Transition

CRITICAL ILLNESS INSURANCE

YOUR CRITICAL ILLNESS DESCRIPTIONS GUIDE

25-illness version

iA Financial Group

Applies to Transition critical illness insurance policies as well as critical illness insurance riders

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Important details about critical illness insurance and coverage

Critical illness insurance pays a non-taxable lump sum if an insured is diagnosed with a critical illness or requires surgery. However, several conditions must be met before such a benefit can be paid.

It is important to be aware of these

In order for you to receive payment of the face amount, the critical illness diagnosis must be consistent with the definition (or description) provided in the policy or the rider.

This means that a benefit will only be paid if the medical specialist's diagnosis of the insured's medical condition exactly meets the criteria stated in the policy or rider.

In addition, the descriptions of critical illnesses may have certain exclusions and limitations.

Match between the insured's diagnosis and the description of the critical illness in the policy or rider

A description of each covered critical illness is available in your policy or rider. This description outlines the criteria we use to determine if a diagnosis of a critical illness made by a medical specialist can lead to the payment of a critical illness benefit.

The degree of severity of the diagnosed illness and the conditions associated with it are determinant in our analysis of eligibility for payment of a benefit.

List of critical illnesses covered

Two versions of the critical illness insurance product are available, whether the policyowner has purchased a policy or a rider:

- comprehensive coverage for 25 critical illnesses → described in this document
- more affordable coverage for the four most common critical illnesses → described in a separate document

The list of covered critical illnesses is detailed in the "Tables of Covered Critical Illnesses" section of this guide.

Important: Only critical illnesses specifically named in the policy or rider are covered.

Waiting periods applicable to certain critical illnesses

There are certain periods of time that must elapse before a critical illness benefit is paid. Depending on the critical illness involved, these periods are as follows:

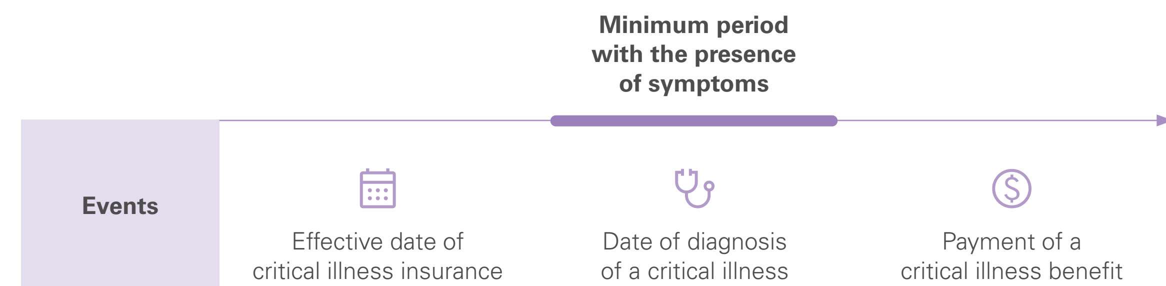
— minimum period with the presence of symptoms
— survival period
— moratorium period

If one of these periods is applicable to a critical illness, the type of period and its duration are indicated directly in the description of the critical illness in question.

A summary of these various applicable periods is available at the very end of this document.

Minimum period with the presence of symptoms

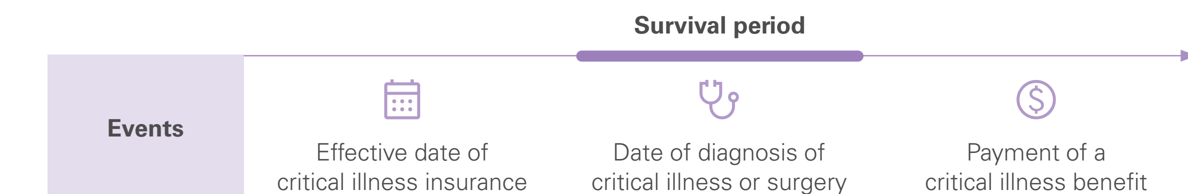
The period of time following the date of diagnosis of the critical illness during which signs or symptoms of that illness must persist.



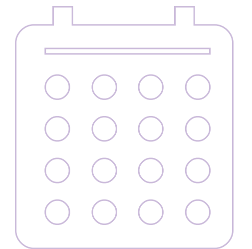
Survival period

The period of time following the date of diagnosis of the insured's critical illness or the date of surgery, as the case may be, during which the insured must still be alive.

In addition, the insured must not have suffered an irreversible cessation of all brain functions.



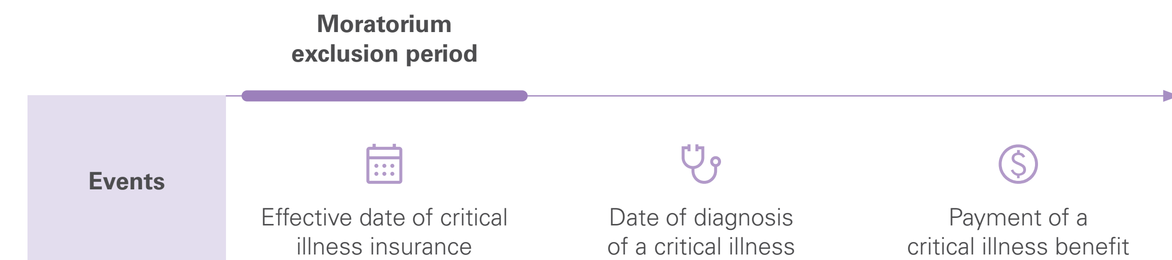
Moratorium exclusion period for cancer, Parkinson's disease and atypical Parkinsonian disorders, benign brain tumour and all cancers covered under the Prevention + benefit



The period of time following the effective date of the critical illness insurance during which the insured must not:

— have been diagnosed with the critical illness subject to the moratorium exclusion period.
— exhibit any signs or symptoms of this illness.
— have undergone investigations leading to a diagnosis of one of the above-mentioned illnesses.

