PACIFIC BLUE CROSS®

CRITICAL ILLNESS

DEFINITIONS GUIDE

What is Critical Illness insurance?

Individual Critical Illness Insurance provides a lump-sum Benefit Amount that helps alleviate some of the financial stress that may result from being diagnosed with a critical illness. With extra financial protection during your recovery, you're able to spend less time worrying about your finances and more time concentrating on getting well. Pacific Blue Cross offers two Individual Critical Illness Insurance Plans. Our Basic plan covers 3 conditions and our Enhanced Plan covers 25 conditions. How do I know what a Covered Critical Condition is? We're here to help you navigate Critical Illness Insurance. Visit our Frequently Asked Questions (FAQ) for more information.

Covered Critical Conditions

Critical Illnesses resulting from Sickness, Disease, or an Accident, specifically defined below, are applicable for insurance under this Policy. We will pay a Covered Critical Condition benefit to you if you have one of the Covered Critical Conditions and:

- The Insured Person has satisfied the Survival Period listed under the Covered Critical Condition.
- The Covered Critical Condition was diagnosed while the Insured Person was insured under this Policy.
- The Insured Person survives the Survival Period.
- The Diagnosis and treatment of any Covered Critical Condition be undertaken by a Specialist or Physician licensed in Canada or the United States of America (or other such jurisdiction as may be approved by Us)
- Any tests or examinations that must be performed in order to satisfy the condition requirements be conducted by a medical professional who is not the Insured Person, or a relative of or business associate of the Insured Person.
- We receive proof of a Covered Critical Condition satisfactory to Us.

What are the Covered Critical Conditions?

Aplastic Anemia

is defined as 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. The Insured Person must survive for 30 days following the date of Diagnosis.

Aortic Surgery
is defined as 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. The Insured Person must survive for 30 days following the date of Diagnosis.

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

Bacterial Meningitis
is defined as a definite Diagnosis of meningitis, confirmed by cerebrospinal fluid showing the presence of pathogenic bacteria. The presence of pathogenic bacteria must be confirmed by culture or other generally medically accepted microbiological testing. The Bacterial Meningitis must result in objective neurological deficits persisting for at least 90 days from the date of Diagnosis.

The Diagnosis of Bacterial Meningitis must be made by a Specialist. The Insured Person must survive for 90 days following the date of Diagnosis.

For purposes of the 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.

Exclusion
No Benefit Amount will be payable under this condition for viral meningitis.

Benign Brain Tumour
is defined as 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 Person 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. The Insured Person must survive for 30 days following the date of Diagnosis.

For purposes of the 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.

Exclusion
No Benefit Amount will be payable under this condition for:
- Pituitary adenomas less than 10 mm;
- Vascular malformations;
- Cholesteatomas; or
- Infectious or inflammatory tumours.

90-Day Exclusion

No Benefit Amount 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 the last reinstatement of the Policy, the Insured Person has any of the following:

- Signs, symptoms or investigations leading directly or indirectly to a Diagnosis of any benign brain tumour (covered or not covered under the Policy), regardless of when the Diagnosis is made; or
- A Diagnosis of any benign brain tumour (covered or not covered 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.

Blindness

is defined as 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. The Insured Person must survive for 30 days following the date of Diagnosis.

Cancer (Life-Threatening)

is defined as the 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 Cancer must be made by a Specialist and must be confirmed by a pathology report. The Insured Person must survive for 30 days following the date of Diagnosis.

For purposes of the 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 mm^2, 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 5 or fewer mitoses per 5 mm^2, 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, 8^{th} 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.

Exclusions

No Benefit Amount will be payable under this condition for the following:

- 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 1.0mm 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 perioperative medication to oppose 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.

90 Day Exclusion

No Benefit Amount 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 the last reinstatement of the Policy, the Insured Person has any of the following:

- Signs, symptoms or investigations leading directly or indirectly to a Diagnosis of any cancer (covered or not covered under the Policy), regardless of when the Diagnosis is made; or
- A Diagnosis of any cancer (covered or not covered 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.

Coma

is defined as 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. The Insured Person must survive for 30 days following the date of Diagnosis.

Exclusion

No Benefit Amount will be payable under this condition for:

- A medically induced coma;
- A coma which results directly from alcohol or drug use; or,
- A Diagnosis of brain death.

