Proposal

Critical Illness Insurance

Part of the Group Benefits Program

VICTOR

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The Need for Critical Illness Insurance

The combination of healthier lifestyles, greater self-awareness and significant advances in medical science have resulted in making today's health risks very different from what they were 25 years ago. The survival rates of Canadians who have suffered a life threatening illness have improved, and will continue to improve, because of these changes.

Although we are beating the odds, an alarming number of Canadians will suffer a critical illness in their lifetime.

Today's Health Risks

- An estimated 206,300 new cases of cancer and 80,800 deaths from cancer occurred in Canada in 2017.
- There are an estimated 62,000 strokes in Canada each year. That's one stroke every 9 minutes.
- Canadians have one of the highest rates of multiple sclerosis in the world.
- There are an estimated 669,600 Canadians living with heart failure and 92,900 new patients are diagnosed each year.

Sources: Canadian Cancer Society Statistics 2018; The Heart and Stroke 2017 Stroke Report; MS Society of Canada

Critical Illness insurance alleviates some of the stress due to financial burden when an insured is diagnosed with a covered condition.

Examples of How the Critical Illness Benefit Can Be Used

- Home Adaptation
- Convalescence
- Vacation
- Private Nursing
- Child Care
- Paying Off Debts
- Change of Lifestyle
- Change of Occupation
- Investment for Future Income
- Supplement Future Pension, etc.

Critical Illness Insurance

Critical Illness is designed to provide the financial resources that will allow employees to adjust to changes in their lifestyle as a result of having suffered a critical illness or injury. A lump sum benefit is provided in the event an employee is diagnosed with one of the covered conditions and survives for a specified period of time after the diagnosis or defined event occurs.

In addition to Employee Only coverage, groups have the option to select Employee and Spouse or Employee and Family coverage.

How It Works

- The insured person receives a lump sum cash benefit if they survive for 30 days (or 90 days for paralysis, loss of independent existence or bacterial meningitis, and 180 days for Multiple Sclerosis or loss of speech) after a covered condition has been diagnosed or after the defined event.
- It is a living benefit.
- Unlike life insurance, the benefit is paid to the insured, not the beneficiary.
- Benefit payment is not contingent on the ability or inability to work during recovery. Full recovery will not affect benefit payment.
- The benefit is paid independent of other medical insurance plans and how the insured uses the funds is entirely up to them.
- The definition of covered conditions reflect industry benchmark definitions, as maintained by the Canadian Life and Health Insurance Association (CLHIA).

Covered Conditions

There are 25 covered conditions for the employee, spouse and dependent children (if spousal or family coverage has been chosen):

- Aortic Surgery
- Aplastic Anemia
- Bacterial Meningitis
- Benign Brain Tumour
- Blindness
- Cancer (Life-Threatening)
- Coma
- Coronary Artery Bypass Surgery
- Deafness
- Dementia, Including Alzheimer's Disease
- Heart Attack
- Heart Valve Replacement or Repair
- Kidney Failure
- Loss of Independent Existence
- Loss of Limbs
- Loss of Speech
- Major Organ Failure on Waiting List
- Major Organ Transplant
- Motor Neuron Disease
- Multiple Sclerosis
- Occupational HIV Infection
- Paralysis
- Parkinson's Disease and Specified Atypical Parkinsonian Disorders
- Severe Burns
- Stroke

There are six additional child-specific covered conditions for dependent children (if family coverage has been chosen):

- Cerebral Palsy
- Congenital Heart Disease
- Cystic Fibrosis
- Down's Syndrome
- Muscular Dystrophy
- Type 1 Diabetes

Plan Summary

Schedule of Benefits

Employee Only Coverage (Standard)

- All full-time employees who are under age 70, residents of Canada and actively at work are eligible.
- Actively at work means actually at work at the employee's usual place of employment and performing all the usual and customary duties of his/her normal occupation on a regular, full-time basis.
- Full-time means a period of work of not less than 20 hours per week at full pay.
- Multiple Event Coverage and AdvanceCare Benefit are included.
- Waiver of Premium benefits are included.

