

Early Critical Illness Benefits Guide

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Important Reminders

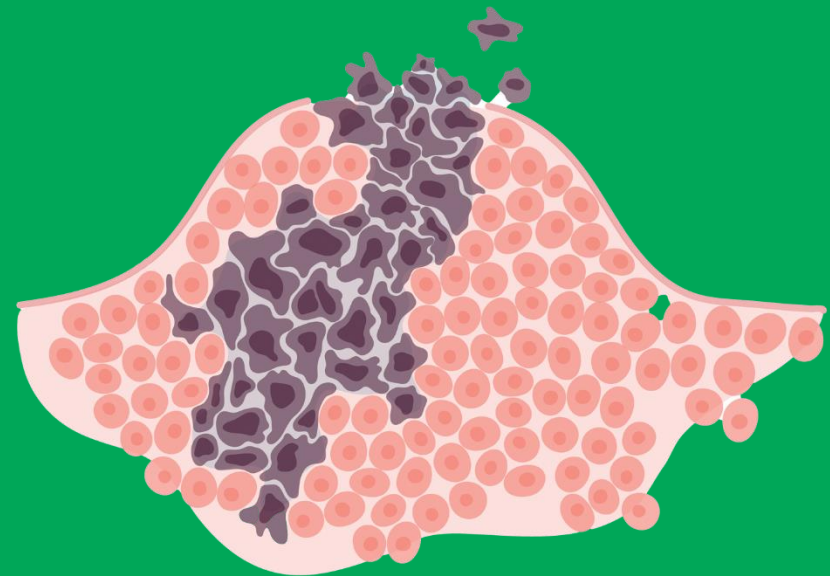
- This CI Guidebook should be read with the proposal and the policy contract. In case of conflict, the policy contract shall prevail.
- The benefit will only be paid if no illness is contracted within 90 days from the policy's effective date or the approval date of the last reinstatement (whichever is later), and if the insured survives a period of not less than 14 days after being diagnosed with a covered illness.
- Exclusions and limitations based on pre-existing conditions may apply.

Disclaimers

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Early-Stage Malignancy



What do we need to know?

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.



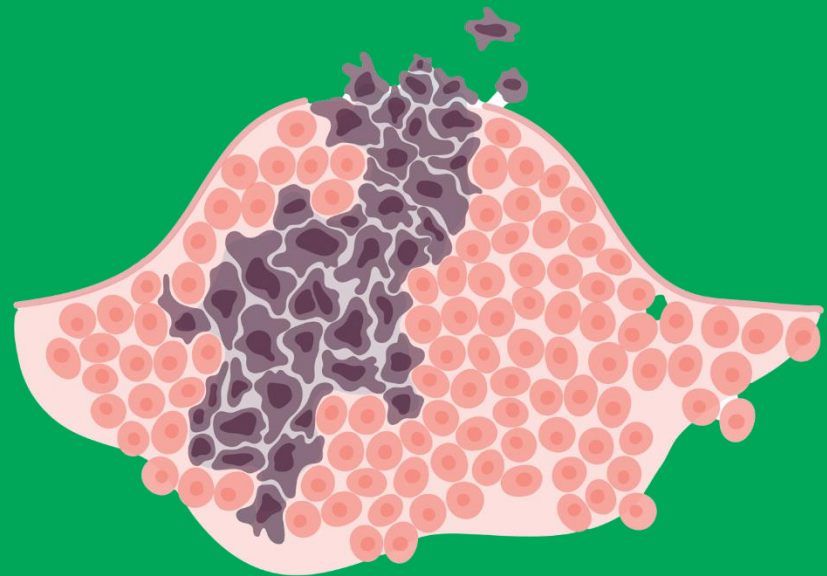
Early-Stage Malignancy



What is covered?

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

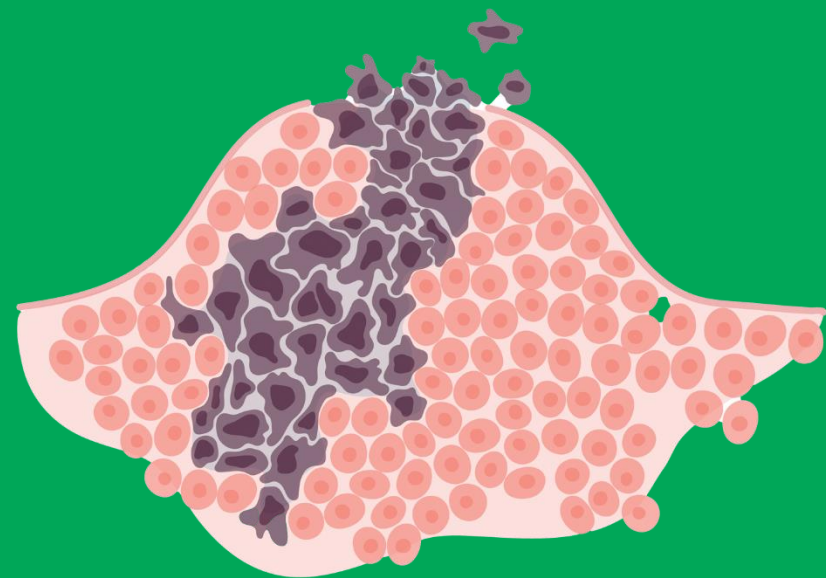
- Chronic lymphocytic leukemia classified as RAI Stage I or II. RAI Staging is used to classify leukemia according to the increased number of white blood cells, enlargement of lymph node, liver, or spleen. RAI Stage I and II are considered early-stage malignant blood cancers.
- Metastatic non melanoma 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

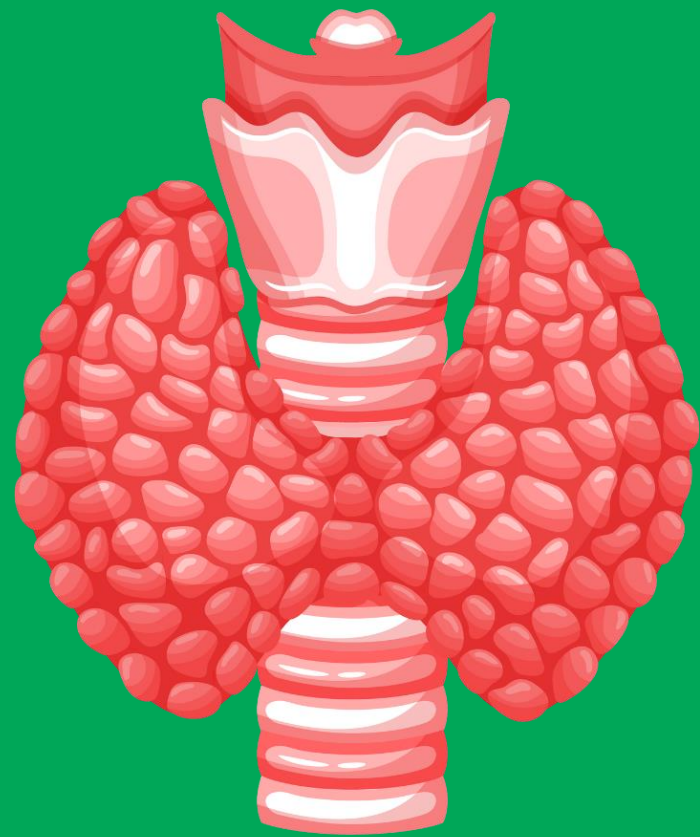


What do we need to know?

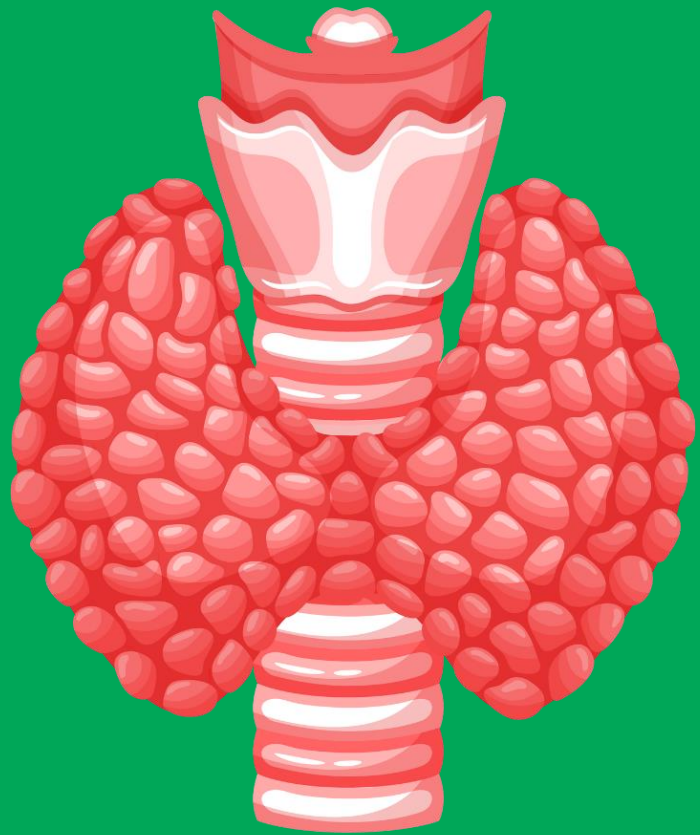
The thyroid, which is about 2-inches long, is a butterfly shaped endocrine gland located in the neck and lies in front of the throat. Its main job is to control the body's metabolism through the thyroid hormones it creates.

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.

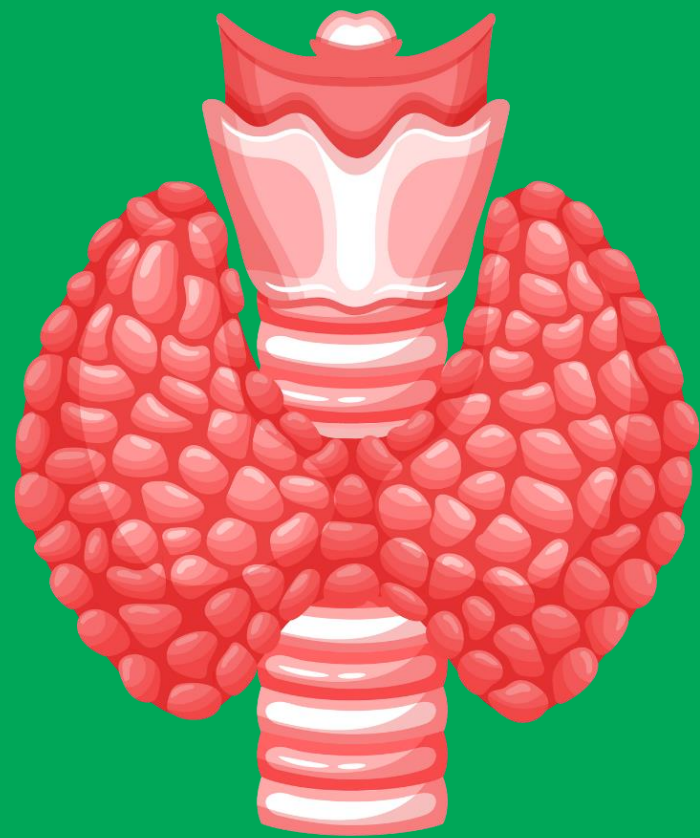


What is NOT covered?

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



Early Thyroid Cancer

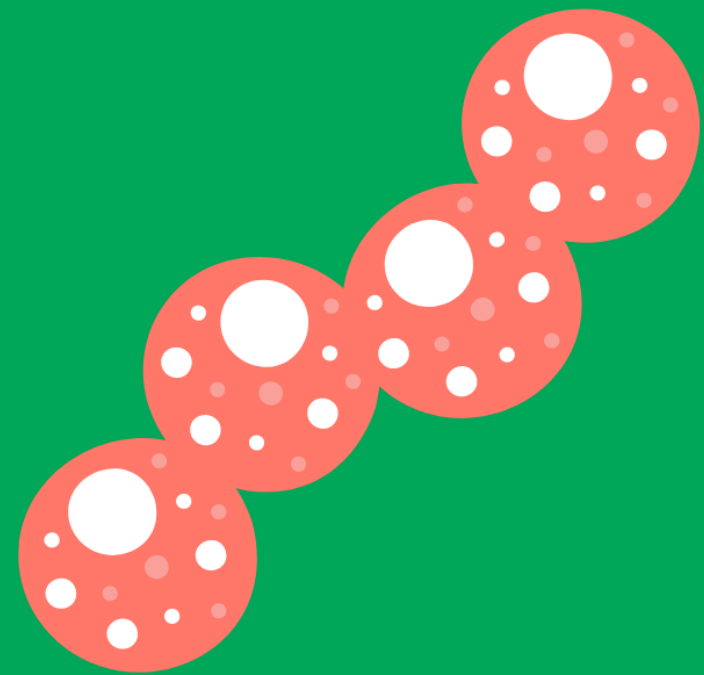


What are the requirements needed?