We will not pay benefits for the above mentioned illnesses if, within 90 days (12 months in the case of Parkinson's disease and atypical Parkinsonian disorders) following the effective date of insurance, the insured has been diagnosed with one of these illnesses, has exhibited signs or symptoms of that illness, or has undergone investigations leading to such a diagnosis.



Exclusions and limitations

Exclusions and limitations may mean that an insured diagnosed with a critical illness or who has undergone surgery may still not be eligible to receive a benefit. Some of these exclusions and limitations are specific to critical illnesses while others are applicable to critical illness insurance in general.

Important: Illness-specific exclusions and limitations appear directly in the critical illness descriptions[1]. These descriptions are in the "Descriptions of the 25 covered critical illnesses," "Descriptions of covered juvenile critical illnesses" and "Descriptions of covered illnesses under Prevention + benefit" sections of this guide.

General exclusions and limitations are listed in the section entitled "General exclusions and limitations of critical illness insurance."

[1] The descriptions of critical illnesses used in this guide correspond to the standardized definitions 2.0 proposed by the Canadian Life and Health Insurance Association (CLHIA).

Eligibility of a critical illness claim

A critical illness insurance benefit will be paid if all following conditions are met:

1. The insured's coverage is in effect on the date of the critical illness diagnosis or surgery.
2. The critical illness suffered by the insured, or the surgery to be performed, as the case may be, is one of the covered critical illnesses specifically named in the policyowner's policy or rider.
3. The diagnosis of the insured's medical condition by the medical specialist exactly meets the criteria set out in the policy or rider.
4. If there is a survival period for the critical illness or surgery, the insured must survive that period.
5. If there is a minimum period with the presence of symptoms for the insured's critical illness, the signs or symptoms of that illness must persist during that period.
6. If there is a moratorium exclusion period for the insured's critical illness, the insured must not have been diagnosed with that illness, have exhibited any signs or symptoms of the illness, or have undergone any investigations leading to the diagnosis of the illness during this period.
7. No exclusion or limitation in the policyowner's policy or rider applies to the critical illness or surgery.
8. The claim submitted must include the following:
   - a full diagnosis by a medical specialist
   - all the relevant information regarding the insured's critical illness or surgery
   - the contact details and signature of the insured's medical specialist

Tables of covered critical illnesses

The insurance provides for payment of the full face amount if the insured is diagnosed with a critical illness or undergoes a covered surgical procedure.

25 critical illnesses

Critical illnesses covered

- ✓ Aortic surgery
- ✓ Aplastic anemia
- ✓ Bacterial meningitis
- ✓ Benign brain tumour
- ✓ Blindness
- ✓ Cancer (life-threatening)
- ✓ Coma
- ✓ Coronary artery bypass surgery
- ✓ Deafness
- ✓ Dementia, including Alzheimer's disease
- ✓ Heart attack
- ✓ Heart valve replacement or repair
- ✓ Kidney failure
- ✓ Loss of independent existence
- ✓ Loss of limbs
- ✓ Loss of speech
- ✓ Major organ failure on waiting list
- ✓ Major organ transplant
- ✓ Motor neuron disease
- ✓ Multiple sclerosis
- ✓ Occupational HIV infection
- ✓ Paralysis
- ✓ Parkinson's disease and specified atypical parkinsonian disorders
- ✓ Severe burns
- ✓ Stroke (cerebrovascular accident)

Juvenile critical illnesses

Juvenile critical illness insurance pays the full face amount if the insured is diagnosed with a juvenile critical illness.

However, the insured must receive this diagnosis before their 25th birthday.

Covered Juvenile Critical Illnesses – 5 or 6 illnesses

- ✓ Cerebral palsy
- ✓ Congenital heart disease
- ✓ Cystic fibrosis
- ✓ Down syndrome[2]
- ✓ Muscular dystrophy
- ✓ Type 1 diabetes mellitus

[2] Down Syndrome is included in the Child Critical Illness and the Transition Child riders only.

Prevention + benefit illnesses

Prevention + benefit **provides a partial benefit of 15% of the face amount** up to $50,000 per benefit, if the insured is diagnosed with a covered illness or undergoes a covered surgical procedure.

This benefit can be paid up to four times per contract, for all covered illnesses, subject to a maximum of one time per illness. A total of $200,000 may be paid under the Prevention + benefit.

Once the benefit is paid, the critical illness insurance continues under the same conditions and the face amount is not reduced by the amount paid.

Illnesses covered under Prevention + benefit – 7 illnesses

- Chronic lymphocytic leukemia (CLL) Rai stage 0
- Coronary angioplasty
- Ductal carcinoma *in situ* of the breast
- Gastrointestinal stromal tumours (GIST) and neuroendocrine tumours (classified less than AJCC stage 2)
- Papillary or follicular thyroid cancer stage T1
- Stage 1 malignant melanoma
- Stage A (T1a or T1b) prostate cancer

Descriptions of the 25 covered critical illnesses

The following descriptions of covered critical illnesses correspond to those found in the policyowner's policy or rider. In addition, an explanation for each of these illnesses is included to facilitate understanding of the covered critical illnesses.

While iA has taken all reasonable steps to ensure the accuracy of the information contained in this document, only the contractual provisions will prevail in any analysis of a claim.

