HEALTH PRIORITIES AND CRITICAL ILLNESS ADVANCE GUIDE*

Description of critical illnesses

Desjardins Insurance
Life • Health • Retirement

* This guide concerns Health Priorities (including Health Priorities – Child) and Critical Illness Advance products purchased since February 2018.

What's the purpose of this guide?

We've created this guide to help you better understand the critical illnesses covered under your insurance contract. This guide doesn't replace the clauses in your contract. If you make a claim, the insurer will apply the definitions found in your insurance contract.

Being diagnosed with a critical illness by your doctor doesn't automatically entitle you to receive any benefits under the contract. What matters is that the diagnosis corresponds to the contract definition. There may also be some limitations and exclusions, such as needing to wait out a moratorium, survival or qualifying period. These are explained further below.

We hope that this guide will help you better understand your coverage.

Table of Contents

How does a critical illness protection work?

If you're ever diagnosed with one of the covered critical illnesses, you'll receive a tax-free benefit, regardless of whether or not you're able to work. It's yours to use however you see fit.

What's required to be eligible for a benefit?

- Only the critical illnesses specifically mentioned in the policy or rider are covered. The medical condition and the specific symptoms must match the definition set out in the contract.
- The diagnosis of the critical illness must be made by the doctor while the contract is in force.
- The survival period* for cardiovascular procedures and conditions must be satisfied. The insured must be alive at the end of the survival period.
- The qualifying period* for certain critical illnesses must be respected. Once a diagnosis has met all of the criteria, the qualifying period begins and must have elapsed for the insured to be eligible for payment of the insurance benefit.
- The moratorium period* is applicable for certain critical illnesses. During this period, the insured must not show any symptoms or first signs of illness that relate to the diagnosis of a critical illness.
- The exclusions and limitations* must be complied with.

* The time periods, exclusions and limitations will be explained in greater detail below.

Is your claim payable in every situation?

It's possible that certain claims won't be payable under your contract. For example, this might occur if your illness isn't covered by the insurance contract or you were diagnosed with cancer (life-threatening) within 90 days of your contract's effective date. When you make a claim, it's important to make sure that your condition meets the definition in the contract. You must also comply with the exclusions, satisfy the time periods and submit all of the requested documents needed to evaluate your claim.

For example, the following illnesses and conditions aren't covered by the contract, even though they may cause suffering:

- Crohn's disease
- Hernia
- Bipolar disorder
- Hip replacement
- Fibromyalgia

What to do if you're diagnosed with a critical illness?

If your doctor diagnoses you with a critical illness, it's important to read the contract definition to ensure you meet all of the criteria. For example:

- Is there a moratorium, survival or qualifying period?
- Does the critical illness qualify for a full or partial benefit payment?
- Is it 1 of the 26 critical illnesses covered by your Health Priorities policy?

To help you figure out what forms you need to fill out and what supporting documents you need to provide, contact our Client Relation Centre or your advisor. They can guide you through the claims process.

Once you've assembled all the necessary documents, send them to Desjardins Insurance so that we can process your claim. Note that we'll only be able to issue a decision once we've received all the documentation we need.

Once we've finished processing your claim, we'll contact you to let you know our decision. If we've approved your claim, we'll explain how your benefit payment will be made. You can expect payment to take several days.

What time periods need to be satisfied?

Depending on the critical illness, certain time periods must be satisfied in order to receive a benefit. These periods are set out in a table on *page 46*.

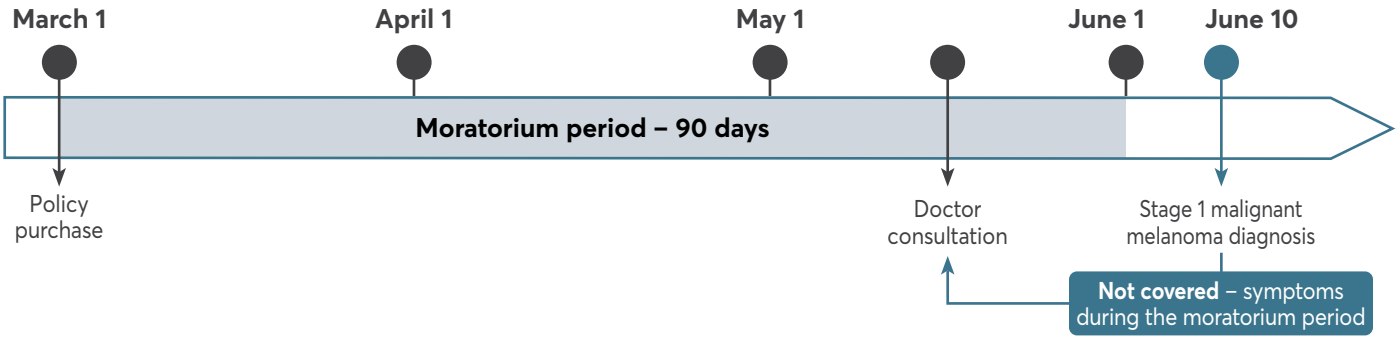
Moratorium period

For certain illnesse to be eligible for a payout, the critical illness insurance needs to be in force for a specific period of time, known as a moratorium period, before:

- The first signs or symptoms appear (regardless of the date of diagnosis)
- Any investigation that may lead to a diagnosis (regardless of the date of your diagnosis) OR
- The actual diagnosis of the disease

Example of a moratorium period

You purchase a Health Priorities policy on March 1. In May, you notice a spot on your arm. You make an appointment with your doctor later that week to make sur it's not anything serious. On June 10 (100 days after your policy began), you're diagnosed with stage 1 malignant melanoma. Even though the diagnosis was made after the applicable 90-day moratorium period, if you were to submit a claim it would be denied, since your symptoms first presented during the moratorium period.



Survival period

The survival period only applies to cardiovascular conditions and procedures. It runs 30 days from the date of diagnosis or surgery. It doesn't include any days during which the insured person is on artificial life support. The insured person must be alive at the end of the survival period and must not have experienced irreversible loss of all brain function.

This period is not required for Life with Critical illness advance products.

Qualifying period

This is a minimum period during which the insured person must present certain symptoms, neurological deficits or functional losses or meet specific criteria.

The start of the qualifying period depends on the contract definition of the critical illness in question. For example, it can begin on the date of diagnosis, the date of the instigating event, the date of functional loss or when the insured person meets the criteria of the contract definition.

IMPORTANT

The qualifying period begins when the eligibility criteria are met.

For example, in the event of a loss of independent existence, the qualifying period begins when you're no longer able to carry out 2 of the 6 activities of daily living as defined in the contract. A medical diagnosis is not always enough. All of the contract criteria must be met in order to qualify for a benefit payment.

Illnesses covered 100%

Cancers and tumours

- Cancer (life-threatening)
- Bening brain tumour

Accidents and functional loss

- Severe burns
- Blindness
- Coma
- Acquired brain injury
- Paralysis
- Loss of speech
- Loss of limbs
- Deafness

Cardiovascular

- Stroke
- Aortic surgery
- Heart attack
- Coronary artery bypass
- Heart valve replacement or repair

Other

- Aplastic anemia
- Occupational HIV infection
- Permanent loss of independent existence

Neurological

- Dementia, including Alzheimer's disease
- Parkinson's disease and specified atypical Parkinsonian disorders
- Motor neuron disease
- Bacterial meningitis
- Multiple sclerosis

Vitals organs

- Major organ failure on waiting list
- Major organ transplant
- Kidney failure

In addition to covering 26 critical illnesses, Health Priorities – Child, 20 Pay can cover up to 6 additional childhood illnesses:

- Type 1 diabetes mellitus
- Muscular dystrophy
- Cystic fibrosis
- Rett syndrome
- Autism spectrum disorder
- Cerebral palsy

Being diagnosed with an illness by your doctor doesn't automatically entitle you to a benefit payment. According to the contract definitions of some illnesses, only severe cases may be covered. The benefit will be paid if your diagnosis corresponds to the contract definition.

