



For customers

Guide to our critical illness definitions

With our critical illness protection, we cover a wide range of illnesses and conditions to help you if the unthinkable happens.

We cover **43** conditions where we'll pay out your full *benefit amount* if you meet the definition, and a further **15** additional conditions where we'll pay out a proportion of your *benefit amount*. All of these conditions are also available for any children you may have.

Our critical illness protection has been awarded 5 Stars by independent rating agencies Defaqto and Moneyfacts. We also won the Best Claims Management Team/Claims Team at the 2019 COVER Customer Care awards, the Life and health claims award at the Protection Review awards 2018 and the Best Protection Service at the Investment Life and Pensions Moneyfacts awards 2018.



When choosing critical illness protection, you want the reassurance that, in a crisis, you, your family and your business, will be covered.

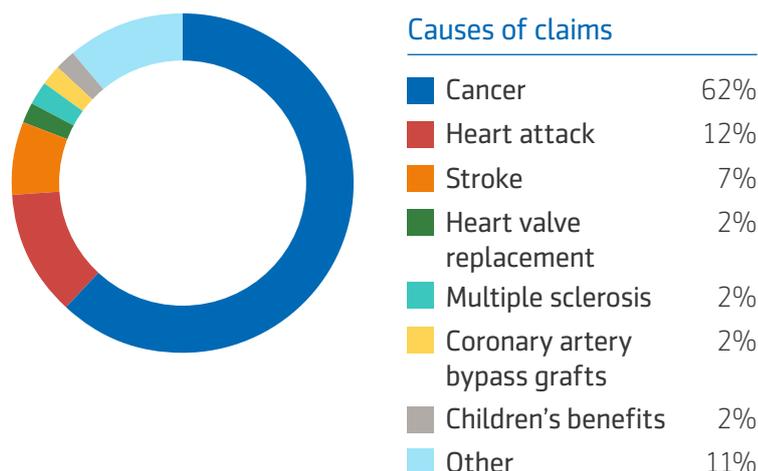
In this guide, we explain what we cover and when we'll pay a claim, so you can easily see what you can claim for.

In 2018, we were able to offer terms to 97% of applicants. We paid more than £37.4 million in critical illness claims, helping over 450 families and businesses across the UK.

We paid 93% of all the critical illness claims we received in 2018.

We know that during a difficult time, money is the last thing you want to have to worry about, so we pay claims as quickly and efficiently as possible.

The diagram opposite shows the most common reasons for critical illness claims in 2018.



Definitions explained

We have three types of definition:

- ABI;
- ABI+, and
- Aegon.

What's an ABI definition?

We've adopted the Association of British Insurer's (ABI) **Guide to minimum standards for critical illness cover**. It sets out model definitions for critical illnesses and exclusions, as well as standard wording to provide clarity by making sure that insurers use common language to describe what their critical illness protection covers.

What's an ABI+ definition?

Sixteen of our critical illness conditions exceed the model definitions set out in the ABI's **Guide to minimum standards for critical illness cover** – giving you more comprehensive cover. We call this ABI+. We've highlighted the definitions that are ABI+, and explained how they're better than the ABI's model definitions.

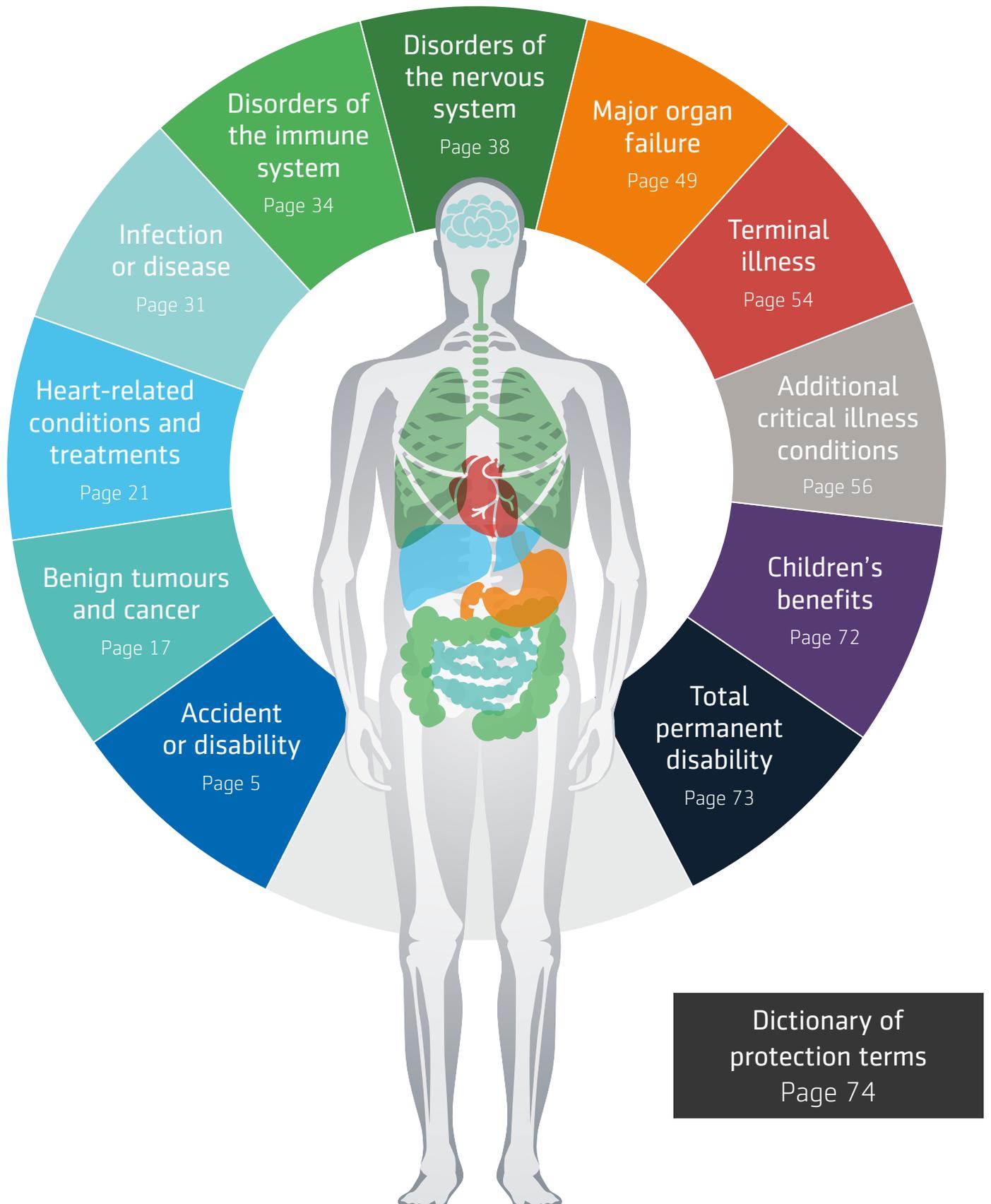
What's an Aegon definition?

In addition to the 21 conditions covered by the ABI's **Guide to minimum standards for critical illness cover**, we also cover a further 22 conditions – giving you broader and more comprehensive protection. We call these Aegon definitions.

Protection terms

Some of our definitions use technical protection terms. We've highlighted these in *italics* throughout the document, and provided an explanation of what these mean in our **Dictionary of protection terms**.

Critical illness (CI) conditions we cover



Accident or disability

The list below shows which conditions we'll pay out your full *benefit amount* for, if you meet the definition.

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Accident or disability

Blindness, including significant visual impairment

– *permanent and irreversible*

ABI+ definition

Permanent and irreversible loss of sight to the extent that even when tested with the use of visual aids, vision is:

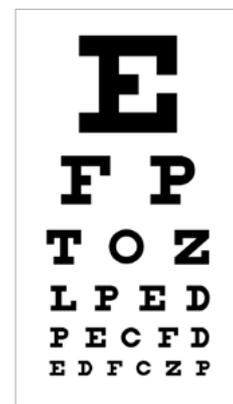
- measured at 3/60 or worse in the better eye using a Snellen eye chart, or
- measured at 4/60 to 6/60 in the better eye using a Snellen eye chart **and** visual field is reduced to 20 degrees or less of arc as certified by a consultant ophthalmologist.

What this means

The insured person might lose their sight due to an *accident* or illness.

We'll pay a claim if they lose sight in both eyes and it's *permanent* and *irreversible*. We use the Snellen eye chart to measure this as it's a commonly used tool for screening visual activity.

We won't pay a claim if they only lose sight in one eye, or the loss of sight is temporary.



What makes our definition ABI+?

The ABI definition states that the insured person's vision needs to be measured at 3/60 or worse in their better eye using a Snellen eye chart for a claim to pay out.