- ✓ 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



Carcinoma -in-situ



What do we need to know?

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



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)

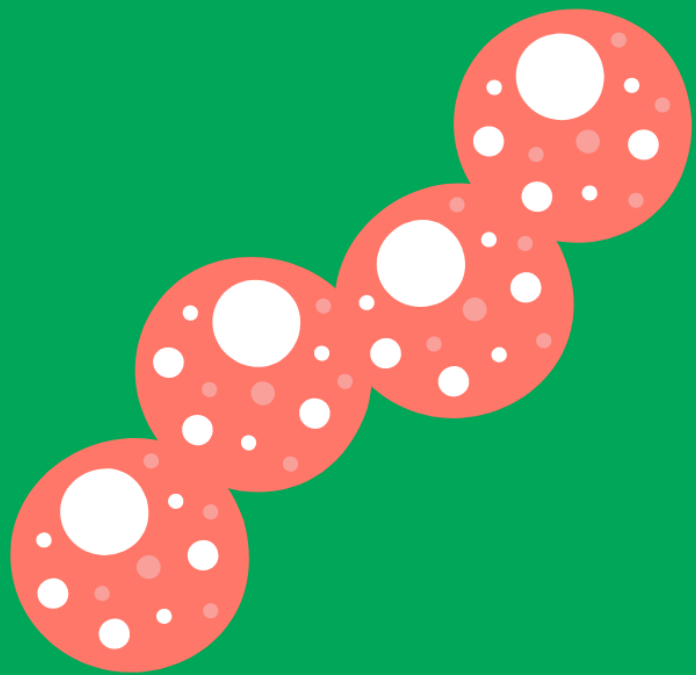


Carcinoma -in-situ



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.

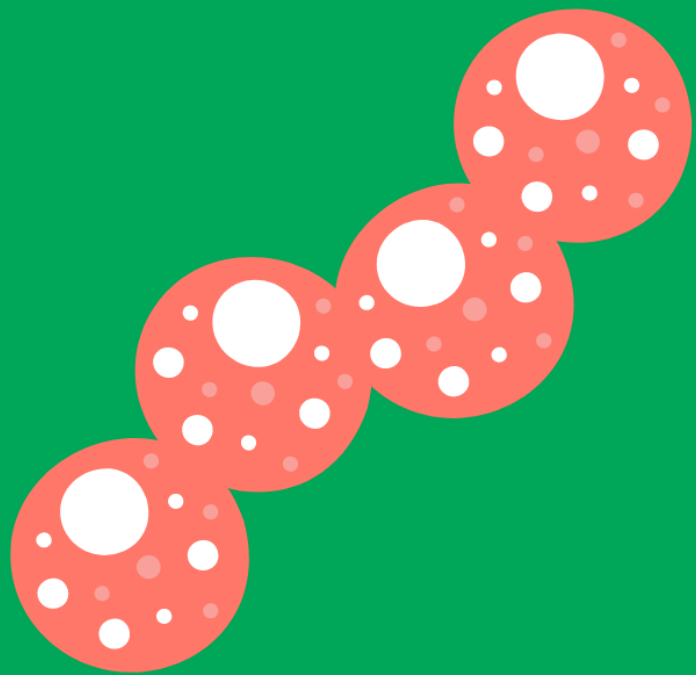


Carcinoma -in-situ



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.

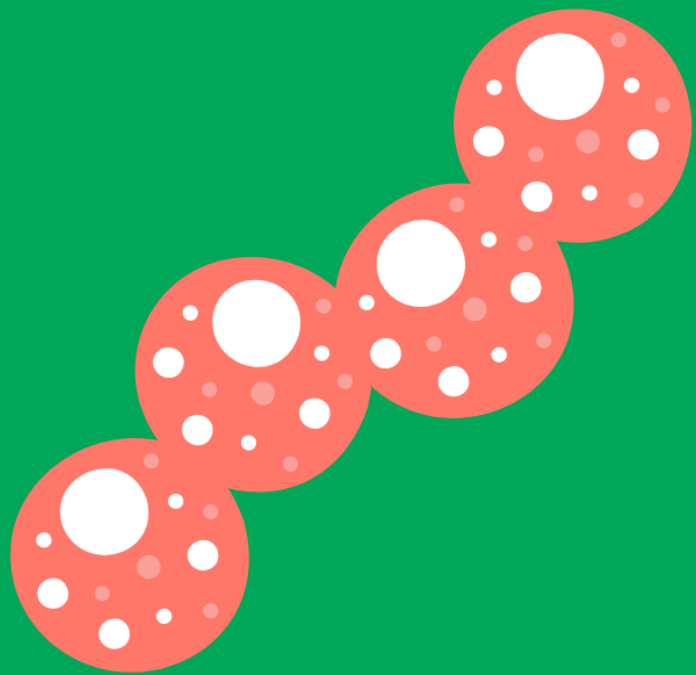


Carcinoma -in-situ



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.



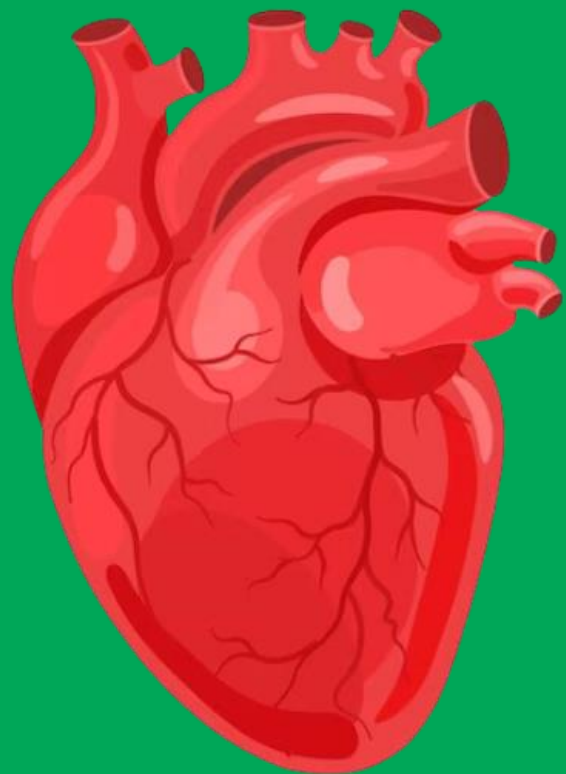
Carcinoma-in-situ

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



Less Severe Heart Attack



What do we need to know?

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.



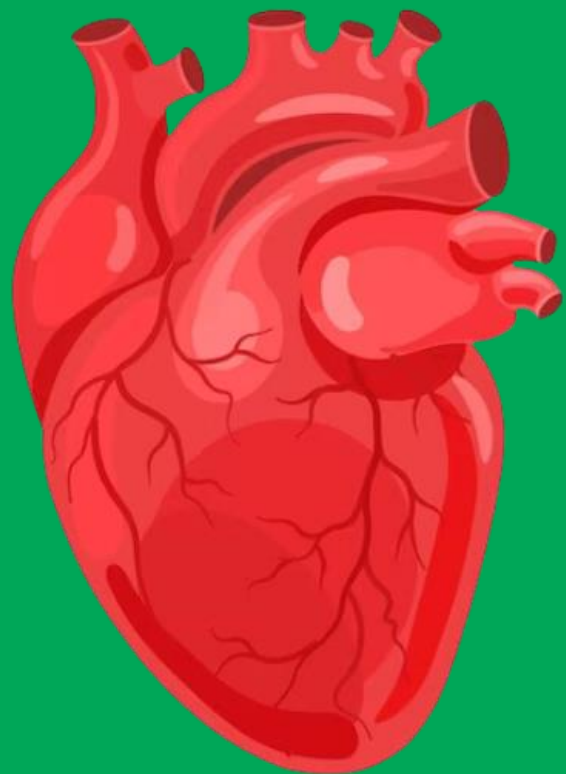
Less Severe Heart Attack



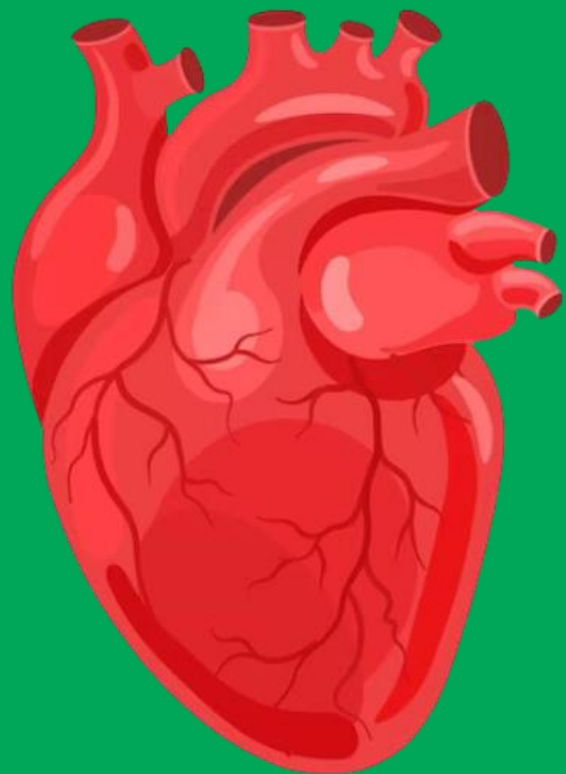
What is covered?

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

- A final diagnosis of a heart attack by a cardiologist
- Chest pain
- New ECG (electrocardiographic) changes indicating heart attack
- Elevated troponin levels (Troponin T > 0.3 mcg/L to ≤ 0.6 mcg/L or Troponin I > 1 mcg/L to ≤ 2 mcg/L).



Less Severe Heart Attack



✘ What is NOT covered?

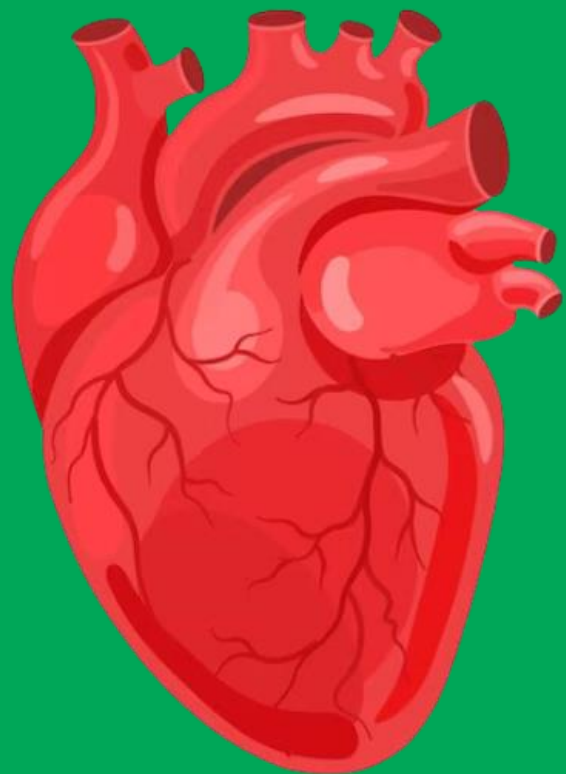
- Acute coronary syndromes and/or angina

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.



Less Severe Heart Attack

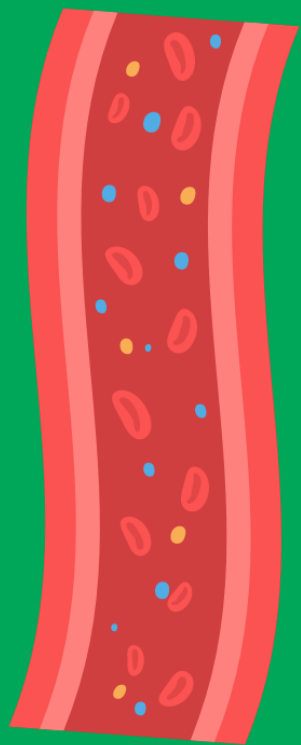


What are the requirements needed?

- ✓ 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



Angioplasty and Other Invasive Treatments for Coronary Artery Disease



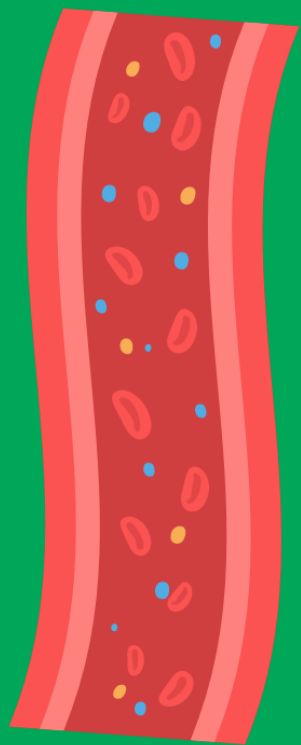
What do we need to know?

