



**Reference Document:
Critical Illness Benchmark Definitions (CIBD)**

October 2018

Introduction

The Critical Illness (CI) Benchmark Definitions are intended to ease some of the perceived complexity around CI definitions.

Use of the definitions is completely voluntary and member companies may make their own determination as to which definition(s) they decide to use in their contracts.

A CLHIA Working Group periodically reviews and updates the definitions to maintain currency with medical advancements and other product developments. The most recent review was completed in October 2018 (prior review October 2013).

Those CI definitions revised as of October 2018 are indicated on the list of 26 Critical Illness definitions with a * (see page 3).

Notes Relating to Use of the Critical Illness Benchmark Definitions

All contracts should include wording which requires that the diagnosis and treatment of any covered condition be undertaken by a Specialist or physician licensed in Canada or the United States of America (or other such jurisdiction as may be approved by the member company).

The Date of Diagnosis must occur while the policy is in force.

All contracts should have a Survival Period.

Formatting or paragraph structure of the definitions may be determined by the insurance company as best suits company branding or print material styles.

Copies of any specified medical journals, articles or references as presently indicated in the definitions should be archived by the insurance company for future reference.

We recommend that the insurance company's medical and legal staff be consulted with regard to all contract wording.

General definitions and terminology used in the Critical Illness Benchmark Definitions

A Specialist is a licensed medical practitioner who has been trained in the specific area of medicine relevant to the covered critical illness condition for which benefit is being claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a Specialist, and as approved by the insurer, a condition may be diagnosed by a qualified medical practitioner practicing in Canada or the United States of America.

Specialist includes, but is not limited to, cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist. The Specialist must not be the policy owner, the insured, a relative of or business associate of the policy owner or of the insured.

Any tests or examinations that must be performed in order to satisfy the condition requirements must be conducted by a medical professional who is not the policy owner, the insured, a relative of or business associate of the policy owner or of the insured.

Survival Period means the period starting on the Date of Diagnosis of the Critical Condition and ending 30 days later, except where modified elsewhere under the policy. The Survival Period does not include the number of days on Life Support. The Insured Person must be alive and must not have experienced irreversible cessation of all functions of the brain at the end of the Survival Period.

For those CI conditions which have a qualifying period, for example, 90 days for Bacterial Meningitis and Paralysis, the Survival Period runs concurrently with that condition's qualifying period.

Life Support means the Insured Person is under the regular care of a licensed physician for nutritional, respiratory and/or cardiovascular support when irreversible cessation of all functions of the brain has occurred.

Please note that certain terms, such as, but not limited to, Irreversible and Surgery, as used in the definitions below, should be defined in the contract.

Alternative wording or terms may be required in the CI definitions based on the words or terms used elsewhere in the member company's contracts.

For example:

"Insured Person" could be replaced with terms such as "Insured", "plan member", "employee", or "group member". "Condition" could be replaced with "critical illness" or "critical condition".

Alternative exclusion wording may also be required for group CI contracts.

For example:

"No benefit will be payable under this condition if, within the first 90 days following the later of, the date the person became insured or, for an increase in coverage, the effective date of the increase, the Insured Person has any of the following".

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**indicates definitions updated in October 2018*

Benchmark Definitions

Aortic Surgery is defined as the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a Specialist.

Exclusions: No benefit will be payable under this condition for:

- Angioplasty;
- Intra-arterial procedures;
- Percutaneous trans-catheter procedures; or
- Non-surgical procedures.

Aplastic Anemia is defined as a definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

- Marrow stimulating agents;
- Immunosuppressive agents; or
- Bone marrow transplantation.

The diagnosis of Aplastic Anemia must be made by a Specialist.

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

The diagnosis of Bacterial Meningitis must be made by a Specialist.

For purposes of the policy, neurological deficits must be detectable by the Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable under this condition for viral meningitis.

Benign Brain Tumour* is defined as a definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The insured must have undergone surgery or radiation treatment or the tumour must have caused irreversible objective neurological deficits.

These deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location and timing with the neurological deficits.

The diagnosis of Benign Brain Tumour must be made by a Specialist.