However we'll pay a claim for vision measured at 4/60 to 6/60 in their better eye using a Snellen eye chart, as well as a reduced visual field.

What do these Snellen chart measurements mean?

A Snellen eye chart consists of a number of rows of letters which get smaller as you read down the chart. Normal eye sight is described as 6/6, which normally means you can read the bottom or second bottom line on the chart from six metres away. The less lines you're able to read indicates deteriorating eyesight. You can claim for blindness if you're unable to read the top line when you're three metres away from the chart.



Accident or disability

Coma – with associated *permanent* symptoms

ABI+ definition

A state of unconsciousness with no reaction to external stimuli or internal needs which:

- requires the use of life support systems, and
- has associated *permanent neurological deficit with persisting clinical symptoms*.

For the above definition, the following aren't covered:

- medically induced coma, and
- coma secondary to drug abuse.

What this means

A coma is a deep state of unconsciousness which can occur when the brain's been damaged, perhaps as a result of a head injury or illness.

We'll pay a claim if the insured person needs a life support system and shows evidence of *permanent neurological deficit with persisting clinical symptoms*, as defined in the **Dictionary of protection terms**.

We won't pay a claim if the coma is a result of drug abuse, or is medically induced.

What makes our definition ABI+?

The ABI definition limits the insured person to being on a life support system for a continuous period of at least 96 hours before a claim will be considered, and excludes coma due to alcohol abuse. Our definition includes coma without a minimum time requirement, and includes coma due to alcohol abuse.



Accident or disability

Deafness – *permanent and irreversible*

ABI+ definition

Permanent and irreversible loss of hearing to the extent that the loss is greater than 90 decibels across all frequencies in the better ear using a pure tone audiogram.

What this means

The insured person may lose their hearing due to an *accident* or illness.

We'll pay a claim if they lose their hearing in both ears and it's *permanent and irreversible*.

We won't pay a claim if they only lose their hearing in one ear or their loss of hearing is only temporary.

What makes our definition ABI+?

For a claim to pay out under the ABI model definition, the insured person mustn't be able to hear frequencies of more than 95 decibels. However we'll pay a claim if they can't hear frequencies of more than 90 decibels. This is better because we'll pay a claim at a lower level of hearing loss.

We use an audiogram to measure your level of hearing. This is a graph which gives a detailed description of your hearing ability after a health care professional has performed a number of tests to help determine if there's any hearing loss. These tests usually involve you wearing a set of headphones and indicating when you can hear certain noises that are played to you.



Accident or disability

Intensive care requiring medical ventilation for 10 consecutive days

Aegon definition

Any sickness or injury resulting in the insured person requiring continuous mechanical ventilation by means of tracheal intubation for 10 consecutive days (24 hours a day) or more in an intensive care unit in a UK hospital.

For the above definition, the following aren't covered:

- sickness or injury as a result of drug or alcohol intake or other self-inflicted means, and
- children under the age of 90 days.

What this means

The insured person may find themselves in intensive care due to *accident*, sickness or an injury.

We'll pay a claim if the insured person needs help to breathe using a machine, with a tube inserted into the windpipe.

We won't pay a claim if the cause of the intensive care stay is:

- self-inflicted;
- as a result of alcohol or drugs, or
- for a child under the age of 90 days.



Accident or disability

Loss of hand or foot – *permanent* physical severance

ABI definition

Permanent physical severance of either a hand or a foot at or above the wrist or ankle joint.

For the above definition, the following aren't covered:

- severance secondary to alcohol abuse, drug abuse or a self-inflicted injury.

What this means

We'll pay a claim if the insured person *permanently* loses a hand or foot.

We won't pay a claim if the loss of the hand or foot is self-inflicted or as a result of alcohol or drugs.



Accident or disability

Loss of speech – total *permanent* and *irreversible*

ABI definition

Total *permanent* and *irreversible* loss of the ability to speak as a result of physical injury or disease.

What this means

We'll pay a claim if the insured person loses their speech totally and *permanently*. This can be due to an *accident* or disease, for example cancer of the larynx.

We won't pay a claim if their speech loss is temporary.



Accident or disability

Paralysis of a limb – total and *irreversible*

ABI definition

Total and *irreversible* loss of muscle function to the whole of any limb.

What this means

We'll cover paralysis and paraplegia (paralysis of the legs or lower body) if the insured person totally and *irreversibly* loses the ability to move or use, one or more limbs. Their disability must be considered *permanent*.



Accident or disability

Removal of an eyeball – due to injury or disease

Aegon definition

Permanent surgical removal of an eyeball as a result of injury or disease.

For the above definition, the following isn't covered:

- self-inflicted injuries.

What this means

We'll pay a claim if the insured person's eyeball has to be *permanently* removed due to injury or disease.

We won't pay a claim if the eyeball's removed due to a self-inflicted injury.



Accident or disability

Third-degree burns – covering 20% of the body's surface area, or 50% loss of surface area of the face, or 30% loss of surface area of the head and neck

ABI+ definition

Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue, and covering at least 20% of the body's surface area or 50% loss of surface area of the face or 30% loss of surface area of the head and neck.

What this means

We provide cover for the most serious type of burn, which involves the destruction of the full thickness of the skin and can harm fat, muscle and bone. Burns of this scale are likely to be life-threatening.

We'll pay a claim if the insured person suffers burns that cover at least:

- 20% of their body;
- 50% of their face, or
- 30% of their head and neck.

We won't pay a claim if they suffer burns that cover less than this surface area.

What makes our definition ABI+?

The ABI definition only covers 20% of the insured person's body. Our definition includes 50% of their face and 30% of their head and neck.



Accident or disability

Total pneumonectomy – for physical injury or disease

Aegon definition

The undergoing of surgery, on the advice of a consultant medical specialist, to remove an entire lung for any physical injury or disease.

What this means

A total pneumonectomy is the surgical removal of an entire lung, which can be performed as a result of lung disease or due to an injury or trauma.

We'll pay a claim if the insured person has to have this surgery.



Accident or disability

Traumatic brain injury – resulting in *permanent* symptoms

ABI definition

Death of brain tissue due to traumatic injury, resulting in *permanent neurological deficit with persisting clinical symptoms*.

What this means

A brain injury can be caused by an *accident*. We'll pay a claim if the insured person's brain tissue dies and there's evidence of *permanent neurological deficit with persisting clinical symptoms*, as defined in the **Dictionary of protection terms**.

The destruction of brain cells could affect speech, movement or memory depending on the extent of the trauma.



Benign tumours and cancer

The list below shows which conditions we'll pay out your full *benefit amount* for, if you meet the definition.

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• Cancer – excluding less advanced cases	20



Benign tumours and cancer

Benign brain tumour – resulting in *permanent* symptoms or requiring treatment by invasive surgery

ABI+ definition

A non-malignant tumour or cyst originating from the brain, cranial nerves or meninges within the skull, resulting in *permanent neurological deficit with persisting clinical symptoms* or requiring treatment by invasive surgery.

For the above definition, the following aren't covered:

- tumours in the pituitary gland;
- tumours originating from bone tissue, or
- angioma and cholesteatoma.

What this means

A benign brain tumour is a non-cancerous abnormal growth. While it might continue to grow in size, it won't invade or destroy surrounding tissue, unlike a malignant tumour. However it can still be very dangerous, as it could be pressing on other areas of the brain. Such growths can be life threatening, so it's sometimes necessary to have them surgically removed.

We'll pay a claim if the insured person has a benign brain tumour and:

- there's evidence of *permanent neurological deficit with persisting clinical symptoms*, as defined in the **Dictionary of protection terms**, or
- they have the tumour surgically removed.

We won't pay a claim if the insured person has a benign brain tumour and:

- their symptoms are temporary;
- it's a tumour in the pituitary gland;
- the tumour originates from bone tissue;
- the tumour is an angioma (a tumour made up of blood or lymph vessels), or
- a cholesteatoma (an abnormal skin growth behind the ear drum).

What makes our definition ABI+?

We'll pay a claim if the insured person has a tumour removed by invasive surgery, whereas the ABI definition only pays out if there's evidence of *permanent neurological deficit with persisting clinical symptoms*.



Benign tumours and cancer

Benign spinal cord tumour – resulting in *permanent* symptoms

Aegon definition

A non-malignant tumour in the spinal canal, involving the meninges or the spinal cord. This tumour must be interfering with the function of the spinal cord which results in *permanent neurological deficit with persisting clinical symptoms*. The diagnosis must be made by a medical specialist and be supported by CT, MRI or histopathological evidence.

For the above definition, the following aren't covered:

- cysts;
- granulomas;
- malformations in the arteries or veins of the spinal cord;
- haematomas;
- abscesses;
- disc protrusions, and
- osteophytes.

