GO FOR LIFE

Your guide to Express Critical Illness Insurance definitions

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Sun Life

Your Guide to EXPRESS Critical Illness Insurance Definitions

This guide to critical illness definitions will help you understand the illnesses and procedures covered by your Express Critical Illness (CI) Insurance policy. Each of the covered illnesses is defined and then explained to you. We have also outlined illness-specific exclusions and the survival periods required.

The diagnosis and treatment of any Covered critical illness must be made by a specialist who is licensed and practising in Canada. A specialist is a licensed medical practitioner who has been trained in the specific area of medicine relevant to the Covered critical illnesses for which a benefit is being claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a specialist a condition may be diagnosed by a qualified medical practitioner practicing in Canada.

This guide is for your reference only, and does not replace the policy. We will not pay for any illness, disorder or surgery not specifically defined under the policy/coverage. For Express Critical Illness Insurance, the complete terms, conditions, exclusions and limitations governing the Critical Illness Insurance coverage are found in your policy issued by Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies.

Your critical illness insurance policy:

- Defines illnesses you are insured for, and
- Includes the terms and conditions you will have to meet to receive the critical illness insurance benefit
- Includes a pre-existing condition provision and how it applies to the critical illness insurance benefit (if that benefit is applied for).*

Please review the policy carefully. For a sample policy please visit www.sunlife.ca/ExpressCI or call 1-877-893-9893.

Illnesses not specifically mentioned or not meeting the stated criteria are not covered. All illnesses must satisfy the description in your policy. For an illness or condition to be covered, it must meet the illness description in your policy.

If your policy ended because it lapsed, you may apply to have it put back into effect if the insured person is alive and has not had a covered critical illness or any signs or symptoms of a covered critical illness. This process is called reinstatement.

If you want to put your policy back into effect, you must:

- Apply within 2 years of the date the policy ended,
- Give us new evidence of insurability that we consider satisfactory, and
- Make a payment equal to the reinstatement charge set by us.

* No benefits are payable for any Covered critical illness that occurs within 12 months of the policy date set out on the Policy particulars page in your contract. And that resulted from any injury, sickness or medical condition (whether diagnosed or not) for which, during the 12 months before the policy due date:

  - the insured person had symptoms,
  - the insured person consulted a physician or other health care practitioner and was provided any health-related care, advice or treatment, or
  - a reasonably prudent person has such injury, sickness or medical condition or symptoms(s) would have consulted a physician or other health care practitioner.

Covered critical illnesses

	Basic Plan	Enhanced Plan	Comfort Plan
Illnesses covered	• Cancer	• Cancer • Heart attack • Stroke	• Cancer • Heart attack • Stroke • Coronary artery bypass surgery • Aortic surgery • Major organ transplant • Major organ failure – on waiting list
Age requirements	• 18-65 years old when you buy the policy	• 18-65 years old when you buy the policy	• 18-65 years old when you buy the policy
Coverage amount	• $25,000	• $25,000	• $50,000 • $5,000 (child benefits)
Additional benefits			• Rate guarantee for the first 5 years • Inflation protection • Teladoc Medical Experts* services - At any point during the lifetime of the policy you can access Teladoc Medical Experts to get answers to any of your medical questions. In addition, if you get critically ill, you will be connected with a leading expert that will review your diagnosis and your treatment plan and provide you with recommendations for moving forward. • Add up to 5 children for $2.50 per month to provide coverage of $5,000 per child

Cancer

Cancer means a definite diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

The diagnosis of cancer must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.

Exclusions

No benefit is payable for a recurrence or metastasis of an original cancer which was diagnosed before the policy date.

No benefit is payable under this condition for the following non-life threatening cancers:

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

90 day exclusion period for cancer:

No benefit is payable for cancer and the insured person's coverage for cancer will terminate if, within 90 days following the later of:

- the most recent date the application for this policy was signed;
- the policy date; or,
- the most recent date this policy was put back in effect (reinstatement),

the insured person has any of the following:

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

While the insured person's coverage for cancer terminates, coverage for all other Covered critical illnesses remain in force.

Your responsibility to report cancer

You must report to us, if within the first 90 days following the later of:

- the policy date, or
- the most recent date this policy was put back into effect (reinstatement),

the insured person has:

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

The information described above must be reported to us within 6 months of the date of the diagnosis. If this information is not provided, we have the right to deny any claim for:

- cancer,
- any critical illness caused by cancer, or
- any critical illness caused by the treatment of cancer.

To report the information, contact us at the toll-free phone number shown at the beginning of this policy for the appropriate form. The report must be in writing.

