Mechanical Contractors Association of Alberta

Critical • Choice • Care

Policy #1RJ85

A Voluntary Insurance Program for Critical Illness for You and Your Dependents

Effective: September 1, 2015

This booklet is an outline of SSQ Insurance Company Inc. Critical·Choice·Care 29 illnesses insurance program offered to Employees of Mechanical Contractors Association of Alberta and their dependents (Spouses and Dependent Children). It is designed to help you learn more about the coverage offered under this insurance program. This booklet should be retained for reference.

The Critical·Choice·Care 29 illnesses #1RJ85 group insurance program's Master Policy, endorsements and attached papers, if any, and the entire contract of insurance, all referred to hereafter as the "Policy", sets forth the terms and conditions of the insurance program. All rights and obligations are determined in accordance with the Policy, not this booklet. For exact provisions of coverage offered, please contact your Human Resources department.

Introduction

What is critical illness insurance?

Critical illness insurance can provide the funds and the means to preserve your quality of life, protect personal assets and allow the freedom and flexibility to choose the kind of health care you want.

Critical·Choice·Care is designed to provide you with a lump sum payment in the event that you are diagnosed with a covered Critical Illness and survive at least 30 days following the diagnosis. Among the many advantages of this coverage, payment of benefits is not limited by your ability to work or even by a full recovery. Should you receive a critical illness diagnosis, the benefit is paid directly to you and you are **free to choose how to use the Critical·Choice·Care benefit payment.**

Why is critical illness insurance important to you and your family?

Research has shown that a significant number of Canadians will face the challenge of a critical illness. Consider the following:

- 40% of Canadian women and 45% of men will develop cancer during their lifetimes.
- On average, 3,300 Canadians will be diagnosed with cancer every week.
- There are an estimated 70,000 heart attacks each year in Canada. One heart attack every 7 minutes.
- More than 50,000 strokes occur in Canada each year. That's one stroke every 10 minutes.
- 75% of stroke victims survive the initial event.
- Approximately 1,000 new cases of multiple sclerosis are diagnosed in Canada each year.

Source: Heart and Stroke Foundation, Canadian Cancer Society and Multiple Sclerosis Society of Canada

Critical illnesses are diagnosed everyday. Although healthy lifestyle choices can help protect against some health risks, a critical illness or condition can strike anyone at any time. Thanks to advances in modern medicine however, Canadians are enjoying longer and healthier lives. As survival rates improve, the need for critical illness insurance, to help provide financial support throughout the recovery process, is becoming more and more important.

A critical illness insurance benefit can help you:

- obtain the appropriate care where and when you decide;
- cover medical expenses not covered under your provincial health care plan;
- focus on your recovery process by funding a leave of absence;
- compensate for reduced family earnings and face increased costs, by using the benefit to pay for:
  - medical bills or private nursing care;
  - mortgage payments or rent;
  - debt or other financial liabilities;
  - child care;
  - hired domestic help;
  - home or vehicle modifications.

What are the advantages of your coverage?

With Critical·Choice·Care's group critical illness insurance program, you benefit from:

- protection up to $25,000 [guaranteed issue amount – employee] for you, up to $15,000 [guaranteed issue amount-spouse] for your spouse, and up to $25,000 for your dependent child, tax-free, without having to answer any medical questions or provide any evidence of insurability;
- affordable coverage thanks to our competitive group rates;
- premium payments by way of payroll deductions;
- continued protection even if your health has diminished while covered under the program – even after having received a critical illness benefit you and your insured spouse may still be covered under our critical illness coverage!

Definitions for a better comprehension of this booklet

Wherever used in this document:

- "**Employee**" means all full-time, part-time employees working for Mechanical Contractors Association of Alberta and is under the age of 70.
- "**Insured Person**" means you or your insured Spouse, or insured Dependent Children, while meeting the Spouse and Dependent Child definition criteria presented in this section, and before the date of coverage termination.
- "**Insurer**", "**We**", "**Us**" means SSQ Insurance Company Inc.
- "**you**" and "**your**" both refer to the insured Employee to whom this booklet was intended.
- "**Spouse**" means an individual under the age of 70:

  (a) to whom you are legally married, or

  (b) with whom you have continuously cohabited in a conjugal relationship for a minimum of one year immediately before a Critical Illness is Diagnosed.

  However, when the individual is the biological or adoptive mother or father of at least one of your children, the spouse shall be so recognized from the date of birth or adoption, if that date precedes the end of the period of one year of cohabitation.

  Only one individual will qualify as your Spouse. If you are legally married but are also cohabiting with an individual as described under Item (b) above, you may elect in writing which one of the individuals will qualify as a Spouse under this Policy. This election must be filed with Mechanical Contractors Association of Alberta The Insurer will not be bound by an election not filed before the occurrence of the event insured against. If an election is not filed, the Spouse will be the individual to whom you are legally married.

- "**Dependent Child**" means a natural child, adopted child, stepchild or child who is in a parent-child relationship with you. The child must be unmarried and dependent upon you for maintenance and support and:

  – under 21 years of age; or

  – under 25 years of age (26 in the province of Quebec) and in attendance at an Institution for Higher Learning on a full-time basis; or

  – no matter his age has been struck with a functional disability while satisfying the conditions under either of the two paragraphs above. Proof of existence of this situation must be presented to the Insurer within 31 days after the child reaches the applicable limiting age indicated above (age at which he would no longer qualify as a Dependent

Child under this provision). Thereafter, the Insurer may periodically require that other proof be submitted establishing to its satisfaction that the situation still exists.

