Understand your critical illness coverage.

BMO Insurance covers you for a number of critical illness conditions.

See inside for definitions.

BMO Insurance®

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Living Benefits – Definitions of Covered Conditions

The following condition 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.

Critical Illness Covered Conditions

Survival Period

The survival period for all Critical Illness 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. Payment is not dependent on the insured's inability to work.

Definition	Interpretation
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. Exclusion: No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.	The aorta is the large artery that carries blood from the heart through the chest and into the abdomen. Surgical replacement of diseased portions of the aorta with a graft is covered by this policy. All non-surgical procedures on the aorta are excluded from coverage.
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; · bone marrow transplantation. The diagnosis of Aplastic Anemia must be made by a Specialist.	Aplastic anemia means failure of the bone marrow to produce red blood cells, some types of white blood cells and the platelets required for normal blood clotting. This results in anemia and an increased risk of infection and abnormal bleeding. Aplastic anemia can appear quickly or slowly at any age and treatment requires a blood transfusion, medication and stem-cell transplantation.
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.	Bacterial meningitis is an infection of the membranes surrounding the brain and spinal cord. A number of different bacteria can cause meningitis and it is treated in hospital with antibiotics. Bacterial meningitis severe enough to cause neurological deficits (e.g., deafness) persisting for at least 90 days is a covered condition. Meningitis caused by a viral infection is a much less serious condition and is not covered by this policy.
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.	Benign brain tumours may arise inside the skull but outside the brain or inside the normal spaces within the brain itself. Typically they are slow growing and don't invade brain tissue but they may cause serious problems due to space limitations inside the skull or by obstructing the normal flow of fluid within the brain.

Definition	Interpretation
Benign Brain Tumour (cont'd) Exclusions: No benefit will be payable under this condition if, within the first 90 days following the later of, the Policy Issue Date of the Policy, or the date of last reinstatement of the Policy, the Insured has any of the following: · signs, symptoms or investigations that lead to a diagnosis of Benign Brain Tumour (covered or excluded under the Policy), regardless of when the diagnosis is made; or · a diagnosis of Benign Brain Tumour (covered or excluded 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. No benefit will be payable under this condition for pituitary adenomas less than 10 mm.	No benefit is payable unless surgical or radiation treatment is necessary or the tumour causes a permanent neurological deficit. Benign tumours of the pituitary gland less than 10 mm in diameter are usually treated with medication and are not covered by this policy. Malignant brain tumours and malignant tumours originating elsewhere in the body that have spread to the brain are covered under Cancer (Life-Threatening).
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.	Blindness may be caused by injury or disease of the eye, the optic nerve, the optic pathways within the brain and the visual cortex itself. The Canadian definition of legal blindness is the definition used in this policy and both eyes must be permanently affected.
Cancer (Life-Threatening) *is defined as* a definite diagnosis of a tumour, which 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. Exclusions: No benefit will be payable under this condition if, within the first 90 days following the later of, the Policy Issue Date of the Policy, or the date of last reinstatement of the Policy, the 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; or · a diagnosis of Cancer (covered or excluded 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. No benefit will be payable for the following: · lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumors classified as Ta; · malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;	The policy definition of Cancer (Life-Threatening) covers most types of malignant tumours including the several types of cancer, lymphomas, leukemias and melanomas. The main exclusions are those cancers generally considered non-life-threatening and readily treatable, benign, premalignant or borderline malignant and any carcinoma in-situ, i.e., non-invasive cancer.

Definition	Interpretation
Cancer (Life-Threatening) (cont'd) • any non-melanoma skin cancer, without lymph node or distant metastasis; • prostate cancer classified as T1a or T1b, without lymph node or distant metastasis; • papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis; • chronic lymphocytic leukemia classified less than Rai stage 1; or • malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2. *For purposes of the Policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010.* *For purposes of the Policy, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.*	
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.	Coma means an unrousable mental state in which there is no meaningful response to environmental stimuli such as speech or pain. The level of coma is measured by the Glasgow Coma Scale and no benefit will be payable unless the coma is level 4 or less and continuous for at least 96 hours. Exclusions include: medically induced coma, coma due to alcohol or drug use and coma due to 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). The surgery must be determined to be medically necessary by a Specialist. Exclusion: No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.	The coronary arteries supply the heart muscle with the blood it needs to work. Coronary artery disease may cause localised narrowing of these arteries and restrict the heart's blood supply. Coronary artery bypass surgery uses grafts made from the patient's own veins or arteries to bypass such narrowings and restore the blood supply and such surgery is covered under this policy. All non-surgical methods of dilating coronary artery narrowings such as with catheters introduced through the skin into arm or leg arteries (angioplasty) are excluded from this definition.
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.	Deafness may be caused by injury or disease. A hearing threshold of 90 decibels or greater means profound deafness and both ears must be affected.