Illnesses covered – partial (advance)

Early-stage cancer

- Carcinoma in situ
- Chronic lymphocytic leukemia – stage 0
- Cutaneous lymphoma without distant metastasis
- Dermatofibrosarcoma
- Ductal carcinoma in situ of the breast or lobular carcinoma in situ of the breast
- Malignant gastrointestinal stromal tumours
- Malignant carcinoid tumours
- Malignant melanoma – stage 1
- Papillary thyroid cancer or follicular thyroid cancer – stage 1
- Prostate cancer – stage T1a or T1b
- Other cancers

Minor cardiovascular conditions and procedures

- Coronary angioplasty
- Endovascular treatment of aortic aneurysm or disease
- Insertion of cardiac pacemaker or cardiac defibrillator

Other

- Total mastectomy
- Total prostatectomy
- Temporary loss of independent existence

How does the advances work?

Health Priorities critical illness insurance also provides partial payment (an advance) for some illnesses and conditions that don't meet the definitions of the 26 covered illnesses. The amount of these payments varies between 1% and 30%. You can receive up to 5 payments (1 per category).

Category	Advance
Early-stage cancers	Advance of 15% of the insurance amount ($25,000 maximum)
Other cancers	Advance of 1% of the insurance amount ($5,000 maximum)
Ablation surgeries	Advance of 30% of the insurance amount ($100,000 maximum)
Minor cardiovascular conditions and procedures	Advance of 15% of the insurance amount ($50,000 maximum)
Temporary loss of independent existence	Advance of 15% of the insurance amount ($25,000 maximum)

IMPORTANT

Throughout the years, if you claim more than one advance categories related to a cancer diagnosis, the payments will be deductible one from the other. For a better understanding, please refer to the following example.

Example of a case study with advances:

Laura purchases a $100,000 Health Priorities critical illness policy.

Five years later, she's diagnosed with basal cell carcinoma (a skin cancer with very favourable outcomes when treated), which falls under the "other cancers" category. That means she's entitled to a $1,000 advance.

Ten years later, Laura is diagnosed with ductal breast carcinoma in situ, which falls under the "early-stage cancers" category. She's therefore entitled to a $15,000 advance, minus the $1,000 she received for her basal cell carcinoma diagnosis 10 years earlier. Laura would receive an additional advance of $14,000.

Over the following year, Laura's cancer progresses to a stage requiring a total mastectomy, which falls under the "ablation surgeries" category. That means she's entitled to a $30,000 advance, minus the $15,000 in payments she previously received, for a benefit payment of another $15,000.

After making these claims, Laura would still be covered for up to the original benefit amount of $100,000 minus the $30,000 she had already received. This means that if Laura were to be diagnosed with a critical illness other than the 3 for which she'd already received an advance, she would be entitled to a benefit of $70,000 ($100,000 minus $30,000).

What are the exclusions?

- All exclusions listed apply to each condition.
- No benefit will be payable for the insured for any condition diagnosed after death.
- No benefit will be payable for the insured for any condition that results directly or indirectly from:
  - Self-inflicted injuries or a suicide attempt, whether the insured person is sane or insane
  - The insured's participation in any criminal act or related act
  - War (whether war is declared or undeclared), riot or revolution, whether or not the insured took part
  - The insured driving a motor vehicle while under the influence of drugs or with a blood alcohol level equal to or greater than 80 mg of alcohol per 100 ml of blood
  - The illegal or illicit use of any drug
  - The voluntary absorption or use of any toxic substance or any type of gas
  - The voluntary consumption of prescription drugs that exceeds the dosage recommended by a healthcare professional or drugs obtained without a prescription that exceeds the manufacturer's recommended dosage.

Description of covered illnesses and conditions

Cancers and tumours

All types of cancer start in the body's cells. Normally, the organism's cells multiply in a controlled way. Cells divide when necessary and die if they've divided too many times or they're damaged.

But, when cells don't divide the way they're supposed to in healthy tissue, they can form a lump in the body called a tumour. There are two types of tumours: Non-cancerous (benign) tumours and cancerous (malignant) tumours.

Non-cancerous tumours are made up of normal-looking cells that stay in one place and don't spead. But these tumours can still get quite big. Non-cancerous tumours don't usually come back after they're removed.

Cancerous tumours are made up of malignant cells, that are different from normal cells. Malignant cells can grow into nearby tissues and spread to other parts of the body. This happens when cancer cells get into the blood or lymphatic system. Even when a cancerous tumour is removed, cancer can still come back because cancer cells might have already spread from the tumour to other parts of the body. Cancers are broken down into stages based on how far advanced they are.

Source: Types of cancer | Canadian Cancer Society

Desjardins' critical illness insurance provides coverage for all types of cancer. Depending on what stage the cancer has progressed to, you'll receive either a partial or total benefit payment.

For a cancer to be covered under the insurance, it must meet the criteria in the previous definition.

Stage grouping: Doctors use the AJCC[1] or TNM[2] description to assign an overall stage from 0 to 4 for many types of cancer. Stages 1 to 4 are usually given as the Roman numerals I, II, III and IV. Generally, the higher the number, the more the cancer has spread. Sometimes stages are subdivided using the letters A, B and C. For most types of cancer, the stages mean the following:

- stage 0 – carcinoma in situ, a precancerous change
- stage 1 – the tumour is usually small and hasn't grown outside of the organ it started in
- stages 2 and 3 – the tumour is larger or has grown outside of the organ it started in to nearby tissue
- stage 4 – the cancer has spread through the blood or lymphatic system to a distant site in the body (metastatic spread).

Source: Staging cancer | Canadian Cancer Society

[1] American Joint Committee on Cancer
[2] TNM stands for tumour, node (lymph node) and metastasis.

The benefit payable can vary depending on the stage of the cancer. Here are some examples to help you understand how benefit payments work following a cancer diagnosis.

Example of the benefit payable for tongue cancer depending on the stage:

Stage 0 tongue cancer is considered *carcinoma in situ*. The benefit payable is therefore 15% of the amount of insurance for your contract. However, if the tongue cancer progresses to a cancer between stages 1 and 4, it will then be considered cancer *(life threatening)*. From stage 1, there is tissue invasion. Therefore, it meets the definition of cancer *(life threatening)*, and the benefit payable is 100%.

Example of the benefit payable for skin cancer depending on the stage:

The benefit payable depends on the thickness of the melanoma, the ulceration and the stage of the cancer.

A stage 0 melanoma (in situ) is covered under *other cancers* in the contract, and the benefit payable is 1% of the amount of insurance.

At stage 1A without ulceration, the cancer is a *malignant melanoma – stage 1* and the benefit payable is 15%. If there is ulceration, the benefit payable is 100% as it meets the definition of cancer *(life threatening)*.

At stage 1B, the melanoma generally meets the definition of cancer *(life threatening)* if it's not ulcerated. However, a stage T1B melanoma that is between 0.8 and 1.0 mm in thickness does not meet the definition of cancer *(life threatening)* but rather the definition of *malignant melanoma – stage 1*.

At stage 2 and above, the melanoma meets the definition of cancer *(life threatening)*, and the benefit payable is 100%.

Therefore, it's important to understand that depending on the cancer diagnosis, the stage of the cancer and several other factors, the cancer may meet a definition other than that of cancer *(life threatening)*. The benefit payment varies based on the applicable definition.

Cancer (life-threatening)

100% benefit payment

Definition	Exclusions
Definite diagnosis of a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of healthy tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma and sarcoma. The diagnosis of cancer (life-threatening) must be made by a specialist.	*No benefit will be payable under the definition of "cancer (life-threatening)" for:* a) carcinoma in situ (Tis), tumours classified as Ta, or lesions described as benign, pre-malignant, uncertain, borderline or non-invasive; b) 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; c) any non-melanoma skin cancer, without lymph node or distant metastasis; d) prostate cancer classified as T1a or T1b, without lymph node or distant metastasis; e) 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; f) chronic lymphocytic leukemia classified less than Rai stage 1; g) malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC stage 2. For the purposes of this exclusion: • 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 • the term "Rai stage 1" 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. *No benefit will be payable under the definition of "cancer (life-threatening)" if:* Within the first 90 days following the later of the effective date of this coverage or the date of last reinstatement of this coverage, the insured person: a) exhibits signs or symptoms or undergoes investigations that lead to a diagnosis of cancer (covered or excluded under this coverage), regardless of when the diagnosis is made; OR b) is diagnosed with cancer (covered or excluded under this coverage). **Obligation to inform the Company** 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 covered condition caused by any cancer or its treatment.