- "**Claimant**" means the person who has requested or is in the process of requesting a settlement after being Diagnosed with an illness covered under the Critical·Choice·Care program.
- "**Critical Illness**" means, with respect to the insured Employee and to the insured Spouse, one of the illnesses, conditions or surgical operations listed under "Covered Critical Illnesses – (for insured Employee and insured Spouse)". With respect to insured Dependent Children, "Critical Illness" means one of the illnesses, conditions or surgical operations listed under "Critical Illnesses Covered for Dependent Children".

  Any Critical Illness or health problem which is not defined, in the section of this booklet pertinent to a benefit of the Critical·Choice·Care program applicable to the Insured Person, is not covered according to such benefit and therefore, no benefit is payable.
- "**Diagnosis**" or "**Diagnosed**" means the time when a Specialist establishes, using tests or other diagnostic methods, that the Insured Person has a specific Critical Illness. The Diagnosis of any covered Critical Illness must be made by a licensed Specialist practising in Canada. Furthermore, his practice must be limited to the branch of medicine directly linked to the Critical Illness for which benefit is being claimed.
- "**Institution for Higher Learning**" means and is limited to universities, colleges, CEGEP's and trade schools.
- "**Irreversible**" means the condition cannot be improved by medical or surgical treatment at the time of Diagnosis. The medical or surgical treatment need not be undertaken if it would involve an undue risk to the Insured Person's health.
- "**Life Support**" means the Insured Person is under the regular care of a licensed physician for nutritional, respiratory and/or cardiovascular support when Irreversible cessation of all functions of the brain has occurred.
- "**Physician**" means an individual who is legally licensed to practice medicine in Canada and provide treatment within the scope of his licence. The Physician must not be the Insured Person, a relative of or business associate of the Insured Person.
- "**Policy**" **means** the Critical·Choice·Care 29 illnesses insurance program's Master Policy, endorsements and attached papers, if any, and contains the entire contract of insurance.
- "**Pre-Existing Condition**" means:
  - the existence of symptom(s) which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 24 month period preceding the Insured Person's effective date of coverage; or

- an illness or condition, for which the Insured Person, during 24 months prior to the effective date of his coverage incurred medical expenses, received medical treatment, took prescribed drugs or medicine or consulted a physician.

- "**Principal Sum**" means the amount applicable to the Insured Person, as listed under the *"Coverage Amount"* section of this booklet.

- "**Specialist**" means a licensed Physician who has been trained in the specific area of medicine relevant to the covered Critical Illness condition for which benefit is being claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a Specialist, and as approved by the Insurer, a condition may be Diagnosed by a qualified Physician practising in Canada. Specialist includes, but is not limited to, cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist. The Specialist must not be the Insured Person, a relative of or business associate of the Insured Person.

- "**Surgery**" means that the Insured Person undergoes medically necessary surgery performed on the written advice of a Specialist. The Surgery must be performed by a Physician in Canada.

- "**Survival Period**" means 30 days following the date of Diagnosis or 30 days following the date of Surgery, if applicable, except where otherwise specified under the Policy. The Survival Period does not include the number of days on Life Support as defined in this section. The Insured Person must be alive at the end of the Survival Period and must not have experienced Irreversible cessation of all functions of the brain. For those conditions which have a qualifying period, for example 90 days for Bacterial meningitis and Paralysis, the Survival Period runs concurrently with that condition's qualifying period.

When referring to a female person, male pronouns used in this document shall be construed as the feminine.

Details of the Program

Eligibility

The **Critical·Choice·Care** insurance program is available to Employees of Mechanical Contractors Association of Alberta and their dependents (Spouse and Dependent Children).

As an active Full – Time or Part - Time Employee of Mechanical Contractors Association of Alberta you are eligible under the Critical·Choice·Care program if you are residing in Canada. If you are absent from active work for any reason other than bona fide vacation, you will only become eligible upon return to active work.

Your spouse is eligible for coverage if he or she resides in Canada and meets the Spouse definition as presented under the "*Definitions – for better understanding of this booklet*" section.

Any of your children who meet the definition of Dependent Child as presented under the "*Definitions – for better understanding of this booklet*" are also eligible for coverage.

***Note**: If you are legally married but also cohabiting with an individual please refer to the Spouse definition for more information.*

Coverage Amounts

Critical·Choice·Care insurance is a voluntary group coverage for you, your Spouse and your Dependent Children.

You have the option to buy an amount of principal sum in units of $5,000 subject to a minimum of $10,000 and up to a maximum of $250,000, subject to acceptance by the Insurer under the basis of proof of insurability and subject to the terms of premium payment indicated in the "*Monthly Premium*" section.

Your Spouse has option to buy an amount of principal sum in units of $5,000 subject to a minimum of $10,000 and up to a maximum of $250,000, subject to acceptance by the Insurer under the basis of proof of insurability and subject to the terms of premium payment indicated in the "*Monthly Premium*" section.

You can enroll your Dependent Children for coverage up to $25,000 of principal sum, each, without having to provide any evidence of insurability.

With regard to evidence of insurability, you may request an amount of coverage equal or less than the guaranteed issue amount of $25,000 and your Spouse may request an amount of coverage equal or less than the guaranteed issue amount of $15,000 without having to answer medical questions or having to present evidence of insurability. However, if you or your Spouse wish to request an amount of coverage greater than the guaranteed issue amount, you and/or your Spouse must submit to the Insurer satisfactory evidence of insurability.

***Note**: Your Spouse may not request an amount of coverage greater than your amount of coverage.*

Insurance Effective Date

If you or your Spouse request an amount of coverage less than or equal to the guaranteed issue amount, your insurance is effective on the later of the following two dates:

1. the effective date of the Policy, if the request is received by Mechanical Contractors Association of Alberta on or prior to the effective date of the Policy; or
2. if the request is received by the Policyholder after the Effective Date of the Policy, coverage becomes effective on the 1st of the month next following three (3) months of continuous service of employment with the Policyholder.