Benefit Schedule

Number of Employees	Benefit Minimum	Benefit Maximum	Non-evidence Maximum
1-2*	$5,000	$25,000	$0
3-9	$5,000	$25,000	$25,000
10-24	$5,000	$50,000	$50,000
25-49	$5,000	$100,000	$100,000
50-299	$5,000	$150,000	$150,000

* All coverage for 1–2 life groups must be medically underwritten and approved prior to coverage going into effect.

Employee and Spouse Coverage (Optional)

- Spouses under age 70 who are residents of Canada are eligible.
- Enrollment is guaranteed.
- The spouse's coverage will be up to 50% of the employee benefit amount, to a maximum of $10,000 for groups with 3-9 lives, to a maximum of $25,000 for groups with 10-24 lives, and to a maximum of $50,000 for groups with 25+ lives.
- Coverage is not available to groups with 1-2 lives.

Employee and Family Coverage (Optional)

- Spouses under age 70 who are residents of Canada are eligible.
- Dependent children up to age 21 (inclusive) (or 25 if a full-time student) who are residents of Canada are eligible.
- Enrollment is guaranteed.
- The spouse's coverage cannot exceed 50% of the employee benefit amount, and will be in units of $5,000 to a maximum of $10,000 for groups with 3-9 lives and to a maximum of $25,000 for groups with 10+ lives.
- The dependent child's coverage will be $5,000 for groups with 3-9 lives, or the option of $5,000 or $10,000 for groups with 10+ lives.
- Coverage is not available to groups with 1-2 lives.

Critical Illness insurance is underwritten by Industrial Alliance Insurance and Financial Services Inc. ("iA Financial Group").

Standard Features

Multiple Event Coverage

This coverage allows employees to claim more than once under the Critical Illness benefit, provided subsequent claims are for unrelated covered conditions, as illustrated in the Multiple Event Coverage (MEC) Grouping chart below.

- The subsequent diagnosis must be for a covered condition in a different MEC grouping.
- An employee cannot claim more than once within each grouping (please note that Stroke is included in both Group 2 and Group 3).
- MEC is not available for spouses or dependent children.

MEC Grouping	Covered Condition
Group 1	Cancer (Life-Threatening)
Group 2	Aortic Surgery, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement or Repair, Stroke
Group 3	Bacterial Meningitis, Benign Brain Tumour, Coma, Dementia Including Alzheimer's Disease, Loss of Independent Existence, Loss of Speech, Motor Neuron Disease, Multiple Sclerosis, Paralysis, Parkinson's Disease and Specified Atypical Parkinsonian Disorders, Stroke
Group 4	Aplastic Anemia, Kidney Failure, Major Organ Failure on Waiting List, Major Organ Transplant
Group 5	Blindness
Group 6	Deafness
Group 7	Severe Burns
Group 8	Loss of Limbs
Group 9	Occupational HIV Infection

AdvanceCare Benefit

This coverage pays 10% of the full Critical Illness benefit amount after the diagnosis of one of the following AdvanceCare Benefit conditions:

- Coronary Angioplasty
- One of several Early Stage Cancers

The benefit is payable for only one AdvanceCare Benefit condition; however, payment of an AdvanceCare Benefit will not affect the payment of a subsequent diagnosis of a covered condition.

This coverage is not available to dependent children.

Claims at TuGo

Critical Illness insurance also provides access to Claims at TuGo. If an insured person chooses to obtain private treatment for a diagnosed condition, Claims at TuGo can help. The service provides assistance in obtaining specialized, private medical treatment at claim time. With access to treatment centres around the world, Claims at TuGo can provide*:

- referral services to physicians at medical centres of excellence, most appropriate for his/her condition and course of treatment
- co-ordination of surgery and pre- and post-operative visits
- co-ordination of travel arrangements, including accommodations for the insured person and his/her travelling companions
- co-ordination of any other details connected to the insured person's medical procedure
- access to discounted rates

*Note that utilization fees may apply.