What this means

A benign spinal cord tumour is a non-cancerous abnormal growth. While it might continue to grow in size, it won't invade or destroy surrounding tissue, unlike a malignant tumour. However it could press on the spine and interfere with function of the spinal cord. To improve function it might be necessary to surgically remove the growth.

We'll pay a claim if the insured person has a benign spinal cord tumour with evidence of *permanent neurological deficit with persisting clinical symptoms*, as defined in the **Dictionary of protection terms**. We'll also need at least one of the following as supporting evidence:

- a computed tomography (CT) scan, which produces an image of the inside of the body using x-rays;
- a magnetic resonance imaging (MRI) scan, which is similar to a CT scan, but uses magnetic and radio waves instead of x-rays to produce the image of the body, or
- histopathological evidence, which is evidence that the tissue has been examined under the microscope.

We won't pay a claim for:

- temporary symptoms;
- cysts or granulomas in the spinal canal;
- malformations in the arteries or veins of the spinal cord;
- haematomas (a collection of blood outside the blood vessels);
- abscesses;
- disc protrusions, or
- osteophytes (bony lumps that form near joints due to the deterioration of cartilage).

We won't consider claims for cancerous tumours in the spinal canal under this definition, but you might be able to claim for it under our cancer definition – see page 20.



Benign tumours and cancer

Cancer – excluding less advanced cases

ABI+ definition

Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

The term malignant tumour includes leukaemia, sarcoma and lymphoma except cutaneous lymphoma (lymphoma confined to the skin).

For the above definition, the following aren't covered:

- all cancers which are histologically classified as any of the following:
 - pre-malignant;
 - non-invasive;
 - cancer in situ;
 - having borderline malignancy, or
 - having low malignant potential;
- all tumours of the prostate unless histologically classified as having a Gleason score of 7 or above or having progressed to at least TNM classification T2bN0M0;
- chronic lymphocytic leukaemia unless histologically classified as having progressed to at least Binet Stage A, and
- any skin cancer (including cutaneous lymphoma) other than:
 - malignant melanoma that has been histologically classified as having caused invasion beyond the epidermis (outer layer of skin), or
 - basal cell carcinoma or squamous cell carcinoma that has spread to lymph nodes or metastasised to distant organs.

What this means

Cancer is a malignant tumour or malignancy which is characterised by uncontrolled growth, often spreading to adjoining tissue and sometimes more distant parts of the body. Unless the cancer's destroyed or removed it will continue to grow, and is likely to result in the patient dying.

A cancer claim is normally valid on the diagnosis of a malignant cancer that's reached the point where it's started to destroy the adjacent surrounding tissue. However, a few types of cancer aren't covered because they are less severe and/or treatable.

Prostate cancer isn't covered until it reaches stage '2b' or has a Gleason score of 7. A staging or Gleason score less than these indicates the cancer's contained within the prostate and growing slowly, reducing the risk and requirement for radical treatment.

Skin cancers are generally only covered once they've started to spread deeper into other areas of the body. Many skin cancers only affect the surface area of the skin and never spread elsewhere.

We also cover some less advanced cancers under our additional critical illness definitions – see page 56 for details.

What makes our definition ABI+?

Our skin cancer cover is wider than the ABI model definition as we cover the most serious forms of skin cancer which are:

- invasive malignant melanoma;
- malignant basal cell carcinoma which has metastasised, and
- malignant squamous cell carcinoma which has metastasised.

The ABI definition wouldn't pay out for skin cancer except invasive malignant melanoma.



Heart-related conditions and treatments

The list below shows which conditions we'll pay out your full *benefit amount* for, if you meet the definition.

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Heart-related conditions and treatments

Aorta graft surgery – for disease or traumatic injury

ABI+ definition

The undergoing of surgery for disease or trauma to the aorta with excision and surgical replacement of a portion of the diseased or damaged aorta with a graft. The term aorta includes the thoracic and abdominal aorta but not its branches.

For the above definition, the following isn't covered:

- any other surgical procedure, for example the insertion of stents or endovascular repair.

What this means

The aorta is the main artery in the body and supplies oxygenated blood to the other arteries. It can become:

- blocked by fatty deposits building up on the artery wall;
- weakened due to a thinning or bulging of the artery wall (aneurysm), or
- damaged during an *accident*.

A graft might be needed to replace or repair the damaged part of the aorta.

We'll pay a claim if the insured person has to have aorta graft surgery which requires a portion of the aorta to be replaced.

We won't pay a claim for surgery to the aorta's branches, or for less invasive surgery.

What makes our definition ABI+?

Our definition for aorta graft surgery is ABI+ because we also cover traumatic injury to the aorta – not just surgery following disease.



Heart-related conditions and treatments

Cardiac arrest – resulting in surgically implanted defibrillator

Aegon definition

A definite diagnosis of cardiac arrest by a consultant cardiologist. There must be sudden loss of heart function with interruption of blood circulation around the body resulting in unconsciousness and resulting in either of the following devices being surgically implanted:

- implantable cardioverter-defibrillator (ICD), or
- cardiac resynchronisation therapy with defibrillator (CRT-D).

For the above definition, the following aren't covered:

- insertion of a pacemaker;
- insertion of a defibrillator without cardiac arrest, or
- cardiac arrest secondary to alcohol or drug abuse.

What this means

A cardiac arrest is when the heart stops pumping blood around the body, leading to unconsciousness. The most common cause of a cardiac arrest is a life-threatening abnormal heart rhythm called ventricular fibrillation (VF).

A cardiac arrest is different to a heart attack.

We'll pay a claim if the insured person suffers a cardiac arrest and is fitted with an implantable defibrillator. This is a device which can give your heart electric shocks to get your heart's rhythm back to normal.

We won't pay a claim if the insured person:

- is fitted with a defibrillator for a reason other than cardiac arrest;
- has a cardiac arrest and is given a pacemaker, or
- suffers a cardiac arrest due to alcohol or drug abuse.



Heart-related conditions and treatments

Cardiomyopathy – of specified severity

Aegon definition

A definite diagnosis of cardiomyopathy by a consultant cardiologist that has resulted in *permanent* damage to the heart muscle and function resulting in both of the following:

- a reduced ejection fraction of 35% or less, and
- impairment to the degree of Class 3 New York Heart Association (NYHA) classification of cardiac impairment¹.

For the above definition, the following aren't covered:

- cardiomyopathy directly related to alcohol or drug abuse, and
- all other forms of heart disease, heart enlargement and myocarditis.

¹NYHA Class 3 – heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain.

What this means

Cardiomyopathy is a heart muscle disorder which can affect the heart's structure and function. Many causes of cardiomyopathy are unknown, but it's been linked to other illnesses and outside factors, such as alcohol and drugs. It can also be inherited.

The NYHA provides a simple way of measuring heart failure, using a scale of classes one to four. We'll pay a claim if the insured person is diagnosed with cardiomyopathy in classes three or four.

We won't pay a claim for cardiomyopathy that:

- results from alcohol or drug abuse;
- is diagnosed as class one or two, or
- any other forms of heart disease, enlargement or myocarditis (inflammation of the heart muscle).



Heart-related conditions and treatments

Coronary artery bypass grafts

ABI+ definition

The undergoing of surgery on the advice of a consultant cardiologist to correct narrowing or blockage of one or more coronary arteries with bypass grafts.

What this means

Coronary artery bypass surgery is one of the main surgical methods used to treat coronary artery disease. If one or more of the arteries become blocked, the flow of oxygenated blood is cut off, and angina or even a heart attack can occur. A coronary artery bypass involves a surgeon grafting around the blockage using a length of alternative blood vessel. The aim of the bypass is to restore the flow of oxygenated blood.

There are a number of treatment options available to treat coronary artery disease. We'll only pay a claim if this is treated by coronary artery bypass graft surgery.

What makes our definition ABI+?

Our definition is ABI+ because the insured person doesn't need to have surgery to divide the breastbone to claim under this definition.



Heart attack

ABI+ definition

Death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction:

- new characteristic electrocardiographic changes (or findings on a heart scan), and
- the characteristic rise of cardiac enzymes or Troponins.

The evidence must show a definite acute myocardial infarction.

For the above definition, the following isn't covered:

- other acute coronary syndromes or angina without myocardial infarction.

What this means

The heart's an essential organ in the body, pumping oxygenated blood to the other organs where it's needed. It needs oxygenated blood to work effectively and when the supply's interrupted, the heart muscle will be damaged. During physical exertion, the heart has to work harder so it needs more fuel. A lack of oxygenated blood can result in chest pain (or angina) but might not cause the heart muscle to die. Where this is the case, we won't pay a claim as we don't provide cover for angina.

However, where the supply of oxygenated blood is significantly reduced, some of the heart muscle can become damaged. Often this is caused by the build-up of fatty materials blocking the artery (known as atheroma) or by a blood clot (known as thrombosis). The damaged muscle seizes up and dies. Doctors call this a myocardial infarction, more commonly known as a heart attack.

