Equitable™

Understanding the covered conditions

About Equitable

As one of Canada's largest mutual life insurance companies, Equitable® is not driven by shareholder pressures for quarterly results. This allows us to focus on management strategies that foster prudent long-term growth, continuity and stability.

We are dedicated to meeting our commitments to our customers – to provide good value and meet their needs for insurance protection and wealth accumulation – now and in the future. That's why Canadians have turned to Equitable since 1920 to protect what matters most.

Equitable is a focused, stable and strong company. We have sufficient earnings and capital to meet our future growth targets, and we continue to grow steadily. Our growth in sales has been driven by our ability to implement our strategic plan, placing a priority on products, service and execution. Our financial success reflects our continued commitment to profitable growth and our ability to navigate a changing regulatory and economic environment.

Our mutual structure is a key element of our value proposition, along with our diversified product portfolio and superior service. As an organization we're progressive, competitive and firmly committed to serving the best interests of our policyholders, through longer-term strategies that foster ongoing stability, growth and profitability.

About this guide

The following provides some background information about the EquiLiving® covered conditions. It is intended to help you understand what is and what is not covered under an EquiLiving policy. Unless otherwise specified in the policy contract, you must survive for 30 days following diagnosis of a covered condition before a benefit payment will be made. While Equitable has made every effort to ensure the accuracy of the information presented here, the policy contract governs in all cases.

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Acquired Brain Injury	A definite Diagnosis of new damage to brain tissue as result of traumatic injury, anoxia (an absence of oxygen) or encephalitis, resulting in one or more signs and symptoms of Neurological Deficits that: • are present and verifiable on clinical examination or neuro-psychological testing; • are corroborated by imaging studies of the brain such as Magnetic Resonance Imaging (MRI) or Computerized Tomography (CT) showing changes that are consistent in character, location and timing with the new damage, and • persist for more than 180 days following the date of diagnosis. The diagnosis of Acquired Brain Injury must be made by a specialist. **Exclusions:** No benefit will be payable under Acquired Brain Injury for: • an abnormality seen on brain scans without definite related clinical impairment; • neurological signs occurring without symptoms of abnormality.	An acquired brain injury is an injury to the brain that occurred after birth and is not hereditary, congenital, or degenerative. Mild concussions with no corresponding abnormal MRI or CT imaging are not covered under this benefit.

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	Contract definition	Background information
Heart Attack (Acute Myocardial Infarction)	A definite diagnosis of death of heart muscle due to obstruction of blood flow, that results in a rise and fall of cardiac biomarkers to levels considered diagnostic of acute myocardial infarction, with at least one of the following: • Heart attack symptoms; • New electrocardiographic (ECG) changes consistent with a heart attack; or • Development of new pathological Q waves on ECG following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and/or angioplasty. A 30-day Survival Period following the date of diagnosis applies. The diagnosis of Heart Attack (Acute Myocardial Infarction) must be made by a specialist. **Exclusions:** No benefit will be payable under Heart Attack (Acute Myocardial Infarction) for: • ECG changes suggestive of a prior myocardial infarction; • Other acute coronary syndromes, including angina pectoris and unstable angina; or • Elevated cardiac biomarkers and/or symptoms that are due to medical procedures or diagnoses other than heart attack.	A heart attack (also known as myocardial infarction) results when the normal supply of blood to the heart is interrupted by a blocked artery or clot causing part of the heart muscle to die. The diagnosis of heart attack is generally confirmed by the detection of abnormal electrical activity over the surface of the heart, which is seen on an electrocardiogram (ECG) and the detection of raised levels of cardiac biochemical markers released from the damaged heart muscle tissue. No benefit is paid should an ECG reveal changes suggesting a previous heart attack.

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Stroke (Cerebrovascular Accident)	A definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis, hemorrhage, or embolism 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 showing changes that are consistent in character, location and timing with the new Neurological Deficits. A 30-day Survival Period following the date of diagnosis applies. The diagnosis of Stroke (Cerebrovascular Accident) must be made by a specialist. **Exclusions:** No benefit will be payable under Stroke (Cerebrovascular Accident) for: • Transient ischaemic attacks; • Intracerebral vascular events due to trauma; • Ischaemic disorders of the vestibular system; • Death of tissue of the optic nerve or retina without total loss of vision of that eye; or • Lacunar infarcts which do not meet the definition of stroke as described above.	A stroke occurs when there is a loss of blood flow resulting in permanent damage to an area of the brain due to any of the following events: • There is bleeding into the brain (a hemorrhage) • An artery supplying the brain becomes blocked by a blood clot (a thrombosis), • A blood clot from another part of the body is carried to the brain and blocks an artery in the brain (an embolus) The effects of a stroke depend on the part of the brain that was damaged, and the amount of damage done and can result in a neurological deficit. The neurological deficit must last for more than 30 consecutive days. Mini strokes that do not produce persistent neurological deficit are not covered.