Waiver of Premium

If an employee is totally disabled for at least six continuous months, the Critical Illness premium will be waived retroactively from the date of total disability. Premium for the insured spouse and/or dependent children will also be waived.

The Waiver of Premium benefit is subject to the following conditions:

- Total disability must occur before the employee's 70th birthday. Please be aware that if a higher termination age is selected, this will be affected.
- No premium will be waived if the total disability is caused or contributed to by an injury or sickness intentionally self-inflicted or resulting from an act of war.

The Waiver of Premium benefit will terminate on the earliest of the following dates:

- For active full-time employees who are under age 63 when total disability commences, waiver of premium will terminate at the earlier of the date the employee attains age 65 or the termination age.
- For active full-time employees who are age 63 or older but under age 80 when total disability commences, waiver of premium will terminate at the end of 24 months, but not beyond the termination age. Please be aware that if a higher termination age is selected, this will be affected.
- For active full-time employees who are age 80 or older when total disability commences, waiver of premium will terminate at the end of 12 months, but not beyond the termination age. Please be aware that if a higher termination age is selected, this will be affected.

Conversion Privilege

If an employee and/or spouse's coverage terminates or changes so that they cease to be eligible under the plan, they may convert their Critical Illness Insurance, without evidence of insurability to a separate critical illness policy, subject to the following:

- The employee and/or spouse must be under age 65 and reside in Canada at the time they cease to be eligible.
- The employee and/or spouse have not received a Covered Condition Benefit or AdvanceCare Benefit under this plan or any other critical illness insurance benefit under any group policy issued by iA Financial Group.

- The maximum amount to be converted will be limited to the lesser of $100,000 for the employee and $25,000 for a spouse and the amount of coverage in force at the date of termination.
- The insurer must be notified of the conversion request within 31 days of the employee and/or spouse ceasing to be eligible.
- Premiums will be charged based on gender, smoker status and age at the time of conversion.
- The converted policy will be of a type then issued by the insurer providing term insurance to age 75 and will be issued without waiver of premium benefit, return of premium benefit, paid-up benefit or guaranteed increase benefit.
- If the employee and/or spouse have not been insured for at least 24 months under the Critical Illness Insurance plan at the time they cease to be eligible, any time remaining under the pre-existing condition exclusion will carry over to the separate policy.
- Dependent children are not eligible for the Conversion Privilege.

Note: Termination of the group benefits plan does not qualify an employee for conversion to a separate critical illness policy.

Termination

Employee coverage under Critical Illness insurance terminates on the earliest of the following dates:

- The termination date of the group benefits plan;
- The employee's 70th birthday;
- The last day of active work, when the employee ceases to be an eligible employee, as defined in the group benefits plan; or
- The premium due date for unpaid premiums if not paid within the 31-day grace period.

Note: The employer may choose to continue group insurance coverage for eligible employees up to age 85. Where this is the case, Critical Illness coverage will continue until the termination age. The employee's coverage will reduce by 50% at age 80.

Conditions of Benefit Payment

1. The employee must survive 30 days after a covered condition has been diagnosed or after the defined event, except for paralysis, loss of independent existence and bacterial meningitis where a waiting period of 90 days applies, and Multiple Sclerosis or loss of speech where a waiting period of 180 days applies.
2. Diagnosis of a covered condition must be made by a medical specialist licensed and practicing in Canada or the United States of America whose practice is limited to the particular branch of medicine relating to the applicable covered condition and who is not the employee, a relative or business associate of the employee.
3. The insurer reserves the right to require examination of the employee to confirm the diagnosis of the covered condition by a medical practitioner appointed by the insurer.
4. The employee must also satisfy the definition of the applicable covered condition under which he/she is claiming.