Definition	Interpretation
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 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. Exclusion: 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 Psychiatr Res. 1975;12(3):189.*	Dementia is an acquired, progressive impairment of cognitive function such as memory, language, orientation in time and place and abstract thought. The presence and progression of dementia can be assessed by standardised tests such as the Mini Mental State Exam and must be at least moderately severe. Impairment of cognitive function due acute delirium or to psychiatric illness such as schizophrenia is excluded.
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.	A heart attack (myocardial infarct) means that a portion of heart muscle has insufficient blood supply to meet its needs for long enough to cause that portion of muscle to die. The commonest cause is obstruction of a coronary artery by coronary artery disease and /or a blood clot. The dying muscle releases chemicals (cardiac enzymes) which can be detected by blood tests and also causes new changes in the electrocardiogram (ECG) and a heart attack diagnosis is made by these test results. The dead muscle is replaced by scar tissue over time. Catheter interventions in the coronary arteries can also cause a rise in cardiac enzymes but unless there are also new ECG changes diagnostic of a heart attack, such a rise is not accepted as evidence of a heart attack and therefore excluded. Also excluded from coverage is the incidental finding on an ECG that an unrecognised heart attack has occurred at some time in the past.

Definition	Interpretation
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. Exclusion: No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.	The four heart valves (tricuspid, pulmonary, mitral, aortic) control the flow of blood into and out of the main right and left pumping chambers (ventricles) of the heart. Valves that leak can be surgically repaired in some instances but may need to be replaced and all valves that are too narrowed need to be surgically replaced by mechanical or tissue valves. All such surgery is covered by this policy. Non-surgical procedures on heart valves are excluded from coverage.
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.	Severe, chronic and irreversible kidney failure must be managed by regular peritoneal dialysis, hemodialysis or by kidney transplantation and all such management of kidney failure is covered by this policy.
Loss of Independent Existence *is defined as* a definite diagnosis of the total inability to perform, by oneself, at least 2 of the following 6 Activities of Daily Living 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 assistive devices; · dressing – the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices; · toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices; · 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 aid of assistive devices; and · feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.	The list of daily activities that we all need to do for ourselves in order to live independently are: bathing, dressing, toileting, control of bowels and bladder, getting in and out of a bed, chair or wheelchair by ourselves or with assistive devices, and feeding ourselves. The loss of the ability to do two or more of these activities without help from another person for at least 90 days and with no reasonable chance of recovery as confirmed by a Specialist physician constitutes Loss of Independent Existence as defined by this policy.
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.	Whether by accidental injury or deliberate amputation because of disease, the Loss of Limbs means the loss by complete severance of two or more limbs at or above the wrist or ankle joint.
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.	Loss of Speech means the total and permanent loss of the ability to express thoughts and ideas by vocal sounds and may result from injury or disease to the brain or larynx. Loss of Speech secondary to psychiatric illness is excluded from coverage.

Definition	Interpretation
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 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's enrolment in the transplant centre. The diagnosis of the major organ failure must be made by a Specialist.	The diagnosis by a specialist of the irreversible failure of the heart, both lungs, the liver, both kidneys or the bone marrow may be managed by the replacement of the failed organ with one obtained from a donor. Enrollment as a recipient on the waiting list for a transplant at a recognised transplant centre in Canada or the United States of America qualifies the policy holder for this benefit. For Survival Period purposes, the Date of Diagnosis is the date of enrollment on the transplantation waiting list.
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 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.	Irreversible failure of the heart, both lungs, the liver, both kidneys and the bone marrow may be managed by replacement of the failed organ with one obtained from a donor. Undergoing surgery that results in the failed listed organ being replaced by a transplanted organ is a covered condition.
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.	Motor Neuron Disease may present in several different ways and a definite diagnosis of any of the listed clinical presentations by a specialist is a covered condition.
Multiple Sclerosis *is 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.	Multiple sclerosis is a chronic inflammatory disease of the brain and / or spinal cord which may present in several different ways and a definite diagnosis by a specialist of any of the listed clinical presentations is a covered condition.
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'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 Policy Issue Date, 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;	Infection with the human immunodeficiency virus (HIV) may result from exposure of those whose occupations (ambulance crew, nurses, medical lab technicians, dentists, physicians, police officers, etc.) may expose them to the blood or bodily fluids of people already infected with HIV. Prompt reporting of such work exposure is required to ensure that subsequent HIV infection is the result of such exposure and thus rule out HIV infections resulting from drug abuse or sexual transmission.