If you or your Spouse request an amount of coverage greater than the guaranteed issue amount, your insurance is effective on the later of the following two dates:

1. the effective date of the Policy, if the approval from the Insurer has been received by Mechanical Contractors Association of Alberta on or prior to effective date of the Policy; or
2. the first of the month coincident with or following the date the approval from the Insurer has been received by Mechanical Contractors Association of Alberta, if the approval from the Insurer has been received by Mechanical Contractors Association of Alberta after the effective date of the Policy.

Your Dependent Child's coverage becomes effective on the date that your insurance becomes effective.

Insurance Termination

Your coverage terminates on the earliest of the following events:

- on the date the Policy is terminated;
- on the premium due date if Mechanical Contractors Association of Alberta . . .fails to pay the required premium, except as the result of an inadvertent error;

- on the next premium due date following the date you reach 70 years of age;
- on the next premium due date following the date you cease to be an active Employee of Mechanical Contractors Association of Alberta on account of resignation, dismissal or retirement;
- on the date of your death;
- on the date the Principal Sum payment for a Loss of Independent Existence claims has been paid;
- on the next premium due date following the date you give notice of cancellation to Mechanical Contractors Association of Alberta

Your insured Spouse's insurance terminates on the earliest of the following events:

- on the date the person ceases to meet the definition criteria for Spouse presented under the "*Eligibility*" section;
- on the date the Principal Sum payment for a Loss of Independent Existence claims has been paid;
- on the date the insured Employee's insurance is terminated.

Your insured Dependent Child's insurance terminates on the earliest of the following events:

- on the date the person ceases to meet the definition criteria for Dependent Child presented under the "*Eligibility*" section;
- on the date the Principal Sum has been paid;
- on the date the insured Employee's insurance is terminated.

Program Benefits

Critical Illness Coverage

If Diagnosed with one of the following Critical Illnesses while insured, you or your insured spouse are entitled to receive a benefit payment equivalent to the Principal Sum applicable to the person Diagnosed with the Critical Illness:

- Alzheimer's Disease
- Aortic Surgery
- Aplastic Anemia
- Bacterial Meningitis
- Benign Brain Tumour
- Blindness
- Cancer (life-threatening)
- Coma
- Coronary Artery Bypass Surgery
- Deafness
- Dilated Cardiomyopathy
- Fulminant Viral Hepatitis
- Heart Attack
- Heart Valve Replacement
- 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
- Muscular Dystrophy
- Occupational HIV Infection
- Paralysis
- Parkinson's Disease
- Primary Pulmonary Hypertension
- Severe Burns
- Stroke (cerebrovascular accident)

The Insured Person's Critical Illness must meet the definition of such illness as presented under the "*Covered Critical Illnesses – (for insured Employee and insured Spouse)*" section in order to be eligible for payment.

Payment is subject to the limitations of the Survival Period as referred to under "*Definitions for better comprehension of this booklet*" section and to the exclusions listed under "*General Exclusions*".

It should be noted that any misrepresentation of smoker status based on the answers given on the application or enrollment card will be deemed to be fraudulent and therefore coverage will become void.

Once an Insured Person has been paid a benefit for any Critical Illness, payment of any future benefit under the program is subject to limitations and exclusions as referred to in the "*Multiple Event Coverage*" section.

Cancer Recurrence Benefit

If you or your insured Spouse has already been diagnosed with cancer and, while insured, a new Diagnosis of Cancer (life-threatening) is made, you, or your insured Spouse will receive a benefit equivalent to the Principal Sum applicable to the person Diagnosed with Cancer, if the following conditions have been met:

- More than 60 months have passed since the previous cancer diagnosis; and
- No treatment relating directly or indirectly to cancer has been received within that 60 month period (treatment does not include preventive medications and follow up visits to the doctor).

The Diagnosed Cancer must meet the definition of Cancer (life-threatening), as presented under the "*Covered Critical Illnesses – (for insured Employee and insured Spouse)*" section in order to be eligible for a payment under this provision.

Payment is subject to the limitations of the Survival Period as referred to under "*Definitions for better comprehension of this booklet*" section and to the exclusions listed under "*General Exclusions*".

Once an Insured Person has been paid a benefit for any Critical Illness, payment of any future benefit under the program is subject to limitations and exclusions as referred to in the "*Multiple Event Coverage*" section.

Complementary Benefit in Case of Certain Illnesses

If Diagnosed with one of the following illnesses while insured, you or your spouse are entitled to receive a benefit payment equivalent to 10% of the Principal Sum applicable to the person Diagnosed with such illness, subject to a maximum of $25,000:

- Coronary Angioplasty;
- Ductal Carcinoma in Situ of the Breast;
- Stage A (T1a or T1b) Prostate Cancer;
- Stage 1A Malignant Melanoma.

Important: The Diagnosed illness must meet one of the definitions presented under section "*Illnesses covered under Complementary Benefit in case of certain Illnesses – (for insured Employee and insured Spouse)*" in order to be eligible under the Critical·Choice·Care program.

Payment for any one of the four illnesses listed above is subject to the limitations of the Survival Period as referred to under "*Definitions for better comprehension of this booklet*" section and to the limitations specified in the "*Re-Entry Exclusions*" section and to the exclusions listed under "*General Exclusions*" section. The sum payable can only be paid once in the Insured Person's lifetime. However, such sum is paid independently of any other benefit under the Critical·Choice·Care program, i.e., the Insurer does not deduct such complementary benefit payment from any previous or later Principal Sum payment.

Multiple Event Coverage

When you or your insured Spouse have been Diagnosed with one of the covered Critical Illnesses listed above for which a Principal Sum has been paid, and are then Diagnosed with another covered Critical Illness from the same list at least 90 days after the Principal Sum payment, you or your insured Spouse will then be paid another benefit equivalent to the Principal Sum applicable to the person Diagnosed with the illness, subject to the limitations and exclusions described in the "*Re-Entry Exclusions*" section.