Covered critical conditions

	Contract definition	Background information
Cancer	A definite diagnosis of a malignant tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma. The diagnosis of Cancer must be made by a specialist and must be confirmed by a pathology report. **Exclusions:** No benefit will be payable under Cancer for the following: • Lesions described as benign, non-invasive, pre-malignant, of low and/or uncertain malignant potential, borderline, carcinoma in situ, or tumours classified as Tis or Ta; • Malignant melanoma of skin that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or accompanied by lymph node or distant metastasis; • Any non-melanoma skin cancer, without lymph node or distant metastasis. This includes but is not limited to, cutaneous T cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma; • Prostate cancer classified as T1a or T1b, without lymph node or distant metastasis; • Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest dimension and classified as T1, without lymph node or distant metastasis; • Chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts; • Gastro-intestinal stromal tumours classified as AJCC Stage 1;	Cancer is an abnormal or malignant (cancerous) cell growth that spreads throughout the body destroying healthy tissue. Some cancers are not considered life threatening and are not covered under this benefit. However, if a cancer spreads to surrounding tissue or organs or progresses, the EquiLiving® benefit will be paid. **Note:** your policy includes an early detection benefit that provides limited coverage for seven non life-threatening cancers as defined under the early detection benefit covered conditions.

Covered critical conditions

	Contract definition	Background information
Cancer (continued)	• Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with Surgery alone and requiring no additional treatment, other than medication to counteract the effects from hormonal over secretion by the tumour; and • Thymomas (stage 1) confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus. **Cancer Exclusion and Requirement to Report:** A 90-day exclusion period and a requirement to report applies to this Covered Condition.	
Dementia, including Alzheimer's Disease	A definite diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function: • Aphasia (a disorder of speech); • Apraxia (difficulty performing familiar tasks); • Agnosia (difficulty recognizing objects); or • Disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behavior), which is affecting daily life.	Dementia is a progressive neurodegenerative disorder characterized by impaired ability to remember, think or make decisions to such extent that it interferes with a person's social life and daily activities. Alzheimer's disease is the most common type of dementia. Other conditions that cause dementia-like symptoms are not covered under this benefit.

Covered critical conditions

	Contract definition	Background information
Dementia, including Alzheimer's Disease (continued)	The Person Insured must exhibit: • Dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and • Evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6-month period. The diagnosis of Dementia must be made by a specialist. **Exclusions:** No benefit will be payable under Dementia, including Alzheimer's Disease for affective or schizophrenic disorders, or delirium.	
Aortic surgery	The undergoing of Surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches. A 30-day Survival Period following the date of Surgery applies. The surgery must be determined to be medically necessary by a specialist. **Exclusions:** No benefit will be payable under Aortic Surgery for: • angioplasty, • intra-arterial procedures, • percutaneous trans-catheter procedures, or • non-surgical procedures.	The aorta is the large blood vessel leading from the heart and supplying branch arteries leading to various organs. If it becomes diseased, it weakens and can rupture. When this happens, the portion of the diseased aorta must be surgically replaced with a graft. The benefit is paid when the surgery occurs.

Covered critical conditions

	Contract definition	Background information
Aplastic anemia	A definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following: • marrow stimulating agents; • immunosuppressive agents; or • bone marrow transplantation. The diagnosis of Aplastic Anemia must be made by a specialist.	Aplastic anemia is a bone marrow disease resulting in lack of production of blood cells (red cells, white cells, platelets) or the blood cells that are produced are damaged or defective. The benefit is paid when one of the specified treatments is required.
Bacterial meningitis	A definite diagnosis of meningitis confirmed by cerebrospinal fluid showing the presence of pathogenic bacteria. The presence of pathogenic bacteria must be confirmed by culture or other generally medically accepted microbiological testing. The Bacterial Meningitis must result in objective Neurological Deficit persisting for at least 90 days from date of diagnosis. The diagnosis of Bacterial Meningitis must be made by a specialist. **Exclusion:** No benefit will be payable under Bacterial Meningitis for viral meningitis.	Bacterial meningitis is an inflammation of the covering of the brain and spinal cord, caused by a bacterial infection. The benefit is paid if the bacterial infection is confirmed by laboratory analysis and there is neurological deficit which lasts for at least 90 consecutive days. Viral Meningitis is not a covered condition.