We'll pay a claim if the insured person has a heart attack.

What makes our definition ABI+?

The ABI definition for a heart attack includes specific levels that cardiac enzymes or Troponins have to rise by before a claim will be paid. Whereas we'll pay a claim when the insured person is diagnosed as having definitely had a heart attack – it doesn't have to be of a required severity.



Heart-related conditions and treatments

Heart valve replacement or repair

ABI+ definition

The undergoing of surgery on the advice of a consultant cardiologist to replace or repair one or more heart valves.

What this means

The heart contains a number of valves that open and close as part of the normal pumping action. Sometimes these become diseased, resulting in a reduced pumping performance by the heart, and/or the valves leaking slightly or not closing properly when they're supposed to. The faulty valve can be replaced or repaired with surgery.

We'll pay a claim if the insured person has to have surgery to repair or replace a heart valve.

What makes our definition ABI+?

Under the ABI definition, the insured person would need to have surgery to divide the breastbone before a claim would be paid. Our definition doesn't require this type of invasive surgery.



Open heart surgery – with surgery to divide the breastbone

Aegon definition

The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a consultant cardiologist, to correct any structural abnormality of the heart.

What this means

Open heart surgery that involves dividing the breastbone can be carried out for reasons such as, treatment for heart failure or to remove a tumour from the heart.



Heart-related conditions and treatments

Primary pulmonary hypertension – of specified severity

Aegon definition

A definite diagnosis of primary pulmonary hypertension by a consultant cardiologist or specialist in respiratory medicine. There must be clinical impairment of heart function, resulting in the *permanent* loss of ability to perform physical activities to at least Class 3 of the New York Heart Association (NYHA) classification of functional capacity².

For the above definition, the following isn't covered:

- pulmonary hypertension secondary to any other known cause, in other words not primary.

² NYHA Class 3 – heart disease resulting in marked limitation of physical activities, where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain.

What this means

Primary pulmonary hypertension is an increase in blood pressure in the pulmonary:

- artery;
- vein, or
- capillaries.

This can lead to shortness of breath, dizziness, fainting and other symptoms, all of which can be made worse by exertion.

We'll pay a claim if the insured person is diagnosed with primary pulmonary hypertension in classes three or four.

We won't pay a claim for secondary pulmonary hypertension.



Heart-related conditions and treatments

Pulmonary artery graft surgery – for disease only

Aegon definition

The undergoing of surgery, on the advice of a consultant cardiologist, for disease of the pulmonary artery to excise and replace the diseased pulmonary artery with a graft.

What this means

The pulmonary artery carries deoxygenated blood from the heart back to the lungs, where the blood becomes oxygenated. The blood then travels back to the heart, where it's pumped around the body. If the pulmonary artery becomes diseased, a graft might be needed to replace the damaged part of the artery.

We'll pay a claim if the insured person needs surgery to remove and replace the damaged part of the artery with a graft.



Infection or disease

The list below shows which conditions we'll pay out your full *benefit amount* for, if you meet the definition.

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• HIV infection – caught in one of the home countries or designated countries, from a blood transfusion, a physical assault or at work	33



Bacterial meningitis – resulting in *permanent* symptoms

Aegon definition

A definite diagnosis of bacterial meningitis by a consultant neurologist. There must be *permanent neurological deficit with persisting clinical symptoms*.

For the above definition, the following aren't covered:

- meningococcal septicaemia, or
- any other form of meningitis.

What this means

Bacterial meningitis is the inflammation of the protective membranes of the brain (meninges) or spinal cord. Most patients will recover from bacterial meningitis without any side effects so won't need to claim. But sometimes there can be *permanent* damage to sight, hearing or speech.

Meningitis can also occur as a result of a virus, but we don't cover this less severe form.

We'll pay a claim if the insured person is diagnosed with bacterial meningitis and there's evidence of *permanent neurological deficit with persisting clinical symptoms*, as defined in the **Dictionary of protection terms**.

We won't pay a claim for:

- meningococcal septicaemia, or
- any other form of meningitis.



Infection or disease

HIV infection – caught in one of the home countries or designated countries³, from a blood transfusion, a physical assault or at work

Aegon definition

Infection by Human Immunodeficiency Virus resulting from:

- a blood transfusion given as part of medical treatment;
- a physical assault, or
- an incident occurring during the course of performing normal duties of employment;

after the start of the policy and satisfying all of the following:

- the incident must have been reported to the appropriate authorities and have been investigated in accordance with the established procedures;
- where HIV infection is caught through a physical assault or as a result of an incident occurring during the course of performing normal duties of employment, the incident must be supported by a negative HIV antibody test taken within five days of the incident;
- there must be a further HIV test within 12 months confirming the presence of HIV or antibodies to the virus, and
- the incident causing infection must have occurred in one of the home countries or designated countries³.

For the above definition, the following isn't covered:

- HIV infection resulting from any other means, including sexual activity or drug abuse.

³Home countries: United Kingdom, the Channel Islands or the Isle of Man.

Designated countries: European Union, Andorra, Australia, Gibraltar, Liechtenstein, Monaco, San Marino, Turkey, the Vatican City State, New Zealand, Canada, Iceland, Norway, Switzerland or the United States of America.

What this means

We won't pay a claim if HIV was contracted by any other means than those listed, including sexual activity or drug abuse.



Disorders of the immune system

The list below shows which conditions we'll pay out your full *benefit amount* for, if you meet the definition.

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Disorders of the immune system

Aplastic anaemia – with *permanent* bone marrow failure

Aegon definition

A definite diagnosis of aplastic anaemia by a consultant haematologist. There must be *permanent* bone marrow failure with anaemia, neutropenia and thrombocytopenia.

What this means

Aplastic anaemia is a rare and serious form of anaemia, which can be present from birth or develop later in life. With this condition, there's a decrease in the quantity of blood-forming cells in the bone marrow, which can lead to impairment in the production of all blood cells.

We'll pay a claim if the insured person is diagnosed with aplastic anaemia and they have *permanent* bone marrow failure with:

- anaemia (a low level of red blood cells or haemoglobin);
- neutropenia (a low level of neutrophils (a type of white blood cell) in their blood), and
- thrombocytopenia (abnormally low levels of platelets which help blood to clot).



Disorders of the immune system

Rheumatoid arthritis – resulting in a loss of the ability to do specified physical activities

Aegon definition

A definite diagnosis by a consultant rheumatologist of chronic rheumatoid arthritis, as evidenced by widespread joint destruction with major clinical deformity.

The insured person must also be *permanently* unable to perform three or more of the following activities:

- **bending** – the ability to get into or out of a standard saloon car, or to bend or kneel to pick up a tea cup (or similar object) from the floor and straighten up again without the assistance of another person but including the use of appropriate aids;
- **dexterity** – the physical ability to use hands and fingers, such as being able to communicate effectively using a pen, pencil or keyboard;
- **lifting** – the ability to lift, carry or otherwise move everyday objects by hand. Everyday objects include a kettle of water, a bag of shopping or an overnight bag or briefcase, or
- **walking** – the ability to walk a distance of 200 metres on a level surface without the assistance of another person, but including the use of appropriate aids, for example, a walking stick.

What this means

Rheumatoid arthritis is a long-term condition that causes inflammation in joints, resulting in pain and stiffness. This can make it difficult to move so that even everyday tasks become difficult.

We'll pay a claim if the insured person is *permanently* unable to carry out at least three of the everyday tasks listed opposite as a result of rheumatoid arthritis.

We won't pay a claim if their limited movement is only temporary.



Systemic lupus erythematosus – with severe complications

Aegon definition

A definite diagnosis of systemic lupus erythematosus by a consultant rheumatologist resulting in either of the following:

- *permanent neurological deficit with persisting clinical symptoms*, or
- the *permanent* impairment of kidney function tests as follows:
 - glomerular filtration rate (GFR) below 30 ml/min/1.73m² together with persisting abnormal urinalysis showing proteinuria or haematuria.

In addition to the above criteria, the disease must also have been unresponsive to disease-modifying drugs for a continuous period of at least 12 months.

What this means

Systemic lupus erythematosus (SLE) is a chronic autoimmune disease. The immune system attacks the body's cells and tissue, resulting in inflammation and tissue damage. SLE can affect any part of the body, but most often harms the heart, joints, skin, lungs, blood vessels, liver, kidneys and nervous system. The course of the disease is unpredictable, with periods of illness (called flare ups) alternating with remission.

We'll pay a claim if the insured person is diagnosed with SLE and either:

- shows evidence of *permanent neurological deficit with persisting clinical symptoms*, as defined in the **Dictionary of protection terms**, or
- their kidney function is *permanently* reduced to the GFR limits stated opposite.