For a benefit payment under the Multiple Event Coverage benefit, the Critical Illness Diagnosed must meet one of the definitions presented under the "*Covered Critical Illnesses – (for insured Employee and insured Spouse)*" section and the Diagnosis must be made at least 90 days after payment of a benefit for a covered condition was made.

Payment is subject to the limitations of the Survival Period as referred to under "*Definitions for better comprehension of this booklet*" section and to the exclusions listed under "*General Exclusions*".

Children Coverage

You will receive a payment equivalent to your Dependent Child's Principal Sum if this Dependent Child is Diagnosed with one of the following illnesses while his coverage is in force:

- Blindness
- Cancer (life-Threatening)
- Cerebral Palsy
- Coma
- Congenital Heart Disease requiring Surgery
- Cystic Fibrosis
- Deafness
- Down's Syndrome

- Loss of Speech
- Major Organ Transplant
- Mental Deficiency
- Muscular Dystrophy
- Paralysis
- Severe Burns
- Spina Bifida Cystica

The Dependent Child's Critical Illness must meet one of the definitions presented under "*Critical illnesses covered for Dependent Children*" section in order to be eligible under the Critical·Choice·Care program.

The payment is subject to limitations of the Survival Period as referred to under the "*Definitions — for better understanding of this booklet*" section and to the exclusions presented in the "*General Exclusions*" section.

Second Medical Opinion Service

Any Insured Person who is Diagnosed with a covered Critical Illness while enrolled in the insurance program is offered access to **AXA Assistance's Second Medical Opinion** program.

This program allows the Insured Person to obtain a second medical opinion from a highly qualified practitioner. It provides a thorough medical review that rigorously analyzes the Insured Person's file to confirm the initial Diagnosis and make recommendations on appropriate treatment.

If you or your insured Spouse or insured Dependent Child have been Diagnosed with a covered Critical Illness, simply call: **1-877-266-6550** in order to benefit from AXA Assistance's Second Medical Opinion program.

General Exclusions

The program does not cover a Critical Illness that results directly or indirectly from any one or more of the following causes or situations:

1. Within 90 days following the effective date of the Insured Person's coverage:
   - Diagnosis of Cancer is made; or
   - any signs, symptoms or investigations that lead to a Diagnosis of Cancer, regardless of when the Diagnosis is made.
2. Within 90 days following the effective date of the Insured Person's coverage:
   - Diagnosis of Benign Brain Tumour is made; or

- any signs, symptoms or investigations that lead to a Diagnosis of Benign Brain Tumour, regardless of when the Diagnosis is made.

3. The insured Person does not satisfy the Survival Period limitations.
4. An intentionally self-inflicted injury or sickness, whether the Insured Person is sane or insane.
5. The use of illicit drugs other than as prescribed and administered by or in accordance with the instruction of a legally licensed medical practitioner.
6. Any cancer that manifests itself prior to the effective date of the Insured Person's insurance when the same cancer either recurs or metastasizes after such effective date unless all the requirements in the "*Cancer Recurrence Benefit*" section have been met.
7. From a Pre-existing Condition except if such Critical Illness is Diagnosed 24 months after the Insured Person's effective date of coverage.

   The Pre-existing Condition exclusion applies only to amounts equal to or below the guaranteed issue limit applicable to the Insured Person. It does not apply to the Insured Person who was approved for a higher amount than the guaranteed issue limit.

Re-entry Exclusions

When a benefit is paid to you or your insured spouse for a Critical Illness and required premium payment is continued, individual insurance continues and a subsequent claim can be made in the event of another Diagnosis, subject to the following:

If a claim was made for a Critical Illness shown in the left column of the table below, no claim can be made for an illness listed in the right column.

Critical Illnesses Claimed for	**Re-entry Exclusions** (Illnesses for which the Insured Person cannot claim)
Alzheimer's Disease	Alzheimer's Disease, Loss of Independent Existence
Aortic Surgery	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Aplastic Anemia	Aplastic Anemia, Cancer (life-threatening), Ductal Carcinoma in Situ of the Breast, Loss of Independent Existence, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma

Critical Illnesses Claimed for	Re-entry Exclusions (Continued) (Illnesses for which the Insured Person cannot claim)
Bacterial Meningitis	Bacterial Meningitis, Blindness, Coma, Deafness, Loss of Independent Existence, Loss of Speech, Paralysis, Stroke
Benign Brain Tumour	Bacterial Meningitis, Benign Brain Tumour, Blindness, Coma, Deafness, Loss of Independent Existence, Loss of Speech, Paralysis, Stroke
Blindness	Blindness, Loss of Independent Existence
Cancer (life-threatening)	Aplastic Anemia, Cancer (life-threatening), Ductal Carcinoma in Situ of the Breast, Loss of Independent Existence, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma
Coma	Blindness, Coma, Deafness, Loss of Independent Existence, Loss of Speech, Paralysis, Stroke
Coronary Artery Bypass Surgery	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Deafness	Deafness, Loss of Independent Existence
Dilated Cardiomyopathy	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Dilated Cardiomyopathy, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Fulminant Viral Hepatitis	Cancer (life-threatening), Ductal Carcinoma in Situ of the Breast, Fulminant Viral Hepatitis, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma
Heart Attack	Alzheimer's Disease, Aortic Surgery, Coronary Angioplasty, Coronary Artery Bypass Surgery, Coma, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Heart Valve replacement	Alzheimer's Disease, Aortic Surgery, Coronary Angioplasty, Coronary Artery Bypass Surgery, Coma, Heart Valve Replacement, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke

Critical Illnesses Claimed for	Re-entry Exclusions (Continued) (Illnesses for which the Insured Person cannot claim)
Kidney Failure	Coma, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke
Loss of Independent Existence	Following claim for Loss of Independent Existence, the Insured Person cannot claim anymore. Insurance coverage terminates
Loss of Limbs	Loss of Independent Existence, Loss of Limbs
Loss of Speech	Loss of Independent Existence, Loss of Speech
Major Organ Failure on Waiting List	Aplastic Anemia, Cancer (life-threatening), Coma, Ductal Carcinoma in Situ of the Breast, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma, Stroke
Major Organ Transplant	Aplastic Anemia, Cancer (life-threatening), Coma, Ductal Carcinoma in Situ of the Breast, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma, Stroke
Motor Neuron Disease	Blindness, Coma, Deafness, Heart Attack, Loss of Independent Existence, Loss of Speech, Motor Neuron Disease, Paralysis, Stroke
Multiple Sclerosis	Blindness, Coma, Deafness, Kidney Failure, Loss of Independent Existence, Loss of Speech, Multiple Sclerosis, Paralysis, Stroke
Muscular Dystrophy	Blindness, Coma, Deafness, Dilated Cardiomyopathy, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Loss of Speech, Major Organ Failure on Waiting List, Major Organ Transplant, Muscular Dystrophy, Paralysis, Stroke
Occupational HIV Infection	Blindness, Cancer (life-threatening), Coma, Deafness, Ductal Carcinoma in Situ of the Breast, Kidney Failure, Loss of Independent Existence, Loss of Speech, Occupational HIV infection, Paralysis, Stage A (T1a or T1b) Prostate Cancer, Stage 1A Malignant Melanoma, Stroke
Paralysis	Coma, Loss of Independent Existence, Loss of Speech, Paralysis
Parkinson's Disease	Coma, Loss of Independent Existence, Loss of Speech, Paralysis, Parkinson's Disease

Critical Illnesses Claimed for	Re-entry Exclusions (Continued) (Illnesses for which the Insured Person cannot claim)
Primary Pulmonary Hypertension	Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Dilated Cardiomyopathy, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Primary Pulmonary Hypertension, Stroke
Severe Burns	Loss of Independent Existence, Paralysis, Severe burns
Stroke (Cerebrovascular Accident)	Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke

Waiver of Premium

The Insurer will waive your or your insured Spouse's premium in the following circumstances:

a) If the Insured Person has Long Term Disability (LTD) Insurance:

From the first day of the month following the date the Insured Person begins to receive monthly disability benefit payments through his LTD Insurance.

b) If the Insured Person does not have Long Term Disability (LTD) Insurance:

When injury or sickness totally disables and prevents the Insured Person from engaging in each and every gainful occupation for which he is or may become reasonably qualified by reason of his education, training or experience, for a period of at least 6 consecutive months. Premiums will be waived on the first day of the month following the 6 consecutive month period.

The Insurer must receive notice of disability within 12 months of the onset of total disability and due proof of such disability within 3 months following this notice.

Premiums will continue to be waived until the earliest of the following dates:

- on the date the Policy is terminated;
- on the date the Insured Person reaches 65 years of age;
- on the date the Insured Person ceases to be totally disabled; or

- on the date the Insured Person fails to provide, within 90 days of request, proof satisfactory to the Insurer of the continuance of total disability or refuse to submit to examination.

Coverage continued under the Waiver of premium benefit will be subject to the terms and provisions of the policy in effect as of the date of commencement of disability, including any provision providing for reductions in amounts of insurance.

Benefits payable for a Diagnosis made while coverage is being continued under the Waiver of Premium provision of the program will in no event exceed the amount of insurance that would have been payable to the Insured Person at the date of commencement of disability.

The Insurer can request proof of the continuance of total disability, and may also require the Insured Person to submit to examination by the Insurer's medical advisor, from time to time as the Insurer may reasonably require.

Conversion Option

If, with the exception of Policy termination, your insurance and/or the insurance of your insured Spouse is terminated due to:

- termination of your employment; or
- cessation of eligibility for insurance under this Policy; or
- cessation of a period of total disability after which you did not return to work for Mechanical Contractors Association of Alberta.

and before having reached age 65, you and/or your insured Spouse make a written request to the Insurer within 31 days before the date of the insurance termination; the Insurer will issue an individual Critical Illness policy without requesting evidence of insurability.

The amount of insurance that may be converted will not exceed the Insured Person's Principal Sum in effect on the date of termination or a total aggregate of $250,000 for all such conversions with the Insurer.

Premiums for the individual policy will be calculated at the Insurer's manual rates then in force for the attained age of the Insured Person at the date of conversion. Premiums will be payable annually in advance and the individual Critical Illness Policy will be issued on an annually renewable basis.

Coverage Payment

Monthly Premium

Monthly rates for each $5,000 of principal sum (provincial taxes not included):

	Male		Female	
Age	**Non-Smoker**	**Smoker**	**Non-Smoker**	**Smoker**
<20	$0.58	$0.64	$0.51	$.056
20-24	$0.61	$0.67	$0.47	$0.53
25-29	$0.82	$0.96	$0.78	$0.94
30-34	$0.88	$1.09	$1.02	$1.33
35-39	$1.01	$1.41	$1.20	$1.82
40-44	$1.42	$2.35	$1.54	$2.77
45-49	$2.36	$4.64	$2.25	$4.55
50-54	$3.69	$8.27	$3.07	$6.53
55-59	$6.34	$15.16	$4.14	$8.67
60-64	$10.79	$25.37	$6.15	$11.84
65	$14.35	$33.76	$8.18	$15.75
66	$15.78	$37.14	$8.99	$17.32
67	$17.36	$40.85	$9.89	$19.04
68	$19.10	$44.94	$10.87	$20.95
69	$21.00	$49.43	$11.95	$23.04

Monthly rate for each $5,000 of principal sum (provincial taxes not included) for Dependent Children: $3.10

To calculate your monthly premium or your Spouse's monthly premium, use the table above to find the unit rate that applies (based on age, gender and smoker status). Multiply the unit rate found by the number of $5,000 units of principal sum selected.

