

Critical Illnesses Guide

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Glossary

Important Reminders

- This Critical Illness Guidebook should be read with the proposal and the policy contract. In case of conflict, the policy contract shall prevail.
- The Critical Illness benefit will only be payable if the following conditions are met:
 1. The Critical Illness condition occurs 60 days after the policy's effective date or the approval of the last reinstatement date (whichever is later)
 2. The Critical Illness condition must be diagnosed while the insured person is still alive for a claim to be eligible.
 3. The Critical Illness condition meets the definition outlined in the policy contract
- All pre-existing conditions must be declared during the application or reinstatement process to determine if we can cover them or not

Pre-existing conditions are defined as any illness or signs or symptoms of an illness or injury that occur before the effective date or the reinstatement date of this rider, whichever is later. Specifically, this includes:

 1. Conditions for which treatment, medication, advice, or diagnosis has been sought or received by the insured.
 2. Conditions known to the insured to exist, regardless of whether treatment, medication, advice, or diagnosis was sought or received.
 3. Conditions that presented signs or symptoms where the natural history can be medically attributed to a specific illness or injury, whether or not the insured was aware of such an illness or injury.

Disclaimers

- The information in this guidebook is aligned with Manulife's contract definitions and internal claims guidelines. Nothing in this material includes any extra information outside of the contract provisions.
- Please note that this material must not be wholly or partially reproduced, distributed, circulated, disseminated, published or disclosed, in any form and for any purpose, to any third party or unintended recipient without prior approval from Manulife Philippines.



Exclusions

Here the following circumstances under which a claim for Critical Illness benefits will not be eligible:

1.Pre-existing Conditions: If you've had a condition before the policy started that was either not accepted by the company or not disclosed when applying or reinstating, it won't be covered. This includes any issues related to that condition.

2.Waiting Period: If the critical illness is contracted within 60 days of the policy starting or reinstatement, it won't be covered.

3.Diagnosis After Death: If the critical illness is diagnosed after the insured person has passed away, it does not qualify for a claim.

4.Congenital Conditions: Illnesses related to conditions present from birth are not covered.

5.HIV/AIDS: Illnesses arising from HIV or AIDS are not covered, except for specific cases like "Occupationally Acquired HIV" or "HIV Due to Blood Transfusion."

6.Self-harm: Any illness resulting from suicide attempts, intentional self-injury, or related actions are not covered, regardless of the insured's mental state.

7.Substance Use: Illnesses caused by the use of narcotics, alcohol, non-prescribed drugs, or harmful substances, unless resulting from a work-related accident, are not covered.

8.War and Violence: Illnesses arising from war, terrorism, civil unrest, or violence during assemblies are excluded.

9.Cosmetic Surgery: Illnesses resulting from cosmetic or plastic surgery done for beautification are not covered.

10.Criminal Activity: Illnesses resulting from involvement in criminal activities, as defined by laws, are not covered. However, illnesses resulting from reckless imprudence are not excluded.

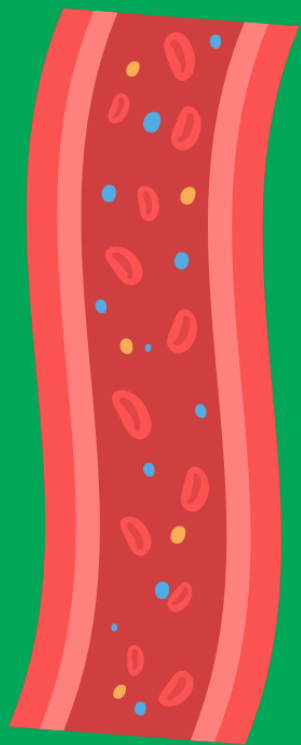
11.Dangerous Activities: Illnesses resulting from high-risk activities, such as flying (except as a regular passenger), military activities, and extreme sports, are not covered





Circulatory System (Heart) Diseases and Medical Procedures

Angioplasty and Other Invasive Treatments for Coronary Artery Disease



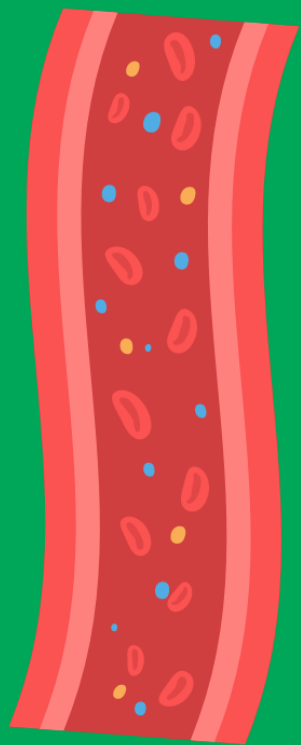
Definition

The coronary arteries are the vessels that supply blood to the heart. Among these coronary arteries, there are four (4) major arteries defined as the: Left Main Stem, Left Anterior Descending, Circumflex, and Right Coronary Artery.

As the coronary arteries become narrowed (stenosis) due to buildup of cholesterol or hardened fatty deposits (plaque), they eventually lead to poor blood flow to the heart. This condition is called coronary artery disease, which is one of the leading causes of heart attacks.



Angioplasty and Other Invasive Treatments for Coronary Artery Disease



What is covered?

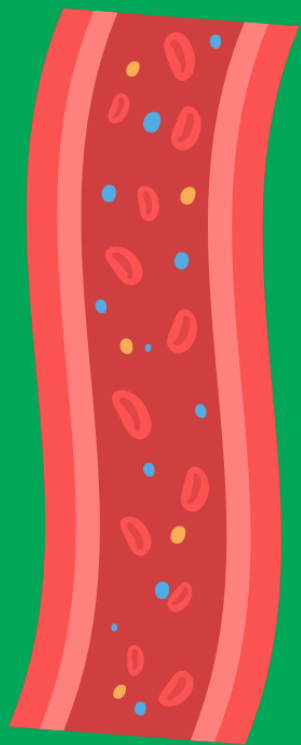
Benefits would be payable if all of the following conditions are met:

Angioplasty or stenting/catheter (balloon angioplasty, atherectomy), or laser treatment (laser angioplasty) needed to correct a narrowing of at least 60% stenosis of one (1) or more major coronary arteries below, must have been performed:

- Left Main Stem
- Left Anterior Descending
- Circumflex
- Right Coronary Artery



Angioplasty and Other Invasive Treatments for Coronary Artery Disease

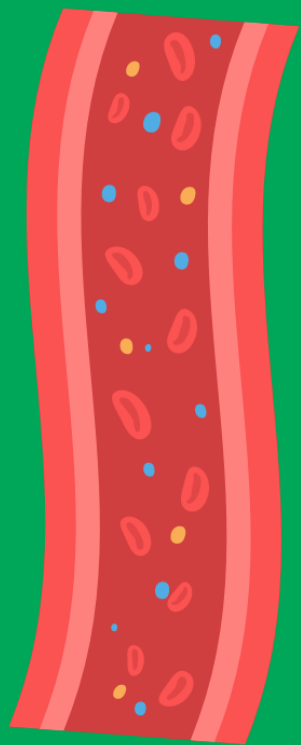


What is covered?

- Must be considered medically necessary by the attending cardiologist
- Presence of severe symptoms of coronary artery disease such as chest pain, shortness of breath, fatigue, and limitation of physical activities
- Abnormal Electrocardiogram (ECG) changes
- Coronary angiography/angiogram results confirming location and degree of stenosis of two or more major coronary arteries
- Coronary angiography/CT angiogram (because these are only investigative procedures)
- Mild coronary artery disease with stenosis (narrowing) less than 60% and/or in one major coronary artery
- Small vessel disease, which is coronary artery disease in the smaller arteries or branches (not in the major coronary arteries)



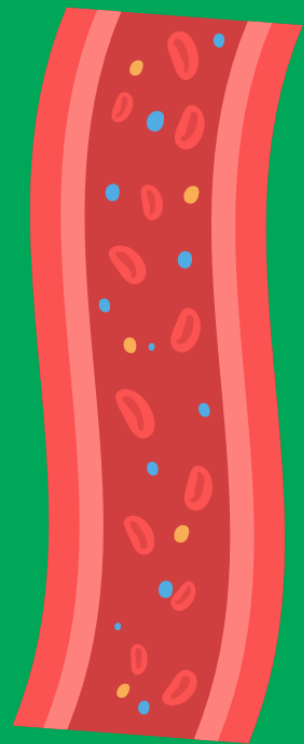
Angioplasty and Other Invasive Treatments for Coronary Artery Disease



✕ What is NOT covered?

- Coronary angiography/CT angiogram (because these are only investigative procedures)
- Mild coronary artery disease with stenosis (narrowing) less than 60% and/or in one major coronary artery
- Small vessel disease, which is coronary artery disease in the smaller arteries or branches (not in the major coronary arteries)

Angioplasty and Other Invasive Treatments for Coronary Artery Disease

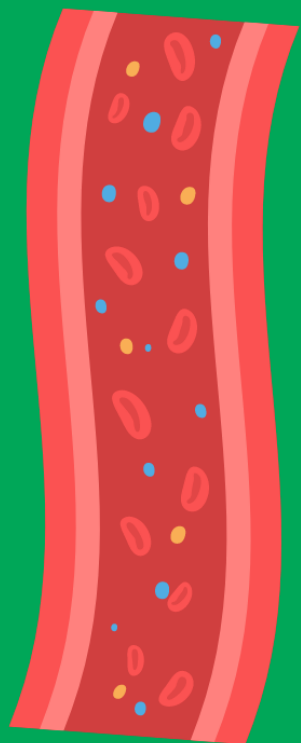


What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Disease/Critical Illness – Other Serious Coronary Artery Disease [APS – Other Serious Coronary Artery Disease (0710)] accomplished by the insured's attending doctor
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Record of Operation or Operative Record - balloon angioplasty, atherectomy or laser treatment
- ✓ Coronary Angiogram Report
- ✓ Electrocardiogram (ECG or EKG) result



Angioplasty and Stenting for Carotid Arteries



Definition

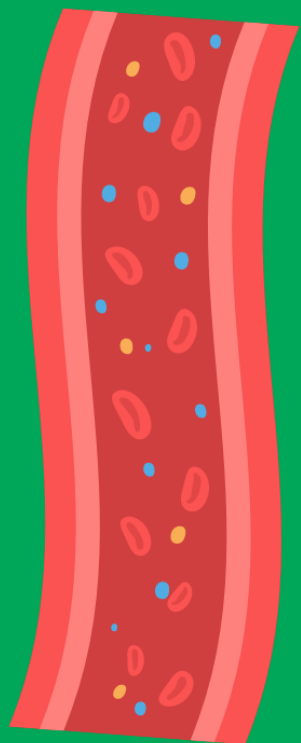
Carotid arteries are the vessels that supply blood to the brain, face, and neck. Among these carotid arteries, there are two large common arteries found on each side of the neck (left and right) which supply blood from the heart to the brain.

As the carotid arteries become narrowed (stenosis) due to buildup of cholesterol or hardened fatty deposits (plaque), they eventually lead to poor blood flow to the brain. This condition is called carotid artery stenosis, which is one of the leading factors of stroke. Mild carotid artery stenosis with minimal blockage is usually treated with medications to reduce the risk of stroke.

This definition only covers severe blockage of carotid arteries treated with less invasive procedures such as angioplasty, stenting (catheter insertion), or atherectomy (use of a catheter or long, narrow tube) to open the narrowed carotid artery and help restore the blood flow to the brain.



Angioplasty and Stenting for Carotid Arteries



What is covered?

Benefits would be payable if all of the following conditions are met:

- Angioplasty, stenting, or atherectomy needed to treat at least 80% stenosis of one or more carotid arteries must have been performed
- Prior experience of a Transient Ischemic Attack (TIA), which is a temporary blockage of blood flow to the brain that does not cause permanent brain damage (TIA usually precedes severe carotid artery stenosis)

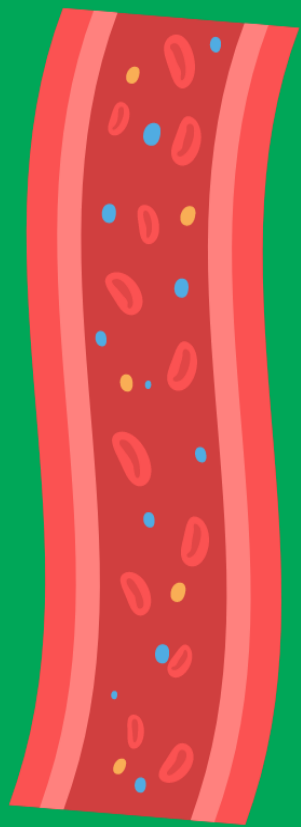


What is NOT covered?

- Mild carotid artery stenosis (narrowing) of less than 80%
- Any other surgical procedure that does not include angioplasty, stenting of carotid arteries or atherectomy



Angioplasty and Stenting for Carotid Arteries

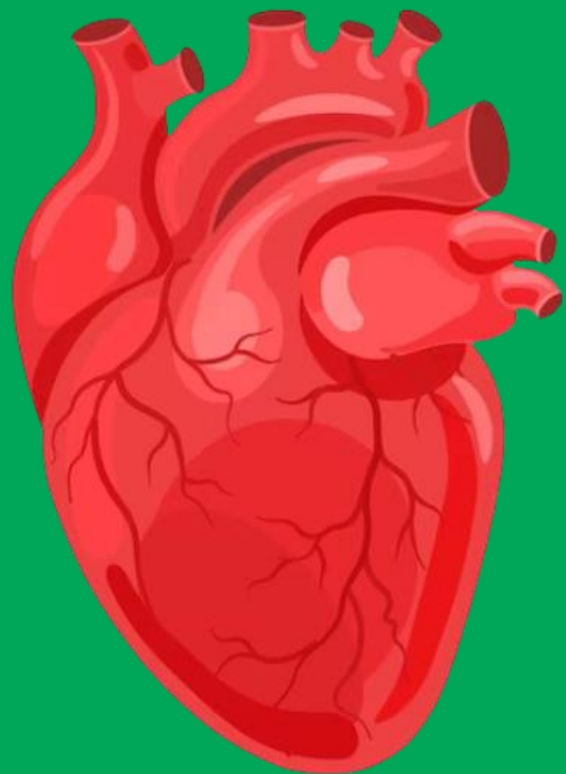


What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Disease/Critical Illness – Other Serious Coronary Artery Disease [APS – Other Serious Coronary Artery Disease (0710)] accomplished by the insured's attending doctor
- ✓ Results of imaging tests such as carotid angiography, carotid doppler
- ✓ Hospital and Surgical Records on angioplasty/stenting of carotid artery



Cardiac Pacemaker Implantation



Definition

Every time the heart beats, it uses electrical signals to control the rhythm and rate of the heart. At rest, the normal heartbeat ranges from 60 to 100 per minute, while during exercise, the heart beats faster and will slowly return to its resting rate after exercise. An arrhythmia, also known as an irregular heartbeat, means the heart beats too fast or too slow, or with an inconsistent pattern. Most of the time, arrhythmias are treatable with medications.

But for serious arrhythmia leading to life-threatening complications like heart failure or cardiac arrest (the heart stops beating), implantable devices such as a cardiac pacemaker and defibrillator are used as a last resort to correct abnormal heart rhythms.

A pacemaker is used to correct a slow, irregular heartbeat, while a defibrillator is used to correct a very fast heartbeat with an irregular rhythm. Both implantable devices require minor surgery to attach them to the heart wall.

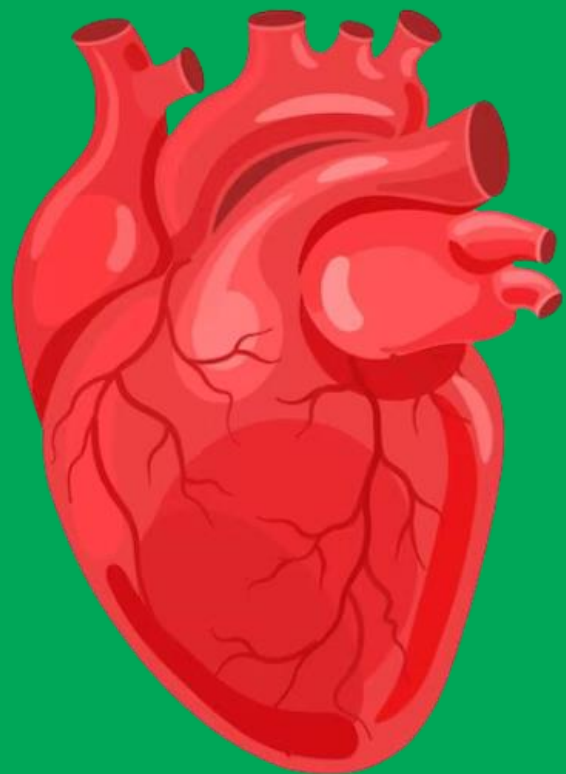


Cardiac Pacemaker Implantation



What is covered?

- A cardiac pacemaker or defibrillator insertion which is needed to treat a serious cardiac arrhythmia must have been performed
- The cardiac arrhythmia cannot be treated via other means



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Disease/Critical Illness – Other Serious Coronary Artery Disease [APS – Other Serious Coronary Artery Disease (0710)] accomplished by the insured's attending doctor
- ✓ Results of heart investigations like ECG, 24-hour Holter monitor, electrophysiologic testing for arrhythmia
- ✓ Hospital and surgical records on cardiac pacemaker or defibrillator insertion



Cardiomyopathy



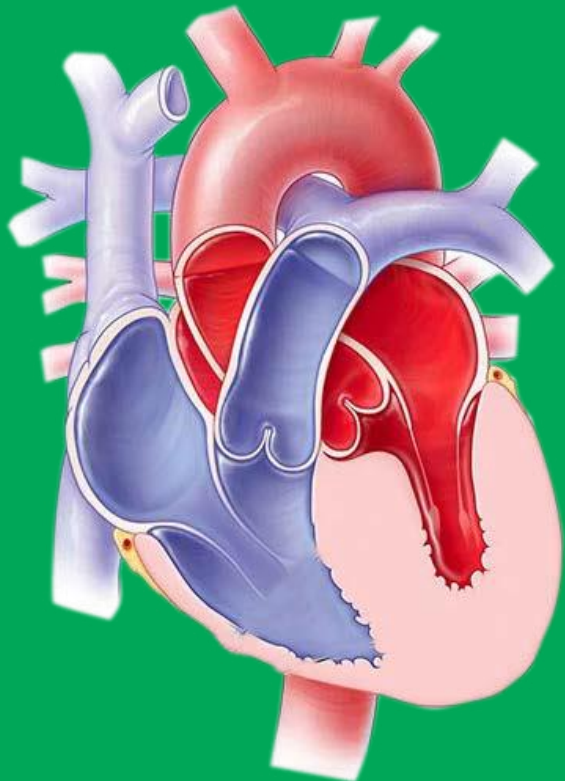
Definition

An impaired function of the heart muscle, unequivocally diagnosed as Cardiomyopathy by a cardiologist.



What is covered?

- Should result in permanent and irreversible physical impairment of Class IV of the New York Heart Association's classification of cardiac impairment.
- The diagnosis has to be supported by abnormal ECG and echocardiographic findings of compromised ventricular performance.
- NYHA classification Class IV means that the patient is symptomatic at rest despite the use of medication and dietary adjustment, and there is evidence of abnormal ventricular function on physical examination and laboratory studies.

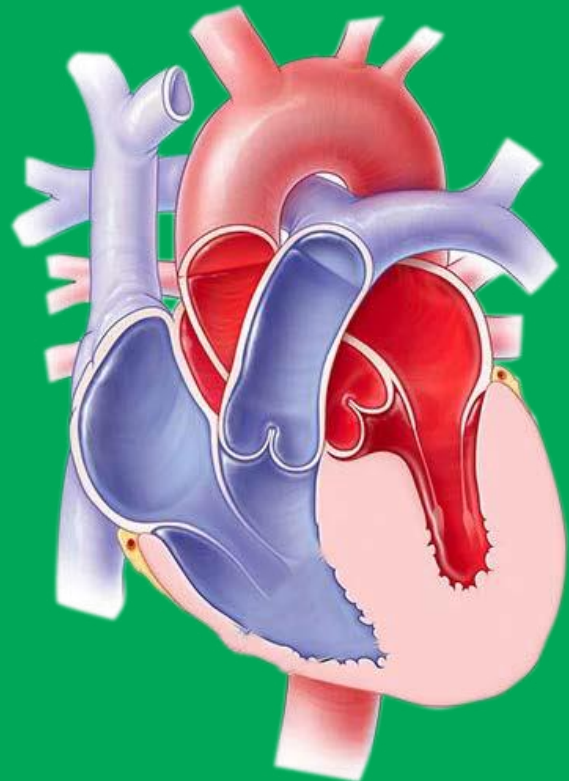


Cardiomyopathy



What is NOT covered?

Cardiomyopathy that is directly related to alcoholic and drug abuse.



What are the requirements needed?

- ✓ Attending Physician Statement for Cardiomyopathy confirmed by Cardiologist [APS - Cardiomyopathy (0710)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Electrocardiogram (ECG) result
- ✓ Medical Certification indicating cardiomyopathy class



Carotid Artery Surgery

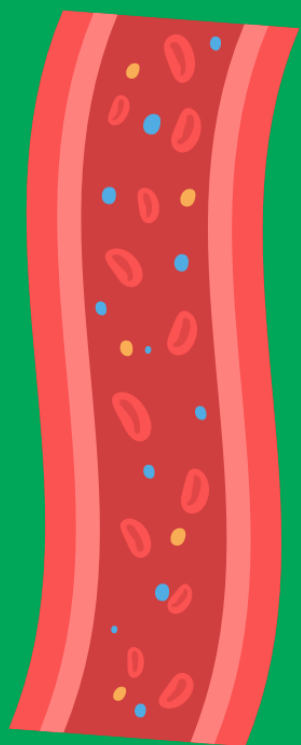


Definition

Carotid arteries are the vessels that supply blood to the brain, face, and neck. Among these carotid arteries, there are two large common arteries found on each side of the neck (left and right) that supply blood from the heart to the brain.

As the carotid arteries become narrowed (stenosis) due to buildup of cholesterol or hardened fatty deposits (plaque), they eventually lead to poor blood flow to the brain. This condition is called carotid artery stenosis, which is one of the leading factors of stroke. Mild carotid artery stenosis with minimal blockage is usually treated with medications to reduce the risk of stroke.

This definition only covers severe blockage of carotid arteries treated with carotid artery surgery called endarterectomy, wherein the carotid artery is surgically opened to remove the blockage and is stitched back together afterwards.



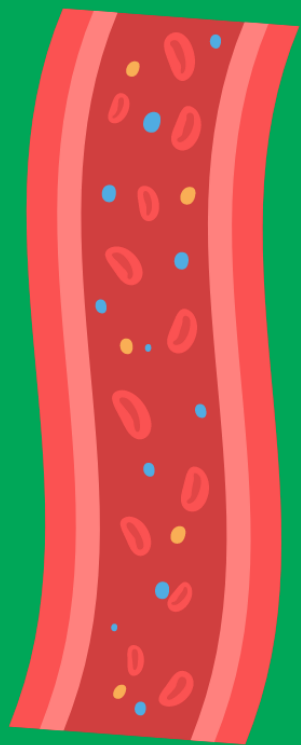
Carotid Artery Surgery



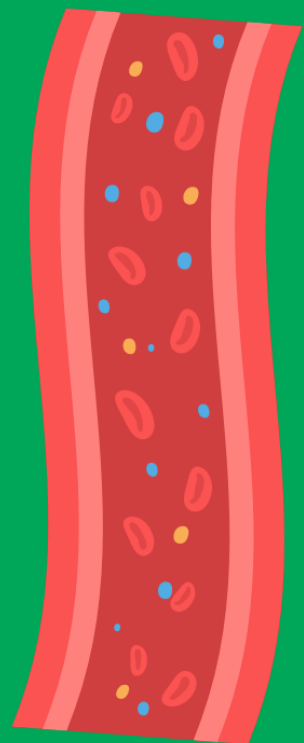
What is covered?

Benefits would be payable if all of the following conditions are met:

- Carotid artery surgery called endarterectomy which is needed to treat at least 80% stenosis of one or more carotid arteries must have been performed
- Prior experience of a Transient Ischemic Attack (TIA) which is a temporary blockage of blood flow to the brain that does not cause permanent brain damage (TIA usually precedes severe carotid artery stenosis)



Carotid Artery Surgery



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Disease/Critical Illness – Others [APS – Others] accomplished by the insured's attending doctor
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Record of operation or Operative Record - Angioplasty and/or Stenting, or Atherectomy
- ✓ Results of imaging tests such as carotid angiography, carotid doppler



Coronary Artery Bypass Surgery



Definition

The actual undergoing of open-heart surgery to correct the narrowing or blockage of one or more coronary arteries with by-pass grafts.



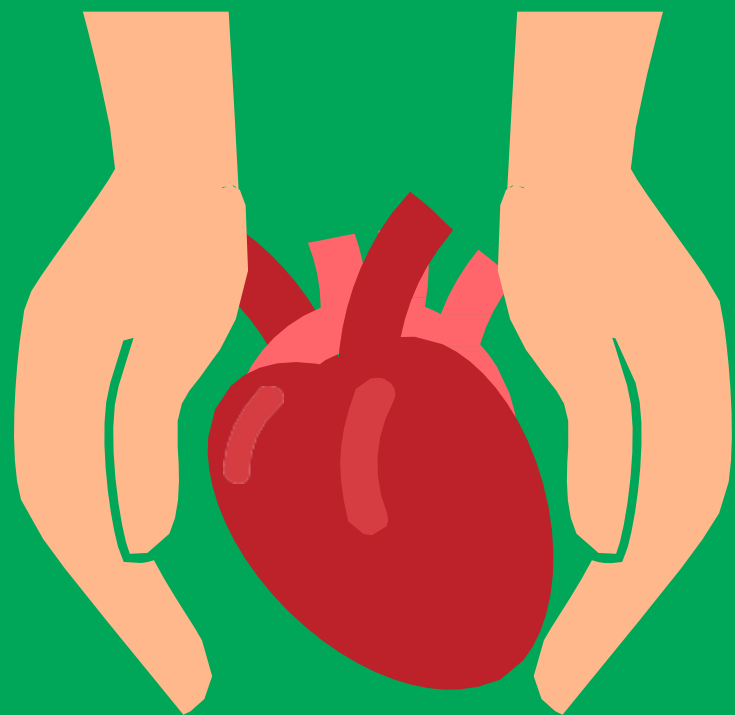
What is covered?

Angiographic evidence of more than 50% coronary artery obstruction must be provided and the procedure must be considered medically necessary by a consultant cardiologist.

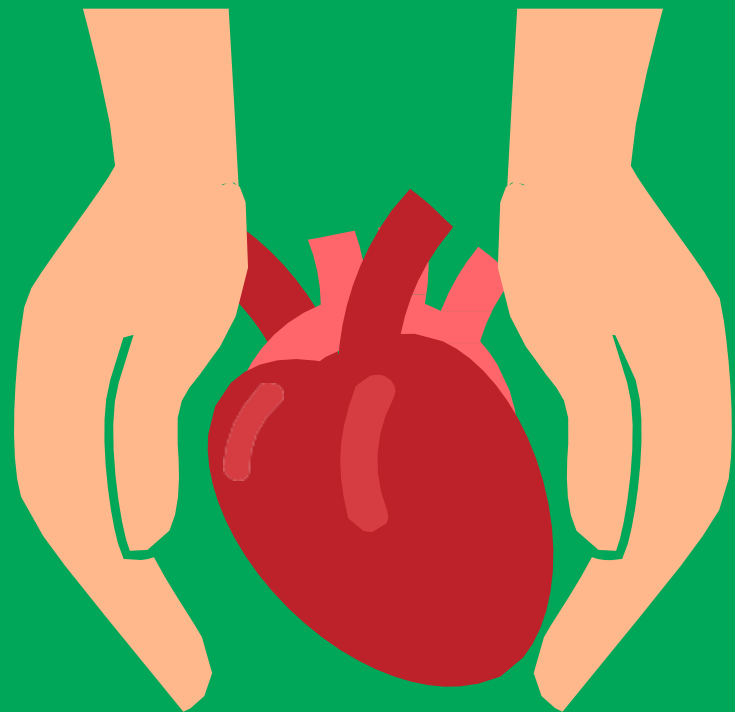


What is NOT covered?

- Angioplasty
- All other intra-arterial catheter-based techniques, or laser procedures
- Coronary artery obstruction is less than 50%



Coronary Artery Bypass Surgery

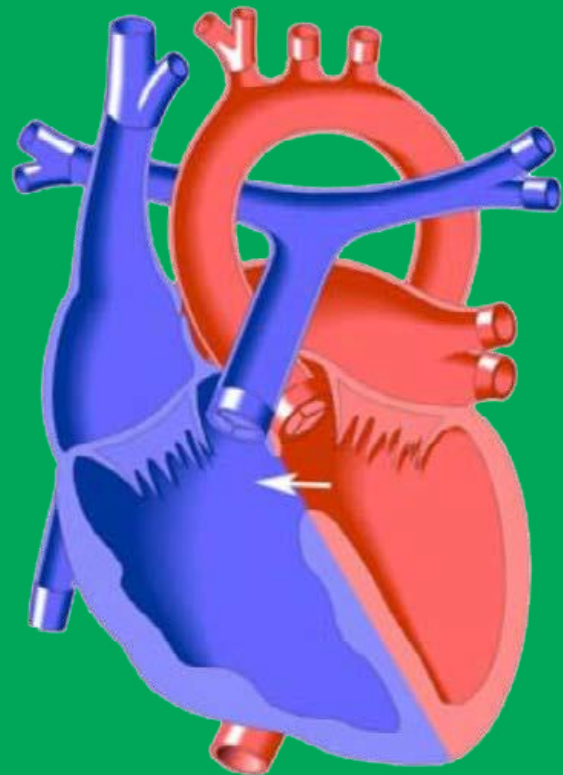


What are the requirements needed?

- ✓ Attending Physician Statement form for APS-Coronary Artery By-Pass Surgery (1009)
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Record of Operation or Operative Record
- ✓ Coronary Angiogram Report



Eisenmenger's Syndrome



Definition

The development of severe pulmonary hypertension and shunt reversal resulting from a heart condition.



What is covered?

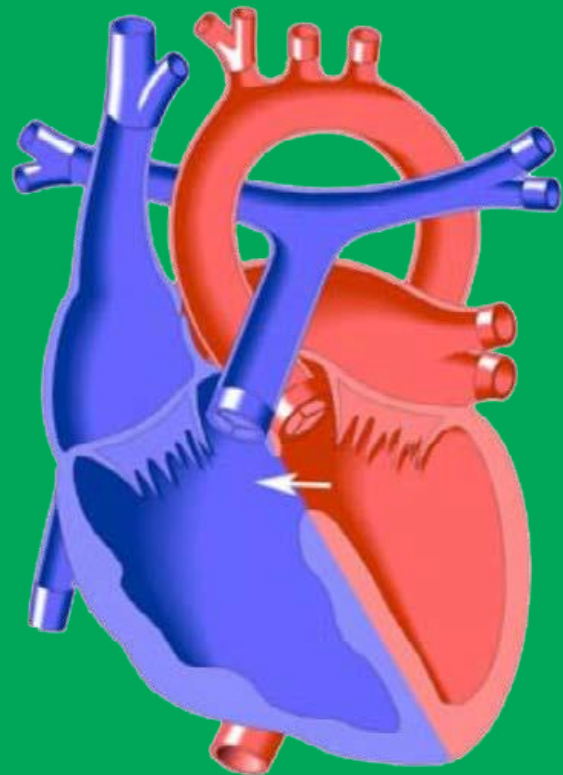
- The development of severe pulmonary hypertension and shunt reversal resulting from a heart condition.
- The diagnosis must be made by a specialist with echocardiography and cardiac catheterization.



Eisenmenger's Syndrome

✕ What is NOT covered?

Diagnosis not confirmed by a Specialist with echocardiography and cardiac catheterization

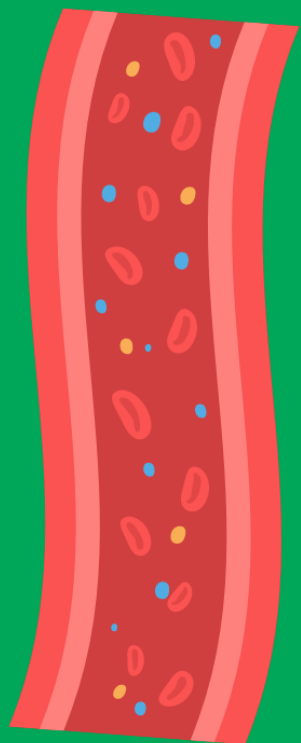


What are the requirements needed?

- ✓ Attending Physician Statement form for Others from Specialist with echocardiography and cardiac catheterization [APS – Others]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Record of Operation or Operative Record



Endovascular Treatment of Peripheral Arterial Disease



Definition

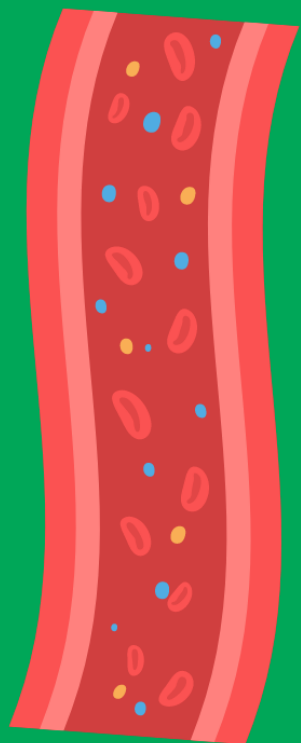
Peripheral arteries are the vessels that carry blood from the heart to other parts of the body. Peripheral arterial disease is the narrowing of the peripheral arteries (stenosis) due to the buildup of cholesterol or hardened fatty deposits (plaque), which can lead to reduced blood flow to the arms, legs, kidneys, and abdomen. Poor blood circulation can lead to leg or foot amputation, heart attack, and stroke.

Mild peripheral arterial disease with minimal blockage is usually treated with medications to reduce the risk of stroke and reduce blood cholesterol.

This definition only covers severe blockage of the peripheral arteries treated with a less invasive treatment such as angioplasty, stenting (catheter insertion) or atherectomy (use of a catheter or a long, narrow tube) to open the narrowed peripheral artery which help restore smooth blood circulation.



Endovascular Treatment of Peripheral Arterial Disease



What is covered?

Benefits would be payable if angioplasty, stenting, or atherectomy needed to treat at least 80% stenosis of one or more of the arteries below must have been performed:

- Arteries supplying blood to lower limbs (legs) or upper limbs (arms)
- Renal arteries (kidneys)
- Mesenteric arteries (abdomen)

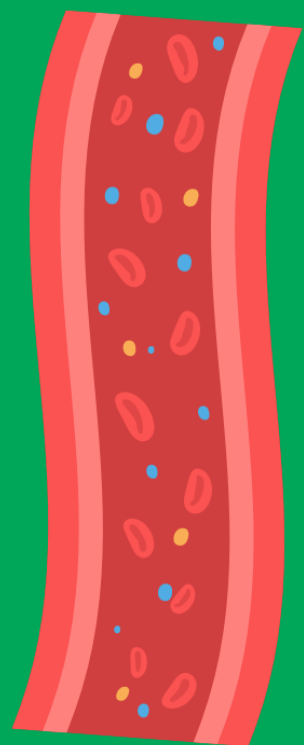


What is NOT covered?

- Mild peripheral arterial disease with stenosis (narrowing) less than 80%
- Any other surgical procedure that does not include angioplasty and/or stenting of peripheral arteries



Endovascular Treatment of Peripheral Arterial Disease

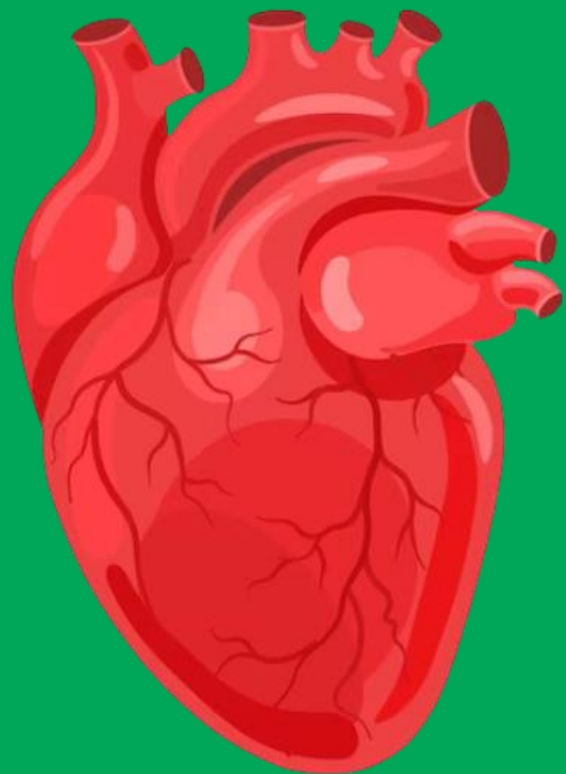


What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Disease/Critical Illness – Others [APS – Others] accomplished by the insured's attending doctor
- ✓ Record of operation or Operative Record - angioplasty and/or stenting or atherectomy
- ✓ Results of imaging tests such as CT angiography, magnetic resonance angiography (MRA), ultrasound



Endovascular Treatments of Aortic Disease or Aortic Aneurysm



Definition

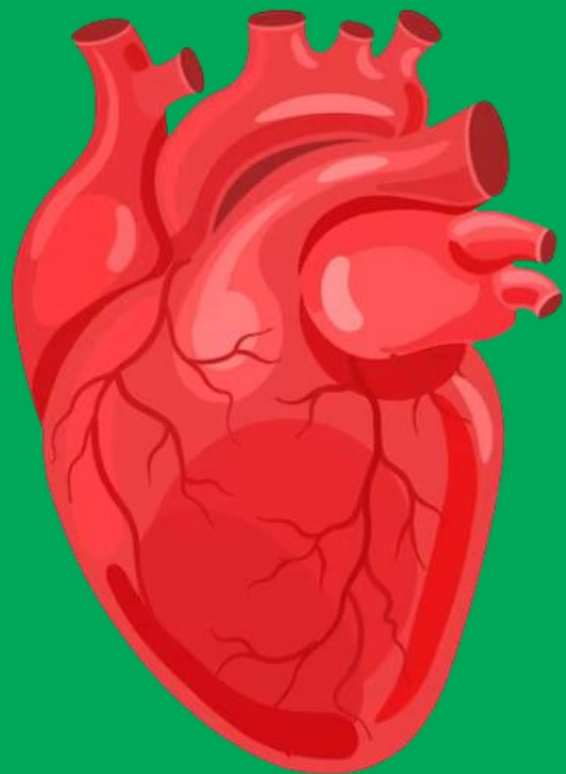
Did you know that the aorta is the largest blood vessel of the body? This main artery carries blood from the heart to other parts of the body. Aortic disease is any disorder that damages the aorta such as:

- aortic aneurysm (bulge or ballooning in the aorta)
- aortic stenosis (narrowing due to the buildup of plaque in the aorta)
- aortic obstruction (blockage in the aorta)
- aortic dissection (tear in the aortic wall)

Usually, if there's damage to the aorta, the heart and the entire blood supply of the body are at high risk and could lead to a life-threatening situation if not immediately treated.



Endovascular Treatments of Aortic Disease or Aortic Aneurysm



What is covered?

Early CI Benefit covers any one of the following:

- Endovascular treatment of the aortic disease of the major branches (abdominal and thoracic aorta) through minimally invasive (less invasive) treatment as using a catheter or thin tubes to open the narrowed aorta or to repair the aortic aneurysm or dissection must have been done
- Aortic Aneurysm (abdominal or thoracic aortic aneurysm or aortic dissection), where the aorta is enlarged by at least 50 mm in diameter (even without the actual procedure of undergoing an endovascular treatment)

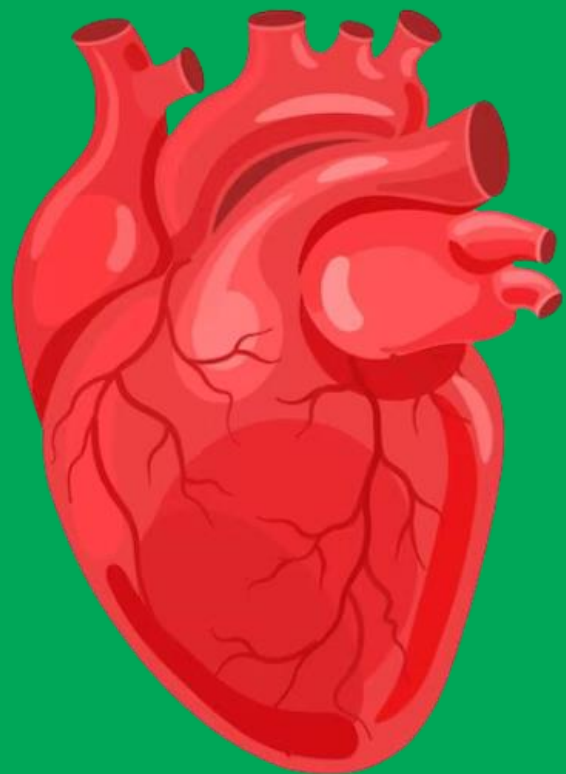


Endovascular Treatments of Aortic Disease or Aortic Aneurysm



What is NOT covered?

- Atherosclerosis of the aorta (buildup of plaque without narrowing or stenosis)
- Affecting the minor branches of the aorta



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Disease/Critical Illness – Others [APS – Others]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Results of imaging test such as Chest X-ray, Lung CT Scan, MRI Scan
- ✓ Record of Operation or Operative Record - Endovascular treatments of aortic disease or aortic aneurysm



Heart Attack

(Myocardial Infarction)



Definition

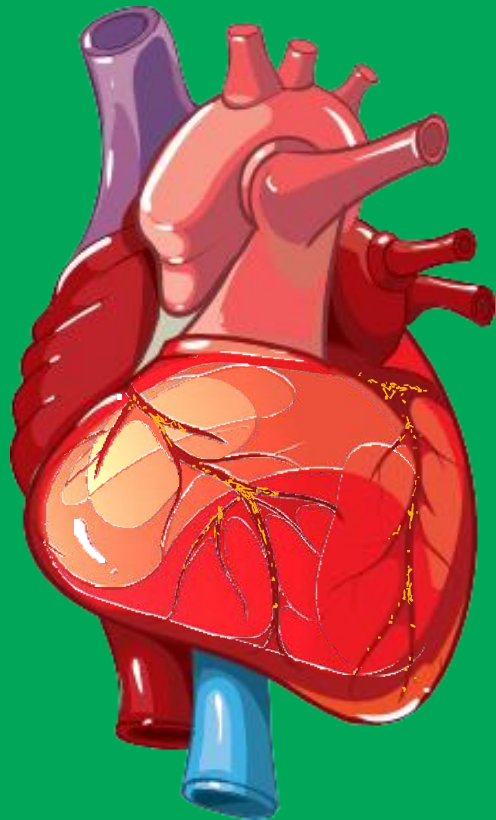
Death of a portion of the heart muscle (myocardium) arising from inadequate blood supply to the relevant area.



What is covered?

The diagnosis must be supported by 3 or more of the following 5 criteria which are consistent with a new heart attack:

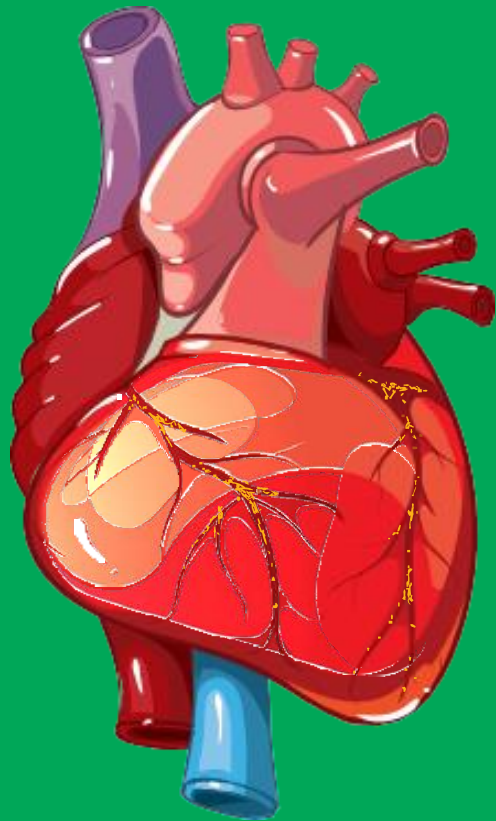
- A history of typical chest pain;
- New electrocardiographic changes proving infarction;
- Diagnostic elevation of cardiac enzyme CK-MB;
- Diagnostic elevation of Troponin T or I at 0.5 mcg/L (0.5 ng/mL) and above; and
- Left ventricular ejection fraction less than 50% measured 3 months or more after the event.



