



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

**December 2024**

**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 December 2024 (prior review October 2018).

Those CI definitions revised as of December 2024 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:

"If, within the first 90 days after the effective date of the policy or within the first 90 days after a reinstatement of the policy, the Insured Person is diagnosed with any ...".

## Table of Contents

This document contains benchmark definitions for the following 26 Critical Illness conditions:

<b>Illness</b>	<b>Page</b>
<b>Aortic Surgery*</b> .....	4
<b>Aplastic Anemia</b> .....	4
<b>Bacterial Meningitis*</b> .....	4
<b>Benign Brain Tumour*</b> .....	4
<b>Blindness</b> .....	5
<b>Cancer*</b> .....	5
<b>Coma*</b> .....	6
<b>Coronary Angioplasty</b> .....	6
<b>Coronary Artery Bypass Surgery</b> .....	6
<b>Deafness</b> .....	6
<b>Dementia, including Alzheimer's Disease</b> .....	6
<b>Severe Heart Attack*</b> .....	7
<b>Heart Valve Replacement or Repair</b> .....	7
<b>Kidney Failure</b> .....	7
<b>Loss of Independent Existence*</b> .....	7
<b>Loss of Limbs</b> .....	8
<b>Loss of Speech</b> .....	8
<b>Major Organ Failure on Waiting List</b> .....	8
<b>Major Organ Transplant</b> .....	8
<b>Motor Neuron Disease</b> .....	8
<b>Multiple Sclerosis*</b> .....	8
<b>Occupational HIV Infection</b> .....	9
<b>Paralysis</b> .....	9
<b>Parkinson's Disease and Specified Atypical Parkinsonian Disorders*</b> .....	9
<b>Severe Burns*</b> .....	10
<b>Stroke*</b> .....	10

*\*indicates definitions updated in December 2024*

## 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 specific to Aortic Surgery: No benefit will be payable under this condition for:

- Angioplasty;
- Heart valve replacement
- 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 neurological deficits must be detectable and measurable by a Specialist. Examples of neurological deficits are measurable weakness in a limb, impaired speech and measurable changes in cognition. Headache or fatigue will not be considered a neurological deficit.

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

Exclusion specific to Bacterial Meningitis: 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 originating in the cranial vault from the brain, meninges, or cranial nerves. The insured must have undergone surgery, radiation treatment or embolization, or the tumour must have caused new irreversible objective neurological deficits on clinical examination.

The new neurological deficits must be detectable and measurable by a Specialist and must be corroborated by diagnostic imaging. The neurological deficits must persist continuously for more than 30 days following the date of diagnosis. Headache, fatigue, or the presence of hormonal imbalances caused by the tumour will not be considered a neurological deficit.

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

Exclusions specific to Benign Brain Tumour: No benefit will be payable under this condition for:

- Vascular malformations;
- Cholesteatomas; or

- Infectious or inflammatory tumours.

**90-Day Exclusion:** If, within the first 90 days after the effective date of the policy or within the first 90 days after a reinstatement of the policy, the Insured Person is diagnosed with any benign brain tumour or develops signs or symptoms that lead to the diagnosis of a benign brain tumour, we will not pay a benefit for this benign brain tumour or any future benign brain tumour diagnosis.

**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 uncontrolled growth of malignant cells and invasion of tissue confirmed by histopathological report.

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

Exclusions specific to Cancer: While most cancers are covered by this policy, the following early-stage cancers are not covered:

- Malignant melanoma of skin that is less than or equal to 1.0mm in thickness that is not ulcerated nor has spread to lymph nodes or other organs;
- Any non-melanoma skin cancer, without lymph node or distant metastases. This includes lymphoma which is confined to the skin.;
- Prostate cancer unless described as AJCC T2 or higher and/or Gleason grade 7 or higher;
- Thyroid cancer, unless described as AJCC T2 or higher, or has spread to lymph nodes or other organs;
- Chronic lymphocytic leukemia classified as Rai stage 0;
- Gastro-intestinal stromal tumours classified as AJCC Stage 1;
- Neuroendocrine tumours classified as AJCC Stage 1;
- Cancers described as carcinoma in situ, Tis or Ta;
- Any pituitary neuroendocrine tumour (PitNET) unless the insured has undergone surgery, radiation treatment or embolization, or the PitNET has caused new, irreversible, objective neurological deficits on clinical examination. The new neurological deficits must be detectable and measurable by a specialist and must be corroborated by diagnostic imaging. Headache, fatigue or the presence of hormonal imbalances caused by the tumour will not be considered a neurological deficit.