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



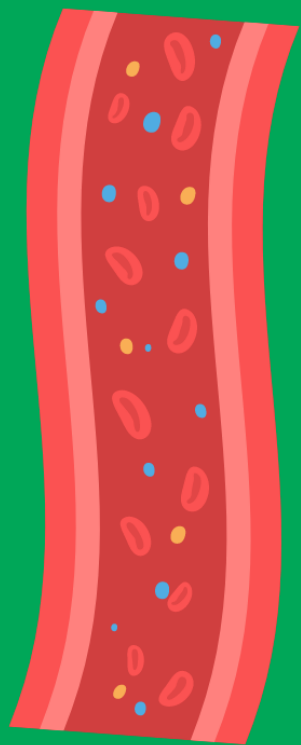
What is covered?

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 two (2) 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

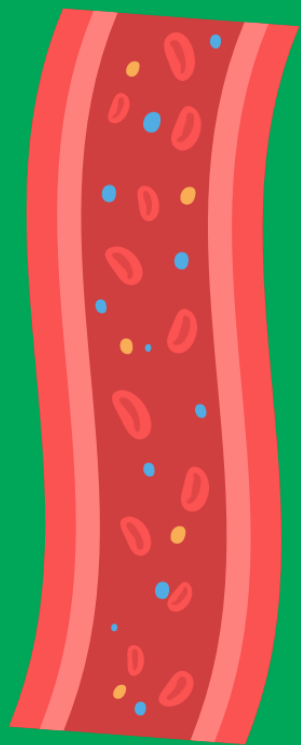


What is covered?

- 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)



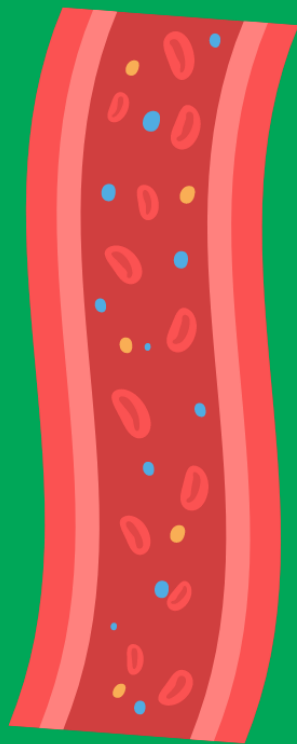
Angioplasty and Other Invasive Treatments for Coronary Artery Disease



✘ 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

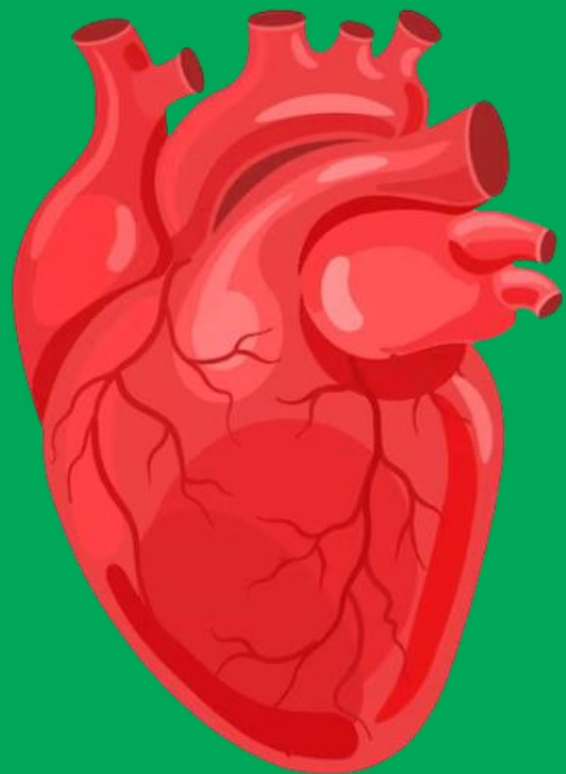


What are the requirements needed?

- ✓ 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



Cardiac Pacemaker Implantation



What do we need to know?

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.

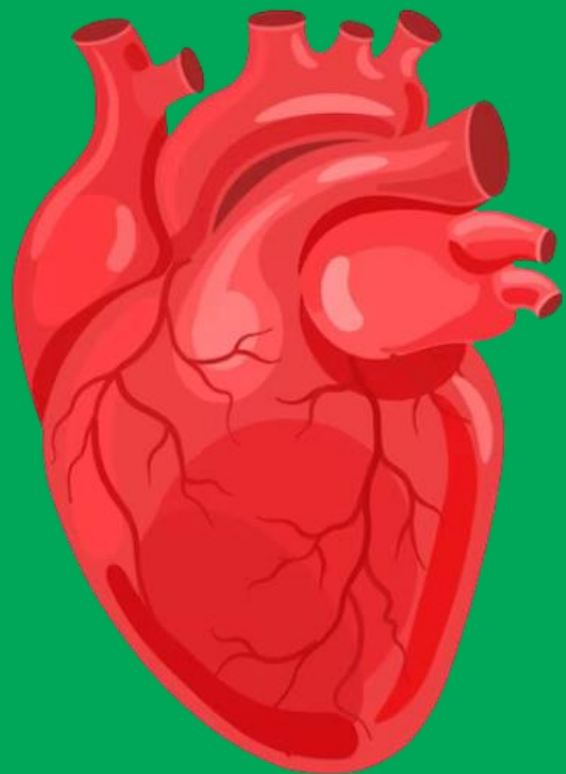


Cardiac Pacemaker Implantation



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

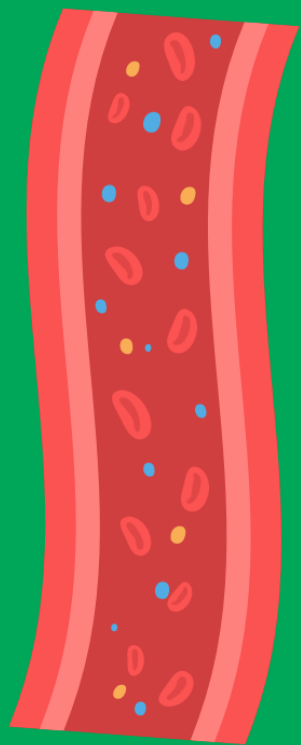


What are the requirements needed?

- ✓ 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



Angioplasty and Stenting for Carotid Arteries



What do we need to know?

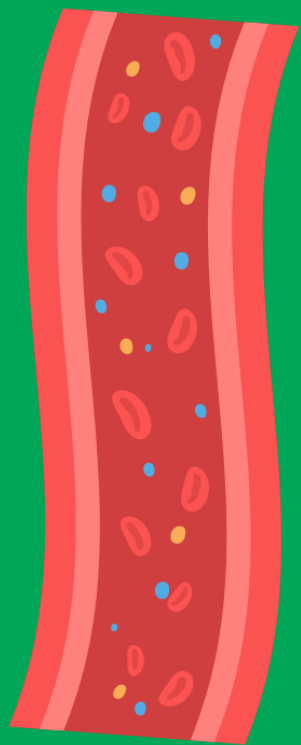
Carotid arteries are the vessels that supply blood to the brain, face, and neck. Among these carotid arteries, there are two large common arteries found on each side of the neck (left and right) which supply blood from the heart to the brain.

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)

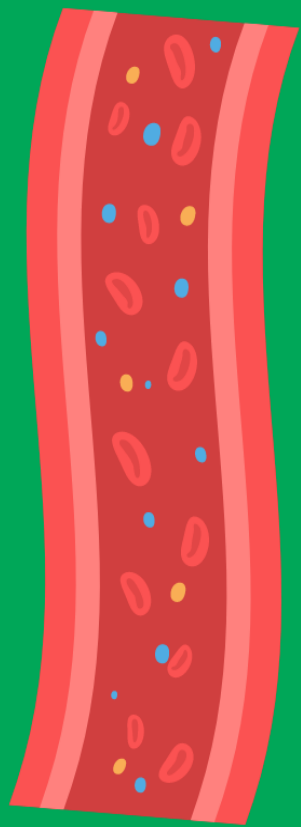


What is NOT covered?

- 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

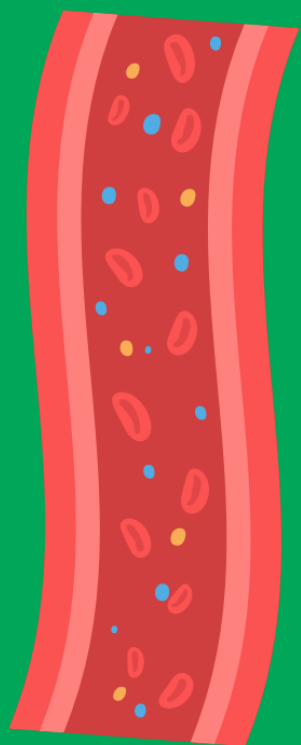


What are the requirements needed?

- ✓ 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



Carotid Artery Surgery



What do we need to know?

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.



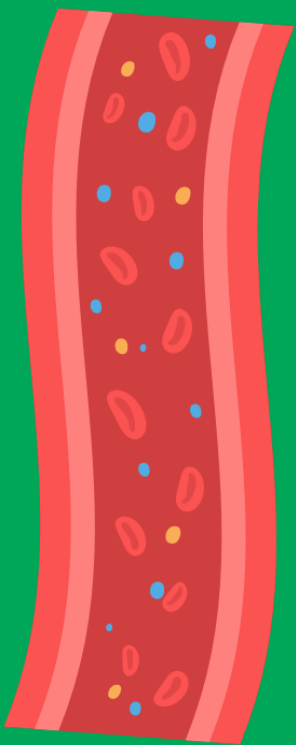
Carotid Artery Surgery



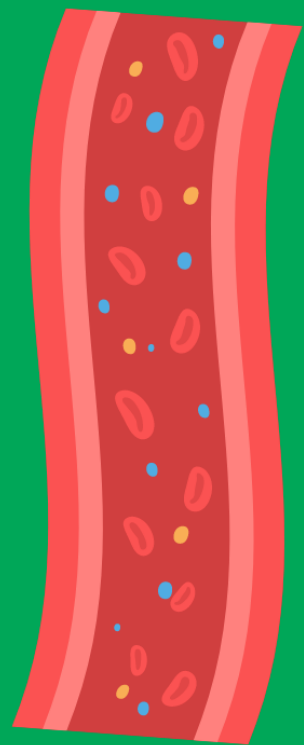
What is covered?

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

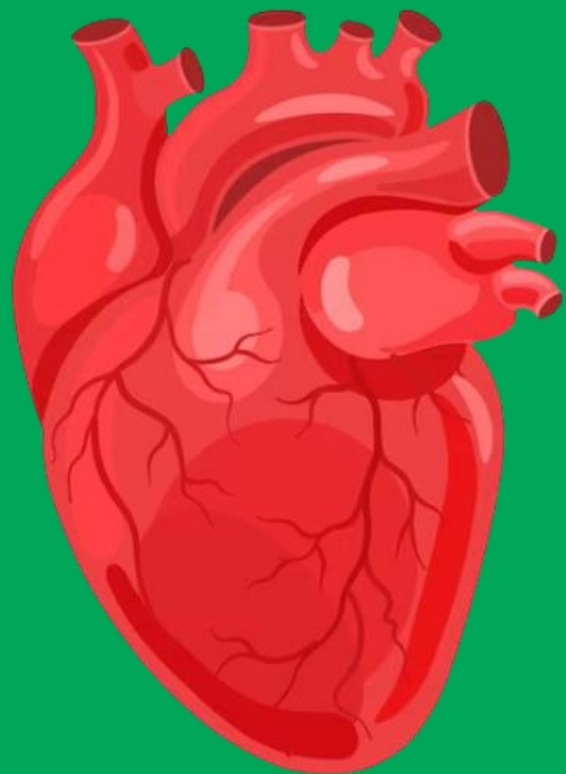


What are the requirements needed?

- ✓ 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



Less Invasive Treatments of Heart Valve Disease



What do we need to know?

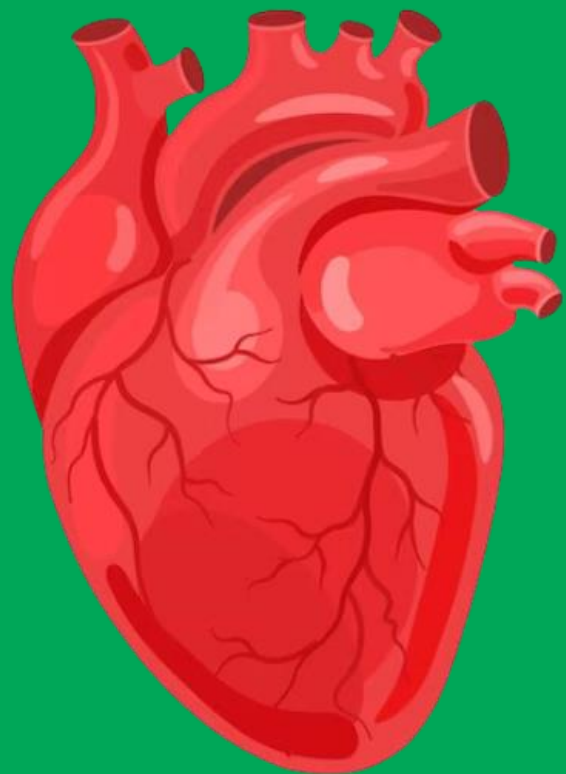
A heart valve acts as a one-way door between chambers of the heart. Heart valve disease happens when one or more of the heart valves do not work properly, such as regurgitation (back flow) when valves are not closed properly (commonly known as prolapse) or stenosis (narrowing of the valve). Usually, 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.

