mm. Furthermore, no Benefit will be payable for a recurrence or metastasis of an original tumour which was diagnosed prior to the effective date of coverage.

Moratorium Period Exclusion: No payment of this Benefit will be made under this condition if, within the 90 days following the later of:

a) the effective date of the Insured's coverage; or
b) the effective date the Insured increases their amount of coverage; or
c) the effective date of last reinstatement of coverage

the Insured has any of the following:

a) 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
b) 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 Manulife within 180 days of the date of the Diagnosis. If this information is not provided within this period, Manulife has the right to deny any Claim for Benign Brain Tumour or, any critical illness caused by any Benign Brain Tumour or its treatment.

If a person's Critical Illness coverage ends but the person is covered again under this Benefit, Manulife will use the latest date of the person's coverage began when applying the Moratorium Period Exclusion.

Blindness is defined as 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.

The Diagnosis of Blindness must be made by a Specialist.

Cancer (Life-Threatening) is defined as 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 must be made by a Specialist.

Exclusions: No payment of this Benefit will be made for the following:

a) lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumors classified as Ta;
b) 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;
c) any non-melanoma skin cancer, without lymph node or distant metastasis;
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 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
f) chronic lymphocytic leukemia classified less than Rai stage 1; or
g) malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2;
h) a recurrence or metastasis of an original Cancer which was diagnosed prior to the effective date of coverage.

For purposes of the policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010.

For purposes of the policy, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

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 the Insured's coverage; or
b) the effective date the Insured increases their amount of coverage; or
c) the effective date of last reinstatement of coverage

the Insured has any of the following:

a) 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
b) 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 Manulife within 180 days of the date of the Diagnosis. If this information is not provided within this period, Manulife has the right to deny any Claim for Cancer or, any critical illness caused by any Cancer or its treatment.

If a person's Critical Illness coverage ends but the person is covered again under this Benefit, Manulife will use the latest date of the person's coverage began when applying the Moratorium Period Exclusion.

Coma is defined as a definite 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 four (4) or less. The Diagnosis of Coma must be made by a Specialist.

Exclusions: No payment of this Benefit will be made under this condition 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

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 graft(s). The surgery must be determined to be medically necessary by a Specialist.

*Exclusion***:** No payment of this Benefit will be made under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures

Deafness is defined as 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 is defined as a definitive 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); or
d. disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life.

The Insured 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.

The Diagnosis of Dementia must be made by a Specialist.

Exclusion: No payment of this Benefit will be made under this condition for affective or schizophrenic disorders, or delirium.

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

Heart Attack is defined as a definite Diagnosis of the death of heart muscle due to obstruction of blood flow, that results in:

Rise and fall of biochemical cardiac markers 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 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 payment of this Benefit will be made under this condition for:

a) 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
b) ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above

Heart Valve Replacement or Repair is defined as 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 payment of this Benefit will be made under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Kidney Failure is defined as a definite Diagnosis of chronic Irreversible failure of both kidneys to function, as a result of which regular hemodialysis, peritoneal dialysis or renal transplantation is initiated. The Diagnosis of Kidney Failure must be made by a Specialist.

Loss of Independent Existence is defined as 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 is defined as 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 is defined as a definite Diagnosis of the total and Irreversible loss of the ability to speak as the 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 payment of this Benefit will be made under this condition for all psychiatric related causes**.**

Major Organ Failure on Waiting List is defined as 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 or Bone Marrow Failure on Waiting List, the Insured must become enrolled as the recipient in a recognized transplant center in Canada that performs the required form of transplant surgery. For the purposes of the Survival Period, the date of Diagnosis is the date of the Insured's enrolment in the transplant center. The Diagnosis of the major organ failure must be made by a Specialist.

Major Organ Transplant is defined as 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 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 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 conditions. The Diagnosis of Motor Neuron disease must be made by a Specialist.

Multiple Sclerosis is defined as a definite Diagnosis of at least one of the following:

a) two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or,
b) well-defined neurological abnormalities lasting more than 180 days, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or,
c) 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 is defined as a definite Diagnosis of infection with 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. The accidental injury leading to the infection must have occurred after the later of the effective date of the Insured's coverage, or the effective date of the last reinstatement of coverage.

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

a) The accidental injury must be reported to the Policyholder and to Manulife within fourteen (14) days of the accidental injury;
b) A serum HIV test must be taken within fourteen (14) days of the accidental injury and the result must be negative;
c) A serum 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 a duly licensed laboratory in Canada;
e) The accidental injury must have been reported, investigated and documented in accordance with current Canadian workplace guidelines.

The Diagnosis of Occupational HIV Infection must be made by a Specialist.

*Exclusions***:** No payment of this Benefit will be made under this condition if:

a) the Insured 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).

Paralysis is defined as 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 is defined as a definitive Diagnosis of primary Parkinson's Disease, permanent neurologic condition, which must be characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. The Insured must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.

Specified Atypical Parkinsonian Disorders are defined as a definite Diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The Diagnosis of Parkinson's Disease or a Specified Atypical Parkinsonian Disorder must be made by a neurologist.

Exclusion: No payment of this Benefit will be made under this condition for any other type of Parkinsonism.

Moratorium Period Exclusion: No payment of this Benefit will be made under this condition if, within the first year following the later of:

a) the effective date of the Insured's coverage; or

b) the effective date the Insured increases their amount of coverage; or
c) the effective date of last reinstatement of coverage

the Insured has any of the following:

a. 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
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 Manulife within 180 days of the date of the Diagnosis. If this information is not provided within this period, Manulife has the right to deny any Claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or, any critical illness caused by Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

Severe Burns is defined as 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) is defined as a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, 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. The Diagnosis of Stroke must be made by a Specialist.

Exclusion: No payment of this Benefit will be made under this condition for:

a) Transient Ischemic Attacks; or,
b) Intracerebral vascular events due to trauma; or
c) Lacunar infarcts which do not meet the definition of stroke as described above.

.

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 14 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 14 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.

The Manufacturers Life Insurance Company (Manulife)

Group Benefit products and services are offered by The Manufacturers Life Insurance Company (Manulife). Manulife, Manulife and Stylized M Design, and Stylized M Design are trademarks of The Manufacturers Life Insurance Company and are used by it, and by its affiliates under license. ©2020 The Manufacturers Life Insurance Company. All rights reserved. PO Box 2580 STN B Montreal QC H3B 5C6.