Covered critical illness	Contractual description	What does it mean?
Aortic surgery	The undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a specialist. A 30-day survival period applies. **Exclusion from this description:** No critical illness benefit will be payable for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.	The aorta is the main blood vessel in the body. It carries the blood pumped by the heart through the chest and down to the abdomen. In order for a benefit to be paid, the insured must have the diseased portions of the aorta surgically removed and replaced with a graft. No benefits are payable for non-surgical procedures on the aorta and for surgical replacement of arteries that arise from the aorta (including those that supply blood to the heart, head and neck, including the carotid arteries, as well as those that supply blood to the upper and lower limbs and internal organs).

Good to know! A survival period must elapse before a benefit is paid for aortic surgery. The insured must survive for at least 30 days after the date of surgery.

Covered critical illness	Contractual description	What does it mean?
Aplastic anemia	A definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following: — marrow stimulating agents; — immunosuppressive agents; — bone marrow transplantation. The diagnosis of aplastic anemia must be made by a specialist.	Aplastic anemia is the inability of the bone marrow to supply the body with sufficient red (anemia) and white (neutropenia) blood cells and platelets (thrombocytopenia) essential for normal blood clotting. This inability not only leads to anemia, but can also increase the risk of infections, bruising and uncontrolled bleeding. In order for a benefit to be paid, the insured must receive a blood transfusion and one of the following treatments: — bone marrow stimulating agents — immunosuppressive agents — bone marrow transplantation
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 from this description:** No critical illness benefit will be payable for viral meningitis.	Bacterial meningitis is an inflammation of the lining of the brain and spinal cord caused by a bacterial infection. This inflammation leads to neurological deficits in the affected person that must be assessed by a specialist. These deficits can take the form of, among other things: — objective loss of feeling — paralysis — localized weakness — difficulty with pronunciation (dysarthria) — language difficulty (dysphasia) — difficulty swallowing (dysphagia) — measurable loss of vision — abnormal gait (difficulty walking) — lack of coordination — measurable decline in neurocognitive function Headaches and fatigue are not considered neurological deficits. The bacterial infection suffered by the insured must be confirmed by a lab analysis.

Good to know! A minimum period with the presence of symptoms must elapse before a benefit is paid for bacterial meningitis. The neurological deficit must, therefore, persist for at least 90 days after the date of diagnosis.

Covered critical illness	Contractual description	What does it mean?
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 from this description:** No critical illness benefit will be payable if, within the first 90 days following the later of, the effective date of the policy, or the date of last reinstatement of the policy, the insured has any of the following: — signs, symptoms or investigations that lead to a diagnosis of benign brain tumour (covered or excluded under the policy), regardless of when the diagnosis is made; or — a diagnosis of benign brain tumour (covered or excluded under the policy). Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the company within 6 months of the date of the diagnosis. If this information is not provided within this period, the company has the right to deny any claim for benign brain tumour or, any critical illness caused by any benign brain tumour or its treatment. No critical illness benefit will be payable for pituitary adenomas less than 10 mm.	A benign brain tumour forms quite slowly and is usually limited to the brain, meninges, cranial nerves or pituitary gland. This means that such a tumour does not spread to other parts of the brain or to other organs and is usually easier to remove surgically than a malignant tumour. In order for a benefit to be paid, the tumour must require treatment by surgery or radiation, or cause a documented and irreversible neurological deficit in the insured. Headache and fatigue are not considered neurological deficits.

Good to know! A moratorium period of exclusion applies in the case of a benign brain tumour. The policy must have been in force for at least 90 days prior to the diagnosis of a benign brain tumour, or prior to the appearance of the first signs or symptoms or prior to a medical consultation leading to this diagnosis. The same conditions apply to reinstatement.

Covered critical illness	Contractual description	What does it mean?
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.	Blindness is the total loss of vision in both eyes. It can be caused by injury, disease or degeneration of the eyeball, the optic nerve or nerve pathways connecting the eye to the brain, or the brain itself. In order for a benefit to be paid, both of the insured's eyes must be irreversibly damaged.

Covered critical illness	Contractual description	What does it mean?
Cancer (life-threatening)	A definite diagnosis of a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma. The diagnosis of cancer must be made by a specialist. **Exclusion from this description:** No critical illness benefit will be payable for the following: — lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma *in situ* (Tis), or tumours classified as Ta; — malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis; — any non-melanoma skin cancer, without lymph node or distant metastasis; — prostate cancer classified as T1a or T1b, without lymph node or distant metastasis; — papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis; — chronic lymphocytic leukemia classified less than Rai stage 1; or — malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC stage 2. In addition, no critical illness benefit will be payable under this condition if, within the first 90 days following the later of, the effective date of the policy, or the date of last reinstatement of the policy, the insured has any of the following: — signs, symptoms or investigations, that lead to a diagnosis of cancer (covered or excluded under the policy), regardless of when the diagnosis is made; or — a diagnosis of cancer (covered or excluded under the policy). Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the company within 6 months of the date of the diagnosis. If this information is not provided within this period, the company has the right to deny any claim for cancer or, any critical illness caused by any cancer or its treatment. For purposes of the policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010. For purposes of the policy, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.	Cancer is defined as abnormal or malignant cell growth that spreads throughout the body and destroys healthy tissue. The term "cancer" is generally used to describe a wide variety of tumours, some of which are serious and some of which are not considered life-threatening. In this regard, the contractual description of "life-threatening cancer" specifically excludes cancers that can be easily treated, benign, pre-cancerous or borderline tumours and carcinomas *in situ* (i.e., non-invasive cancers). However, if a cancer spreads to surrounding tissues or organs, or if it progresses, a benefit may be paid, provided that the diagnosis made by the specialist meets exactly the criteria set out in the contractual description.

Good to know! A moratorium period of exclusion applies to any life-threatening cancer. This means that the policy must have been in force for at least 90 days prior to the diagnosis of cancer (life threatening), or prior to the appearance of the first signs or symptoms, or priorto medical consultation leading to this diagnosis. The same conditions apply to reinstatement.