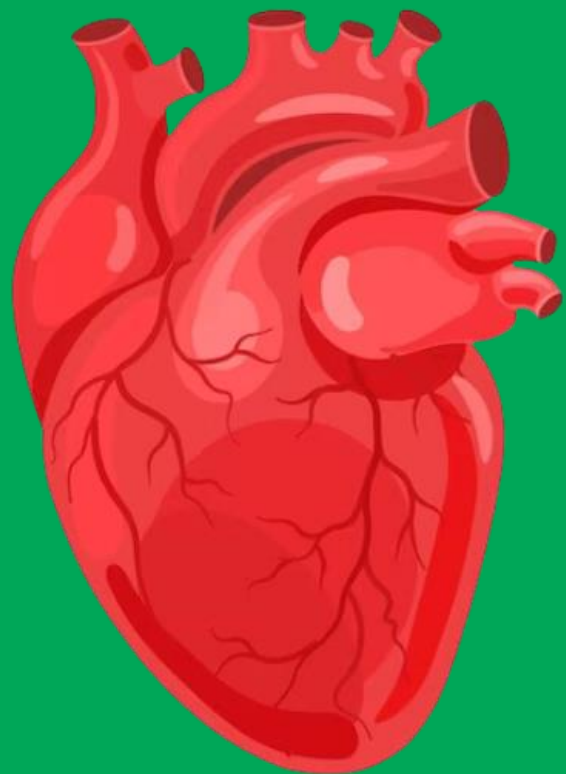


What is NOT covered?

- 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

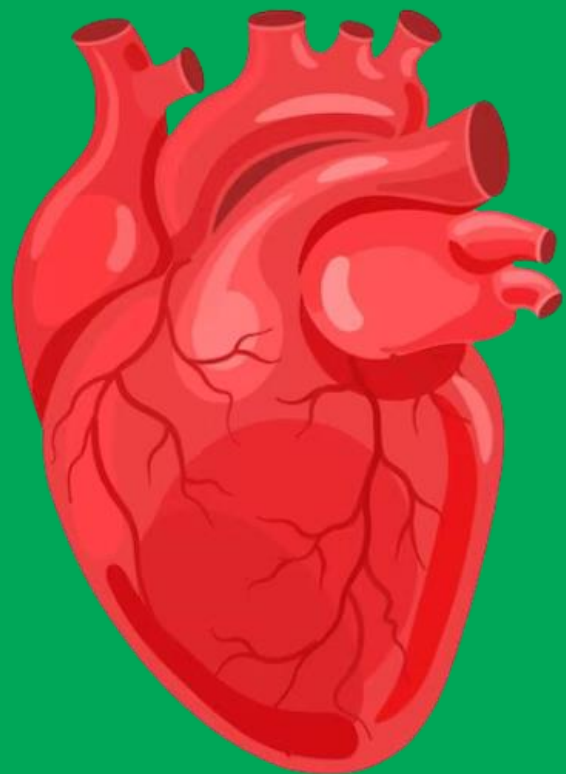


What are the requirements needed?

- ✓ 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



Endovascular Treatments of Aortic Disease or Aortic Aneurysm



What do we need to know?

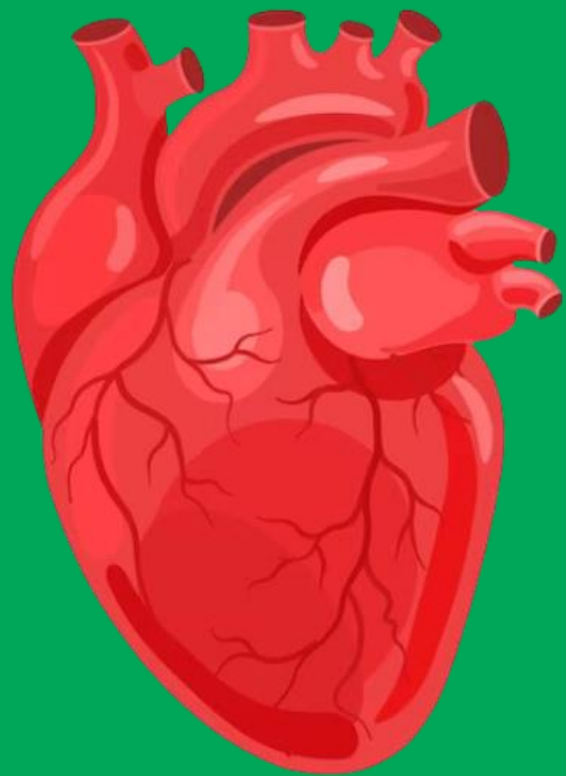
Did you know that the aorta is the largest blood vessel of the body? This main artery carries blood from the heart to other parts of the body. Aortic disease is any disorder that damages the aorta such as:

- 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)

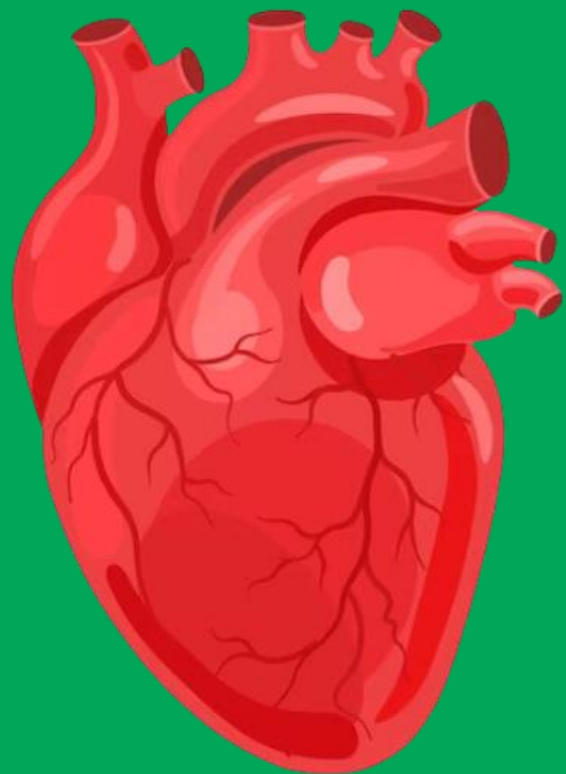


Endovascular Treatments of Aortic Disease or Aortic Aneurysm



What is NOT covered?

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

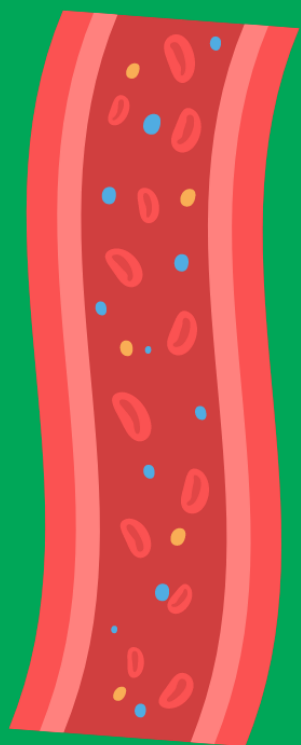


What are the requirements needed?

- ✓ 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



Endovascular Treatment of Peripheral Arterial Disease



What do we need to know?

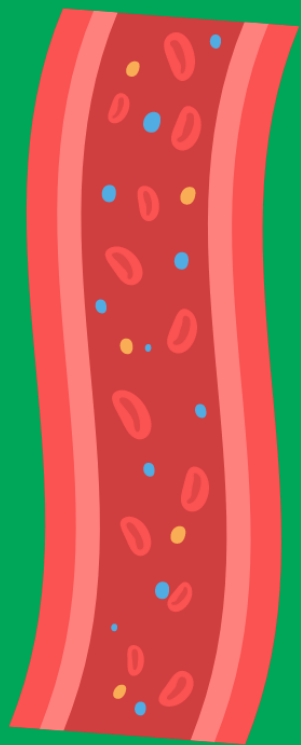
Peripheral arteries are the vessels that carry blood from the heart to other parts of the body. Peripheral arterial disease is the narrowing of the peripheral arteries (stenosis) due to the buildup of cholesterol or hardened fatty deposits (plaque), which can lead to reduced blood flow to the arms, legs, 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:

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

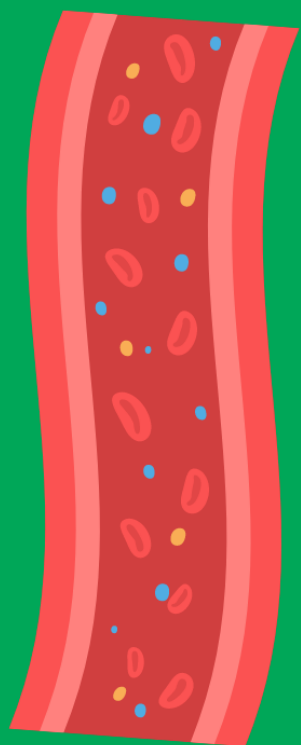


What is NOT covered?

- 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



Insertion of a vena-cava filter



What do we need to know?

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



Pericardiectomy

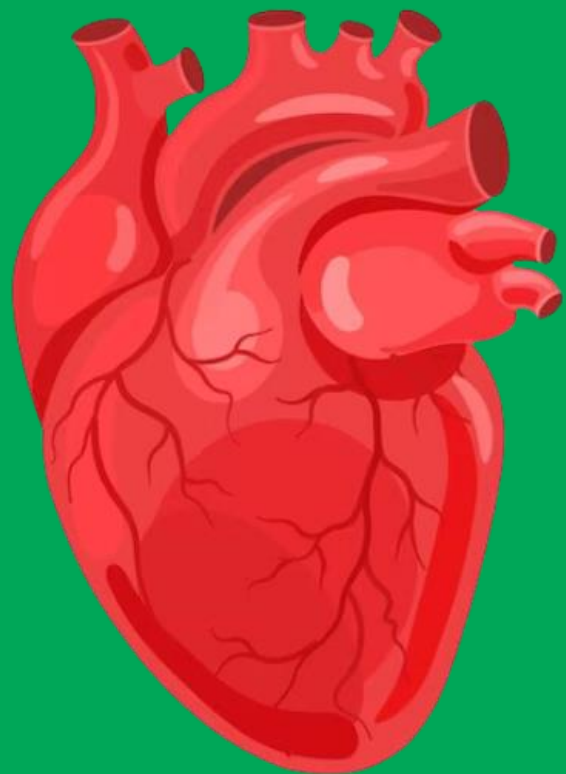


What do we need to know?

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.

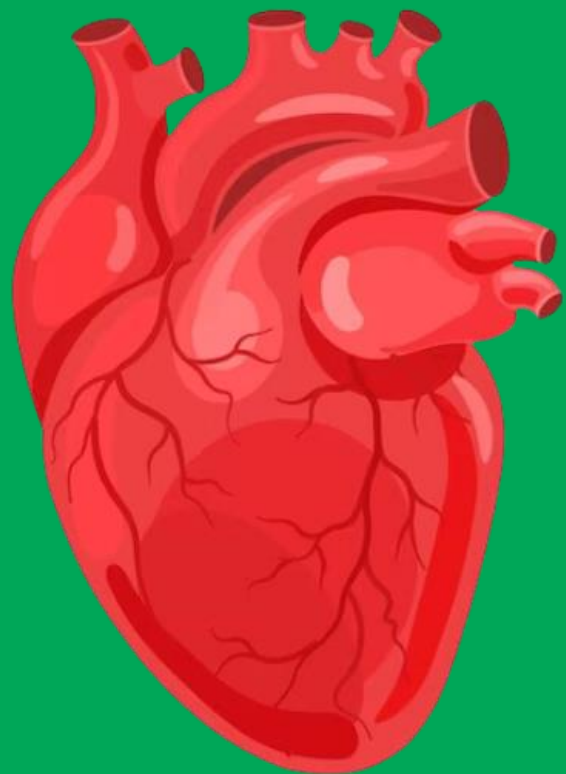


Pericardiectomy



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



Cerebral Aneurysm or Arteriovenous Malformation Requiring Surgery



What do we need to know?

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



Endovascular Treatment of Cerebral Aneurysm



What do we need to know?