Heart Attack (Myocardial Infarction)

✕ What is NOT covered?

- Angina
- Heart attack of indeterminate age; and
- A rise in cardiac biomarkers or Troponin T or I following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.



What are the requirements needed?

- ✓ Attending Physician Statement form for Heart Attack [APS - Heart Attack (0809)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Electrocardiogram (ECG or EKG) result
- ✓ CK-MB result
- ✓ Troponin I or Troponin T result
- ✓ 2D Echocardiogram result [measured at least 3 months after the event]



Heart Valve Replacement



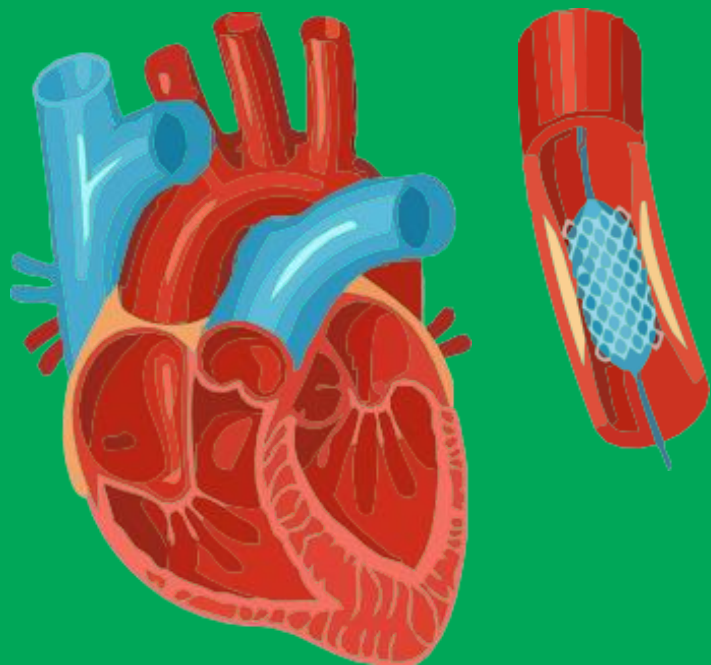
Definition

The actual undergoing of open-heart surgery to replace or repair heart valve abnormalities.



What is covered?

Evidence of the heart valve abnormality from cardiac catheterization or echocardiogram must be provided and the procedure must be considered medically necessary by a consultant cardiologist.



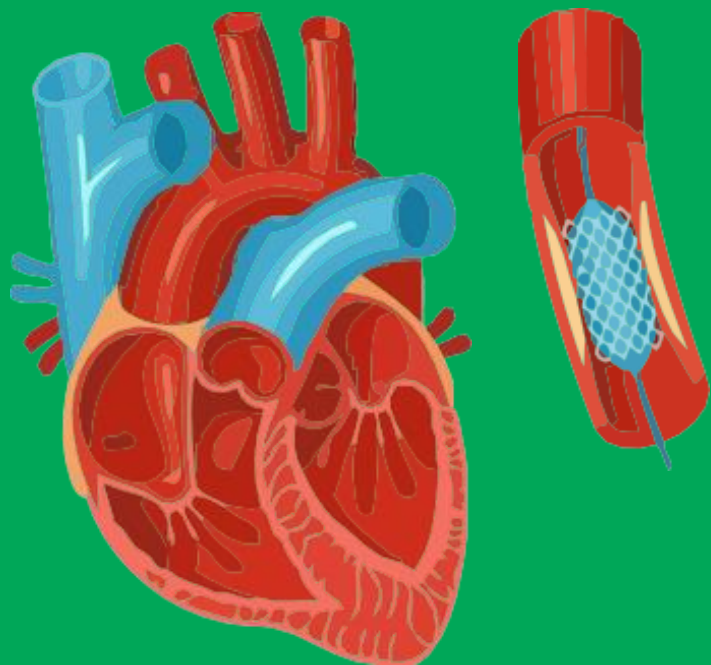
Heart Valve Replacement

✕ What is NOT covered?

- Balloon valvotomy
- Heart valve replacement that is not considered medically necessary

What are the requirements needed?

- ✓ Attending Physician Statement form for Heart Valve Replacement [APS - Heart Valve Replacement (1009)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Echocardiogram
- ✓ Record of Operation or Operative Record



Insertion of a vena-cava filter



Definition

A pulmonary embolism is a blood clot that usually develops in the deep veins of the leg that breaks off and travels to the lungs, causing a sudden blockage of blood flow that can be life-threatening if not immediately treated.

Treatment varies depending on the severity of the blood clot. A small embolus (blood clot) with no symptoms may still be treated with blood-thinning medications. Huge or recurrent pulmonary embolisms with symptoms need immediate surgical insertion of a vena-cava filter.

An inferior vena-cava filter (IVCF) is a small metal device placed in the inferior vena cava (the body's largest vein) that filters blood clots and stops them from traveling up to the lungs.



Insertion of a vena-cava filter



What is covered?

The actual insertion of inferior vena-cava filter (IVCF) needed to treat pulmonary embolism must have been performed



Insertion of a vena-cava filter



What is NOT covered?

- Insertion of superior vena-cava (SVC) filter
- Pulmonary embolism without insertion of vena-cava filter

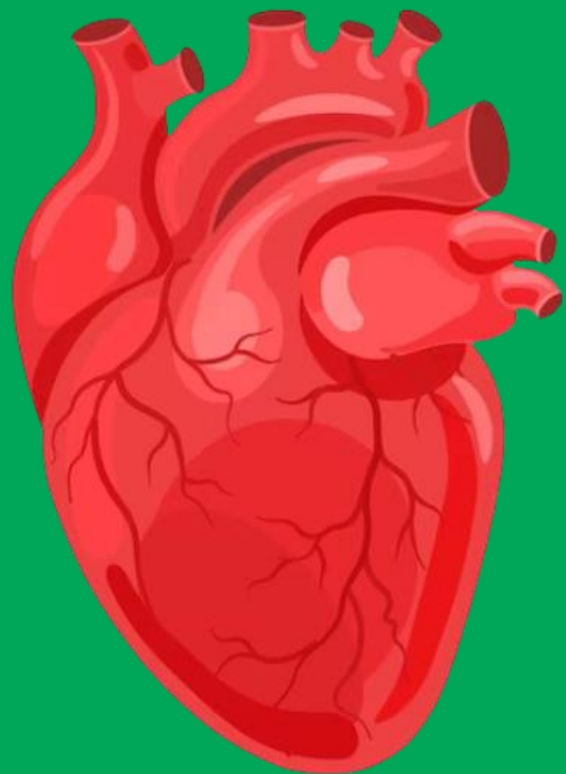


What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Disease/Critical Illness – Others [APS – Others] accomplished by the insured's attending doctor
- ✓ Results of imaging tests such as MDCTA or pulmonary angiography
- ✓ Laboratory/blood test screening results
- ✓ Hospital and Surgical Records on IVCF insertion



Less Invasive Treatments of Heart Valve Disease



Definition

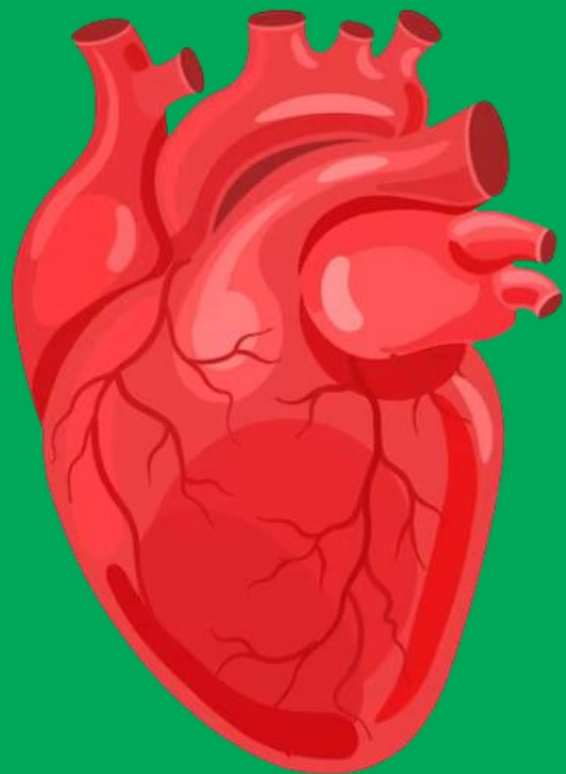
A heart valve acts as a one-way door between chambers of the heart. Heart valve disease happens when one or more of the heart valves do not work properly, such as regurgitation (back flow) when valves are not closed properly (commonly known as prolapse) or stenosis (narrowing of the valve). Usually, asymptomatic or mild heart valve disease does not require any treatment. However, severe heart valve disease entails heart valve repair or replacement to prevent further damage to the heart.

Early CI Benefit covers severe heart valve diseases treated with less invasive procedures such as:

- Percutaneous (using a catheter or thin tube) heart valve repair, such as valvuloplasty or valvotomy (opening of a narrowed valve through a catheter)
- Percutaneous valve replacement (replacement of valve through a catheter)



Less Invasive Treatments of Heart Valve Disease



What is covered?

Percutaneous heart valve repair, such as valvuloplasty or valvotomy and percutaneous valve replacement, which is needed to treat severe heart valve disease.

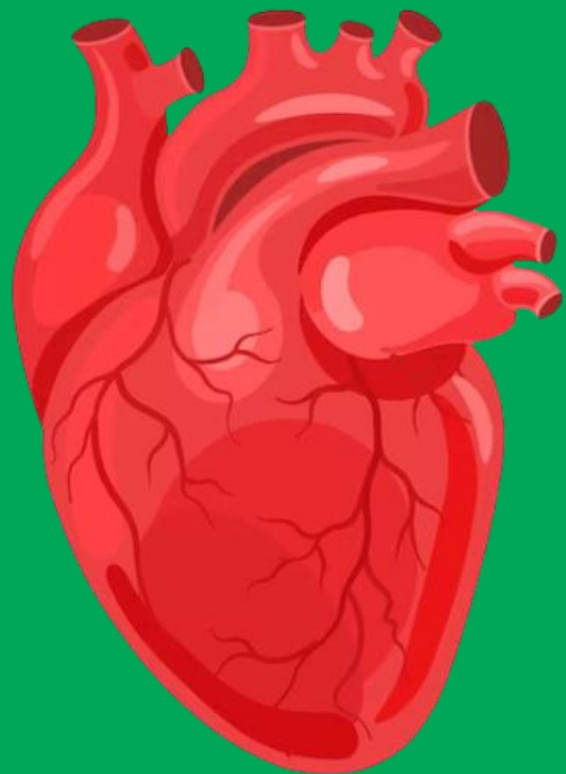


What is NOT covered?

- Heart valve disease not requiring heart valve repair
- Percutaneous heart valve repair for correction of a congenital heart abnormality



Less Invasive Treatments of Heart Valve Disease

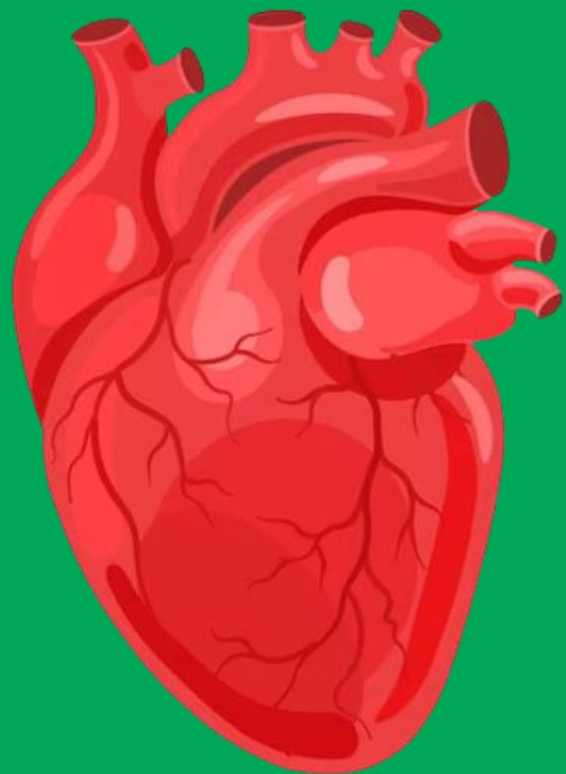


What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Heart Valve Replacement [APS – Heart Valve Replacement (1009)] accomplished by the insured's cardiologist
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Record of Operation or Operative Record - valvuloplasty or valvotomy, and percutaneous valve replacement



Non-ST Elevation Myocardial Infarction (Less Severe Heart Attack)



Definition

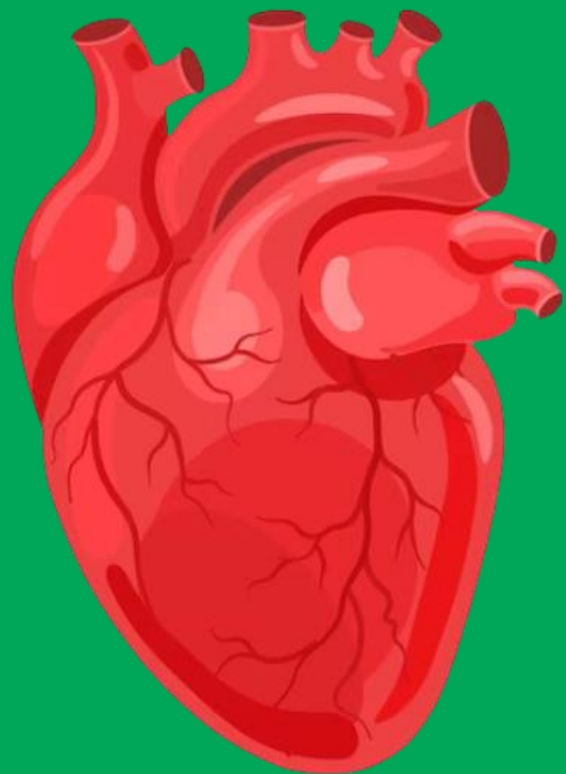
Heart attack, also known as Myocardial Infarction, is a death of a portion of a heart muscle resulting from inadequate blood flow, which may be caused by a blockage of the coronary arteries that supply blood to the heart. If blood flow is not restored quickly, this life-threatening condition can lead to massive damage to the heart muscle and cause sudden death.

Heart attacks have varying severity depending on how many heart muscles have been affected. The more severe the damage, the more extensive the symptoms are the weaker the heart becomes, with a lower percentage of blood being pumped out at every heartbeat.

Early CI Benefit covers less severe heart attacks characterized by chest pain, new ECG changes, and elevated troponin blood tests, which are highly sensitive proteins released into the blood by damaged heart muscle.



Non-ST Elevation Myocardial Infarction (Less Severe Heart Attack)



What is covered?

Benefits would be payable if all of the following conditions are met:

- A cardiac event occurs due to inadequate blood supply to the heart muscle (myocardium), resulting in the death of a limited amount of heart muscle.
- This is demonstrated by a reduced ejection fraction of less than 50%.
- There is an elevation of troponin or CKMB levels at least 20% above the relevant reference range, both measured within 48 hours after the event.

Non-ST Elevation Myocardial Infarction (Less Severe Heart Attack)

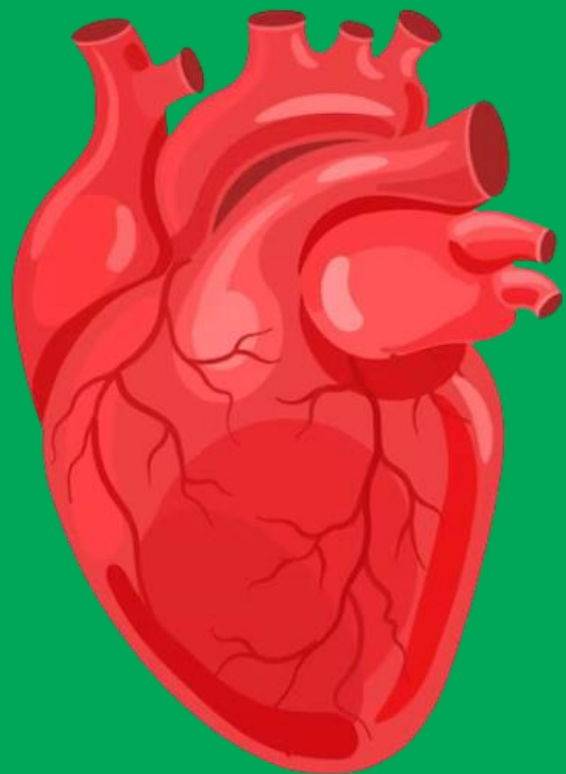


What is NOT covered?

- Acute coronary syndromes and/or angina

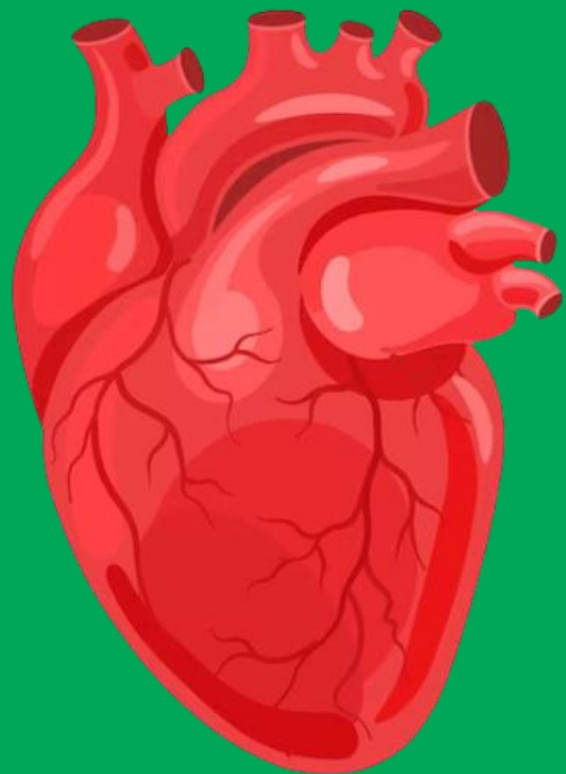
Although symptoms of acute coronary syndrome and angina are similar to a heart attack, there is no damage to the heart muscle and troponin levels are within normal range. This is not a critical condition, but it serves as a warning of an impending heart attack.

- Microinfarction and/or Minimal myocardial damage as these do not cause permanent damage to the heart muscle. Old ECG changes indicating heart attack. These are incidental ECG findings of an old heart attack. ECG findings alone are not accurate enough to diagnose a heart attack.



Non-ST Elevation Myocardial Infarction

(Less Severe Heart Attack)



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Heart Attack [APS – Heart Attack (0809)] accomplished by the insured's attending doctor
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Electrocardiogram (ECG or EKG) result
- ✓ Troponin I or Troponin T result



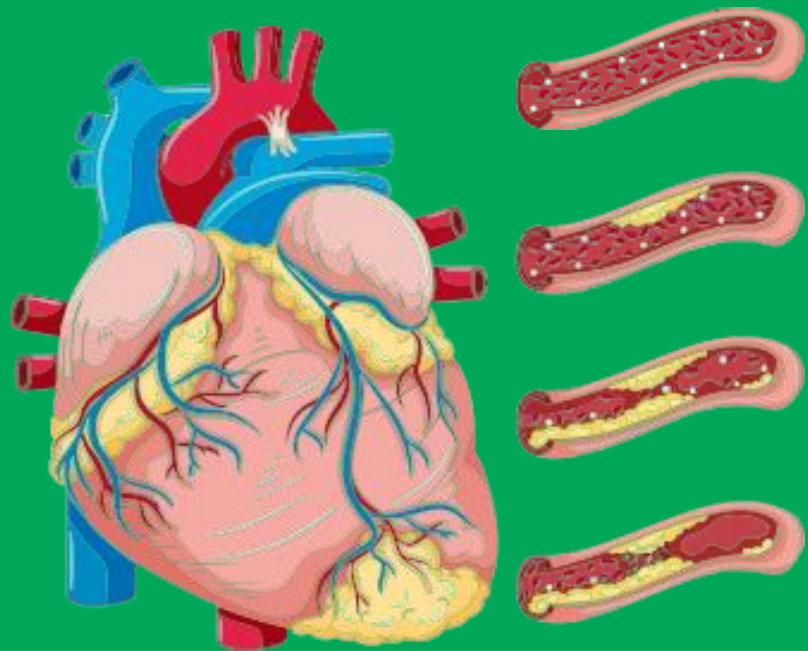
Other Serious Coronary Artery Disease



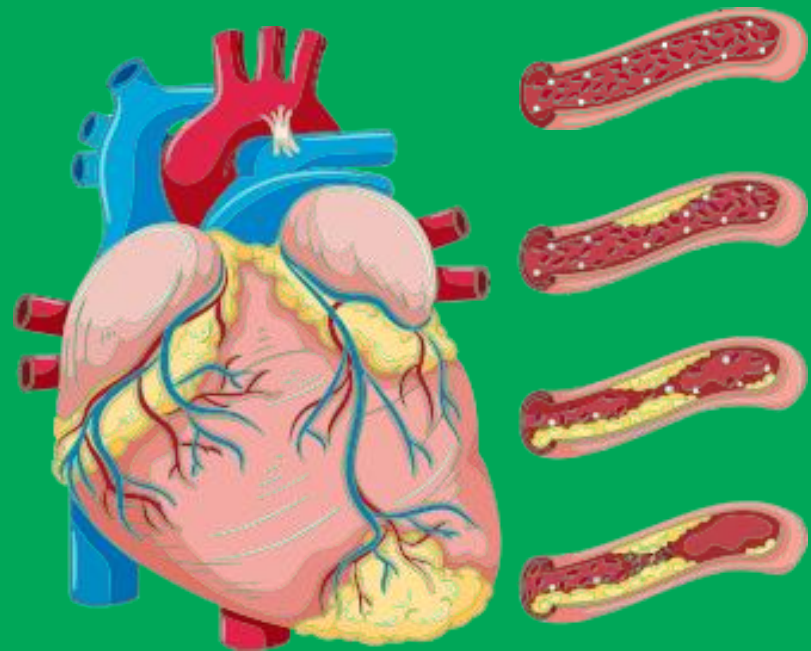
Definition

Severe coronary artery disease in which at least three (3) major coronary arteries are individually occluded by a minimum of sixty percent (60%) or more, as proven by coronary angiogram only.

For purposes of this definition, “major coronary artery” refers to any of the left main stem artery, left anterior descending artery, circumflex artery and right coronary artery (but not including their branches with exception of LMS).



Other Serious Coronary Artery Disease



What is covered?

At least three (3) major coronary arteries are individually occluded by a minimum of sixty percent (60%) or more, as proven by coronary angiogram only.

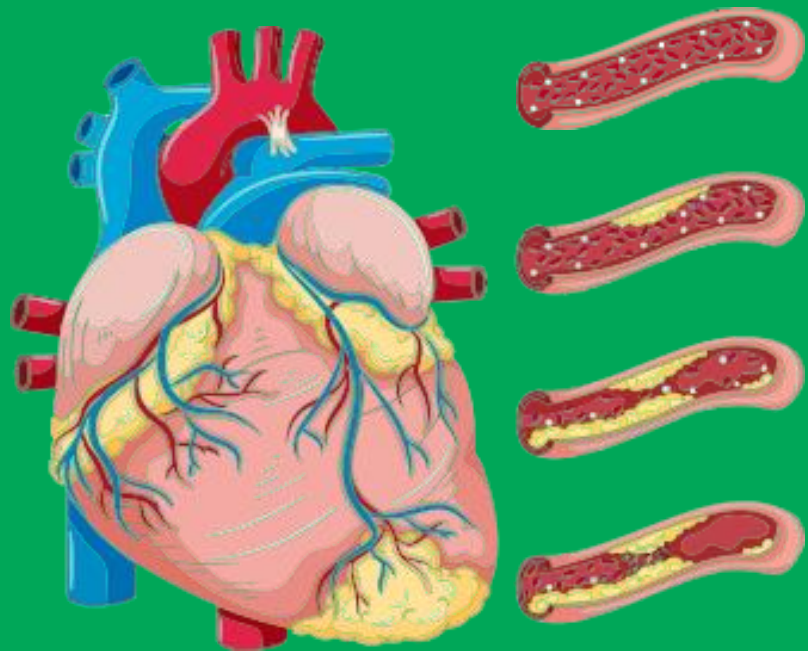
If the occlusion of at least 60% is found on the left main stem artery this is to be considered as occlusion to 2 arteries (LCX and LAD) as they are branches of left main and the latter supplies blood to both.



What is NOT covered?

- Less than three (3) major arteries are occluded
- Occlusion of the three (3) major arteries is less than 60%

Other Serious Coronary Artery Disease



What are the requirements needed?

- ✓ Attending Physician Statement form for Other Serious Coronary Artery Disease [APS - Other Serious Coronary Artery Disease (0710)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Coronary Angiogram Report

Pericardiectomy

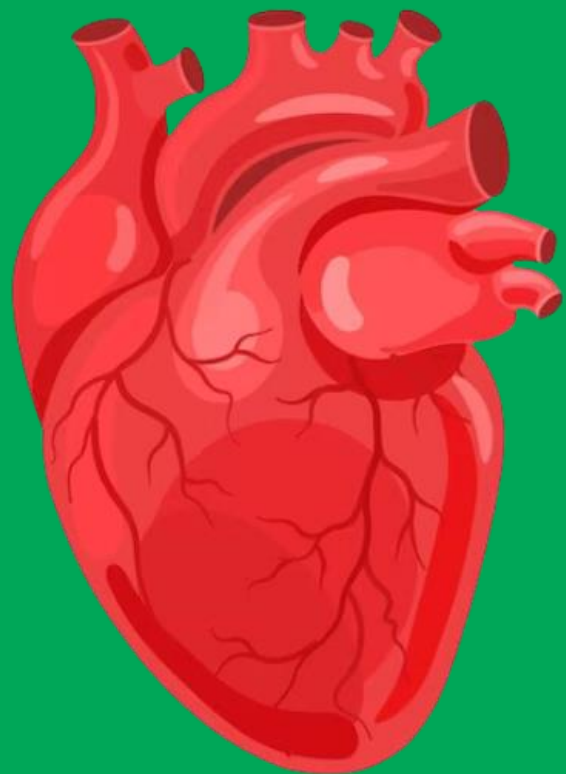


Definition

The pericardium is a sac with a small amount of fluid that surrounds the heart and reduces friction between the heart and other organs. When the pericardium gets swollen and calcified due to disease or injury (pericarditis), it may squeeze the heart, causing severe chest pain and difficulty breathing.

If the pericardial disease is mild, medications can help improve the symptoms and will usually be resolved in 1 to 2 weeks. But for recurrent or severe pericardial disease, surgery is the last resort to remove part or all of the pericardium.

Early CI Benefit only covers severe pericardial disease treated with pericardiectomy which is an open-heart surgery or a less invasive keyhole cardiac surgery.

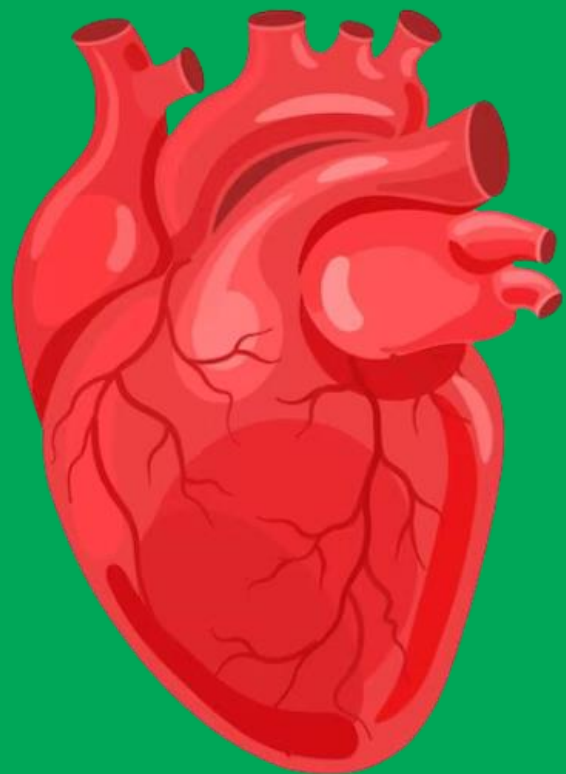


Pericardiectomy



What is covered?

A pericardiectomy or keyhole cardiac surgery which is needed to treat a severe pericardial disease must have been performed.



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Disease/Critical Illness – Others [APS – Others] accomplished by the insured's attending doctor Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Record of Operation or Operative Record - Pericardiectomy or a keyhole cardiac surgery



Primary Pulmonary Arterial Hypertension



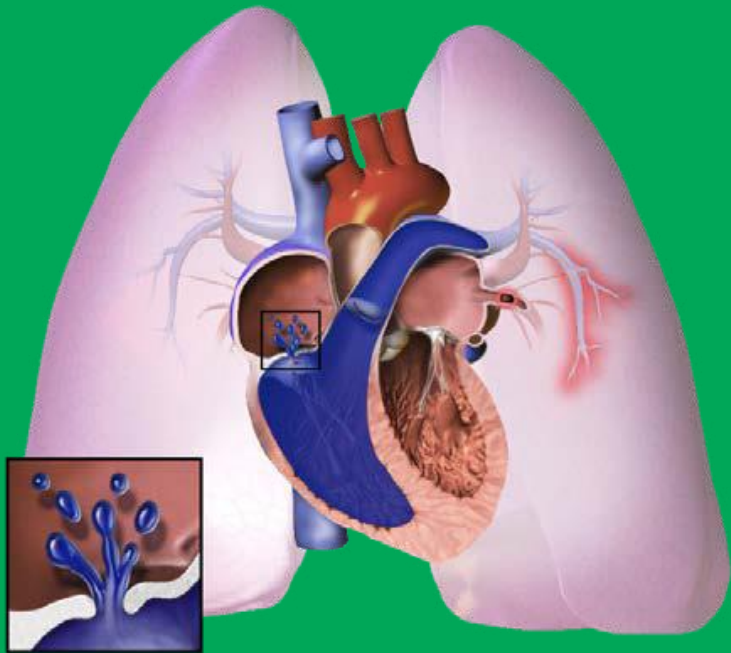
Definition

A primary and unexplained increase in pulmonary artery pressure causing signs of right heart strain and failure.



What is covered?

- There must be permanent irreversible physical impairment to the degree of at least Class III of the New York Heart Association Classification of cardiac impairment.
- The diagnosis of primary pulmonary hypertension needs to be made by a cardiologist or a specialist in respiratory medicine and needs to be supported by data provided at cardiac Catheterization.
- The diagnosis must be supported by all three (3) of the following criteria:
 - Mean pulmonary artery pressure > 40 mmHg; and
 - Pulmonary vascular resistance $> 3\text{mmHg.min/L}$; and
 - Normal pulmonary wedge pressure < 15 mmHg



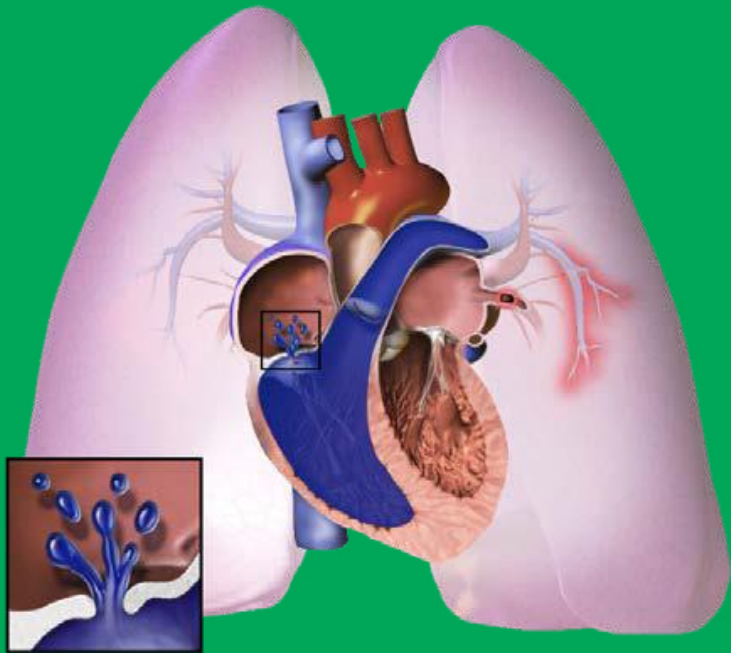
Primary Pulmonary Arterial Hypertension

✕ What is NOT covered?

- Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, diseases of the left side of the heart and congenital heart disease.
- Not all three (3) criteria are satisfied.

What are the requirements needed?

- ✓ Attending Physician Statement form for Primary Pulmonary Arterial Hypertension confirmed by a Cardiologist or a specialist in respiratory medicine [APS - Primary Pulmonary Arterial Hypertension (0710)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ 2d Echocardiogram result
- ✓ Pulmonary Artery Result
- ✓ Medical Certification indication of the New York Association Classification



Severe Infective Endocarditis



Definition

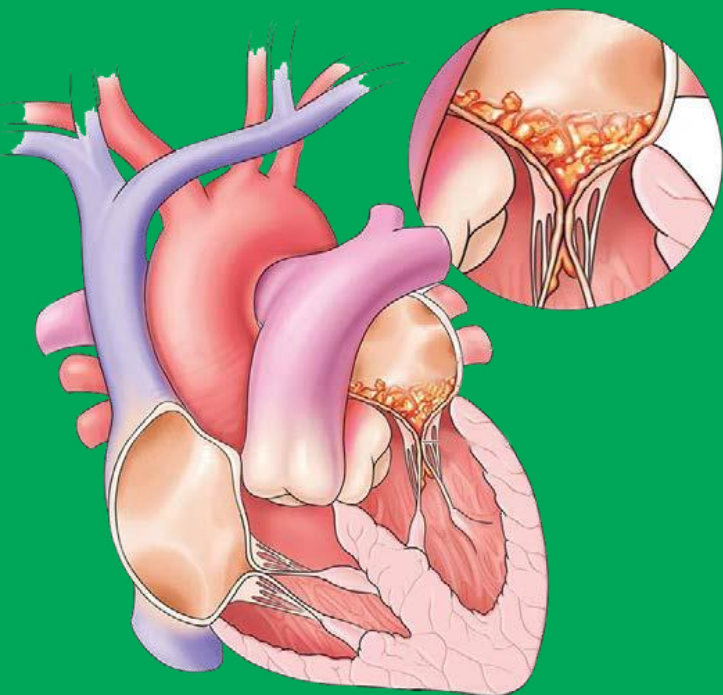
Inflammation of the inner lining of the heart caused by infectious organisms.



What is covered?

All of the following criteria must be met:

- Positive result of the blood culture proving presence of the infectious organism(s):
 - Microorganisms: demonstrated by culture of histology that has embolized, or in an intracardiac abscess; or
 - Pathological lesions: vegetation or intracardiac abscess present, confirmed by histology showing active endocarditis; or
 - Typical microorganism consistent with Infective Endocarditis from two (2) separate blood cultures; or
 - Microorganisms consistent with Infective Endocarditis form persistently positive blood cultures.



Severe Infective Endocarditis



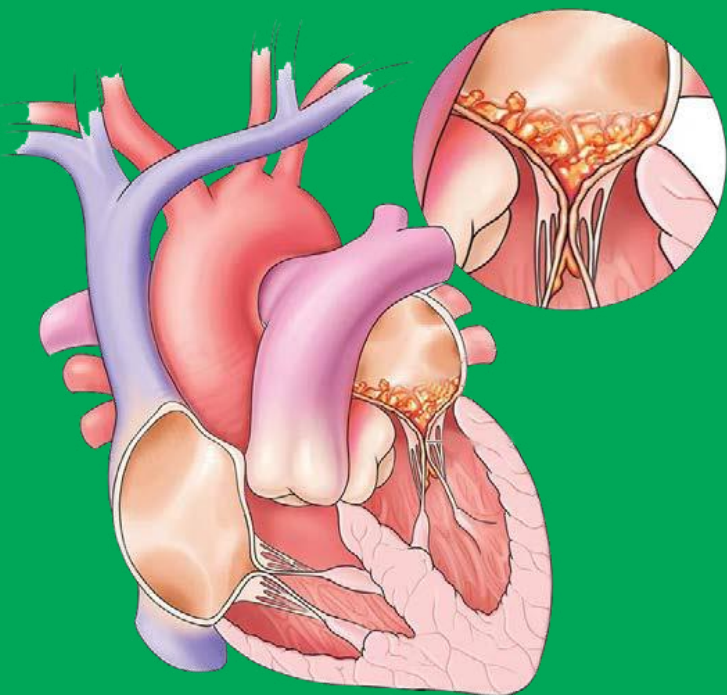
What is covered?

- Presence of at least moderate heart valve incompetence (meaning regurgitant fraction of 20% or above) or moderate heart valve stenosis (resulting in heart valve area of 30% or less of normal value) attributable to Infective Endocarditis; and
- The Diagnosis of Infective Endocarditis and the severity of valvular impairment are confirmed by a Medical Practitioner who is a qualified specialist.

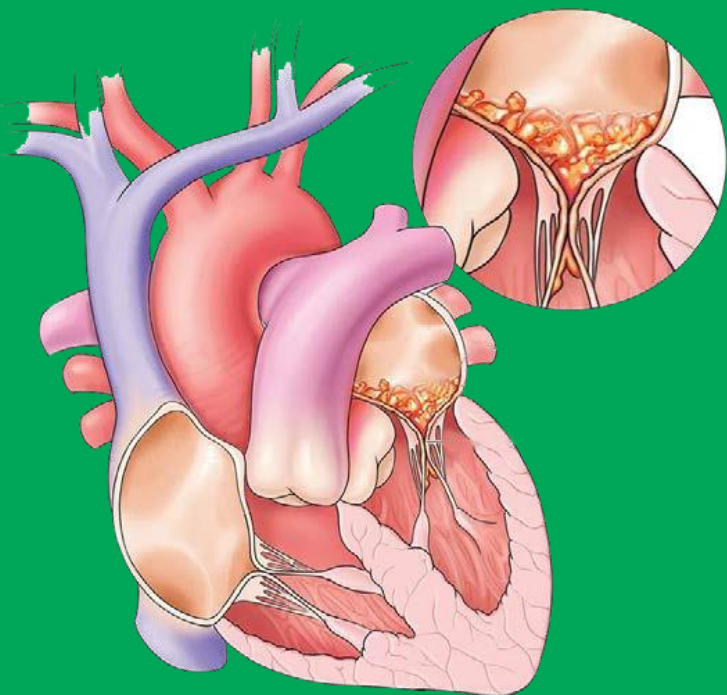


What is NOT covered?

If any of the 3 criteria for Severe Infective Endocarditis is not met.



Severe Infective Endocarditis



What are the requirements needed?

- ✓ Attending Physician Statement form from Others confirmed by a Medical Practitioner who is a qualified specialist. [APS – Others]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Culture and sensitivity result



Surgery to Aorta



Definition

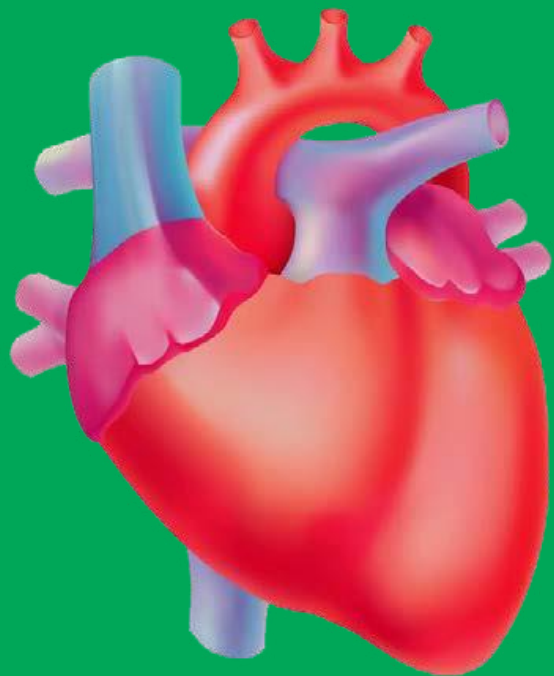
The actual undergoing of laparotomy or thoracotomy to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen.

For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.



What is covered?

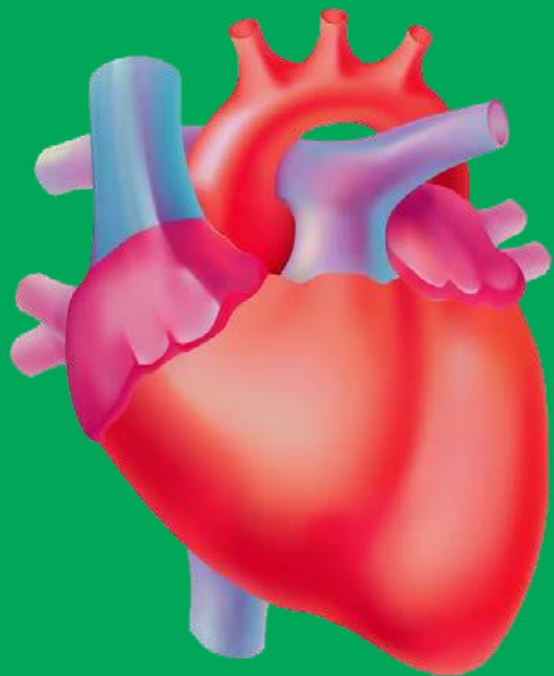
The actual undergoing of laparotomy or thoracotomy to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen.



Surgery to Aorta

✕ What is NOT covered?

Surgery performed using only minimally invasive or intra arterial techniques.



What are the requirements needed?

- ✓ Attending Physician Statement form for Surgery of Aorta [APS-Surgery to Aorta (1009)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Record of Operation or Operative Record





Nervous System (Brain) Diseases and Medical Procedures

Alzheimer's Disease



Definition

Progressive and permanent deterioration of memory and intellectual capacity as evidenced by accepted standardized questionnaires and cerebral imaging.



What is covered?

- The diagnosis of Alzheimer's disease must be confirmed by a neurologist.
- There must be significant reduction in mental and social functioning requiring the continuous supervision of the Insured.
- There must also be a permanent inability of the Insured to perform, without any form of assistance, at least three (3) of the six (6) Activities of Daily Living for a continuous period of at least 180 days.



Alzheimer's Disease



What is NOT covered?

- Psychiatric illnesses and alcohol related brain damage.
- There is no significant reduction in mental and social functioning and does not require continuous supervision of the insured.
- Inability to perform less than three (3) ADLs for a continuous period of at least 180 days.
- Inability to perform at least three (3) ADLs lasts for less than 180 days.

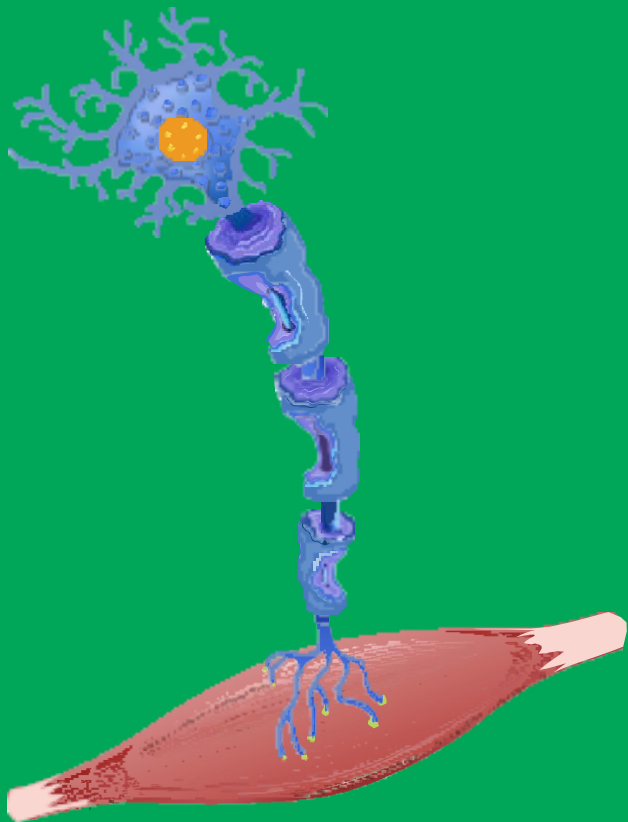


What are the requirements needed?

