My Optional **Critical Illness** Benefit

Health Association Nova Scotia is a not-for-profit, non-government, membership-based association with over 60 years' experience in delivering shared services. Serving over 130 health and health-related organizations from across Nova Scotia, we are dedicated to achieving service excellence through innovation, outstanding performance, and an exceptional customer experience. One of our core service offerings is Group Benefits Solutions. We provide a range of comprehensive and cost-effective employee benefits plans, designed to help protect plan members and their families. We offer both mandatory and optional (voluntary) coverage. Your employer may offer all or some of the Health Association's benefits.

This is a summary of the Health Association Nova Scotia **Critical Illness Plan.** For more detailed information, visit our website at www.healthassociation.ns.ca or contact your Benefits Administrator.

In the event of a discrepancy between this publication and the contracts, the contracts will prevail.

ELIGIBILITY

Who is eligible?

If you have been hired as a **permanent employee** to work at least 40% of a regular work week, you are entitled to coverage for you, your spouse and dependents.

Your spouse is defined as someone to whom you are married legally or common law (defined as having lived with your partner for 12 months or more; the 12 month cohabitation period is waived in the event a child is born of such relationship). This includes a spouse of the same sex.

Your dependent child is defined as an employee's or spouse's child who:

- is either under age 21 or under age 26 and a full-time student at an accredited school, college, or university; and
- is unmarried (legally or common law); and
- is not employed on a full-time basis; and
- is not eligible for benefits as an employee under this or any other group plan.

A child who is incapable of employment due to a mental or physical condition that occurred before reaching the maximum age will continue to be covered if approved by the insurance company.

When will coverage begin?

Critical Illness Insurance coverage for you, and/or your spouse and/or your dependents starts the date your employer receives your application.

You must be actively at work on the coverage effective date in order for coverage to become effective.

When will coverage end?

Your Critical Illness coverage ends when you are no longer eligible, retire, reach age 70, or employment is terminated, whichever comes first.

Coverage for your spouse ends when they no longer meet the definition of spouse, you reach age 70, your spouse reaches age 70, your employment is terminated, or at your retirement, whichever comes first.

Coverage for your dependent children ends when they no longer meet the definition of dependent child, you reach age 70, your employment is terminated or at your retirement, whichever comes first.

Coverage ends when a claim is paid.

COVERAGE FOR YOU AND/OR YOUR SPOUSE

What is covered?

Critical Illness coverage is available for you and/or your spouse in units of $5,000, with a minimum of $10,000 and a maximum of $150,000. Proof of good health is not required for the first $25,000, but you must provide proof of good health and be approved by the insurer for all amounts greater than $25,000.
*Pre-existing condition applies to the $25,000

The Critical Illness benefit is payable if one of the following conditions is diagnosed (**restrictions apply**).

- Alzheimer's Disease
- Aortic Surgery
- Benign Brain Tumor
- Blindness
- Cancer (Life-Threatening)
- Coma
- Coronary Artery Bypass Surgery
- Deafness
- Heart Attack
- Heart Valve Replacement
- Kidney Failure
- Loss of Limbs
- Loss of Speech
- Major Organ Failure and On Waiting List for Transplant
- Major Organ Transplant
- Motor Neuron Disease
- Multiple Sclerosis
- Occupational HIV Infection
- Paralysis
- Parkinson's Disease
- Severe Burns
- Stroke (Cerebrovascular Accident)

For definitions of eligible Critical Illness conditions, see Appendix A

If while insured for this benefit you are diagnosed with one of the covered illnesses and you survive for a period of 30 days (survival period) from the date of diagnosis, the benefit will become payable. Written notice of claim must be given to Insurance provider within 90 days after date of diagnosis.

What are the exceptions for adult coverage?

The employee must be actively at work on the coverage effective date in order for coverage to become effective.

Unless you and/or your spouse submit a medical questionnaire and are approved for coverage by the insurer, Critical Illness benefits are not payable for conditions resulting directly or indirectly from a pre-existing condition within the first 24 months of coverage.

*A pre-existing condition is defined as an illness or injury for which the Insured person has exhibited signs or symptoms, received medical treatment, care or services (including diagnostic measurements), consulted a physician or has been prescribed medication; or where treatment would have been sought by a prudent individual during the 24 months prior to the effective date of coverage or the latest date of reinstatement for this Benefit.

In addition to pre-existing conditions, benefits are not payable for the diagnosis of any life-threatening cancer or benign brain tumour made within the first 90 days of coverage.

Exclusions:
No benefits are payable related to:
- Self-inflicted injuries or illnesses whether the insured is sane or insane
- Abuse of addictive substances, including but not limited to legal and illegal drugs and alcohol
- War, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- The committing of or the attempt to commit an assault or criminal offence
- Injuries sustained while operating a motor vehicle, either while under the influence of any intoxicant or if the insured blood contained more than 80 milligrams of alcohol per 100 milliliters of blood at the time of the injury
- Intentionally taking a poisonous substance or inhaling toxic gases or fumes
- Any specific exclusion relating to any given condition, as more particularly set out in covered critical illness conditions appendix.