However, a partial benefit may be paid for a less severe or non-life threatening cancer under Prevention+ benefit. These non-life threatening cancers are:

- Stage A (T1a or T1b) prostate cancer
- Papillary or follicular thyroid cancer stage T1
- Ductal carcinoma *in situ* of the breast
- Rai stage 0 chronic lymphocytic leukemia (CLL)
- Stage 1 malignant melanoma
- Gastrointestinal stromal tumours (GIST) and neuroendocrine tumours, classified less than AJCC stage 2

Covered critical illness	Contractual description	What does it mean?
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 4 or less. The diagnosis of coma must be made by a specialist. **Exclusion from this description:** No critical illness benefit will be payable for: — a medically induced coma; or, — a coma which results directly from alcohol or drug use; or, — a diagnosis of brain death.	Coma is a severe state of altered consciousness characterized by the absence of response to external stimuli or internal needs. The severity of coma is assessed using the Glasgow coma score. In order for a benefit to be paid, the Glasgow coma score must indicate a level of 4 or less and the insured must remain at that level for at least 96 consecutive hours. The following comas are excluded from this coverage: medical coma, coma due to alcohol or drug use and coma due to brain death.

Good to know! A minimum period with the presence of symptoms must elapse before a benefit is paid for a coma. The loss of consciousness suffered by the insured must last for at least 96 hours.

Covered critical illness	Contractual description	What does it mean?
Coronary artery bypass surgery	The undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The surgery must be determined to be medically necessary by a specialist. A 30-day survival period applies. **Exclusion from this description:** No critical illness benefit will be payable for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.	Coronary artery bypass surgery is an open-heart surgery to correct narrowing or blockage of at least one coronary artery. This procedure is designed to improve the blood supply to the heart muscle. In order for a benefit to be paid, the insured must undergo coronary artery bypass surgery.

Good to know! A survival period must elapse before a benefit is paid for coronary artery bypass surgery. This means that the insured must survive for more than 30 days after the date of surgery.

Coronary angioplasty is not included under this specific coverage, but may be subject to a partial benefit under the Prevention+ Benefit.

Covered critical illness	Contractual description	What does it mean?
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.	In order for a benefit to be paid, the insured must suffer total, permanent and irreversible loss of hearing in both ears due to physical injury, accident or illness.

Covered critical illness	Contractual description	What does it mean?
Dementia, including Alzheimer's disease	A definite diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function: — aphasia (a disorder of speech); — apraxia (difficulty performing familiar tasks); — agnosia (difficulty recognizing objects); or — disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life. The insured must exhibit: — dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and — evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6-month period. The diagnosis of dementia must be made by a specialist. **Exclusion from this description:** No critical illness benefit will be payable for affective or schizophrenic disorders, or delirium. For purposes of the policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatric Res. 1975; 12(3):189.	Dementia, like Alzheimer's disease, is a syndrome characterized by a progressive deterioration of memory and cognitive or mental functions, such as reasoning and the ability to perform activities of daily living. The diagnosis made by the specialist must show disturbances in certain cognitive functions in the insured person. These disturbances must be detectable in at least one of the following ways: — speech disorder (aphasia) — difficulty performing routine tasks (apraxia) — difficulty recognizing objects (agnosia) — a disturbance in cognitive functions that affects daily life In addition, in order for a benefit to be paid, certain elements, detailed in the contractual description, must be observable in the insured.

Good to know! A minimum period with the presence of symptoms must elapse before a benefit is paid for dementia or Alzheimer's disease. The progressive deterioration of cognitive functions and the disruption of activities of daily living experienced by the insured must last for at least 6 months.

Covered critical illness	Contractual description	What does it mean?
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; — 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. A 30-day survival period applies. **Exclusion from this description:** No critical illness benefit will be payable 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.	A heart attack (also known as a myocardial infarction) can occur when a coronary artery is blocked due to aortocoronary disease or a clot. The occurrence of a heart attack means that part of the heart muscle is deprived of adequate blood supply for a period of time long enough to cause the death of that part of the muscle. The heart muscle then releases chemicals (heart enzymes) that can be detected by blood tests. In order for a benefit to be paid, the diagnosis of a heart attack must include at least one of the following: — symptoms of a heart attack — recent changes in the electrocardiogram (ECG) that indicate a heart attack — the appearance of new Q waves (wide and/or deep waves on the ECG tracing) during or immediately after an intra-arterial cardiac procedure, including coronary angiography or coronary angioplasty

Good to know! A survival period must elapse before a benefit is paid for a heart attack. This means that the insured must survive for at least 30 days after the date the heart attack is diagnosed.

Covered critical illness	Contractual description	What does it mean?
Heart valve replacement or repair	The undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a specialist. A 30-day survival period applies. **Exclusion from this description:** No critical illness benefit will be payable for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.	Heart valve replacement or repair is a surgical procedure performed when one of the heart valves (i.e., aortic, pulmonary, mitral or tricuspid) can no longer control the flow of blood between the chambers of the heart. In order for a benefit to be paid, the insured must have one or more valves replaced or repaired with human, animal or mechanical valves.

Good to know! A survival period must elapse before a benefit is paid for a heart valve replacement or repair. This means that the insured must survive for more than 30 days after the date of surgery.