Disorders of the nervous system

The list below shows which conditions we'll pay out your full *benefit amount* for, if you meet the definition.

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• Dementia including Alzheimer's disease – resulting in <i>permanent</i> symptoms	40
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Disorders of the nervous system

Creutzfeldt-Jakob disease (CJD) – resulting in *permanent* symptoms

Aegon definition

A definite diagnosis of Creutzfeldt-Jakob disease by a consultant neurologist. There must be *permanent* clinical impairment of motor function and loss of the ability to do all of the following:

- remember;
- reason, and
- perceive, understand, express and give effect to ideas.

For the above definition, the following isn't covered:

- other types of dementia.

What this means

Creutzfeldt-Jakob disease (CJD) is a degenerative brain disorder which can be inherited or acquired in later life. It's often referred to as 'mad cow disease'. As the disease progresses, there will be increased loss of muscle control and typical signs of dementia. At present there's no known cure.

We'll pay a claim if the insured person is diagnosed with CJD, and has deteriorated to the point where they're unable to:

- remember;
- reason, and
- perceive, understand, express and give effect to ideas.

We won't pay a claim if their symptoms are temporary, or for any other form of dementia. However, we do cover dementia separately – see page 40.



Disorders of the nervous system

Dementia including Alzheimer's disease – resulting in *permanent* symptoms

ABI+ definition

A definite diagnosis of dementia including Alzheimer's disease by a consultant neurologist, psychiatrist or geriatrician.

There must be *permanent* clinical loss of the ability to do all of the following:

- remember;
- reason, and
- perceive, understand, express and give effect to ideas.

For the above definition, the following aren't covered:

- non-organic psychiatric illnesses.

What this means

Dementia is a chronic, and usually progressive, disorder which affects the person's memory, their ability to think and their behaviour. Quite often they'll appear confused and won't be able to remember recent events.

We'll pay a claim if the insured person is diagnosed with dementia or Alzheimer's disease and is *permanently* unable to:

- remember;
- reason, and
- perceive, understand, express and give effect to ideas.

We won't pay a claim if the symptoms are temporary, or for any non-organic psychiatric illnesses, for example depression and bipolar disorder.

What makes our definition ABI+?

We cover all dementia, including Alzheimer's disease, whereas the ABI definition excludes all dementia except Alzheimer's disease.



Disorders of the nervous system

Encephalitis – resulting in *permanent* symptoms

Aegon definition

A definite diagnosis of encephalitis by a consultant neurologist resulting in *permanent neurological deficit with persisting clinical symptoms*.

For the above definition, the following aren't covered:

- chronic fatigue syndrome, and
- myalgic encephalomyelitis.

What this means

Encephalitis is a severe inflammation of the brain, usually caused by a virus or bacteria. Viruses known to cause this disease include chicken pox, measles and mumps.

We'll pay a claim if the insured person is diagnosed with encephalitis and there's evidence of *permanent neurological deficit with persisting clinical symptoms*, as defined in the **Dictionary of protection terms**.



Disorders of the nervous system

Motor neurone disease – resulting in *permanent* symptoms

ABI+ definition

A definite diagnosis of one of the following motor neurone diseases by a consultant neurologist:

- amyotrophic lateral sclerosis (ALS);
- primary lateral sclerosis (PLS);
- progressive bulbar palsy (PBP);
- progressive muscular atrophy (PMA), or
- Kennedy's disease, also known as spinal and bulbar muscular atrophy (SBMA).

There must also be *permanent* clinical impairment of motor function.

What this means

Motor neurone disease is a progressive degenerative disorder which affects the central nervous system that controls muscular activity. The disease advances quite quickly leading to severe disability, and ultimately death.

We'll pay a claim if the insured person is diagnosed with motor neurone disease and their ability to move or function normally is *permanently* reduced.

We won't pay a claim if their ability to move is only impacted temporarily, or they're not diagnosed with one of the motor neurone conditions listed opposite.

What makes our definition ABI+?

We now also cover Kennedy's disease (also known as spinal and bulbar muscular atrophy) which isn't covered under the ABI definition.



Disorders of the nervous system

Multiple sclerosis – with persisting symptoms

ABI+ definition

A definite diagnosis of multiple sclerosis by a consultant neurologist.

One of the following must be present:

- clinical impairment of motor or sensory function, which must have persisted from the time of diagnosis, or
- two or more attacks of impaired motor or sensory function together with findings of clinical evidence of objective neurological investigations, such as lumbar puncture, evoked visual responses or MRI.

The evidence must show definite multiple sclerosis.

What this means

Multiple sclerosis (MS) is an incurable disease of the central nervous system. Nerve fibres are covered by a myelin sheath which normally protects and insulates them. With MS, these myelin sheaths are attacked and inflamed. They can become damaged, leaving fibrous tissue which restricts the ability of the nerve fibres to conduct impulses to parts of the body.

Symptoms can include:

- temporary blurred vision or blindness;
- double vision;
- involuntary movement of the eyeballs;
- tremors to the hands;
- weakness of arms or legs;
- lack of coordination, or
- slurred speech.

The disease is progressive but can run a variable course. There can be long periods of remission during which symptoms can diminish or even disappear completely. As the range of symptoms is extensive, it's a very difficult disease to diagnose. Modern magnetic resonance imaging (MRI) scanning can now help make an earlier diagnosis.

We'll pay a claim if the insured person is diagnosed with MS or there's evidence of two or more historical attacks.

What makes our definition ABI+?

To claim under the ABI definition, the insured person needs to have had MS for at least six months. We'll pay a claim as long as the insured person has been diagnosed with MS or has had two or more historical attacks regardless of how long ago they were diagnosed with the condition.



Disorders of the nervous system

Neuromyelitis optica (Devic's disease) – with persisting symptoms

Aegon definition

A definite diagnosis of neuromyelitis optica by a consultant neurologist. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least three months.

For the above definition, the following isn't covered:

- any of the neuromyelitis optica spectrum disorders.

What this means

Neuromyelitis optica (commonly known as Devic's disease) is a disease similar to multiple sclerosis, affecting the brain and spinal cord. It's an autoimmune disorder that affects the ability of the body to defend itself against infection. The immune system attacks the myelin cells in the spinal cord and/or optic nerves. Symptoms can include visual loss and paralysis.

We'll pay a claim if the insured person is diagnosed with Devic's disease and shows evidence of symptoms for at least three months.



Disorders of the nervous system

Parkinson's disease – resulting in *permanent* symptoms

ABI+ definition

A definite diagnosis of Parkinson's disease by a consultant neurologist. There must be *permanent* clinical impairment of motor function with associated tremor or muscle rigidity.

For the above definition, the following aren't covered:

- Parkinsonian syndromes/Parkinsonism.

What this means

Parkinson's disease is a progressive, degenerative disorder of the central nervous system. Symptoms are tremors, slow movements and muscular rigidity.

We'll pay a claim if the insured person is diagnosed with Parkinson's disease and *permanently* experiences symptoms including tremors and muscle rigidity.

What makes our definition ABI+?

The ABI definition states that the insured person will only be paid a claim in the event that they're diagnosed with Parkinson's and have a *permanent* clinical impairment of motor function with associated tremor, muscle rigidity **and** postural instability.

We'll pay a claim if the insured person has a *permanent* clinical impairment of motor function with associated tremor **or** muscle rigidity **or** postural instability.



Disorders of the nervous system

Parkinson plus syndromes – resulting in *permanent* symptoms

Aegon definition

A definite diagnosis by a consultant neurologist of one of the following Parkinson syndromes:

- multiple system atrophy;
- progressive supranuclear palsy;
- Parkinsonism-dementia-amyotrophic lateral sclerosis complex;
- corticobasal ganglionic degeneration, or
- diffuse Lewy body disease.

There must be also *permanent* clinical impairment of at least one of the following:

- motor function with associated rigidity of movement;
- the ability to coordinate muscle movement;
- eye movement disorder;
- the ability to coordinate muscle movement;
- bladder control and postural hypotension, or
- dementia.

What this means

Parkinson plus syndromes are a group of neurological conditions that are similar to Parkinson's disease, but have some very unique characteristics.

Multiple system atrophy affects the body in three ways. It:

- causes problems with balance, coordination and speech;
- causes slow body movement and stiff muscles, and
- can affect a person's breathing, heart rate and digestion.

Progressive supranuclear palsy replicates Parkinson's in terms of symptoms, but in addition the sufferer will experience problems with eye movements.

Parkinsonism-dementia-amyotrophic lateral sclerosis complex usually appears as a change in personality and behaviour. There may be a lack of emotion, mood swings, restlessness or over activity. At the same time there may also be progression of limb weakness, muscle wasting, shortness of breath or swallowing problems.