Exclusions

In addition to the exclusions included within the definitions of certain covered conditions, no benefit will be paid if a covered condition or AdvanceCare Benefit condition results directly or indirectly from any one or more of the following:

1. Attempted suicide;
2. Any illness, disease, mental, nervous or psychiatric condition or disorder for which any one of medical advice, treatment, service, prescribed medication, diagnosis or consultation including consultation to investigate and/or diagnose (where diagnosis has not yet been made) was received by the insured or would have been received by a prudent individual within the 24 months immediately preceding the effective date of an insured's coverage. This exclusion applies for the 24 months following the effective date of an insured's coverage
3. Taking any drug other than as prescribed by a licensed physician;
4. Taking poison or inhaling gas, whether voluntarily or involuntarily, not connected with the insured's employment;
5. Participation in a criminal act or any attempt to commit a criminal offense, including but not limited to, operating a motor vehicle while the concentration of alcohol in 100 millilitres of the insured's blood exceeds 80 milligrams;
6. Intentionally self-inflicted injury, while sane or insane; and/or
7. No benefit will be paid if the insured suffers Paralysis, Blindness, Deafness, Severe Burns, Stroke, Coma or Loss of Limbs, as a result, directly or indirectly, from amateur or professional boxing, bungee jumping, B.A.S.E. jumping, cliff diving, mountain climbing, motor vehicle racing or speed competition on land and/or water, parachuting or underwater activities, including scuba diving and snuba diving.

Limitations

1. No benefit will be paid if Cancer (Life-Threatening) is diagnosed, or any signs, symptoms or investigations leading to the diagnosis of Cancer (Life-Threatening), regardless of when the diagnosis is made, are initiated within 90 days following the effective date of the insured's Critical Illness insurance coverage. In the event of such a diagnosis:

    - an insured employee's coverage will remain in force but Cancer (Life-Threatening) will no longer be considered a covered condition for the employee;
    - an insured spouse's or insured dependent child's critical illness coverage will be voided in its entirety.

2. No benefit will be paid if a Benign Brain Tumour is diagnosed, or any signs, symptoms or investigations leading to the diagnosis of a Benign Brain Tumour, regardless of when the diagnosis is made, are initiated within 90 days following the effective date of the insured's Critical Illness insurance coverage.
   In the event of such a diagnosis:

    - an insured employee's coverage will remain in force but Benign Brain Tumour and the other covered conditions in MEC Group 3 will no longer be considered a covered condition for the employee;
    - an insured spouse's or insured dependent child's critical illness coverage will be voided in its entirety.

3. No benefit will be paid if Early Stage Cancer is diagnosed, or any signs, symptoms or investigations leading to the diagnosis of Early Stage Cancer, regardless of when the diagnosis is made, are initiated within 90 days following the effective date of the insured's Critical Illness insurance coverage.
   In the event of such a diagnosis:

    - the AdvanceCare Benefit will not be payable;
    - Critical Illness Insurance remains in force but Early Stage Cancer will be removed as an AdvanceCare Benefit condition for such insured.

Definitions of Covered Conditions

Employee, Spouse and Dependent Children Covered Conditions

Aortic Surgery

Aortic Surgery means 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. The surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Aplastic Anemia

Aplastic Anemia means a definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following: marrow stimulating agents; immunosuppressive agents; bone marrow transplantation. The diagnosis of Aplastic Anemia must be made by a Specialist.

Bacterial Meningitis

Bacterial Meningitis means a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis. The diagnosis of Bacterial Meningitis must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for viral meningitis.

Benign Brain Tumour

Benign Brain Tumour means a definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s). The diagnosis of Benign Brain Tumour must be made by a Specialist.

Exclusion: No benefit will be payable under this condition if, within the first 90 days following the later of the issue date of an insured person's coverage, or the last reinstatement date of an insured person's coverage, such insured person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of Benign Brain Tumour (covered or excluded under the policy), regardless of when the diagnosis is made; or
- a diagnosis of Benign Brain Tumour (covered or excluded under the policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the 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 benefit will be payable under this condition for pituitary adenomas less than 10mm.