Papillary thyroid cancer or follicular thyroid cancer – Stage 1

Advance of 15% ($50,000 maximum)

Definition	Exclusions
Definite diagnosis or 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 stage 1 papillary thyroid cancer or follicular thyroid cancer must be supported by histopathological biopsy and made by a specialist.	*No benefit will be payable under the definition of "papillary thyroid cancer or follicular thyroid cancer – stage 1" if:* Within the first 90 days following the later of the effective date of this coverage or the date of last reinstatement of this coverage, the insured person: a) exhibits signs or symptoms or undergoes investigations that lead to a diagnosis of cancer (covered or excluded under this coverage), regardless of when the diagnosis is made; OR b) is diagnosed with cancer (covered or excluded under this coverage). **Obligation to inform the Company** 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 covered condition caused by any cancer or its treatment.

Prostate cancer – Stage T1A or T1B

Advance of 15% ($50,000 maximum)

Definition	Exclusions
Definite diagnosis of prostate cancer that is stage T1a or T1b, without lymph node or distant metastasis. The diagnosis of stage T1a or T1b prostate cancer must be supported by histopathological biopsy and made by a specialist.	*No benefit will be payable under the definition of "prostate cancer – stage T1a or T1b" if:* Within the first 90 days following the later of the effective date of this coverage or the date of last reinstatement of this coverage, the insured person: a) exhibits signs or symptoms or undergoes investigations that lead to a diagnosis of cancer (covered or excluded under this coverage), regardless of when the diagnosis is made; OR b) is diagnosed with cancer (covered or excluded under this coverage). **Obligation to inform the Company** 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 covered condition caused by any cancer or its treatment.

Ductal Carcinoma In Situ Of The Breast Or Lobular Carcinoma In Situ Of The Breast

Advance of 15% ($50,000 maximum)

Definition	Exclusions
Definite diagnosis of ductal carcinoma in situ of the breast or lobular carcinoma in situ of the breast. The diagnosis of ductal carcinoma in situ of the breast or lobular carcinoma in situ of the breast must be supported by histopathological biopsy and made by a specialist.	*No benefit will be payable under the definition of "ductal carcinoma in situ of the breast or lobular carcinoma in situ of the breast" if:* Within the first 90 days following the later of the effective date of this coverage or the date of last reinstatement of this coverage, the insured person: a) exhibits signs or symptoms or undergoes investigations that lead to a diagnosis of cancer (covered or excluded under this coverage), regardless of when the diagnosis is made; OR b) is diagnosed with cancer (covered or excluded under this coverage). **Obligation to inform the Company** 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 covered condition caused by any cancer or its treatment.

Carcinoma in situ

Advance of 15% ($50,000 maximum)

Definition	Exclusions
Definite diagnosis of a focal autonomous new growth of carcinomatous cells which has not yet resulted in the invasion of normal tissues. "Invasion" means an infiltration beyond the epithelial basement membrane. The diagnosis of carcinoma in situ must be supported by histopathological biopsy and made by a specialist.	*No benefit will be payable under the definition of "carcinoma in situ" for:* a) basal cell carcinoma, squamous cell carcinoma or any intra-epidermal carcinomas of the skin; b) stage TaN0M0 papillary urothelial carcinoma of the bladder c) cervical lesions, if detected by Pap smear test and characterized by the presence of stage 1, 2 or 3 cervical intraepithelial neoplasia (CIN I, CIN II or CIN III); d) all tumours which are histologically described as benign, pre-malignant, borderline or of low malignant potential; all grades of dysplasia, all grades of squamous intraepithelial lesions (HSIL and LSIL), and all grades of intra-epithelial neoplasia unless specifically classified as Tis or carcinoma in situ as per AJCC classification. For the purposes of this exclusion, the terms "Tis and carcinoma in situ as per AJCC classification" are to be applied as defined in the American Joint Committee on Cancer (AJCC) Cancer Staging Manual, 7th Edition, 2010. *No benefit will be payable under the definition of "carcinoma in situ" if:* Within the first 90 days following the later of the effective date of this coverage or the date of last reinstatement of this coverage, the insured person: a) exhibits signs or symptoms or undergoes investigations that lead to a diagnosis of cancer (covered or excluded under this coverage), regardless of when the diagnosis is made; OR b) is diagnosed with cancer (covered or excluded under this coverage). **Obligation to inform the Company** 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 covered condition caused by any cancer or its treatment.

Dermatofibrosarcoma

Advance of 15% ($50,000 maximum)

Definition	Exclusions
Definite diagnosis of dermatofibrosarcoma confined to the skin, without lymph node or distant metastasis. The diagnosis of dermatofibrosarcoma must be supported by histopathological biopsy and made by a specialist.	*No benefit will be payable under the definition of "dermatofibrosarcoma" if:* Within the first 90 days following the later of the effective date of this coverage or the date of last reinstatement of this coverage, the insured person: a) exhibits signs or symptoms or undergoes investigations that lead to a diagnosis of cancer (covered or excluded under this coverage), regardless of when the diagnosis is made; OR b) is diagnosed with cancer (covered or excluded under this coverage). **Obligation to inform the Company** 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 covered condition caused by any cancer or its treatment.

Chronic Lymphocytic Leukemia – Stage 0

Advance of 15% ($50,000 maximum)

Definition	Exclusions
Definite diagnosis of chronic lymphocytic leukemia Rai stage 0. The diagnosis of chronic lymphocytic leukemia Rai stage 0 must be confirmed by blood tests or other clinically approved diagnostic tests and made by a specialist. For the purposes of this definition, the term "Rai stage 0" is to be applied as set out in KR Rai, A Sawitsky, EP Conkite, AD Chanana, RN Levy and BS Pasternack: Clinical Staging of Chronic Lymphocytic Leukemia. Blood 46:219, 1975.	*No benefit will be payable under the definition of "chronic lymphocytic leukemia – stage 0" if:* Within the first 90 days following the later of the effective date of this coverage or the date of last reinstatement of this coverage, the insured person: a) exhibits signs or symptoms or undergoes investigations that lead to a diagnosis of cancer (covered or excluded under this coverage), regardless of when the diagnosis is made; OR b) is diagnosed with cancer (covered or excluded under this coverage). **Obligation to inform the Company** 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 covered condition caused by any cancer or its treatment.

Primary cutaneous lymphoma

Advance of 15% ($50,000 maximum)

Definition	Exclusions
Definite diagnosis of primary skin (meaning it started in the skin) T-cell, NK-cell or B-cell lymphoma, without lymph node or distant metastasis. The diagnosis of cutaneous lymphoma without metastasis must be supported by histopathological biopsy or other clinically approved diagnostic tests and made by a specialist.	*No benefit will be payable under the definition of "primary cutaneous lymphoma" if* Within the first 90 days following the later of the effective date of this coverage or the date of last reinstatement of this coverage, the insured person: a) exhibits signs or symptoms or undergoes investigations that lead to a diagnosis of cancer (covered or excluded under this coverage), regardless of when the diagnosis is made; OR b) is diagnosed with cancer (covered or excluded under this coverage). **Obligation to inform the Company** 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 covered condition caused by any cancer or its treatment.