Coronary Artery Bypass Surgery

is defined as 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. The Insured Person must survive for 30 days following the date of Diagnosis.

Exclusion

No Benefit Amount will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures; or non-surgical procedures.

Deafness

is defined as 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. The Insured Person must survive for 30 days following the date of Diagnosis.

Dementia, including Alzheimer's Disease

is defined as 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 Person must exhibit:

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

The Diagnosis of Dementia must be made by a Specialist. The Insured Person must survive for 30 days following the date of Diagnosis.

Exclusion
No Benefit Amount will be payable under this condition for affective or schizophrenic disorders, or delirium.

For purposes of the coverage, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res. 1975;12(3):189.

Heart Attack (acute myocardial infarction)
is defined as a definite Diagnosis of death of heart muscle due to obstruction of blood flow, that results in:

A rise and fall of cardiac biomarkers to levels considered diagnostic of acute myocardial infarction, with at least one of the following:

- Heart attack symptoms;
- New electrocardiographic (ECG) changes consistent with a heart attack;
- 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. The Insured Person must survive for 30 days following the date of Diagnosis.

Exclusion
No Benefit Amount will be payable under this 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
is defined as 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. The Insured Person must survive for 30 days following the date of Diagnosis.

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

Kidney Failure
is defined as 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 Insured Person must survive for 30 days following the date of Diagnosis.

Loss of Independent Existence
is defined as a definite Diagnosis of the total inability, due to Disease or Injury, to perform independently:

- with or without the aid of assistive devices;
- at least 3 of 6 Activities of Daily Living listed below;
- for a continuous period of at least 90 days;
- with no reasonable chance of recovery; and
- The Diagnosis must be made by a physician and supported by an independent home care assessment made by an occupational therapist or equivalent.

Activities of Daily Living are as follows:

- **Bathing**: washing oneself in a bathtub, shower or by sponge bath;
- **Dressing**: putting on and removing necessary clothing, braces, artificial limbs or other surgical appliances;
- **Toileting**: getting on and off the toilet and maintaining personal hygiene;
- **Bladder and bowel continence**: managing your bladder and bowel function with or without protective undergarments or surgical appliances so that hygiene is maintained;
- **Transferring:** moving in and out of a bed, chair or wheelchair;
- **Feeding**: consuming food or drink that already have been prepared and made available.

No additional Survival Period is required once the conditions described above are satisfied.

Loss of Limbs
is defined as 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. The Insured Person must survive for 30 days following the date of Diagnosis.

Loss of Speech
is defined as 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. The Insured Person must survive for 30 days following the date of Diagnosis.

Exclusion
No Benefit Amount will be payable under this condition for all psychiatric related causes.

Major Organ Failure on Waiting List
is defined as 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 of America 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 enrolment in the transplant centre. The Diagnosis of the major organ failure must be made by a Specialist. The Insured Person must survive for 30 days following the date of Diagnosis.

Major Organ Transplant
is defined as 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. The Insured Person must survive for 30 days following the date of Diagnosis.

Motor Neuron Disease
is defined as 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. The Insured Person must survive for 30 days following the date of Diagnosis.

Multiple Sclerosis
is defined as a definite Diagnosis of at least one of the following occurring after the later of the Effective Date, or the date of the last reinstatement of the Policy:

- Two or more separate clinical attacks confirmed by at least one magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
- A single attack, with objective neurological deficits lasting more than 6 months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or
- A single attack, confirmed by repeated MRI of the nervous system, which shows multiple new lesions of demyelination which have developed at intervals at least one month apart.

The Diagnosis of Multiple Sclerosis must be made by a Specialist. The Insured Person must survive for 30 days following the date of Diagnosis.

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.

Exclusion:
No Benefit Amount will be payable for the following:

- Solitary sclerosis;
- Clinically isolated syndrome;
- Radiologically isolated syndrome;
- Neuromyelitis optica spectrum disorders; or
- Suspected multiple sclerosis or probable multiple sclerosis.