Covered critical conditions

	Contract definition	Background information
Benign brain tumour	A definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The Person Insured must have undergone surgery or radiation treatment or the tumour must have caused irreversible objective Neurological Deficits. These neurological deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location and timing with the neurological deficits. The diagnosis of Benign Brain Tumour must be made by a specialist. **Exclusions:** No benefit will be payable under Benign Brain Tumour for pituitary adenomas less than 10.0 mm, vascular malformations, Cholesteatomas, or infectious or inflammatory tumours. **90-day exclusion period:** No Covered Condition Benefit will be provided for any benign brain tumour or any Covered Condition defined under the policy contributed to or caused by any type of benign brain tumour (covered or not covered under the policy) if within the first 90 days following the effective date of the policy, or 90 days from the date of last Reinstatement of the policy, the Person Insured has any of the following: • a diagnosis of benign brain tumour (covered or not covered under the policy); or • one or more signs, symptoms, tests, investigations and/or medical consultations that lead directly or indirectly to a diagnosis of benign brain tumour (covered or not covered under the policy), regardless of the date of diagnosis.	A benign (non-cancerous) brain tumor is a mass of cells that grows relatively slowly in the brain or its protective membranes (meninges), cranial nerves or pituitary gland. The benefit is paid when the tumour or its treatment caused neurological deficit. No benefit is payable under the policy if a benign brain tumour is diagnosed or if there are any signs, symptoms, tests, or consultations that lead to a diagnosis of benign brain tumor within 90 days of the effective day of the policy or the policy reinstatement. If the date of the diagnosis falls within the 90 day exclusion period and you will notify us within 180 days of the date of the diagnosis you may elect to keep the coverage for all the other covered conditions.

Covered critical conditions

	Contract definition	Background information
Benign brain tumour (continued)	**Requirement to report:** The owner or Person Insured must give written notification to Equitable's Head Office in Waterloo, Ontario, within 180 days if, following the later of 90 days from the effective date of the policy or 90 days from the date of last Reinstatement of the policy, the Person Insured has any diagnosis or one or more signs, symptoms, tests, investigations and/or medical consultations for benign brain tumour (covered or not covered under the policy). If the owner or Person Insured under the policy fails to disclose this information, Equitable reserves the right to deny a claim for Benign Brain Tumour, or any Covered Condition caused by any benign brain tumour or treatment of any benign brain tumour. The owner may, by writing request to maintain the policy in effect, provided the written request is received in Equitable's Head Office in Waterloo, Ontario, within 30 days of the date Equitable confirms that the 90-Day Benign Brain Tumour Exclusion and Requirement to Report applies. Upon receipt of the written request, Equitable may in the absence of fraud or misrepresentation, maintain the policy in effect, with the condition that no Covered Condition Benefit will be payable for any: • subsequent diagnosis of any form of benign brain tumour (covered or not covered under the policy); • Covered Condition directly resulting from any benign brain tumour (covered or not covered under the policy); and • Covered Condition directly resulting from the treatment of any benign brain tumour (covered or not covered under the policy). If no written request is received as described above, the policy will terminate, and Equitable will return all premiums paid for the policy and no Cover Condition Benefit will be payable.	

Covered critical conditions

	Contract definition	Background information
Blindness	A definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by: • the corrected visual acuity being 20/200 or less in both eyes; or • the field of vision being less than 20 degrees in both eyes. The diagnosis of Blindness must be made by a specialist.	Blindness is the total and irreversible loss of vision in both eyes.
Coma	A definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less. The diagnosis of Coma must be made by a specialist. **Exclusions:** No benefit will be payable under Coma for: • medically induced coma; • a coma which results directly from alcohol or drug use; or • a diagnosis of brain death.	Coma is a state of profound unconsciousness in which a person is unable to move and cannot be woken even with intense external stimulation. The coma state must continue for a continuous period of 96 hours with a Glasgow score of four or less. Life support systems must be required and the coma must not be medically, drug or alcohol induced for the benefits to be paid.