Corticobasal ganglionic degeneration will cause many areas of the brain to shrink, which will cause rigid movements, tremor, problems with balance and coordination.

Diffuse Lewy body disease is a brain disease that causes gradual changes with movement or thinking. The progression of this condition is slow.

We'll pay a claim if the insured person is diagnosed with one of these syndromes and *permanently* has one of the conditions listed opposite.



Disorders of the nervous system

Spinal stroke – resulting in *permanent* symptoms

Aegon definition

Death of spinal cord tissue due to inadequate blood supply or haemorrhage within the spinal column resulting in *permanent neurological deficit with persisting clinical symptoms*.

What this means

A spinal stroke is caused by a disruption of the blood supply in the spinal column. Like strokes that affect the brain, this might happen when there's a blockage in the blood supply or there's a bleed due to a burst blood vessel. A spinal stroke can result in paralysis and neurological problems such as:

- incontinence;
- tingling sensations, and
- weakening of muscles.

We'll pay a claim if the insured person suffers a spinal stroke with *permanent neurological deficit with persisting clinical symptoms* as defined in the **Dictionary of protection terms**.



Disorders of the nervous system

Stroke – resulting in *permanent* symptoms

ABI+ definition

Death of brain tissue due to inadequate blood supply or haemorrhage within the skull resulting in either:

- *permanent neurological deficit with persisting clinical symptoms*, or
- definite evidence of death of brain tissue or haemorrhage on a brain scan and neurological deficit with persistent clinical symptoms lasting at least 24 hours.

For the above definition, the following aren't covered:

- transient ischaemic attack, and
- death of tissue of the optic nerve or retina/eye stroke.

What this means

A stroke involves *permanent* damage to the brain. It's a term often used for a number of medical conditions:

- cerebral haemorrhage due to the bursting of a blood vessel;
- cerebral thrombosis (the formation of a clot within an artery in the brain);
- cerebral embolism (the movement of a clot from one part of the body which becomes lodged in an artery in the brain), and
- interference of the blood supply caused by a tumour, inflammation or injury.

Following a stroke, there's often *permanent* brain damage that could result in *permanent* damage, which might be:

- paralysis down one side of the body;
- loss of speech or sight, or
- loss of mobility or strength.

Sometimes the residual damage will be minor. We don't cover transient ischaemic attacks. These are attacks that produce temporary symptoms similar to a mild stroke, but a complete recovery is normally made within 24 hours. They're sometimes referred to as 'mini strokes'.

We'll pay a claim if the insured person shows evidence of *permanent neurological deficit with persisting clinical symptoms*, as defined in the **Dictionary of protection terms** or there's medical evidence that supports a stroke has occurred and clinical symptoms have continued for 24 hours or more.

We also offer cover for eye strokes under our central retinal artery occlusion definition – see page 62 for details.

What makes our definition ABI+?

We'll pay a claim based on medical evidence that supports a stroke has occurred, without the requirement of *permanent neurological deficit with persisting clinical symptoms*, detailed in the ABI definition.



Major organ failure

The list below shows which conditions we'll pay out your full *benefit amount* for, if you meet the definition.

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• Liver failure – advanced stage	51
• Major organ transplant – from another donor	52
• Respiratory failure – of advanced stage	53



Major organ failure

Kidney failure – requiring *permanent* dialysis

ABI definition

Chronic and end-stage failure of both kidneys to function, as a result of which, regular dialysis is *permanently* required.

What this means

The body normally has two kidneys whose job is to filter unwanted waste material from the bloodstream. If the kidneys stop working, these waste products can build up in the blood and eventually prove life-threatening. A single kidney can take on the workload of two, as long as it stays healthy.

The kidney's cleansing role can be carried out artificially – this is known as dialysis.

We'll pay a claim if both of the insured person's kidneys fail, resulting in the need for regular dialysis.

Medical treatment takes various forms. The kidney can be replaced by one from a donor – this is known as a transplant. We cover transplants in our 'Major organ transplant' definition on page 52.

We also provide donor cover if the insured person donates their kidney to a family member – see page 67 for full details.



Major organ failure

Liver failure – advanced stage

Aegon definition

Advanced stage liver failure due to cirrhosis and resulting in all of the following:

- *permanent* jaundice;
- ascites, and
- encephalopathy.

For the above definition, the following isn't covered:

- liver disease secondary to alcohol or drug abuse.

What this means

The liver is the largest glandular organ in the body, performing a number of vital jobs, including:

- glycogen storage;
- regulating the lipid metabolism;
- regulating protein metabolism;
- detoxification, and
- bile manufacture and secretion.

Liver failure can occur due to a genetic abnormality, or as a complication of another illness.

We'll pay a claim if the insured person suffers from advanced stage liver failure with all of the following:

- *permanent* jaundice (yellowing of the skin and whites of the eyes);
- ascites (abdominal swelling), and
- encephalopathy (loss of brain function).

We won't pay a claim if the liver failure is as a result of alcohol or drug abuse.



Major organ failure

Major organ transplant – from another donor

ABI+ definition

The undergoing, as a recipient of a transplant from another donor, of bone marrow or of a complete heart, kidney, liver, lung, or pancreas, or a whole lobe of the lung or liver, or inclusion on an official UK waiting list for such a procedure.

For the above definition, the following isn't covered:

- transplant of any other organs, parts of organs, tissues or cells.

What this means

The heart, kidney, liver, lung and pancreas can be severely damaged by disease, so much so that a transplant is the only viable option to save the person's life.

The donor and recipient are carefully matched to achieve the best possible results. Even then, drugs are given to reduce the likelihood of the recipient's natural defences rejecting the donated organ.

Considerable time can be spent on official waiting lists waiting for a suitable donor to be available. We'll pay a claim as long as the insured person is accepted onto an official waiting list.

We also provide donor cover if the insured person donates their kidney, or part of their liver or lung, to a family member – see page 67 for full details.

What makes our definition ABI+?

We include replacement of a whole lobe of a lung or liver, whereas this isn't covered by the ABI model definition.



Major organ failure

Respiratory failure – of advanced stage

Aegon definition

Advanced-stage emphysema or other chronic lung disease, resulting in all of the following:

- the need for oxygen therapy for a minimum of 15 hours a day, and evidence that daily oxygen therapy has been required for a minimum period of six months, and
- the *permanent* impairment of lung function tests as follows:
 - forced vital capacity (FVC) and forced expiratory volume at 1 second (FEV1) being less than 40% of normal.

What this means

Emphysema and other lung diseases are normally managed with medication, such as inhalers.

We'll pay a claim once the insured person's condition has progressed to the stage where they've needed continuous daily oxygen therapy for at least 15 hours a day, for at least six months. This must also be supported by evidence of the *permanent* impairment of lung function, as described opposite.



Terminal illness

We'll pay out your full *benefit amount* if you meet the definition.

- **Terminal illness** – where death is expected within 12 months

Page

55



Terminal illness

Terminal illness – where death is expected within 12 months

Aegon definition

A definite diagnosis by the attending consultant of an illness that satisfies both of the following:

- the illness either has no known cure or has progressed to the point where it cannot be cured, and
- in the opinion of the attending consultant, the illness is expected to lead to the death of the insured person within 12 months.

For life only protection, our chief medical officer will also need to agree that the illness is expected to lead to death of the insured person within 12 months.

What this means

We'll pay a claim as long as the agreed medical opinion is that the insured person isn't expected to live longer than 12 months.

There's often confusion that this benefit will pay out if you're diagnosed with an illness which has no known cure. However, this isn't the case. It's the life expectancy that we have to be certain about.

If you're making a terminal illness claim under life cover (not critical illness), we won't pay a claim within 12 months of the policy ending.



Additional critical illness conditions

We also automatically include 15 additional critical illness conditions at no extra cost, where, if you meet the definition, we'll pay an additional benefit amount. These conditions are in addition to the main critical illnesses we cover.

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• Borderline ovarian tumour (low malignant potential) – requiring surgery to remove an ovary	57
• Carcinoma in situ of the breast – requiring surgery to remove the tumour	58
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• Central retinal artery occlusion or central retinal vein occlusion (eye stroke) – resulting in <i>permanent</i> visual loss	62
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• Partial loss of sight – <i>permanent and irreversible</i>	70
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If we pay a valid claim for an additional critical illness condition, this won't affect the *benefit amount* for any main critical illness benefits under your policy. If we pay a claim on the main critical illness benefit, all additional critical illness benefits will stop.



Additional critical illness conditions

Borderline ovarian tumour (low malignant potential) – requiring surgery to remove an ovary

We'll pay an additional critical illness benefit amount of the lower of 25% of the *benefit amount* and £25,000 upon diagnosis of a borderline ovarian tumour (low malignant potential) that has been positively diagnosed with histological confirmation. Treatment must have resulted in the complete surgical removal of the ovary (oophorectomy).