Malignant melanoma – Stage 1

Advance of 15% ($50,000 maximum)

Definition	Exclusions
Definite diagnosis of stage 1 malignant melanoma that is less than or equal to 1.0 mm in thickness, without ulceration or lymph node or distant metastasis. The diagnosis of stage 1 malignant melanoma must be supported by histopathological biopsy and made by a specialist.	*No benefit will be payable under the definition of "malignant melanoma – stage 1" if:* Within the first 90 days following the later of the effective date of this coverage or the date of last reinstatement of this coverage, the insured person: a) exhibits signs or symptoms or undergoes investigations that lead to a diagnosis of cancer (covered or excluded under this coverage), regardless of when the diagnosis is made; OR b) is diagnosed with cancer (covered or excluded under this coverage). **Obligation to inform the Company** 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 covered condition caused by any cancer or its treatment.

Benign brain tumour

100% benefit payment

Definition	Exclusions
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.	No benefit will be payable under the definition of "benign brain tumour" for pituitary adenomas less than 10 mm in diameter. *No benefit will be payable under the definition of "benign brain tumour" if:* Within the first 90 days following the later of the effective date of this coverage or the date of last reinstatement of this coverage, the insured person: a) exhibits signs or symptoms or undergoes investigations that lead to a diagnosis of benign brain tumour (covered or excluded under this coverage), regardless of when the diagnosis is made; OR b) is diagnosed with a benign brain tumour (covered or excluded under this coverage). **Obligation to inform the Company** 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 covered condition caused by any cancer or its treatment.

GOOD TO KNOW

Note regarding neurological deficits

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.

Malignant carcinoid tumours

Advance of 15% ($50,000 maximum)

Definition	Exclusions
Definite diagnosis of malignant carcinoid tumours classified less than AJCC stage 2. The diagnosis of malignant carcinoid tumours must be supported by histopathological biopsy and made by a specialist.	For the purposes of this definition, the term "classified less than AJCC stage 2" is to be applied as defined in the American Joint Committee on Cancer (AJCC) Cancer Staging Manual, 7th Edition, 2010. *No benefit will be payable under the definition of "malignant carcinoid tumours" if:* Within the first 90 days following the later of the effective date of this coverage or the date of last reinstatement of this coverage, the insured person: a) exhibits signs or symptoms or undergoes investigations that lead to a diagnosis of cancer (covered or excluded under this coverage), regardless of when the diagnosis is made; OR b) is diagnosed with cancer (covered or excluded under this coverage). **Obligation to inform the Company** 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 covered condition caused by any cancer or its treatment.

Malignant gastrointestinal stromal tumours

Advance of 15% ($50,000 maximum)

Definition	Exclusions
Definite diagnosis of malignant gastrointestinal stromal tumours classified less than AJCC stage 2. The diagnosis of malignant gastrointestinal stromal tumours must be supported by histopathological biopsy and made by a specialist.	For the purposes of this definition, the term "classified less than AJCC stage 2" is to be applied as defined in the American Joint Committee on Cancer (AJCC) Cancer Staging Manual, 7th Edition, 2010. *No benefit will be payable under the definition of "malignant gastrointestinal stromal tumours" if:* Within the first 90 days following the later of the effective date of this coverage or the date of last reinstatement of this coverage, the insured person: a) exhibits signs or symptoms or undergoes investigations that lead to a diagnosis of cancer (covered or excluded under this coverage), regardless of when the diagnosis is made; OR b) is diagnosed with cancer (covered or excluded under this coverage **Obligation to inform the Company** 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 covered condition caused by any cancer or its treatment.

Other cancer

Advance of 1% ($5,000 maximum)

Definition	Exclusions
Definite diagnosis of any cancer that does not meet the criteria of the "cancer (life-threatening)" definition or any of the definitions of the "early-stage cancers" group of covered conditions as described in this coverage. The diagnosis of any "other cancer" must be supported by histopathological biopsy and made by a specialist.	*No benefit will be payable under the definition of "other cancer" for:* a) cervical lesions, if detected by Pap smear test and characterized by the presence of stage 1 or 2 cervical intraepithelial neoplasia (CIN I or CIN II); b) all tumours which are histologically described as benign, pre-malignant, borderline or of low malignant potential; all grades of dysplasia, all grades of squamous intraepithelial lesions (HSIL and LSIL) and all grades of intra-epithelial neoplasia unless specifically classified as Tis or carcinoma in situ as per AJCC classification. For the purposes of this exclusion, the terms "Tis and carcinoma in situ as per AJCC classification" are to be applied as defined in the American Joint Committee on Cancer (AJCC) Cancer Staging Manual, 7th Edition, 2010. No benefit will be payable under the definition of "other cancer" for the duration of this coverage if the diagnosis is made in the 12 months following the effective date of this coverage or the date of last reinstatement of this coverage, whichever is later.

Cardiovascular

Heart disease is any condition that affects the structure or function of the heart. Most people think of heart disease as one condition. But in fact, heart disease is a group of conditions with many different root causes.

Source: Types of heart disease | Heart and Stroke Foundation

**** Please note that the survival period is not applicable for Life with Critical illness advance products.**

Stroke (Cerebrovascular accident)

100% benefit payment

Definition	Exclusions
Definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or hemorrhage or embolism from an extra-cranial source 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. The diagnosis of stroke must be made by a specialist.	*No benefit will be payable under the definition of "stroke (cerebrovascular accident)" for:* a) **transient ischemic attacks**; b) intracerebral vascular events due to trauma; c) **lacunar infarcts** which do not meet the definition of "stroke" as described above.

GOOD TO KNOW

Transient ischemic attack: A transient ischemic attack – or mini stroke – is caused by a small clot that briefly blocks an artery. TIA and minor ischemic stroke fall along a continuum. TIA symptoms disappear completely within 24 hours (usually within one hour).

Source: TIA | Heart&stroke foundation (heartandstroke.ca)

Lacunar infarction: Lacunar infarction refers to tiny ischemic strokes, typically no larger than about a third of an inch (1 centimeter). In lacunar infarction, one of the small arteries deep in the brain becomes blocked when part of its wall deteriorates and is replaced by a mixture of fat and connective tissue—a disorder called lipohyalinosis.

Source: Ischemic Stroke – Brain, Spinal Cord, and Nerve Disorders – Merck Manuals Consumer Version

GOOD TO KNOW

Note regarding neurological deficits

Neurological deficits must be detectable by a specialist and may include, but are not limited to, measurable hearing loss, measurable vision loss, measurable decline in neurocognitive function, objective loss of sensitivity, paralysis, localized weakness, dysarthria (pronunciation difficulties), dysphasia (language difficulties), dysphagia (difficulty swallowing), abnormal gait (difficulty walking), lack of balance, lack of coordination, or the appearance of seizures that are being treated. For the purposes of the contract, headache and fatigue are not considered neurological deficits.

ARE STROKES ALWAYS COVERED?

Mark goes to the emergency room after experiencing a partial, unexpected loss of vision in his right eye. He also has a progressive headache in his left forehead.

After undergoing medical exams and tests, he is diagnosed with a left occipital stroke.

Mark completely recovers vision in his right eye while he's in the hospital and is discharged. However, he still has headaches and takes medication to reduce their frequency and intensity.

Mark visits his neurologist 4 weeks after he is hospitalized. He explains that he doesn't have new neurological symptoms but that he still has mild headaches and feels too tired since his stroke to return to work.

Although Mark suffered a stroke and initially presented with an objective neurological deficit (loss of vision in the right eye), this subsided within 30 days. Also, even though he has experienced headaches and has felt tired since his stroke, his symptoms aren't objective neurological deficits that can be observed during a clinical examination. As a result, Mark's stroke doesn't meet the requirements of the definition in his contract.

Coronary angioplasty

Advance of 15% ($50,000 maximum)

Definition	Exclusions
Undergoing of surgery to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The surgery must be determined to be medically necessary and performed by a specialist.	A 30-day survival period applies.

Aortic aneurysm

Advance of 15% ($50,000 maximum)

Definition	Exclusions
Definite diagnosis of aortic aneurysm, where the aorta is enlarged to at least 55 mm in diameter for males or 50 mm for females. For the purposes of this definition, "aorta" means the thoracic and abdominal aorta, but not its branches. The diagnosis of aortic aneurysm must be evidenced by diagnostic imaging testing and made by a specialist.	A 30-day survival period applies.