Covered critical conditions

	Contract definition	Background information
Coronary artery bypass surgery	The undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts. A 30-day Survival Period following the surgery applies. The surgery must be determined to be medically necessary by a specialist. **Exclusions**: No benefit will be payable under Coronary Artery Bypass Surgery for: • angioplasty; • intra-arterial procedures; • percutaneous trans-catheter procedures; or • non-surgical procedures.	Coronary artery bypass surgery is an open heart surgery to redirect blood around the blocked portion of an artery using a piece of a healthy blood vessel from elsewhere in one's body. No other procedures to improve blood flow to the heart are covered. **Note:** your policy includes an early detection benefit that provides limited coverage for coronary angioplasty as defined under the early detection benefit covered conditions.
Deafness	A definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. The diagnosis of Deafness must be made by a specialist.	Deafness is the total and irreversible loss of hearing in both ears.

Covered critical conditions

	Contract definition	Background information
Heart valve replacement or repair	The undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. A 30-day Survival Period following the date of the procedure applies. The procedure must be determined to be medically necessary by a specialist. **Exclusions:** No benefit will be payable under Heart Valve Replacement or Repair for: • Angioplasty; • Intra-arterial procedures; • Percutaneous trans-catheter procedures; or • Non-surgical procedures.	When a heart valve is damaged it can either be surgically repaired or if it's beyond repair, surgically replaced by a new valve, either natural or man-made.
Kidney failure	A definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular hemodialysis, peritoneal dialysis or renal transplantation is initiated. The diagnosis of Kidney Failure must be made by a specialist.	There is a permanent loss of function of both kidneys. The Person insured must have regular dialysis treatment or kidney transplantation has been initiated. Only one benefit will be paid for Kidney Failure, Major Organ Failure on Waiting List or Major Organ Transplant.

Covered critical conditions

	Contract definition	Background information
Loss of independent existence	A definite diagnosis of the total inability, due to disease or injury, to perform independently: • with or without the aid of assistive devices; • at least 2 of 6 Activities of Daily Living listed below; • for a continuous period of at least 90 days; • with no reasonable chance of recovery. The diagnosis of Loss of Independent Existence must be made by a specialist or other person as approved by Equitable and supported by an independent home care assessment made by an occupational therapist or equivalent. Activities of Daily Living are as follows: • Bathing-washing oneself in a bathtub, shower, or by sponge bath; • Dressing–putting on and removing necessary clothing including braces, artificial limbs or other surgical appliances; • Toileting–getting on and off the toilet and maintaining personal hygiene; • Bladder and bowel continence–managing your bowel and bladder function with or without protective undergarments or surgical appliances so that hygiene is maintained; • Transferring–moving in and out of a bed, chair or wheelchair; and • Feeding–consuming food or drink that has already been prepared and made available.	Loss of independent existence describes a total and permanent inability to perform by oneself, at least two of the activities of daily living. The diagnosis of loss of independent existence must be confirmed for a continuous period of 90 days.

Covered critical conditions

	Contract definition	Background information
Loss of independent existence (continued)	**Juvenile policies:** **Exclusions:** No benefit will be payable under Loss of Independent Existence for a Person Insured's inability to perform independently 2 Activities of Daily Living that are due to delayed achievement of developmental milestones. To qualify under Loss of Independent Existence, Activities of Daily Living must have been achieved and maintained and then subsequently lost due to disease or injury.	
Loss of limbs	A definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis of Loss of Limbs must be made by a specialist.	Two or more limbs are cut off at or above the wrist or ankle joint, as a result of an accident, injury or illness.
Loss of speech	A definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for at least 180 days. The diagnosis of Loss of Speech must be made by a specialist. **Exclusion:** No benefit will be payable under Loss of Speech for all psychiatric related causes.	If you have a total, permanent and irreversible loss of speech due to a physical injury or disease which has lasted for at least 180 consecutive days, the benefit becomes payable.