For the above definition, the following isn't covered:

- removal of an ovary due to a cyst(s) or any other reason.

What this means

Borderline ovarian tumours are different to ovarian cancer because they don't grow into the supportive tissue of the ovary. They're also called tumours of low malignant potential. They grow slowly, with most diagnosed at an early stage when the abnormal cells are still within the ovary. Borderline ovarian tumours are treated in a different way to ovarian cancers and are usually cured with surgery alone.

We'll pay a claim if the insured person is diagnosed with an ovarian tumour that could become malignant. A biopsy of the tumour (where a sample of tissue is taken under local anaesthetic) will confirm if there's a risk of malignancy.



Additional critical illness conditions

Carcinoma in situ of the breast – requiring surgery to remove the tumour

We'll pay an additional critical illness benefit amount of the lower of 25% of the *benefit amount* and £25,000, where carcinoma in situ of the breast is positively diagnosed with histological confirmation by biopsy together with the undergoing of surgery to remove the tumour.

What this means

Carcinoma in situ (non-invasive) of the breast is the early development of cancer cells in a specific area of the breast that hasn't spread to surrounding tissue in the breast or armpit. The two types of non-invasive breast cancer are ductal carcinoma in situ (DCIS) and lobular carcinoma in situ (LCIS).

We'll pay a claim if the insured person goes for a biopsy (where a sample of tissue is taken from the area under local anaesthetic), and it's confirmed that they have non-invasive breast cancer, and they then have surgery to remove the tumour.



Additional critical illness conditions

Carcinoma in situ of the oesophagus – requiring surgery to remove the tumour

We'll pay an additional critical illness benefit amount of the lower of 25% of the *benefit amount* and £25,000 where carcinoma in situ of the oesophagus is positively diagnosed with histological confirmation by biopsy together with undergoing of surgery to remove the tumour.

For the above definition the following isn't covered:

- treatment other than total surgical removal of the tumour.

What this means

The oesophagus carries food from the throat to the stomach. Carcinoma in situ of the oesophagus is an early stage of cancer where severely abnormal cells are present but they're contained within the lining of the oesophagus. If left untreated, the cells may develop into an invasive cancer. There are usually no symptoms at this stage. Smoking and alcohol consumption contribute to the risk of contracting oesophageal cancer.

We'll pay a claim if, as the result of a biopsy (where a sample of tissue is taken under local anaesthetic), the insured person is diagnosed with carcinoma in situ of the oesophagus, which has led to the tumour being surgically removed.



Additional critical illness conditions

Carcinoma in situ of the testicle – requiring surgery to remove at least one testicle

We'll pay an additional critical illness benefit amount of the lower of 25% of the *benefit amount* and £25,000 where carcinoma in situ of the testicle, also known as intratubular germ cell neoplasia (ITGCN) or testicular intraepithelial neoplasia (TIN), is histologically confirmed by biopsy and treated with an orchidectomy (complete surgical removal of the testicle).

What this means

Carcinoma in situ of the testicle means there are abnormal cells in the testicle. If left untreated, the cells may develop into an invasive cancer. Carcinoma in situ of the testicle can be treated by removing the testicle.

We'll pay a claim if, as the result of a biopsy (where a sample of tissue is taken under local anaesthetic), the insured person is diagnosed with carcinoma in situ of the testicle, and he's had his complete testicle surgically removed.



Carcinoma in situ of the urinary bladder

We'll pay an additional critical illness benefit amount of the lower of 25% of the *benefit amount* and £25,000 where carcinoma in situ of the urinary bladder has been histologically confirmed on a pathology report.

For the above definition, the following aren't covered:

- any non-invasive papillary carcinoma(s) of the bladder staged as Ta, and
- all other forms of non-invasive carcinoma.

What this means

Carcinoma in situ of the urinary bladder means that abnormal cells are only present in the inner lining of the bladder. The condition is treated by surgery or laser treatment and is often followed by chemotherapy to reduce the risk of cancer recurring in that area.

The diagnosis will be made following a biopsy of the bladder (a sample of tissue is taken from the bladder under local anaesthetic) which when examined shows abnormal cells.

We'll pay a claim if, as the result of a biopsy, the insured person is diagnosed with carcinoma in situ of the urinary bladder.

We won't pay a claim if the carcinoma is non-invasive or staged as Ta.



Additional critical illness conditions

Central retinal artery occlusion or central retinal vein occlusion (eye stroke) – resulting in *permanent* visual loss

We'll pay an additional critical illness benefit amount of the lower of 25% of the *benefit amount* and £25,000 upon death of optic nerve or retinal tissue due to inadequate blood supply within the central retinal artery or vein. This must result in *permanent* visual impairment.

For the above definition the following aren't covered:

- branch retinal artery or branch retinal vein occlusion or haemorrhage, or
- traumatic injury to tissue of the optic nerve or retina.

What this means

Like other strokes, an eye stroke occurs when the blood flow to the retina is obstructed and results in visual loss. The resulting loss of vision will depend on the location and extent of the obstruction in the arteries or veins in the retina.

We'll pay a claim if the insured person becomes *permanently* visually impaired as a result of their optic nerve or retinal tissue dying because there was inadequate blood supply within the central artery or vein.

We won't pay a claim if the insured person's visual impairment isn't *permanent*, or is as a result of an injury or haemorrhage in a branch of the central eye artery or vein.



Additional critical illness conditions

Cerebral aneurysm – requiring specified surgical procedures

We'll pay an additional critical illness benefit amount of the lower of 25% of the *benefit amount* and £25,000 upon undergoing either of the following surgical procedures in order to treat a cerebral aneurysm:

- surgical correction by craniotomy (surgical opening of the skull), or
- endovascular treatment using coils or other materials (embolisation).

We won't pay this benefit amount if it has already been paid for cerebral arteriovenous malformation.

What this means

A cerebral aneurysm is a bulge in a blood vessel in the brain. It can be caused by a weakness in the vessel wall. As blood passes through the vessel, the blood pressure causes a bulge like a balloon. Surgical treatment is recommended to prevent rupture in the future.

We'll pay a claim if the insured person has to have this corrected either by surgery where the skull is opened, or an alternative to surgery, called endovascular embolisation. This procedure is performed under anaesthetic. A doctor inserts a hollow plastic tube into the artery, and threads it through the body to where the aneurism is. Then using materials such as coils, they fill the aneurism, causing the blood to clot, which effectively destroys the aneurism.

We won't pay the additional benefit amount if it's already been paid for cerebral arteriovenous malformation.



Additional critical illness conditions

Cerebral arteriovenous malformation – requiring specified surgical procedures

We'll pay an additional critical illness benefit amount of the lower of 25% of the *benefit amount* and £25,000 upon undergoing either of the following surgical procedures to treat a cerebral arteriovenous malformation:

- surgical correction by craniotomy (surgical opening of the skull), or
- endovascular treatment using coils or other materials (embolisation).

We won't pay this benefit amount if it has already been paid for cerebral aneurysm.

What this means

A cerebral arteriovenous malformation is an abnormal connection between arteries and veins in the brain. Symptoms include headaches, seizures and ear noise.

The two invasive treatments used to treat this condition are a craniotomy and endovascular treatment. Which one of these treatments is used will depend upon where the abnormality is.

A craniotomy is the surgical opening of the skull, and endovascular treatment is where a doctor inserts a hollow plastic tube into the artery, and threads it through the body to where the malformation is. Then using materials such as coils, they correct the malformation.

We won't pay the additional benefit amount if it's already been paid for cerebral aneurysm.



Critical fracture cover

We'll pay an additional critical illness benefit amount of £1,500 on one occasion for each insured person during the life of the policy if, due to an *accident*, the insured person suffers a fracture of any of the following bones:

- the portion of the skull enclosing the brain (neurocranium);
- pelvis, or
- cervical spine (the neck).

For the above definition, the following fractures aren't covered:

- fractures of the facial bones (viscerocranium);
- fractures of the coccyx (tail bone);
- stress fractures, this includes both fatigue fractures and insufficiency fractures, and
- pathological fractures.

What this means

A fracture is a crack in the bone which can occur in any bone in the body. They generally result from high energy trauma, such as a car *accident* or fall.

Fractures of the cranium (skull), pelvis and cervical spine can impact your daily living.

We'll pay a claim if you crack your skull, pelvis or cervical spine (neck).

We won't pay a claim for:

- cracks to bones in the face;
- cracks to the coccyx (tail bone);
- stress fractures (a fracture caused by repetitive stress, like you might get in sports, strenuous exercise, or heavy physical labour), and
- pathological fractures (a crack caused by disease which has led to the bone being weak and easily broken or fractured).