Covered critical illness	Contractual description	What does it mean?
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.	The term "kidney failure" is used to describe several health problems affecting the kidneys. Chronic and irreversible kidney failure must be managed with regular treatment, either by peritoneal dialysis, haemodialysis or a kidney transplant. In order for a benefit to be paid, the insured must be undergoing one of the above treatments.
Loss of independent existence	A definite diagnosis of the total inability to perform, by oneself, at least 2 of the following 6 activities of daily living for a continuous period of at least 90 days with no reasonable chance of recovery. The diagnosis of loss of independent existence must be made by a specialist. Activities of daily living are: — bathing: the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices; — dressing: the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices; — toileting: the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices; — bladder and bowel continence: the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained; — transferring: the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and — feeding: the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.	A loss of independent existence is characterized by a total and permanent inability to perform at least two of the six activities of daily living on one's own, with no reasonable prospect of recovery. The six activities of daily living are detailed in the contractual description.

Good to know! A minimum period with the presence of symptoms must elapse before a benefit is paid for a loss of independent existence. The total and permanent inability of the insured to perform at least two of the six activities of daily living must persist for at least 90 days.

Covered critical illness	Contractual description	What does it mean?
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.	In order for a benefit to be paid, two or more of the insured's limbs must be amputated at or above the wrist or ankle as a result of an accident, injury or illness suffered by the insured.
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 from this description:** No critical illness benefit will be payable for all psychiatric related causes.	In order for a benefit to be paid, the insured must suffer total, permanent and irreversible loss of speech due to physical injury, accident or illness. No benefit is payable for loss of speech due to psychiatric causes.

Good to know! A minimum period with the presence of symptoms must elapse before a benefit is paid for loss of speech. The loss of speech suffered by the insured must persist for at least 180 days after the date of the event causing the loss.

Covered critical illness	Contractual description	What does it mean?
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 must become enrolled as the recipient in a recognized transplant centre in Canada or the United States of America that performs the required form of transplant surgery. The date of diagnosis is the date of the insured's enrolment in the transplant centre. The diagnosis of the major organ failure must be made by a specialist.	In some circumstances, the heart, lungs, liver, kidneys or bone marrow are damaged to such an extent that a specialist diagnoses the failure of a major organ. It then becomes necessary for the insured to undergo an organ transplant. In order for a benefit to be paid, the insured must be registered as a recipient at a recognized organ transplant centre in Canada or the United States. The claim can be made from that point on. Only one benefit may be paid, either for the failure of a major organ (with registration on a waiting list for a transplant) or for the transplant of a major organ, not both.

Covered critical illness	Contractual description	What does it mean?
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 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.	In some circumstances, the heart, lungs, liver, kidneys or bone marrow are damaged to such an extent that a specialist diagnoses the failure of a major organ. It then becomes necessary for the insured to undergo an organ transplant. In order for a benefit to be paid, the insured must undergo surgery to replace the diseased organ with a transplanted organ. Only one benefit may be paid, either for the failure of a major organ (with registration on a waiting list for a transplant) or for the transplant of a major organ, not both.
Motor neuron disease	A definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions. The diagnosis of motor neuron disease must be made by a specialist.	Motor neuron disease is a group of neurodegenerative disorders that affect the cells that control the body's voluntary muscles, the motor neurons. Motor neuron disease is a progressive and degenerative condition characterized by muscle weakness and deterioration of the muscles without sensory changes. The most common form of motor neuron disease is amyotrophic lateral sclerosis (ALS).
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 of demyelination; or, — well-defined neurological abnormalities lasting more than 6 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.	Multiple sclerosis (MS) is a disease of the central nervous system in which the immune system attacks the myelin (nerve sheath) in the brain, spinal cord and optic nerves, disrupting communication between the central nervous system and the rest of the body. MS is a progressive disease with multiple and varied neurological symptoms and signs. Multiple tests are necessary for the specialist to make and confirm the diagnosis. In order for a benefit to be paid, a definitive diagnosis of one of the clinical manifestations must be made by a specialist and certain medical test requirements, detailed in the contract description, must be met.

Covered critical illness	Contractual description	What does it mean?
Occupational HIV infection	A definite diagnosis of infection with human immunodeficiency virus (HIV) resulting from accidental injury during the course of the insured's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the later of the effective date of the policy, or the effective date of last reinstatement of the policy. The critical illness benefit is payable if all of the following conditions are satisfied: — The accidental injury must be reported to the insurer within 14 days of the accidental injury; — A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative; — A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive; — All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America; — The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines. The diagnosis of occupational HIV infection must be made by a specialist. **Exclusion from this description:** No critical illness benefit will be payable if: — The insured 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.	Human immunodeficiency virus (HIV) infection is a viral infection that progressively destroys certain white blood cells and can lead to Acquired Immunodeficiency Syndrome (AIDS). In order for a benefit to be paid, the HIV infection must be due to an insured's exposure, in the course of their duties, to the blood or bodily fluids of a person already infected with HIV. In order to demonstrate that the HIV infection was indeed caused by an accidental exposure of the insured at work, the claim for benefits must meet certain testing and medical reporting requirements. In addition, certain periods of time must be met before a benefit is paid. These requirements and the length of these periods are detailed in the contract description.
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.	Paralysis is the complete and permanent loss of use of two or more limbs due to injury or disease. Therefore, no benefits are paid for temporary paralysis.

Good to know! A minimum period with the presence of symptoms must elapse before a benefit is paid for paralysis. The paralysis must persist for at least 90 days after the date of the event that caused the paralysis.