For purposes of the policy, neurological deficits must be detectable by the Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of

coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusions: No benefit will be payable under this condition for:

- Pituitary adenomas less than 10 mm;
- Vascular malformations;
- Cholesteatomas; or
- Infectious or inflammatory tumours.

90-Day Exclusion: No benefit will be payable under this condition if, within the first 90 days following the later of, the effective date of the policy, or the date of the last reinstatement of the policy, the Insured Person has any of the following:

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

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Company within 6 months of the date of the diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Benign Brain Tumour or, any critical illness caused by any benign brain tumour or its treatment.

Blindness is defined as a definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

- The corrected visual acuity being 20/200 or less in both eyes; or,
- The field of vision being less than 20 degrees in both eyes.

The diagnosis of Blindness must be made by a Specialist.

Cancer* is defined as the definite diagnosis of a malignant tumour. This tumour must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

The diagnosis of Cancer must be made by a Specialist and must be confirmed by a pathology report.

For purposes of the policy:

- T1a or T1b prostate cancer means a clinically inapparent tumour that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue.
- The term gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1 means:
 - Gastric and omental GISTs that are less than or equal to 10 cm in greatest dimension with five or fewer mitoses per 5 mm², or 50 per HPF; or
 - Small intestinal, esophageal, colorectal, mesenteric and peritoneal GISTs that are less than or equal to 5 cm in greatest dimension with 5 or fewer mitoses per 5 mm², or 50 per HPF;
- The terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 1 are as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 8th Edition, 2018.
- The term Rai stage 0 is as defined in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

Exclusions: No benefit will be payable under this condition for the following:

- Lesions described as benign, non-invasive, pre-malignant, of low and/or uncertain malignant potential, borderline, carcinoma in situ, or tumors classified as Tis or Ta;

- Malignant melanoma of skin that is less than or equal to 1.0mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- Any non-melanoma skin cancer, without lymph node or distant metastasis. This includes but is not limited to, cutaneous T cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma;
- Prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0cm in greatest dimension and classified as T1, without lymph node or distant metastasis;
- Chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;
- Gastro-intestinal stromal tumours classified as AJCC Stage 1;
- Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormonal oversecretion by the tumour; or
- Thymomas (stage 1) confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus.

90-Day Exclusion: No benefit will be payable under this condition if, within the first 90 days following the later of, the effective date of the policy, or the date of the last reinstatement of the policy, the Insured Person has any of the following:

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

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis, must be reported to the Company within 6 months of the date of the diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Cancer or, any critical illness caused by any cancer or its treatment.

Coma is defined as a definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be 4 or less. The diagnosis of Coma must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for:

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

Coronary Angioplasty is defined as the undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be medically necessary by a Specialist.

Coronary Artery Bypass Surgery is defined as the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The surgery must be determined to be medically necessary by a Specialist.

Exclusions: No benefit will be payable under this condition for:

- Angioplasty;
- Intra-arterial procedures;
- Percutaneous trans-catheter procedures; or

- Non-surgical procedures.

Deafness is defined as a definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. The diagnosis of Deafness must be made by a Specialist.

Dementia, including Alzheimer's Disease is defined as a definite diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

- Aphasia (a disorder of speech);
- Apraxia (difficulty performing familiar tasks);
- Agnosia (difficulty recognizing objects); or
- Disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour), which is affecting daily life.

The Insured Person must exhibit:

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

The diagnosis of Dementia must be made by a Specialist.

Exclusions: No benefit will be payable under this condition for affective or schizophrenic disorders, or delirium.

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

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

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

- Heart attack symptoms;
- New electrocardiographic (ECG) changes consistent with a heart attack;
- Development of new pathological Q waves on ECG following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and/or angioplasty.

The diagnosis of heart attack (acute myocardial infarction) must be made by a Specialist.

Exclusions: No benefit will be payable under this condition for:

- ECG changes suggestive of a prior myocardial infarction;
- Other acute coronary syndromes, including angina pectoris and unstable angina; or
- Elevated cardiac biomarkers and/or symptoms that are due to medical procedures or diagnoses other than heart attack.

Heart Valve Replacement or Repair is defined as the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a Specialist.