To calculate your Dependent Child's monthly premium, multiply the unit rate of $3.10 by the number of $5,000 units of Principal Sum selected for your Dependent Child.

Example: Male-Non Smoker, aged 45 with a Principal Sum of $50,000 = $23.60 per month

Any misrepresentation of smoker status on your application or enrollment card will be deemed fraudulent and therefore coverage will become void.

Premium Payment

Premiums for your coverage, your Spouse's coverage and your Dependent Child's coverage, if applicable, are paid by you, using the means of payroll deductions.

In the Event of a Claim

Area of Diagnosis

Should a Critical Illness occur or be diagnosed outside of Canada, payment of the Principal Sum may be considered upon the Insured Person's return to Canada for medical assessment and confirmation of the Diagnosis of a Critical Illness.

Notice of Claim and Proof of Illness

In the event of a Diagnosis of Critical Illness, a notice of this Critical Illness must be given to the Human Resources department of Mechanical Contractors Association of Alberta., who will then give notice of the claim to the Insurer in a timely manner.

The notice must be received by the Insurer within 30 days of the Diagnosis.

The Insurer, upon receipt of such notice will furnish to the Claimant such forms as are usually furnished by it for filing proofs of a Critical Illness. If such forms are not furnished by the Insurer within 15 days after the receipt of such notice, the Claimant will be deemed to have complied with the requirements of the insurance program as to proof of such Critical Illness upon submitting, within the 90 days time fixed for filing proofs of Critical Illness, written proof covering the occurrence, character and extent of the Critical Illness for which claim a notice has been given.

Written proof of Critical Illness must be furnished to the Insurer within 90 days after the date of Diagnosis.

Failure to furnish such proof within such time will not invalidate any claim, if it is shown not to have been reasonably possible to furnish such proof during such time and that such proof was furnished as soon as was reasonably possible, but in no event not later than 1 year after the date of the Diagnosis.

The Insurer reserves the right to confirm the Diagnosis by appointing a medical practitioner to examine the Insured Person.

The benefit provided under the insurance program’s coverage will be paid immediately after receipt of due proof.

All moneys payable under the insurance program are payable in Canadian dollars.

Benefit Payment

With respect to you or your insured Spouse, benefits payable in the event of a Critical Illness or as specified in the "*Complementary Benefit in Case of Certain Illnesses*" section will be paid to the Insured Person who was Diagnosed with the illness.

Accrued benefits unpaid at the time you or your insured Spouse become unable to legally receive payment of benefits, if any, will be paid to the estate of the person who was Diagnosed with the illness.

With respect to the insured Dependent Child, the Principal Sum payable in the event of a Critical Illness will be payable to the insured Employee.

NOTE: The payment of the benefit is subject to the limitations of the Survival Period as defined in this document under the "*Definitions – for better understanding of this booklet*" section.

Legal Recourse

To take any legal action in order to recover a benefit amount under this program, the Claimant must wait 60 days after having submitted proof of claim to the Insurer. Thereafter, the Claimant will be limited to a one year period [3 years in the province of Quebec] during which legal action may be taken.

If any time limitation specified in the Policy for giving notice of claim or undertaking legal action is less than that permitted by law of the province in which the Insured Person is residing at the time of claim, and then the time limitation will not be less than that provided for by provincial law.

Critical Illness Definitions

Covered Critical Illnesses – (for insured Employee and insured Spouse)

With respect to the insured Employee and the insured Spouse, "Critical Illness" means one of the following illnesses, conditions or surgical operations:

Alzheimer's Disease
A definite Diagnosis of a progressive degenerative disease of the brain. The Insured Person must exhibit the loss of intellectual capacity involving impairment of memory and judgement, which results in a significant reduction in mental and social functioning, and requires a minimum of eight hours of daily supervision. The Diagnosis of Alzheimer's Disease must be made by a Specialist.

Exclusion**:** No benefit will be payable under this condition for all other dementing organic brain disorders and psychiatric illnesses.

Aortic Surgery
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.

Aplastic Anemia
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
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
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 for pituitary adenomas less than 10 mm.

Moratorium Period Exclusion

No benefit will be payable under this condition if:
Within the first ninety (90) days following the later of:

- the effective date of the Insured Person's insurance; or
- the effective date of last reinstatement of the Insured Person's insurance, such person has any of the following:
  - signs, symptoms or investigations that lead to a diagnosis of Benign Brain Tumour, regardless of when the diagnosis is made; or
  - a diagnosis of Benign Brain Tumour.

This medical information as described above must be reported to the Insurer within six months of the date of the diagnosis. If this information is not provided, 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.

Blindness
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)
A definite Diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The Diagnosis of Cancer must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for the following non-life-threatening cancers:

- carcinoma in situ; or

- Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion); or
- any non-melanoma skin cancer that has not metastasized; or
- Stage A (T1a or T1b) prostate cancer.

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

- the effective date of the Insured Person's insurance; or
- the effective date of last reinstatement of the Insureds Person's insurance,

such 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).

This medical information as described above must be reported to the Insurer within six months of the date of the Diagnosis. If this information is not provided, the Insurer has the right to deny any claim for Cancer or, any Critical Illness caused by any cancer or its treatment.

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

Coronary Artery Bypass Surgery
The undergoing of heart Surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s), excluding any non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction. The Surgery must be determined to be medically necessary by a Specialist.

Deafness
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.