Aortic surgery

100% benefit payment

Definition	Exclusions
Undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. For the purposes of this definition, "aorta" means the thoracic and abdominal aorta, but not its branches. The surgery must be determined to be medically necessary and performed by a specialist.	A 30-day survival period applies. *No benefit will be payable under the definition of "aortic surgery" for:* a) angioplasty; b) intra-arterial or percutaneous trans-catheter surgery; OR c) non-surgical procedures.

Heart attack

100% benefit payment

Definition	Exclusions
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: a) heart attack symptoms; b) new electrocardiogram (ECG) changes consistent with a heart attack; c) 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. *No benefit will be payable under the definition of "heart attack" for:* a) elevated biochemical cardiac markers as the result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty in the absence of new Q waves; b) ECG changes suggesting a prior myocardial infarction that does not meet the "heart attack" definition as described above.

CAN AN ILLNESS GIVE RISE TO BENEFITS FROM THE MOMENT WHEN THERE ARE SYMPTOMS INDICATIVE OF A HEART ATTACK?

Kathy goes to the emergency room with shortness of breath and tightness in the chest. She believes that she's having a heart attack. After an electrocardiogram and blood test, she is instead diagnosed with angina.

In this situation, Kathy isn't covered by her insurance because she was diagnosed with angina, not a heart attack, despite the presence of similar symptoms.

Insertion of cardiac pacemaker or permanent cardiac defibrillator

Advance of 15% ($50,000 maximum)

Definition	Exclusions
Undergoing of surgery to insert a permanent cardiac pacemaker or a permanent cardiac defibrillator that is required as the result of: a) serious cardiac arrhythmia which cannot be treated via any other method; OR b) **cardiac resynchronization** therapy The surgery must be determined to be medically necessary and performed by a specialist.	A 30-day survival period applies.

GOOD TO KNOW

Cardiac Resynchronization: Some people with advanced heart failure experience a delay between the contraction of their right and left ventricles (lower chambers of the heart). In cardiac resynchronization therapy (CRT), a small electronic apparatus is surgically implanted to help both ventricles contract together.

Source: Cardiac Resynchronization Therapy (CRT) (Biventricular Pacemaker) | Heart and Stroke Foundation

Coronary artery bypass surgery

100% benefit payment

Definition	Exclusions
Undergoing of heart surgery to unblock or widen one or more coronary arteries with bypass graft(s). The surgery must be determined to be medically necessary and performed by a specialist.	A 30-day survival period applies. *No benefit will be payable under the definition of "coronary artery bypass surgery" for:* a) angioplasty; b) intra-arterial or percutaneous trans-catheter surgery; OR c) non-surgical procedures.

Heart valve replacement or repair

100% benefit payment

Definition	Exclusions
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 and performed by a specialist.	A 30-day survival period applies. *No benefit will be payable under the definition of "heart value replacement or repair" for:* a) angioplasty; b) intra-arterial or percutaneous trans-catheter surgery; OR c) non-surgical procedures.

Endovascular treatment or aortic aneurysm or disease

Advance of 15% ($50,000 maximum)

Definition	Exclusions
Undergoing of surgery performed via minimally invasive or intra-arterial techniques to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta. For the purposes of this definition, "aorta" means the thoracic and abdominal aorta, but not its branches. The surgical procedure must be determined to be medically necessary, evidenced by diagnostic imaging testing and performed by a specialist.	A 30-day survival period applies.

Neurological

Neurology is the branch of medicine concerned with the study of the nervous system in health and disease. Neurologists diagnose and treat nervous system disorders involving the brain and spinal cord and other nerve and muscular conditions. Many neurological problems are characterized by pain and are chronic, debilitating and untreatable.

Source : Neurology Profile (cma.ca)

Dementia (including Alzheimer's disease)

100% benefit payment

Definition	Exclusions
Definite diagnosis of dementia, meaning the progressive deterioration of memory and at least one of the following cognitive disturbances: a) aphasia (a disorder of speech); b) apraxia (difficulty performing familiar tasks); c) agnosia (difficulty recognizing objects); d) 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: a) dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam score of 20/30 or less, or an equivalent score on another generally medically accepted test or tests of cognitive function; AND b) evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6-month period. For the purpose of this definition, reference to the "Mini Mental State Exam" is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res. 1975;12(3):189. The diagnosis of dementia (including Alzheimer's disease) must be made by a specialist.	*No benefit will be payable under the definition of "dementia (including Alzheimer's disease)" for affective or schizophrenic disorders or delirium.*

IS ALZHEIMER'S DISEASE ALWAYS COVERED?

Laura now finds that she needs to take notes because her memory isn't as good as it used to be. She also notices that she has increasing difficulty finding the right words to express herself. She decides to see her family doctor, who refers her to a specialist. After seeing the doctor, Laura is diagnosed with mild Alzheimer's disease.

Even though the illness has been confirmed by a specialist, Laura is not eligible for a benefit at this time because her illness is in the early stage and does not currently meet the criteria set out in her contract.

Two years later, Laura visits her doctor with her daughter. Her daughter explains to the doctor that her mother has had increasingly high levels of cognitive difficulties and is no longer able to perform daily tasks alone due to considerable memory problems.

The doctor confirms that her condition has progressed to moderate Alzheimer's disease.

This means that she now meets the criteria in her contract for Alzheimer's disease and will receive the total amount payable for her critical illness insurance coverage.

Parkinson's disease and specified atypical parkinsonian disorders

100% benefit payment

Definition	Exclusions

Parkinson's disease:

Definite diagnosis of primary Parkinson's disease, a permanent neurological condition which must be characterized by bradykinesia (slowness of movement) and at least one of:

a) muscular rigidity; OR

b) 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 another generally medically accepted equivalent treatment for Parkinson's disease.

Specified atypical parkinsonian disorders:

Definite diagnosis of **progressive supranuclear palsy**, **corticobasal degeneration** or **multiple system atrophy**.

The diagnosis of Parkinson's disease or specified atypical parkinsonian disorder must be made by a neurologist.

No benefit will be payable under the definition of "Parkinson's disease and specified atypical parkinsonian disorders" for any other type of parkinsonism.

No benefit will be payable under the definition of "Parkinson's disease and specified atypical parkinsonian disorders" if:

Within 12 months following the later of the effective date of this coverage or the date of last reinstatement of this coverage, the insured person:

a) exhibits signs or symptoms or undergoes investigations that lead to a diagnosis of Parkinson's disease, specified atypical parkinsonian disorder or any other type of parkinsonism, regardless of when the diagnosis is made; OR

b) is diagnosed with Parkinson's disease, specified atypical parkinsonian disorder or any other type of parkinsonism.

Obligation to inform the Company

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 covered condition caused by Parkinson's disease or specified atypical parkinsonian disorders or treatment thereof.

GOOD TO KNOW

Progressive Supranuclear Palsy: Progressive Supranuclear Palsy (PSP) is an uncommon neurological disease. It is caused by damage to nerve cells in specific areas of the brain. As the disease progresses these symptoms worsen and difficulties with eye movements, speech, swallowing, and thinking occur.

Source: Atypical Parkinsonisms – Parkinson Canada

Corticobasal degeneration: (CBD) is a rare neurological disease in which parts of the brain deteriorate or degenerate.

Source: Atypical Parkinsonisms – Parkinson Canada

Multiple system atrophy: Multiple system atrophy is a progressive, fatal disorder that causes symptoms resembling those of Parkinson disease (parkinsonism), loss of coordination, and malfunction of internal body processes (such as blood pressure and bladder control).