Blindness

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

- the corrected visual acuity being 20/200 or less in both eyes; or
- the field of vision being less than 20 degrees in both eyes.

The diagnosis of Blindness must be made by a Specialist.

Cancer (Life-Threatening)

Cancer (Life-Threatening) means a definite diagnosis of a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma and sarcoma. The diagnosis of Cancer (Life-Threatening) must be made by a Specialist.

Exclusion: No benefit will be payable under this condition if, within the first 90 days following the later of the issue date of an insured person's coverage, or the last reinstatement date of an insured person's coverage, such insured person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of cancer (covered or excluded under the policy), regardless of when the diagnosis is made; or
- a diagnosis of cancer (covered or excluded under the policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the 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 (Life-Threatening) or any Critical Illness caused by any cancer or its treatment.

No benefit will be payable for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in situ (Tis) or tumours classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1; or
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

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.

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 four or less. The diagnosis of Coma must be made by a Specialist.

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

- a medically induced coma;
- a coma which results directly from alcohol or drug use; or
- a diagnosis of brain death.

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

Exclusion: No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

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. The diagnosis of Deafness must be made by a Specialist.

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:

- aphasia (a disorder of speech);
- aphraxia (difficulty performing familiar tasks);
- agnosia (difficulty recognizing objects); or
- disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor and stop complex behavior), which is affecting daily life.

The insured person must exhibit:

- Dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
- Evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6-month period.

The diagnosis of Dementia, Including Alzheimer's Disease must be made by a Specialist.

Exclusion: No benefit will be payable under this 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

Heart Attack means a definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in the rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

- heart attack symptoms;
- new electrocardiogram (ECG) changes consistent with a heart attack; or
- 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.

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

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or
- ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

Heart Valve Replacement or Repair

Heart Valve Replacement or Repair means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this condition for angioplasty, inter-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Kidney Failure

Kidney Failure means the definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated. The diagnosis of Kidney Failure must be made by a Specialist.

Loss of Independent Existence

Loss of Independent Existence means a definite diagnosis of the total inability to perform, by oneself, at least two of the following six 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 including 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 use of assistive devices
- 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

Loss of Limbs means a definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis of Loss of Limbs must be made by a Specialist.

Loss of Speech

Loss of Speech means a definite diagnosis of the total and irreversible loss of the ability to speak as a result of physical injury or disease, for a period of at least 180 days. The diagnosis of Loss of Speech must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for all psychiatric-related causes.

Major Organ Failure on Waiting List

Major Organ Failure on Waiting List means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List, the insured must become enrolled as the recipient in a recognized transplant center in Canada or the United States of America that performs the required form of transplant surgery. For the purpose of the survival period, the date of diagnosis is the date of the insured person's enrollment in the transplant center. 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 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

Motor Neuron Disease means a definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions. The diagnosis of Motor Neuron Disease must be made by a Specialist.

Multiple Sclerosis

Multiple Sclerosis means a definite diagnosis of at least one of the following:

- two or more separate clinical attacks, confirmed by a magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
- well-defined neurological abnormalities lasting more than six months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
- a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

The diagnosis of Multiple Sclerosis must be made by a Specialist.

Occupational HIV Infection

Occupational HIV Infection means 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 latest reinstatement of such insured's insurance coverage.

Payment under this condition requires satisfaction of all of the following:

- the accidental injury must be reported to the insurer within 14 days of the accidental injury;
- a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
- a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
- all HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America; and
- the accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

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

Exclusion: No benefit will be payable under this condition if:

- the insured has elected not to take any available licensed vaccine offering protection against HIV;
- a licensed cure for HIV infection has become available prior to the accidental injury; or
- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis

Paralysis means a definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event. The diagnosis of Paralysis must be made by a Specialist.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders

Parkinson's Disease and Specified Atypical Parkinsonian Disorders means a definite diagnosis of either a) Parkinson's Disease or b) Specified Atypical Parkinsonian Disorders, as defined below.

a. Parkinson's Disease means a definite diagnosis of primary Parkinson's disease, a permanent neurological condition which must be characterized by bradykinesia (slowness of movement) and at least one of the following: muscular rigidity or rest tremor. The insured person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.
b. Specified Atypical Parkinson's Disorders means a definite diagnosis of progressive supranuclear palsy, corticobasal degeneration or multiple system atrophy.