Definition	Interpretation
Occupational HIV Infection (cont'd) 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 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.	The total loss of muscle function (Paralysis) of 2 or more limbs must persist for at least 90 days following the injury or disease causing the paralysis in order to eliminate temporary paralysis.
Parkinson's Disease and Specified Atypical Parkinsonian Disorders **Parkinson's Disease** *is defined as* a definite diagnosis of primary Parkinson's disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of: · muscular rigidity; or · rest tremor The 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. Exclusion: No benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of parkinsonism.	Primary Parkinson's disease is the second most common neuro-degenerative disorder after Alzheimer's disease and its incidence in the population rises with age. Progressive slowing of movement and muscular rigidity and / or resting tremor are needed for diagnosis and lead to impairment of the activities of daily living. Progressive deterioration of function for at least one year in spite of appropriate medical treatment by a neurologist is a covered condition. Specified Atypical Parkinsonian Disorders as defined are also covered conditions but Parkinson's Disease and Specified Atypical Parkinsonian Disorders due to any other cause such as medications are excluded from this coverage. Symptoms of Parkinson's Disease or Specified Atypical covered Parkinsonian Disorders will not be considered a Payable benefit if such Symptoms occurred within the first year of policy issue regardless when the diagnosis is made.

Definition	Interpretation
Parkinson's Disease and Specified Atypical Parkinsonian Disorders Exclusion Period No benefit will be payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if, within the first year following the later of, the Policy Issue, or the date of last reinstatement of the Policy, the Insured has any of the following: • signs, symptoms or investigations that lead 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.	
Severe Burns *is defined as* 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.	Third degree burns destroy the full thickness of the skin and for Severe Burns as defined, at least 20% of the total body surface area must be burned to this degree.
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.	Interruption of the blood flow in an artery supplying blood to an area of the brain results in the death (infarction) of that area which may cause a clinical Stroke. The interruption in flow may be caused by blood clotting in a diseased artery, by a blood clot originating elsewhere (usually in the heart) that is carried into a brain artery by the blood flow or by bleeding from rupture of a brain artery. Depending on the area of the brain involved, new clinical symptoms and signs such as limb weakness or paralysis and impairment of sensation, speech or vision may occur which are termed neurological deficits. Confirmation of brain infarction on brain imaging studies and of neurological deficits persisting for more that 30 days from the onset of the Stroke event confirmed by a specialist are required to make a Stroke diagnosis covered by this policy. Stroke events causing neurological deficits that persist for less than 30 days and events caused by trauma, not by vascular disease, are excluded from coverage.

Early Discovery Covered Conditions

Survival Period

The survival period for all Early Discovery 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. Payment is not dependent on the insured's inability to work.

Definition	Interpretation
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 of some conditions that are excluded by policy definition from the list of critical illness covered conditions above may be covered by the Early Discovery Covered Conditions clause. Under this clause, some cancers that are generally considered non life-threatening such as ductal breast cancer in-situ, early prostate cancer, early skin cancer and chronic lymphocytic leukemia may be covered and also some types of uncommon early intestinal cancers and some early thyroid cancers. Localised coronary artery narrowings that are not surgically bypassed but are stretched open (coronary angioplasty) by a balloon on the end of a catheter introduced through an arm or leg artery are covered under this clause.
Early Breast Cancer *is defined as* ductal carcinoma in situ of the breast as confirmed by a biopsy and diagnosed by a Specialist.	
Early Prostate Cancer *is defined as* prostate cancer that is either T1A or T1B, without lymph node or distant metastasis as confirmed by biopsy and diagnosed by a Specialist.	
Early Skin Cancer *is defined as* malignant melanoma skin cancer that is less than or equal to 1.0 mm thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis as confirmed by biopsy and diagnosed by a Specialist.	
Early Stage Blood Cancer *is defined as* chronic lymphocytic leukemia classified less than Rai stage 1, confirmed by appropriate blood tests and diagnosed by a Specialist.	
Early Stage Intestinal Cancer *is defined as* malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2, as confirmed by biopsy and diagnosed by a Specialist.	
Early Thyroid Cancer *is defined as* papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis, as confirmed by biopsy and diagnosed by a Specialist.	
For purposes of the Policy, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975. *For purposes of the Policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010.* Exclusions: No benefit will be payable under the Early Discovery Benefit if: Within the first 90 days following the later of: · the Policy Issue Date of the Policy, or · the effective date of last reinstatement of the Policy, the Insured has any of the following: · signs, symptoms or investigations that lead to a diagnosis of an Early Discovery Covered Condition, regardless of when the diagnosis is made, · a diagnosis of an Early Discovery Covered Condition	

Definition	Interpretation
(cont'd) 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 an Early Discovery Covered Condition or, any critical illness caused by an Early Discovery Covered Condition or its treatment. The Early Discovery Benefit is payable only once for the occurrence of any Early Discovery Covered Condition. If this Policy is the result of a conversion where under the original Policy or Rider the Early Discovery Benefit Amount has already been paid, the Early Discovery Benefit will not be payable on this Policy. Any payment of the Early Discovery Benefit Amount will not reduce the Policy Premiums or reduce the Critical Illness Benefit.	

Notes: **Please review your policy carefully.** 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 or Early Discovery 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 Covered Condition must be made by a Specialist.

Specialist is a legally 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 BMO Insurance, 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 cannot be the Insured, the Owner of the Policy, a relative of or business associate of either the Owner or the Insured.

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