1-Year Exclusion

No Benefit Amount will be payable under this condition if, within the first year following the later of the Effective Date of the Policy or the date of the last reinstatement of the Policy, the Insured Person has any of the following:

- Signs, symptoms or investigations leading directly or indirectly to a Diagnosis of multiple sclerosis (covered or not covered under the Policy) regardless of when the Diagnosis is made; or
- A Diagnosis of multiple sclerosis (covered or not covered 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 Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Multiple Sclerosis or, any critical illness caused by multiple sclerosis or its treatment.

Occupational HIV Infection
is defined as 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 Policy, or the Effective Date of last reinstatement of the Policy.

Payment under this condition requires satisfaction of all the following:

- The accidental Injury must be reported to the insurer within 14 days of the accidental Injury;
- A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
- A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
- All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America;
- 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. The Insured Person must survive for 30 days following the date of Diagnosis.

Exclusion

No Benefit Amount 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
is defined as 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. The Insured Person must survive for 30 days following the date of Diagnosis.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders
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 Person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.

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. The Insured Person must survive for 30 days following the date of Diagnosis.

1-Year Exclusion
No Benefit Amount 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 Person has any of the following:

- Signs, symptoms or investigations leading directly or indirectly 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 Benefit Amount will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of parkinsonism.

Severe Burns
is defined as 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. The Insured Person must survive for 30 days following the date of Diagnosis.

Stroke (cerebrovascular accident resulting in persistent neurological deficits)
is defined as a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis, haemorrhage, or embolism, with:

- Acute onset of new neurological symptoms, and
- New objective neurological deficits on clinical examination

persisting continuously 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 must be made by a Specialist. The Insured Person must survive for 30 days following the date of Diagnosis.

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.

Exclusion

No Benefit Amount will be payable under this condition for:

- Transient Ischaemic Attacks;
- Intracerebral vascular events due to trauma;
- Ischaemic 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.

Supplementary Care Benefits

The Insured will receive 15% of the face amount of coverage, to a maximum of $25,000 for four of the following six events (no more than 1 payment for the same condition). These payouts are independent of the major conditions, and do not impact the Insured Person's eligibility for claiming the Benefit Amount for a Covered Critical Condition. Any Supplementary Care payout will not reduce the sum insured, the policy premiums, or eligibility to claim a rider (return of premium upon expiry, waiver of premium, or child rider) benefit. The Insured Person must survive for 30 days following the date of Diagnosis.

Coronary angioplasty

is defined as 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. The Insured Person must survive for 30 days following the date of Diagnosis.

Non-Life-Threatening Cancer

Exclusion

No Benefit Amount will be payable under this condition if, within the first 90 days following the later of, the Effective Date of the coverage, or the date of last reinstatement of the coverage, 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)

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.

Ductal carcinoma in situ (DCIS) of breast

DCIS is a non-invasive cancer of the breast. The Diagnosis of DCIS of breast must be made by a Specialist and confirmed by pathological examination of the tissue. The Insured Person must survive for 30 days following the date of Diagnosis. Requires confirmation by biopsy.

Early Chronic Lymphocytic Leukemia

means a definite Diagnosis of Rai stage 0 chronic lymphocytic leukemia (CLL). The Diagnosis of stage 0 chronic lymphocytic leukemia must be made by a Specialist and confirmed by pathological examination of the tissue. The Insured Person must survive for 30 days following the date of Diagnosis.

Early Thyroid Cancer

papillary thyroid cancer or follicular thyroid cancer (early thyroid cancer) means a definite Diagnosis of 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. The Diagnosis of early thyroid cancer must be made by a Specialist and confirmed by pathological examination of the tissue. The Insured Person must survive for 30 days following the date of Diagnosis.

Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness)
Stage 1A malignant melanoma is a melanoma confirmed by biopsy to be less than or equal to 1.0mm in thickness, not ulcerated and without Clark level IV or level V invasion. The Diagnosis of stage 1A malignant melanoma must be made by a Specialist and confirmed by pathological examination of the tissue. The Insured Person must survive for 30 days following the date of Diagnosis.

Stage T1a or T1b (stage A) prostate cancer
The Diagnosis of stage A (T1a or T1b) prostate cancer must be made by a Specialist and confirmed by pathological examination of the tissue. The Insured Person must survive for 30 days following the date of Diagnosis.

Return of Premium Rider

If elected, the Return of Premium Upon Expiry Rider provides for the return of eligible premium paid for the Policy should the Policy be in force on the Insured Person's 75th birthday.