- ✓ Attending Physician Statement for Alzheimer's Disease [APS - Alzheimer's Disease (0710)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Caregiving questionnaire



Amyotrophic Lateral Sclerosis (ALS)



Definition

Unequivocal diagnosis by a consultant neurologist confirming well defined neurological deficit with persistent signs of involvement of the spinal nerve columns and the motor centers in the brain and with spastic weakness and atrophy of the muscles of the extremities.



What is covered?

Unequivocal diagnosis by a consultant neurologist confirming well defined neurological deficit with persistent signs of involvement of the spinal nerve columns and the motor centers in the brain and with spastic weakness and atrophy of the muscles of the extremities.

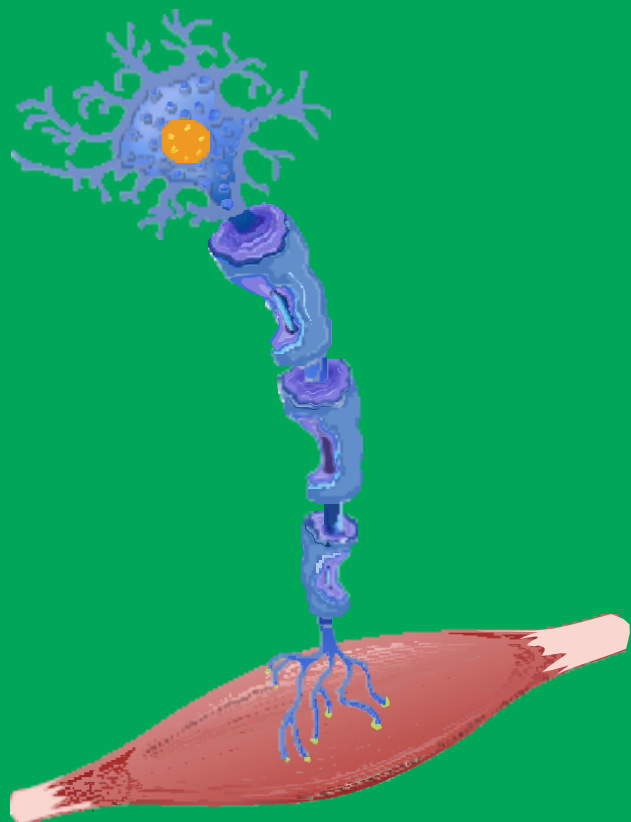


Amyotrophic Lateral Sclerosis (ALS)



What is NOT covered?

- Diagnosis of Amyotrophic Lateral Sclerosis that does not show well defined neurological deficit with persistent signs of involvement of the spinal nerve columns and the motor centers in the brain.
- No spastic weakness and atrophy of the muscles of the extremities.



What are the requirements needed?

- ✓ Attending Physician Statement for Amyotrophic Lateral Sclerosis [Amyotrophic Lateral Sclerosis (1009)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Electromyogram report (EMG)



Apallic Syndrome



Definition

An irreversible Apallic Syndrome or Unresponsive Wakefulness, caused by necrosis or permanent functional failure of the cerebral cortex, while brain stem functions remain intact.



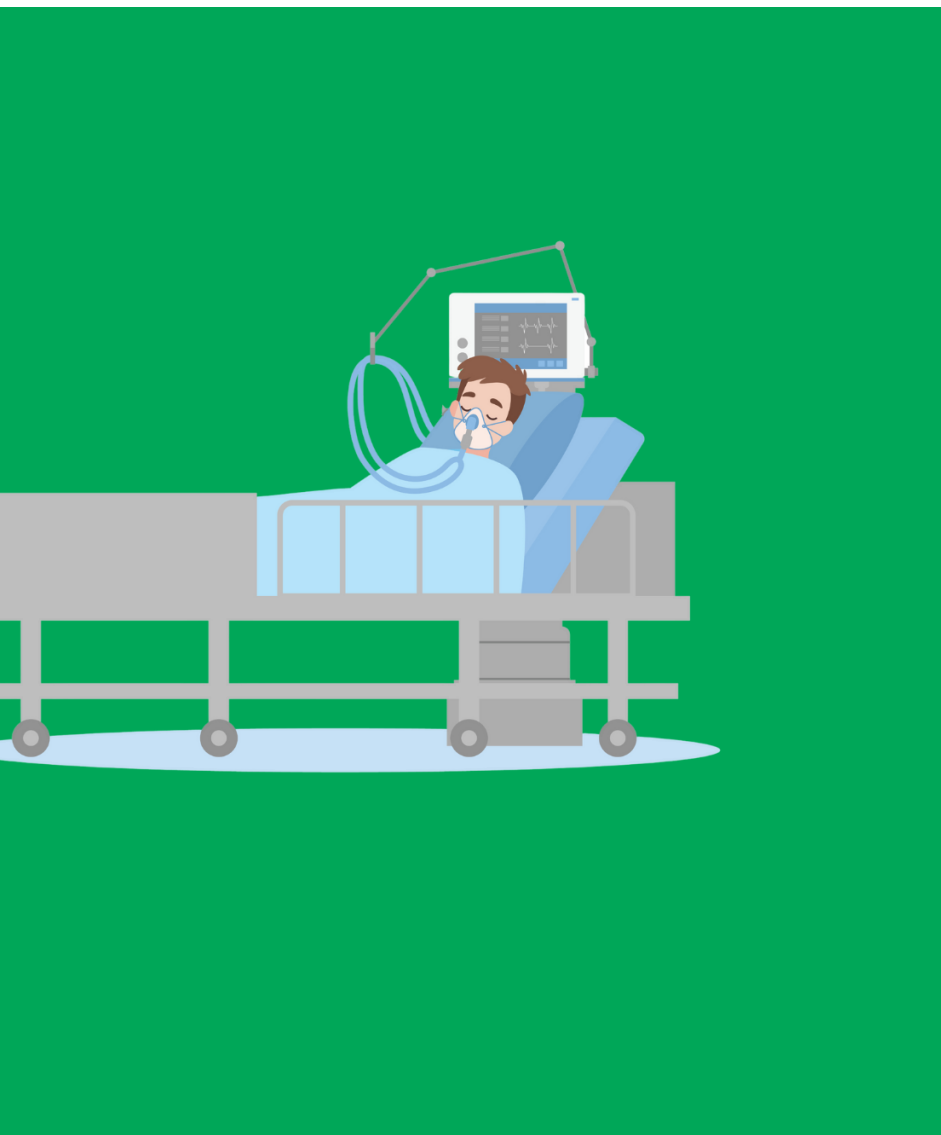
What is covered?

- This condition must be diagnosed by a neurologist and must be confirmed by clinical investigations such as a brain CT or MRI.
- The claimant must be under 24-hour medical supervision for one month or more.



What is NOT covered?

- Incomplete or no medical documentation
- Medically documented for less than one (1) month



Apallic Syndrome



What are the requirements needed?

- ✓ Attending Physician Statement for Apallic Syndrome confirmed by Neurologist [APS - Apallic Syndrome (0710)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility



Bacterial Meningitis



Definition

Bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in significant and permanent functional neurological impairment.



What is covered?

- Significant and permanent neurological impairment lasting for a minimum period of thirty (30) days.
- Diagnosis must be made by a consultant neurologist.
- Bacterial infection must be confirmed in the cerebrospinal fluid via a lumbar puncture.



Bacterial Meningitis

✕ What is NOT covered?

- All other forms of meningitis, including viral meningitis
- Neurological impairment lasting less than 30 days



What are the requirements needed?

- ✓ Attending Physician Statement form for Bacterial Meningitis from consultant neurologist [APS - Bacterial Meningitis (0710)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Lumbar puncture test result



Benign Brain Tumor



Definition

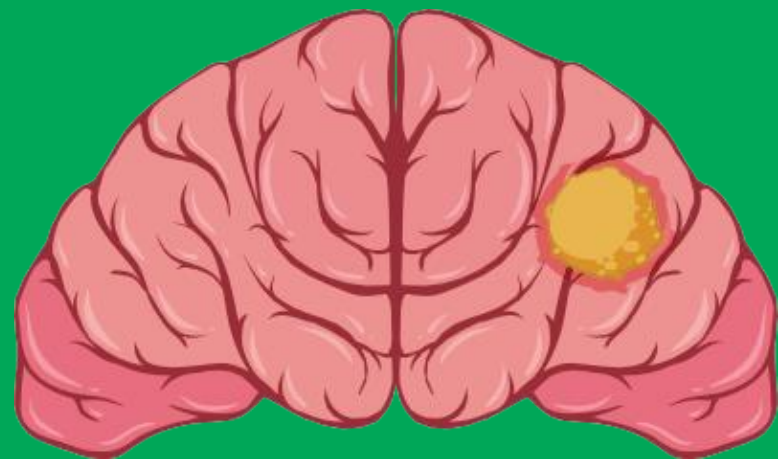
A non-malignant tumor in either the brain, meninges or cranial nerves



What is covered?

Must meet all of the following conditions:

- It is life threatening
- It has caused damage to the brain
- It has undergone surgical removal, or, if inoperable, has caused a permanent neurological deficit
- Its presence must be confirmed by a neurologist or neurosurgeon and supported by findings on Magnetic Resonance Imaging (MRI), Computerized Tomography, or other reliable imaging techniques

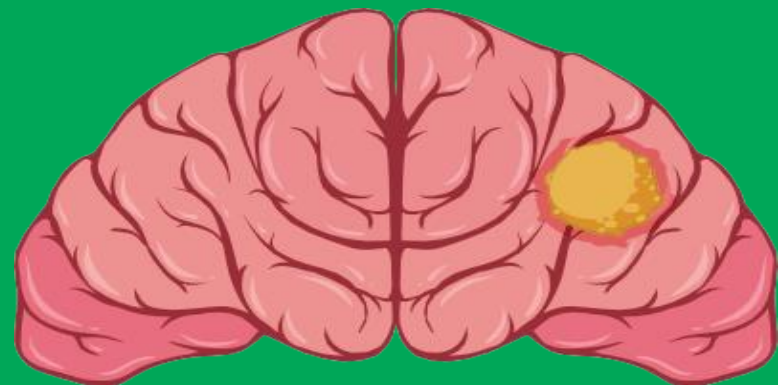


Benign Brain Tumor



What is NOT covered?

- Cysts
- Abscess
- Angioma
- Granuloma
- Vascular malformation
- Hematoma
- Tumors of the pituitary gland, spinal cord or skull base.



What are the requirements needed?

- ✓ Attending Physician Statement for Benign brain tumor [APS - Benign Brain Tumor (1009)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Histopathology / Biopsy
- ✓ Magnetic Resonance Imaging
- ✓ Record of Operation or Operative Record



Brain Surgery



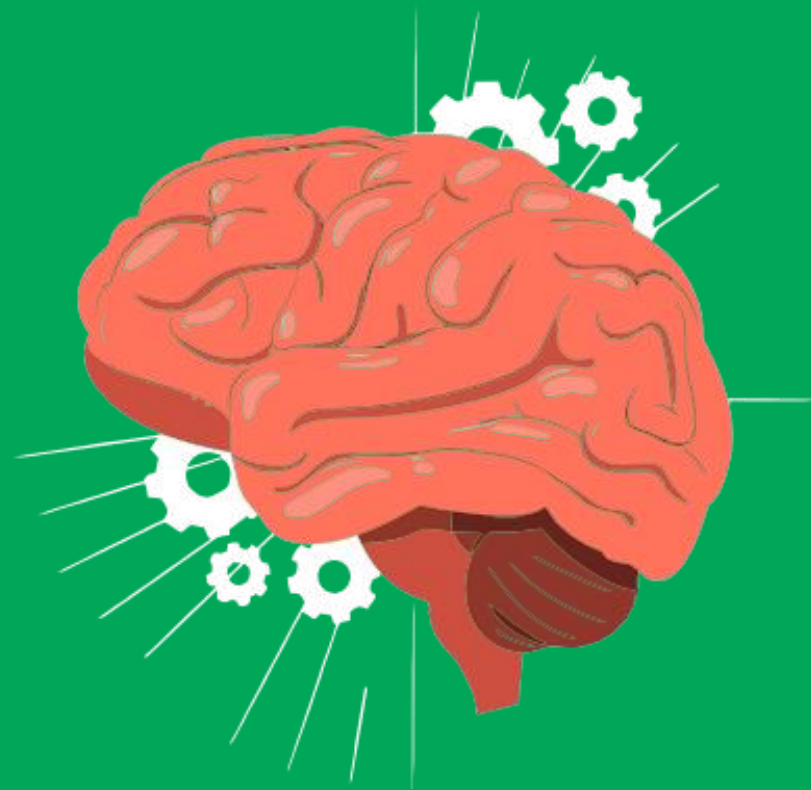
Definition

The actual undergoing of surgery to the brain under general anesthesia during which a craniotomy is performed.



What is covered?

- Keyhole surgery is included
- The procedure must be considered medically necessary and confirmed by a neurologist or neurosurgeon

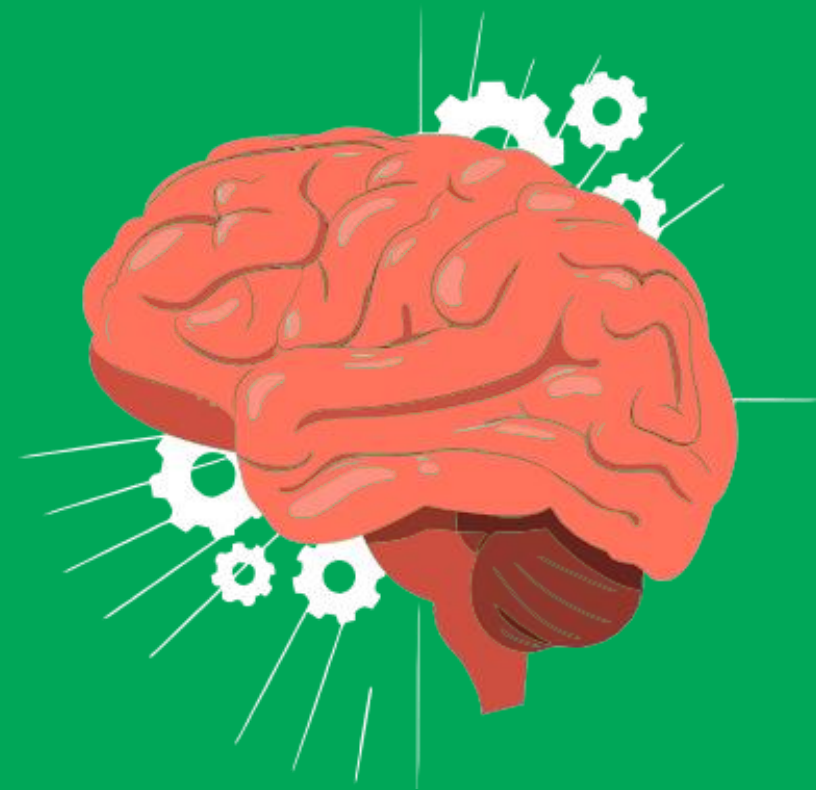


Brain Surgery



What is NOT covered?

- Transsphenoidal or Endoscopic assisted procedures
- Endovascular neuroradiological interventions such as embolization, thrombolysis and, stereotactic biopsy
- Minimally invasive treatment where surgical incision is performed to expose the target, such as irradiation by gamma knife.
- Brain surgery as a result of an accident



What are the requirements needed?

- ✓ Attending Physician Statement for Benign Brain Tumor [APS - Benign Brain Tumor (1009)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Record of Operation or Operative Record



Cerebral Aneurysm or Arteriovenous Malformation Requiring Surgery



Definition

Cerebral aneurysm, also known as brain aneurysm, is a bulge or ballooning in a blood vessel, while arteriovenous malformation (AVM) is a tangle of blood vessels in the brain. Both cerebral aneurysm and arteriovenous malformation are like ticking time bombs that may rupture at any time and may cause massive bleeding, leading to stroke and even sudden death.



What is covered?

Early CI Benefit covers two types of brain surgery:

- Intracranial surgery, also known as open craniotomy, where a piece of the skull will be surgically opened to clip, repair or remove a cerebral aneurysm or arteriovenous malformation.
- Gamma Knife radiosurgery (radiation instead of open surgery) where tiny beams of radiation are aimed at the target arteriovenous malformation



Cerebral Aneurysm or Arteriovenous Malformation Requiring Surgery

✕ What is NOT covered?

- Cerebral aneurysm or arteriovenous malformation in the brain without the need for surgery
- Any other surgical procedure that does not include intracranial surgery or Gamma Knife radiosurgery

What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Benign Brain Tumor [APS – Benign Brain Tumor (1009)] accomplished by the insured's attending doctor Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Record of Operation or Operative Record - craniotomy or Gamma Knife radiosurgery



Cerebral Shunt insertion



Definition

Cerebrospinal fluid is a clear, colorless, watery fluid that flows in and around the brain and spinal cord and serves as a cushion from sudden impact or injury.

If there is an excess cerebrospinal fluid in the brain (hydrocephalus) caused by an injury or brain tumor, this will put harmful pressure on the brain tissue, which could lead to permanent brain damage or even sudden death when left untreated.

A cerebral shunt is a thin plastic tube placed in the brain to help drain the excess cerebrospinal fluid and redirects it to the abdomen, lungs, or heart to help relieve the raised pressure in the brain. The surgical implantation of the shunt is expensive, and the implanted shunt can get worn out or infected at any time, which may lead to another costly hospitalization.



Cerebral Shunt insertion



What is covered?

The actual insertion of a cerebral shunt needed to relieve the increased pressure in the brain must have been performed.



What is NOT covered?

Cerebral shunt insertion for hydrocephalus arising from a congenital condition



Cerebral Shunt insertion



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Disease/Critical Illness – Others [APS – Others] accomplished by the insured's attending doctor
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Record of operation or Operative Record
- ✓ Results of brain imaging tests such as MRI, CT Scan



Coma



Definition

A coma that persists for at least 96 hours.



What is covered?

The diagnosis must be supported by evidence of all of the following:

- a. No response to external stimuli for at least 96 hours;
- b. Life support measures are necessary to sustain life; and
- c. Brain damage resulting in permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.



Coma

✕ What is NOT covered?

- Coma resulting directly from alcohol or drug abuse
- Medically induced coma
- Coma lasting less than 96 hours
- Not all criteria are satisfied

What are the requirements needed?

- ✓ Attending Physician Statement for Coma [APS - Coma (1009)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Complete Neurological examination report



Creutzfeldt-Jacob Disease (CJD)



Definition

An incurable brain infection that causes rapidly progressive deterioration of mental function and movement.



What is covered?

- A neurologist must make a definite diagnosis of Creutzfeldt-Jacob disease based on clinical assessment, EEG and imaging.
- There must be objective neurological abnormalities on exam along with severe progressive dementia.



Creutzfeldt-Jacob Disease (CJD)

✕ What is NOT covered?

Diagnosis of Creutzfeldt-Jacob Disease (CJD) that does not show neurological abnormalities on exam along with severe progressive dementia.

What are the requirements needed?

- ✓ Attending Physician Statement form for Creutzfeldt-Jacob Disease [APS - Creutzfeldt-Jacob Disease (CJD) (0710)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Electroencephalogram (EEG) result
- ✓ CT scan / MRI result
- ✓ Complete Neurological examination



Encephalitis



Definition

Diagnosis of severe inflammation of the brain, associated with viral infections



What is covered?

- The inflammation must result in permanent functional neurological impairment confirmed by a neurologist lasting at least 30 days
- The permanent neurological impairment includes, but is not limited to mental retardation and paralysis.



Encephalitis

✕ What is NOT covered?

- Encephalitis resulting from HIV infection
- Functional neurological impairment lasts less than 30 days



What are the requirements needed?

- ✓ Attending Physician Statement form for Others [APS – Others]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Care giving questionnaire form
- ✓ Complete Neurological Examination Report



Endovascular Treatment of Cerebral Aneurysm



Definition

Cerebral aneurysm, also known as brain aneurysm, is a bulge or ballooning of a blood vessel. Did you know that a sudden, severe headache can be related to a cerebral aneurysm? They form and grow when blood flowing through the blood vessel puts pressure on the weak area of the vessel wall, which may rupture at any time and cause bleeding in the brain (stroke). This is a life-threatening condition that can lead to sudden death.



What is covered?

Early CI Benefit covers less invasive endovascular interventions to treat cerebral aneurysm rather than intracranial surgery, such as:

- Endovascular embolization, coiling, angioplasty and/or stenting (mesh tubes) or the insertion of a flow diverter which is needed to prevent the rupture of a cerebral aneurysm or to stop the bleeding of a ruptured aneurysm



Endovascular Treatment of Cerebral Aneurysm



What is NOT covered?

- Cerebral aneurysm without the need for endovascular treatment
- Any other surgical procedure that does not include endovascular treatment

What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Disease/Critical Illness – Others [APS – Others] accomplished by the insured's attending doctor
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Record of Operation or Operative Record - endovascular intervention
- ✓ Results of imaging test such as CT Angiography, Magnetic Resonance Angiography (MRA)



Less Severe Bacterial Meningitis



Definition

Did you know that meninges are membranes that act as shock absorbers and protectors of the brain and spinal cord? Meningitis is the inflammation (swelling) of the meninges of the brain or spinal cord and puts pressure on the brain or spinal cord. Meningitis can be caused by a virus or bacterial infection.

Only meningitis caused by bacterial infection is covered in Early CI, as bacterial meningitis is more serious, fatal, and can lead to permanent brain damage or paralysis, whereas viral meningitis can be resolved in a week even without treatment.

Less severe bacterial meningitis, even without permanent symptoms, can already be covered by the Early CI Benefit.



Less Severe Bacterial Meningitis



What is covered?

Benefits would be payable if all the following conditions are met:

- A final diagnosis of bacterial meningitis confirmed by a neurologist
- In-patient treatment (hospitalization)



What is NOT covered?

- Viral meningitis
- Meningitis not caused by bacterial infection (e.g., certain drugs, injuries)
- Bacterial meningitis in the presence of HIV



Less Severe Bacterial Meningitis



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Bacterial Meningitis [APS – Bacterial Meningitis (0710)] accomplished by the insured's neurologist
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Lumbar puncture test result



Less Severe Coma



Definition

Coma is a severe medical emergency with a deep state of prolonged unconsciousness and unresponsiveness. During a coma, the brain is unresponsive and cannot be awakened by any kind of external stimuli, such as sound, touch, sensation, or even pain.

Depending on the severity of the brain injury, a coma may persist for at least 96 hours and may progressively lead to brain damage resulting in permanent symptoms.

Less severe coma lasting for at least 48 hours, even without permanent symptoms, can already be covered by the Early CI Benefit.



Less Severe Coma



What is covered?

Benefits are payable if all the following conditions are met:

- The coma lasts for at least 48 hours
- There is no response to external stimuli
- Mechanical life support is required (machines to sustain life)



What is NOT covered?

- Coma caused by alcohol or drug abuse
- Medically induced coma (temporary coma brought on by anesthesia)



Less Severe Coma



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Coma [APS – Coma (1009)] accomplished by the insured's attending doctor
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Complete Neurological examination report



Less Severe Encephalitis



Definition

The brain is the control center of the body. It is composed of three major parts: cerebral hemisphere (right and left), brainstem, and cerebellum. When an infection spreads to the brain, it results in encephalitis or inflammation of the brain.

Encephalitis is most often caused by a viral infection and can be life-threatening if not treated early. Severe encephalitis may lead to symptoms persisting for at least six (6) weeks.

Less severe encephalitis requiring hospitalization, can already be covered by the Early CI Benefit even if there are no permanent symptoms.



Less Severe Encephalitis



What is covered?

A final diagnosis of viral encephalitis confirmed by a neurologist or specialist doctor requiring in-patient treatment (hospitalization)



What is NOT covered?

- Bacterial encephalitis
- Encephalitis in the presence of HIV



Less Severe Encephalitis



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician Statement form for Others [APS – Others]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Lumbar puncture (fluid sample is taken from the spine and checked for viral infection)
- ✓ Results of imaging test such as brain CT Scan, MRI



Major Head Trauma



Definition

Accidental head injury resulting in permanent neurological deficit to be assessed no sooner than six (6) weeks from date of the accident.



What is covered?

- Accidental head injury resulting in permanent neurological deficit to be assessed **no sooner than six (6) weeks from date of the accident.**
- The injury must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.



Major Head Trauma

✕ What is NOT covered?

- Spinal cord injury
- Head injury due to any other causes
- Injury resulting in temporary neurological deficit
- Injury not caused solely and directly by accidental, violent, external and visible means.

What are the requirements needed?

- ✓ Attending Physician Statement for Other [APS – Others]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ MRI/Computerized tomography or other reliable imaging techniques
- ✓ Complete Neurological exam report
- ✓ Police report



Multiple Sclerosis



Definition

A disease due to demyelination of neurological brain tissue.



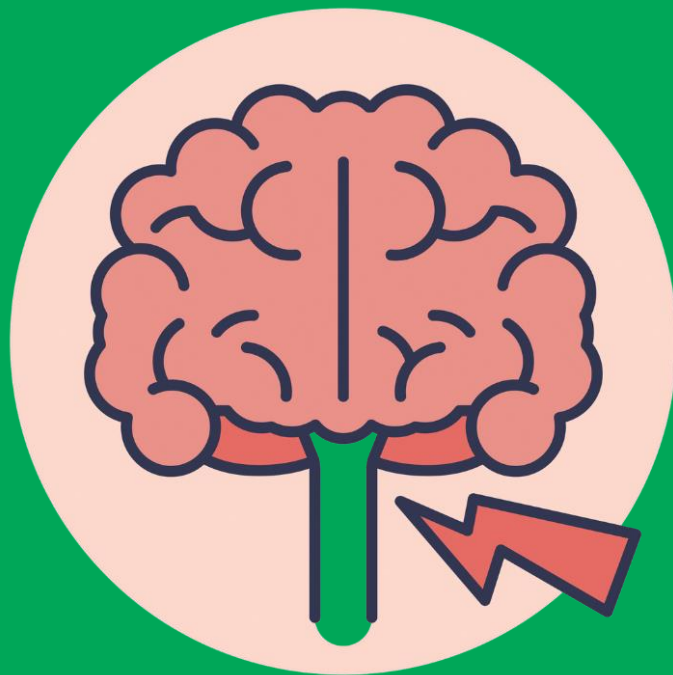
What is covered?

There must be evidence of permanent neurological signs which have persisted for a continuous period of at least six (6) months.



What is NOT covered?

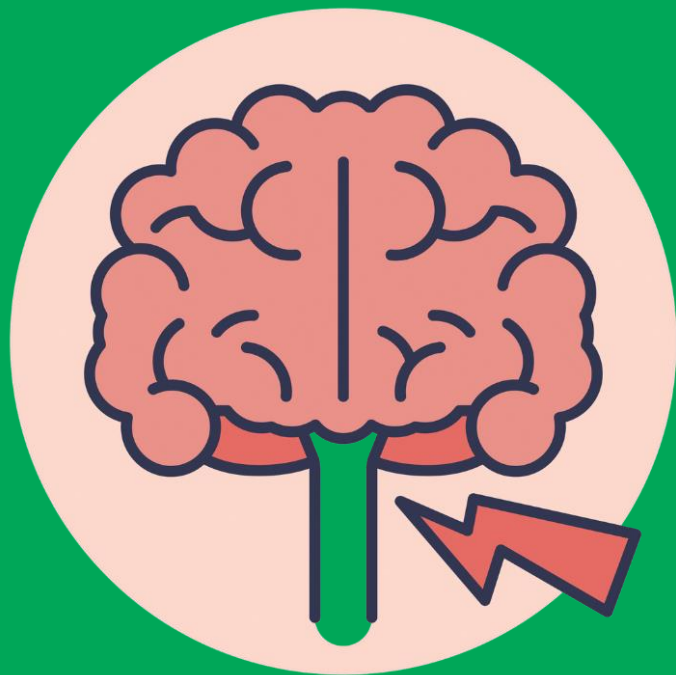
- Other causes of neurological damage such as Systemic Lupus Erythematosus (SLE) and Human Immunodeficiency Virus (HIV)
- Neurological signs persist for less than six (6) months



Multiple Sclerosis

What are the requirements needed?

- ✓ Attending Physician Statement for Multiple Sclerosis [APS – Multiple Sclerosis (1009)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Copy of MRI, computerized tomography or other reliable imaging techniques
- ✓ Complete Neurological Examination Report



Myasthenia Gravis



Definition

An acquired autoimmune disorder of neuromuscular transmission leading to fluctuating muscle weakness and fatigability.



What is covered?

All of the following must be met:

- Presence of permanent muscle weakness categorized as Class IV or V according to the Myasthenia Gravis Foundation of America Clinical Classification below; and
- The Diagnosis of Myasthenia Gravis and categorization are confirmed by a neurologist.



Myasthenia Gravis



What is covered?

- Myasthenia Gravis Foundation of America Clinical Classification:
 - Class I: Any eye muscle weakness, possible ptosis, no other evidence of muscle weakness elsewhere.
 - Class II: Eye muscle weakness of any severity, mild weakness of other muscles.
 - Class III: Eye muscle weakness of any severity, moderate weakness of other muscles
 - Class IV: Eye muscle weakness of any severity, severe weakness of other muscles.
 - Class V: Intubation needed to maintain airway.



Myasthenia Gravis

✕ What is NOT covered?

Muscle weakness falls under classes I to III only.



What are the requirements needed?

- ✓ Attending Physician Statement form for Others [APS – Others]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Medical Certificate indicating Myasthenia Gravis class



Parkinson's Disease



Definition

Degenerative disease of the central nervous systems as a result of loss of pigment containing neurons of the brain.



What is covered?

There must be an unequivocal diagnosis by a consultant neurologist where the condition:

- Cannot be controlled with medication
- Shows signs of progressive impairment; and
- There is the permanent inability to perform, without any form of assistance, three (3) of the six (6) Activities of Daily Living

Only idiopathic Parkinson's Disease is covered.



Parkinson's Disease

✕ What is NOT covered?

- Drug induced or toxic causes of Parkinsonism.
- The condition is controlled through medication.
- There are no signs of progressive impairment.
- The insured was unable to perform at least three (3) ADLs



What are the requirements needed?

- ✓ Attending Physician's Statement Parkinson's Disease [APS-Parkinson's Disease (1109)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Care giving questionnaire



Poliomyelitis



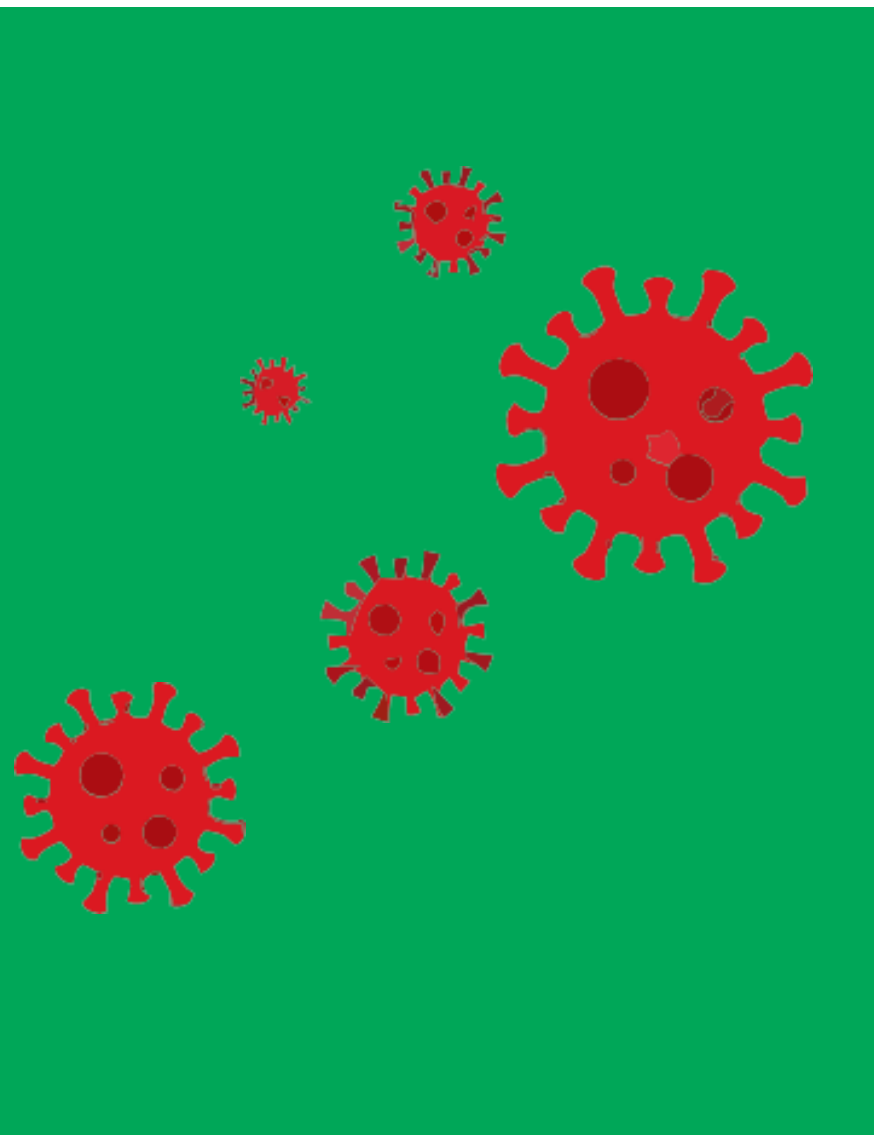
Definition

Unequivocal diagnosis by a consultant neurologist of acute infection by the polio virus leading to paralytic disease as evidenced by impaired motor function or respiratory weakness that must persist for at least three months.



What is covered?

- Unequivocal diagnosis by a consultant neurologist of acute infection by the polio virus leading to paralytic disease as evidenced by impaired motor function or respiratory weakness that must persist for at least three months.
- The polio virus must be identified as the cause of paralytic disease as evidenced by impaired motor function or respiratory weakness that must persist for at least three months



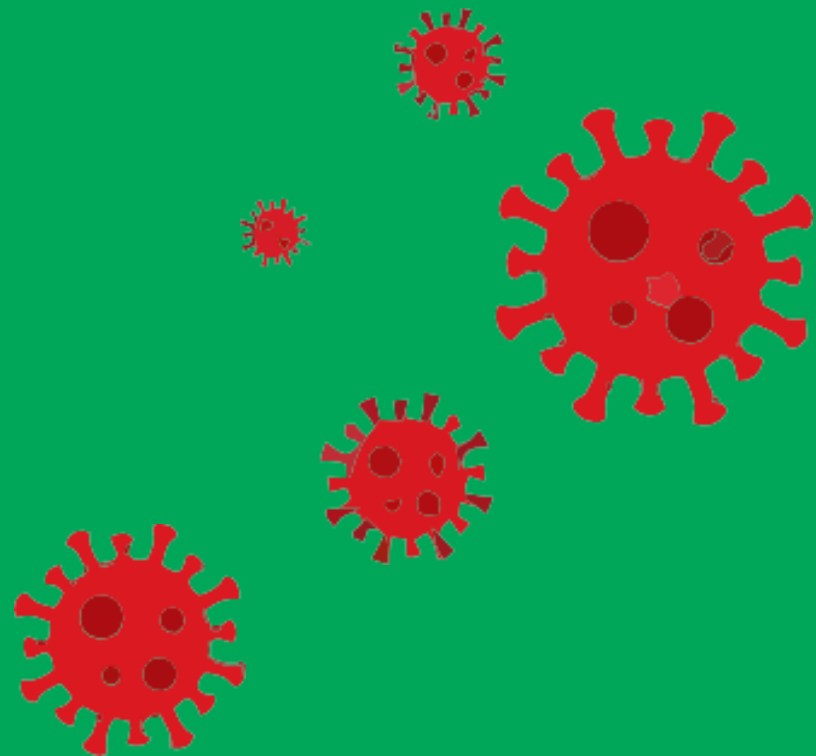
Poliomyelitis

✕ What is NOT covered?

- Cases not involving paralysis
- Motor function or respiratory weakness lasts for less than three (3) months
- Paralysis not caused by the polio virus

What are the requirements needed?

- ✓ Attending Physician Statement for Poliomyelitis signed by a Neurologist [APS-Poliomyelitis (1109)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement.
- ✓ Complete Neurological examination report



Progressive Supranuclear Palsy



Definition

Progressive supranuclear palsy resulting independently of all other causes with unequivocal diagnosis made by a consultant neurologist.



What is covered?

The condition must result in:

- a neurological deficit
- the permanent inability to perform, without any form of assistance, at least three (3) of the six (6) Activities of Daily Living



Progressive Supranuclear Palsy

✕ What is NOT covered?

The condition does not result in permanent inability to perform, without any form of assistance, at least three (3) of the six (6) Activities of Daily Living

What are the requirements needed?

- ✓ Attending Physician Statement form for Others [APS – Others]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Complete Neurological Examination Report
- ✓ Caregiving questionnaire



Stroke



Definition

An acute cerebrovascular event including infarction of brain tissue, cerebral, subarachnoid hemorrhage, cerebral embolism, or cerebral thrombosis resulting in permanent neurological impairment.



What is covered?

All of the following conditions must be met:

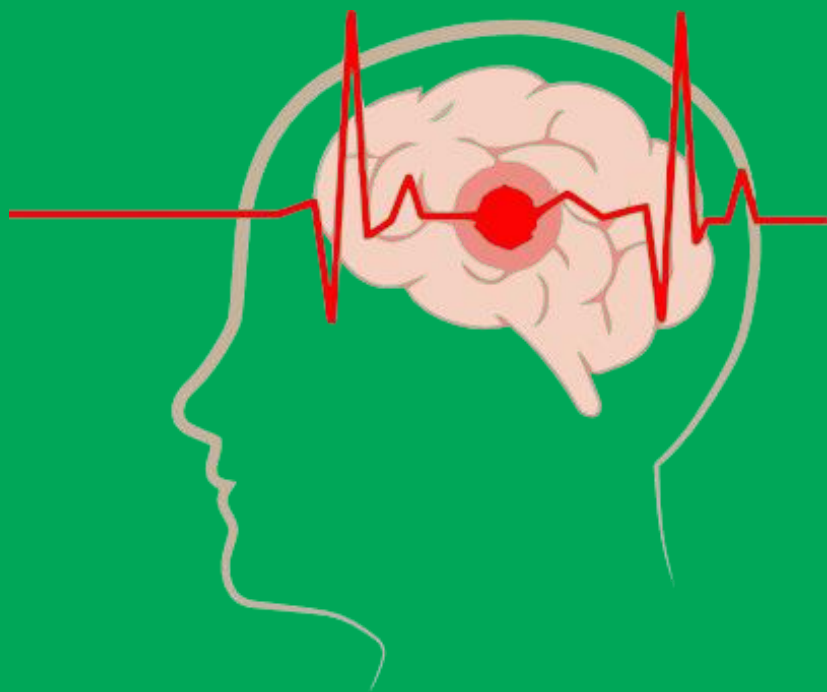
1. Clinical evidence of a new neurological and functional impairment must be present.
2. The impairment must be supported by results from a brain CT scan or MRI.
3. A neurologist must confirm the diagnosis at least 30 days after the initial event.



Stroke

✕ What is NOT covered?

- Transient ischemic attacks or reversible ischemic neurological events
- Brain damage or vascular event due to an injury or infection
- Disorders of the optic nerve or the blood vessels affecting the eye
- Ischemic disorders of the vestibular system
- Microvascular ischemia



What are the requirements needed?

- ✓ Attending Physician Statement form for Stroke signed by a Neurologist [at least 6 weeks after the event] [APS - Stroke (0809)]
- ✓ Latest MRI or CT Scan result
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement



Surgery for Idiopathic Scoliosis



Definition

Surgery for idiopathic scoliosis with spinal surgery to recorrect abnormal spine curvature to its normal shape (as a straight line viewed from the back).

This scoliosis condition means that the spine curve position is more than 40 cobb angle degrees.



What is covered?

Surgery where the spine curve position is more than 40 cobb angle degrees.



Surgery for Idiopathic Scoliosis



What is NOT covered?

Spine curve position is less than 40 cobb angle degrees.



What are the requirements needed?

- ✓ Attending Physician Statement form for Others [APS – Others]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Record of Operation or Operative Record
- ✓ X-ray result showing spine curve position



Surgery for Subdural Hematoma



Definition

A subdural hematoma is a buildup of blood in the covering of the brain, called subdural space (within the skull), but outside the brain tissue, which is usually caused by a head injury.

Large subdural hematomas are dangerous and potentially life-threatening, as they may cause pressure on the brain if not immediately treated. Burr Hole surgery, where a small hole is drilled in the skull and a flexible tube is used to drain the hematoma, is the common surgical procedure to treat this condition



Surgery for Subdural Hematoma



What is covered?

The Burr Hole surgery needed to drain subdural hematoma in the brain due to an accident, must have been done



What is NOT covered?

- Self-inflicted injuries
- Subdural hematoma due to illness
- Hemophilia (an inherited blood disorder)

Surgery for Subdural Hematoma



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Disease/Critical Illness – Others [APS – Others] accomplished by the insured's attending doctor
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Record of Operation or Operative Record - Burr Hole Surgery
- ✓ Police report / Traffic Accident Report or Incident report



Surgical Removal of Pituitary Tumor

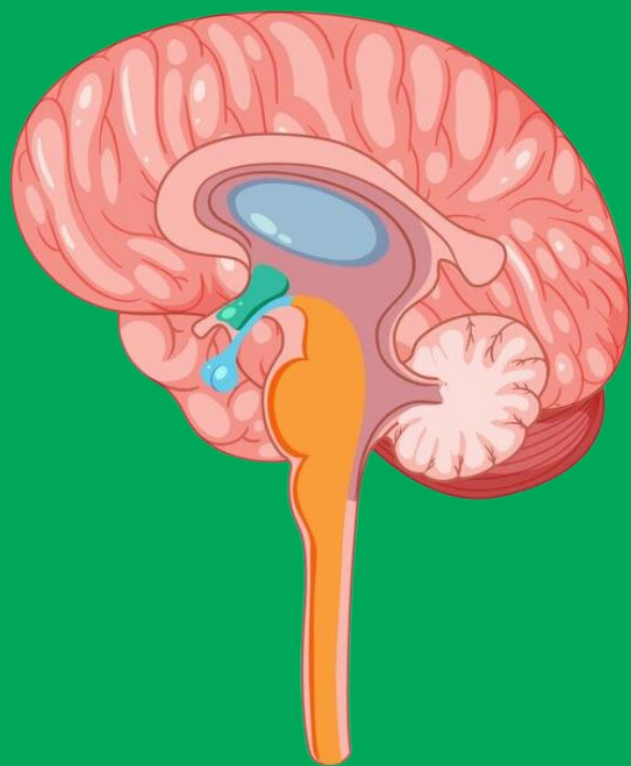


Definition

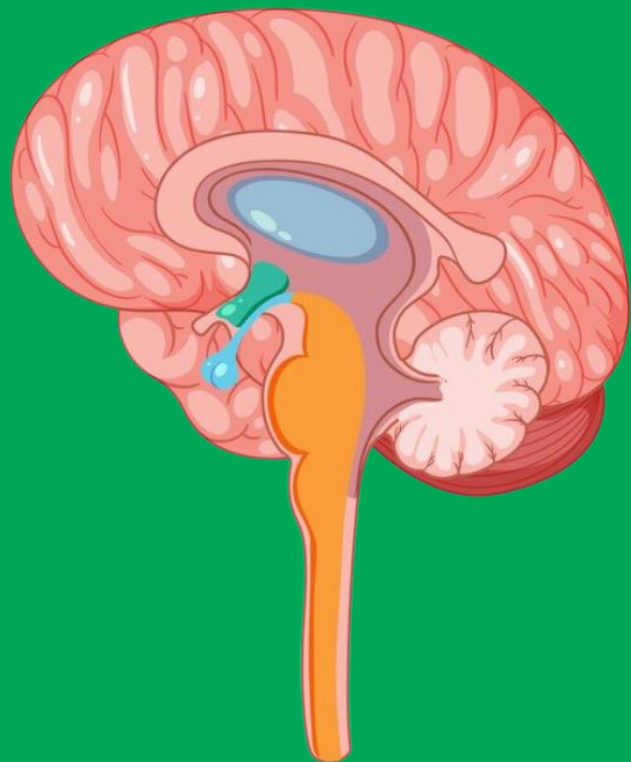
Although the pituitary gland is as small as a pea, it is called the ‘master’ gland because it commands and controls the activity of most other glands in the body to regulate its vital functions. It is located at the base of the brain, just behind the tip of the nose.