Covered critical conditions

	Contract definition	Background information
Major organ failure on waiting list	A definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys, or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List, the Person Insured must become enrolled as the recipient in a recognized transplant centre in Canada or the United States of America that performs the required form of transplant Surgery. The date of diagnosis is the date of the Person Insured's enrollment in the transplant centre. The diagnosis of the major organ failure must be made by a specialist.	In certain conditions, any of the heart, lungs, liver, kidneys or bone marrow can become injured or diseased sufficiently such that the Person Insured needs an organ transplant. Because finding a suitable donor may be a lengthy process, the insured person may claim for this benefit once enrolled in a recognized transplant program. Only one benefit will be paid for either Major Organ Failure on Waiting List or Major Organ Transplant, not both.
Major organ transplant	A definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys, or bone marrow and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Person Insured must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of the major organ failure must be made by a specialist.	In certain conditions, any of the heart, lungs, liver, kidneys or bone marrow can become injured or diseased sufficiently such that the Person insured needs an organ transplant. This benefit will be paid when the Person insured undergoes transplant surgery as a recipient. Only one benefit will be paid for either Major Organ Failure on Waiting List or Major Organ Transplant, not both.
Motor neuron disease	A definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy. The diagnosis of Motor Neuron Disease must be made by a specialist.	Motor neuron diseases are a group of progressive neurological disorders, which occurs when certain nerve cells degenerate and die, causing muscles to weaken and deteriorate. The most common form is amyotrophic lateral sclerosis (ALS).

Covered critical conditions

	Contract definition	Background information
Multiple sclerosis	A definite diagnosis of at least one of the following occurring after the later of the effective date, or the date of last Reinstatement of the policy: Two or more separate clinical attacks, confirmed by at least one magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; A single attack, with objective Neurological Deficits lasting more than 180 days, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or A single attack, confirmed by repeated MRI of the nervous system, which shows multiple new lesions of demyelination which have developed at intervals at least one month apart. The diagnosis of Multiple Sclerosis must be made by a specialist. **Exclusions:** No benefit will be payable under Multiple Sclerosis for the following: Solitary sclerosis; • Clinically isolated syndrome; • Radiologically isolated syndrome; • Neuromyelitis optica spectrum disorders; or • Suspected multiple sclerosis or probable multiple sclerosis.	Multiple sclerosis is a progressive brain and spinal cord disease with multiple and varied neurological symptoms and signs. For this reason, MS can be difficult to diagnose and usually takes several tests before it is confirmed. No benefit is payable under the policy if there is a diagnosis of Multiple Sclerosis or one or more signs, symptoms or investigations that lead to a diagnosis of Multiple Sclerosis within one year of the effective date of the policy or policy reinstatement. If the date of the diagnosis falls within the one-year exclusion period and you notify us within 180 days of the date of the diagnosis, you may elect to keep the coverage for all the other covered conditions.

Covered critical conditions

	Contract definition	Background information
Multiple sclerosis (continued)	**One-Year exclusion period:** No benefit will be payable for Multiple Sclerosis if, within the first year following the later of the effective date of the policy or the date of the last Reinstatement of the policy, the Person Insured has any of the following: • One or more signs, symptoms or investigations that lead directly or indirectly to a diagnosis of multiple sclerosis (covered or not covered under the policy) regardless of when the diagnosis is made; or • A diagnosis of multiple sclerosis (covered or not covered under the policy). **Requirement to report:** Medical information about the diagnosis of Multiple Sclerosis and one or more signs, symptoms or investigations leading to the diagnosis of Multiple Sclerosis must be reported to Equitable's Head Office in Waterloo, Ontario, within 180 days of the date of diagnosis. If this information is not provided within this period, Equitable has the right to deny any claim for Multiple Sclerosis or any Covered Condition caused by Multiple Sclerosis or its treatment.	
Occupational HIV infection	A definite diagnosis of infection with the Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Person Insured's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the later of the effective date of the policy, or the date of the last Reinstatement of the policy.	The HIV (AIDs virus) infection must be caused by an accidental exposure to HIV-contaminated blood or bodily fluids, in the course of performing your job or occupation. In order to give reasonable assurances that the HIV infection was caused by an accidental exposure at work, certain reporting requirements and medical lab testing must be met as specified.

Covered critical conditions

	Contract definition	Background information
Occupational HIV infection (continued)	Payment under this condition requires satisfaction of all of the following: • the accidental injury must be reported to Equitable's Head Office in Waterloo, Ontario, within 14 days of the accidental injury; • a serum HIV test must be taken within 14 days of the accidental injury and the test result must be negative; • a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive; • all HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America; and • the accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines. The diagnosis of Occupational HIV Infection must be made by a specialist. **Exclusions:** No benefit will be payable under Occupational HIV Infection if: • the Person Insured has elected not to take any available licensed vaccine offering protection against HIV; • a licensed cure for HIV infection has become available prior to the accidental injury; or • HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.	

