Definitions of Covered Conditions

Critical Illness

We've changed the definitions of flexibility

BMO Insurance

Living Benefits – Definitions of Covered Conditions

Critical Illness Conditions*

The following definitions, provided for informational purposes, are covered under the Living Benefits series. In the event of a discrepancy between this wording and the actual Policy, the Policy will prevail. The survival period for all Covered Conditions is thirty (30) days after diagnosis unless otherwise stated. In all cases, the policy contract will be used to determine the validity of a claim. BMO® Insurance reserves the right to require the medical diagnosis and treatment of any covered condition be undertaken by a certified physician or specialist for the specific condition. Payment is not dependent on your inability to work.

* 15-Pay Living Benefit 100 does not include Loss of Independent Existence.

Alzheimer's Disease is defined as "a definite diagnosis of a progressive degenerative disease of the brain. The Life Insured must exhibit the loss of intellectual capacity involving impairment of memory and judgement, which results in a significant reduction in mental and social functioning, and requires a minimum of 8 hours of daily supervision. The diagnosis of Alzheimer's Disease must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for all other dementing organic brain disorders and psychiatric illnesses."

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

Aplastic Anaemia 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;
- 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 growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis. The diagnosis of Bacterial Meningitis must be made by a Specialist.

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 tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s). The diagnosis of Benign Brain Tumour must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for pituitary adenomas less than 10 mm.

Moratorium Period 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 effective date of the last reinstatement of the policy,

the Life Insured has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of Benign Brain Tumour, regardless of when the diagnosis is made.
- a diagnosis of Benign Brain Tumour

This medical information as described above must be reported to the Company within 6 months of the date of the diagnosis. If this information is not provided, 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 (Life-Threatening) is defined as "a definite diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The diagnosis of Cancer must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for the following non-life-threatening cancers:

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

Moratorium Period 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 effective date of the last reinstatement of the policy,

the Life Insured has any of the following:

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

This medical information as described above must be reported to the Company within 6 months of the date of the diagnosis. If this information is not provided, 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; or,
- a coma which results directly from alcohol or drug use; or,
- a diagnosis of brain death."

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), excluding any non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction. The surgery must be determined to be medically necessary by a Specialist."

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."

Heart Attack is defined as "a definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in:

Rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

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

The diagnosis of Heart Attack must be made by a Specialist.

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

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

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

Exclusion: No benefit will be payable under this condition for heart valve repair."

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:

- a total inability to perform, by oneself, at least 2 of the following 6 Activities of Daily Living, or,
- Cognitive Impairment, as defined below,

for a continuous period of at least 90 days with no reasonable chance of recovery. The diagnosis of Loss of Independent Existence must be made by a Specialist.

"**Activities of Daily Living**" are:

- **Bathing** – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
- **Dressing** – the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
- **Toileting** – the ability to get on and off the toilet and maintain personal hygiene.
- **Bladder and Bowel Continence** – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
- **Transferring** – the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
- **Feeding** – the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

"**Cognitive Impairment**" is defined as "mental deterioration and loss of intellectual ability, evidenced by deterioration in memory, orientation and reasoning, which are measurable and result from demonstrable organic cause as diagnosed by a Specialist. The degree of cognitive impairment must be sufficiently severe as to require a minimum of 8 hours of daily supervision.

Determination of a Cognitive Impairment will be made on the basis of clinical data and valid standardized measures of such impairments."

Exclusion: No benefit will be payable under this condition for any mental or nervous disorder without a demonstrable organic cause."

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 Life Insured must become enrolled as the recipient in a recognized transplant centre in Canada or the United States of America that performs the required form of transplant surgery. For the purposes of the Survival Period, the date of Diagnosis is the date of the Life Insured'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 Life Insured must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of the major organ failure must be made by a Specialist."

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 defined as "a definite diagnosis of at least one of the following:

- two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or,
- well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or,
- a single attack, confirmed by repeated MRI imaging of the nervous system,which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

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

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 Life Insured's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the later of the effective date of the Policy, or the 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;
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.

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

- The Life Insured has elected not to take any available licensed vaccine offering protection against HIV; or,
- 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 is defined as "a definite diagnosis of primary idiopathic Parkinson's Disease, which is characterized by a minimum of two or more of the following clinical manifestations: muscle rigidity, tremor, or bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses). The Life Insured must require substantial physical assistance from another adult to perform at least 2 of the following 6 Activities of Daily Living. The diagnosis of Parkinson's Disease must be made by a Specialist.

"Activities of Daily Living" are:

- **Bathing** – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
- **Dressing** – the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
- **Toileting** – the ability to get on and off the toilet and maintain personal hygiene.
- **Bladder and Bowel Continence** – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
- **Transferring** – the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
- **Feeding** – the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

Exclusion: No benefit will be payable under this condition for all other types 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) is defined as "a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

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

persisting for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing. The diagnosis of Stroke must be made by a Specialist.

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

- Transient Ischaemic Attacks; or,
- Intracerebral vascular events due to trauma; or,
- Lacunar infarcts which do not meet the definition of stroke as described above."

Early Discovery Benefit is defined as the Diagnosis by a Specialist for one of the following conditions:

Early Discovery Insured Conditions:

1) **Early Prostate Cancer** is defined as "the presence of Early Prostate Cancer, either Stage T1A or T1B, as defined under the TNM Classification system, as confirmed by biopsy."
2) **Ductal Breast Cancer** is defined as "the presence of ductal carcinoma in-situ of the breast, as confirmed by biopsy."
3) **Superficial Malignant Melanoma** is defined as "the presence of any malignant melanoma that is equal to or less than 1.0 millimeter in depth."
4) **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."

The Early Discovery Benefit Amount payable is the lesser of:

- 10% of the then current Sum Insured; or
- $25,000.00

The Early Discovery Benefit is payable only once for the occurrence of any Early Discovery Insured Condition. If the Early Discovery Benefit Amount becomes payable, the Sum Insured of the policy is then reduced immediately by the claim amount payable for this Benefit. This means that any claim amount paid for this Benefit is being deducted from any Sum Insured that may subsequently become payable for a Critical Illness Benefit.

Any payment of the Early Discovery Benefit Amount will not reduce the Policy Premiums.

EXCLUSIONS: Please refer to the Exclusions and Limitations section of the Policy.

NOTES: Any illness or disorder not specifically defined under the Covered Conditions section of the Policy shall not be insured under the Critical Illness Benefit provisions and no Benefit shall be payable. Payment is limited to only the first insured condition to occur as defined in these provisions.

Diagnosis of any Critical Illness must be made by a Specialist. 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 Us, a condition may be diagnosed by a qualified medical practitioner practising 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 Owner, the Life Insured, a relative of or business associate of the Owner or the Life Insured.

For more information about BMO Insurance or our products, please consult with your insurance advisor or contact us at 1-877-742-5244.

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