The Insured Person must be living on their 75th birthday and must not have experienced irreversible cessation of all functions of the brain. The Return of Premium Upon Expiry Benefit Rider will not be payable if the Critical Condition Benefit Amount, or any other benefit that results in the termination of the Policy, is payable. This Return of Premium Upon Expiry Benefit Rider is part of the Policy to which they are attached, provided the Return of Premium Upon Expiry Benefit Rider is specified in the benefit and premium information in the Individual Enhanced Critical Illness Policy Schedule of this Policy

For purposes of determining the Return of Premium Upon Expiry Benefit, eligible premium is the sum of:

- the premium for the Benefit Amount;
- the premium paid under the Return of Premium Upon Expiry Benefit Rider; and,
- any premium ratings.

It will not include any interest, additional fees, or premiums waived by Us. The Return of Premium Upon Expiry Benefit will be the lesser of:

- eligible premium paid for the Policy from the Policy Effective Date to the Insured Person's 75th birthday; and
- the Benefit Amount

The Return of Premium Upon Expiry Rider is only available at Policy issue. Individuals age 18 to 60 are eligible to apply for a Return of Premium upon Expiry Rider as part of their Individual Enhanced Critical Illness Insurance Policy.

Waiver of Premium Rider

If elected, the Waiver of Premium Rider provides for the payment of the premium while the Insured Person is totally disabled.

Prior to their 60th birthday, if the Insured has been totally disabled for 90 consecutive days, we will refund any premium paid during this 90 day period and waive any premium that comes due while disability continues. The Insured Person is responsible for premiums payable from the date the Insured Person is no longer totally disabled. Coverage under this Waiver of Premium Benefit Rider ends when the Insured Person reaches age 75 or if the Insured Person recovers from their disability, whichever event occurs first. This Waiver of Premium Benefit Rider is part of the Policy to which they are attached, provided the Waiver of Premium Rider Benefit is specified in the benefit and premium Information in the Individual Enhanced Critical Illness Policy Schedule of this Policy. The Waiver of Premium Rider is only available at Policy issue. Individuals prior to age 60 are eligible to apply for a Waiver of Premium Rider as part of their Individual Enhanced Critical Illness Insurance Policy.

Total Disability or Totally Disabled
means that, due to Injury or Sickness, and subject to Our assessment, the Insured Person cannot perform the essential duties of their Regular Occupation and are not working in any Gainful Occupation, during the first two years of disability. Thereafter, the Insured Person is Totally Disabled if they cannot work in any Gainful Occupation.

The Insured Person is receiving, from a Physician, care which is appropriate for the condition causing the disability. Availability of work is not considered when assessing disability.

Child Critical Illness Benefit Rider

Child Critical Illness Benefit Rider coverage provides a lump-sum payment of $25,000 at the end of a 30-day Survival Period from date of Diagnosis, for one of the covered conditions (Autism, Blindness, Cancer, Cerebral Palsy, Congenital Heart Conditions, Cystic Fibrosis, Deafness, Down's Syndrome, Kidney Failure, Major Organ Transplant and Major Organ Failure on Waiting List, Muscular Dystrophy, and Paralysis). All Child Critical Illness Benefit Rider Covered Conditions are subject to a 30 day Survival Period.

If elected, children ages 0 to 17 years old are eligible for Child Critical Illness Benefit Rider. Once insured, the Insured Child can be covered up to age 21 or 25 if they are attending school full time (who is wholly dependent on the life insured for support) or age 75 of the Insured Person, if earlier. The Child Critical Illness Benefit Rider can be purchased anytime while the Insured Person's Policy is inforce.

Should the Insured Person choose to add a Child Rider at Policy issue or after the Effective Date of this Policy, their Insured Child(ren) will be medically underwritten. Children are medically underwritten on an accept or decline basis. Should the Insured Person have child(ren), including adopted child(ren) and stepchild(ren), after the Child Critical Illness Benefit Rider under this Policy has been issued, the Insured Person must provide Us notification to add new child(ren) to the issued Policy.

Insured Child
Insured Child means any child, stepchild or legally adopted child of the Insured Person named in the application for this Policy who has not reached his or her 18th birthday on the Effective Date of said issued Policy.