Covered critical illness	Contractual description	What does it mean?
Parkinson's disease and specified atypical parkinsonian disorders	**Parkinson's disease** is defined as a definite diagnosis of primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. The insured must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's disease. **Specified atypical parkinsonian disorders** are defined as a definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy. The diagnosis of Parkinson's disease or a specified atypical parkinsonian disorder must be made by a neurologist. **Exclusion from this description:** No critical illness benefit will be payable for Parkinson's disease or specified atypical parkinsonian disorders if, within the first year following the later of, the effective date of the policy, or the date of last reinstatement of the policy, the insured has any of the following — signs, symptoms or investigations that lead to a diagnosis of Parkinson's disease, a specified atypical parkinsonian disorder or any other type of parkinsonism, regardless of when the diagnosis is made; or — a diagnosis of Parkinson's disease, a specified atypical parkinsonian disorder or any other type of parkinsonism. Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the company within 6 months of the date of the diagnosis. If this information is not provided within this period, the company has the right to deny any claim for Parkinson's disease or specified atypical parkinsonian disorders or, any critical illness caused by Parkinson's disease or specified atypical parkinsonian disorders or its treatment. No critical illness benefit will be payable for any other type of parkinsonism.	Parkinson's disease and atypical parkinsonian disorders are neurodegenerative diseases of the central nervous system characterized by a progressive slowing of movement, muscle rigidity or tremors at rest. These signs of progressive deterioration of function must be permanent and interfere with the insured's ability to carry out activities of daily living. The diagnosis of Parkinson's disease or atypical parkinsonian disorders made by the specialist must mention these signs of deterioration, which must have been observed for at least one year, despite appropriate medical follow-up.

Good to know! A minimum period with the presence of symptoms must elapse before a benefit is paid for Parkinson's disease or atypical parkinsonian disorders. The objective signs of progressive deterioration of the function suffered by the insured must persist for at least one year.

In addition, a moratorium period of exclusion applies to Parkinson's disease and atypical parkinsonian disorders. This means that the policy must have been in force for at least one year prior to the diagnosis of Parkinson's disease or atypical parkinsonian disorders, or prior to the appearance of the first signs or symptoms, or prior to medical consultation leading to this diagnosis. The same conditions shall apply to reinstatement.

Covered critical illness	Contractual description	What does it mean?
Severe burns	A definite diagnosis of third-degree burns over at least 20% of the body surface. The diagnosis of severe burns must be made by a specialist.	Third-degree burns affect all layers of the skin. This type of burn is considered to be the most serious, as it can be life threatening. For severe burns, at least 20% of the total body surface must be burned in the third degree. In order for a benefit to be paid, the insured must have suffered third-degree burns covering at least 20% of their body surface.
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. A 30-day survival period applies. **Exclusion from this description:** No critical illness benefit will be payable 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.	A stroke occurs when the blood supply to the brain or part of the brain is reduced or interrupted. This loss of blood flow causes permanent damage to the brain and can affect certain functions. The reduction or interruption of blood flow can be caused by any of the following: — bleeding in the brain (intracranial hemorrhage) — a blood clot blocks an artery that supplies blood to the brain (thrombosis) — a blood clot from another part of the body enters an artery in the brain and causes a blockage (extracranial embolism) Permanent damage to the brain can be detected by the appearance of certain neurological deficits, as determined by a specialist. These deficits can be manifested by: — paralysis — localized weakness — difficulty with pronunciation (dysarthria) — language difficulty (dysphasia) — difficulty swallowing (dysphagia) — abnormal gait (difficulty walking) — lack of coordination; — measurable decline in neurocognitive function Headache, fatigue and lack of concentration are not considered neurological deficits.

Good to know! There are minimum symptom and survival periods that must elapse before a benefit is paid for a stroke. The symptoms and neurological deficits experienced by the insured must persist for at least 30 days after the date of diagnosis. The insured must also survive for at least 30 days after the date of diagnosis.

Descriptions of covered juvenile critical illnesses

Cerebral palsy

Contractual description

A definitive diagnosis of cerebral palsy, a non-progressive neurological defect characterized by spasticity and incoordination of movements.

The diagnosis of cerebral palsy must be made by a specialist.

Congenital heart disease

Contractual description

A definite diagnosis of congenital heart disease listed below, made by a specialist, and supported by appropriate cardiac imaging.

A 30-day survival period applies. The survival period is the latter of that 30-day survival period and the 30-day period following the birth of the insured.

1. The following congenital heart diseases are covered:

- Atresia of any heart valve
- Coarctation of the aorta
- Double inlet ventricle
- Double outlet left ventricle
- Ebstein's anomaly
- Eisenmenger syndrome
- Hypoplastic left heart syndrome
- Hypoplastic right ventricle
- Single ventricle
- Tetralogy of Fallot
- Total anomalous pulmonary venous connection
- Transposition of the great vessels
- Truncus arteriosus

2. The following congenital heart diseases are covered if open-heart surgery is determined medically necessary by a specialist :

- Aortic stenosis
- Atrial septal defect
- Discrete subvalvular aortic stenosis
- Pulmonary stenosis
- Ventricular septal defect

Exclusion

No critical illness benefit will be payable if the congenital heart disease is not listed in items 1) and 2) above and for techniques such as valvuloplasty and percutaneous interauricular communication closure.

Cystic fibrosis

Contractual description

A definitive diagnosis of cystic fibrosis with evidence of chronic lung disease and pancreatic insufficiency and high levels of chlorine in sweat (60 mmol/L or higher).

The diagnosis of cystic fibrosis must be made by a specialist.

Down syndrome (Trisomy 21)[3]

Contractual description

A definitive diagnosis of down syndrome supported by chromosomal evidence of Trisomy 21.

The diagnosis of down syndrome must be made by a specialist.

Muscular dystrophy

Contractual description

A definitive diagnosis of muscular dystrophy, characterized by well-defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

The diagnosis of muscular dystrophy must be made by a specialist.

Type 1 diabetes mellitus

Contractual description

A definite diagnosis of type 1 diabetes mellitus characterized by an absolute deficiency of insulin secretion and continued dependence on exogenous insulin for survival. In addition, there must be proof that there has been insulin dependence for a minimum of three months.

The diagnosis must be made by a specialist practicing in Canada or the United States of America.

[3] Down syndrome is included in the Child Critical Illness and the Transition Child riders only.