Pituitary tumors (adenomas) are usually benign growths that develop in the pituitary gland and may cause too much or too little production of pituitary hormones. A microadenoma is a very small pituitary tumor that does not need any surgical treatment if there are no symptoms.

However, macroadenoma, a large pituitary tumor, may grow larger over time, causing pressure (intracranial pressure) on nearby nerves and the brain. This is when a surgical removal of the pituitary tumor is necessary, which is a covered condition in the Early CI Benefit.



Surgical Removal of Pituitary Tumor



What is covered?

The actual procedure of undergoing a surgical removal of a pituitary tumor must have been performed, which is needed to relieve the increased pressure in the brain and treat hormonal imbalance (endocrine disorder).

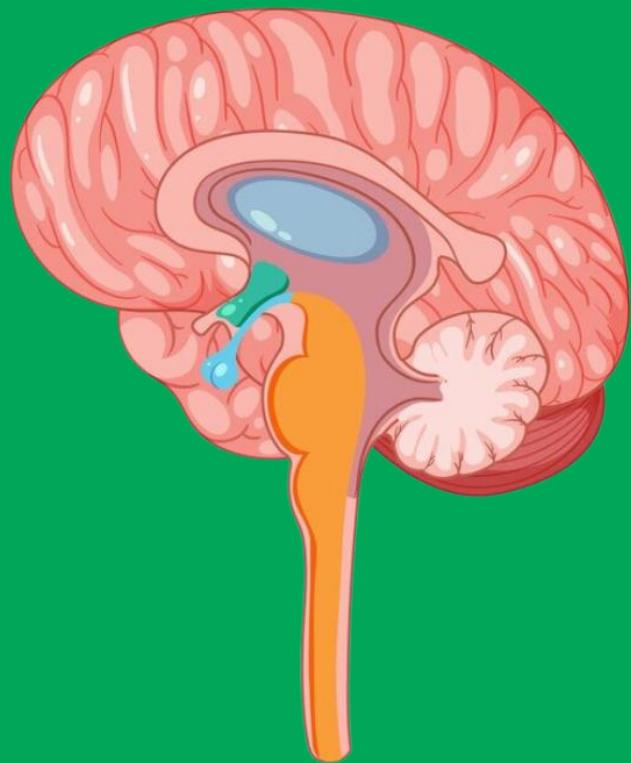


What is NOT covered?

- Surgical excision of pituitary microadenoma (tumor of size 8mm or below)
- Pituitary tumor without surgical removal



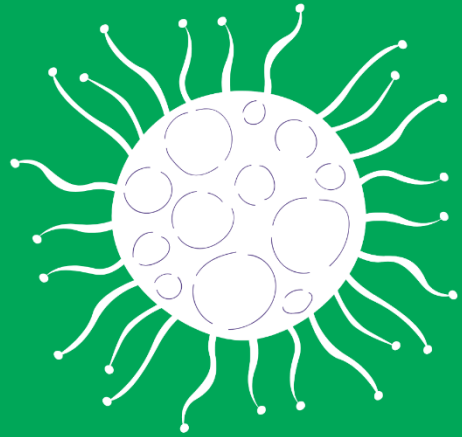
Surgical Removal of Pituitary Tumor



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Disease/Critical Illness – Others [APS – Others] accomplished by the insured's attending doctor
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Record of Operation or Operative Record - Removal of pituitary tumor
- ✓ Results of brain imaging tests such as MRI Scan or CT Scan





Oncological Conditions and Early- Stage Cancers

Cancer



Description

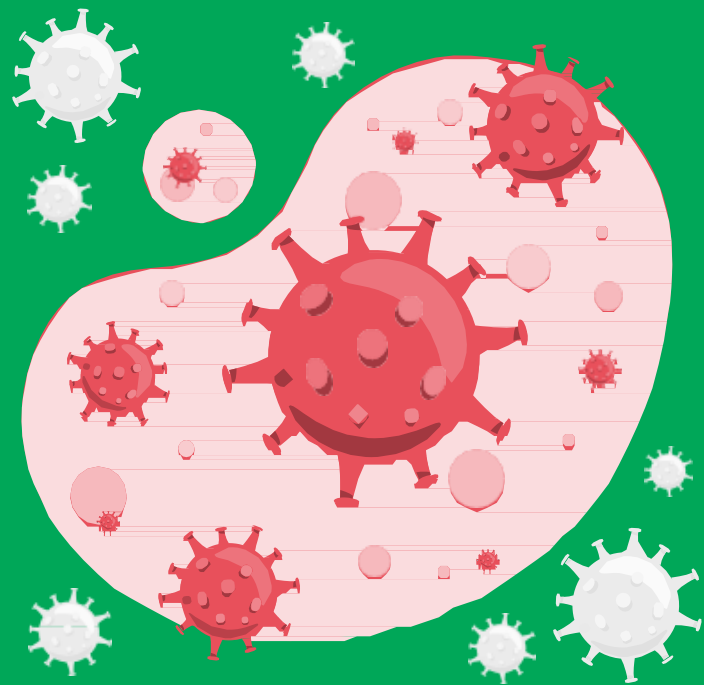
A malignant tumor positively diagnosed with histological confirmation and characterized by the uncontrolled growth of malignant cells with invasion and destruction of normal tissue. The term malignant tumor includes leukemia, lymphoma and sarcoma.



What is covered?

Cancer is covered beginning Stage 1 **except** for the following:

- Prostate Cancer (Covered starting Stage 2)
- Thyroid Cancer (Covered starting Stage 2)
- Urinary bladder tumors (Covered starting Stage 2)
- Gastro-intestinal stromal tumors (Covered starting Stage 2)
- Certain types of skin cancers (refer to number 4b and 4c of contract)
- Chronic Lymphocytic Leukemia (covered starting RAI Stage 3)



Cancer

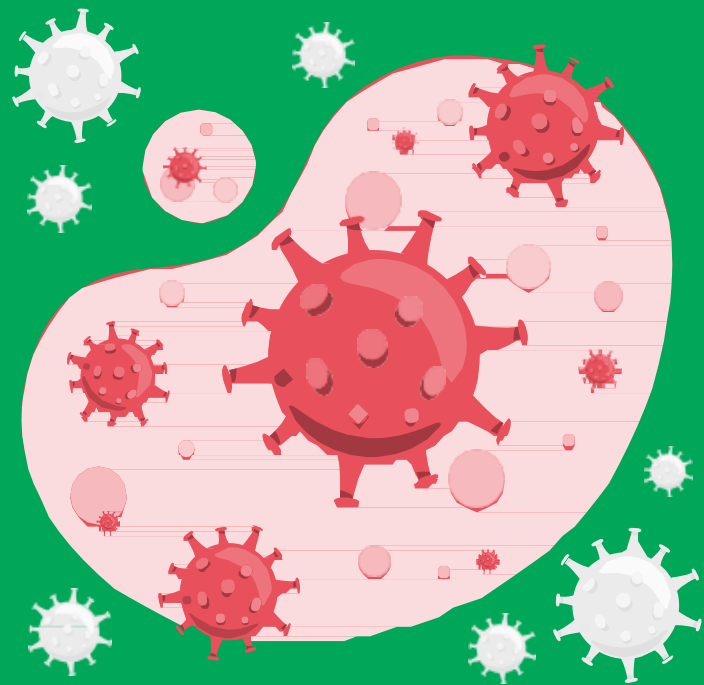
✕ What is NOT covered?

All tumors which are histologically classified as any of the following:

- Pre-malignant;
- Non-invasive;
- Carcinoma-in-situ;
- Having borderline malignancy;
- Having any degree of malignant potential; Having suspicious malignancy;
- Neoplasm of uncertain or unknown behavior;
- Cervical Dysplasia CIN-1, CIN-2 and CIN-3;

Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;

Malignant melanoma that has not caused invasion beyond the epidermis;

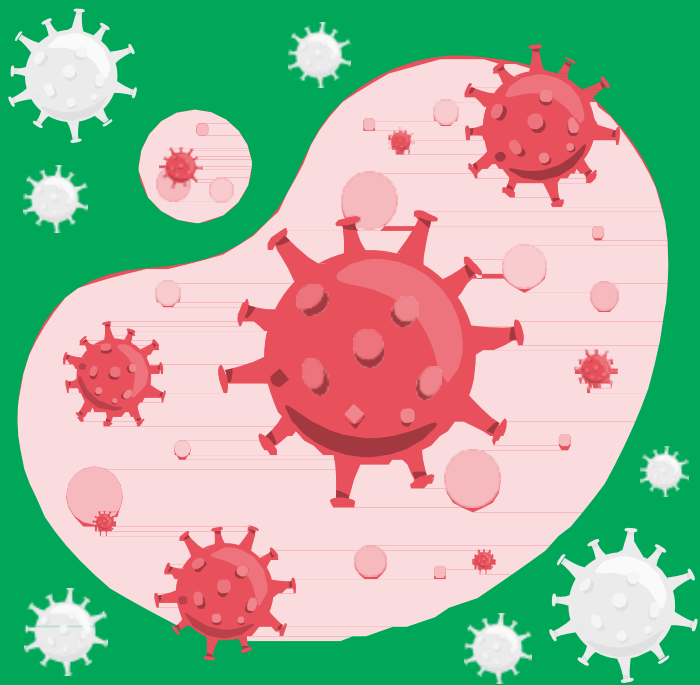


Cancer



What is NOT covered?

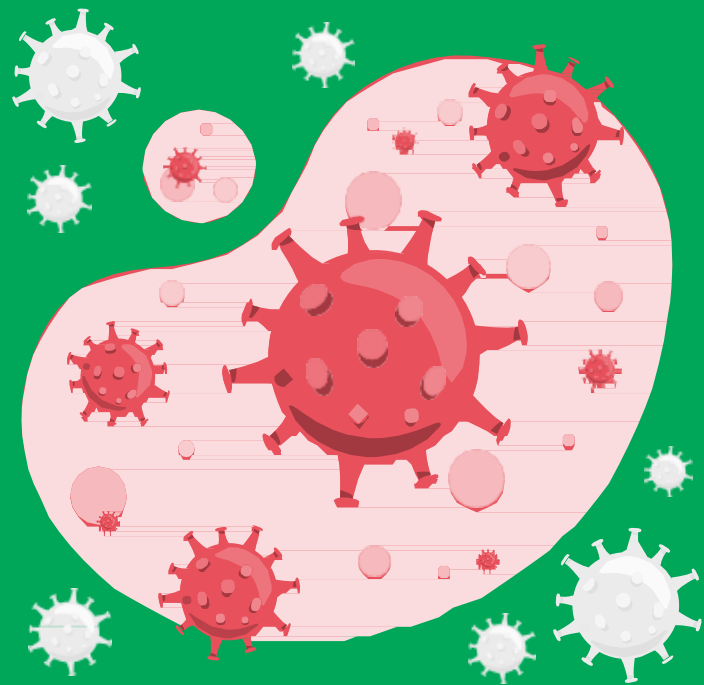
- All Prostate cancers histologically described as T1N0M0 (TNM Classification) or below; or
- Prostate cancers of another equivalent or lesser classification;
- All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- All tumors of the Urinary Bladder histologically classified as T1N0M0 (TNM Classification) or below;
- All Gastro-Intestinal Stromal tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
- Chronic Lymphocytic Leukemia less than RAI Stage 3; and
- All tumors in the presence of HIV infection.



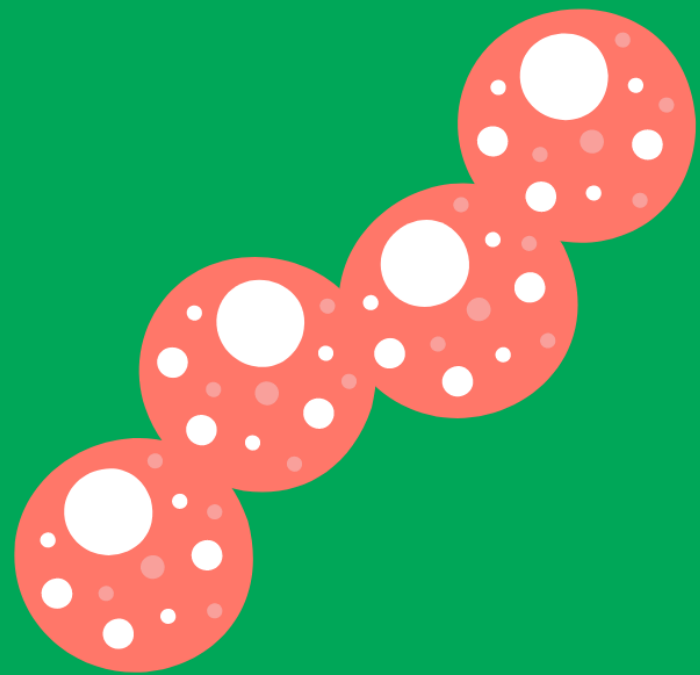
Cancer

What are the requirements needed?

- ✓ Attending Physician Statement form for Cancer [APS - Cancer (0809)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Histopathology or Biopsy Result



Carcinoma -in-situ (Stage 0 Cancer)



Definition

Carcinoma-in-situ is a group of abnormal cells that has not spread beyond where it was first formed (in-situ) to another part of the body. It is not cancer, and it is not malignant (no invasion and/or active destruction of normal tissue). With medical advances, carcinoma-in-situ is less serious compared to cancer, since this can now be easily treated before it becomes cancerous.

Carcinoma-in-situ requires an expensive treatment, which is why it is eligible for Early CI Benefits, with a partial payout for certain organs where carcinoma-in-situ is most common.



Carcinoma -in-situ (Stage 0 Cancer)



What is covered?

- Carcinoma-in-situ benefit is limited to these organs:
 - a. Breast
 - b. Cervix uteri or uterus
 - c. Colon and rectum
 - d. Liver
 - e. Lung
 - f. Nasopharynx
 - g. Ovary or fallopian tube
 - h. Penis
 - i. Stomach and esophagus
 - j. Testicles
 - k. Urinary tract (including carcinoma-in-situ of the urinary bladder)
 - l. Vagina

(Organs with left and right components shall be considered one and the same organ)

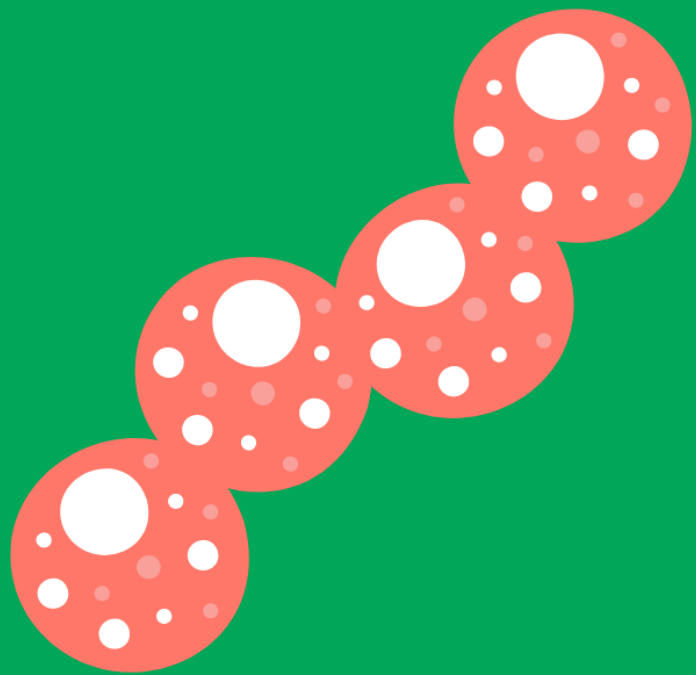


Carcinoma -in-situ (Stage 0 Cancer)



What is covered?

- A final diagnosis of carcinoma-in-situ must be confirmed by a histopathology report (biopsy result)
- For carcinoma-in-situ of the cervix uteri, the final diagnosis must be confirmed by a cone biopsy or colposcopy with cervical biopsy results.
- For carcinoma-in-situ of the uterus, the final diagnosis must be classified as TisN0M0, where Tis is indicative of carcinoma-in-situ, N0 means it has not spread to the lymph nodes, and M0 means it has not spread to other parts of the body.

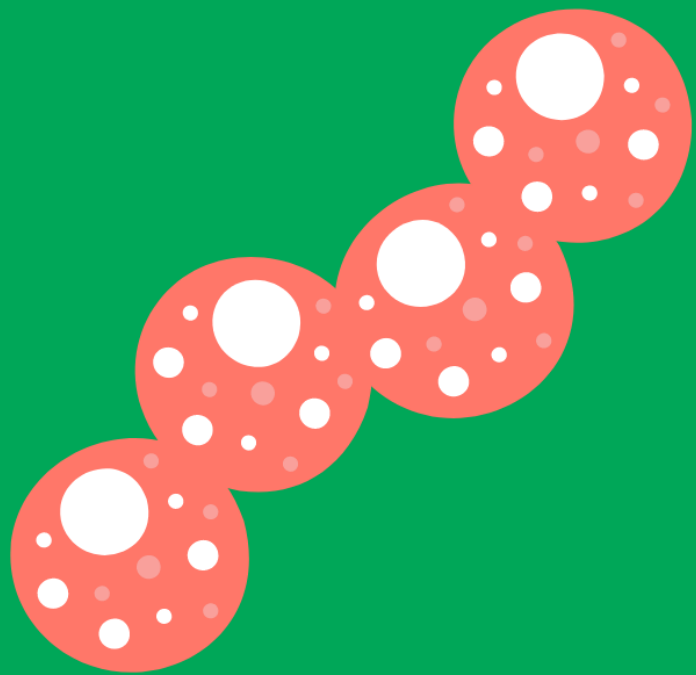


Carcinoma -in-situ (Stage 0 Cancer)



What is covered?

- For carcinoma-in-situ of the ovary, the final diagnosis must be classified as T1aN0M0, where T1a is indicative of carcinoma-in-situ where the surgically removed ovary has an intact capsule with no spread of abnormal cells on the surface of the ovary, N0 means no spread to the lymph nodes, and M0 means no spread to other parts of the body.
- For carcinoma-in-situ of the fallopian tube, the final diagnosis must be classified as Tis, where Tis is indicative of carcinoma-in-situ which is confined to its lining (mucosa) and has not yet spread to other parts of the fallopian tube.
- For carcinoma-in-situ of the vagina, the final diagnosis must be classified as Tis, where Tis or FIGO 0 which are both indicative of carcinoma-in-situ.

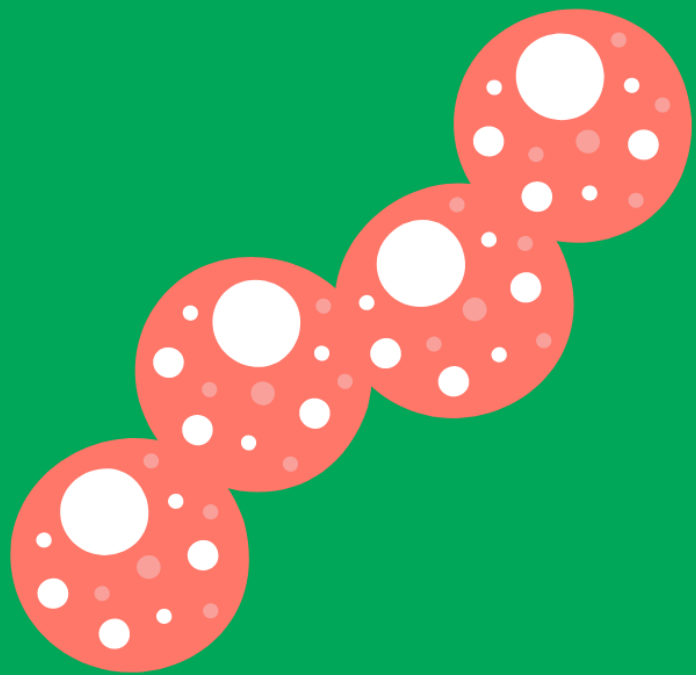


Carcinoma -in-situ (Stage 0 Cancer)



What is NOT covered?

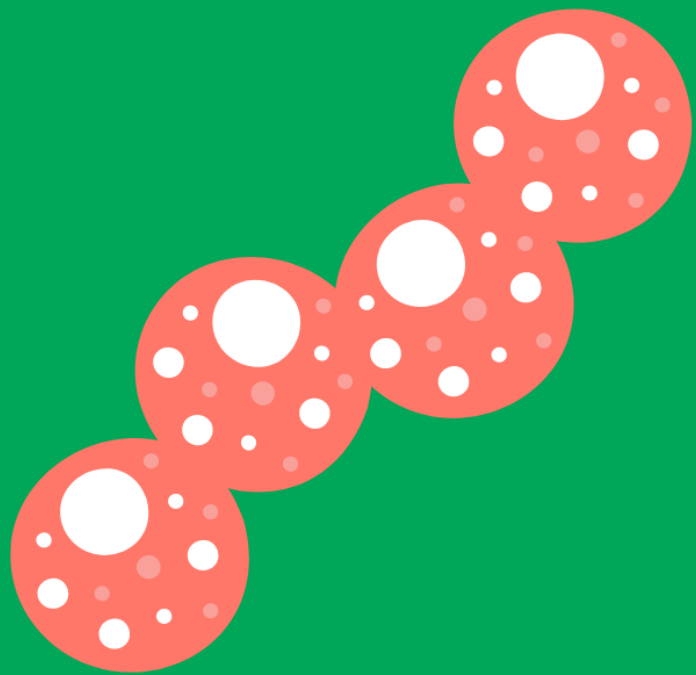
- Carcinoma-in-situ of organs not listed above.
- Cervix uteri dysplasia (classified as CIN I and CIN II through pap smear) where abnormal cells grow in the cervix is not carcinoma-in-situ, though is a precursor for cervical cancer if not treated early.
- Non-metastatic non-melanoma skin cancer or carcinoma-in-situ is not covered, as this non-metastatic (no spread) type of cancer can be easily treated and is no longer considered a critical condition.



Carcinoma -in-situ (Stage 0 Cancer)

What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Cancer [APS – Cancer (0809)] from the oncologist or specialist doctor
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ All histopathology reports or biopsy results



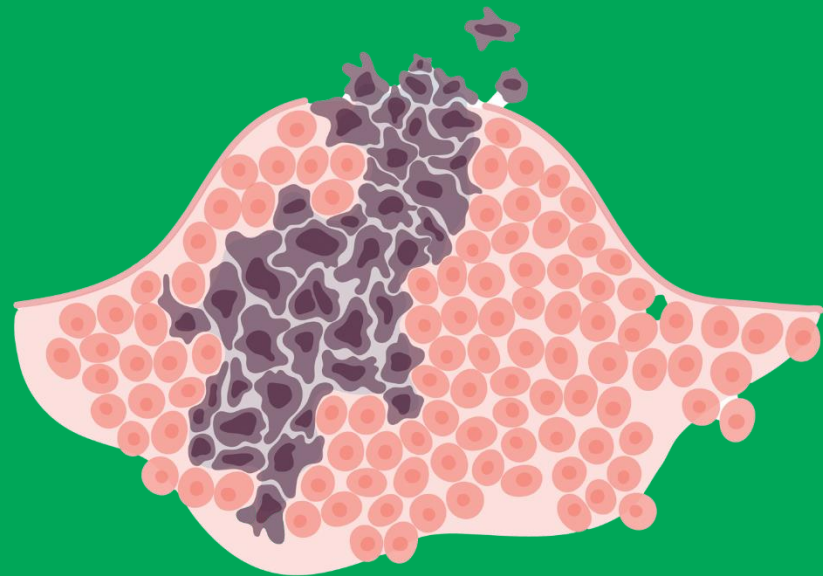
Early-Stage Malignancy



Definition

Early-stage malignancy, often referred to as early-stage cancer or stage 1, is where the cancer is small and localized to one area and has not spread to the lymph nodes or other organs of the body. This is one of the most curable forms of cancer, typically with surgery, chemotherapy, radiation, or its combination.

Despite medical advances, the expensive cost of cancer treatment for early-stage malignancy for chronic lymphocytic leukemia (blood cancer), skin, and prostate, is a deterrent for the needed medical treatment and follow-up care.



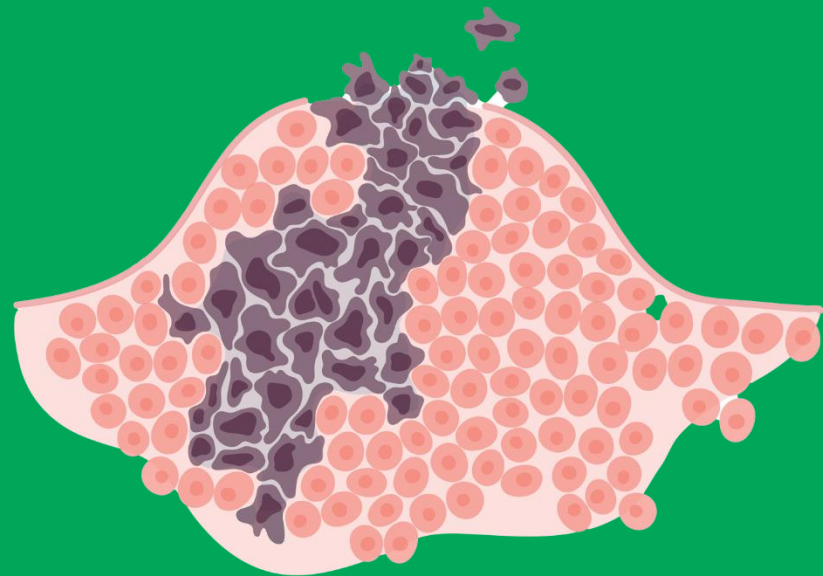
Early-Stage Malignancy



What is covered?

Early-stage malignancy is limited to a final diagnosis of these specific cancers:

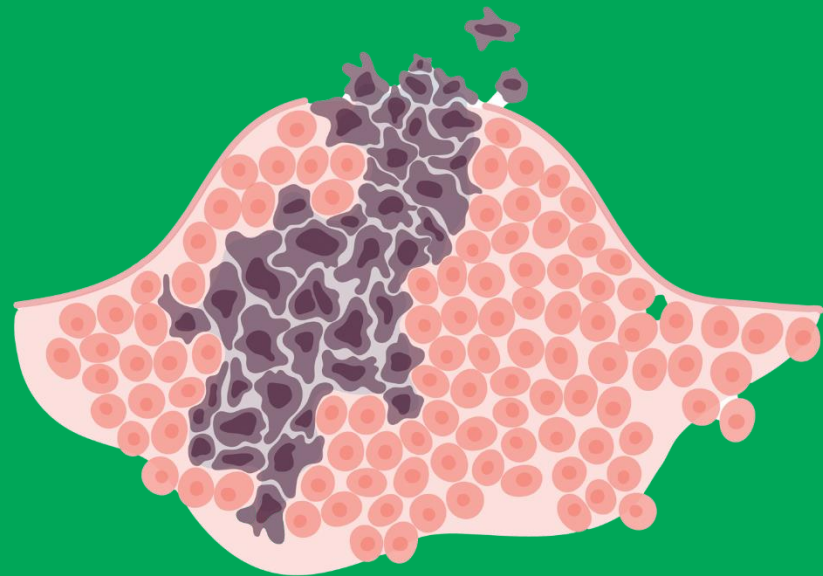
- Chronic lymphocytic leukemia classified as RAI Stage I or II. RAI Staging is used to classify leukemia according to the increased number of white blood cells, enlargement of lymph node, liver, or spleen. RAI Stage I and II are considered early-stage malignant blood cancers.
- Metastatic non melanoma skin cancer is an early-stage malignant skin cancer that has spread to other parts of the body (metastatic)
- Prostate cancer T1a or T1b (according to TNM Staging, a method to describe the size and spread of cancer) is indicative of early-stage malignancy



Early-Stage Malignancy

✕ What is NOT covered?

- Early-stage malignancy for cancers not listed above
- Pre-malignant or borderline lesions are not cancers, but are at risk of becoming malignant.



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Cancer [APS – Cancer (0809)] from the oncologist or specialist doctor
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ All histopathology reports or biopsy results for skin and prostate cancer
- ✓ Bone marrow biopsy and blood test results for chronic lymphocytic leukemia



Early Thyroid Cancer

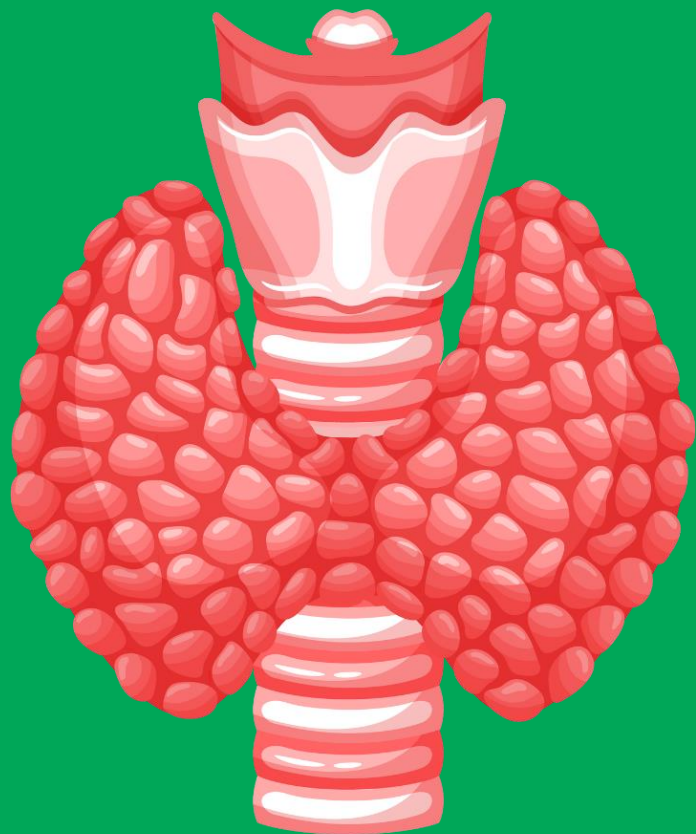


Definition

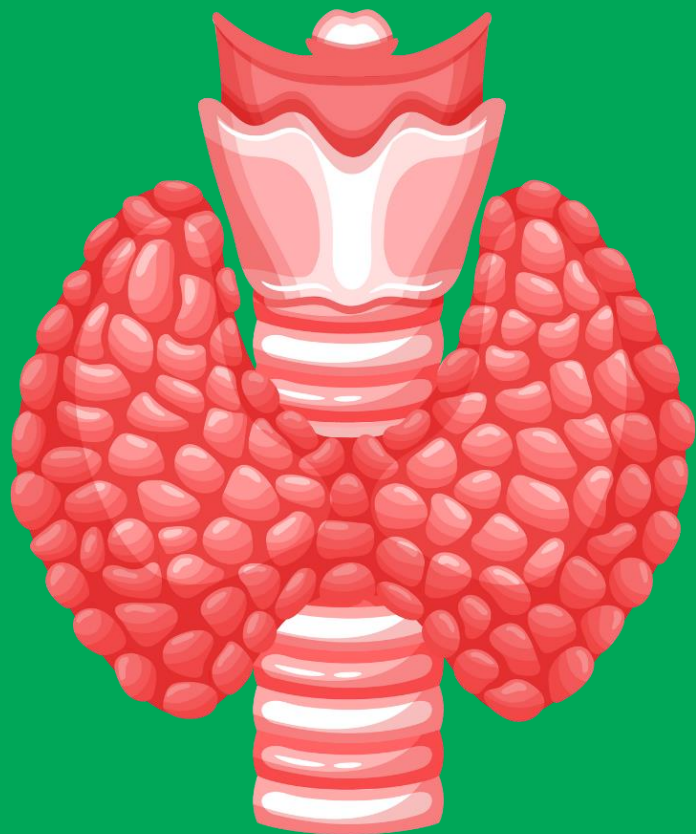
The thyroid, which is about 2-inches long, is a butterfly shaped endocrine gland located in the neck and lies in front of the throat. Its main job is to control the body's metabolism through the thyroid hormones it creates.

Thyroid cancer is a growth of malignant cancer cells in the thyroid gland. The incidence of early detection of thyroid cancer has been increasing nowadays due to improved imaging tests and frequent use of ultrasound and fine needle aspiration (needle biopsy) for thyroid lumps.

Although thyroid cancer has an excellent prognosis if treated early by surgery, radioactive iodine treatment, chemotherapy, radiotherapy, or its combination, the overall treatment cost can be expensive.



Early Thyroid Cancer



What is covered?

A final diagnosis of early thyroid cancer as confirmed through a histopathology report (biopsy result). It must be classified as T1N0M0, where T1 is indicative of an early stage, N0 means it has not spread to the lymph nodes, and M0 means it has not spread to other parts of the body.

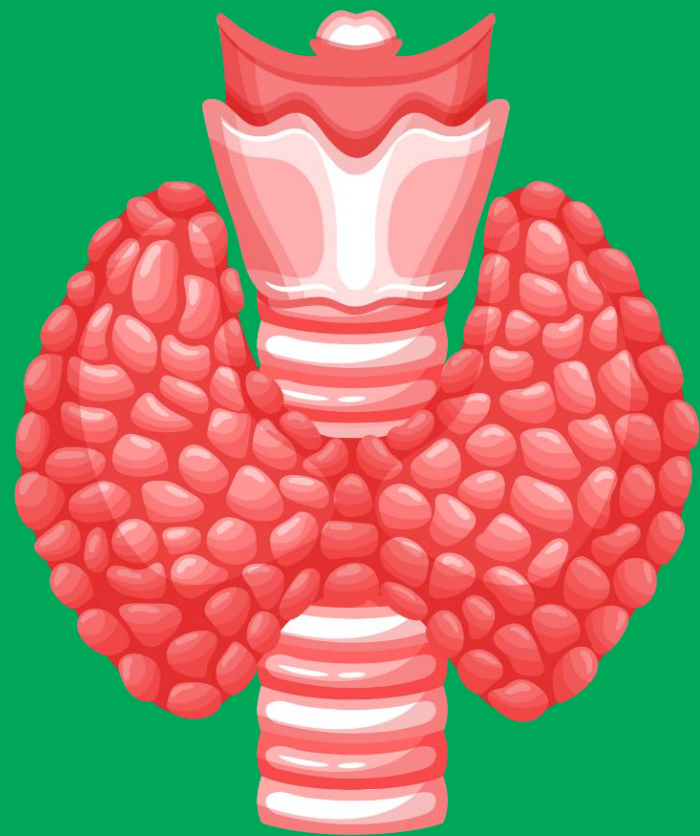


What is NOT covered?

- Benign or non-cancerous thyroid tumor
- Pre-malignant or borderline thyroid lesions which are not thyroid cancers



Early Thyroid Cancer



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement from for Cancer [APS – Cancer (0809)], accomplished by the insured's oncologist or specialist doctor
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Histopathology or Biopsy Result for thyroid cancer
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Histopathology or Biopsy Result for thyroid cancer





Excretory System Diseases and Medical Procedures

Adrenalectomy for Adrenal Adenoma



Definition

Have you ever experienced the adrenaline rush, the extra strength which you feel during unexpected situations that make you focus and take charge? Adrenaline, also known as the stress hormone, is just one of the hormones produced by the adrenal glands.

Adrenal glands are small glands located on top of each kidney that produce important hormones that regulate blood pressure, metabolism, and the immune system. Adrenal adenoma is a tumor or growth in the adrenal glands that sometimes causes the production of higher-than-normal hormones in the blood, resulting in significant symptoms affecting blood pressure, weight gain, and fatigue. Adrenalectomy, a surgical procedure to remove the adrenal adenoma or even the entire adrenal gland, is necessary if the adrenal adenoma is cancerous or actively producing excessive hormones.



Adrenalectomy for Adrenal Adenoma



What is covered?

Early CI Benefit covers two types of adrenalectomy:

- Conventional surgery or otherwise known as open surgery in the abdomen to remove the adrenal adenoma
- Laparoscopic surgery (small incisions) inserted through the laparoscope to remove the adrenal adenoma



What is NOT covered?

- Adrenal adenoma without the need for any surgery
- Any other surgical procedure that does not include adrenalectomy



Adrenalectomy for Adrenal Adenoma

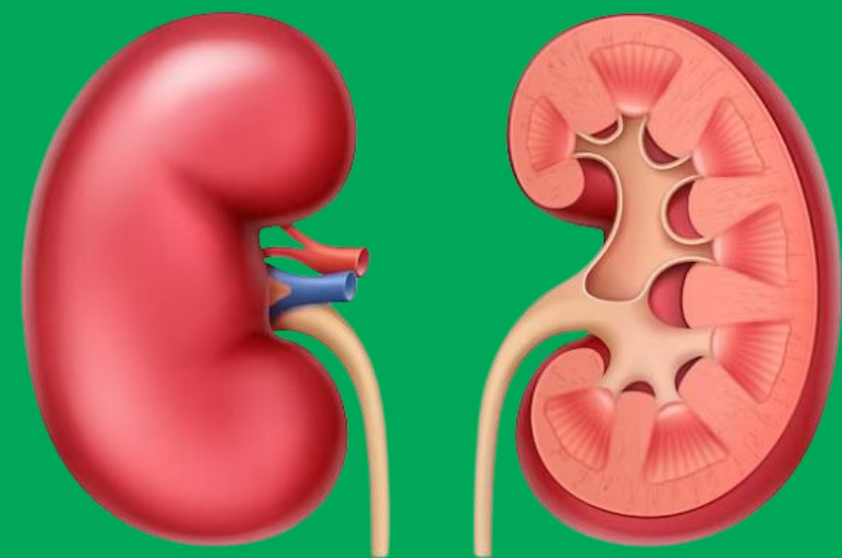


What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Disease/Critical Illness – Others [APS – Others] accomplished by the insured's neurologist
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Results of brain imaging tests such as MRI, CT Scan, PET Scan
- ✓ Record of Operation or Operative Record
- ✓ Histopathology or Biopsy Result



Chronic Kidney Disease Stage 4



Definition

Did you know that kidneys filter about half a cup of blood every minute? Kidneys are the filtration system of the body. They remove waste from the blood as well as excess water to make urine.

Severe kidney disease is also called chronic renal insufficiency, which means poor kidney function causing a harmful buildup of waste in the blood that may eventually lead to kidney failure. Kidney failure occurs when the kidneys have completely stopped working and permanent kidney dialysis or kidney transplantation is required to survive.

glomerular Filtration Rate (GFR) is a measurement of how well the kidney filters blood. It is normally expressed per 1.73 m² body surface area. The normal GFR is 90 or higher. A GFR below 30 means there is severe kidney disease and below 15 is indicative of kidney failure.

Less severe kidney disease that persists for at least 90 days continuously with a GFR below 30, even without permanent kidney dialysis or kidney transplantation, can already be covered by the Early CI Benefit.



Chronic Kidney Disease Stage 4



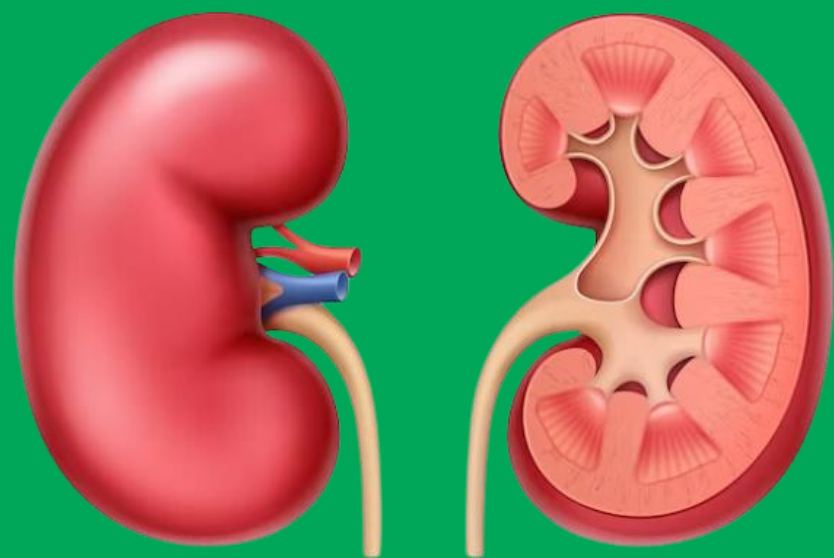
What is covered?

Less severe kidney disease or an advanced stage of chronic renal insufficiency that persisted for at least 90 days continuously, with a GFR below 30 even without permanent kidney dialysis or transplant.

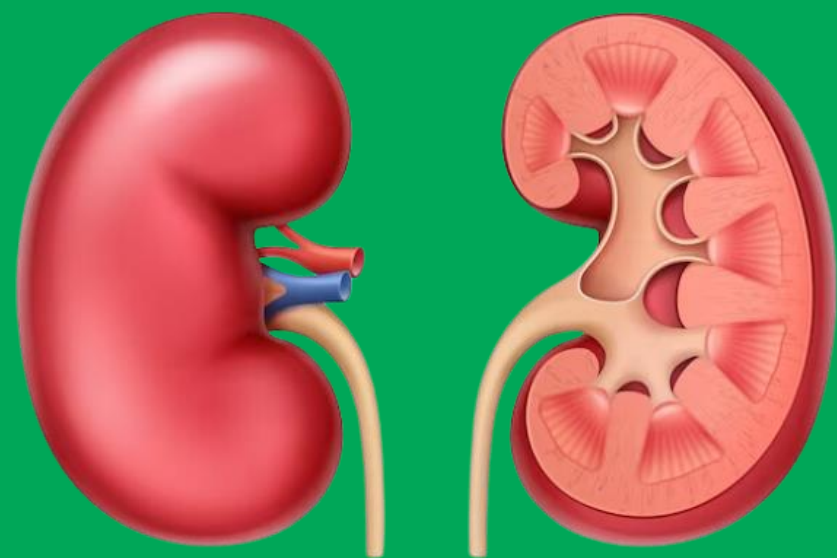


What is NOT covered?

- Severe kidney disease due to congenital diseases
- Acute kidney injury which is treatable and reversible



Chronic Kidney Disease Stage 4



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Kidney Failure [APS - Kidney Failure (1009)] accomplished by the insured's nephrologist
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Creatinine result
- ✓ E-GFR result, If any



Kidney Failure



Definition

Chronic irreversible failure of both kidneys requiring either permanent renal dialysis or kidney transplant.



What is covered?

- Diagnosis of CKD Stage IV or V, Early-Stage Renal Disease, Early-Stage Renal Failure
- EGFR result of at least 29 mL/min/1.73m²



Kidney Failure

✕ What is NOT covered?

- Condition does not require permanent renal dialysis or kidney transplant
- CKD Stages I to III
- EGFR result is more than 29 mL/min/1.73m²



What are the requirements needed?

- ✓ Attending Physician Statement form for Kidney Failure [APS - Kidney Failure (1009)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Creatinine result
- ✓ E-GFR result, If any
- ✓ Kidney disease Treatment plan

Medullary Cystic Disease



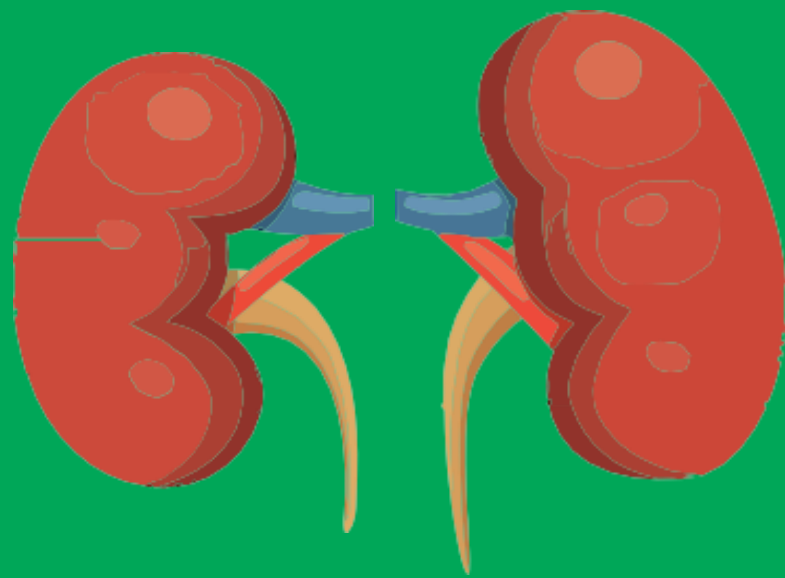
Definition

A hereditary kidney disorder characterized by gradual and progressive loss of kidney function because of cysts in the kidney medulla.