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)



Cerebral Shunt insertion



What do we need to know?

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



Less Severe Bacterial Meningitis



What do we need to know?

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?

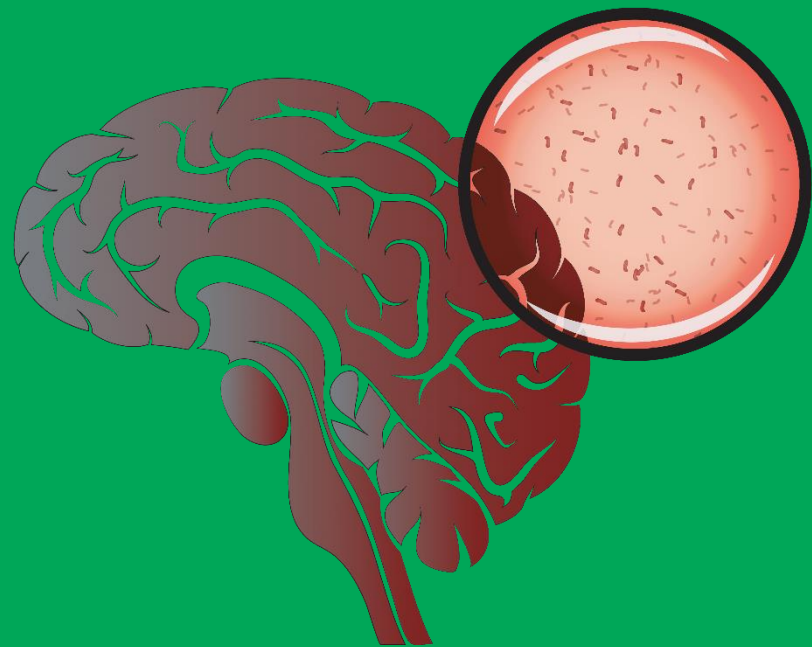
Benefits would be payable if all the following conditions are met:

- 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



What do we need to know?

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



What do we need to know?

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



Surgery for Subdural Hematoma



What do we need to know?

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

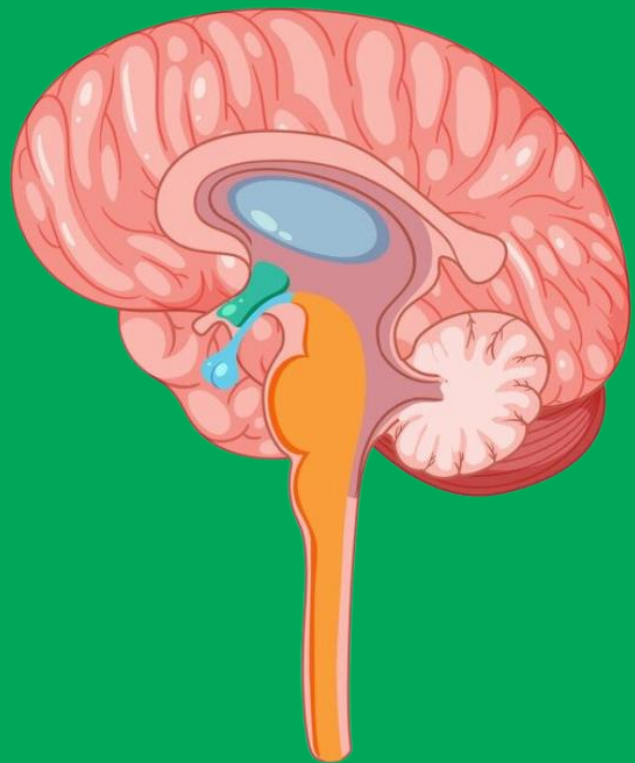


What do we need to know?

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



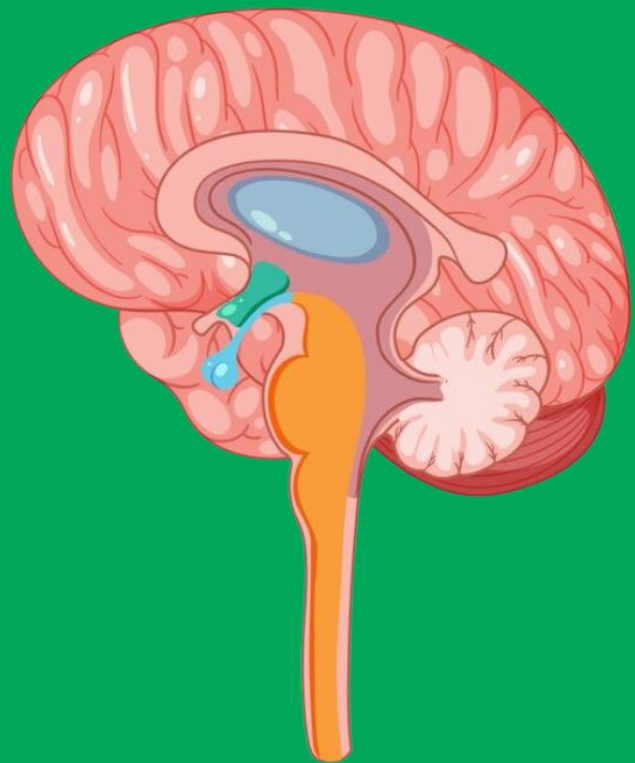
What is covered?

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).

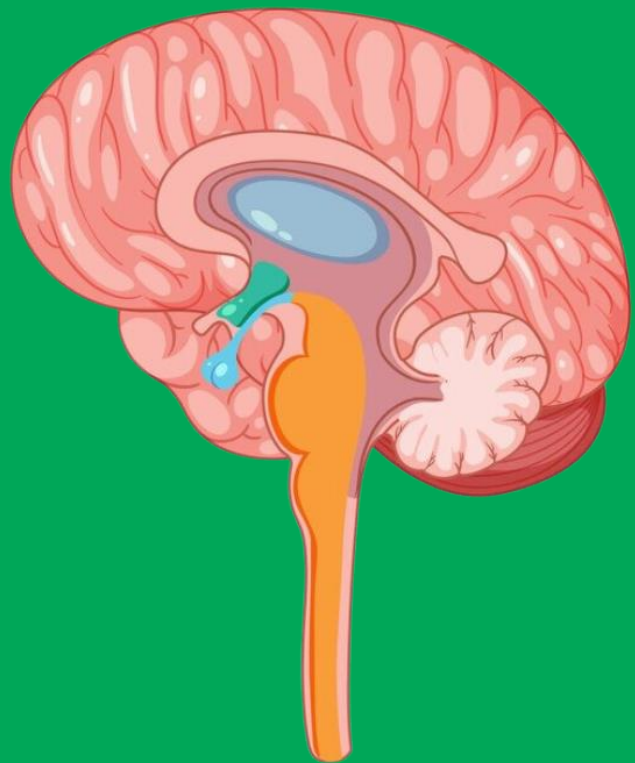


What is NOT covered?

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



Surgical Removal of Pituitary Tumor

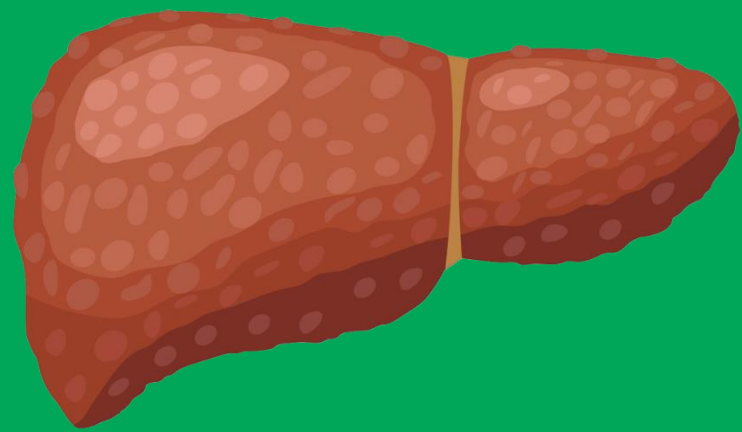


What are the requirements needed?

- ✓ 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



Hepatitis with Cirrhosis



What do we need to know?

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?

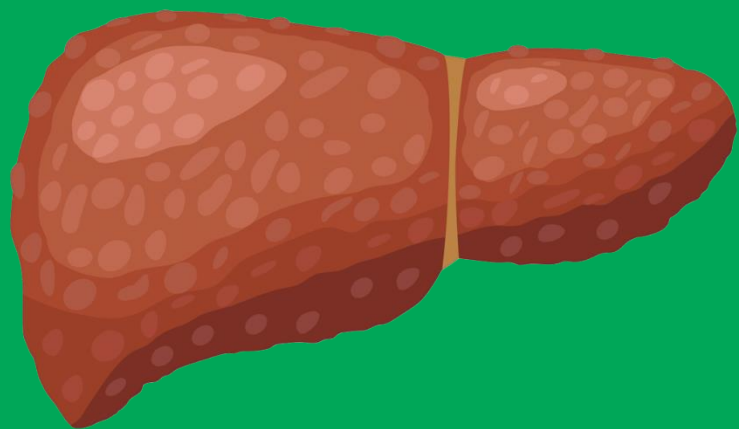
Benefits would be payable if all the following conditions are met:

- 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

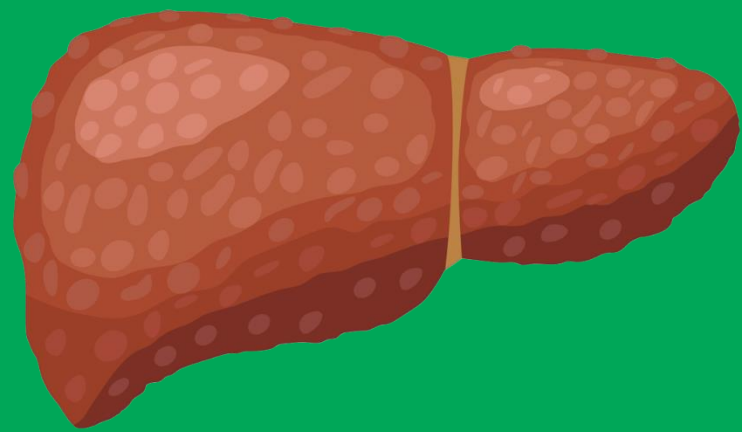


What is NOT covered?

- 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

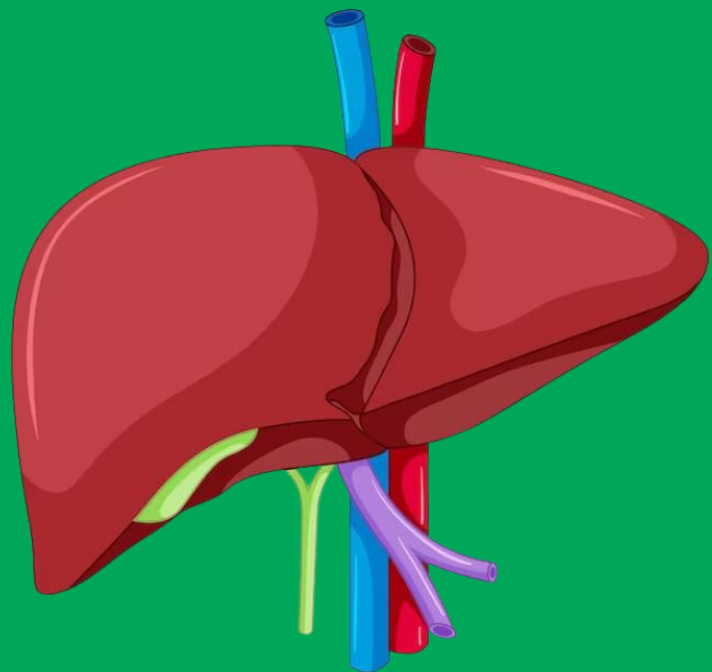


What do we need to know?

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



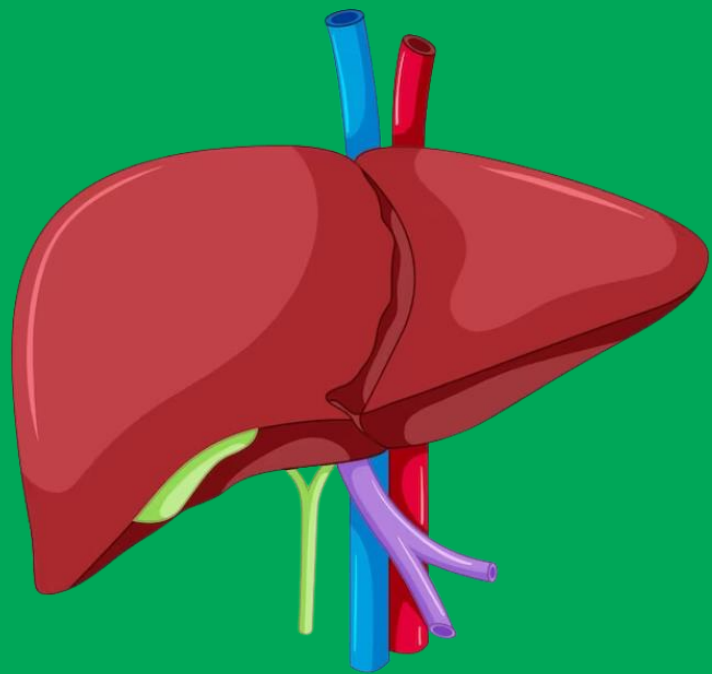
What is covered?