Descriptions of covered illnesses under Prevention + benefit

Coronary angioplasty

Contractual description

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.

A 30-day survival period applies.

Ductal carcinoma *in situ* of the breast

Contractual description

A definite diagnosis of ductal carcinoma *in situ* of the breast, confirmed by biopsy.

The diagnosis must be made by a specialist.

Gastrointestinal stromal tumours (GIST) and neuroendocrine tumours (classified less than AJCC stage 2)[4]

Contractual description

A definite diagnosis of malignant gastrointestinal stromal tumours (GIST) and malignant neuroendocrine tumours, classified less than AJCC stage 2.

The diagnosis must be made by a specialist and confirmed by biopsy.

Papillary or follicular thyroid cancer stage T1

Contractual description

A definite diagnosis of papillary or follicular thyroid cancer or both, that is less than or equal to two centimetres in greatest diameter and classified as T1, without lymph node or distant metastasis, confirmed by a biopsy.

The diagnosis must be made by a specialist.

Rai stage 0 chronic lymphocytic leukemia (CLL)[5]

Contractual description

A definite diagnosis of Rai stage 0 chronic lymphocytic leukemia (CLL) confirmed by appropriate blood tests.

The diagnosis must be made by a specialist.

Exclusion

No critical illness benefit will be payable for any monoclonal lymphocytosis of undetermined significance (MLUS).

Stage A (T1a or T1b) prostate cancer

Contractual description

A definite diagnosis of stage A (T1a or T1b) prostate cancer, confirmed by biopsy.

The diagnosis must be made by a specialist.

Stage 1 malignant melanoma

Contractual description

A definite diagnosis of stage 1A or 1B malignant melanoma not ulcerated into the dermis equal to or lower than a depth of one millimetre confirmed by biopsy.

The diagnosis must be made by a specialist.

Exclusion

No critical illness benefit will be payable for any malignant melanoma *in situ.*

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

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

General exclusion – Moratorium exclusion period

The following moratorium period applies for all cancers described above:

- Ductal carcinoma *in situ* of the breast
- Gastrointestinal stromal tumours (GIST) and neuroendocrine tumours (classified less than AJCC stage 2)
- Papillary or follicular thyroid cancer stage 1
- Rai stage 0 chronic lymphocytic leukemia (CLL)
- Stage A (T1a or T1b) prostate cancer
- Stage 1 malignant melanoma

No critical illness benefit will be payable under this condition if, within the first 90 days following the later of, the effective date of the policy, or the date of last reinstatement of the policy, the insured has any of the following:

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

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the company within 6 months of the date of the diagnosis. If this information is not provided within this period, the company has the right to deny any claim for cancer or, any critical illness caused by any cancer or its treatment.

General exclusions and limitations of critical illness insurance

In addition to the exclusions and limitations specific to certain critical illnesses that are directly mentioned in the description of the illness in question, the following exclusions and limitations are also provided for all critical illnesses, juvenile critical illnesses and Prevention + benefit illnesses.

No critical illness benefit is payable if the critical illness:

a) results directly or indirectly from self-inflicted injuries or attempted suicide, whether or not the insured was conscious of their actions.

b) results directly or indirectly from voluntarily intake by the insured of any medications, drugs, steroids, narcotics or toxic substances, unless taken as prescribed by a physician.

c) results directly or indirectly from war or armed conflicts, riots, insurrection or public demonstrations regardless of whether or not the insured was an active participant.

d) results directly or indirectly from the insured's service in the armed forces of a country engaged in war or in the observation or peacekeeping duties in time of war, whether war be declared or not.

e) results directly or indirectly from committing, attempting to commit, or provoking a criminal offence.

f) occurs while the insured is driving a vehicle under the influence of drugs or while the alcohol in the insured's blood is in excess of 80 milligrams per 100 milliliters of blood.

Some definitions related to critical illness insurance

Below are some important definitions that are commonly used in critical illness insurance:

Critical illness: an illness or condition, an alteration of health or a disorder of the body, which occurs while the insured's coverage is in effect, and whose signs and symptoms must be assessed and documented by a specialist.

Diagnosis: an objective medical evidence supporting an eligible critical illness suffered by the insured.

The diagnosis must be formal and made by a medical specialist while the insured's coverage is in effect.

Face amount: the amount of insurance chosen by the insured (or the policyholder), for which the premium is paid.

Irreversible: this term indicates that the insured's condition cannot be reversed or improved by medical or surgical treatment at the time of diagnosis. Such medical or surgical treatment must not be undergone if it involves a risk to the insured's health.

Physician: a person who is legally entitled to practice medicine and provide care and treatment within the scope of their licence in Canada, the United States or any other location duly approved by the company where medical services are rendered.

The physician cannot be the policyowner or the insured, be directly or indirectly related to either of them, or be a business partner of the policyowner or the insured.

Specialist: a physician who is licensed and has specialized medical training related to the critical illness for which a benefit is claimed and whose special competence has been recognized by a specialty examining board. If a specialist is not available, and subject to the company's approval, the critical illness may be diagnosed by a physician licensed to practice in Canada or the United States.

The term "specialist" includes, but is not limited to, a cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist.

The specialist cannot be the policyowner or the insured, be directly or indirectly related to either of them, or be a business partner of the policyowner or the insured.