Covered critical conditions

	Contract definition	Background information
Paralysis	A definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event. The diagnosis of Paralysis must be made by a specialist.	Paralysis is the complete and permanent loss of voluntary movement in at least two limbs, for a continuous period of at least 90 consecutive days, whether caused by an accident, illness or disease.
Parkinson's Disease and Specified Atypical Parkinsonian Disorders	Parkinson's Disease is defined as a definite diagnosis of primary Parkinson's Disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of muscular rigidity, or rest tremor. The Person Insured must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease. Specified Atypical Parkinsonian Disorders are defined as a definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy. The diagnosis of Parkinson's Disease or a Specified Atypical Parkinsonian Disorder must be made by a neurologist. Exclusion: No benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for all other types of Parkinsonism.	Parkinson's disease and Specified Atypical Parkinsonian Disorders is a progressive degenerative disease of the central nervous system that affects movement and is characterized by rigid muscles, tremor and slow movements. If the date of the diagnosis falls within the one-year exclusion period and you notify us within 180 days of the date of the diagnosis, you may elect to keep the coverage for all the other covered conditions.

Covered critical conditions

	Contract definition	Background information
Parkinson's Disease and Specified Atypical Parkinsonian Disorders (continued)	**One-Year exclusion period:** No benefit will be payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if, within the first year following the later of, the Effective Date of the policy, or the date of last Reinstatement of the policy, the Person Insured has any of the following: • one or more signs, symptoms or investigations that lead directly or indirectly to a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the diagnosis is made; or • a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism. **Requirement to report:** Medical information about the Diagnosis of Parkinson's Disease or Specified Atypical Parkinsonian Disorders and one or more signs, symptoms or investigations leading to the Diagnosis of Parkinson's Disease or Specified Atypical Parkinsonian Disorder must be reported to Equitable's Head Office in Waterloo, Ontario, within 180 days of the date of the Diagnosis. If this information is not provided within this period, Equitable 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 their treatment.	
Severe burns	A definite diagnosis of third degree burns over at least 20% of the body surface. The diagnosis of Severe Burns must be made by a specialist.	Only third degree burns are covered under the policy. They are the most serious type of burn, involving all layers of the skin. Coverage is provided if the Person Insured has third degree burns covering at least 20% of the body.

Additional covered conditions for children (issue ages 30 days – 17 year)

	Contract definition	Background information
Cerebral palsy	A definite diagnosis of Cerebral Palsy, a non-progressive neurological defect characterized by spasticity and incoordination of movements. The diagnosis of Cerebral Palsy must be made by a specialist.	Cerebral palsy is caused by damage that occurs to the brain and affects movement and muscle tone or posture.
Congenital heart disease	a) A definite diagnosis of one of the following heart conditions: • Total Anomalous Pulmonary Venous Connection • Truncus Arteriosus • Transposition of The Great Vessels • Tetralogy of Fallot • Atresia of any heart valve • Eisenmenger Syndrome • Coarctation of the Aorta • Double Inlet Ventricle • Single Ventricle	

Additional covered conditions for children

	Contract definition	Background information
Congenital heart disease (continued)	• Hypoplastic Right Ventricle • Hypoplastic Left Heart Syndrome • Ebstein's Anomaly • Double Outlet Left Ventricle A 30-Day Survival Period following the date of diagnosis applies. The diagnosis of the heart condition must be made by a qualified pediatric cardiologist and supported by appropriate cardiac imaging. OR b) The undergoing of open-heart surgery for correction of one of the following conditions: • Pulmonary Stenosis • Aortic Stenosis • Discrete Subvalvular Aortic Stenosis • Ventricular Septal Defect • Atrial Septal Defects A 30-day Survival Period following the surgery applies. The diagnosis must be made by a qualified pediatric cardiologist and supported by appropriate cardiac imaging and the surgery must be determined to be medically necessary and performed by a specialist. **Exclusions:** No benefit will be payable under Congenital Heart Disease for trans-catheter procedures such as balloon valvuloplasty or percutaneous Atrial Septal Defect closure. All other congenital conditions are excluded.	Congenital heart disease refers to a group of cardiac malformations that are present at birth, but may not be diagnosed until later in childhood. The insured must either be diagnosed with one of the 13 heart conditions listed or undergoing open-heart surgery for one of the five heart conditions listed.