Additional critical illness conditions

Crohn's disease – with specified severity

We'll pay an additional critical illness benefit amount of the lower of 25% of the *benefit amount* and £25,000 upon diagnosis of Crohn's disease with fistula formation and intestinal strictures by a consultant gastroenterologist.

There must have been two or more bowel segment resections on separate occasions and evidence of continued inflammation with ongoing symptoms, despite optimal therapy with diet restriction, medication use and surgical interventions.

What this means

Crohn's disease is a long-term condition that causes inflammation of the lining of the digestive system. Over time, inflammation can damage sections of the digestive system, resulting in narrowing of the intestine (stricture) and formation of fistulas (*permanent* abnormal passageways between two organs in the body, or between an organ and the outside of the body). When medication stops being effective, surgery becomes necessary.

We'll pay the additional benefit amount if the insured person is diagnosed as having either this narrowing of the intestine (stricture) or if *permanent* abnormal passageways (fistula formation) have formed.



Donor cover

We'll pay one cash lump sum of £2,500 in the event that the insured person undergoes a living donation of one of the following organs to a family member:

- kidney;
- portion of liver, or
- portion of lung.

Bone marrow transplant is also covered if the recipient has undergone pre-conditioning with myeloablative chemotherapy and/or radiotherapy.

For the above definition, the following aren't covered:

- stem cell donation;
- islet cell donation, or
- donation of any other organ or tissue.

In addition, the recipient mustn't have been suffering with any symptoms or any illness whether diagnosed or not, leading to the donation, before the policy start date.

What this means

We'll pay £2,500 to an insured person who donates one of the following to a member of their family:

- a kidney;
- a portion of liver or lung, or
- some bone marrow.

We won't pay a claim if the person receiving the donation was suffering from the illness or medical condition that resulted in the donation before the policy started.



Early stage prostate cancer – with specified severity

We'll pay an additional critical illness benefit amount of the lower of 25% of the *benefit amount* and £25,000 upon diagnosis of prostate cancer with a Gleason score of 2 to 6, and the tumour has progressed to at least clinical TNM classification T1N0M0 and has been treated by complete removal of the prostate or external beam, or interstitial implant radiotherapy.

For the avoidance of doubt the following treatments of prostate cancer aren't covered:

- cryotherapy or less radical treatments (for example transurethral resection of the prostate);
- experimental treatments, and
- hormone therapy.

What this means

Early stage prostate cancer is where the cancer hasn't spread outside the prostate gland. The treatment choice for cancer contained within the prostate gland is different to a cancer that's spread outside the prostate gland.

We'll pay a claim if treatment involves surgery to remove the prostate gland, external radiotherapy to the prostate or internal radiotherapy (brachytherapy).

We won't pay a claim for any of the alternative treatments listed opposite.



Additional critical illness conditions

Hospitalisation due to an accidental injury, for 28 or more consecutive days

We'll pay an additional critical illness benefit amount of £5,000 for an *accident* that results in physical injury which requires the insured person to stay in hospital for 28 or more consecutive days on the advice of the attending consultant.

For the above definition, the following isn't covered:

- an *accident* that is secondary to alcohol or drug abuse.

What this means

Hospitalisation due to an *accidental* injury means a bodily injury resulting solely and independently from causes not related to a pre-existing illness, disease or physical disorder, for example hospitalisation following a road traffic *accident*.

We'll pay a claim if the insured person is hospitalised for 28 or more days as a result of an *accident* of any kind. However, we won't pay a claim if the *accident* was a result of alcohol or drug abuse.



Additional critical illness conditions

Partial loss of sight – *permanent and irreversible*

We'll pay an additional critical illness benefit amount of the lower of 25% of the *benefit amount* and £25,000, where the insured person suffers from *permanent and irreversible* loss of sight to the extent that, even when tested with the use of visual aids:

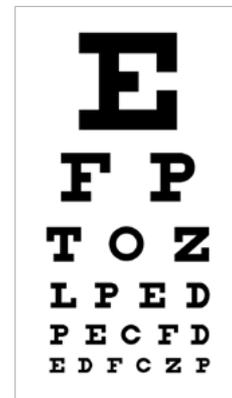
- vision is measured at 4/60 to 6/60 in the better eye using a Snellen eye chart, **or**
- visual field is reduced to 20° or less of arc as certified by a consultant ophthalmologist.

What this means

Loss of sight can be caused by an *accident* or illness. We'll pay a claim if the loss of sight in both eyes is *permanent and irreversible*.

The Snellen eye chart is a commonly used tool for screening visual activity. It consists of a number of rows of letters which get smaller as you read down the chart.

Normal eye sight is described as 6/6, which normally means you can read the bottom or second bottom line on the chart from six metres away. The less lines you're able to read indicates deteriorating eyesight.



Additional critical illness conditions

Ulcerative colitis – treated with total colectomy

We'll pay an additional critical illness benefit amount of the lower of 25% of the *benefit amount* and £25,000 upon diagnosis of severe ulcerative colitis by a consultant gastroenterologist and treated with total colectomy.

What this means

Ulcerative colitis is a long-term condition resulting in inflammation of the colon. Symptoms include abdominal pain, diarrhoea and weight loss. When medication stops being effective, surgery (colectomy) is generally needed.

We'll pay a claim if the insured person is diagnosed with a severe case of ulcerative colitis, and is treated with a total colectomy. A colectomy is a surgical procedure to remove all or part of your colon (large intestine). Your colon is a long tube-like organ at the end of your digestive tract.



Children's benefits

With Personal Protection we also provide critical illness cover if any children of the insured person, between the ages of 30 days and their 18th birthday (21st birthday if in full-time education), becomes critically ill or dies.

We define children as any natural child, stepchild or legally adopted child of the insured person. For the purposes of this definition, a stepchild is the child of an insured person's husband or wife from a previous marriage.

Diagnosis of a critical illness

We'll pay the lower of 50% of the *benefit amount* and £25,000 if the child is diagnosed with any of our main or additional critical illnesses, and lives for at least 14 days from when they were first diagnosed.

We'll only pay a claim once for each condition listed, for each child. If both parents have single-life critical illness benefits with us, they can claim separately under their individual benefits.

Death of a child

We'll pay a lump sum of £5,000 if the child dies.

We've included children's benefits with our Personal Protection as we understand that when a child becomes seriously ill or dies, it can have a financial, as well as an emotional, impact on the family. For example you might need:

- to take some time off work;
- bereavement counselling, or
- help towards funeral costs.

We won't pay children's benefits if:

- the condition was present from birth;
- the child experienced symptoms of their condition before the policy started;
- they live for less than 14 days from when they were first diagnosed with the condition, or
- we have paid a claim for any of the critical illnesses, to the insured person and their CI benefit stops.



Total permanent disability

You also have the option of adding total permanent disability benefit to your critical illness cover.

When you choose total permanent disability one of the following two definitions will apply. Your policy schedule will tell you which definition applies. When you reach age 65, if your definition is 'unable to do your own *occupation* ever again', we'll automatically change it to 'unable to look after yourself ever again'. The full definition of disability is contained in your policy conditions.

Unable to do your own *occupation* ever again

You must show that the disability, which must have been caused through *accident* or *sickness*, is both *permanent* and *irreversible* and stops you from performing the main duties and tasks of your *occupation*.

Unable to look after yourself ever again

Under this definition your disability is measured against your physical ability to carry out six tasks:

- washing;
- getting dressed and undressed;
- feeding yourself;
- maintaining personal hygiene;
- getting between rooms, and
- getting in and out of bed.

We'll pay a claim if you demonstrate that you're unable to perform three of these tasks ever again.





Dictionary of protection terms

Throughout this document we've highlighted various technical 'protection' terms in *italics*. The following explanations should help clarify what these mean.

Accident/Accidental

Accident is a bodily injury resulting solely and independently from causes not related to a pre-existing illness, disease or physical disorder.

Benefit amount

This is the amount of critical illness cover that you're insured for. You'll find this on your policy schedule.

Irreversible

Can't be reasonably improved on by medical treatment and/or surgical procedures used by the National Health Service (NHS) in the UK at the time of the claim.

Occupation

A trade, profession or type of work undertaken for profit or pay. It isn't a specific job with any particular employer and is independent of location and availability.

Permanent/Permanently

Expected to last throughout life with no prospect of improvement, irrespective of when the cover ends or the insured person expects to retire.

Permanent neurological deficit with persisting clinical symptoms

Symptoms of dysfunction in the nervous system that's present on clinical examination and expected to last throughout the insured person's life.

Symptoms that are covered include: numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

The following aren't covered:

- an abnormality seen on brain or other scans without definite related clinical symptoms;
- neurological signs occurring without symptomatic abnormality, for example brisk reflexes without other symptoms, and
- symptoms of psychological or psychiatric origin.

We hope you've found this guide useful, and better understand what you're covered for.

If you have any questions, please call us on 03456 00 14 02.



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