What is covered?

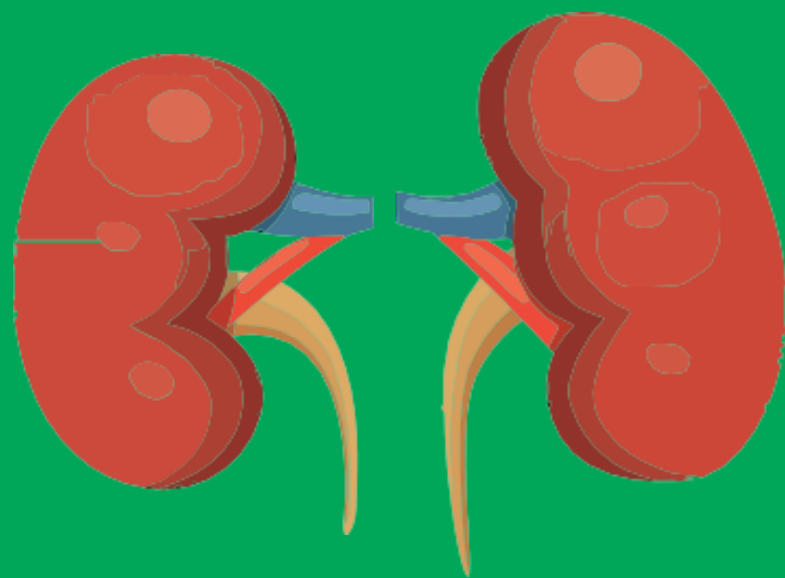
Diagnosis must be supported by imaging evidence of multiple medullary cysts with cortical atrophies.



Medullary Cystic Disease

✗ What is NOT covered?

Diagnosis is not supported by any imaging evidence of multiple medullary cysts with cortical atrophy showing gradual and progressive loss of kidney function



What are the requirements needed?

- ✓ Attending Physician Statement for Medullary Cystic Disease [APS-Medullary Cystic Disease (1009)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Imaging test such as: ultrasound, CT scan or MRI

Surgical Removal of One Kidney

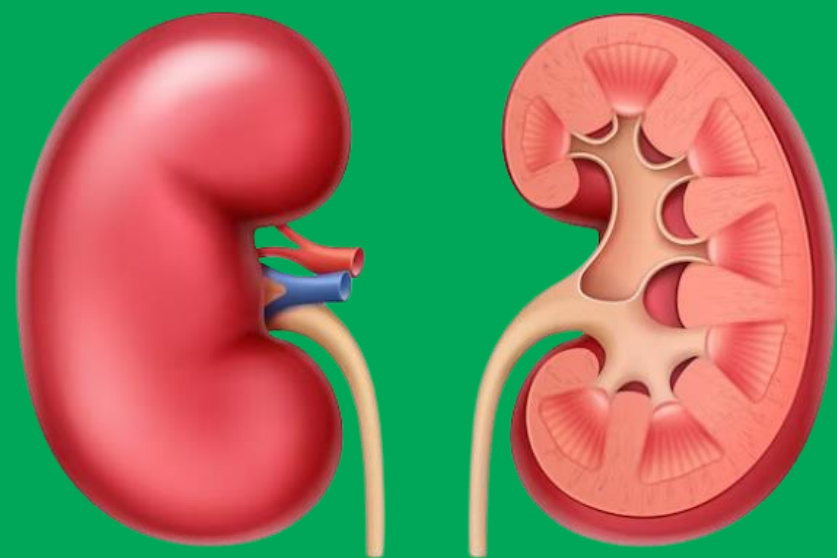


Definition

Did you know that kidneys filter about half a cup of blood every minute? We have two (2) kidneys working together as the filtration system of the body that cleanses our blood, removes waste, and gets rid of extra water to make urine.

When a kidney is damaged due to accident or disease (such as a benign kidney tumor or kidney cancer), complete surgical removal of the kidney, called nephrectomy, is the treatment of choice.

A person can live with one kidney but needs to take extra care of it because there will be no other kidney to take over once it fails.



Surgical Removal of One Kidney



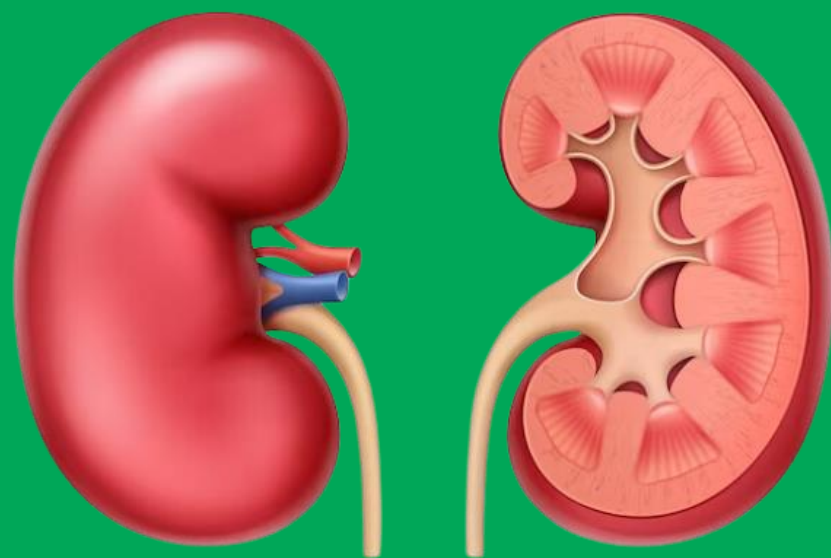
What is covered?

The actual surgical removal of one kidney, which is medically necessary due to a disease or accident

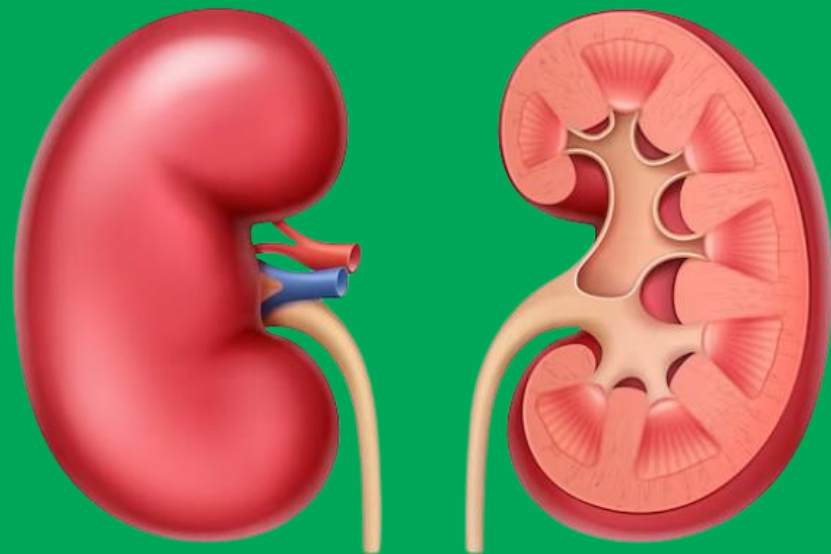


What is NOT covered?

- Surgical removal as a kidney donor
- Surgery due to congenital diseases of the kidney
- Surgery due to Self-inflicted injuries
- Partial removal of a kidney (part of a kidney)



Surgical Removal of One Kidney



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Disease/Critical Illness – Others [APS – Others] accomplished by the insured's attending doctor
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Record of Operation or Operative Record
- ✓ Police report / Traffic Accident Report or Incident report (if due to accidental injury)



Digestive System Diseases and Medical Procedures

Biliary Tract Reconstruction Surgery



Definition

As the food moves through the stomach, a greenish-yellow fluid called bile is important to digest the food and allow the body to absorb fats. With the help of the biliary tract comprising of liver (makes bile), gall bladder (stores bile), pancreas, and tiny tubes called bile ducts, the bile smoothly flows through the small intestine assisting in digestion and in getting rid of waste products.

If the biliary tract becomes narrowed or damaged, there will be a buildup of bile in the liver which can be life threatening, if not treated with surgery.

There are many types of biliary tract reconstruction surgery ranging from small incisions (laparoscopic surgery) to major open surgery such as creating an opening between the bile duct and intestine called choledochoenterostomy which is the last resort for severe damage to the biliary tract. Only biliary tract reconstruction surgery involving choledochoenterostomy is covered in the Early CI Benefits due to high risk of complications after the surgery.



Biliary Tract Reconstruction Surgery



What is covered?

The actual procedure of biliary tract reconstruction surgery involving choledochoenterostomy must have been performed to treat disease or injury of the biliary tract such as the liver, gall bladder, pancreas, or bile ducts.

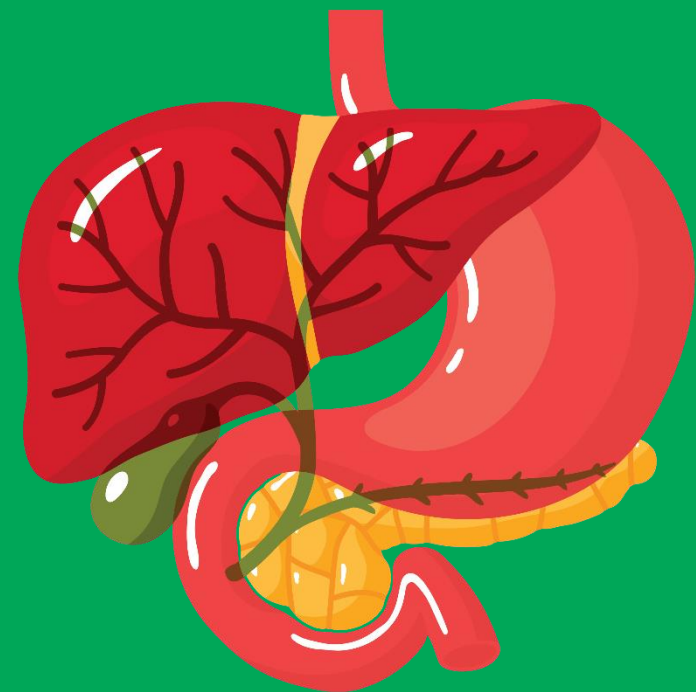


What is NOT covered?

- Biliary atresia, a rare congenital condition detected in babies with absence or blocked biliary tract
- Any other surgical procedure that does not include choledochoenterostomy



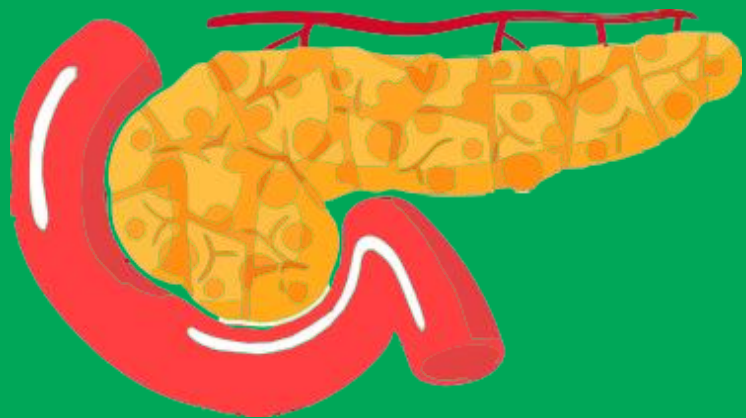
Biliary Tract Reconstruction Surgery



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Disease/Critical Illness – Others [APS – Others] accomplished by the insured's attending doctor
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Record of operation or Operative Record

Chronic Relapsing Pancreatitis



Definition

More than three (3) attacks of pancreatitis resulting in pancreatic dysfunction causing malabsorption needing enzyme replacement therapy.



What is covered?

More than three (3) attacks of pancreatitis resulting in pancreatic dysfunction causing malabsorption needing enzyme replacement therapy.

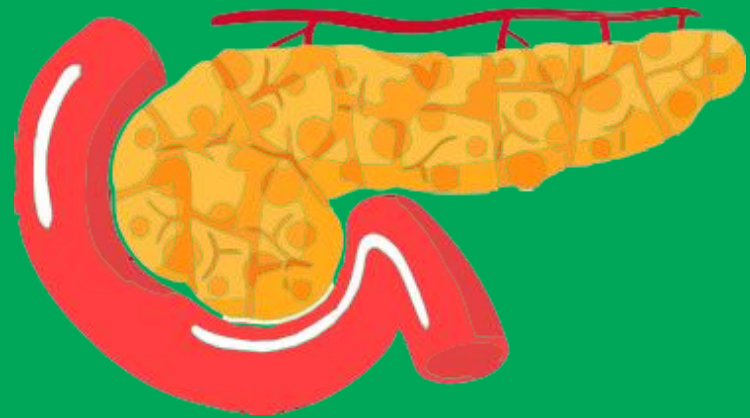
Chronic Relapsing Pancreatitis

✕ What is NOT covered?

- Chronic Relapsing Pancreatitis caused by alcohol use.
- Attacks of three (3) times or less.
- Attacks which do not result in pancreatic Dysfunction causing malabsorption.
- Enzyme replacement therapy is not required.

What are the requirements needed?

- ✓ Attending Physician Statement for Chronic Relapsing Pancreatitis signed by Gastroenterologist [APS-Chronic Relapsing Pancreatitis (1009)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement.
- ✓ Endoscopic Retrograde Cholangiopancreatography



Crohn's Disease



Definition

Is a chronic, transmural inflammatory disorder of the bowel.



What is covered?

To be considered as severe, there must be evidence of continued inflammation in spite of optimal therapy, with all of the following having occurred:

- Stricture formation causing intestinal obstruction requiring admission to hospital, and
- Fistula formation between loops of bowel, and
- At least one bowel segment resection.

The diagnosis must be made by a specialist Gastroenterologist and be proven histologically on a pathology report and/or the results of sigmoidoscopy or colonoscopy.



Crohn's Disease

✕ What is NOT covered?

If any of the three (3) criteria for Crohn's Disease is not met.



What are the requirements needed?

- ✓ Attending Physician Statement form for Others [APS – Others] confirmed by Gastroenterologist
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Sigmoidoscopy or Colonoscopy report
- ✓ Record of operation or Operative Record regarding bowel segment resection

End-Stage Liver Failure



Definition

End-stage liver failure which is permanent and irreversible as evidenced by all of the following with diagnosis by a specialist:

- a. Permanent jaundice
- b. Ascites
- c. Hepatic encephalopathy

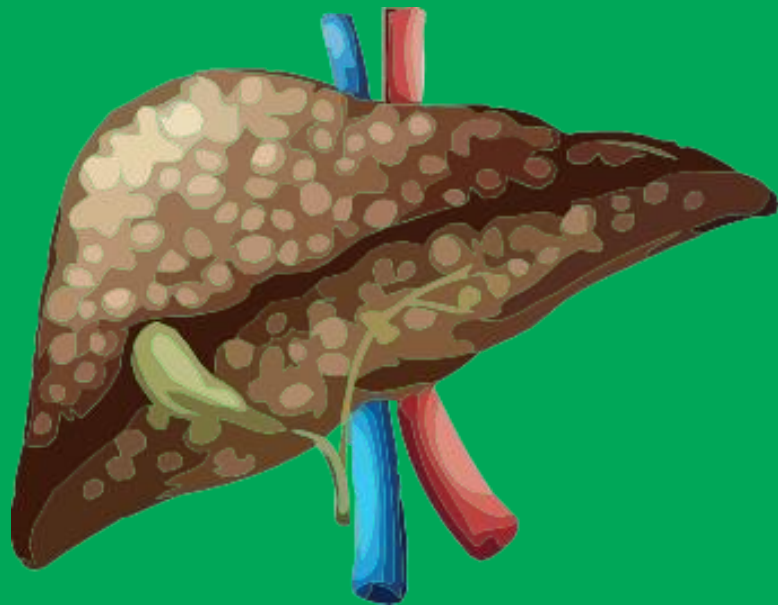


What is covered?

Permanent and irreversible End-stage liver failure as evidenced by all of the following:

- a. Permanent jaundice
- b. Ascites
- c. Hepatic encephalopathy

Must be diagnosed by a specialist



End-Stage Liver Failure

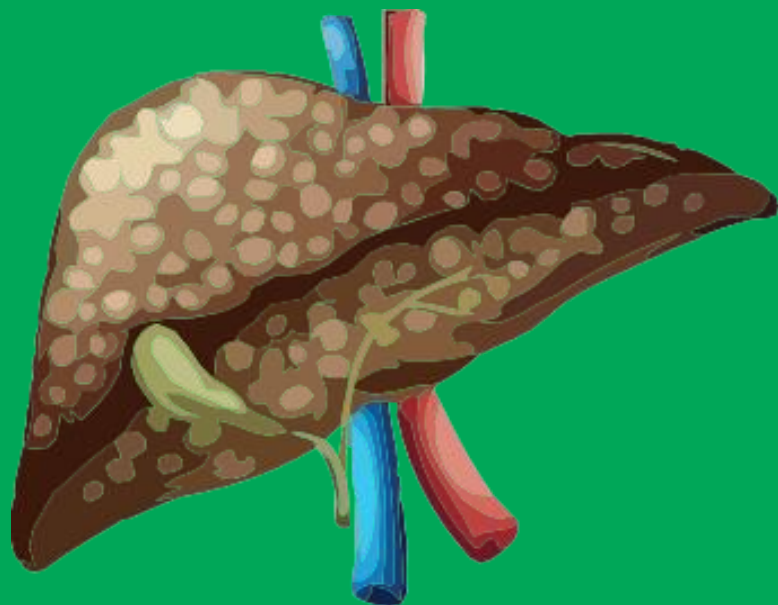


What is NOT covered?

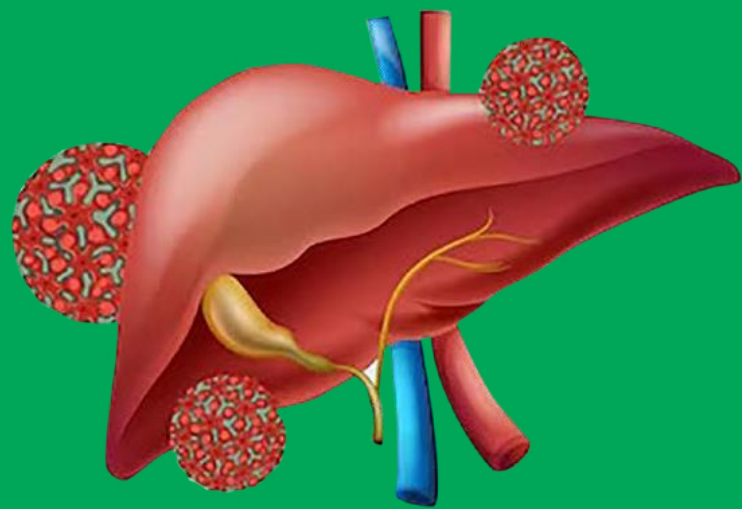
- Liver disease secondary to drug or alcohol abuse.
- Liver failure is not permanent and irreversible and is not characterized by permanent jaundice, ascites and encephalopathy.

What are the requirements needed?

- ✓ Attending Physician Statement for Chronic Liver Disease [APS-Chronic Liver Disease (1009)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Liver function test
- ✓ Imaging tests - ultrasound, CT scan and MRI



Fulminant Hepatitis



Definition

A massive necrosis of the liver caused solely by viral hepatitis, leading precipitously to liver failure, in the absence of preexisting liver disease



What is covered?

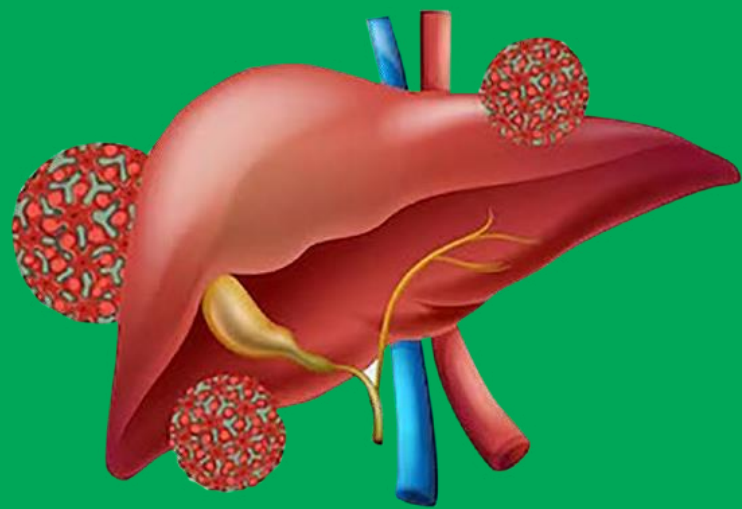
The diagnosis of this illness must meet all of the following criteria:

- A rapidly decreasing liver size and necrosis involving entire lobules as confirmed by either abdominal ultrasound, pathology, MRI or equivalent imaging.
- Rapid deterioration of liver functions tests Evidence must be produced by liver function test showing massive parenchymal liver disease.
- Jaundice. Evidence must be produced by objective signs of porta systematic encephalopathy

Fulminant Hepatitis

✕ What is NOT covered?

If any of the three (3) criteria for Fulminant Hepatitis is not met



What are the requirements needed?

- ✓ Attending Physician Statement form for Fulminant Hepatitis [APS - Fulminant Hepatitis (0710)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Abdominal ultrasound result
- ✓ Liver Function Test result

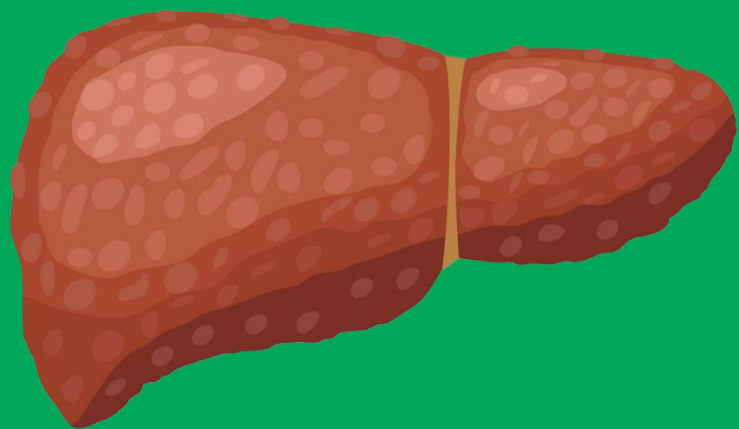
Hepatitis with Cirrhosis



Definition

Liver is a soft and smooth organ that filters the blood in the body, removing the toxins and waste products from the blood.

Cirrhosis is severe liver damage where the soft tissues of the liver are replaced by permanent scars and become hard, preventing the liver from functioning normally. Among the many causes of chronic liver disease leading to cirrhosis, only hepatitis, which is the inflammation (swelling) of the liver caused by an infection from a virus, is covered in the Early CI Benefit. There is no cure for cirrhosis and life-threatening complications may develop due to liver failure.



Hepatitis with Cirrhosis



What is covered?

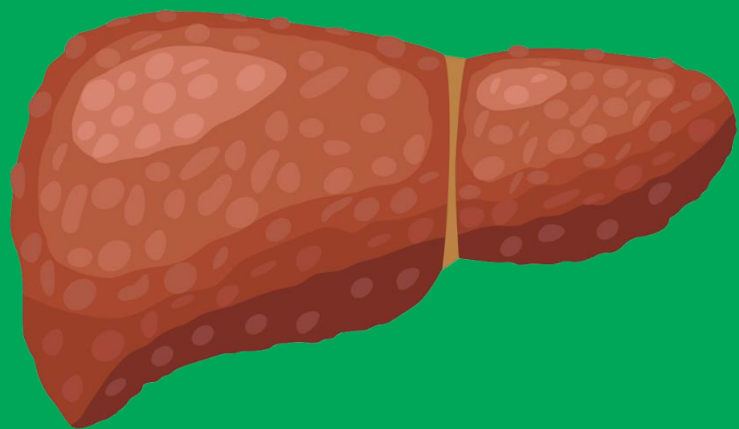
Benefits would be payable if all the following conditions are met:

- A final diagnosis of liver cirrhosis due to hepatitis virus as confirmed by a hepatologist (medical doctor who treats diseases and conditions of the liver) or specialist doctor
- Liver biopsy showing a Metavir score of F4 or a Knodell fibrosis score of 4, both indicative of late stage of liver cirrhosis

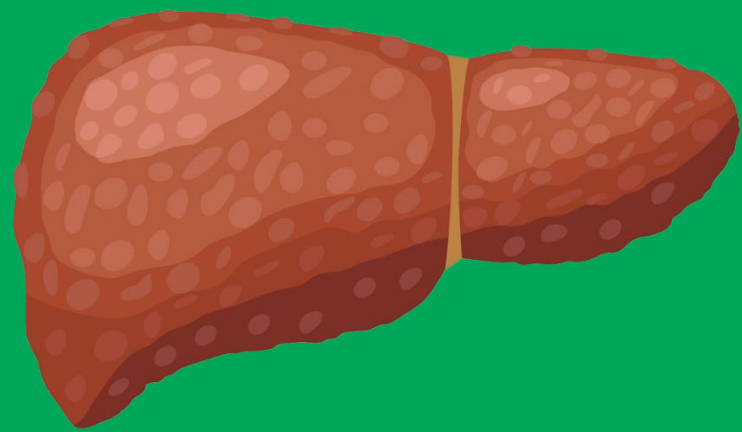


What is NOT covered?

- All other liver diseases due or related to alcohol or drug abuse
- Cirrhosis not caused by the hepatitis virus (e.g., certain drugs, cancer)



Hepatitis with Cirrhosis



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Disease/Critical Illness - Others [APS – Others] accomplished by the insured's attending doctor
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Liver biopsy showing histological stage F4 by Metavir grading or a Knodell fibrosis score of 4



Liver Surgery

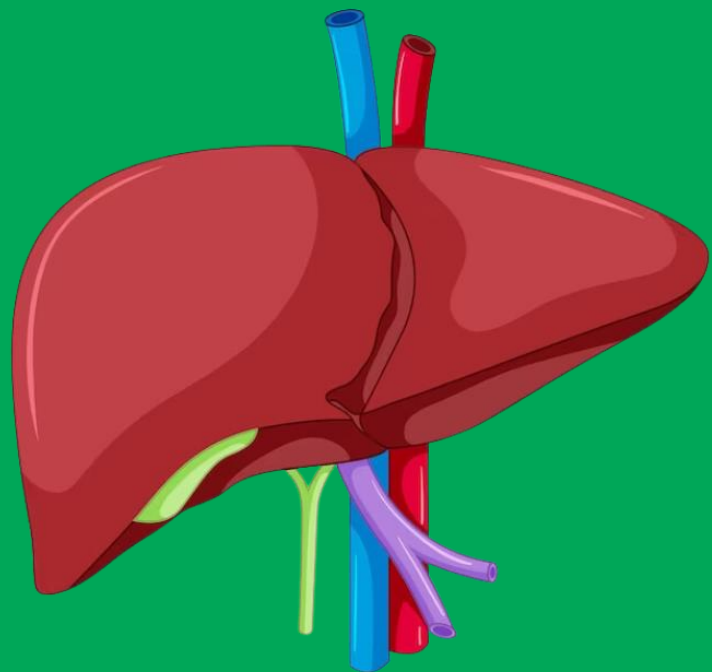


Definition

The liver is a soft and smooth organ that filters the blood in the body, thereby removing toxins and waste products. It is made up of four lobes and produces enzymes that help digest food.

Partial hepatectomy is a surgical procedure to remove a portion of the liver, such as one entire left or entire right lobe, to treat a cancerous or benign liver tumor or liver injury as a result of an accident.

Did you know that liver can regrow to its former size even if a partial hepatectomy has been done, if the remaining liver is healthy?



Liver Surgery



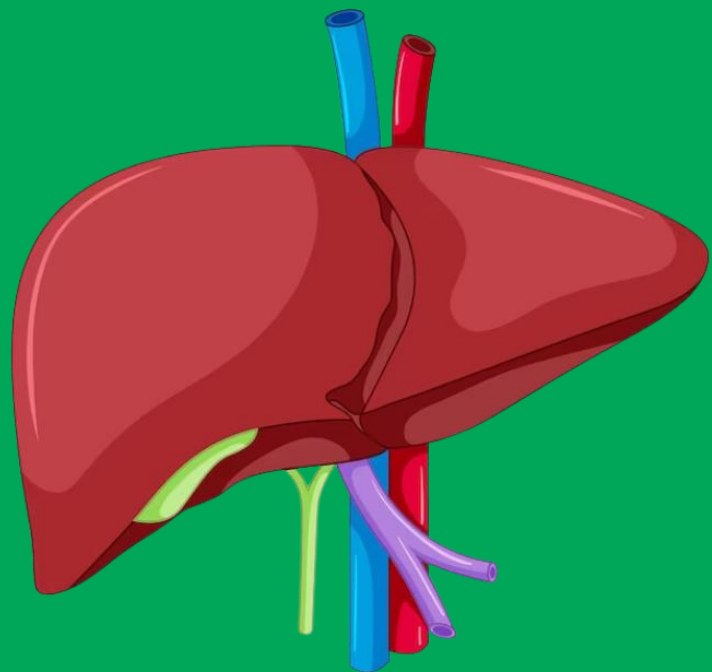
What is covered?

Medically necessary partial hepatectomy of at least one entire left or entire right lobe of the liver because of illness or accident

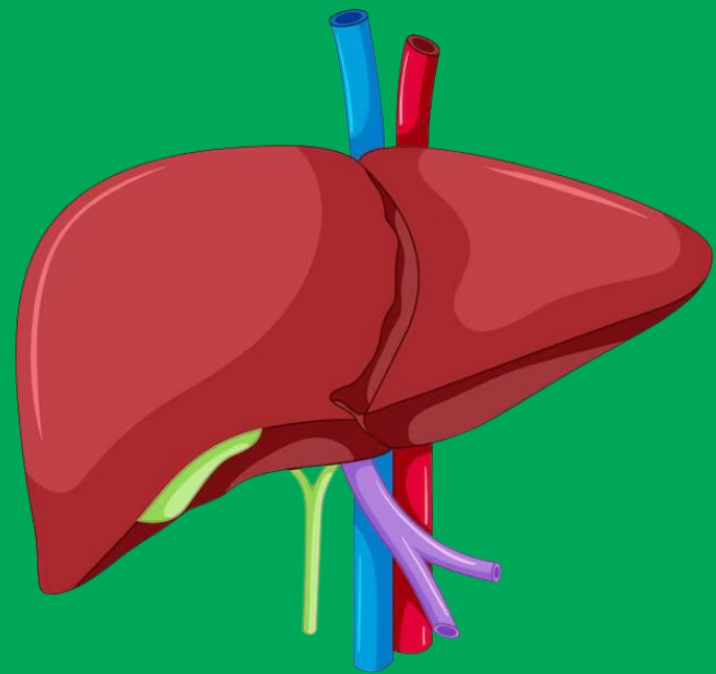


What is NOT covered?

- All other liver diseases due or related to alcohol or drug abuse
- Partial hepatectomy as a liver donor
- Partial hepatectomy to treat a congenital abnormality
- Any other liver surgery that does not include partial hepatectomy



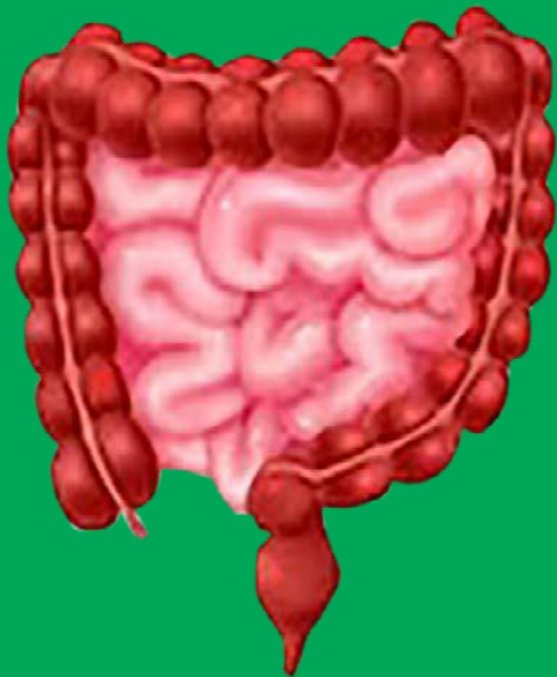
Liver Surgery



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Disease/Critical Illness – Others [APS – Others]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Record of Operation or Operative Record - Partial hepatectomy

Severe Ulcerative Colitis



Definition

Acute fulminant ulcerative colitis with life threatening electrolyte disturbances.



What is covered?

All of the following criteria must be met:

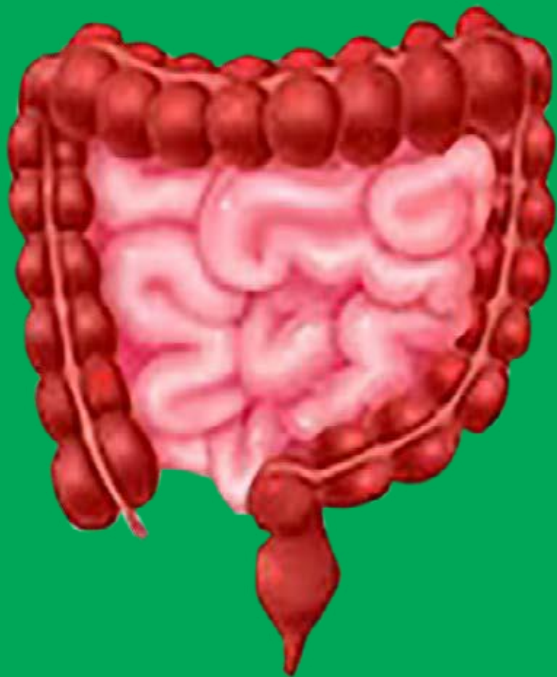
- The entire colon is affected, with severe bloody diarrhea; and
- The necessary treatment is total colectomy and ileostomy; and
- The diagnosis must be based on histopathological features and confirmed by a specialist in gastroenterology.



Severe Ulcerative Colitis

✕ What is NOT covered?

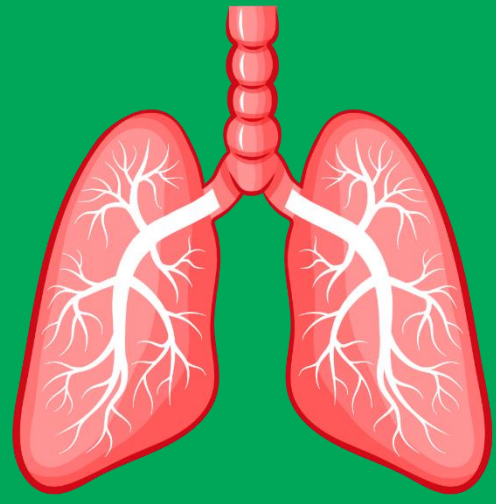
If any of the 3 criteria for Severe Ulcerative Colitis is not met.



What are the requirements needed?

- ✓ Attending Physician Statement form for Others confirmed by gastroenterology [APS – Others]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Record of Operation or Operative Record (colectomy and ileostomy)
- ✓ Colonoscopy report
- ✓ Histopathology report





Respiratory System (Lungs)

Diseases and Medical Procedures

Chronic Lung Disease



Definition

Chronic lung disease is an umbrella of different disorders that causes breathing problems and damage to the structures of the lungs. Interstitial fibrosis, also known as interstitial lung disease, is one of the chronic lung diseases that causes progressive scarring of lung tissue (pulmonary fibrosis), which makes it difficult to breathe and lowers the oxygen level in the body.

Once lung scarring occurs, it is often permanent and gets worse over time. Only oxygen therapy and medications may help improve the symptoms and slow down the damage in the lungs.



Chronic Lung Disease



What is covered?

Benefits would be payable if all of the following conditions are met:

- A final diagnosis of an interstitial fibrosis is confirmed by a pulmonologist or specialist
- The condition requires oxygen therapy (intermittent or long-term)
- Consistent reduction in Forced Vital Capacity (FVC) or Total Lung Capacity (TLC) to 70% or less of predicted value under medication

FVC and TLC are both pulmonary function tests that measures the respiratory function



Chronic Lung Disease



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Disease/Critical Illness – Others [APS – Others] accomplished by the insured's attending doctor
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Results of imaging test such as Chest X-ray, Lung CT Scan, MRI Scan or Bronchoscopy
- ✓ Pulmonary function test results - Forced Vital Capacity (FVC) or Total Lung Capacity (TLC)
- ✓ Oxygen Therapy Report

End Stage Lung Disease



Definition

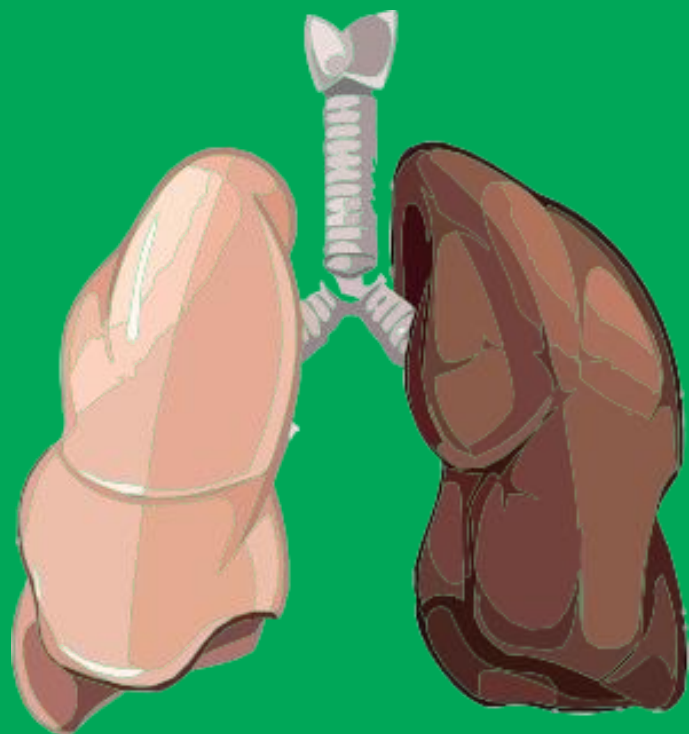
End stage lung disease, causing chronic respiratory failure, as evidenced by a Forced Expiratory Volume at one second (FEV1) test results consistently less than 1 liter and requiring permanent supplementary oxygen therapy for hypoxemia.



What is covered?

The following criteria should be met:

- Forced Expiratory Volume at one second (FEV1) test results consistently less than 1 liter and requiring permanent supplementary oxygen therapy for hypoxemia.
- Arterial blood gas analyses must show a partial oxygen pressure of 55mmHg or less ($\text{PaO}_2 < 55\text{mmHg}$) and there must be dyspnea at rest.



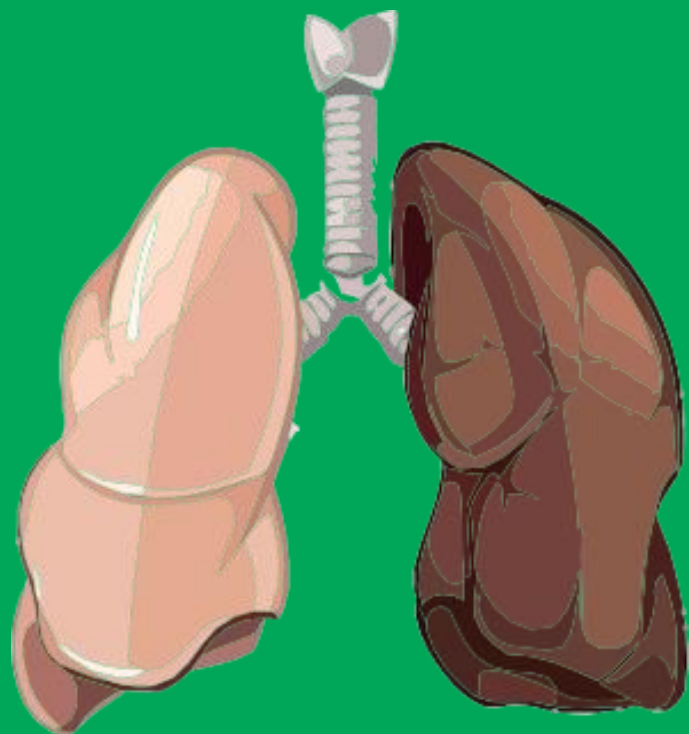
End Stage Lung Disease

✕ What is NOT covered?

Diagnosis of End Stage Lung Disease that does not meet FEV1 test and Arterial blood gas analysis criteria

What are the requirements needed?

- ✓ Attending Physician Statement form for End Stage Lung Disease [APS- End Stage Lung Disease (1009)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Forced Expiratory Volume at one second (FEV1) test result
- ✓ Arterial blood gas analysis



Miliary Tuberculosis



Definition

Tuberculosis, a bacterial infection, is one of the most serious health concerns in the Philippines, causing a heavy financial burden for affected individuals and their families.

There are different types of tuberculosis depending on the affected parts of the body. The most common type is pulmonary tuberculosis, which affects the lungs and can be treated with medication. Miliary tuberculosis, on the other hand, affects the blood and rapidly spreads throughout the body (wide dissemination), damaging one or more organs, such as the liver, bone marrow, and kidneys.

Thousands of small spots in the affected organs called minute tubercles are the unique features of miliary tuberculosis seen from an imaging test.

Only miliary tuberculosis is covered in the Early CI Benefit, as this is a life-threatening condition with very high risk of sudden death if left untreated.



Miliary Tuberculosis



What is covered?

A final diagnosis of miliary tuberculosis by a specialist doctor



What is NOT covered?

- Other types of tuberculosis
- Complication of HIV infection



Miliary Tuberculosis



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Disease/Critical Illness – Others [APS – Others] accomplished by the insured's attending doctor
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Results of blood culture, urine, cerebrospinal fluid, skin test
- ✓ Results of imaging test such as Chest x-ray, CT Scan, MRI Scan



Surgical Removal of One Lung



Definition

Our left and right lungs are important parts of the respiratory system that work together to help us breathe.

A complete surgical removal of one entire right or left lung (pneumonectomy) is usually done because of an accidental lung injury or illness such as a benign lung tumor, lung cancer, tuberculosis, or other lung diseases.

A person can live with one lung, but may have difficulty breathing during strenuous exercise or physical activity since the lung capacity will be reduced by half.



Surgical Removal of One Lung



What is covered?

The actual surgical removal of one lung, either right lung or entire left lung, which is medically necessary due to an illness or accident



What is NOT covered?

- Partial removal of a lung (lobectomy)
- Surgical removal as a living lung donor
- Surgery due to congenital diseases of the lungs
- Surgery due to self-inflicted injury



Surgical Removal of One Lung



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Disease/Critical Illness – Others [APS – Others] accomplished by the insured's attending doctor
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Record of Operation or Operative Record
- ✓ Police report / Traffic Accident Report or Incident report (if due to accidental injury)



Muscular System Diseases

Hemolytic Streptococcal Gangrene



Definition

An infection of the superficial and/or deep fascia investing the muscles of an extremity or the trunk, progress being fulminant and needing immediate surgical intervention and debridement.



What is covered?

Infected wound should need immediate surgical intervention and debridement. Hemolytic Streptococcal Gangrene diagnosis evidenced by culture and sensitivity result and confirmed by a specialist after surgical exploration.



Hemolytic Streptococcal Gangrene

✕ What is NOT covered?

- Wound infection is not due to Hemolytic Streptococcal Gangrene
- Wound not requiring immediate surgical intervention and debridement

What are the requirements needed?