Dilated Cardiomyopathy
A condition of impaired ventricular function resulting in significant physical impairment of at least Class III of the New York Heart Association Classification of Cardiac Impairment. The Diagnosis of Dilated Cardiomyopathy must be made by a Specialist and must be confirmed by new abnormal cardiac function demonstrated in echocardiographic with a persistent low ejection fraction (less than 40%) for at least 3 months.

NYHA Class III cardiomyopathy impairment means that the patient is comfortable at rest and is symptomatic during less than ordinary daily activities despite the use of medication and dietary adjustment, with evidence of abnormal ventricular function on physical examination and laboratory studies.

Exclusion: No benefit will be payable under this condition for ischemic and toxic causes (including alcohol, prescription and nonprescription drug use) of dilated cardiomyopathy.

Fulminant Viral Hepatitis
A definite Diagnosis of a sub-massive to massive necrosis of the liver caused by any virus leading precipitously to liver failure. Payment under this condition requires satisfaction of all of the following:

- a rapidly decreasing liver size as confirmed by abdominal ultrasound;
- necrosis involving entire lobules, leaving only a collapsed reticular framework to include histology, if available;
- rapidly deteriorating liver function tests;
- deepening jaundice.

The Diagnosis of Fulminant Viral Hepatitis must be made by a Specialist.

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

- chronic hepatitis; or
- liver failure caused by alcohol, toxins and/or drugs.

Heart Attack
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:

- 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
The undergoing of Surgery to replace any heart valve with either a natural or mechanical valve. The Surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this condition for heart valve repair.

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

Loss of Independent Existence
A definite Diagnosis of:

- A total inability to perform, by oneself, at least two of the following six Activities of Daily Living; or
- Cognitive Impairment, as defined below, 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 equipment.
- Dressing — the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
- Toileting — the ability to get on and off the toilet and maintain personal hygiene.
- 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 equipment.
- Feeding — the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

Cognitive Impairment means a mental deterioration and loss of intellectual ability, evidenced by deterioration in memory, orientation and reasoning, which are measurable and result from demonstrable organic cause as Diagnosed by a Specialist. The degree of cognitive impairment must be sufficiently severe as to require a minimum of eight hours of daily supervision.

Determination of a cognitive impairment will be made on the basis of clinical data and valid standardized measures of such impairments.

Exclusion: No benefit will be payable under this condition for any mental or nervous disorder without a demonstrable organic cause.

Loss of Limbs
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
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 benefit will be payable under this condition for all psychiatric related causes.

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

Major Organ Transplant
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 Person 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
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
A definite Diagnosis of at least one of the following:

- two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions or demyelination; or
- 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.

Muscular Dystrophy
A definite Diagnosis of all of the following:

- clinical presentation including skeletal muscle weakness, muscle pain and myotonia;
- characteristic electromyography changes;
- muscle biopsy confirming Diagnosis of muscular dystrophy.

The Diagnosis of Muscular Dystrophy must be made by a Specialist.

Occupational HIV Infection
A definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person'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 coverage, or the effective date of last reinstatement of the Policy.

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

- The accidental injury must be reported to the Insurer within fourteen days of the accidental injury;
- A serum HIV test must be taken within fourteen 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 United States;
- The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States 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 Person has elected not to take any available licensed vaccine offering protection against HIV; or
- 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
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

A definite Diagnosis 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 Diagnosis of Parkinson's disease must be made by a Specialist.

Exclusion**:** No benefit will be payable under this condition for all other types of Parkinsonism.

Primary Pulmonary Hypertension
(idiopathic pulmonary arterial hypertension and familial pulmonary arterial hypertension)

A definite Diagnosis of primary pulmonary hypertension with a substantial right ventricular enlargement confirmed by investigations including cardiac catheterization, resulting in permanent Irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of Cardiac Impairment. The Diagnosis of Primary Pulmonary Hypertension must be made by a Specialist.

The NYHA Classification of Cardiac Impairment (source: Current Medical Diagnosis and Treatment-39th Edition) states the following about Class IV: "Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest."

Exclusion**:** No benefit will be payable under this condition for all other types of pulmonary arterial hypertension.

Severe Burns
A definite Diagnosis of third (3rd) degree burns over at least 20% of the body surface. The Diagnosis of Severe Burns must be made by a Specialist.

Stroke (cerebrovascular accident)
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 ischaemic attacks; or
- intracerebral vascular events due to trauma; or
- lacunar infarcts which do not meet the definition of Stroke as described above.

Illnesses covered for Complementary Benefit in Case of Certain Illnesses – (for insured Employee and insured Spouse)

Under the Complementary Benefit in Case of Certain Illnesses, only the four (4) illnesses and surgical operations presented below are covered for an insured Employee or an insured Spouse:

Coronary Angioplasty
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.

Ductal Carcinoma in Situ of the Breast
The Diagnosis of this illness must be made by a Specialist and must be confirmed by biopsy.

Stage A (T1a or T1b) Prostate Cancer
The Diagnosis of this illness must be made by a Specialist and must be confirmed by pathological examination of prostate tissue.

Stage 1A Malignant Melanoma
A melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion. The Diagnosis of this illness must be made by a Specialist and must be confirmed by biopsy.

Critical Illnesses covered for Dependent Children
With respect to any insured Dependent Child, "Critical Illness" means one of the following illnesses, conditions or surgical operations:

Blindness
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)
A definite Diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The Diagnosis of Cancer must be made by a Specialist.

Exclusion**:** No benefit will be payable under this condition for the following non-life-threatening cancers:

- carcinoma in situ; or
- Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion); or
- any non-melanoma skin cancer that has not metastasized; or
- Stage A (T1a or T1b) prostate cancer.

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

- the effective date of the Insured Person Insurance; or
- the effective date of last reinstatement of the Insured Person insurance ,

the 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).