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

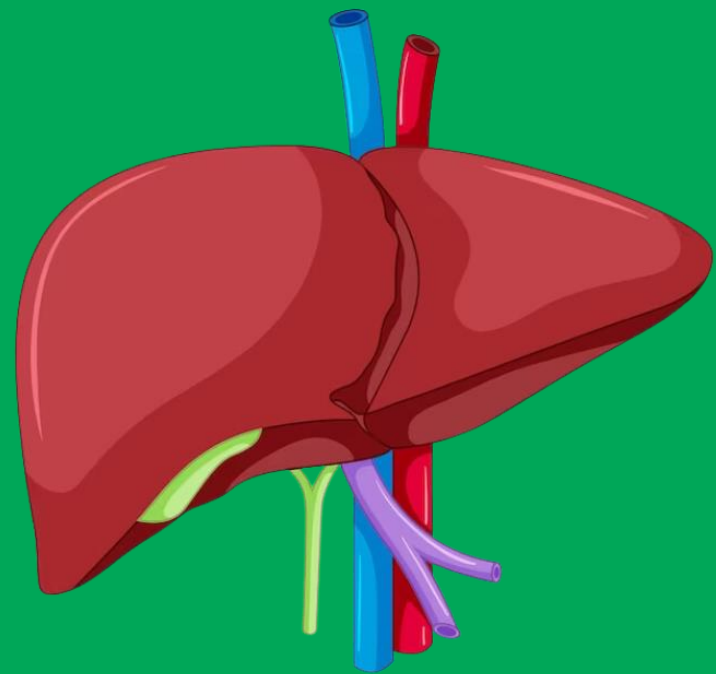


What is NOT covered?

- 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



Biliary Tract Reconstruction Surgery



What do we need to know?

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.

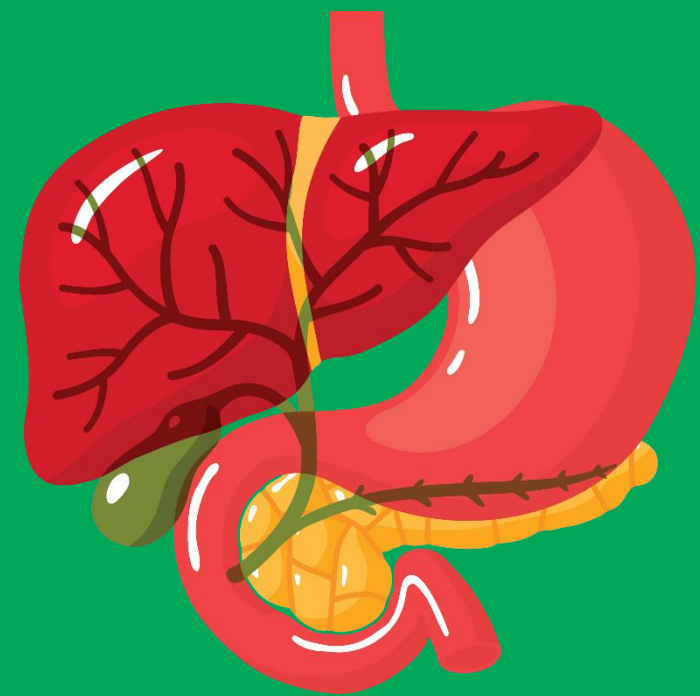


What is NOT covered?

- 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



Miliary Tuberculosis



What do we need to know?

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



Chronic Lung Disease



What do we need to know?

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



Surgical Removal of One Lung



What do we need to know?

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

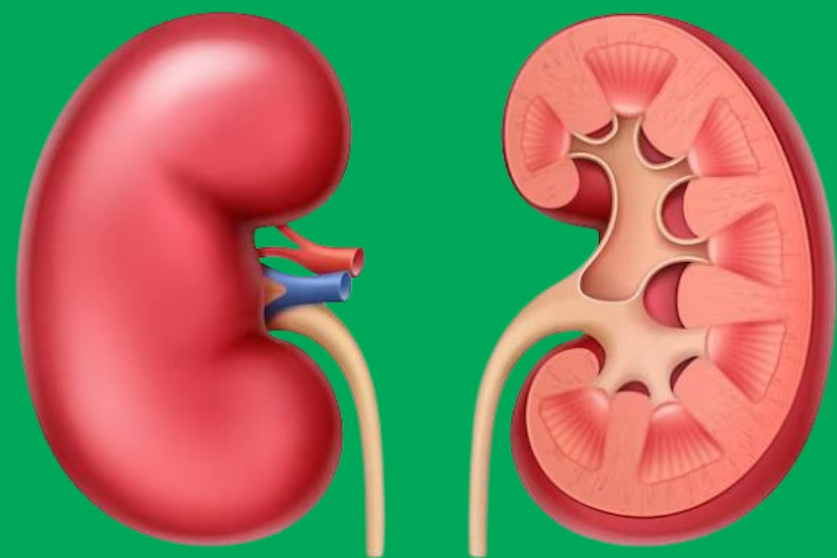


What are the requirements needed?

- ✓ 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)



Less Severe Kidney Disease



What do we need to know?

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.



Less Severe Kidney Disease



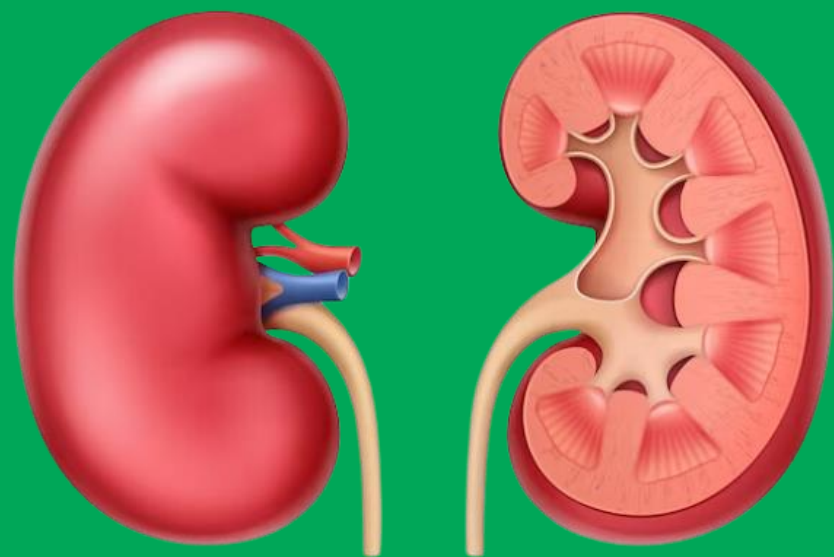
What is covered?

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.

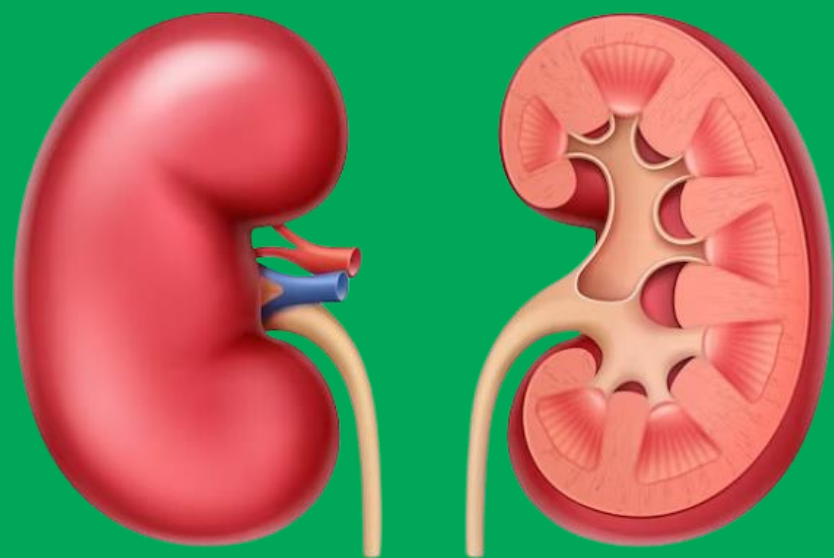


What is NOT covered?

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



Less Severe Kidney Disease

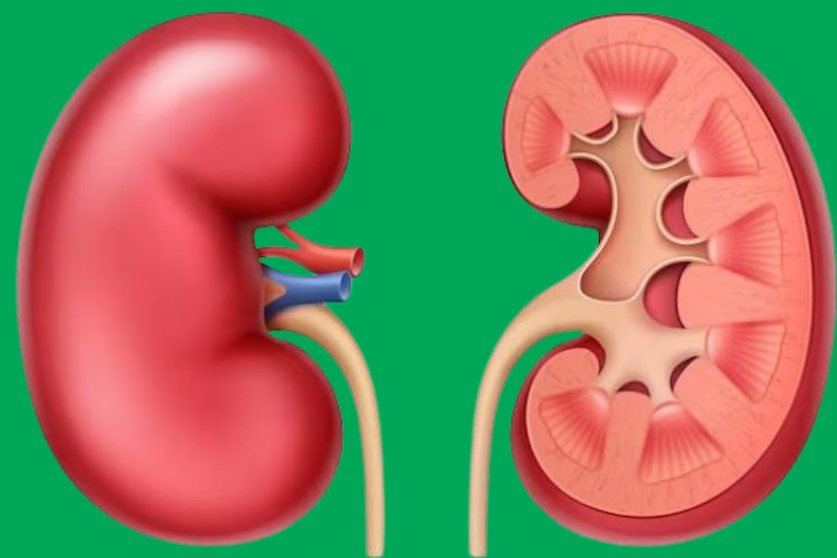


What are the requirements needed?

- ✓ Claimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- ✓ Attending Physician's Statement for 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



Surgical Removal of One Kidney



What do we need to know?

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



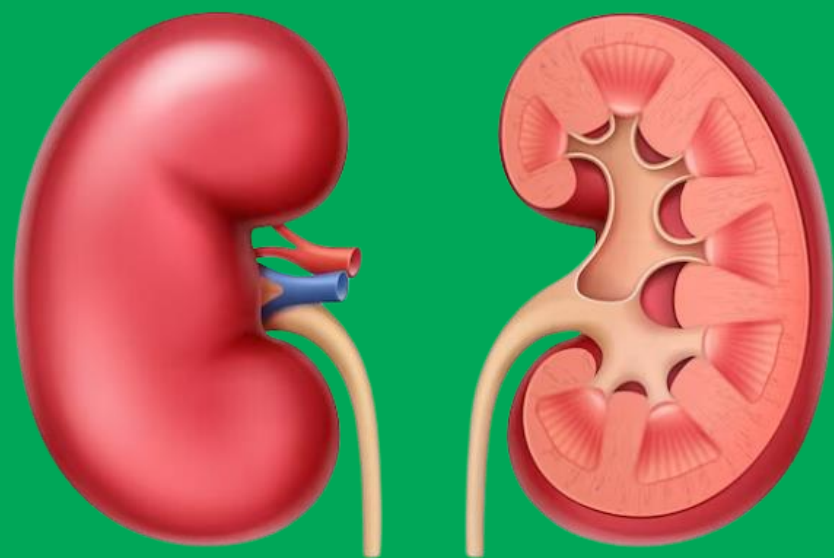
What is covered?

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

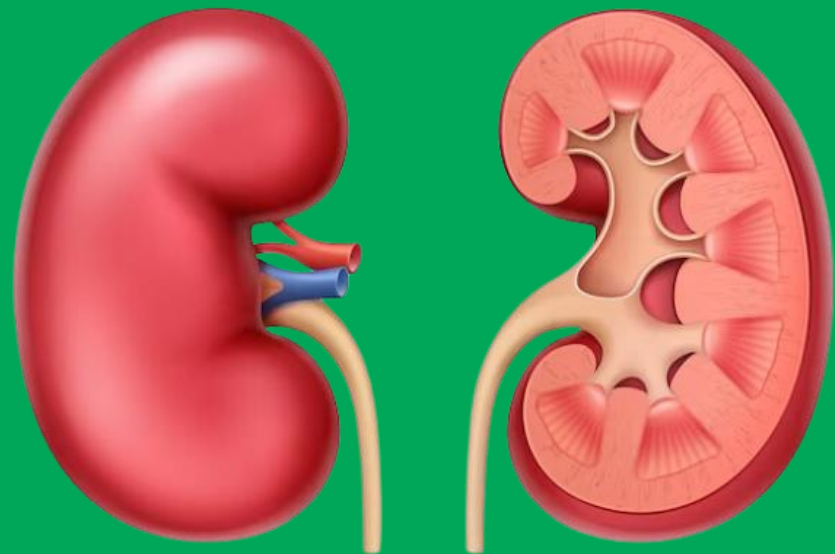


What is NOT covered?