- ✓ Attending Physician Statement form Others confirmed by a surgeon [APS – Others]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Culture and Sensitivity result
- ✓ Record of Operation or Operative Record



Muscular Dystrophy



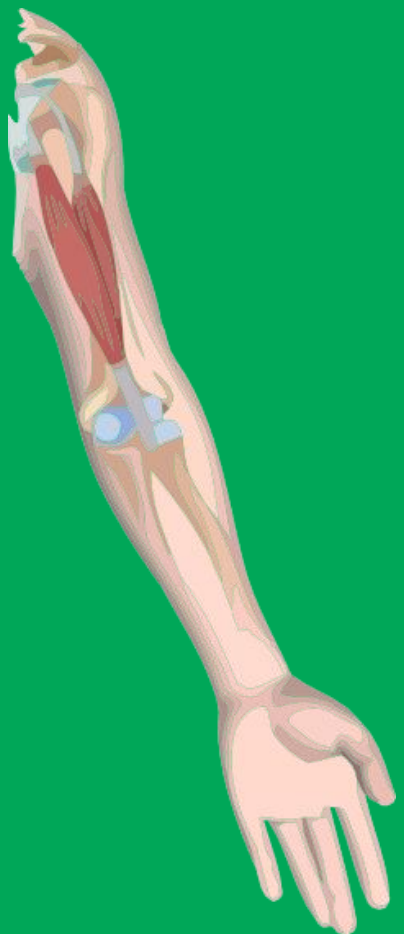
Description

A group of hereditary degenerative diseases of muscle characterized by progressive weakness and atrophy of muscle.



What is covered?

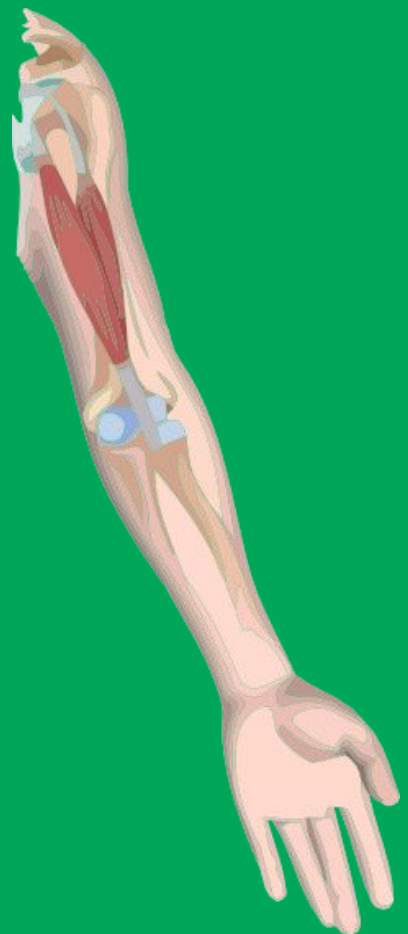
- The diagnosis of muscular dystrophy must be unequivocal and made by a consultant neurologist and confirmed by appropriate neuromuscular testing such as Electromyogram (EMG).
- The condition must result in the permanent inability to perform, without any form of assistance, at least three (3) of the six (6) Activities of Daily Living for a continuous period of at least 180 days.



Muscular Dystrophy

✕ What is NOT covered?

The condition does not result in permanent inability to perform, without any form of assistance, at least three (3) of the six (6) Activities of Daily Living for a continuous period of at least 180 days.



What are the requirements needed?

- ✓ Attending Physician Statement for Muscular dystrophy signed by a neurologist [APS-Muscular Dystrophy (1109)]
- ✓ Caregiving questionnaire
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Electromyogram report (EMG)



Progressive Bulbar Palsy



Description

Degenerative wasting of the muscles including the bulbar muscles as diagnosed by a consultant neurologist.



What is covered?

- Degenerative wasting of the muscles including the bulbar muscles as diagnosed by a consultant neurologist
- Must be confirmed by appropriate neuromuscular testing such as Electromyogram (EMG)



Progressive Bulbar Palsy

✕ What is NOT covered?

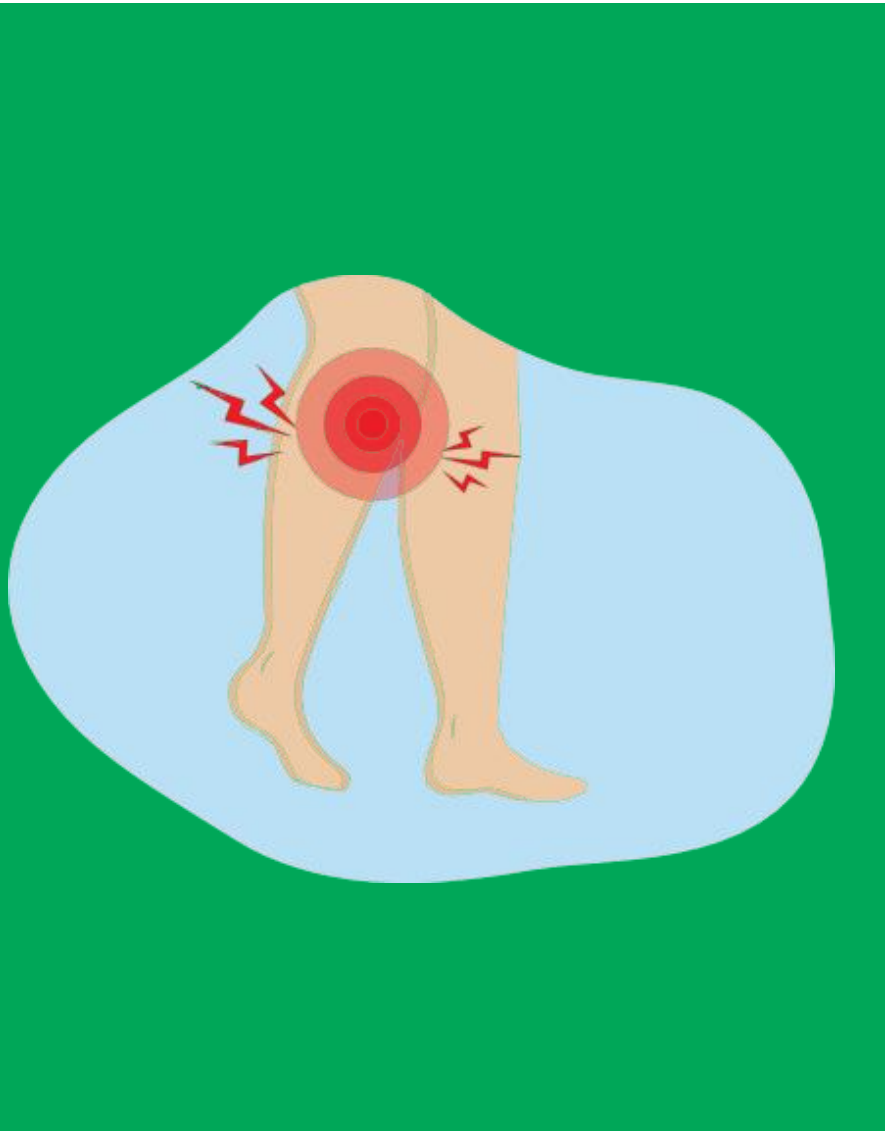
Diagnosis of Progressive Bulbar Palsy without wasting of the muscles

What are the requirements needed?

- ✓ Attending Physician Statement for Progressive Bulbar Palsy signed by a Neurologist [APS-Progressive Bulbar Palsy (1109)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Electromyogram (EMG) result



Progressive Muscular Atrophy



Description

Involving the wasting of muscles, increased spasticity, and the Insured's permanent inability to perform, without any form of assistance, at least three (3) of the six (6) Activities of Daily Living as diagnosed by a consultant neurologist.



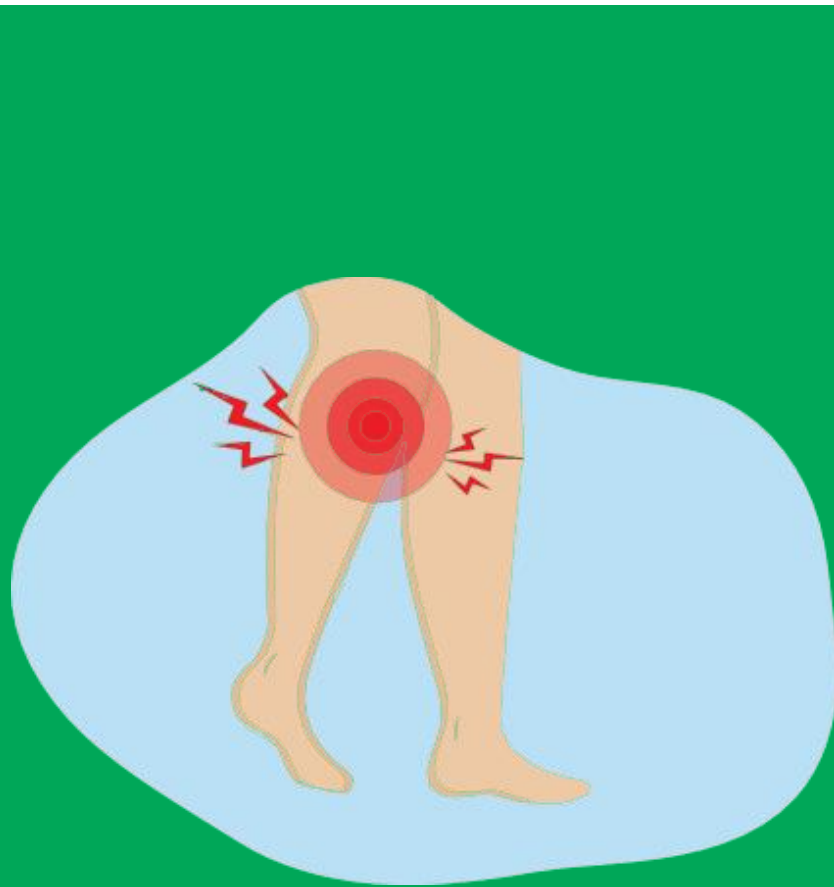
What is covered?

Involving the wasting of muscles, increased spasticity, and the Insured's permanent inability to perform, without any form of assistance, at least three (3) of the six (6) Activities of Daily Living as diagnosed by a consultant neurologist

Progressive Muscular Atrophy

✕ What is NOT covered?

- Ability to perform more than three (3) ADLs
- Temporary inability to perform at least three (3) ADLs



What are the requirements needed?

- ✓ Attending Physician Statement signed by a Neurologist [APS- Progressive Muscular Atrophy (1109)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Electromyogram (EMG) result
- ✓ Caregiving questionnaire





Rheumatologic and Musculoskeletal Diseases

Less Severe Systemic Lupus Erythematosus

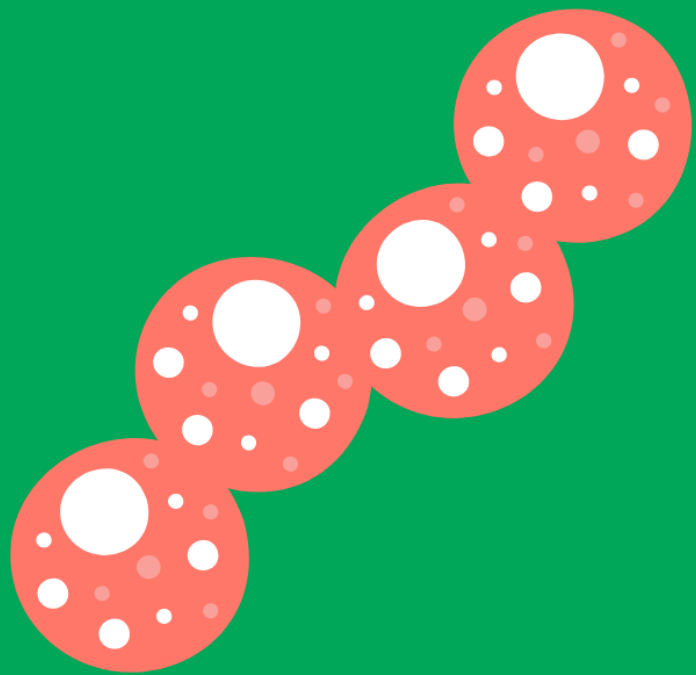


Definition

Systemic lupus erythematosus (SLE), also known as lupus, is a long-term autoimmune disease where the immune system mistakenly attacks healthy cells and tissues, creating antibodies that work against them. This causes widespread inflammation in many parts of the body (multisystem), such as joints, skin, blood, lungs, kidneys, and the brain.

SLE can present itself in different ways, with mild symptoms to life-threatening complications when left untreated. There is no cure for SLE but symptoms can be managed through control of inflammation and prevention of organ damage.

Less severe SLE with at least 2 criteria satisfied, even without permanent kidney damage or permanent neurological symptoms, can be covered by the Early CI Benefit.



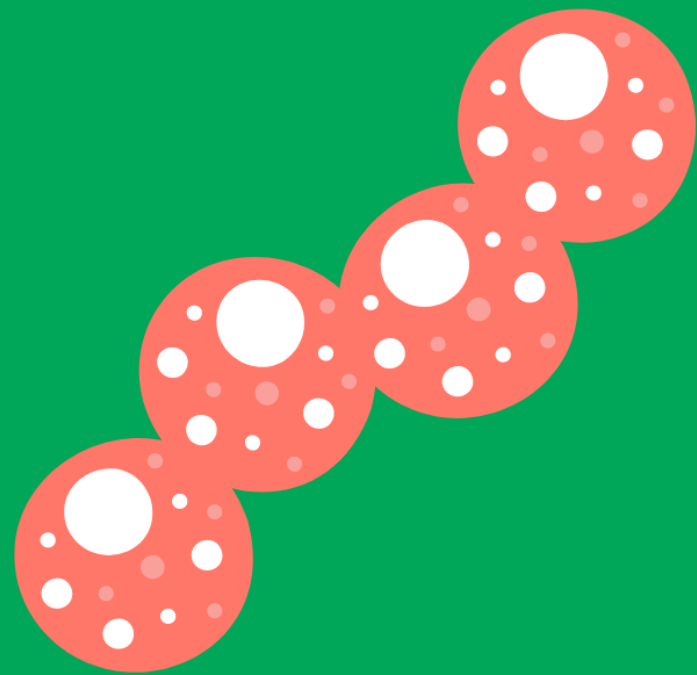
Less Severe Systemic Lupus Erythematosus



What is covered?

A final diagnosis of SLE confirmed by specialist doctor in rheumatology and immunology, with at least 2 of the following 5 criteria:

1. Arthritis (joint inflammation): non-erosive arthritis, involving 2 or more joints
2. Serositis (membrane inflammation):
 - Pleuritis (inflamed membrane of the lungs)
 - Pericarditis (inflamed membrane of the heart)
3. Renal Disorder (one of the following):
 - Persistent proteinuria > 0.5 g per day (protein in urine; kidney disease)
 - Persistent cellular casts (indicative of kidney disease)
4. Hematologic disorder (blood disorders): (one of the following)
 - Hemolytic anemia (low number of red blood cells)
 - Leukopenia (low number of white blood cells)
 - Lymphopenia (low number of lymphocytes, a type of white blood cells)
 - Thrombocytopenia (low number of platelets)
5. Positive anti-nuclear antibody (ANA) test, Anti-dsDNA, or anti-Smith antibody (antibodies suggestive of lupus)



Less Severe Systemic Lupus Erythematosus

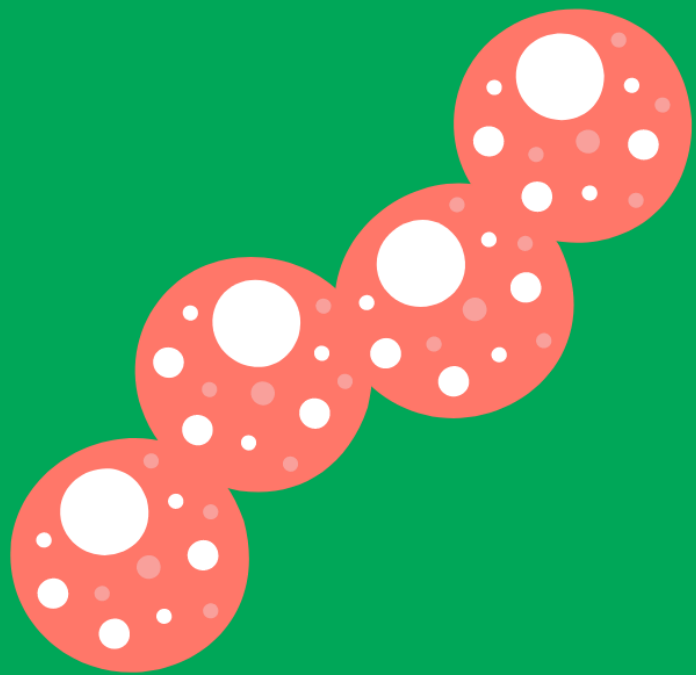


What is NOT covered?

- Discoid lupus (very mild lupus affecting only the skin)
- Other autoimmune disorders with similar symptoms as lupus

What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician Statement form for Systemic Lupus Erythematosus [APS - Systematic Lupus Erythematosus (1109)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Anti-nuclear antibody (ANA) test, Anti-dsDNA, or anti-Smith antibody test results
- ✓ Results of all Urinalysis and Complete Blood count
- ✓ Results of scans such as Chest x-ray, ultrasound and CT Scan



Myelitis



Definition

Myelitis is the inflammation of the spinal cord that damages the myelin (insulating layer around the nerves). There are different types of myelitis depending on the cause of infection (bacterial myelitis, viral myelitis) or the affected area of the spinal cord (transverse myelitis). Myelitis may result in an injury to the spinal cord, which could be life-threatening if not treated early.

Myelitis with hospitalization and significant symptoms such as muscle weakness, difficulty in movement, paralysis, or numbness of the arms or legs lasting for at least 14 consecutive days can already be covered by the Early CI Benefit.



Myelitis



What is covered?

A final diagnosis of myelitis confirmed by a neurologist or specialist doctor requiring in-patient treatment (hospitalization) with significant symptoms such as muscle weakness, difficulty in movement, paralysis, or numbness of the arms or legs lasting for at least 14 consecutive days



What is NOT covered?

Myelitis in the presence of HIV



Myelitis



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Paralysis [APS – Paralysis (1009)] accomplished by the insured's attending doctor
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Results of imaging tests, such as MRI Scan
- ✓ Blood and urine test to check on infection and antibodies for myelitis
- ✓ Lumbar puncture result (fluid sample is taken from the spine and checked for infection)



Osteoporosis With Fracture



Definition

Osteoporosis is a disease that makes the bones less dense, thinner, weaker, and brittle, which can increase the risk of fractures (broken bones) in older people.

Fractures caused by osteoporosis most often occur in the hips (usually at the femoral neck) or vertebrae of the spine.

The early stage of osteoporosis usually has no symptoms; however, once the bones become more fragile, pain symptoms may be felt if a fracture occurs, even from a mild fall or from bending over.

Severe stages of osteoporosis resulting in fractures treated with surgery are covered in the Early CI Benefit, as the cost of treatment and rehabilitation is expensive.

Osteoporosis With Fracture



What is covered?

Benefits would be payable if all of the following conditions are met:

- A final diagnosis of severe osteoporosis by a specialist doctor
- Bone mineral density or DEXA scan indicative of severe osteoporosis or CT Scan (T-score of less than -2.5 is a diagnosis for osteoporosis)
- Fracture of the neck of femur (hip fracture) or two vertebral body fractures (spine fracture)
- Surgical procedure (internal fixation of screws, plates, wires or replacement of the fractured bone has been done)

Note: This benefit terminates when the insured reaches age 70

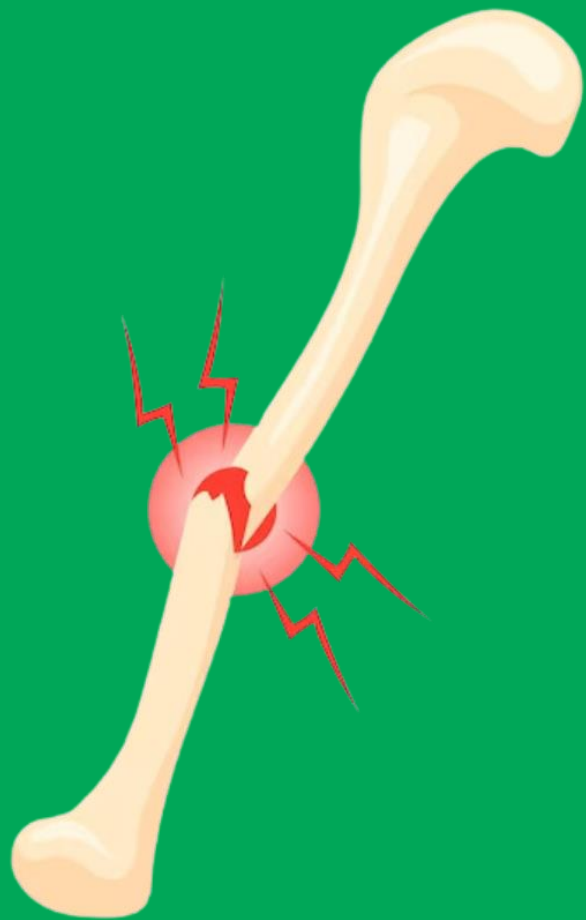


Osteoporosis With Fracture



What is NOT covered?

- Mild to moderate osteoporosis
- Arthritis
- Other types of fractures



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Disease/Critical Illness – Others [APS – Others] accomplished by the insured's attending doctor
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Record of Operation or Operative Record - internal fixation or replacement of the fractured bone
- ✓ Results of imaging tests, such as CT Scan for osteoporosis (T score), Bone mineral density scan (DEXA)



Progressive Scleroderma



Definition

A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs.



What is covered?

The diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.



Progressive Scleroderma



What is NOT covered?

- Localized scleroderma (linear scleroderma or morphea);
- Eosinophilic fasciitis; and
- CREST syndrome.

What are the requirements needed?

- ✓ Attending Physician Statement form for Others [APS – Others]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Biopsy Result



Severe Rheumatoid Arthritis



Definition

Chronic Rheumatoid arthritis as a result of autoimmune disturbance which is diagnosed by a rheumatologist and immunologist.



Severe Rheumatoid Arthritis



What is covered?

All of the following criteria should be met:

- Diagnosis based on American College of Rheumatology guidelines, and
- Chronic progressive joint destruction with deformity, affecting at least three following joints (e.g. interphalangeal hand joints, wrists, elbows, knees, hips, ankles, cervical bones, or interphalangeal foot joints). The diagnosis must be supported by clinical examination and imaging study evidenced the involvement.
- There is the permanent inability to perform, without any form of assistance, three (3) of the six (6) Activities of Daily Living for a continuous period of at least 180 days.



Severe Rheumatoid Arthritis



What is NOT covered?

Not all three criteria are satisfied.



What are the requirements needed?

- ✓ Attending Physician Statement form for Severe Rheumatoid Arthritis confirmed by rheumatologist and immunologist [APS - Severe Rheumatoid Arthritis (0809)]
- ✓ Latest discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Care giving questionnaire form



Systemic Lupus Erythematosus (SLE)



Definition

A multisystem, autoimmune disorder characterized by the development of autoantibodies directed against various self- antigens.



What is covered?

- Systemic lupus erythematosus will be restricted to those forms which involve the kidneys (Type III to Type V Lupus Nephritis, established by renal biopsy) or Central Nervous System (CNS).
- CNS Lupus means seizures with permanent neurological deficit. The final diagnosis must be confirmed by a certified doctor specializing in Rheumatology and Immunology.



Systemic Lupus Erythematosus (SLE)

✕ What is NOT covered?

Other forms of lupus, including discoid lupus and forms which involve only blood or joint are specifically excluded.

WHO Lupus Classification:

- Class I - Minimal change glomerulonephritis
- Class II - Mesangial glomerulonephritis
- Class III - Focal Segmental glomerulonephritis
- Class IV - Diffuse glomerulonephritis
- Class V - Membranous glomerulonephritis

Lupus Nephritis other than Types III to V

CNS Lupus without permanent neurological deficit

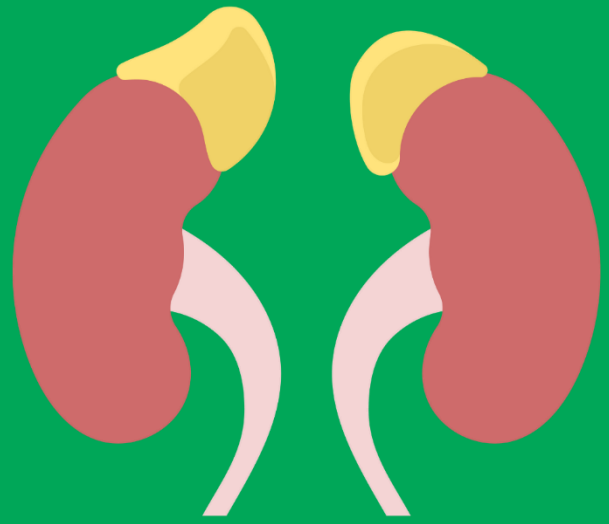


Systemic Lupus Erythematosus (SLE)

What are the requirements needed?

- ✓ Attending Physician Statement form for Systemic Lupus Erythematosus [APS - Systematic Lupus Erythematosus (1109)]
- ✓ Renal Biopsy
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Medical Certification stating type of Lupus Nephritis





Endocrine System- Related Diseases

Chronic Adrenal Insufficiency (Addison's Disease)



Definition

An autoimmune disorder causing a gradual destruction of the adrenal gland resulting in the need for life-long glucocorticoid and mineral corticoid replacement therapy.



What is covered?

Must be confirmed by a medical practitioner who is a qualified specialist through:

- ACTH simulation tests;
- Insulin-induced hypoglycemia test;
- Plasma ACTH level measurement; and
- Plasma Renin Activity (PRA) level measurement.

Only autoimmune cause of primary adrenal insufficiency is included.



Chronic Adrenal Insufficiency (Addison's Disease)



What is NOT covered?

Adrenal insufficiency not caused by autoimmune disorder

What are the requirements needed?

- ✓ Attending Physician Statement form for Others [APS – Others]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ ACTH test result
- ✓ Insulin-induced hypoglycemia test
- ✓ Plasma ACTH level measurement; and
- ✓ Plasma Renin Activity (PRA) level measurement



Pheochromocytoma



Definition

Presence of a neuroendocrine tumor of the adrenal or extra-chromaffin tissue that secretes excess catecholamines requiring the actual undergoing of surgery to remove the tumor.



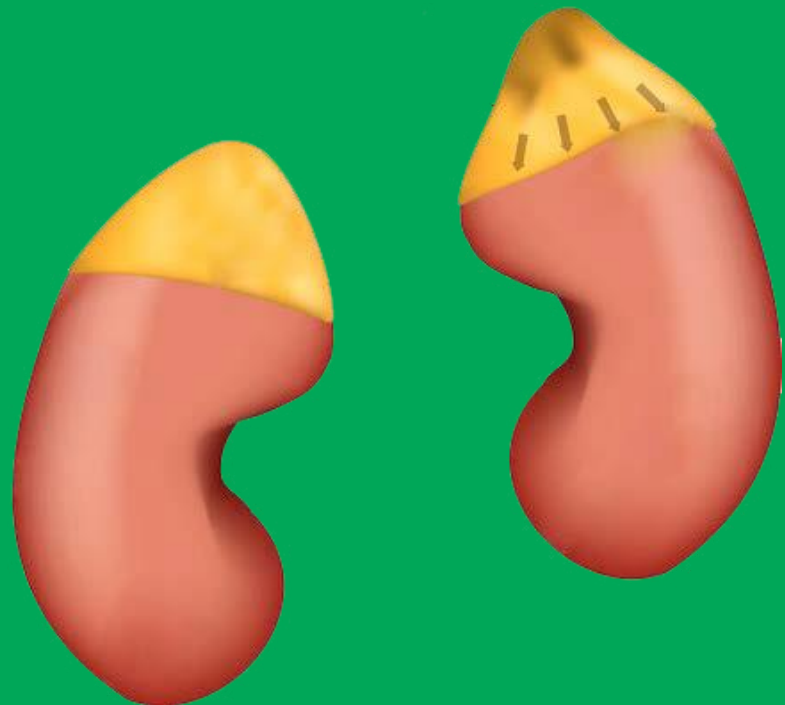
What is covered?

Tumor that requires surgery for removal

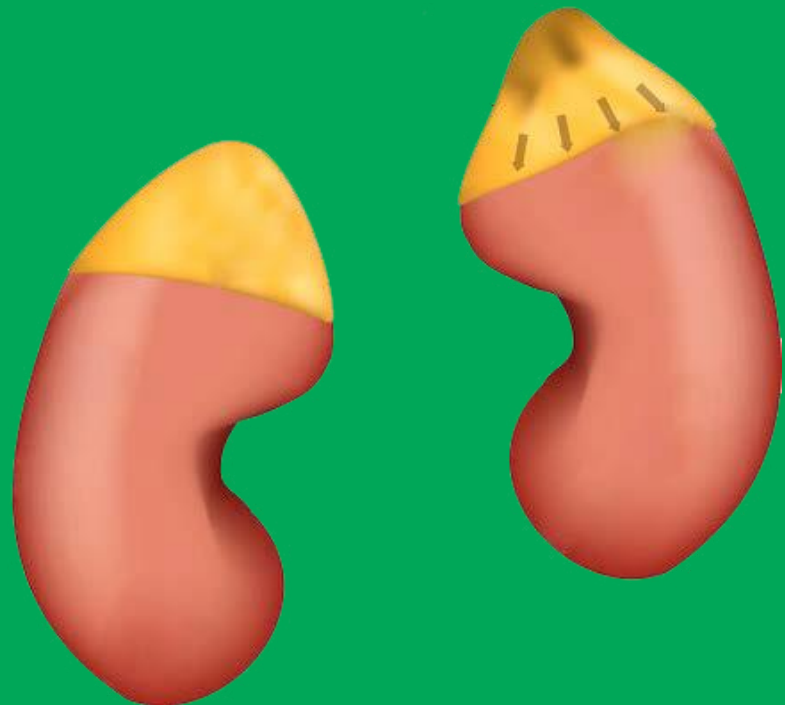


What is NOT covered?

Tumor not requiring surgery



Pheochromocytoma



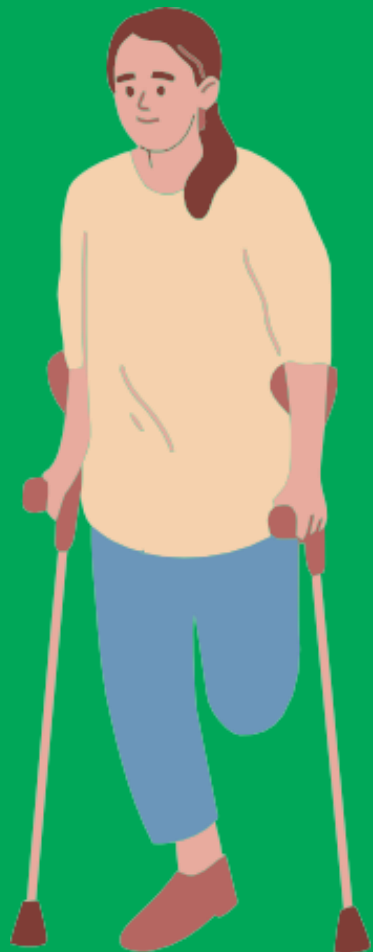
What are the requirements needed?

- ✓ Attending Physician Statement form for Others [APS – Others]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Record of Operation or Operative Record



Accidents and Forms of Disability

Amputation due to complication from Diabetes



Description

The actual undergoing of amputation of a leg or foot at or above the level of the ankles to treat gangrene that has occurred as a complication of diabetes.



What is covered?

The actual undergoing of amputation of a leg or foot at or above the level of the ankles to treat gangrene that has occurred as a complication of diabetes.

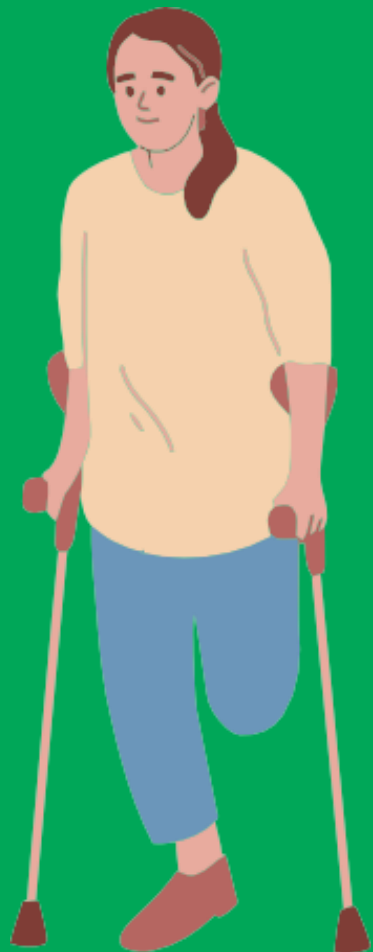


What is NOT covered?

- Amputation has not been done.
- Amputation is below the level of the ankles.



Amputation due to complication from Diabetes



What are the requirements needed?

- ✓ Attending Physician Statement Others [APS – Others]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Record of Operation or Operative Record



Blindness



Definition

Permanent and irreversible loss of sight in both eyes as a result of illness or accident to the extent that even when tested with the use of visual aids, vision is measured at 6/60 (or 20/200) or worse in both eyes using a Snellen eye chart or equivalent test, or visual field of 20 degrees or less in both eyes



What is covered?

- Permanent and irreversible loss of sight in both eyes due to illness or accident. This is defined as vision measuring 6/60 (or 20/200) or worse in both eyes, even with visual aids, using a Snellen eye chart or equivalent test, or having a visual field of 20 degrees or less in both eyes.
- The blindness must be confirmed by an ophthalmologist.



Blindness



What is NOT covered?

- Temporary and reversible loss of sight.
- Only 1 eye is declared as blind.

What are the requirements needed?

- ✓ Attending Physician Statement for Blindness signed by an Ophthalmologist [APS - Blindness (1009)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Visual acuity test result



Cochlear Implant Surgery



Definition

The cochlea is a snail-like, coiled tube in the inner part of the ear which is a vital organ for hearing. As the sound waves travel through the ear canal to the ear drum, these sounds turn into vibration, which the cochlea converts into signals through the auditory nerve and transmits them to the brain, which then interprets them into sounds.

Cochlear implants need surgery to provide a sense of hearing for the deaf or for those with severe hearing impairments by electrically stimulating the auditory nerve to transmit signals to the brain. Although a cochlear implant cannot restore normal hearing, it may allow hearing of sounds and understanding speech.

A cochlear implant is different from hearing aid in that it amplifies the sound for mild to moderate hearing impairment.



Cochlear Implant Surgery



What is covered?

Benefits would be payable if all the following conditions are met:

- A surgical cochlear implant required due to permanent damage to the cochlea or auditory nerve is done.
- Severe sensorineural hearing impairment (hearing loss in cochlea or auditory nerve) in both ears for over twelve (12) consecutive months



What is NOT covered?

- Hearing aids
- Conductive hearing impairment (hearing loss caused by outer and middle ear)



Cochlear Implant Surgery



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Loss of Hearing [APS – Loss of Hearing (1009)] accomplished by the insured's ENT
- ✓ Audiometric and sound-threshold tests results for the past 12 months
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement



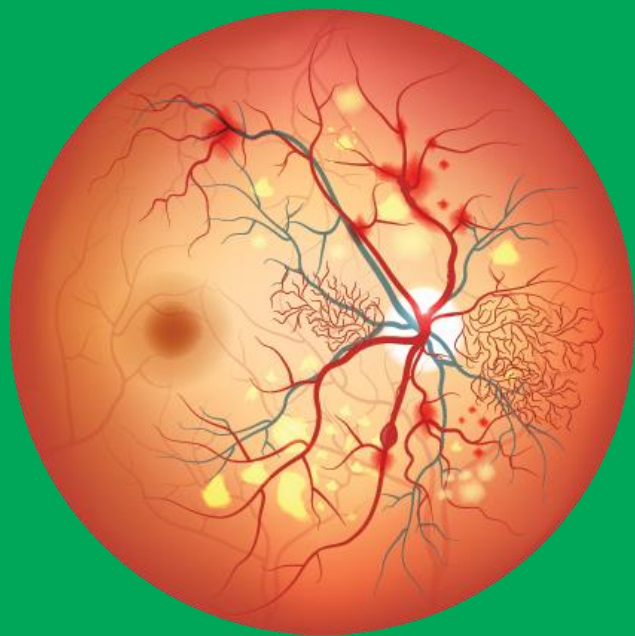
Diabetic Retinopathy



Definition

Diabetes mellitus (diabetes) is related to high blood sugar level in the body, which can lead to serious health problems such as heart disease, stroke, kidney disease, and limb amputations. As diabetes damages the blood vessels in our body, it can also damage the blood vessels in the retina (part of the eye that detects light and transmits signals to the brain), causing vision loss and blindness, called diabetic retinopathy.

Diabetic retinopathy usually does not present any symptoms during its early stages, but if diabetes is not well controlled, it could lead to progressive damage to the retina, leading to irreversible loss of vision and permanent blindness.



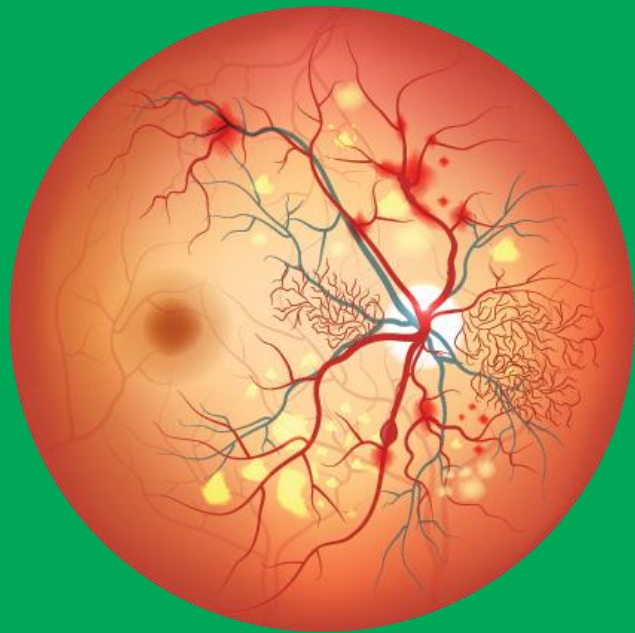
Diabetic Retinopathy



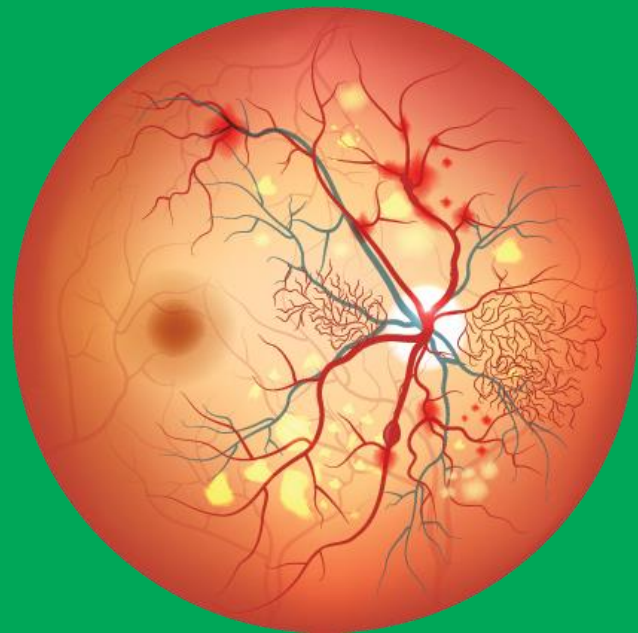
What is covered?

Benefits would be payable if all the following conditions are met:

- Presence of diabetes mellitus at the time of diagnosis of Diabetic Retinopathy by an ophthalmologist (eye doctor) and a diabetic doctor
- Impaired vision with a visual acuity of both eyes at 6/18 or worse using the Snellen eye chart (measures visual acuity)
- Retinal laser treatment or eye surgery done to prevent vision loss



Diabetic Retinopathy



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Blindness [APS – Blindness (1009)] accomplished by the insured's ophthalmologist or diabetic doctor
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Visual acuity test result
- ✓ Record of Operation or Operative Record retinal laser treatment or eye surgery

Facial Burns due to Accident



Definition

Facial burns from an accident can be devastating. If not immediately treated, facial burn injuries may cause permanent loss of function (sight, speech, swallowing, smelling, and hearing), damaged physical appearance, severe pain, infection, emotional distress, and loss of self-esteem.

Burns are classified as first-degree (superficial), second-degree (partial-thickness skin destruction), or third-degree (full-thickness skin destruction) depending on the severity, extent, and depth of the skin damaged. The higher the degree, the more severe the burn.

Among these, only third-degree burn, which is a serious burn injury destroying all the layers of the skin and requiring immediate medical treatment, are covered in the Early CI Benefits.



Facial Burns due to Accident

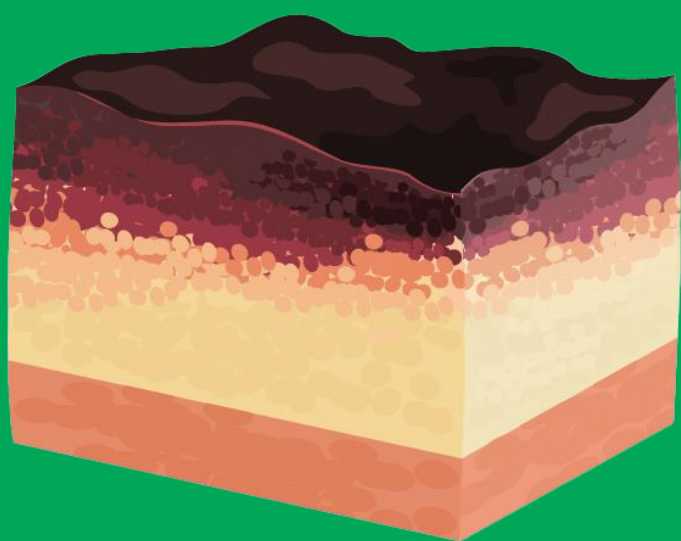


What is covered?

- Third degree burn (full thickness skin destruction) because of an accident* covering at least thirty (30%) percent of the surface of the face confirmed by a specialist doctor.

*An accident is any external, sudden, unforeseen, visible, and unexpected physical event resulting in bodily injury.

Note: Only one claim shall be made for the related burn injuries. Where both 'facial burns due to accident' and 'less severe burns to the body due to accident' are caused by the same accident, only one claim shall be made under the Early CI Benefit for the related burn injuries.



Facial Burns due to Accident



What is NOT covered?

- First- and second-degree facial burns
- Burns not caused by accidents.

What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician Statement for Major Burns [APS - Major Burns (1009)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Police report / Traffic Accident Report or Incident report
- ✓ Hospital Records on burn documentation, admitting history of accidental burn injury, severity, extent (burned surface area of the face), and depth of burn, and treatment



Facial Reconstructive Surgery for Injury due to Accident

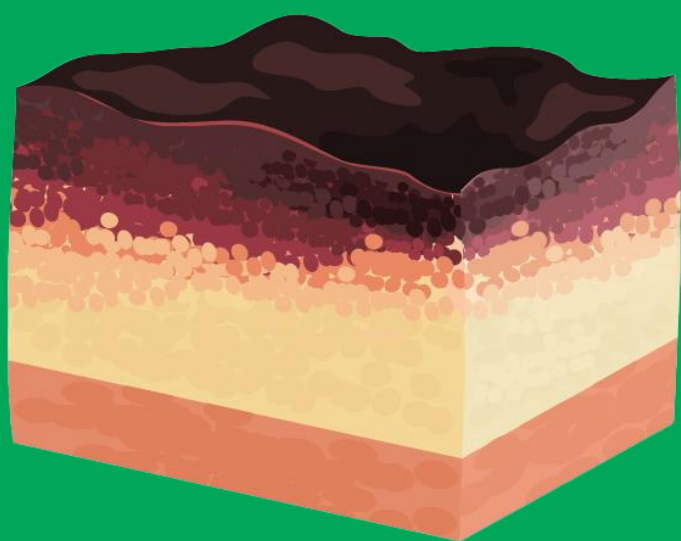


Definition

Our face has important functional features which are critical to survival, such as eyes, nose, mouth, and ears. Beyond these functional features, our face plays a vital role for human interactions, communication, identity, and quality of life.

Facial injury due to accident can cause permanent loss of functions (sight, speech, swallowing, smelling, and hearing), damaged facial appearance (disfigurement), severe bleeding, extreme pain, and loss of self-esteem.