What are the Covered Critical Conditions for the Child Critical Illness Benefit Rider?

Autism
is defined as an organic defect in brain development characterized by failure to develop communicative language or other forms of social communication, with the Diagnosis confirmed by a Specialist before the third birthday. The Diagnosis of Autism must be made by a Specialist. The Insured Child must survive for 30 days following the date of Diagnosis.

Exclusions:
Asperger's Syndrome and Rett Syndrome are excluded.

Blindness
is defined as 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. The Insured Child must survive for 30 days following the date of Diagnosis.

Cancer (Life-Threatening)
is defined as the 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 Cancer must be made by a Specialist and must be confirmed by a pathology report.
The Insured Child must survive for 30 days following the date of Diagnosis.

For purposes of the 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 mm^2, 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 5 or fewer mitoses per 5 mm^2, 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.

Exclusions

No Benefit Amount will be payable under this condition for the following:

- 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 1.0mm 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 perioperative medication to oppose 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.

90 Day Exclusion

No Benefit Amount 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 the last reinstatement of the Policy, the Insured Person has any of the following:

- Signs, symptoms or investigations leading directly or indirectly to a Diagnosis of any cancer (covered or not covered under the Policy), regardless of when the Diagnosis is made; or
- A Diagnosis of any cancer (covered or not covered 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.

Cerebral Palsy

means a definite Diagnosis of a non-progressive neurological defect affecting muscle control. This defect is characterized by spasticity and incoordination of movements. The Diagnosis of Cerebral Palsy must be made by a Specialist. The Insured Child must survive for 30 days following the date of Diagnosis.

Congenital Heart Disease

a Diagnosis of the following heart conditions:

The following conditions are covered following a 30-day survival period from Diagnosis or birth whichever comes later.
The Diagnosis must be made by a qualified pediatric cardiologist and supported by appropriate cardiac imaging.

- Total Anomalous Pulmonary Venous Connection
- Truncus Arteriosus
- Transposition of The Great Vessels
- Tetralogy of Fallot
- Atresia of any heart valve
- Eisenmenger Syndrome
- Coarctation of The Aorta
- Double Inlet Ventricle
- Single Ventricle

- Hypoplastic Right Ventricle
- Hypoplastic Left Heart Syndrome
- Ebstein's Anomaly
- Double Outlet Left Ventricle

The following conditions are covered only when open heart surgery is performed for correction of the condition and following a 30 day Survival Period from Diagnosis or birth whichever comes later. The Diagnosis must be made by a qualified pediatric cardiologist and supported by appropriate cardiac imaging. The Surgery must be recommended by a qualified pediatric cardiologist and performed by a cardiac surgeon in Canada or the U.S.

- Pulmonary Stenosis
- Aortic Stenosis
- Discrete Subvalvular Aortic Stenosis
- Ventricular Septal Defect
- Atrial Septal Defect

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

The Insured Child must survive for 30 days following the date of Diagnosis.

Cystic Fibrosis
means a definite Diagnosis of Cystic Fibrosis with evidence of chronic lung disease and pancreatic insufficiency. The Diagnosis of Cystic Fibrosis must be made by a Specialist. The Insured Child must survive for 30 days following the date of Diagnosis.

Deafness
is defined as 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 cycles per second. The Diagnosis of Deafness must be made by a Specialist. The Insured Child must survive for 30 days following the date of Diagnosis.

Down's Syndrome
is defined as a definite Diagnosis of Down's Syndrome supported by chromosomal evidence of Trisomy 21. The Diagnosis of Down's Syndrome must be made by a Specialist. The Insured Child must survive for 30 days following the date of Diagnosis.

Kidney Failure
is defined as 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 Insured Child must survive for 30 days following the date of Diagnosis.

Major Organ Failure on Waiting List
is defined as 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 of America 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 enrolment in the transplant centre. The Diagnosis of the major organ failure must be made by a Specialist. The Insured Child must survive for 30 days following the date of Diagnosis.

Major Organ Transplant
is defined as 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. The Insured Child must survive for 30 days following the date of Diagnosis.

Muscular Dystrophy
means a definite 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. The Insured Child must survive for 30 days following the date of Diagnosis.

Paralysis
is defined as 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. The Insured Child must survive for 30 days following the date of Diagnosis.