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

Exclusions: No benefit will be payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if, within the first year following the later of the issue date or the latest reinstatement date of an insured person's coverage, such insured person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the diagnosis is made; or
- a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of Parkinsonism.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the 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 benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of Parkinsonism.

Severe Burns

Severe Burns means a definite diagnosis of third-degree burns over at least 20% of the body surface. The diagnosis of Severe Burns must be made by a Specialist.

Stroke (Cerebrovascular Accident)

Stroke (Cerebrovascular Accident) means a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source with:

- acute onset of new neurological symptoms; and
- new objective neurological deficits on clinical examination, persisting for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing. The diagnosis of Stroke must be made by a Specialist.

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

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

Note: Any illness or disorder not specifically defined as a covered condition will not be payable. Payment of the benefit for a spouse or dependent child is limited to the first covered condition to occur.

Definitions of AdvanceCare Benefit Conditions

(Applicable to insured employees and insured spouses only.)

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. The procedure must be determined to be medically necessary by a Specialist.

Early Stage Cancer

Early Stage Cancer refers to one of the following conditions:

- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1;
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2; or
- Ductal Carcinoma in situ of the Breast.

The diagnosis of an Early Stage Cancer must be made by a Specialist.

Specific Dependent Children Covered Conditions

(In addition to the 25 Covered Conditions referenced previously, the following six child conditions also apply to an insured dependent child.)

Cerebral Palsy

Cerebral Palsy means a non-progressive neurological defect characterized by spasticity and incoordination of movements.

Congenital Heart Disease

Congenital Heart Disease means a diagnosis of one of the following heart conditions following a 30-day survival period from diagnosis or birth, whichever comes later. The diagnosis must be made by a qualified pediatric cardiologist and supported by appropriate cardiac imaging.

- Total Anomalous Pulmonary Venous Connection
- Transposition of the Great Vessels
- Atresia of any heart valve
- Coarctation of the Aorta
- Single Ventricle
- Hypoplastic Left Heart Syndrome
- Double Outlet Left Ventricle
- Truncus Arteriosus
- Tetralogy of Fallot
- Eisenmenger Syndrome
- Double Inlet Ventricle
- Hypoplastic Right Ventricle
- Ebstein's Anomaly

Exclusion: Trans-catheter procedures such as balloon valvuloplasty or percutaneous Atrial Septal Defect closure are excluded. All other congenital cardiac conditions are excluded.

Cystic Fibrosis

Cystic Fibrosis means a definitive diagnosis of Cystic Fibrosis with evidence of chronic lung disease and pancreatic insufficiency.

Down's Syndrome

Down's Syndrome means a definitive diagnosis of Down's Syndrome supported by chromosomal evidence of Trisomy 21.

Muscular Dystrophy

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

Type 1 Diabetes

Type 1 Diabetes means a diagnosis of type 1 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 or the United States of America and there must be evidence of dependence on insulin for a minimum of three months.

Note: Any illness or disorder not specifically defined as a covered condition will not be payable. Payment of the benefit for a Dependent Child is limited to the first covered condition to occur.

This proposal has been designed to provide an overview of the benefits available through the ENCON Group Benefits Program.

This is a proposal of coverage only. Your plan advisor will provide a quotation which confirms benefit selections and the associated premium costs.

Log in to victorinsurance.ca/gbconnect for more information.

Victor Insurance Managers inc., 600-55 Standish Court, Mississauga, Ontario L5R 4B2