This medical information as described above must be reported to the Insurer within six months of the date of the Diagnosis. If this information is not provided, the Insurer has the right to deny any claim for Cancer or, any Critical Illness caused by any cancer or its treatment.

Cerebral Palsy
The definite Diagnosis of a chronic disorder that appears in the first few years of life, caused by damage to the motor areas of the brain, characterized by varying degrees of limb weakness, involuntary movements and speech problems. The Diagnosis of Cerebral Palsy must be made by a Specialist.

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

Congenital Heart Disease requiring Surgery
The definite Diagnosis of any serious cardiac malformation present at birth, for which corrective Surgery has been performed. The Diagnosis of congenital heart disease must be made by a Specialist.

Cystic fibrosis
The definite Diagnosis of a genetic disease affecting the sweat and mucous glands particularly in the lungs and digestive system, characterized by excess production of thick mucous leading to chronic progressive respiratory disease and nutritional problems. The Diagnosis of Cystic Fibrosis must be made by a Specialist.

Deafness
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.

Down's Syndrome
A congenital condition caused by an extra copy of chromosome 21, primarily characterized by varying degrees of mental retardation, though other defects, particularly congenital heart disease, may be present. The Diagnosis of Down’s Syndrome must be made by a Specialist.

Loss of Speech
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 benefit will be payable under this condition for all psychiatric related causes.

Major Organ Transplant
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 Person 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.

Mental Deficiency
The definite Diagnosis of an intellectual deficiency as demonstrated by an intelligence quotient (IQ) on standardized testing of less than 70. The Diagnosis of Mental Deficiency must be made by a Specialist.

Muscular Dystrophy
A definite Diagnosis of all of the following:

- clinical presentation including skeletal muscle weakness, muscle pain and myotonia;
- characteristic electromyography changes;
- muscle biopsy confirming Diagnosis of muscular dystrophy.

The Diagnosis of Muscular Dystrophy must be made by a Specialist.

Paralysis
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.

Severe Burns
A definite Diagnosis of third (3rd) degree burns over at least 20% of the body surface. The Diagnosis of Severe Burns must be made by a Specialist.

Spina Bifida Cystica
Definite Diagnosis of a congenital defect caused by failure of the spine to close properly allowing the spinal cord and its protective covering (meninges) to protrude through the skin, characterized by varying degrees of the following:

- hydrocephalus;
- paralysis;
- bowel problems; and
- bladder problems.

The Diagnosis of Spina Bifida Cystica must be made by a Specialist.

Exclusion**:** No benefit will be payable under this condition for Spina Bifida Occulta.

Frequently Asked Questions

1. Will I/we remain entitled to long term disability (LTD) benefits if I/we receive a benefit for a covered illness?

Critical·Choice·Care benefits will not affect your long term disability benefit payments.

2. How do I/we file a claim?

Filing a claim is a very simple process. You should notify Mechanical Contractors Association of Alberta of your claim, either in writing or verbally, as soon as a covered illness is diagnosed. Mechanical Contractors Association of Alberta verifies the coverage and notifies the Insurer that they received a notice of claim. The Insurer will then send you a letter and claim forms to be completed pertaining to the diagnosed illness.

3. Can I/we make a claim even if I/we have a Pre-Existing Condition?

The Critical·Choice·Care program covers 29 illnesses. The Pre-existing Condition limitation applies only when diagnosed with an illness that is linked to the Pre-Existing Condition. Nevertheless, a claim should be submitted because each claim is reviewed on its own merits.

4. Am I/Are we still covered after having received a benefit under this program?

Yes, coverage remains in force after payment of a benefit, subject to the limitations specified in the "*Re-Entry Exclusions*" section.

5. What is a Second Medical Opinion Program?

The Insurer, in cooperation with AXA Assistance Canada, agrees to provide the Second Medical Opinion Program to Insured Persons of Mechanical Contractors Association of Alberta However, this program does not form part of the contract between Mechanical Contractors Association of Alberta and the Insurer.

The Second Medical Opinion Program provides:

1) The following services free of charge (unless stated otherwise) will be provided to any Insured Person diagnosed with one of the Critical Illnesses covered under this Critical·Choice·Care insurance program:

   – Selection of the specialist which is best suited to provide medical services included in the Second Medical Opinion Program pertaining to the Insured Person's diagnosed Critical Illness;

- Transmission, to the selected specialist, of necessary and pertinent medical documents received from the Insured Person or attending physician;
- Communication of the second medical opinion's schedule, as established after evaluation;
- Arrangements for a meeting with the selected specialist, if deemed necessary and if the Insured Person agrees to the meeting. The expenses incurred will be charged to the Insured Person;
- Analysis of the medical documents and rendering of a diagnosis by the selected specialist as well as recommendations on treatment options, all registered in a medical report;
- Transmission of the medical report to the Insured Person and the attending physician;
- At the Insured Person's request, referral to 3 specialists medically qualified to treat the Insured Person.

2) The services listed below for out-of-country medical care to any Insured Person diagnosed with a Critical Illness covered under this Critical·Choice·Care insurance program. Incurred expenses will be charged to the Insured Person:

- Arrangements to set up medical appointments with attending physicians or specialists outside of Canada;
- Admission to medical clinics located outside Canada;
- Hotel reservations;
- Travel arrangements;
- Referrals to translation services or interpreter services when appropriate;
- Administrative assistance for settlement of medical fees and claims, associated with medical services or treatments received outside of Canada, if such assistance is requested by the Insured Person.

When in need of the Second Medical Opinion Program services, the individual contacting AXA Assistance must be prepared to provide the following information:

- the name of the person calling, telephone number and relationship to the insured Employee;
- the insured Employee's name, and the Policy number;

– the name, address and telephone number of the attending physician and/or any other specialist if applicable.

The telephone number to call is **1-877-266-6550**.