Additional covered conditions for children

	Contract definition	Background information
Cystic fibrosis	A definite diagnosis of Cystic Fibrosis with evidence of chronic lung disease and pancreatic insufficiency. The diagnosis of Cystic Fibrosis must be made by a specialist.	Cystic fibrosis is an inherited disorder that affects the cells that produce mucus, sweat and digestive fluids. This can cause severe damage to the lungs, digestive system and other organs in the body.
Muscular dystrophy	A definite diagnosis of Muscular Dystrophy, characterized by well-defined neurological abnormalities, confirmed by electromyography and muscle biopsy. The diagnosis of Muscular Dystrophy must be made by a specialist.	Muscular dystrophy is a hereditary condition in which there is a progressive weakening and wasting of muscles.
Type 1 diabetes mellitus	A 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 the Person insured's dependence on insulin for a minimum of 3 months. The diagnosis of Type 1 Diabetes Mellitus must be made by a qualified pediatrician or endocrinologist.	Type 1 diabetes mellitus is an autoimmune disease that leads to the destruction of the pancreatic insulin-producing cells. This results in a daily dependence on insulin injections for survival.

Early detection benefit covered conditions

	Contract definition	Background information
Coronary angioplasty	The undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. A 30-day Survival Period following the date of the procedure applies. The procedure must be determined to be medically necessary by a specialist.	These eight conditions covered under the early detection benefit are very responsive to treatment and not life threatening. This benefit can be paid multiple times during the lifetime of the policy, but only once for any of the Early Detection Benefit covered conditions. The benefit is limited to 15% of the current sum insured up to a maximum of $50,000. Any payment of an early detection benefit will not reduce the sum insured or the premium.
Ductal breast cancer	A definite diagnosis of the presence of ductal carcinoma in-situ of the breast. The diagnosis of Ductal Breast Cancer must be made by a specialist and confirmed by pathological examination of the tissue. **Cancer Exclusion and Requirement to Report:** A 90-day exclusion period and a requirement to report applies to this Early Detection Benefit Covered Condition.	

Early detection benefit covered conditions

	Contract definition	Background information
Early prostate cancer	A definite diagnosis of either stage T1a or T1b prostate cancer, confirmed without lymph node or distant metastasis. The diagnosis of Early Prostate Cancer must be made by a specialist and must be confirmed by pathological examination of the tissue. For purposes of the policy, Stage T1a or T1b prostate cancer means a clinically inapparent tumour that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue. **Cancer Exclusion and Requirement to Report:** A 90-day exclusion period and a requirement to report applies to this Early Detection Benefit Covered Condition.	
Gastrointestinal Stromal Tumours (AJCC Stage 1)	A definite Diagnosis of malignant gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1. The Diagnosis of Gastrointestinal Stromal Tumours (AJCC Stage 1) must be made by a Specialist and confirmed by pathological examination of the tissue. For purposes of this Policy, gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1 means: -Gastric and omental GISTs that are less than or equal to 10.0 cm in greatest dimension with five or fewer mitoses per 5.0 mm2, or 50 per HPF; or -Small intestinal, esophageal, colorectal, mesenteric and peritoneal GIST that are less than or equal to 5.0 cm in greatest dimension with five or fewer mitoses per 5.0 mm2, or 50 per HPF. **Cancer Exclusion and Requirement to Report:** A 90-day exclusion period and a requirement to report applies to this Covered Condition. Please refer to the “Exclusions and Limitations” section of this Policy.	

Early detection benefit covered conditions

	Contract definition	Background information
Grade 1 Neuroendocrine Tumours (Carcinoid)	A definite Diagnosis of Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with Surgery alone and requiring no additional treatment other than medication to counteract the effects from hormonal oversecretion by the tumour. The Diagnosis of Grade 1 Neuroendocrine Tumours (Carcinoid) must be made by a Specialist and confirmed by biopsy. **Cancer Exclusion and Requirement to Report:** A 90-day exclusion period and a requirement to report applies to this Covered Condition. Please refer to the "Exclusions and Limitations" section of this Policy.	
Papillary or Follicular Thyroid Cancer Stage T1	A definite Diagnosis of papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 centimetres in greatest diameter and classified as T1, without lymph node or distant metastasis. The Diagnosis of Papillary or Follicular Thyroid Cancer Stage T1 must be made by a Specialist and confirmed by pathological examination of the tissue. **Cancer Exclusion and Requirement to Report:** A 90-day exclusion period and a requirement to report applies to this Covered Condition. Please refer to the "Exclusions and Limitations" section of this Policy.	