Source: Multiple System Atrophy (MSA) – Brain, Spinal Cord, and Nerve Disorders – Merck Manuals Consumer Version

Motor neuron disease

100% benefit payment

Definition	Exclusions
Definite diagnosis of one of the following exclusively: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive muscular atrophy, progressive bulbar palsy or pseudo bulbar palsy. The diagnosis of motor neuron disease must be made by a specialist.	—

Bacterial Meningitis

100% benefit payment

Definition	Exclusions
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.	*No benefit will be payable under the definition of "bacterial meningitis" for viral meningitis.*

GOOD TO KNOW

Difference between viral meningitis and bacterial (purulent) meningitis

Meningitis means inflammation of the meninges (meninges is the medical term for lining of the brain). Inflammation of the meninges, or meningitis, is most often caused by an infection, but can be caused by other things such as medications or other medical conditions. To determine whether a person is suffering from viral or bacterial meningitis, doctors will have to perform a lumbar puncture. This involves collecting a sample of the cerebrospinal fluid (CSF) that surrounds the brain and spinal cord to find out what is causing the meningitis. If the results of the lumbar puncture identify a specific virus or bacteria then the diagnosis is clear.

Source: What's the difference between bacterial and viral meningitis? | Meningitis Research Foundation

Note regarding neurological deficits

Neurological deficits must be detectable by a specialist and may include, but are not limited to, measurable hearing loss, measurable vision loss, measurable decline in neurocognitive function, objective loss of sensitivity, paralysis, localized weakness, dysarthria (pronunciation difficulties), dysphasia (language difficulties), dysphagia (difficulty swallowing), abnormal gait (difficulty walking), lack of balance, lack of coordination, or the appearance of seizures that are being treated. For the purposes of the contract, headache and fatigue are not considered neurological deficits.

Multiple sclerosis

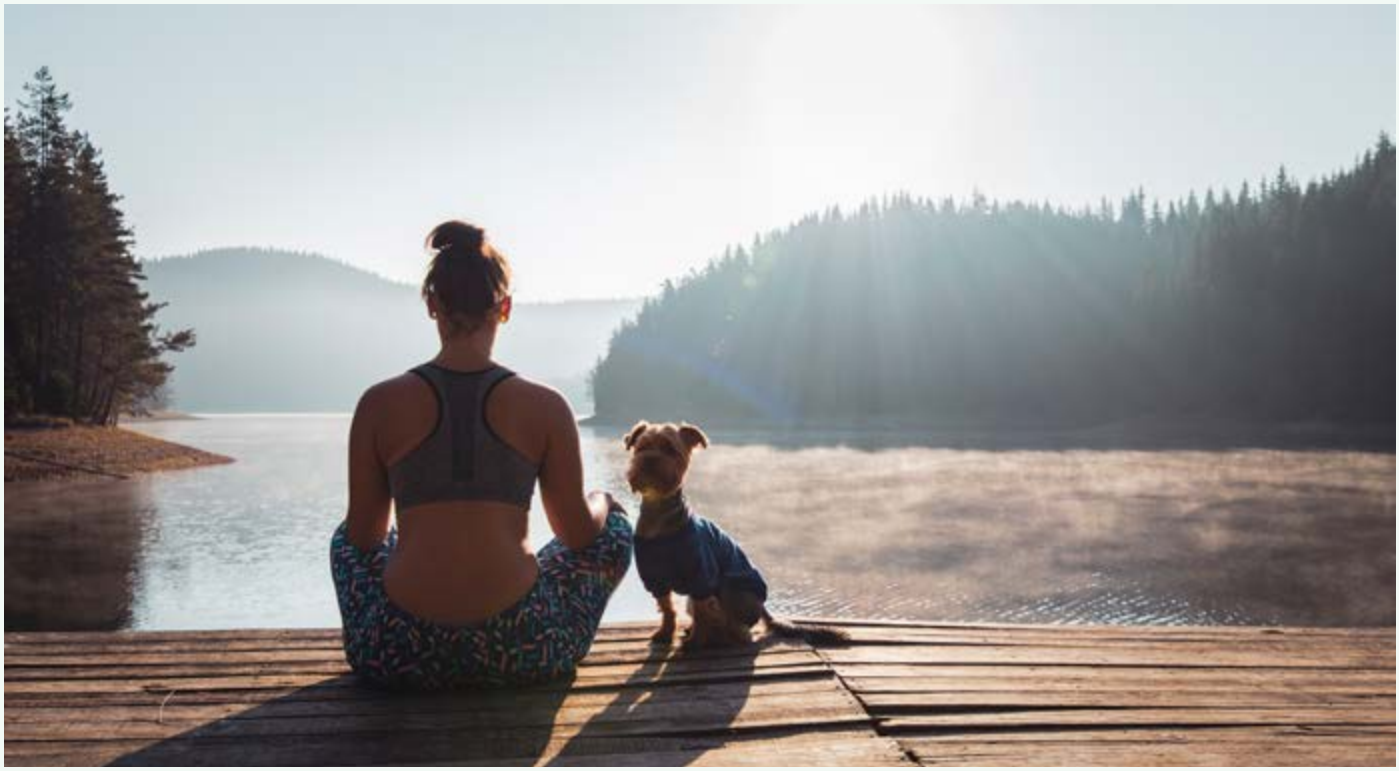
100% benefit payment

Definition	Exclusions
Definite diagnosis of at least one of the following: a) 2 or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of **demyelination**; b) well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; c) a single attack, confirmed by repeated MRI of the nervous system, showing 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.	—

GOOD TO KNOW

Demyelination: Demyelination is the destruction of the tissues that wrap around nerves, called the myelin sheath.

Source: Other Primary Demyelinating Diseases – Brain, Spinal Cord, and Nerve Disorders – Merck Manuals Consumer Version



Vital organs

The human body contains five organs that are considered vital for survival. They are the heart, the brain, the kidneys, the liver and the lungs. If any of the five vital organs stop functioning, the death of the organism is imminent without medical intervention.

Source: Vital Organs – Physiopedia (physio-pedia.com)

Major organ failure on waiting list

100% benefit payment

Definition	Exclusions
Definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow for which transplantation is medically necessary. To qualify for the benefit payable under the definition of "major organ failure on waiting list", the insured person must become enrolled as a recipient at a recognized transplant centre in Canada or the United States that performs the required form of transplant surgery. The diagnosis of major organ failure must be made by a specialist.	—

Major organ transplant

100% benefit payment

Definition	Exclusions
Undergoing of medically necessary surgery due to the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow. To qualify for the benefit payable under the definition of "major organ transplant", the insured person must undergo transplantation surgery as the recipient of a heart, lung, liver, kidney or bone marrow exclusively. The diagnosis of major organ failure must be made by a specialist, and the transplantation surgery must be performed by a specialist.	—

Kidney failure

100% benefit payment

Definition	Exclusions
Definite diagnosis of chronic irreversible failure of both kidneys as the result of which regular hemodialysis, peritoneal dialysis or renal transplantation is required. The diagnosis of kidney failure must be made by a specialist.	—

ABLATION SURGERIES

In medicine, the term indicates the removal of a growth, tissue, organ, or bone using a scalpel, laser, or another cutting tool.

Source: What It Means to Excise Something During Surgery (verywellhealth.com)

Total mastectomy

Advance of 30% ($100,000 maximum)

Definition	Exclusions
Undergoing of surgery to remove one or both breasts to stop the spread of cancer cells after the diagnosis of carcinoma in situ of the breast. The surgery must be determined to be medically necessary and performed by a specialist.	—

Total prostatectomy

Advance of 30% ($100,000 maximum)

Definition	Exclusions
Undergoing of surgery to remove the prostate, seminal vesicles and a portion of the urethra to stop the spread of cancer cells after the diagnosis of prostate cancer. The surgery must be determined to be medically necessary and performed by a specialist.	—

ACCIDENTS AND FUNCTIONAL LOSS

Your critical illness insurance contract can also cover health problems that occur due to an accident or certain other health problems that may arise from illness.