- 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)



Adrenalectomy for Adrenal Adenoma



What do we need to know?

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



Less Severe Systemic Lupus Erythematosus

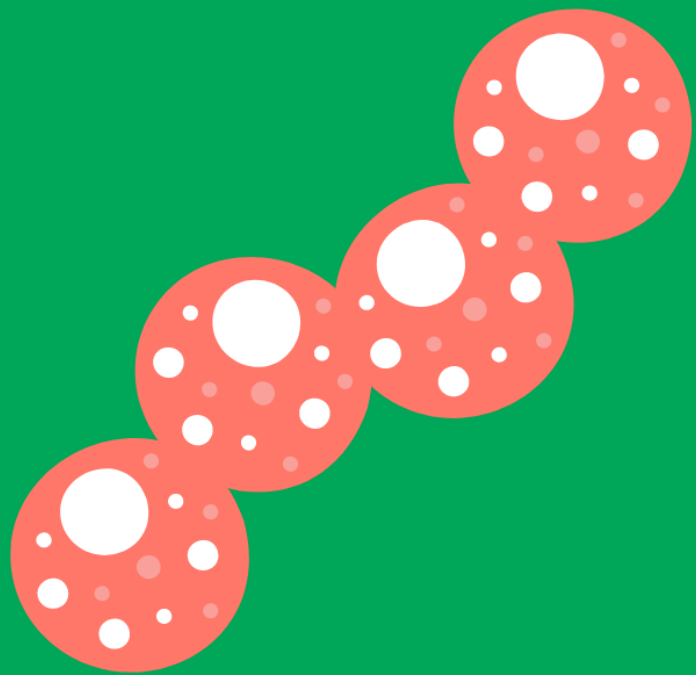


What do we need to know?

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

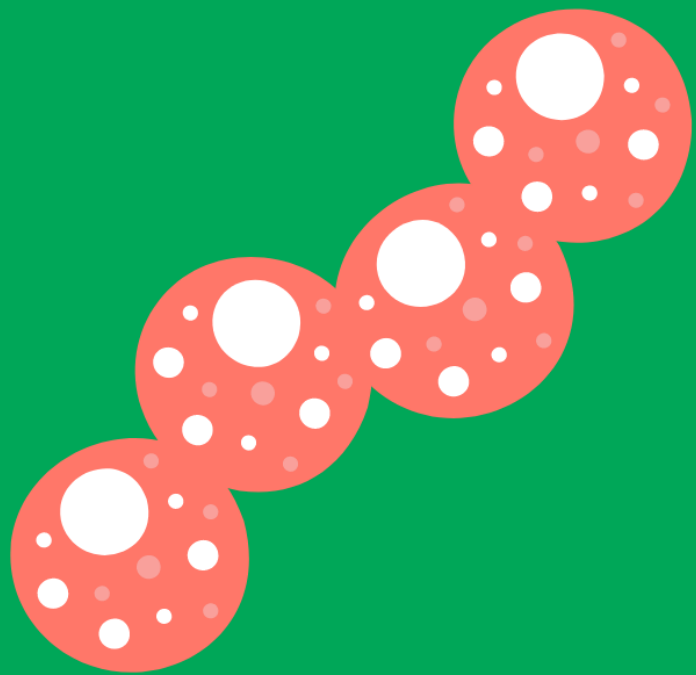


What is NOT covered?

- 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



Osteoporosis With Fracture



What do we need to know?

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.

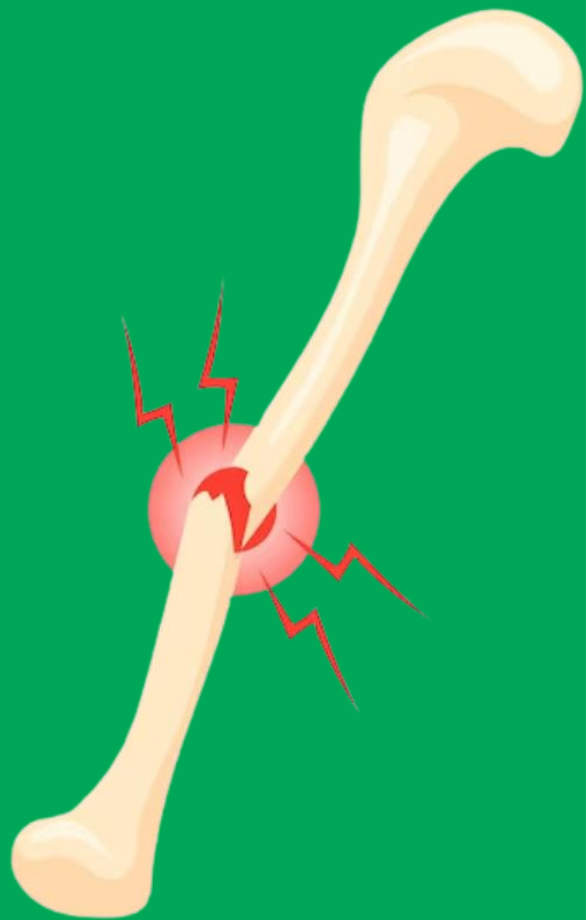
Fractures caused by osteoporosis most often occur in the hips (usually at the femoral neck) or vertebrae of the spine.

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)



Myelitis



What do we need to know?

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)



Facial Burns due to Accident



What do we need to know?

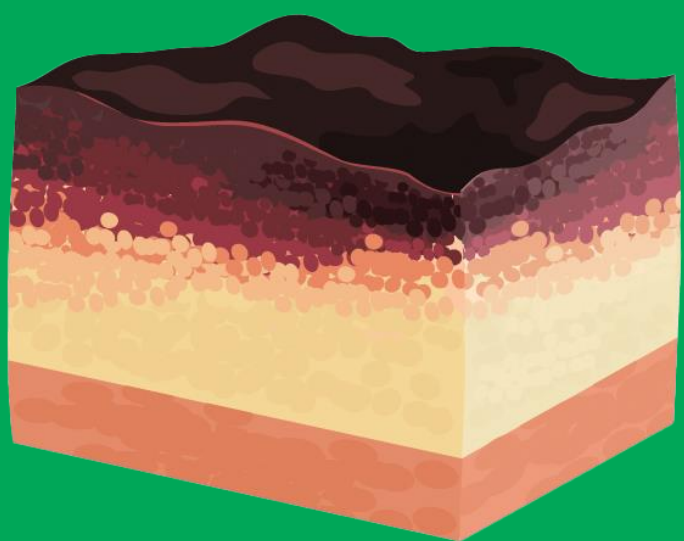
Facial burns from an accident can be devastating. If not immediately treated, facial burn injuries may cause permanent loss of function (sight, speech, swallowing, smelling, and hearing), damaged physical appearance, severe pain, infection, emotional distress, and loss of self-esteem.

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



Less Severe Burns To Body due to Accident



What do we need to know?

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



Facial Reconstructive Surgery for Injury due to Accident



What do we need to know?

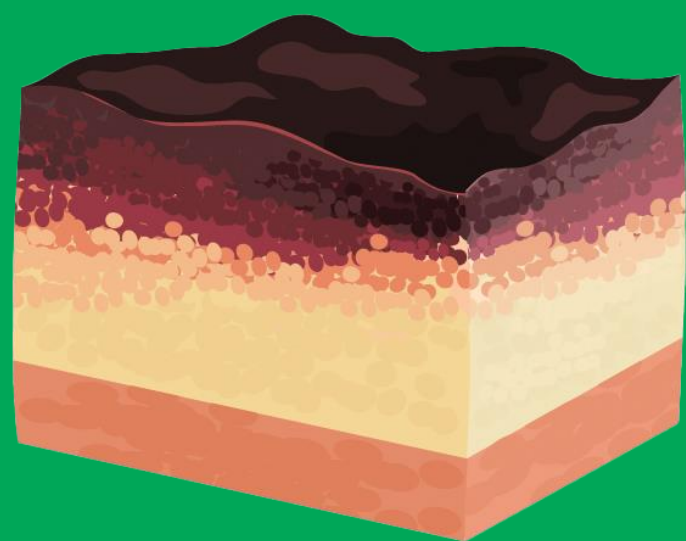
Our face has important functional features which are critical to survival, such as eyes, nose, mouth, and ears. Beyond these functional features, our face plays a vital role for human interactions, communication, identity, and quality of life.

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?

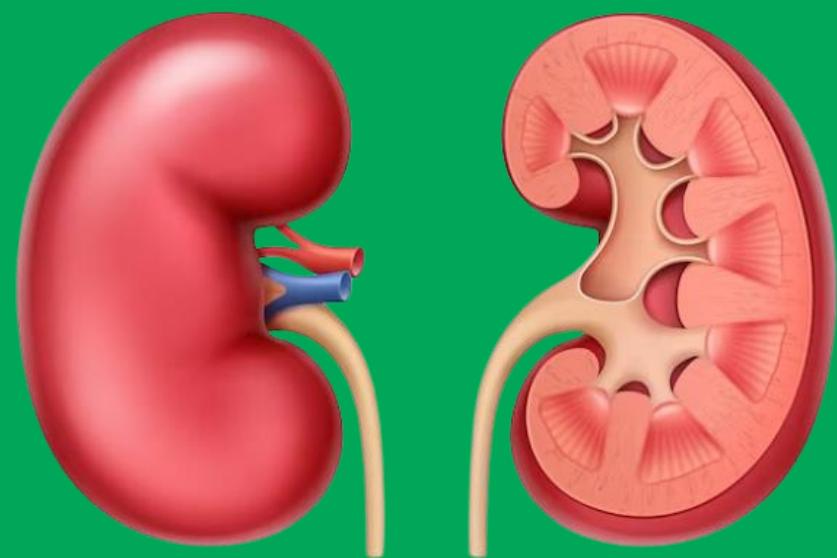
- Facial reconstructive surgery for cosmetic reasons
- Facial reconstructive surgery for correction of a congenital facial abnormality
- Isolated dental restorations, isolated nasal fractures, or isolated skin wound
- Non-accidental cause

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



Major Organ Transplantation (on Waiting List)



What do we need to know?

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.

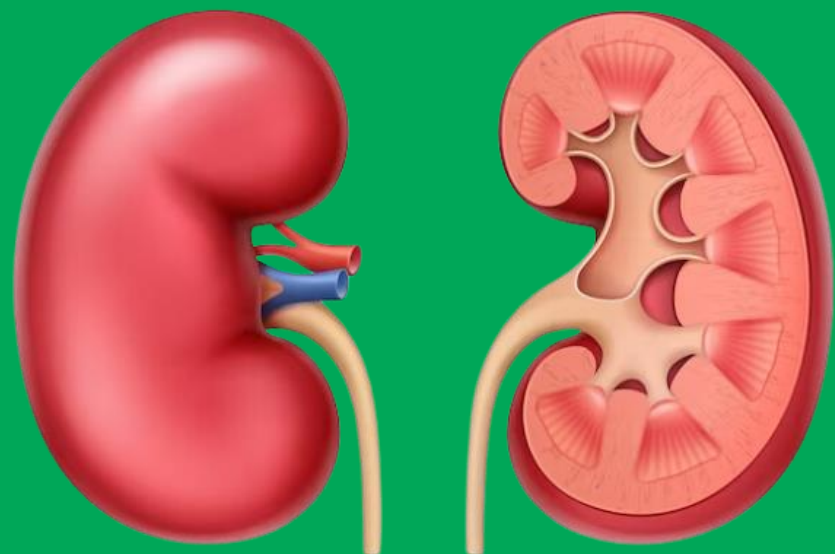


What is NOT covered?

- 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



Loss of One Limb



What do we need to know?

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 One Limb

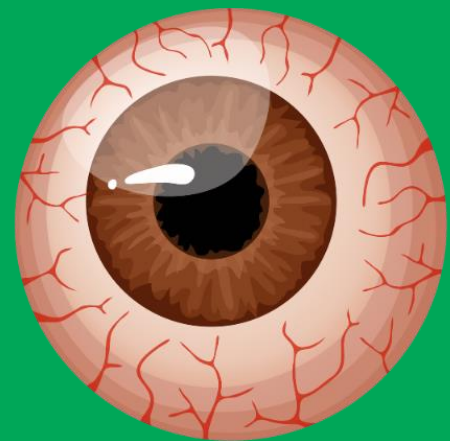


What are the requirements needed?