When coverage for cancer ends

The coverage for cancer will end and we will not make any payment if within the first 90 days following the later of:

- the policy date, or
- the most recent date this policy was put back into effect (reinstatement),

the insured person has:

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

Coverage for all other Covered critical illnesses will continue provided the insured person's critical illness does not result directly or indirectly from any cancer or cancer treatment.

Heart attack

Heart attack means a definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

- heart attack symptoms;
- new electrocardiogram (ECG) changes consistent with a heart attack; or,
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The diagnosis of heart attack must be made by a specialist. The insured person must survive for 30 days following the date of diagnosis.

Exclusions

Heart attack does not include:

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or,
- ECG changes suggesting a prior myocardial infarction, which do not meet the heart attack definition as described above.

Stroke

Stroke (cerebrovascular accident) means a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

- acute onset of new neurological symptoms; and
- new objective neurological deficits on clinical examination, persisting for more than 30 days following the date of diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing.

The diagnosis of stroke must be made by a specialist. The insured person must survive for 30 days following the date of the diagnosis.

Exclusions

No benefit is payable under this condition for:

- transient ischaemic attacks;
- intracerebral vascular events due to trauma; or,
- lacunar infarcts which do not meet the definition of stroke as described above.

Aortic surgery

Aortic surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches.

The surgery must be determined to be medically necessary by a specialist. The insured person must survive for 30 days following the date of surgery.

Coronary artery bypass surgery

Coronary artery bypass surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s), excluding any non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction.

The surgery must be determined to be medically necessary by a specialist. The insured person must survive for 30 days following the date of surgery.

Major organ failure on waiting list

Major organ failure on waiting list means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under major organ failure on waiting list, the insured person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant surgery.

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

Major organ transplant means 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 for transplantation 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 their transplant.

Additional Benefits

- rate guarantee for the first 5 years,
- inflation protection
- Teladoc Medical Experts™ services – A valuable service available to you, your spouse, dependent children, parents and parents-in-law at any point during the lifetime of the policy. You can access Teladoc Medical Experts to get answers to any of your medical questions (they do not need to be questions relating to an illness covered under this policy). In addition, if you get critically ill, you will be connected with a leading expert that will review your diagnosis and your treatment plan and provide you with recommendations for moving forward. What's more, you can still use Teladoc Medical Experts services up to 4 months from the time your claim is paid.
- add up to 5 children for $2.50 per month to provide coverage of $5,000 per child

Child critical illness insurance benefit

This additional benefit covers only the critical illnesses and benefit payment described in the Child critical illness insurance benefit. Additional illnesses or procedures that are not specifically mentioned are not covered. To qualify for the Child critical illness insurance benefit, all requirements for the Child covered critical illnesses must be satisfied while this policy is in effect.

The diagnosis and treatment of any covered critical illnesses must be made by a specialist who is licensed and practicing in Canada. A specialist is a licensed medical practitioner who has been trained in the specific area of medicine relevant to the Child covered critical illnesses for which a benefit is being claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a specialist, a condition may be diagnosed by a qualified medical practitioner practicing in Canada.

The diagnosis, treatment, tests or examinations performed to satisfy the Child covered critical illnesses definition may not be done by a specialist or medical professional who is:

- the owner,
- any insured child under this policy,
- anyone entitled to make a claim under this policy,
- any relative or business associate of these people, or
- any person who normally resides in the insured child's household.

Each covered critical illness describes a survival period. The insured child must be alive at the end of the survival period.

The insured child for this benefit, the policy date and the amount of the Child covered critical illnesses benefit are shown on the **Policy particulars** page in your contract.

We make a payment if the insured child has a Child covered critical illness as defined earlier in this policy. The beneficiary is you or your estate, unless you make a change in writing to us.

If the insured child qualifies for a Child covered critical illness we make a one-time payment. The amount we pay is:

- the Child critical illness insurance benefit amount at the time the benefit is payable,
- minus any unpaid premiums plus interest at the time the benefit is payable.

If payment is made on an insured child, the coverage ends for that child on the date we make the payment.

Pre-existing condition provision

No benefits are payable for any Covered critical illness that occurs within 12 months of the policy date set out on the Policy particulars page in your contract, and that resulted from any injury, sickness or medical condition (whether diagnosed or not) for which, during the 12 months before the policy date:

- the insured child had symptoms,
- the insured child consulted a physician or other health care practitioner and was provided any health-related care, advice or treatment, or
- a reasonably prudent person whose child has such injury, sickness or medical condition or symptom(s) would have consulted a physician or other health care practitioner.