Severe burns

100% benefit payment

Definition	Exclusions
Definite diagnosis of 3rd-degree burns over at least 20% of the body surface. The diagnosis of severe burns must be made by a specialist.	—

Blindness

100% benefit payment

Definition	Exclusions
Definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by: a) the corrected visual acuity being 20/200 or less in both eyes; OR b) the field of vision being less than 20 degrees in both eyes. The diagnosis of blindness must be made by a specialist.	—

Coma

100% benefit payment

Definition	Exclusions
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** is 4 or less. The diagnosis of coma must be made by a specialist.	*No benefit will be payable under the definition of "coma" for:* a) a medically induced coma; b) a coma which results directly from alcohol or drug use; c) a diagnosis of brain death.

GOOD TO KNOW

Glasgow coma score: The Glasgow Coma Scale is used to objectively describe the extent of impaired consciousness in all types of acute medical and trauma patients. The scale assesses patients according to three aspects of responsiveness: eye-opening, motor, and verbal responses.

Source: Glasgow Coma Scale – StatPearls – NCBI Bookshelf (nih.gov)

Acquired brain injury

100% benefit payment

Definition	Exclusions
Definite diagnosis of new damage to brain tissue caused by traumatic injury, **anoxia** or **encephalitis**, resulting- in signs and symptoms of neurological impairment that: a) are present and verifiable on clinical examination or neuro-psychological testing; b) are corroborated by imaging studies of the brain such as magnetic resonance imaging (MRI) of the nervous system or computerized **tomography** (CT) showing changes that are consistent in character, location and timing with the new damage; AND c) persist for more than 180 days following the date of diagnosis. The diagnosis of acquired brain injury must be made by a specialist.	*No benefit will be payable under the definition of "acquired brain injury" for:* a) an abnormality seen on brain or other scans without definite related clinical impairment; b) post-concussion symptoms; c) neurological signs occurring without symptoms of abnormality.

GOOD TO KNOW

Anoxia: Anoxia occurs when the brain is deprived of oxygen. It's often used interchangeably with hypoxia, although hypoxia refers to a partial loss of oxygen and happens first, typically leading to anoxia or a total lack of oxygen. In both cases, there is still adequate blood flow to the brain and bodily tissues. Cells in the body die. This is part of a natural process called apoptosis. However, anoxia causes many neural cells to die at one time and can lead to anoxic brain injury.

Source: Encephalopathy: Types, Causes, Symptoms, Stages, Treatment (medicinenet.com)

Encephalitis: Encephalitis is inflammation of the brain. It's an uncommon non-traumatic brain injury but can cause severe damage or even death.

Source: Encephalitis – Brain Injury Canada

Tomography: A computed tomography (CT) scan is an imaging test that uses a computer to put a series of x-ray images together to create detailed 3D images of organs, tissues, bones and blood vessels in the body.

Source: Computed tomography (CT) scan | Canadian Cancer Society

Paralysis

100% benefit payment

Definition	Exclusions
Definite diagnosis of the total loss of muscle function of 2 or more limbs as the result of injury or disease affecting 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.	—

Loss of speech

100% benefit payment

Definition	Exclusions
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.	*No benefit will be payable under the definition of "loss of speech" for all psychiatric causes.*

Loss of limbs

100% benefit payment

Definition	Exclusions
Definite diagnosis of the complete severance of 2 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.	—

Deafness

100% benefit payment

Definition	Exclusions
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.	—

OTHER

Critical illness insurance from Desjardins Insurance covers other medical conditions that are not cancer or cardiovascular and neurological diseases.

Aplastic anemia

100% benefit payment

Definition	Exclusions
Definite diagnosis of a chronic persistent bone marrow failure which results in anemia, **neutropenia** and **thrombocytopenia** requiring blood product transfusion and treatment with at least one of the following: a) marrow stimulating agents; b) immunosuppressive agents; c) bone marrow transplantation. The diagnosis of aplastic anemia must be confirmed by biopsy and made by a specialist.	—

GOOD TO KNOW

Neutropenia: Neutropenia and leukopenia are terms used to refer to lowered numbers of white blood cells (WBCs) in the blood.

Source: Low white blood cell count (neutropenia) | Canadian Cancer Society

Thrombocytopenia: Thrombocytopenia is a condition caused by a low number of platelets in the blood.

Source: Low platelet count (thrombocytopenia) | Canadian Cancer Society

Occupational HIV infection

100% benefit payment

Definition	Exclusions
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 this coverage or the effective date of last reinstatement of this coverage. *For a benefit to be paid under the definition of "occupational HIV infection", ALL OF THE FOLLOWING REQUIREMENTS must be met:* a) the accidental injury must be reported to the Company within 14 days of the accidental injury; b) a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative; c) a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive; d) all HIV tests must be performed by a duly licensed laboratory in Canada or the United States; e) the accidental injury must have been reported, investigated and documented in accordance with current Canadian or American workplace guidelines. The diagnosis of occupational HIV infection must be made by a specialist.	*No benefit will be payable under the definition of "occupational HIV infection" if:* a) the insured person elected not to take any available licensed vaccine offering protection against HIV; b) a licensed cure for HIV infection became available prior to the accidental injury; c) the HIV infection occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous drug use.

Permanent loss of independent existence

Advance of 15% ($25,000 maximum)

Definition	Exclusions
Definite diagnosis of the total and permanent 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. Activities of daily living are: a) bathing: the ability to wash oneself in a bathtub, in a shower or by sponge bath, with or without the aid of assistive devices; b) 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; c) toileting: the ability to get on and off the toilet and maintain personal hygiene, with or without the aid of assistive devices; d) bladder and bowel continence: the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of personal hygiene is maintained; e) transferring: the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; f) feeding: the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices. The diagnosis of permanent loss of independent existence must be made by a specialist.	—

Temporary loss of independent existence

Advance of 15% ($25,000 maximum)

Définition	Exclusions
Definite diagnosis of the total inability to perform, by oneself, at least 2 of 6 activities of daily living for a continuous period of at least 90 days. Activities of daily living are listed under the "permanent loss of independent existence" definition. Activities of daily living are: a) bathing: the ability to wash oneself in a bathtub, in a shower or by sponge bath, with or without the aid of assistive devices; b) 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; c) toileting: the ability to get on and off the toilet and maintain personal hygiene, with or without the aid of assistive devices; d) bladder and bowel continence: the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of personal hygiene is maintained; e) transferring: the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; f) feeding: the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices. The diagnosis of temporary loss of independent existence must be made by a specialist.	—

Childhood illnesses

In addition to covering 26 critical illnesses, Health Priorities – Child, 20 Pay covers the insured child against 3 childhood illnesses (autism spectrum disorder, cystic fibrosis, Rett syndrome) and offers the option to add 3 additional childhood illnesses (Type 1 diabetes mellitus, muscular dystrophy, and cerebral palsy).

Cystic fibrosis

100% benefit payment

Definition	Exclusions
Definite diagnosis of cystic fibrosis evidenced by chronic lung disease and pancreatic insufficiency. The diagnosis of cystic fibrosis must be made by a specialist.	No benefit will be payable under the definition of "cystic fibrosis" if the diagnosis is made after the insured person's 24th birthday.

Rett syndrome

100% benefit payment

Definition	Exclusions
Definite diagnosis of a genetic disorder affecting the development of the central nervous system. The diagnosis of Rett syndrome must be characterized by at least 2 of the following: • partial or complete loss of the use of the hands; • partial or complete loss of acquired language; • deterioration of the ability to crawl or walk; • stereotypic hand movements (e.g., clapping, wringing, rubbing, tapping). Any loss or developmental deterioration must be followed by a period of recovery or stabilization. The diagnosis of Rett syndrome must be made by a specialist.	a) No benefit will be payable under the definition of "Rett syndrome" for an insured person whose 3rd birthday occurs prior to the effective date of this coverage. b) No benefit will be payable under the definition of "cystic fibrosis" if the diagnosis is made after the insured person's 6th birthday.