- Physical eClaimant's Statement for Major Disease/Critical/Terminal Illness [MP CL CSMDCTI (v. 02/2020)]
- Attending Physician's Statement for Loss of Limbs [APS – Loss of Limbs (0710)] accomplished by the insured's attending doctor
- Record of Operation or Operative Record
- Latest Discharge summary or clinical abstract or medical abstract of the confinement
- Record of Operation or Operative Record
- Latest Discharge summary or clinical abstract or medical abstract of the confinement
- Record of Operation or Operative Record
- Photos of severed limb
- Police report / Traffic Accident Report or Incident report



Loss of Sight in One Eye



What do we need to know?

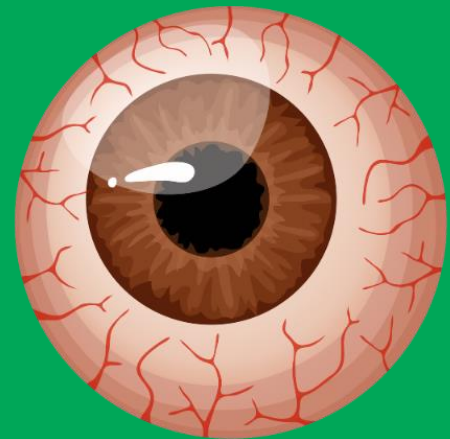
Our eyes are not just windows to the soul; they are windows into our brain. Did you know that 80% of the information from the world around us—colors, shapes, movement, and more — that reaches our brain comes from our eyes?

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?

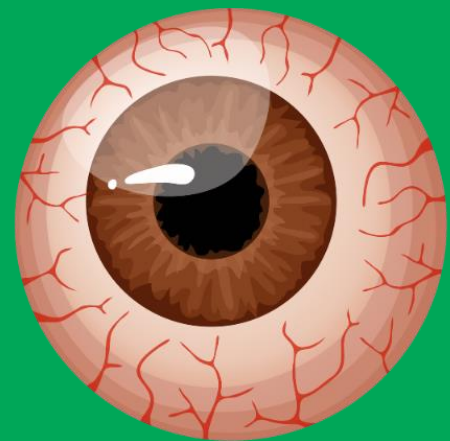
Total and irreversible loss of sight in one eye due to illness or injury



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 Hearing in One Ear



What do we need to know?

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



Moderately Severe Paralysis



What do we need to know?

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 lasting for a consecutive period of three (3) months

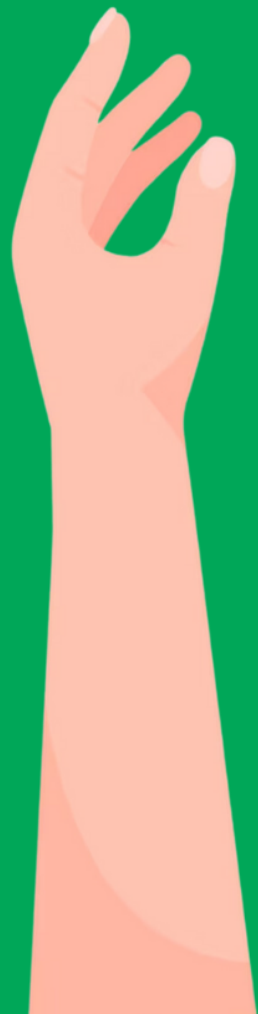


What is NOT covered?

- 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



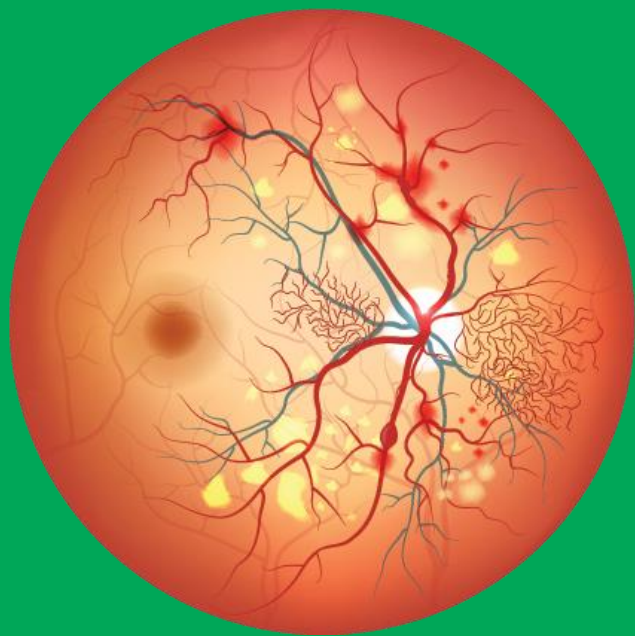
Diabetic Retinopathy



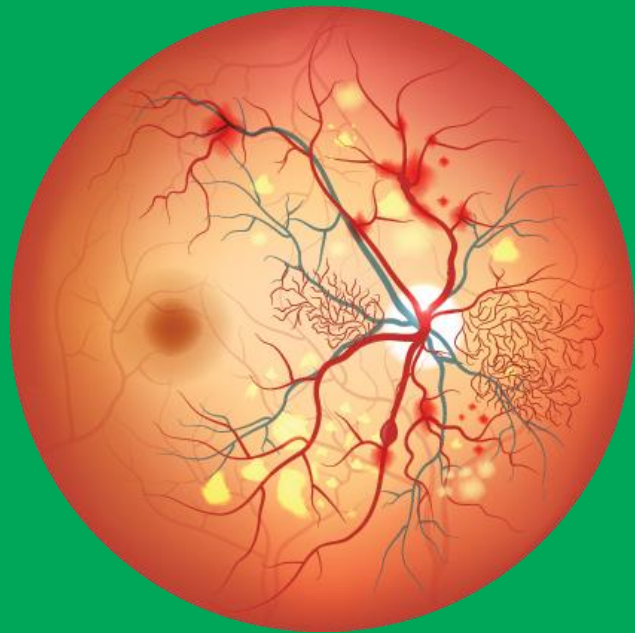
What do we need to know?

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



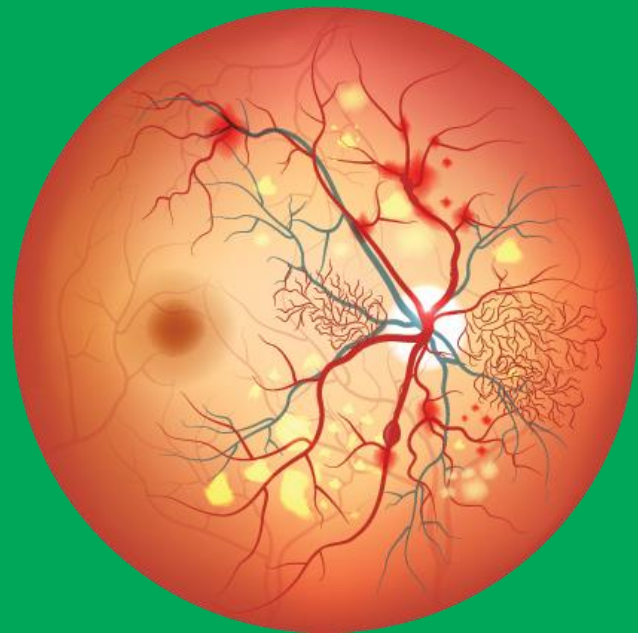
What is covered?

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



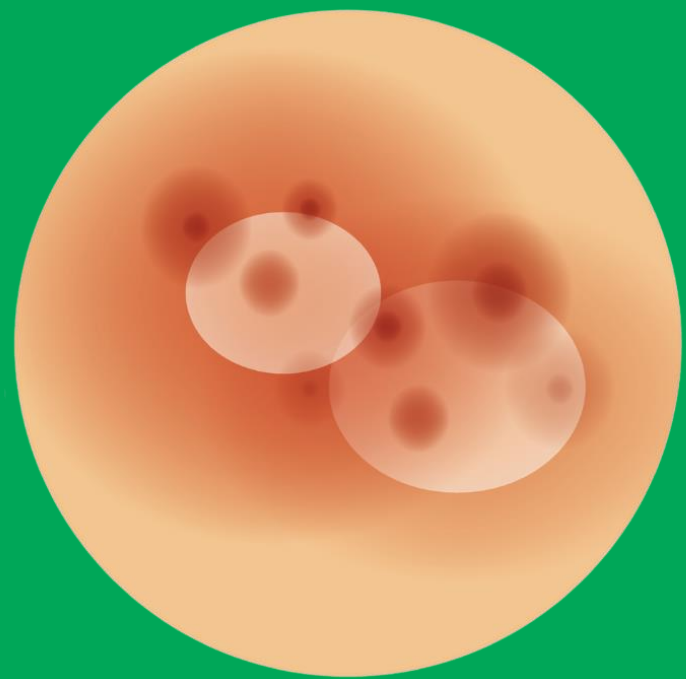
Skin Transplantation



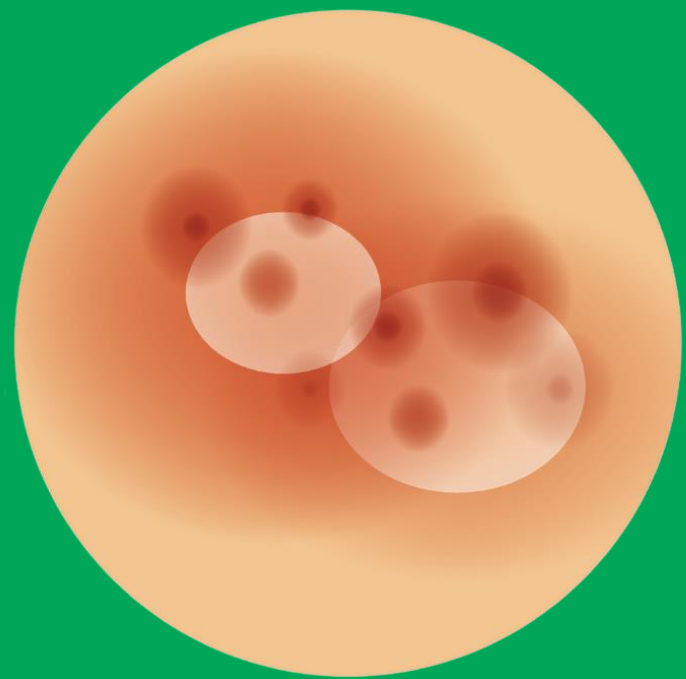
What do we need to know?

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?

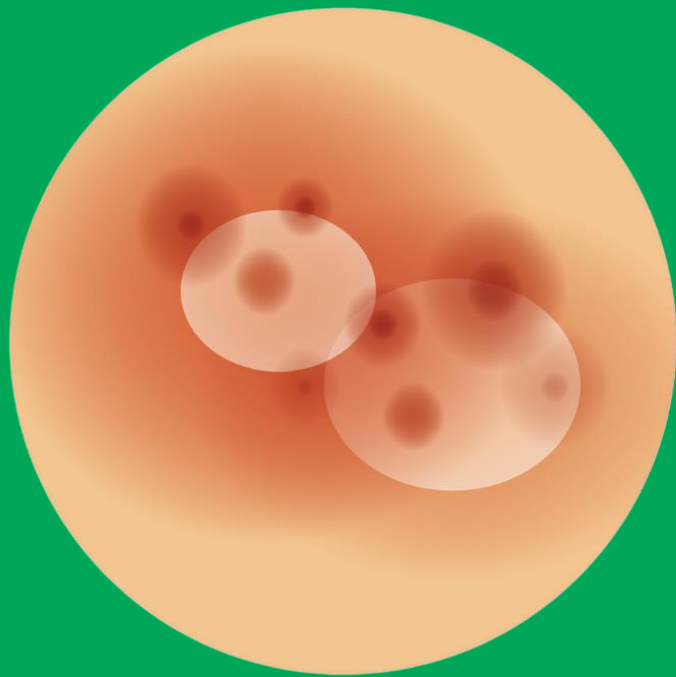
- Loss of skin due to self-inflicted injury
- Loss of skin due to injuries while under the influence of drugs or alcohol
- Skin transplant for cosmetic reasons



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



Cochlear Implant Surgery



What do we need to know?

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



About Manulife

Manulife Financial Corporation is a leading international financial services provider, helping people make their decisions easier and lives better. With our global headquarters in Toronto, Canada, we provide financial advice and insurance, operating as Manulife across Canada, Asia, and Europe, and primarily as John Hancock in the United States. Through Manulife Investment Management, the global brand for our Global Wealth and Asset Management segment, we serve individuals, institutions, and retirement plan members worldwide. At the end of 2022, we had more than 40,000 employees, over 116,000 agents, and thousands of distribution partners, serving over 34 million customers. We trade as 'MFC' on the , 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.

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](http://www.facebook.com/ManulifePH)), and Instagram (@manulifeph).

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



(+632) 8884 7000



phcustomercare@manulife.com



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



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