Canada Protection Plan®
Simply Peace of Mind

Critical Illness Coverage Definitions

CLAIMS FOR COVERED CONDITION OCCURING OUTSIDE OF CANADA OR THE UNITED STATES If a covered condition is diagnosed or undergone while the insured is outside of Canada or the United States, then no benefit amount will be paid unless, in addition to the requirements for a claim for a covered condition occurring in Canada or the United States:

A | We are provided with the insured's medical records that we request;

B | Those medical records provide confirmation, satisfactory to us, that the same diagnosis would have been made or the same surgery would have been advised, if the insured had been in Canada or the United States and

C | If required by us the insured undergoes a medical examination by a physician, we appoint

COVERED CONDITIONS – Coverage is provided under this policy for the conditions, disorders, illnesses and surgeries described below:

CATEGORY 1 - CARDIAC PROTECT CI	EXCLUSIONS
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.	We will not pay the benefit amount under this covered condition for: • Angioplasty • Intra-arterial procedures • Percutaneous trans-catheter procedures or • Non-surgical procedures
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.	We will not pay the benefit amount under this covered condition for: • Angioplasty • Intra-arterial procedures • Percutaneous trans-catheter procedures or • Non-surgical procedures
Heart Attack (Acute Myocardial Infarction) A definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in the rise and fall of biochemical cardiac markers to levels considered diagnostic of acute 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 pathological Q waves on ECG following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and/or angioplasty The diagnosis of heart attack (acute myocardial infarction) must be made by a specialist.	We will not pay the benefit amount under this covered condition for: • ECG changes suggestive of a prior myocardial infarction • Other acute coronary syndromes, including angina pectoris and unstable angina or • Elevated cardiac biomarkers and/or symptoms that are due to medical procedures or diagnoses other than heart attack
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.	We will not pay the benefit amount under this covered condition for: • Angioplasty • Intra-arterial procedures • Percutaneous trans-catheter procedures or • Non-surgical procedures
Stroke **(Cerebrovascular Accident Resulting in Persistent Neurological Deficits)** A definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis, hemorrhage, or embolism, with: (a) Acute onset of new neurological symptoms and (b) New objective neurological deficits on clinical examination persisting for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing showing changes that are consistent in character, location and timing with the new neurological deficits. The diagnosis of stroke (cerebrovascular accident resulting in persistent neurological deficits) must be made by a specialist. For purposes of the policy, neurological deficits must be detectable by a specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.	We will not pay the benefit amount under this covered condition for: • Transient Ischemic Attacks • Intracerebral vascular events due to trauma • Ischemic disorders of the vestibular system • Death of tissue of the optic nerve or retina without total loss of vision of that eye or • Lacunar infarcts which do not meet the definition of stroke as described above

Source: 2018 CLHIA Guidelines

CATEGORY 2 – CANCER PROTECT CI	EXCLUSIONS
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 or • Bone marrow transplantation The diagnosis of aplastic anemia must be made by a specialist.	
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 insured must have undergone surgery or radiation treatment or the tumour must have caused irreversible objective neurological deficits. These deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location and timing with the neurological deficits. The diagnosis of benign brain tumour must be made by a specialist. For purposes of this policy, neurological deficits must be detectable by the specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.	No benefit will be payable under this covered condition for: • Pituitary adenomas less than 10 mm • Vascular malformations • Cholesteatomas or • Infectious or inflammatory tumours **Moratorium Period Exclusion** – We will not pay the benefit amount under this covered condition if, during the moratorium period, the insured has any of the following: • A sign, symptom or investigation leading, directly or indirectly, to a diagnosis of benign brain tumour (covered or not covered under this policy), regardless of when the diagnosis is made or • A diagnosis of benign brain tumour (covered or not covered under this policy) Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to us within six months of the date of the diagnosis. If this information is not reported to us within this six month period we have the right to deny any claim for benign brain tumour, or any critical illness caused by any benign brain tumour or its treatment.

Life-Threatening Cancer
A definite diagnosis of a malignant tumour. This tumour 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 life-threatening cancer must be made by a specialist and must be confirmed by a pathology report.
 	
For purposes of this policy:
• T1a or T1b prostate cancer means a clinically inapparent tumour that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue
• The term gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1 means
  • Gastric and omental GISTs that are less than or equal to 10 cm in greatest dimension with five or fewer mitoses per 5 mm2, or 50 per HPF or
  • Small intestinal, esophageal, colorectal, mesenteric and peritoneal GISTs that are less than or equal to 5 cm in greatest dimension with five or fewer mitoses per 5 mm2, or 50 per HPF
• The terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 1 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018
• The term Rai stage 0 is as defined in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975
	We will not pay the benefit amount under this covered condition for:
	• Lesions described as benign, non-invasive, pre-malignant, of low and/or uncertain malignant potential, borderline, carcinoma in situ, or tumors classified as Tis or Ta
	• Malignant melanoma of skin 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. This includes but is not limited to, cutaneous T cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma
	• 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 2.0cm in greatest dimension and classified as T1, without lymph node or distant metastasis
	• Chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts
	• Gastro-intestinal stromal tumours classified as AJCC Stage 1
	• Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than medication to counteract the effects from hormonal oversecretion by the tumour or
	• Thymomas (stage 1) confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus
	
	Moratorium Period Exclusion – We will not pay the benefit amount under this covered condition if, during the moratorium period, the insured has any of the following:
	• A sign, symptom or investigation leading, directly or indirectly, to a diagnosis of cancer (covered or not covered under this policy), regardless of when the diagnosis is made or
	• A diagnosis of cancer (covered or not covered under this policy)
	
	Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to us within six months of the date of the diagnosis. If this information is not reported to us within this six month period we have the right to deny any claim for life-threatening cancer, or any critical illness caused by any cancer or its treatment.

Source: 2018 CLHIA Guidelines