Exclusions: No benefit will be payable under this condition for:

- Angioplasty;
- Intra-arterial procedures;

- Percutaneous trans-catheter procedures; or
- Non-surgical procedures.

Kidney Failure is defined as a definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated. The diagnosis of Kidney Failure must be made by a Specialist.

Loss of Independent Existence* is defined as a definite diagnosis of the total inability, due to disease or injury, to perform independently:

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

Activities of Daily Living are as follows:

Bathing: washing oneself in a bathtub, shower or by sponge bath;

Dressing: putting on and removing necessary clothing, braces, artificial limbs or other surgical appliances;

Toileting: getting on and off the toilet and maintaining personal hygiene;

Bladder and bowel continence: managing your bladder and bowel function with or without protective undergarments or surgical appliances so that hygiene is maintained;

Transferring: moving in and out of a bed, chair or wheelchair;

Feeding: consuming food or drink that already have been prepared and made available.

No additional survival period is required once the conditions described above are satisfied.

Loss of Limbs is defined as a definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The diagnosis of Loss of Limbs must be made by a Specialist.

Loss of Speech is defined as a definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The diagnosis of Loss of Speech must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for all psychiatric related causes.

Major Organ Failure on Waiting List is defined as a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List, the Insured Person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States of America that performs the required form of transplant surgery. For the purposes of the Survival Period, the date of Diagnosis is the date of the Insured Person's enrolment in the transplant centre. The diagnosis of the major organ failure must be made by a Specialist.

Major Organ Transplant is defined as a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of the major organ failure must be made by a Specialist.

Motor Neuron Disease is defined as a definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal

muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions. The diagnosis of Motor Neuron disease must be made by a Specialist.

Multiple Sclerosis* is defined as a definite diagnosis of at least one of the following occurring after the later of the effective date, or the date of the last reinstatement of the policy:

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

The diagnosis of Multiple Sclerosis must be made by a Specialist.

For purposes of the policy, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusion: No benefit will be payable for the following:

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

1-Year Exclusion - No benefit will be payable under this condition if, within the first year following the later of the effective date of the policy or the date of the last reinstatement of the policy, the Insured Person has any of the following:

- Signs, symptoms or investigations leading directly or indirectly to a diagnosis of multiple sclerosis (covered or not covered under the policy) regardless of when the diagnosis is made; or
- A diagnosis of multiple sclerosis (covered or not covered under the policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Company within 6 months of the date of diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Multiple Sclerosis or, any critical illness caused by multiple sclerosis or its treatment.

Occupational HIV Infection is defined as a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the later of the effective date of the policy, or the effective date of last reinstatement of the policy.

Payment under this condition requires satisfaction of all of the following:

- a) The accidental injury must be reported to the insurer within 14 days of the accidental injury;

- b) A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
- c) A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
- d) All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America; and
- e) 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 this condition if:

- The Insured Person 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.

Paralysis is defined as a definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event. The diagnosis of Paralysis must be made by a Specialist.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders is defined as a definite diagnosis of primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor. The Insured Person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.

Specified Atypical Parkinsonian Disorders are defined as a definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The diagnosis of Parkinson's Disease or a Specified Atypical Parkinsonian Disorder must be made by a neurologist.

1-Year Exclusion: 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 Insured Person has any of the following:

- Signs, symptoms or investigations leading directly or indirectly to a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the diagnosis is made; or
- A diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Company within 6 months of the date of the diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or, any critical illness caused by Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

No benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of parkinsonism.

Severe Burns is defined as a definite diagnosis of third-degree burns over at least 20% of the body surface. The diagnosis of Severe Burns must be made by a Specialist.

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

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

persisting continuously for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing showing changes that are consistent in character, location and timing with the new neurological deficits.

The diagnosis of Stroke must be made by a Specialist.

For purposes of the policy, neurological deficits must be detectable by a Specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia, (difficulty with speech) dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusions: No benefit will be payable under this condition for:

- Transient Ischaemic Attacks;
- Intracerebral vascular events due to trauma;
- Ischaemic disorders of the vestibular system;
- Death of tissue of the optic nerve or retina without total loss of vision of that eye; or,
- Lacunar infarcts which do not meet the definition of stroke as described above.