COVERAGE FOR YOUR DEPENDENT CHILDREN

What is covered?

Coverage is available for your dependent children. It provides a lump sum payment of $10,000 should your child be diagnosed with one of a number of specified conditions.

Optional Critical Illness Insurance for your dependent children starts the date your employer receives the application.

In addition to the previously listed adult illnesses, the following childhood conditions are covered (**restrictions apply**; please see definitions for eligible conditions at www.heathassociation.ns.ca/benefits for details):

- Autism
- Cerebral Palsy
- Congenital Heart Disease (certain conditions apply)
- Cystic Fibrosis
- Down Syndrome
- Muscular Dystrophy
- Type 1 Diabetes Mellitus

For definitions of eligible Critical Illness conditions. see Appendix A

What are the exceptions to a dependents coverage?

The employee must be actively at work on the coverage effective date in order for coverage to become effective.

No critical illness benefit will be paid in relation to a child who is born within the first ten (10) months of coverage effective date and who is diagnosed with a child covered condition within those ten months.

In addition, benefits are not payable for diagnosis of any life-threatening cancer or benign brain tumour made within first 90 days of coverage.

Autism diagnosis must be before the child's third birthday.

Exclusions:
No benefits are payable related to:
- Self-inflicted injuries or illnesses whether the insured is sane or insane
- Abuse of addictive substances, including but not limited to legal and illegal drugs and alcohol
- War, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion
- The committing of or the attempt to commit an assault or criminal offence
- Injuries sustained while operating a motor vehicle, either while under the influence of any intoxicant or if the insured blood contained more than 80 milligrams of alcohol per 100 milliliters of blood at the time of the injury
- Intentionally taking a poisonous substance or inhaling toxic gases or fumes
- Any specific exclusion relating to any given condition, as more particularly set out in covered critical illness conditions appendix.

CLAIMING

How do I make a claim?

In the event of a claim, you must notify your employer and complete and submit the Critical Illness Notification form. The claimant (you, your spouse and/or your eligible dependents) must survive 30 days from the date of diagnosis. Written notice of claim must be given to the insurance provider within 90 days after the date of the diagnosis.

CONTINUATION OF COVERAGE
What happens during a leave of absence?

If you take an approved paid leave of absence your deductions and coverage would continue. Coverage can continue up to 24 months. Coverage will not be reinstated automatically.

If you take an approved unpaid leave of absence, or a maternity or parental leave, you may continue for up to 24 months as long as you pay your required premiums. If you choose not to continue the benefit during your leave, you may re-apply for coverage when you return to work. Coverage will not be reinstated automatically.

If you are on an approved sick leave you may continue benefits for up to 24 months.

If you are approved for Health Association Nova Scotia Long Term Disability (LTD) benefits (after January 1, 2009), coverage continues and you do not pay premiums for as long as you are receiving the LTD benefit.

What happens to coverage when I retire?

Critical Illness coverage ceases.

Can I convert coverage?

There is no conversion option when your Critical Illness coverage ends.

HEALTH SERVICE NAVIGATOR... A SERVICE AVAILABLE TO CRITICAL ILLNESS PLAN MEMBERS

In addition to the critical illness coverage, the insurance provider offers you, your spouse and your eligible dependents with access to Health Service Navigator (HSN), a comprehensive, integrated health information and online resource centre.

Health Service Navigator:
- Provides a resource to help you navigate the Canadian health care system
- Provides access to you and your eligible family members
- Is available even when you are not making a critical illness claim
- Provides access to a world-class medical second opinion service.

To use the service, please visit www.healthservicenavigator.com. Once you agree to the Terms you can access the resources available.

Questions?

If you have any questions about your benefits, talk to your Benefits Administrator (Employer) or contact Health Association Nova Scotia.

Group Benefits Solutions
Health Association Nova Scotia
2 Dartmouth Road, Bedford, Nova Scotia B4A 2K7
Toll-free: 1-866-886-7246

For more information, visit www.healthassociation.ns.ca and select the Benefits Plan Member Information button

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Covered Critical Illness Conditions Appendix

Effective Date: March 1, 2010

This Appendix contains definitions for those Conditions that are covered under the Manulife Financial's Group Critical Illness plan, ***effective March 1, 2010***.

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 Financial 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.

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.

Covered Critical Illness Conditions Appendix

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 Financial within 6 months of the date of the first diagnosis. If this information is not so provided, Manulife Financial 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.

Covered Critical Illness Conditions Appendix

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 Financial within 6 months of the date of the first diagnosis. If this information is not so provided, Manulife Financial 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.

Covered Critical Illness Conditions Appendix

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 nonsurgical 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 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.

Covered Critical Illness Conditions Appendix

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.

Covered Critical Illness Conditions Appendix

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 Financial:

a) 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

b) A diagnosis of Multiple Sclerosis by a neurologist ,in accordance with definitions established by the International Panelon MS Diagnostic Criteria in the tables below:

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

Covered Critical Illness Conditions Appendix

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.