Early detection benefit covered conditions

	Contract definition	Background information
Rai Stage 0 Chronic Lymphocytic Leukemia (CLL)	A definite Diagnosis of chronic lymphocytic leukemia (CLL) classified as Rai Stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts. The Diagnosis of Rai Stage 0 Chronic Lymphocytic Leukemia (CLL) must be made by a Specialist and confirmed by appropriate blood tests. **Exclusions:** No benefit will be payable under Rai Stage 0 Chronic Lymphocytic Leukemia (CLL) for Monoclonal Lymphocytosis of Undetermined Significance (MLUS). **Cancer Exclusion and Requirement to Report:** A 90-day exclusion period and a requirement to report applies to this Covered Condition. Please refer to the "Exclusions and Limitations" section of this Policy.	
Superficial malignant melanoma	A definite diagnosis of stage 1A or 1B malignant melanoma of the skin that has not ulcerated into the dermis and is less than or equal to 1.0 mm in thickness. The diagnosis of Superficial Malignant Melanoma must be made by a specialist and confirmed by pathological examination of the tissue. **Exclusions:** No benefit will be payable under Superficial Malignant Melanoma for any malignant melanoma in situ. **Cancer Exclusion and Requirement to Report:** A 90-day exclusion period and a requirement to report applies to this Early Detection Benefit Covered Condition.	

The following applies to the conditions that have "Cancer Exclusion and Requirement to Report" as part of their definition.

90-Day Cancer Exclusion and Requirement to Report:

No Covered Condition Benefit will be provided for any cancer or any Covered Condition defined under the policy contributed to or caused by any type of cancer (covered or not covered under the policy) if within the first 90 days following the effective date of the policy, or 90 days from the date of last Reinstatement of the policy, the Person Insured has any of the following:

a) a diagnosis of any form of cancer (covered or not covered under the policy); or

b) one or more signs, symptoms, tests, investigations and/or medical consultations that lead directly or indirectly to a diagnosis of cancer (covered or not covered in the policy), regardless of the date of diagnosis.

The Owner or Person Insured must give written notification to Equitable's Head Office in Waterloo, Ontario, within 180 days, if, following the later of 90 days from the effective date of the policy or 90 days from the date of last Reinstatement of the policy the Person Insured has any diagnosis or one or more signs, symptoms, tests, investigations and/or medical consultations for any form of cancer (covered or not covered under the policy). If the Owner or Person Insured under the policy fails to disclose this information, Equitable reserves the right to deny a claim for any cancer, or any Covered Condition caused by any cancer or treatment of cancer.

The Owner may, by writing, request to maintain the policy in effect, provided the written request is received in Equitable's Head Office in Waterloo, Ontario, within 30 days of the date Equitable confirms that the 90-Day Cancer Exclusion and Requirement to Report applies. Upon receipt of the written request, Equitable may in the absence of fraud or misrepresentation, maintain the Policy in effect, with the condition that no Covered Condition Benefit will be payable for any:

- subsequent diagnosis of any form of cancer (covered or not covered under the policy);
- Covered Condition directly resulting from any cancer (covered or not covered under the policy), and
- Covered Condition directly resulting from the treatment of any cancer (covered or not covered under the policy).

If no written request is received as described above, the policy will terminate, and Equitable will return all premiums paid for the policy and no Covered Condition Benefit will be payable.

Background information:

No benefit is payable under the policy if a cancer is diagnosed or if there are any signs, symptoms, tests, or consultations that lead to a diagnosis of cancer within 90 days of the effective day of the policy or the policy reinstatement.

If the date of the diagnosis falls within the 90 day exclusion period and you will notify us within 180 days of the date of the diagnosis you may elect to keep the coverage for all the other covered conditions.

About Equitable

At Equitable we believe in the power of working together. This guides how we work with each other. How we help our clients and partners. And how we support the communities where we live and work.

Together, with partners across Canada, we offer Individual Insurance, Group Insurance and Savings and Retirement solutions. To help our clients protect today and prepare tomorrow.

We believe the world is better when we work together to build an Equitable life for all.

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