Summary of the various waiting periods applicable to certain critical illnesses

Critical illness	Minimum period with the presence of symptoms	Survival period	Moratorium period
Aortic surgery	–	30 days following the date of surgery	–
Bacterial meningitis	90 days	–	–
Benign brain tumour	–	–	90 days following the effective date of insurance
Cancer (life-threatening)	–	–	90 days following the effective date of insurance
Coma	96 hours	–	–
Coronary artery bypass surgery	–	30 days following the date of surgery	–
Dementia, including Alzheimer's disease	6 months	–	–
Heart attack	–	30 days following the date of diagnosis	–
Heart valve replacement or repair	–	30 days following the date of surgery	–
Loss of independent existence	90 days	–	–
Loss of speech	180 days	–	–
Multiple sclerosis	Refer to the full description	–	–
Occupational HIV infection	Refer to the full description	–	–
Paralysis	90 days	–	–
Parkinson's disease and atypical Parkinsonian disorders	12 months	–	12 months following the effective date of insurance
Stroke	30 days	30 days following the date of diagnosis	–

Covered Juvenile critical illnesses	Minimum period with the presence of symptoms	Survival period	Moratorium period
Congenital heart disease	–	30 days following the date of diagnosis	–
Type 1 diabetes mellitus	3 months	–	–

Covered illnesses – Prevention + benefit	Minimum period with the presence of symptoms	Survival period	Moratorium period
Coronary angioplasty	–	30 days following the date of surgery	–
Ductal carcinoma *in situ* of the breast	–	–	90 days following the effective date of insurance
Gastrointestinal stromal tumours and neuroendocrine tumours (classified less than AJCC stage 2)	–	–	90 days following the effective date of insurance
Papillary thyroid cancer or stage T1 follicular thyroid cancer	–	–	90 days following the effective date of insurance
Rai stage 0 chronic lymphocytic leukemia (CLL)	–	–	90 days following the effective date of insurance
Stage A (T1a or T1b) prostate cancer	–	–	90 days following the effective date of insurance
Stage 1 malignant melanoma	–	–	90 days following the effective date of insurance

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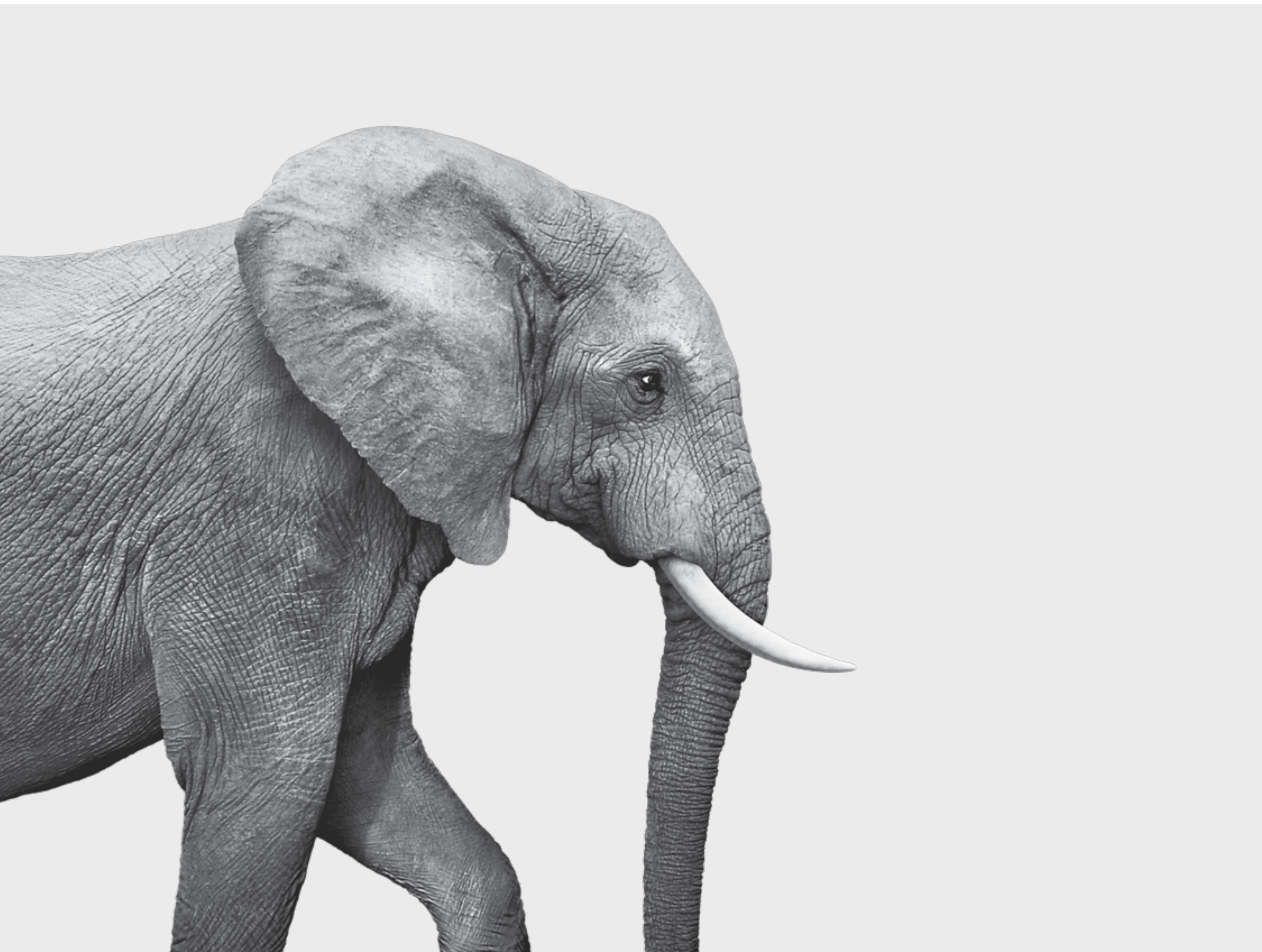
Important:

This guide is not part of your policy. In the event of any discrepancies between its contents and your policy, the provisions of your policy will prevail, particularly for the processing of insurance claims.



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