Tumours (neoplasms) that are classified as uncertain malignant potential, borderline, or that are not classified as cancer (malignant) are not covered under this covered condition. Classification is based on the most current WHO Classification of Tumours series, also known as the ICD-O (International Classification of Diseases for Oncology), published by the International Agency of Research on Cancer (IARC).

Staging or classification refers to the most current (as of date of diagnosis) American Joint Committee on Cancer, AJCC Prognostic Staging Guide or Rai Staging System.

**90-Day Exclusion:** If, within the first 90 days after the effective date of the policy or within the first 90 days after a reinstatement of the policy, the Insured Person is diagnosed with any cancer or develops signs or symptoms that lead to an eventual cancer diagnosis, we will not pay a benefit for this cancer or for any future cancer diagnosis.

**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 72 hours, and for which period the Glasgow coma score must be 6 or less. The diagnosis of Coma must be made by a Specialist.

Exclusion specific to Coma: 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 specific to Coronary Artery Bypass Surgery: 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 specific to Dementia: 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.

**Severe 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:

Heart attack symptoms, accompanied by a rise and fall of cardiac biomarkers to levels considered diagnostic of acute myocardial infarction, with at least one of the following:

- New electrocardiographic (ECG) changes consistent with an acute myocardial infarction;
- New diagnostic imaging changes consistent with an acute myocardial infarction;
- Development of new pathological Q waves on ECG after an intra-arterial cardiac procedure including, but not limited to, coronary angiography and/or angioplasty.

Exclusions specific to Severe Heart Attack: No benefit will be payable under this condition if:

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

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

**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 specific to Heart Valve Replacement Repair: 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 (without help), with or without the aid of assistive devices:

- at least 2 of the 5 Activities of Daily Living listed below;
- for a continuous period of at least 90 days;
- and with no reasonable chance of recovery.

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; self grooming, nail and oral care;

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

**Transferring:** being able to stand from a sitting position, as well as getting in and out of bed. The ability to walk independently from one location to another, getting on and off the toilet and maintaining personal hygiene;

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

Exclusion specific to Loss of Independent Existence: No benefit will be payable under this condition if the Loss of Independent Existence is the result of a condition for which the Critical Illness Insurance benefit was declined for the 90-day or 1-Year Exclusion.

**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 specific to Loss of Speech: 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\*** means the diagnosis of multiple sclerosis as defined by the consensus diagnostic criteria for multiple sclerosis in use in Canada at the time of diagnosis. The diagnosis must be made by a neurologist.

Exclusions specific to Multiple Sclerosis: No benefit will be payable for the following:

- Solitary sclerosis;
- Clinically isolated syndrome;
- Radiologically isolated syndrome; or
- Suspected multiple sclerosis or probable multiple sclerosis.

1-Year Exclusion: If, within the first year after the effective date of the policy or within the first year after a reinstatement of the policy, the Insured Person is diagnosed with multiple sclerosis or develops signs or symptoms that lead to a multiple sclerosis diagnosis, we will not pay a benefit for this multiple sclerosis or for any future multiple sclerosis diagnosis.

**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 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 specific to Occupational HIV Infection: 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: If, within the first year after the effective date of the policy or within the first year after a reinstatement of the policy, the Insured Person is diagnosed with Parkinson's disease or specified atypical Parkinsonian disorder or develops signs or symptoms that lead to a Parkinson's disease or specified atypical Parkinsonian disorder diagnosis, we will not pay a benefit for this Parkinson's disease or specified atypical Parkinsonian disorder or for any future Parkinson's disease or specified atypical Parkinsonian disorder diagnosis.

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 or full thickness burns over at least 18% of the body surface. The diagnosis of Severe Burns must be made by a Specialist.

**Stroke\*** (resulting in severe neurological deficits) is defined as death of brain tissue, due to an inadequate blood supply or hemorrhage, with:

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

The new symptoms and deficits must be corroborated by diagnostic imaging. The neurological deficits must persist continuously for more than 30 days following the date of diagnosis.

The neurological deficits must be detectable and measurable by a Specialist. Examples of neurological deficits are measurable weakness in a limb, impaired speech and measurable changes in cognition. Headache or fatigue will not be considered a neurological deficit.

The diagnosis of Stroke must be made by a Specialist.

Exclusions specific to Stroke: No benefit will be payable under this condition for:

- Transient Ischaemic Attacks;
- Trauma causing damage to intracerebral blood vessels;
- Disorders of the blood vessels of the inner ear; or
- Death of the optic nerve or retina unless there is total loss of vision of that eye;