When we will not make a payment under the Critical illness insurance benefit (exclusions and reductions of coverage)

We will not make any payment if the Child covered critical illness is directly or indirectly caused by or associated with the insured child operating a vehicle while their blood alcohol level is more than 80 milligrams of alcohol per 100 milliliters of blood. A vehicle includes any form of ground, air or marine transportation that can be put into motion by any means, including muscular power. We do not take into account whether or not the vehicle is in motion.

We will not make any payment if the Child covered critical illness is directly or indirectly caused by or associated with the insured child:

- committing or attempting to commit a criminal offence
- taking or attempting to take their own life, while sane or insane
- causing themself bodily injury, while sane or insane
- intentionally taking any drug other than as prescribed by a licensed medical practitioner and in accordance with the instructions given
- intentionally taking any intoxicant, narcotic or poisonous substance. This does not include smoking cigarettes, cigarillos, cigars or occasional use of alcohol.

We will not make any payment if the Child covered critical illness is directly or indirectly caused by or associated with civil disorder or war, whether declared or not.

When this benefit ends

For an insured child, this benefit automatically ends on the earliest of:

- the policy anniversary following their 18th birthday, or
- upon payout of their benefit amount, or
- their death, or
- the date this benefit ends, shown on the Policy particulars page in your contract, or
- the date your policy ends.

There is no benefit payable under this benefit after the date your policy ends.

Child covered critical illnesses

Aortic surgery

Aortic surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches.

The surgery must be determined to be medically necessary by a specialist. The insured child must survive for 30 days following the date of surgery.

Cancer

Cancer means a definite diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

The diagnosis of cancer must be made by a specialist. The insured child must survive for 30 days following the date of diagnosis.

Exclusions

No benefit is payable for a recurrence or metastasis of an original cancer which was diagnosed before the policy date.

No benefit is payable under this condition for the following non-life threatening cancers:

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

90 day exclusion period for cancer:

No benefit is payable for cancer and the insured child's coverage for cancer will terminate if, within 90 days following the later of:

- the most recent date the application for this policy was signed;
- the policy date; or,
- the most recent date this policy was put back in effect (reinstatement),

the insured child has any of the following:

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

While the insured child's coverage for cancer terminates, coverage for all other Covered critical illnesses remain in force.

Your responsibility to report cancer

You must report to us, if within the first 90 days following the later of:

- the policy date, or
- the most recent date this policy was put back into effect (reinstatement),

the insured child has:

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

The information described above must be reported to us within 6 months of the date of the diagnosis. If this information is not provided, we have the right to deny any claim for:

- cancer,
- any critical illness caused by cancer, or
- any critical illness caused by the treatment of cancer.

To report the information, contact us at the toll-free phone number shown at the beginning of this policy for the appropriate form. The report must be in writing.

When coverage for cancer ends

The coverage for cancer will end and we will not make any payment if within the first 90 days following the later of:

- the policy date, or
- the most recent date this policy was put back into effect (reinstatement),

the insured child has:

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

Coverage for all other Covered critical illnesses will continue provided the insured child's critical illness does not result directly or indirectly from any cancer or cancer treatment.

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Heart attack

Heart attack means a definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

- heart attack symptoms;
- new electrocardiogram (ECG) changes consistent with a heart attack; or,
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The diagnosis of heart attack must be made by a specialist. The insured child must survive for 30 days following the date of diagnosis.

Exclusions

Heart attack does not include:

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or,
- ECG changes suggesting a prior myocardial infarction, which do not meet the heart attack definition as described above.

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Major organ failure on waiting list means 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 child must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant surgery.

The date of diagnosis is the date of the insured child'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

Major organ transplant means 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 child must undergo a transplantation procedure as the recipient for transplantation 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 their transplant.

Stroke (cerebrovascular accident) means a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

- acute onset of new neurological symptoms; and
- new objective neurological deficits on clinical examination,

persisting for more than 30 days following the date of diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing.

The diagnosis of stroke must be made by a specialist. The insured person must survive for 30 days following the date of the diagnosis.

Exclusions

No benefit is payable under this condition for:

- transient ischaemic attacks;
- intracerebral vascular events due to trauma; or,
- lacunar infarcts which do not meet the definition of stroke as described above.

Questions? We are here to help

Call toll-free to speak with a licensed Financial Services Consultant*at 1-844-528-0583 Monday to Friday between 8 a.m. – 8 p.m. ET.

*Identified as Financial Security Advisors in the province of Quebec.

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