Facial reconstructive surgery is essential for the restoration of its normal functioning, affected by facial injury and for optimizing the shape and appearance of facial structures above the neck. Facial injury due to an accident would necessitate in-patient treatment to assess the degree of the trauma and subsequently perform facial reconstructive surgery.



Facial Reconstructive Surgery for Injury due to Accident



What is covered?

Benefits would be payable if all the following conditions are met:

- Plastic or facial reconstructive surgery, required to restore or reconstruct the shape and appearance of facial structures above the neck which are defective, missing, or damaged due to an accident*, which has already been done

*An accident is any external, sudden, unforeseen, visible, and unexpected physical event resulting in bodily injury.

- Prior in-patient treatment (hospitalization) is required prior to the plastic or facial reconstructive surgery.



Facial Reconstructive Surgery for Injury due to Accident



What is NOT covered?

- Facial reconstructive surgery for cosmetic reasons
- Facial reconstructive surgery for correction of a congenital facial abnormality
- Isolated dental restorations, isolated nasal fractures. or isolated skin wound
- Non-accidental cause

What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Disease/Critical Illness - Others [APS – Others] accomplished by the insured's attending doctor
- ✓ Results of imaging test such as x-ray, CT scan, MRI scan
- ✓ Hospital and Surgical Records on facial reconstructive surgery including admitting history of accidental injury, severity, extent of facial injuries, and treatment



Less Severe Burns To Body due to Accident



Definition

Severe burns from an accident can be devastating. This life-threatening emergency must be treated urgently as it may cause permanent loss of function, breathing complications, severe pain, blood infection (sepsis), and shock (a dangerous drop in blood pressure).

Burns are classified as first-degree, second-degree, or third-degree depending on the severity and how deep the skin has been damaged. The higher the degree, the more severe the burn.

Among these, only third-degree burn (full thickness skin destruction), which is a serious burn injury destroying all the layers of the skin and requiring immediate medical treatment, is covered in Early CI,

Third-degree burns have varying extents or sizes of damage to the total skin area. For Early CI Benefit, at least 10% of the total skin area is damaged as measured by the Rule of Nines or Lund and Browder chart for estimating the total body surface area affected.



Less Severe Burns To Body due to Accident



What is covered?

Third degree burn (full thickness skin destruction), caused by an accident*, covering at least ten (10%) percent of the total skin area as confirmed by a specialist

*An accident is any external, sudden, non-disease, unforeseen, visible, and unexpected physical event resulting in body injury.

Note: Only one claim shall be made for burn injuries. Where both 'less severe burns to the body due to accident' and 'facial burns due to accident' are caused by the same accident, only one claim shall be made under the Early CI Benefit for the related burn injuries.



What is NOT covered?

- First- or second-degree burns
- Burns not caused by accidents



Less Severe Burns To Body due to Accident



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician Statement for Major Burns [APS - Major Burns (1009)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Police report / Traffic Accident Report or Incident report



Loss of Hearing



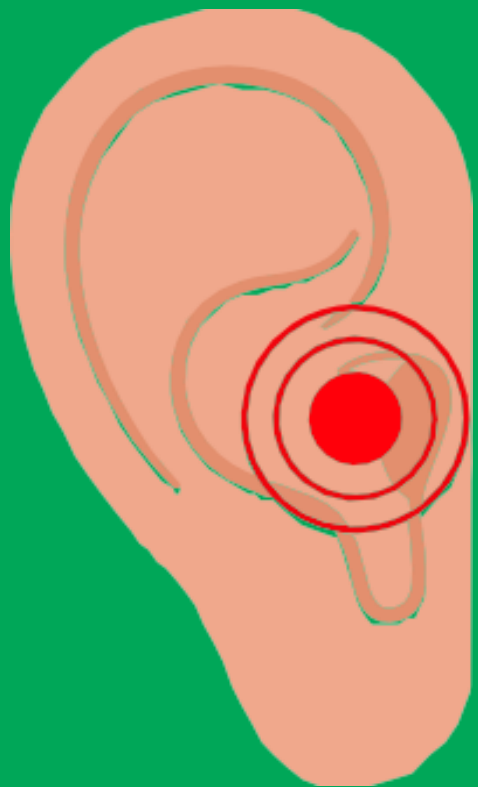
Definition

Total and irreversible loss of hearing in both ears as a result of illness or accident.



What is covered?

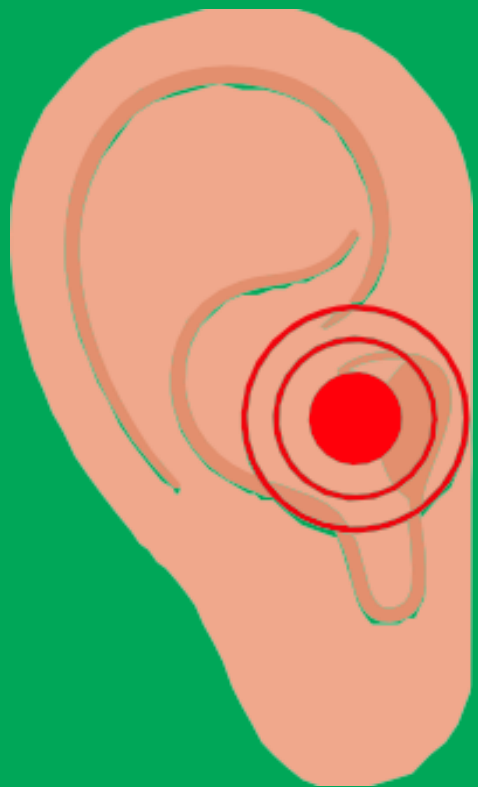
- This diagnosis must be supported by audiometric and sound-threshold tests provided and certified by an Ear, Nose, Throat (ENT) specialist.
- Total means the loss of at least 80 decibels in all frequencies of hearing.



Loss of Hearing

✕ What is NOT covered?

- Hearing loss does not reach 80 decibels on all frequencies
- Temporary and reversible loss of hearing
- Hearing loss in only one (1) ear



What are the requirements needed?

- ✓ Attending Physician Statement Loss of Hearing signed by an ENT specialist [APS – Loss of Hearing) (1009)]
- ✓ Audiometric and sound-threshold tests
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement

Loss of Hearing in One Ear



Definition

Our ears are among the most important sensory organs of our body. Apart from detecting, localizing, and identifying sounds, they are essential for communication, interaction, and for our sense of balance.

Loss of hearing has different types and severity. It can be partial or total, temporary or permanent (irreversible), and can affect one or both ears. Among these, only total and permanent loss of hearing involving the loss of at least 80 decibels in all frequencies is covered in the Early CI Benefit.

The Early CI Benefit covers loss of hearing in one ear even if hearing in the other ear is within normal limits.



Loss of Hearing in One Ear



What is covered?

Total and irreversible loss of hearing (involving the loss of at least 80 decibels in all frequencies of hearing) in one ear because of illness or injury.



What is NOT covered?

- Loss of hearing in one ear since birth



Loss of Hearing in One Ear



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement Loss of Hearing [APS – Loss of Hearing) (1009)] accomplished by an ENT specialist
- ✓ Audiometric and sound-threshold tests
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement

Loss of Independent Existence



Definition

The permanent loss of independent existence resulting in a permanent inability to perform, without any form of assistance at least three (3) of the six (6) Activities of Daily Living for a continuous period of at least 180 days with or without using mechanic tool, special tool or other assistance and adaptation to use such tool for the disabled people.



Loss of Independent Existence



What is covered?

- The permanent loss of independent existence resulting in a permanent inability to perform, without any form of assistance at least three (3) of the six (6) Activities of Daily Living for a continuous period of at least 180 days with or without using mechanic tool, special tool or other assistance and adaptation to use such tool for the disabled people.
- Loss of independent existence must be confirmed by doctor.
- Permanent means that the condition would not be recovered by current knowledge and technology.



Loss of Independent Existence



What are the requirements needed?

- ✓ Attending Physician Statement form for Others [APS – Others]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Complete Neurological Exam report
- ✓ Care Giving Questionnaire



Loss of Limbs



Definition

Total and irreversible severance of two limbs at or above the wrist or ankle.



What is covered?

Total and irreversible severance of two limbs at or above the wrist or ankle.



What is NOT covered?

Only 1 limb or no limb is severed.



Loss of Limbs



What are the requirements needed?

- ✓ Attending Physician Statement [APS-Loss of Limbs (0710)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Record of Operation or Operative Record
- ✓ Photos of severed limb

Loss of One Limb



Definition

Loss or severance of a limb is the permanent physical separation or total loss of one limb at or above the wrist or ankle due to an illness or severe injury. Loss of limb affects functional capacity and body image, which significantly impacts overall physical and mental health.

Amputation is a surgery that removes all or a portion of a limb. The level at which the amputation has been performed – permanent physical severance of either above the wrist joint (loss of hand), or above the ankle (loss of foot), or entire limb – determines the eligibility for Early CI Benefit.

Early CI Benefit covers loss of one (1) limb at or above wrist (loss of hand) or ankle (loss of foot).



Loss of One Limb



What is covered?

Physical severance or total and permanent loss of any of the following due to an illness or injury:

- one entire limb
- loss of one (1) hand (above the wrist joint)
- loss of one (1) foot (above the ankle joint)



What is NOT covered?

- Loss of one limb due to attempted suicide or self-inflicted injury
- Loss of one limb while under the influence of drugs or alcohol
- Amputation due to congenital abnormality



Loss of Sight in One Eye

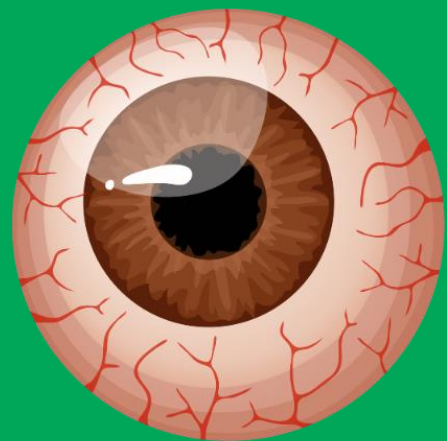


Definition

Our eyes are not just windows to the soul; they are windows into our brain. Did you know that 80% of the information from the world around us—colors, shapes, movement, and more — that reaches our brain comes from our eyes?

Loss of sight has a significant impact on our physical health, mobility, independence, and quality of life. It can be partial or total, temporary or permanent (irreversible), and can affect one or both eyes. Among these, only total and permanent loss of sight that cannot be corrected with glasses, contact lenses, or any medical procedure is covered by the Early CI Benefit.

Early CI Benefit covers loss of sight in one eye even if the sight in the other eye is within normal limits.



Loss of Sight In One Eye



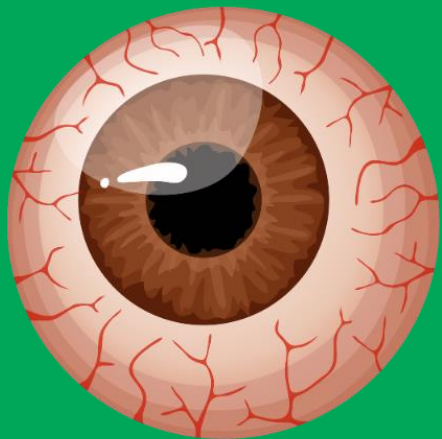
What is covered?

Total and irreversible loss of sight in one eye due to illness or injury

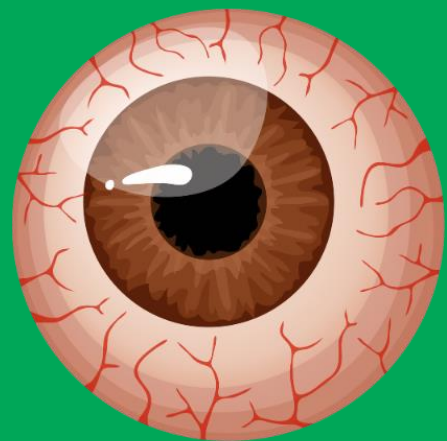


What is NOT covered?

- Congenital blindness



Loss of Sight in One Eye



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Blindness [APS – Blindness (1009)] accomplished by the insured's ophthalmologist
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Visual acuity test result
- ✓ Police report / Traffic Accident Report or Incident report (if due to accidental injury)

Loss of Speech



Definition

Total and irrecoverable loss of the ability to speak due to physical damage to the vocal cords which must be established for a continuous period of six (6) months



What is covered?

- Total and permanent inability to speak due to physical damage to the vocal cords lasting at least six (6) continuous months.
- The diagnosis must be supported by medical evidence furnished by an appropriate specialist.



Loss of Speech

✕ What is NOT covered?

- All psychiatric related causes are excluded
- Loss of speech not lasting for a continuous 6-month period



What are the requirements needed?

- ✓ Attending Physician Statement for Loss of Speech [APS – Loss of Speech (1009)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement



Major Burns



Description

Third degree burns which results in full thickness skin destruction of at least 20% of the total skin area of the Insured's body.



What is covered?

Third degree burns which results in full thickness skin destruction of at least 20% of the total skin area of the Insured's body.



Major Burns



What are the requirements needed?

- ✓ Attending Physician Statement for Major Burns [APS - Major Burns (1009)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement

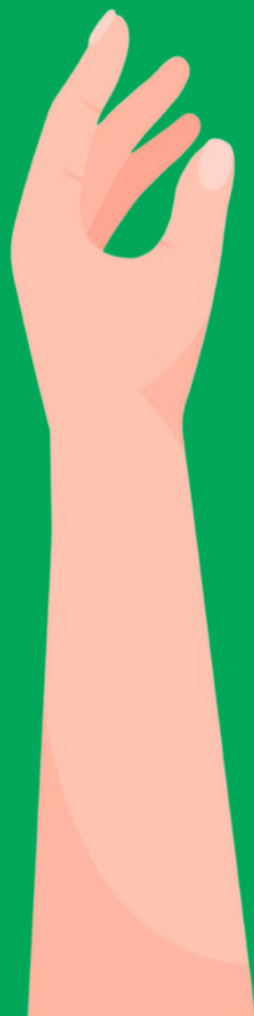
Moderately Severe Paralysis



Definition

Paralysis of the limb (arm or leg) means the loss of the ability to use, move, and feel in the affected limb, which has a significant impact on balance, mobility, independence, and quality of life. It can be partial or total, temporary or permanent (irreversible), and can affect one or both limbs, depending on the extent of damage to the brain, spinal cord, or nerves due to an illness or injury.

Among these, only complete (total) and permanent loss of use of the one entire limb through paralysis is covered.



Moderately Severe Paralysis



What is covered?

Complete (total) and permanent (irreversible) loss of use of one entire arm or one entire leg through paralysis, caused by illness or injury. Loss of use means total and permanent functional disablement and is treated like the total loss of the said limb



What is NOT covered?

- Mild or temporary paralysis
- Due to congenital abnormality
- Due to psychological causes due to mental and behavioral health issues
- Self-inflicted injury



Moderately Severe Paralysis

What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Paralysis [APS – Paralysis (1009)] accomplished by the insured's attending doctor
- ✓ Latest discharge summary or clinical/medical abstract if the insured was confined in a medical facility
- ✓ Caregiving questionnaire



Paralysis



Definition

Total and irreversible loss of use of at least two (2) entire limbs due to injury or disease. This condition must be confirmed by an appropriate medical specialist.



What is covered?

Total and irreversible loss of use of at least two (2) entire limbs due to injury or disease.



Paralysis

✕ What is NOT covered?

- Paralysis due to self-inflicted injuries
- Loss of use of at least two (2) entire limbs is not total and irreversible
- Total and irreversible loss of use of only one entire limb



What are the requirements needed?

- ✓ Attending Physician Statement for Paralysis [APS-Paralysis (1009)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Caregiving questionnaire



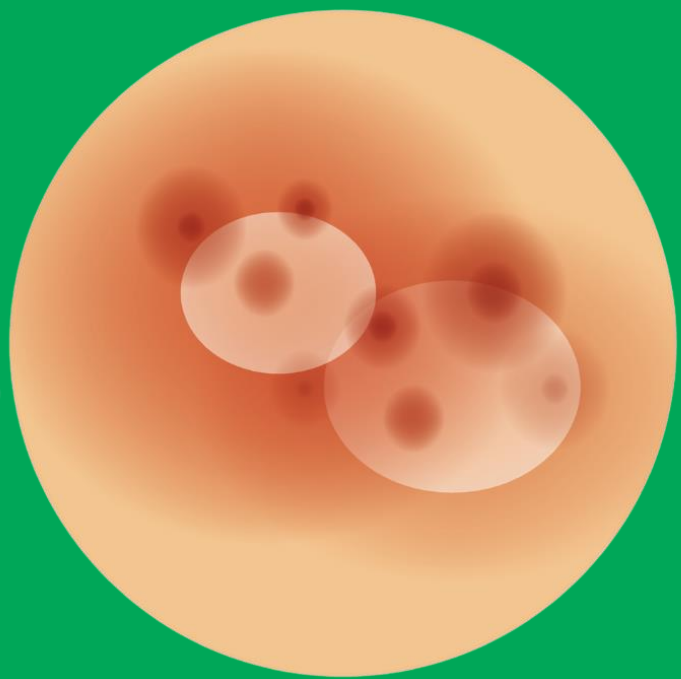
Skin Transplantation



Definition

Did you know that the skin is the largest organ in the body? It covers the whole body and protects it from too much heat or cold, chemicals, injuries, and infections.

Skin transplantation is the treatment of choice if the damaged skin cannot heal on its own. This procedure includes taking healthy skin from one part of the body or from a donated cadaver, and transplanting it to cover the damaged or missing skin. Eventually, the skin graft will develop blood vessels, connect to the surrounding skin, and heal it.



Skin Transplantation



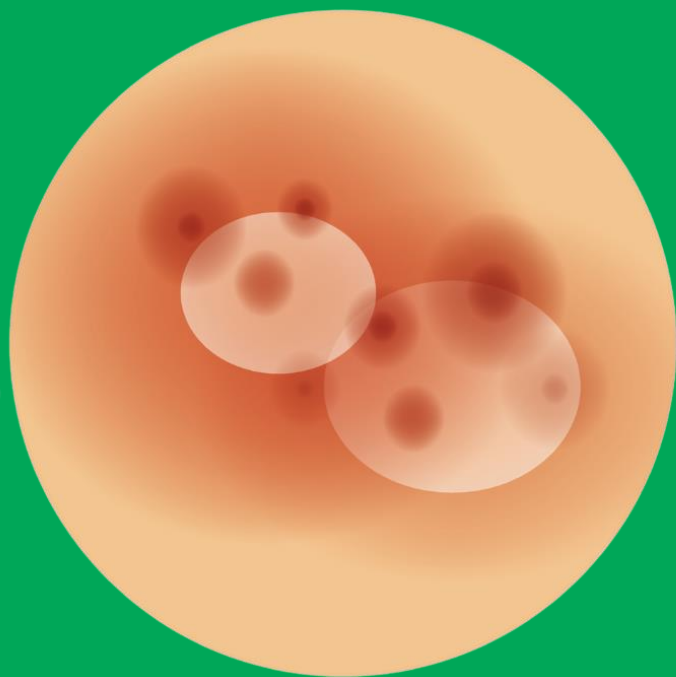
What is covered?

Actual skin transplant to treat loss of skin following a disease or injury caused by thermal, chemical or electric agents, with a skin graft covering at least 10% of the body surface area as measured by The Rule of Nines or the Lund and Browder Body Surface Chart



What is NOT covered?

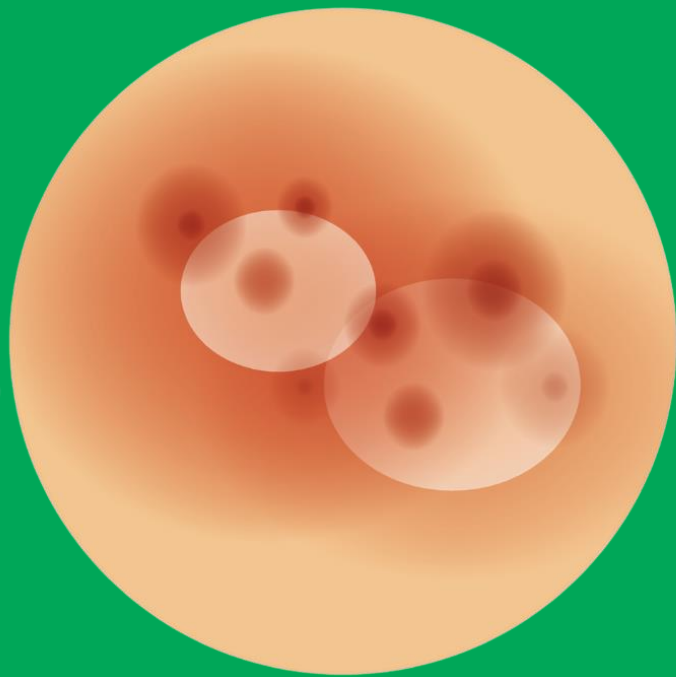
- Loss of skin due to self-inflicted injury
- Loss of skin due to injuries while under the influence of drugs or alcohol
- Skin transplant for cosmetic reasons



Skin Transplantation

What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Disease/Critical Illness – Others [APS – Others]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Record of Operation or Operative Record - skin grafting



Total and Permanent Disability



What is covered?

- The Insured has suffered a disability between the ages of 18 and 65, caused by disease or bodily injury which is total and permanent leading to a state of inability to engage in any occupation or from performing any work for remuneration or profit. Such state of inability must have continued without interruption for at least 180 days; or
- Insured has suffered total and irrecoverable loss of use of:
 - both eyes, or
 - any two limbs at or above the wrist or ankle, or
 - one eye and any one limb at or above the wrist or ankle
- Insured has suffered a disability caused by disease or bodily injury which is total and permanent leading to a state of inability to perform, without any form of assistance, at least three (3) of the six (6) Activities of Daily Living for a continuous period of at least 180 days.



Total and Permanent Disability



What is NOT covered?

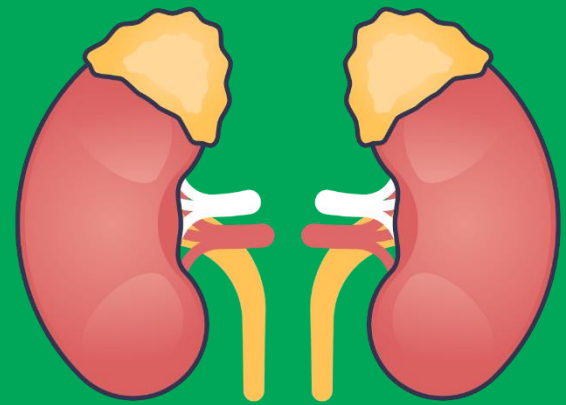
- The disability lasts for less than 180 days; or
- Loss of use of only one eye; or
- Loss of only one limb; or
- Loss of two limbs below the wrist or ankle; or
- Inability to perform three (3) ADLs for less than 180 days; or
- Inability to perform less than three (3) ADLs for at least 180 days.

Total and Permanent Disability



What are the requirements needed?

- ✓ Attending Physician Statement form for Total and Permanent Disability [APS - Total and Permanent Disability (1109)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Care Giving Questionnaire Form
- ✓ Neurological Exam Report (if stroke or neuro related)



Specific Diseases and Procedures

Elephantiasis



Description

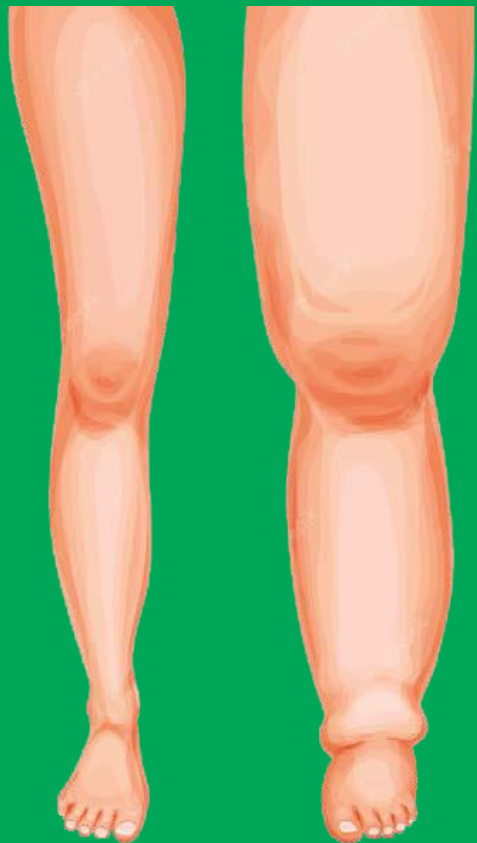
End stage Lymphatic Filariasis



What is covered?

Must meet all of the following criteria:

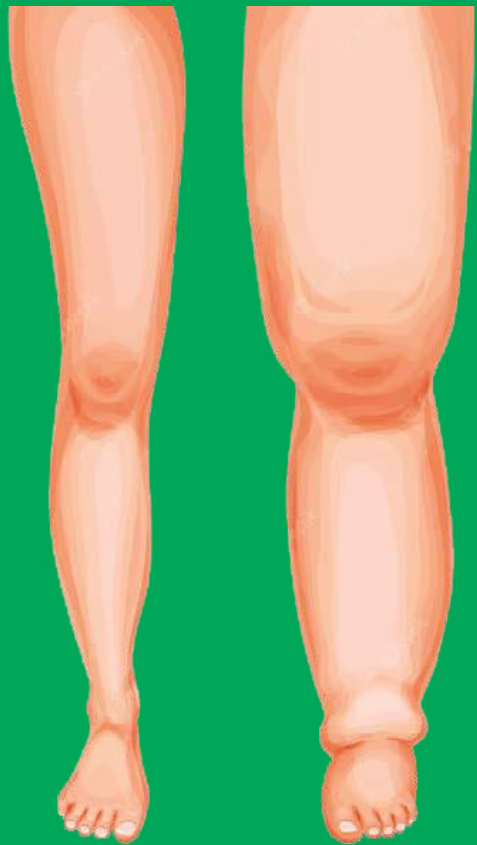
- Significant enlargement and disfiguration of the infected body (legs, genitals or breasts) due to blockage of the lymphatic system by filariae parasites;
- The diagnosis of permanent lymphatic obstruction must be made by a Medical Practitioner who is a qualified specialist.
- Diagnosis must be supported by laboratory tests showing circulating filariae antigen or microfilariae in a blood smear (*Wuchereria bancrofti* or *Brugia malayi*).



Elephantiasis

✕ What is NOT covered?

- Other forms of lymphedema or acute lymphangitis
- Not all criteria are satisfied



What are the requirements needed?

- ✓ Attending Physician Statement form for Others [APS – Others]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Circulating filariae antigen or microfilariae blood result

HIV due to Blood Transfusion



Description

Infection with the Human Immunodeficiency Virus (HIV) through a blood transfusion.



What is covered?

All of the following must be met:

- The blood transfusion was medically necessary or given as part of a medical treatment;
- The blood transfusion was received in the Philippines after the Effective Date, date of Endorsement or date of any reinstatement of this Policy, whichever is later;
- The source of the infection is established to be from the Institution that provided the blood transfusion and the Institution is able to trace the origin of the HIV tainted blood; and
- The Insured does not suffer from Thalassemia Major or Hemophilia.



HIV due to Blood Transfusion



What is NOT covered?

- HIV infection not caused by blood transfusion
- Not all criteria are satisfied



What are the requirements needed?

- ✓ Attending Physician Statement form for Others [APS – Others]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Incident Report
- ✓ All blood related laboratory results



Major Organ Transplantation



Description

The actual undergoing , as a recipient of, a transplant of bone marrow using hematopoietic stem cells preceded by total bone marrow ablation, or transplant of a heart, lung, liver, pancreas, or kidney.



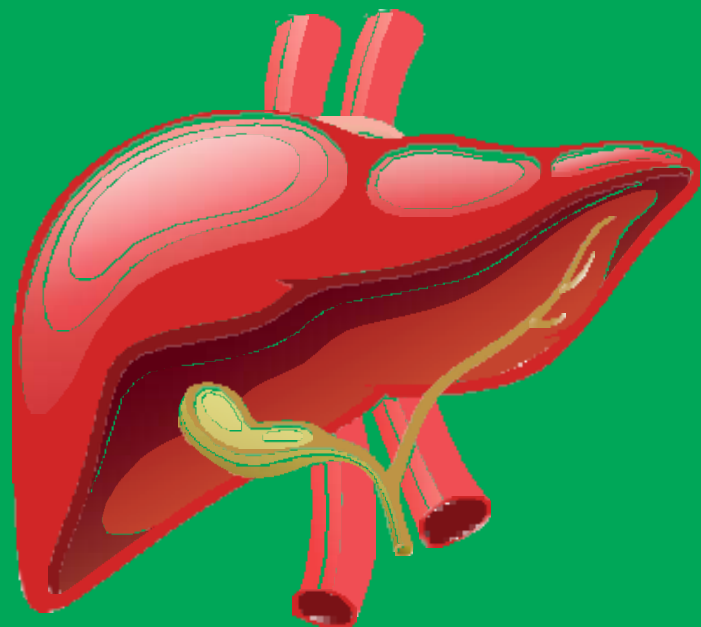
What is covered?

The transplant must have been clinically necessary to treat irreversible end stage failure of the relevant organ.

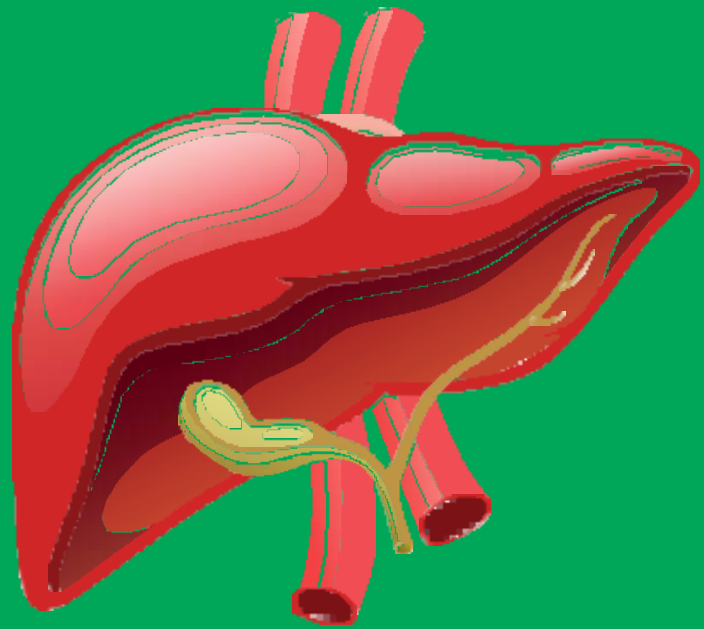


What is NOT covered?

- Other stem cell transplants, islet cell transplants and transplants of part of an organ
- Transplant is not clinically necessary



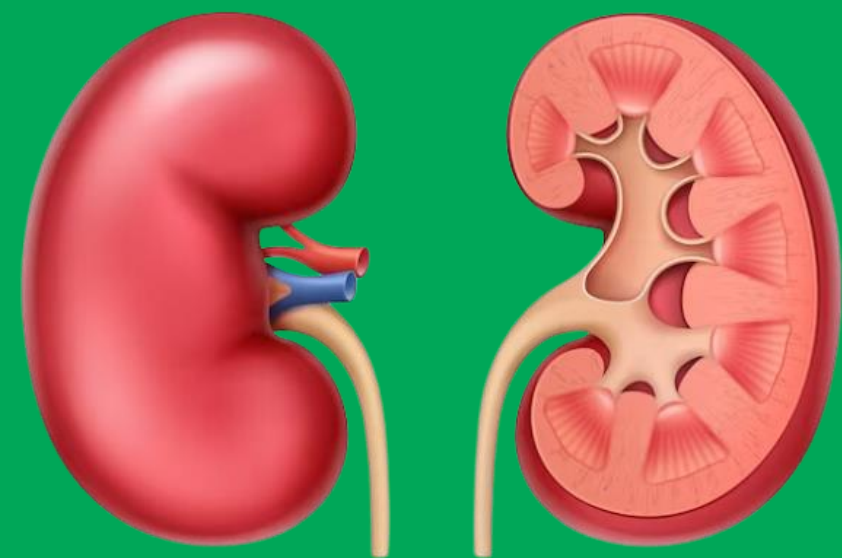
Major Organ Transplantation



What are the requirements needed?

- ✓ Attending Physician Statement for Major Organ Transplantation [APS - Major Organ Transplantation (1009)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Record of operation or Operative Record

Major Organ Transplantation (on Waiting List)



Definition

Keeping our major organs like the heart, liver, lungs, and kidneys healthy is key to a long and happy life. However, life threatening illnesses or severe injuries can damage our organs and may lead to irreversible organ failure, where the major organ stops working.

Transplantation is the best treatment for irreversible organ failure. Unfortunately, in the Philippines, the number of organ recipients on the waiting list is greater than the number of available organ donors. This is why those included in the active national waiting list for major organ transplant are already eligible for Early CI Benefit, even if the actual transplant has not been done.



Major Organ Transplantation (on Waiting List)



What is covered?

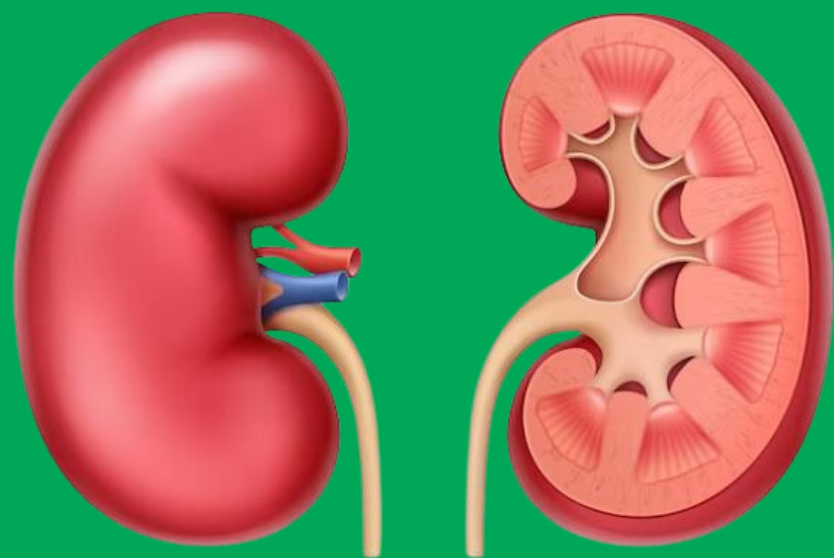
Benefits would be payable if all of the following conditions are met:

- Final diagnosis of irreversible organ failure made by a specialist doctor for any of the following:
 - Heart
 - Liver
 - Both Lungs
 - Both Kidneys
 - Bone Marrow
- Transplant must be medically necessary
- Must be included in the active national waiting list for major organ transplant.

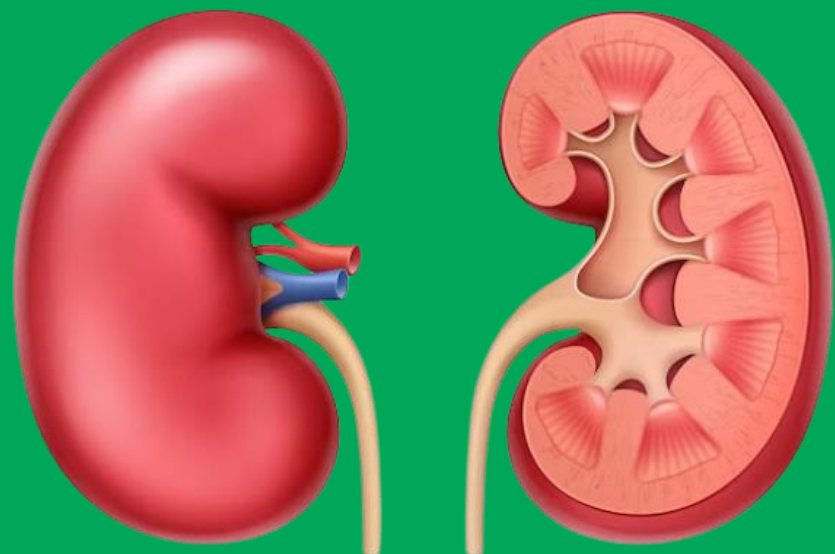


What is NOT covered?

- All other organ transplants are not covered
- Being an organ donor
- Illegal organ trade
- Organ failure due to alcohol or drug abuse



Major Organ Transplantation (on Waiting List)



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for Major Organ Transplantation [APS – Major Organ Transplantation (1009)] accomplished by the insured's attending specialist
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Inclusion in the national waiting list for organ recipients through Philippine Network for Organ Sharing (PHILNOS) under the Department of Health (DOH), or Human Organ Preservation Effort of the National Kidney and Transplant Institute (HOPE-NKTI) or any of its international counterparts

Necrotizing Fasciitis



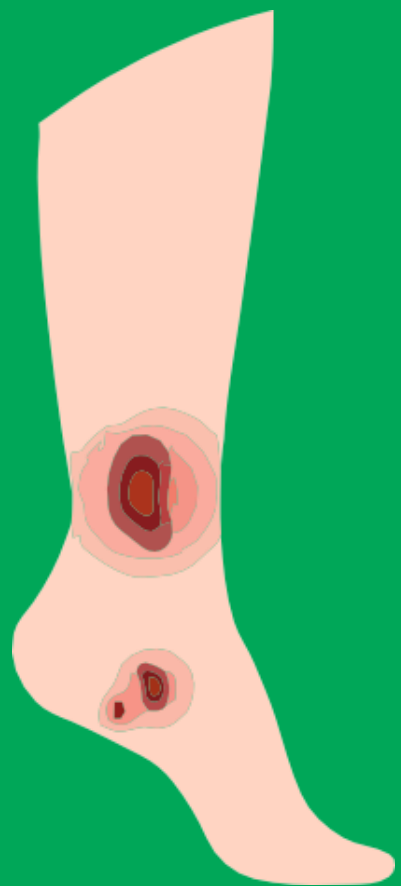
Description

Necrotizing fasciitis is a progressive, rapidly spreading, infection located in the deep fascia causing necrosis of the subcutaneous tissues.



What is covered?

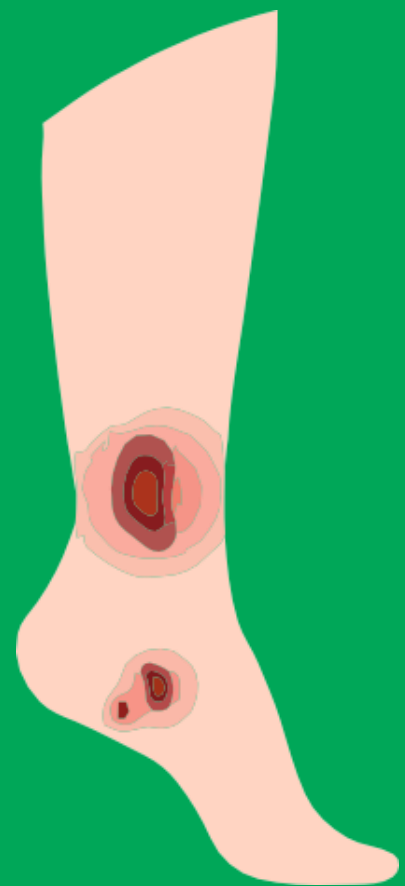
- An unequivocal diagnosis of necrotizing fasciitis must be made by a Medical Practitioner who is a specialist and the diagnosis must be supported with laboratory evidence of the presence of a bacterium that is a known cause of necrotizing fasciitis.
- There must also be widespread destruction of muscle and other soft tissues that results in a total and permanent loss or function of the affected body part.



Necrotizing Fasciitis

✕ What is NOT covered?

No widespread destruction of muscle and other soft tissues resulting in total and permanent loss or function of the affected body part



What are the requirements needed?

- ✓ Attending Physician Statement form for Others [APS – Others]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Laboratory results indicating the cause of infection is necrotizing fasciitis

Occupationally Acquired HIV



Description

Infection with the Human Immunodeficiency Virus (HIV) which resulted from an occupational accident occurring after the Policy Effective Date, date of Endorsement or date of any reinstatement of this Policy, whichever is the later.

The Company must be given access to independently test all the blood samples used and to take such additional samples as may be deemed necessary.

This benefit will not apply where a cure has become available before the infection. “Cure” means any treatment that renders the HIV inactive or non-infectious.



Occupationally Acquired HIV



What is covered?

The occupational accident must occur while the Insured was carrying out the normal professional duties of his or her occupation in the Philippines, subject to the following:

- (a) The accident must give rise to the infection within thirty (30) days of the accident taking place, and
- (b) Proof that the accident involved a definite source of the HIV infection, and
- (c) Proof of sero-conversion from HIV negative to HIV positive occurring during the one hundred and eighty (180) days after the documented accident. This proof must include a negative HIV antibody test conducted within five (5) days of the accident.



Occupationally Acquired HIV

✕ What is NOT covered?

HIV resulting from any other means including sexual activity and the use of intravenous drugs



What are the requirements needed?

- ✓ Attending Physician Statement form for Others [APS – Others]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility
- ✓ Incident report
- ✓ Certificate of employment, if any
- ✓ All blood related laboratory results



Terminal Illness



Description

The suffering by the Insured from a disease which, in the opinion of and agreed to by the Company's doctor, the advent of death is highly likely within twelve (12) months



What is covered?

Likelihood of death within twelve (12) months as confirmed by the Insured's Medical Practitioner



What is NOT covered?

- Terminal illness in the presence of HIV infection
- Life expectancy is more than twelve (12) months

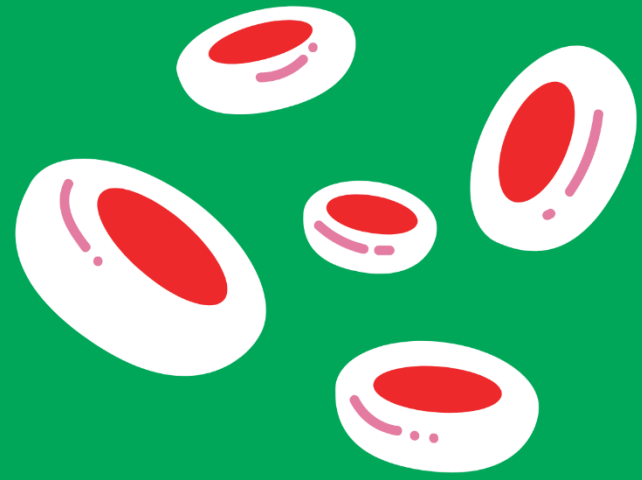


Terminal Illness

What are the requirements needed?

- ✓ Attending Physician Statement form for Terminal Illness [APS - Terminal Illness (1009)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract if insured was confined to a medical facility





Hematology-Related Diseases

Aplastic Anemia



Definition

Chronic persistent bone marrow failure which results in anemia, neutropenia and thrombocytopenia.

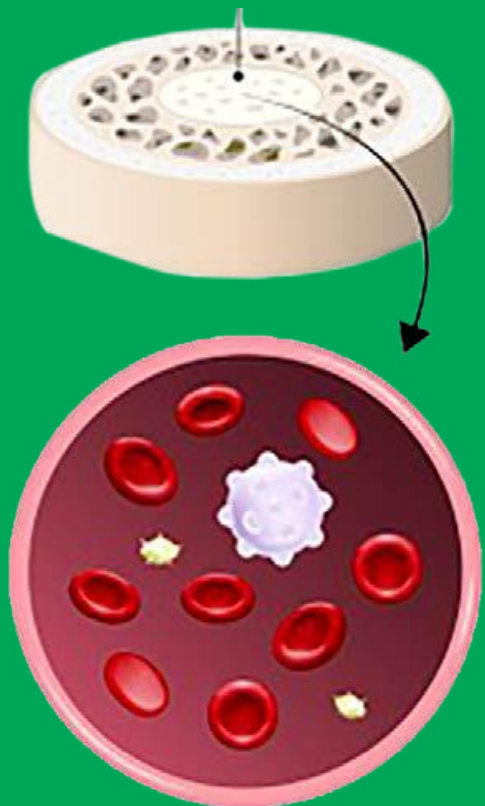


What is covered?

Diagnosis supported by a Bone Marrow Biopsy confirmed by Consultant Hematologist.

Requiring treatment with at least one of the following:

- Blood product transfusion,
- Marrow stimulating agents,
- Immunosuppressive agents, or
- Bone marrow transplantation.