Autism spectrum disorder

100% benefit payment

Definition	Exclusions
Definite diagnosis of autism spectrum disorder, as defined in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) published by the American Psychiatric Association (APA). The diagnosis of autism spectrum disorder must be made by a specialist. The autism spectrum disorder must be characterized by the following: a) Persistent deficits in social communication and social interaction across multiple contexts as manifested by at least 1 of the following: • deficits in social-emotional reciprocity; • deficits in nonverbal communicative behaviours used for social interaction; • deficits in developing, maintaining and understanding relationships. AND b) Restricted, repetitive patterns of behaviour, interests or activities, as manifested by at least 2 of the following: • stereotyped or repetitive motor movements, use of objects or speech; • insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behaviour; • highly restricted, fixated interests that are abnormal in intensity or focus; • hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment. AND c) Symptoms cause clinically significant impairment in social, occupational or other important areas of current function.	a) No benefit will be payable under the definition of "autism spectrum disorder" for an insured person whose 3rd birthday occurs prior to the effective date of this coverage. b) No benefit will be payable under the definition of "autism spectrum disorder" if the diagnosis is made after the insured person's 6th birthday.

GOOD TO KNOW

Autism spectrum disorder (ASD): ASD is a neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave. Although autism can be diagnosed at any age, it is described as a "developmental disorder" because symptoms generally appear in the first 2 years of life.

Source: Autism Spectrum Disorder – National Institute of Mental Health (NIMH) (nih.gov)

Type 1 diabetes mellitus

100% benefit payment

Definition	Exclusions
Definite diagnosis of type 1 diabetes mellitus characterized by absolute insulin deficiency and continuous dependence on exogenous insulin for survival. There must be evidence of dependence on insulin for a minimum of 3 months. The diagnosis of type 1 diabetes mellitus must be made by a specialist.	No benefit will be payable under the definition of "type 1 diabetes mellitus" if the diagnosis is made after the insured person's 24th birthday.

GOOD TO KNOW

In an individual with type 1 diabetes, the pancreas is no longer able to produce insulin. That is why insulin must be injected several times per day to mimic normal pancreatic function.

Source: What is insulin? | Diabetes Quebec

Muscular dystrophy

100% benefit payment

Definition	Exclusions
Definite diagnosis of muscular dystrophy characterized by well-defined neurological abnormalities. The diagnosis of muscular dystrophy must be made by a specialist and confirmed by **electromyography** and muscle biopsy.	No benefit will be payable under the definition of "muscular dystrophy" if the diagnosis is made after the insured person's 24th birthday.

Cerebral palsy

100% benefit payment

Definition	Exclusions
Definite diagnosis of cerebral palsy evidenced by non-progressive neurological impairments characterized by spasticity and incoordination of movements. The diagnosis of cerebral palsy must be made by a specialist.	No benefit will be payable under the definition of "cerebral palsy" if the diagnosis is made after the insured person's 24th birthday.

GOOD TO KNOW

Electromyography: Electromyography is a diagnostic procedure to assess the health of muscles and the nerve cells that control them (motor neurons). It results can reveal nerve dysfunction, muscle dysfunction or problems with nerve-to-muscle signal transmission.

Source: Electromyography (EMG) – Mayo Clinic

What time periods need to be satisfied and how long are they depending on the illness or health problem?

Being diagnosed with a critical illness by your doctor doesn't automatically mean you qualify for benefit payments. Benefits are paid according to the contract definitions of the covered illnesses. There may also be some limitations and exclusions, such as needing to satisfy a moratorium, survival or qualifying period.

Cancers and tumours

Illnesses	Survival period	Moratorium period	Qualifying period	Payment
Cancer (life threatening)	—	90 days	—	100%
Papillary thyroid cancer or follicular thyroid cancer – Stage 1	—	90 days	—	15% ($50,000 maximum)
Prostate cancer – Stage T1a or T1b	—	90 days	—	15% ($50,000 maximum)
Ductal carcinoma in situ of the breast or lobular carcinoma in situ of the breast	—	90 days	—	15% ($50,000 maximum)
Carcinoma in situ	—	90 days	—	15% ($50,000 maximum)
Dermatofibrosarcoma	—	90 days	—	15% ($50,000 maximum)
Chronic lymphocytic leukemia – Stage 0	—	90 days	—	15% ($50,000 maximum)
Primary cutaneous lymphoma	—	90 days	—	15% ($50,000 maximum)
Malignant melanoma – Stage 1	—	90 days	—	15% ($50,000 maximum)
Malignant carcinoid tumours	—	90 days	—	15% ($50,000 maximum)
Benign brain tumour	—	90 days	—	100%
Malignant gastrointestinal stromal tumours	—	90 days	—	15% ($50,000 maximum)
Other cancers	—	12 months	—	1% ($5,000 maximum)

Cardiovascular

Illnesses	Survival period	Moratorium period	Qualifying period	Payment
Stroke	—	—	30 days	100%
Coronary angioplasty	30 days	—	—	15% ($50,000 maximum)
Aortic aneurysm	30 days	—	—	15% ($50,000 maximum)
Aortic surgery	30 days	—	—	100%
Heart attack	30 days	—	—	100%
Insertion of a permanent cardiac pacemaker or cardiac defibrillator	30 days	—	—	15% ($50,000 maximum)
Endovascular treatment of aortic aneurysm or disease	30 days	—	—	15% ($50,000 maximum)
Coronary artery bypass	30 days	—	—	100%
Heart valve replacement or repair	30 days	—	—	100%

Note that the survival period is not required for Life with Critical illness advance products.

Neurological

Illnesses	Survival period	Moratorium period	Qualifying period	Payment
Dementia, including Alzheimer's disease	—	—	6 months	100%
Parkinson's disease and specified atypical Parkinsonian disorders	—	12 months	—	100%
Motor neuron disease	—	—	—	100%
Bacterial meningitis	—	—	90 days	100%
Multiple sclerosis	—	—	6 months*	100%

* Some criterias may cause the 6-month period to be circumvented.

Vital organs

Illnesses	Survival period	Moratorium period	Qualifying period	Payment
Major organ failure on waiting list	—	—	—	100%
Major organ failure on waiting list	—	—	—	100%
Kidney failure	—	—	—	100%

Ablation surgeries

Illnesses	Survival period	Moratorium period	Qualifying period	Payment
Total mastectomy	—	—	—	30% ($100,000 maximum)
Total prostatectomy	—	—	—	30% ($100,000 maximum)

Accidents and functional loss

Illnesses	Survival period	Moratorium period	Qualifying period	Payment
Severe burns	—	—	—	100%
Blindness	—	—	—	100%
Coma	—	—	96 hour	100%
Acquired brain injury	—	—	180 days	100%
Paralysis	—	—	90 days	100%
Loss of speech	—	—	180 days	100%
Loss of limbs	—	—	—	100%
Deafness	—	—	—	100%

Other

Illnesses	Survival period	Moratorium period	Qualifying period	Payment
Aplastic anemia	—	—	—	100%
Occupational HIV infection	—	—	90 to 180 days	100%

Long-term care

Illnesses	Survival period	Moratorium period	Qualifying period	Payment
Permanent loss of independent existence	—	—	90 days	100%
Temporary loss of independent existence	—	—	90 days	15% ($25,000 maximum)

Childhood diseases

Illnesses	Survival period	Moratorium period	Qualifying period	Payment
Type 1 diabetes mellitus	—	—	3 months	100%
Autism spectrum disorder	—	—	—	100%
Cystic fibrosis	—	—	—	100%
Rett syndrome	—	—	—	100%
Muscular dystrophy	—	—	—	100%
Cerebral palsy	—	—	—	100%

Look to the future with confidence

Choose Desjardins Insurance

Choose the strength and stability of a company specialized in life and health insurance and group retirement savings that over 7.5 million Canadians count on each day to ensure their financial security. Backed by over a century of experience, it is also one of the country's leading life insurers.

Choose Desjardins Group, the largest cooperative financial group in North America and one of the country's best capitalized financial institutions. Desjardins Group enjoys excellent credit ratings comparable to those of several major Canadian and international banks and is recognized as one of the most stable financial institutions in the world according to *The Banker* magazine.

desjardinslifeinsurance.com | desjardins.com

Desjardins
Insurance
Life • Health • Retirement