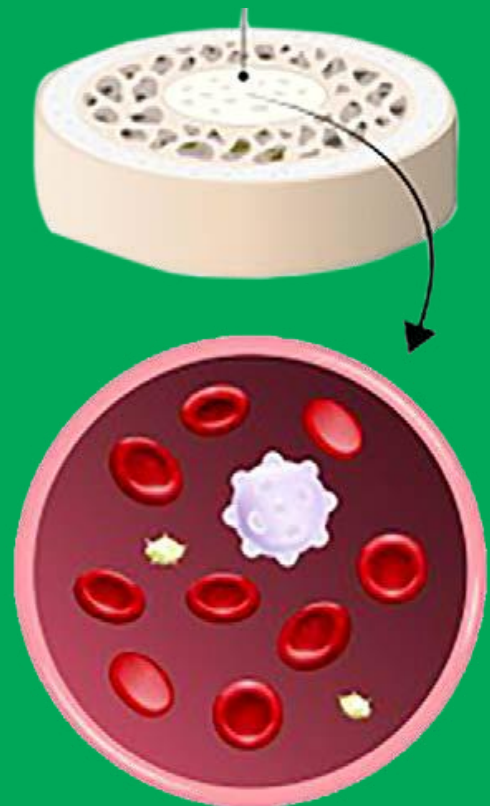


Aplastic Anemia



What is NOT covered?

- No Bone Marrow Biopsy supporting diagnosis of Aplastic Anemia.
- No treatment required.



What are the requirements needed?

- ✓ Attending Physician Statement for Aplastic Anemia signed by a Hematologist [APS - Aplastic Anemia (1009)]
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Bone Marrow Biopsy
- ✓ Treatment plan of the disease





Child-specific Diseases



Autism



Definition

Autism, which is now called the Autism Spectrum Disorder (ASD) means a wide variety of types and symptoms related to brain development which is often detected during early childhood with difficulties in these three (3) common areas: social interaction, communication, and behavior.



Why are we concerned?

Although there's no cure for autism, treatments used to manage it, such as therapies, doctor's check-ups, special education, and medical care, are very expensive and can bring additional unexpected costs to the family.



Autism



What is covered?

Only severe types of autism are covered as they may become severely disabled over time, if left untreated.

In order for a severe autism to be covered, a child must meet all three (3) common areas of difficulty, with a total of six (6) manifestations based on the criteria below:

- (a) Difficulty in social interaction - must meet at least two (2) of the following:
 - 1. Problems in non-verbal communication – inability to interact non-verbally such as little or no eye contact and difficulties in understanding facial expressions, body language, and hand gestures



Autism



What is covered?

2. Problems in developing peer relationships – struggle in making friends; only wants to play by themselves; prefers to be alone.
3. No interest in peer relationships – inability to share enjoyment, interests or achievements with other people.
4. Lack of social or emotional reciprocity – inability to initiate or respond in social interactions, including back and forth conversation.



Autism



What is covered?

(b) Difficulty in communication - must meet at least one (1) of the following:

1. Lack or delay in development of spoken language – very limited speaking skills with no attempts to use other modes of communication such as gestures or mime.
2. Poor interest to initiate or sustain conversation with other people – for some autistic children that may have adequate speech, they are not able to carry or sustain a two-way conversation.
3. Use repetitive, stereotyped, idiosyncratic language – repeating syllables, words, or phrases, made-up words or expressions, skipping words, cluttered speech.
4. Very limited play skills (lack of varied, spontaneous make-believe play or social imitative play).



Autism



What is covered?

(c) Difficulty in behavior, interests, and activities - must meet at least one (1) of the following:

1. Very narrowed fields of interest (all-encompassing preoccupation) that are restricted, repetitive, stereotyped that is abnormally intense and obsessive – e.g. non-stop talking about an interest or repeatedly asking questions about it
2. Rigid routines (inflexible adherence to routines) – follows strict routines, dislikes changes to routines, mood swings if things do not happen the same way (compulsive-like behavior)
3. Stereotyped and repetitive mannerisms – e.g. hand or finger flapping or twisting, snapping fingers, rocking the body, tip-toe walking, rubbing a particular object, or complex body movements
4. Persistent preoccupation with parts of objects rather than the whole object – e.g., fascinated with the spinning of a wheel but does not play with the whole car



Autism



What is covered?

(d) **Plus, two (2) other manifestations from any points (a), (b), (c) have to be met:**

- A final diagnosis of severe case of autism by a pediatric psychiatrist (medical doctor who specializes in children's behavior, thinking, and feeling)
- Requiring psychosocial interventions, special education, and/or behavior therapy
- Continuous treatment for at least a period of six (6) months from the date of diagnosis



Autism



What is NOT covered?

- Asperger's syndrome – high functioning form of Autism Spectrum Disorder, with average or above average intelligence but with some difficulty in communicating and interacting with other people. This is not covered in the Child CI Benefit because children with this condition often lead a full and independent life.
- Atypical autism – may have some mild symptoms of autism but is called 'atypical' because the symptoms are not enough to meet the required criteria for autism. This is not covered in the Child CI Benefit because with early treatment, they can still function better than those with typical autism.
- Attention-deficit Hyperactivity Disorder (ADHD) is not autism.



Autism



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/ Critical/ Terminal Illness (Form no. MP CL CSMDCTI)
- ✓ Attending Physician's Statement for Major Disease Critical Illness – Others (Form name APS - Others) from the pediatric psychiatrist
- ✓ Reports from the occupational therapist, speech and language therapist, etc.
- ✓ Special education student's progress reports



Dengue Hemorrhagic Fever



Definition

Dengue is caused by a virus carried by infected mosquitoes which is common in tropical countries like in the Philippines. Based on severity and symptoms, there are two types of dengue:

- Non-hemorrhagic fever (mild dengue fever with no internal bleeding)
- Dengue hemorrhagic fever (severe form of dengue with internal bleeding)



Why are we concerned?

Just a single mosquito bite can lead to Dengue Hemorrhagic Fever which tends to be more severe and fatal among children.



Dengue Hemorrhagic Fever



What is covered?

Only severe case of Dengue Hemorrhagic Fever is covered in the Child CI Benefits as this is a life-threatening condition if not treated in time.

Benefits would be payable if all of the following conditions are met:

- A final diagnosis of severe case of dengue hemorrhagic fever by a doctor
- Presence of any of the following severe dengue hemorrhagic fever symptoms:
 - Excessive bleeding such as gum/nose bleeding, blood in the stools, vomiting blood, very low platelet count (hemorrhagic phenomena)
 - Increase in the size of liver (hepatomegaly)
 - Significant drop in blood pressure, weak pulse, collapse of organs, difficulty of breathing, shock (circulatory failure)



Dengue Hemorrhagic Fever

✕ What is NOT covered?

- Non-hemorrhagic Dengue Fever (dengue fever with no internal bleeding)

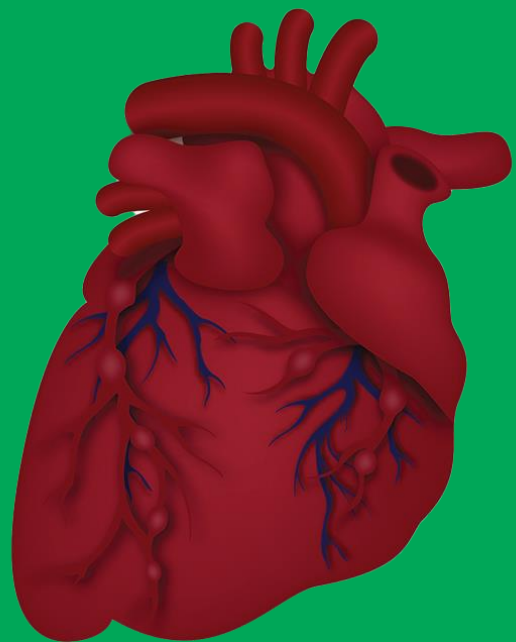


What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/ Critical/ Terminal Illness (Form no. MP CL CSMDCTI)
- ✓ Attending Physician's Statement for Major Disease Critical Illness – Others (Form name APS - Others) from the attending physician
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Results of blood test such as platelet count
- ✓ Results of Abdominal Ultrasound indicating Hepatomegaly (increased liver size)



Kawasaki Disease



Definition

Kawasaki Disease mostly affects young children which causes swelling of the blood vessels throughout the body (necrotizing vasculitis). If detected and treated early, most children recover without permanent damage to the blood vessels.



Why are we concerned?

Although symptoms may just start out mild such as fever, rashes, sore throat, weakness, poor appetite, and swelling of the lymph nodes, Kawasaki Disease is one of the most common causes of acquired heart disease in children.



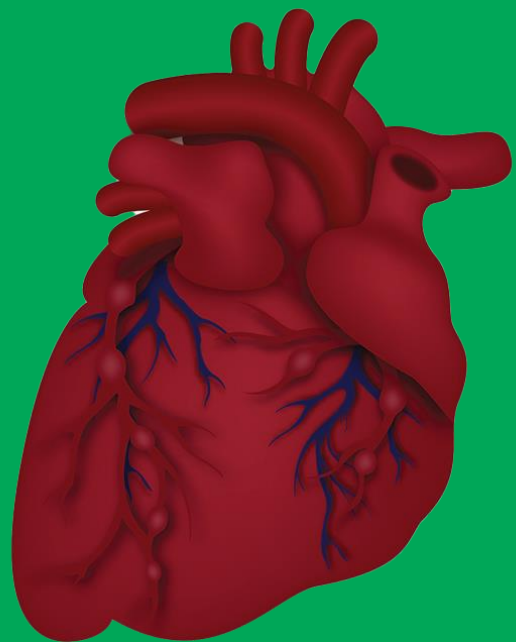
Kawasaki Disease



What is covered?

Benefits would be payable if all of the following conditions are met:

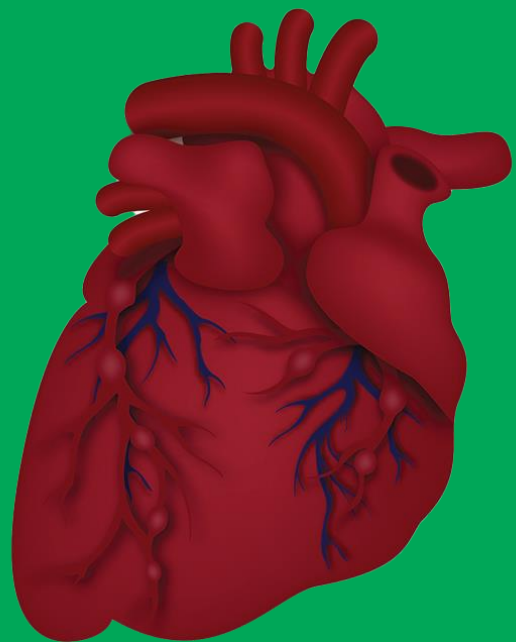
- A final diagnosis of Kawasaki Disease by a cardiologist (medical doctor who treats diseases and conditions of the cardiovascular system (i.e. heart and blood vessels))
- Presence of coronary artery damage due to Kawasaki Disease such as abnormal widening (dilation) or weak bulging area (aneurysm) in one or more coronary arteries with:
 - Abnormal widening of at least six (6) millimeters in diameter; and
 - Damage that lasts for at least six (6) months from the date of initial diagnosis



Kawasaki Disease

✕ What is NOT covered?

Kawasaki Disease with normal coronary arteries (no dilation or aneurysm)



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness (Form no. MP CL CSMDCTI)
- ✓ Attending Physician's Statement for Major Disease Critical Illness – Others (Form name APS - Others) from a cardiologist
- ✓ Results of echocardiogram (ECG), cardiac catheterization, or imaging test of coronary artery damaged



Rheumatic Fever with Valvular Involvement



What do we need to know?

Rheumatic Fever (acute rheumatic fever) is a sudden condition where in the immune system attacks the body, thereby causing swelling of the joints, heart, and brain. If rheumatic fever is not treated early, it can eventually lead to rheumatic heart disease which permanently damages the heart valves, which act as one-way door in between the chambers of the heart.



Why are we concerned?

Any child could get rheumatic fever with heart valve damage, after having a strep throat infection which was not properly treated.



Rheumatic Fever with Valvular Involvement



What is covered?

Only rheumatic fever with heart valve damage is covered in the Child CI Benefits as this would eventually require expensive heart valve surgery to prevent life- threatening heart complications.

Benefits would be payable if all of the following conditions are met:

- A final diagnosis of acute rheumatic fever by a pediatrician (medical doctor who treats children) using the revised Jones Criteria, a point system guide used by doctors to diagnose acute rheumatic fever such as presence of strep infection, swelling of joints/heart, fever, rashes, uncontrollable hand/feet movements, etc.
- Presence of heart valve structure or function damaged in one or more heart valves due to rheumatic fever, confirmed by a cardiologist (medical doctor who treats diseases and conditions of the cardiovascular system)



Rheumatic Fever with Valvular Involvement



What is NOT covered?

Rheumatic fever with normal heart valves (no damage in structure and function)



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/ Critical/ Terminal Illness (Form no. MP CL CSMDCTI)
- ✓ Attending Physician's Statement for Major Disease Critical Illness – Others (Form name APS - Others) from a pediatrician
- ✓ Results of positive strep infection such as throat swab test, blood test
- ✓ Results of echocardiogram (ECG) confirming heart valve damage
- ✓ Medical Certification from a cardiologist indicating one or more heart valve incompetence



Severe Asthma



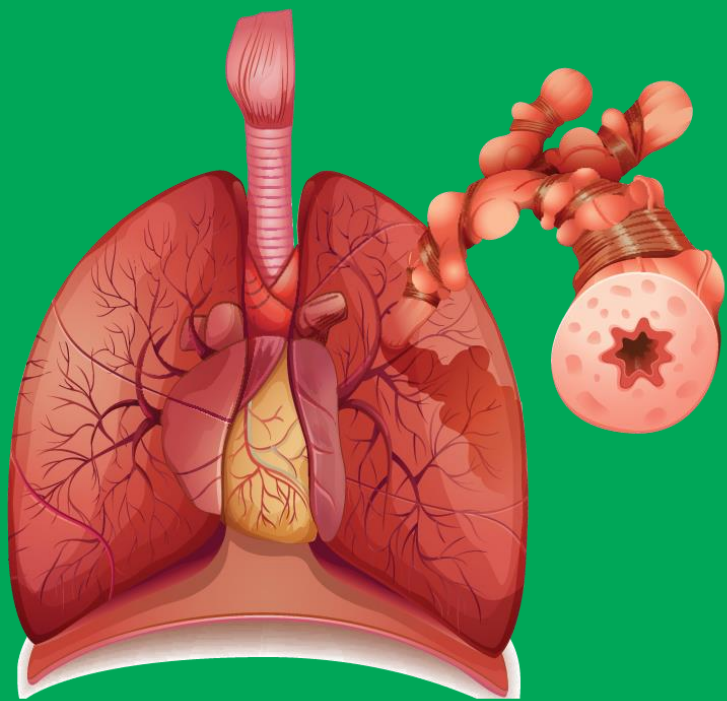
Definition

Asthma is one of the most common respiratory conditions among children where the airways in the lungs become inflamed and tightened, obstructing the airway, making it harder for them to breathe, with wheezing, coughing, and shortness of breath symptoms.



Why are we concerned?

Although asthma can be effectively controlled, it is not curable. Children with severe asthma have increased risk for permanent lung damage and severely limits their normal daily physical abilities.



Severe Asthma

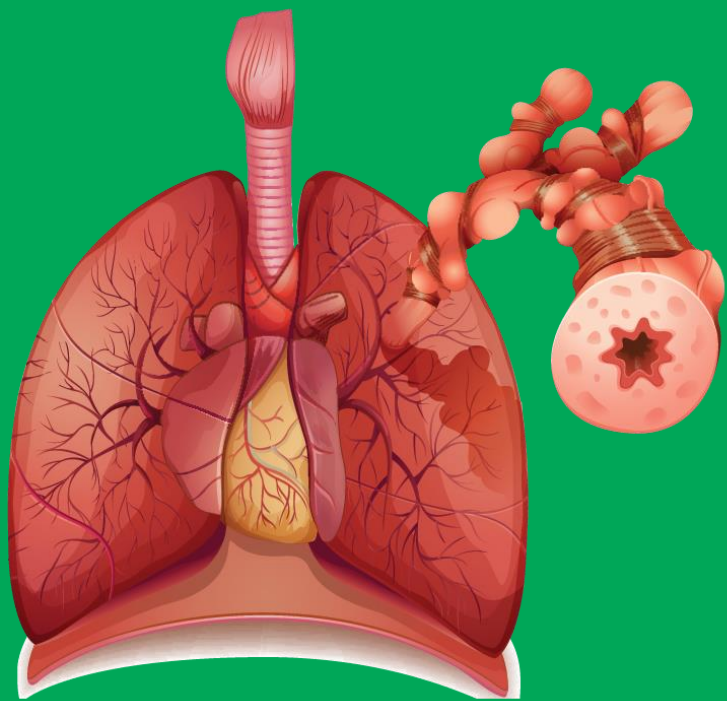


What is covered?

Only severe asthma with complications as this is a life-threatening condition and at a very high risk for sudden death.

Benefits would be payable if all of the following conditions are met:

- A final diagnosis of severe asthma by a pediatrician (medical doctor who treats children) or pulmonologist (medical doctor who specializes in respiratory conditions)
- Presence of any four of the following severe asthma complications:
 - Occurrence of a severe life-threatening asthma medical emergency (status asthmaticus) in the last two (2) years
 - Significant and continuous limitation in exercise or physical activity
 - Chest deformities such as large bulging chest puffed like a barrel as the air gets trapped in the lungs (hyperinflation)
 - The need for medically prescribed oxygen therapy at home Oral steroids (corticosteroids) are taken every day for a minimum period of at least six (6) months to treat severe asthma that no longer responds to asthma medicines



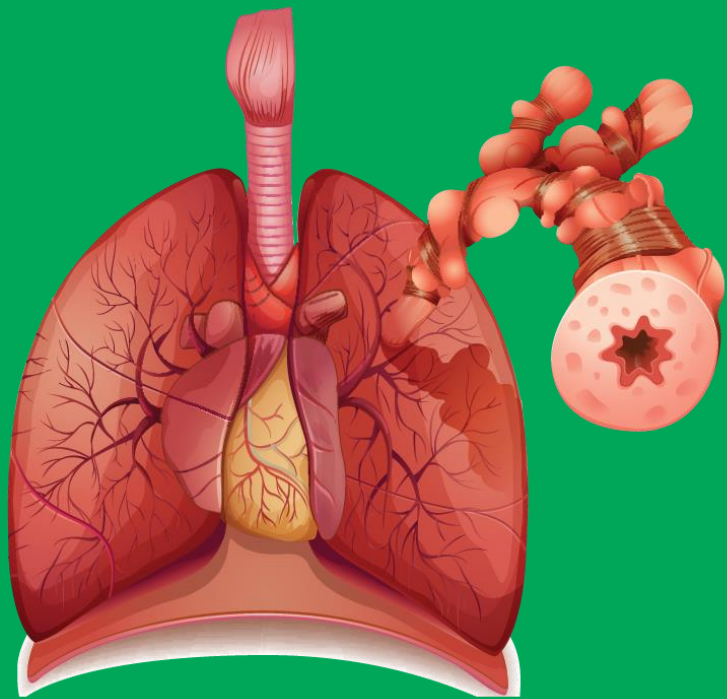
Severe Asthma

✕ What is NOT covered?

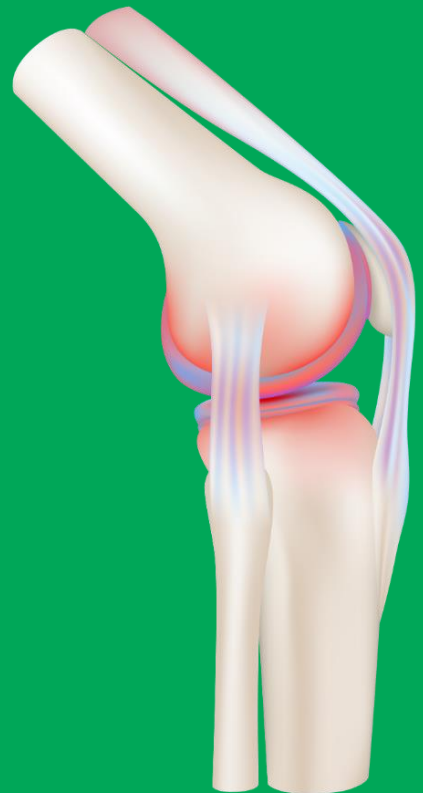
Mild to moderate cases of asthma without complications

What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/ Critical/ Terminal Illness (Form no. MP CL CSMDCTI)
- ✓ Attending Physician's Statement for Major Disease Critical Illness – Others (Form name APS - Others) from a pediatrician or pulmonologist
- ✓ Results of imaging test if the Chest such as X-ray or CT scan or MRI scan
- ✓ Asthma Treatment plan / report indicating Oral Steroid and Oxygen therapy for the past 6 months



Still's Disease



Definition

Still's Disease is also known as juvenile chronic arthritis, which is a rare condition that usually affects children, where the immune system attacks the healthy joints causing inflammation (arthritis), high fever, and salmon-colored (pale red/pink) rash in the trunk, arms, and legs. Continuous inflammation can eventually cause destruction of the joints in many parts of the body.

Only the most severe case of Still's Disease, where destruction of hip or knee joints are extensive and disabling is covered in the Child CI Benefits.



Why are we concerned?

Still's Disease has no cure, and it cannot be prevented. It can lead to serious destruction of joints if the inflammation is not effectively controlled.



Still's Disease

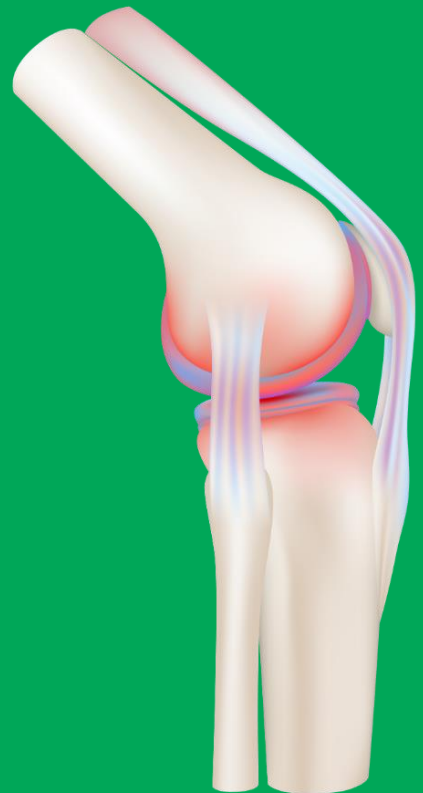


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Benefits would be payable if all of the following conditions are met:

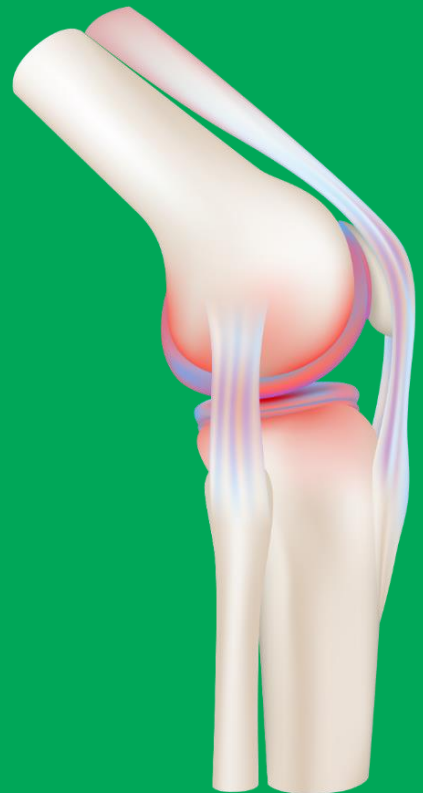
- A final diagnosis of severe Still's Disease by a rheumatologist (medical doctor who specializes in inflammatory (rheumatic) conditions and autoimmune diseases)
- Presence of extensive and disabling destruction of the hip or knee joints requiring hip or knee replacement surgery



Still's Disease

✕ What is NOT covered?

Mild to moderate cases of Still's Disease without destruction of hip or knee joints

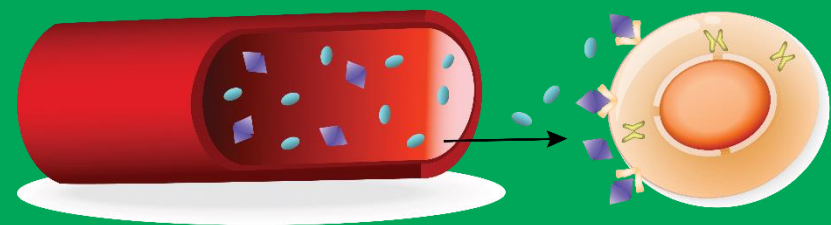


What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/ Critical/ Terminal Illness (Form no. MP CL CSMDCTI)
- ✓ Attending Physician's Statement for Major Disease Critical Illness – Others (Form name APS - Others) from a rheumatologist
- ✓ Results of blood tests diagnosing Still's Disease, such as C-Reactive Protein (CRP) Test, Antinuclear Antibodies (ANA), Erythrocyte Sedimentation Rate (ESR), Ferritin test
- ✓ Results of imaging test such as CT scan, MRI scan, X-ray of hip or knee joint



Type 1 Diabetes Mellitus



Definition

Diabetes Mellitus (Diabetes) is related to high blood sugar levels in the body which can lead to serious health problems such as heart disease, stroke, kidney disease, blindness, and even limb amputations, if not properly controlled.

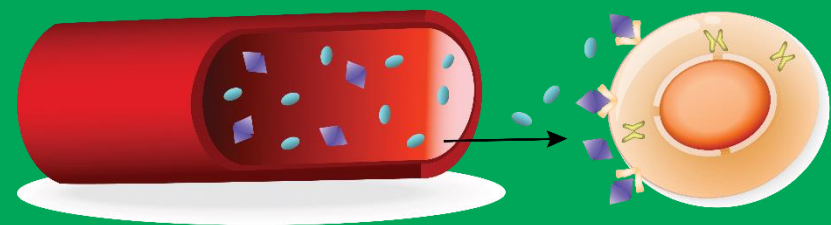


Why are we concerned?

Type 1 diabetes cannot be prevented, and symptoms usually occur suddenly in healthy children without any known causes. Untreated Type 1 diabetes has a devastating impact on the child's well-being as it gets worse over time.



Type 1 Diabetes Mellitus



What is covered?

Among the many types of diabetes, only Type 1 diabetes in children is covered in the Child CI Benefits which is a long-term chronic condition without any cure.

Children with Type 1 diabetes need lifelong insulin injections every day because their immune system attacks the pancreatic cells which create insulin.

Benefits would be payable if all of the following conditions are met:

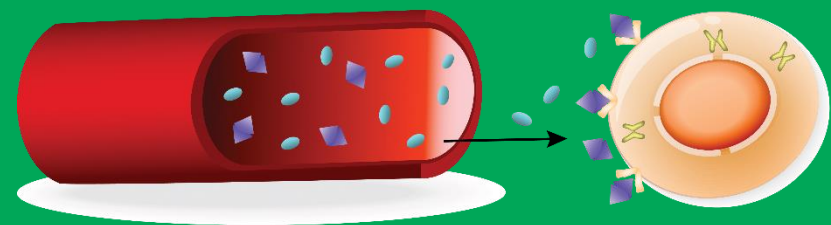
- A final diagnosis of Type 1 diabetes by a diabetes doctor or endocrinologist (medical doctor who specializes in diagnosing and treating health conditions related to problems with the body's hormones like insulin)
- Requiring lifelong insulin injections every day
- Continuous treatment for at least a period of six (6) months from the date of diagnosis



Type 1 Diabetes Mellitus

✕ What is NOT covered?

All other types of diabetes, such as Type 2 diabetes and gestational diabetes

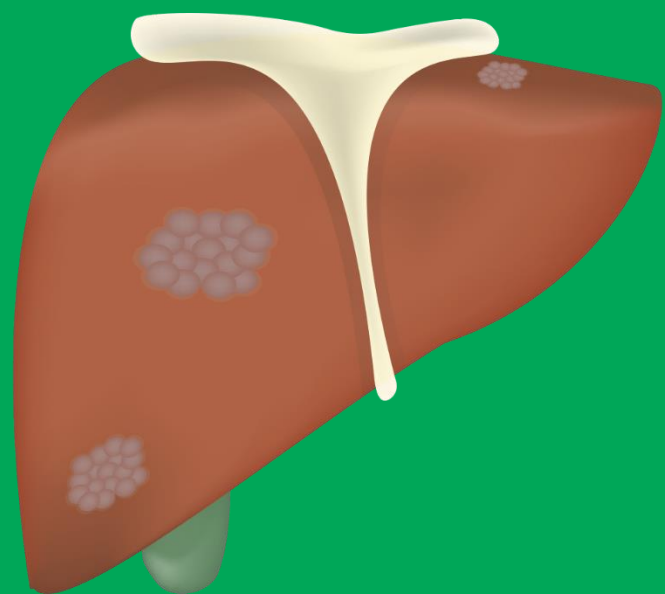


What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness (Form no. MP CL CSMDCTI)
- ✓ Attending Physician's Statement for Major Disease Critical Illness – Others (Form name APS - Others) from a diabetes doctor or endocrinologist from a diabetic doctor or endocrinologist
- ✓ Results of blood sugar tests (HbA1c) and urine tests
- ✓ Insulin
- ✓ Treatment plan



Wilson's Disease



Definition

Copper is a mineral we get from food that makes our nerves, brain, and bones healthy, and is normally excreted from the body. Children with Wilson's Disease, which is a rare disorder where copper is not being properly eliminated, develop an excessive buildup of copper in the liver and brain (copper toxicity) which can eventually cause potentially fatal destruction or damage if left untreated.



Why are we concerned?

Wilson's Disease is an inherited disorder (high risk for those with family members who also have Wilson's Disease). It may be present at birth, but symptoms may develop over time and are only detected at a life-threatening stage.

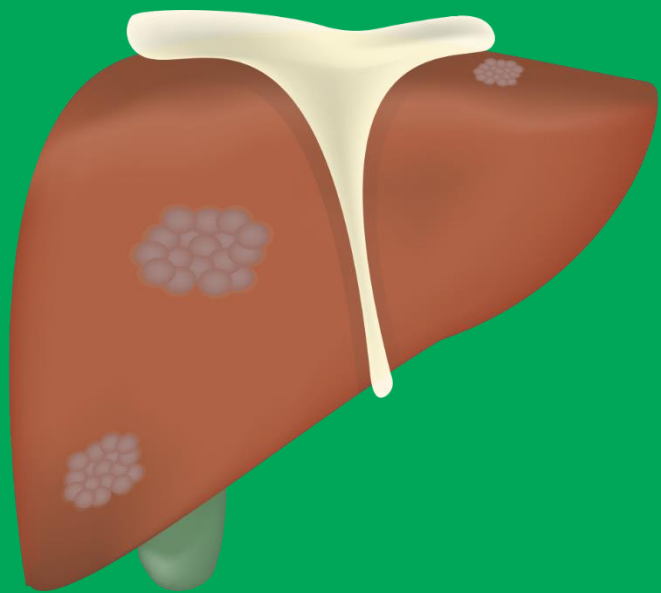


Wilson's Disease

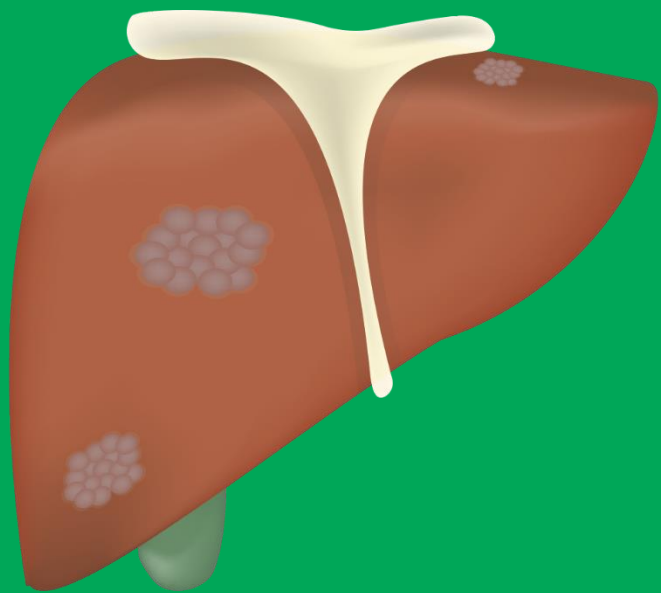


What is covered?

- A final diagnosis of Wilson's Disease by a pediatric doctor
- Presence of progressive liver disease such as scarring of the liver (cirrhosis), elevation of liver enzymes, prolonged yellowing of the skin/eyes (jaundice)
- Presence of neurological difficulties such as uncontrolled movements, muscle stiffness, hand tremors, speech difficulties



Wilson's Disease



What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/ Critical/ Terminal Illness (Form no. MP CL CSMDCTI)
- ✓ Attending Physician's Statement for Major Disease Critical Illness – Others (Form name APS - Others) from the attending physician
- ✓ Latest Discharge summary or clinical abstract or medical abstract of the confinement
- ✓ Results of copper levels in blood and urine tests
- ✓ Results of imaging test such as CT scan, MRI scan of the liver and/or brain



ANTIGEN

A substance that induces an immune response in the body.

ASCITES

The build-up of fluid in the space between the lining of the abdomen and abdominal organs.

ATROPHY

Decrease in size of a body part, cell, organ or other tissue.

AUTO ANTIBODIES

An antibody produced by the immune system that is directed against one or more of the body's own proteins.

AUTOIMMUNE DISEASE

A condition in which the body's immune system mistakes its own healthy tissues as foreign and attacks them.

BACTERIAL MENINGITIS

An infection of the membranes (meninges) that protect the spinal cord and brain which causes swelling.

BALLOON VALVOTOMY

A minimally invasive treatment used to open a narrowed heart valve.

BIOPSY

A sample of tissue taken from the body in order to examine it more closely.

BRAINSTEM

The structure that connects the cerebrum of the brain to the spinal cord and cerebellum.

BULBAR MUSCLES

A group of muscles in the head and neck that are used in speaking, swallowing, chewing, and holding the jaw in place.

CANCER

A malignant tumor positively diagnosed with histological confirmation and characterized by the uncontrolled growth of malignant cells with invasion and destruction of normal tissue.

CARCINOMA IN-SITU

A condition in which abnormal cells are found only in the place where they were first formed and have not spread to nearby tissue.

CATECHOLAMINE

A type of neurohormone that is important in stress responses.

CEREBELLUM

The part of your brain located at the back of your head, just above and behind where your spinal cord connects to your brain itself. It maintains balance, coordinates movement of the eyes and body.

CEREBRAL CORTEX

The brain's outermost layer of nerve cell tissue.

CEREBRUM

The largest part of the brain that manages conscious thoughts.

CERVICAL DYSPLASIA

A pre-cancerous condition in which abnormal cells grow on the surface of the cervix.

CHRONIC

Persisting for a long time or constantly recurring.

CK-MB

Creatinine Kinase – Myocardial Band; this enzyme is found mostly in the heart muscle. A higher than normal level may indicate the presence of an inflammation of the heart muscle or a current or recent heart attack.

CLINICAL ABSTRACT

A record of a patient's pertinent medical information.

COLONOSCOPY

An examination of the inside of the large intestine, including the colon, rectum and anus.

CONGENITAL

A condition present at birth.

CRANIOTOMY

The surgical removal of part of the bone from the skull to expose the brain.

DEBRIDEMENT

Thorough cleaning of a wound.

DECIBEL

A unit used to measure sound.

DEGENERATIVE

Declining or deteriorating.

DIALYSIS

A procedure used to remove waste products and excess fluid from the blood when the kidneys stop working properly.

DISCHARGE SUMMARY

A document that explains why the patient was admitted, what transpired during confinement, and all related medications or treatments.

DISCOID LUPUS

The most common type of lupus that affects the skin.

DISSECTION OF THE AORTA

A tear in the inner layer of a weakened area of the aorta.

EJECTION FRACTION

Amount of blood pumped by the heart each time it beats.

ELECTROCARDIOGRAM (ECG)

A non-invasive test used to record the electrical activity of the heart and assess the presence of cardiovascular diseases.

ELECTROLYTE

Chemicals that conduct electricity when dissolved in water.

ELECTROMYOGRAM (EMG)

A test that measures muscle response or electrical activity in response to a nerve's stimulation of the muscle and is used to help detect neuromuscular abnormalities.

ENCEPHALOPATHY

A general term that refers to brain disease, damage, or malfunction.

ENDOSCOPIC RETROGRADE COLANGIOPANCREATOGRAPHY (ERCP)

A procedure used to diagnose and treat problems in the liver, gallbladder, bile ducts, and pancreas.

ENDOVASCULAR SURGERY

Minimally invasive procedures which diagnose and treat vascular diseases.

ENZYME

Proteins that help speed up metabolism, or the chemical reactions in our bodies.

EOSINOPHILIC FASCIITIS

A syndrome in which tissue under the skin and over the muscle, called fascia, becomes swollen, inflamed and thick.

FASCIA

A thin casing of connective tissue that surrounds and holds every organ, blood vessel, bone, nerve fiber and muscle in place.

FISTULA

An abnormal connection between two body parts, such as an organ or blood vessel and another structure, usually resulting from an injury, surgery, infection or inflammation.

FOCAL SEGMENTAL GLOMERULONEPHRITIS

Scar tissue in the filtering unit of the kidney.

FORCED EXPIRATORY VOLUME

Measures how much air a person can exhale during a forced breath.

FULMINANT

Severe and sudden in onset.

GAMMA KNIFE

An advanced radiation treatment for adults and children with small to medium brain tumors, abnormal blood vessel formations, epilepsy, and other neurological conditions.

GANGRENE

Localized death and decomposition of body tissue, resulting from either obstructed circulation or bacterial infection.

GLOMERULONEPHRITIS

Inflammation of the tiny filters in the kidneys.

GLUCOCORTICOID

Steroid hormones produced from the cortex of adrenal glands.

GRANULOMA

A small, non-cancerous cluster of white blood cells and other tissue that can be found in the lungs, head, skin or other parts of the body in some people, formed as a reaction to infections, inflammation, irritants or foreign objects.

HEMATOMA

A pool of mostly clotted blood caused by a broken blood vessel that was damaged by surgery or injury. It can occur anywhere in the body, including the brain.

HEMATOPOIETIC STEM CELL

An immature cell that can develop into all types of blood cells, including white blood cells, red blood cells, and platelets.

HEPATIC ENCEPHALOPATHY

An often-temporary neurological disorder due to chronic, severe liver disease.

HEPATITIS

Inflammation of the liver.

HEREDITARY

The genetic passing of characteristics or diseases from a parent to a child.

HISTOPATHOLOGY

The study and diagnosis of diseases of the tissues.

HUMAN IMMUNODEFICIENCY VIRUS (HIV)

A virus that attacks the body's immune system.

HYPOXEMIA

Having a low oxygen level in the blood.

INTRA-ARTERIAL

Within an artery.

JAUNDICE

A yellow discoloration of the body tissue resulting from the accumulation of excess bilirubin.

KIDNEY FAILURE

A chronic irreversible failure of both kidneys requiring either permanent renal dialysis or kidney transplantation.

LAPAROTOMY

A surgical incision into the abdominal cavity.

LYMPHANGITIS

Inflammation of the lymphatic channels.

LYMPHATIC FILARIASIS

A parasitic disease caused by microscopic, thread-like worms that live only in the human lymph system.

LYMPHATIC SYSTEM

Helps maintain fluid balance in the body by collecting excess fluid and particulate matter from tissues and depositing them in the bloodstream.

LYMPHEDEMA

Swelling due to build-up of lymph fluid in the body.

LYMPHOMA

A general term for cancers that start in the various lymph glands around the body.

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MAGNETIC RESONANCE IMAGING (MRI)

A non-invasive technique that produces high- resolution images used to examine the organs, tissues and skeletal system.

MEDICAL ABSTRACT

A record of a patient's pertinent medical information.

MEDULLA OBLONGATA

The connection between the brainstem and the spinal cord.

MELANIN

A substance in your body that produces hair, eye and skin pigmentation.

MELANOMA

The most serious type of skin cancer that develops in the cells that produce melanin.

MORPHEA

A rare skin condition characterized by small red or purple patches that develop firm white or ivory centers.

NECROSIS

Death of body tissue.

NEOPLASM

A new and abnormal growth of tissue in some part of the body, especially as a characteristic of cancer.

PANCREAS

An organ that produces enzymes that help with digestion and sends out hormones that control the amount of sugar in your bloodstream.

PANCREATITIS

Inflammation of the pancreas.

PROGRESSIVE SUPRANUCLEAR PALSY

A rare neurological disorder that affects your body movements, walking and balance, and eye movement.

PTOSIS

Drooping of the upper eyelid due to paralysis or disease, or as a congenital condition.

SARCOMA

A type of cancer that develops in the bones and connective tissues.

SCOLIOSIS

An abnormal lateral curvature of the spine.

SHUNT

A hollow tube surgically placed in the brain or the spine to help drain cerebrospinal fluid and redirect it to another location in the body where it can be reabsorbed.

STROKE

A cerebrovascular incident including infarction of brain tissue, cerebral and subarachnoid hemorrhage, intracerebral embolism and cerebral thrombosis resulting in permanent neurological deficit with persisting clinical symptoms.

SUBCUTANEOUS

Situated under the skin.

THORACOTOMY

A surgical procedure in which a cut is made between the ribs to see and reach the lungs or other organs in the chest or thorax.

THROMBOCYTOPENIA

Deficiency of platelets in the blood that causes bleeding into the tissues, bruising, and slow blood clotting after injury.

TOMOGRAPHY

An x-ray technique in which shadows of superimposed structures are blurred out by a moving x-ray tube.

TRANSIENT ISCHEMIC ATTACK

A stroke which lasts only for a few minutes and is caused by a temporary disruption in the blood supply to part of the brain.

TROPONIN

A type of protein found in the muscles of the heart which help regulate muscle contractions. Composed of three (3) subunits: Troponin C, Troponin T, Troponin I.

TROPONIN T AND TROPONIN I

Proteins that are released when the heart muscle has been damaged, such as during a heart attack.

TUMOR

An abnormal mass of tissue that forms when cells grow and divide more than they should or do not die when they should. It may be either benign or cancerous.

ULCERATIVE COLITIS

A chronic inflammatory bowel disease (IBD) in which abnormal reactions of the immune system cause inflammation and ulcers on the inner lining of the large intestine.

About Manulife

Manulife Financial Corporation is a leading international financial services provider, helping our customers make their decisions easier and lives better. With our global headquarters in Toronto, Canada, we operate as Manulife across Canada, Asia, and Europe, and primarily as John Hancock in the United States, providing financial advice and insurance for individuals, groups and businesses. Through Manulife Wealth & Asset Management, we offer global investment, financial advice, and retirement plan services to individuals, institutions, and retirement plan members worldwide. At the end of 2024, we had more than 37,000 employees, over 109,000 agents, and thousands of distribution partners, serving over 36 million customers. We trade as 'MFC' on the Toronto, New York, and the Philippine stock exchanges, and under '945' in Hong Kong. Not all offerings are available in all jurisdictions. For additional information, please visit [manulife.com](https://www.manulife.com).

About Manulife Philippines

The Manufacturers Life Insurance Company opened its doors for business in the Philippines in 1907. Since then, Manulife's Philippine Branch and later The Manufacturers Life Insurance Co. (Phils.), Inc. (Manulife Philippines) has grown to become one of the leading life insurance companies in the country. Manulife Philippines is a wholly-owned domestic subsidiary of Manulife Financial Corporation, among the world's largest life insurance companies by market capitalization. Learn more about Manulife Philippines by visiting their website www.manulife.com.ph and following them on Facebook ([www.facebook.com/ ManulifePH](https://www.facebook.com/ManulifePH)), and Instagram (@manulifeph).

**Your right partner with better solutions.
Let's talk! We're here for you.**



The Manufacturers Life
Insurance Co. (Phils.), Inc.



(+632) 8884 7000



phcustomercare@manulife.com



[manulifeph](https://www.manulife.com.ph)



www.manulife.com.ph