HEALTH PROTECTION PROGRAM AGREEMENT

KNOW ALL MEN BY THESE PRESENTS:

This AGREEMENT executed and entered into by and between:

> _________________________________, a corporation duly organized and existing under the laws of the Republic of the Philippines, with principal office address at ____, represented herein by its __________________, ____________________, hereinafter referred to as the HMO

- and -

> **PHILIPPINE DEPOSIT INSURANCE CORPORATION**, a government instrumentality created and existing by virtue of Republic Act 3591, as amended, with principal office address at SSS Building, 6782 Ayala Avenue corner V.A. Rufino Street, Makati City, represented herein by its _______________, __________________, hereinafter referred to as PDIC

WITNESSETH: That

WHEREAS, PDIC requires the services of a Health Maintenance Organization (HMO) to provide PDIC personnel with comprehensive medical program/protection via a network of healthcare providers;

WHEREAS, PDIC conducted a public bidding to interested HMO service providers and the HMO submitted the most favorable bid and was declared the winning bidder, as evidenced by the Notice of Award issued by PDIC dated _______________;

NOW, THEREFORE, for and in consideration of the foregoing premises and in accordance with the following stipulations herein set forth, the parties have agreed as follows:

I. DEFINITION OF TERMS

A. **MEMBER** – An enrollee who has complied with all the requirements of membership under the HMO program and entitled to its medical benefits. Unless otherwise specified, all MEMBERS are entitled to all benefits.

B. **MEDICAL BENEFITS** – The medical, surgical and dental services available as out-patient or in-patient benefits at no cost to MEMBERS, whenever the need for them arises, and when rendered by and in HMO accredited doctors, hospitals and clinics.

C. **MEDICAL SERVICE UNITS/TEAMS** – A group of HMO physicians and other allied health professionals, who will carry out the delivery of HMO medical and hospital services to the MEMBERS.

D. **PRIMARY PHYSICIAN/ACCREDITED PHYSICIAN/COORDINATOR** – The officer-in-charge physician who acts as the family physician of the MEMBERS in their HMO accredited hospital. He directs the MEMBERS' medical care, examines, treats and/or refers MEMBERS to specialists, orders x-ray and other laboratory tests, prescribes medicines and arranges for hospitalization, if needed.

E. **HMO ACCREDITED HOSPITALS/CLINICS** – Hospitals and clinics accredited by the HMO, where the designated physician assigns the MEMBERS for hospitalization and check-up.

F. **HEALTH PROTECTION PROGRAM AGREEMENT** – Refers to this AGREEMENT. It contains the provisions of enrollment eligibility and effective date; benefits and coverages; claims and member satisfaction provisions; exclusions and limitations of benefits; payment of membership fees; termination of coverages; etc.

G. **HMO IDENTIFICATION CARD** – Issued to the MEMBERS for their identification. It contains the MEMBER'S name, account number and validating signature.

H. **IN-PATIENT** – A person who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a HMO physician.

I. **OUT-PATIENT** – A person receiving medical services under the direction of a HMO physician, but not as an in-patient.

J. **CONVALESCENT CARE OR REHABILITATION CARE** – The restoration of a person's ability to function as normally as possible after a disabling illness or injury.

K. **CUSTODIAL OR MAINTENANCE CARE** – Care furnished primarily to provide room and board (which may or may not include nursing care, training in personal hygiene and other forms of self-care and/or supervisory care by a physician); or care furnished to a person who is mentally and physically disabled and:

1. who is not under specific medical, surgical or psychiatric treatment so as to reduce the disability to such extent necessary as to enable him/her to live outside an institution providing such care; or

2. when, despite such treatment, there is no reasonable likelihood that the disability will be so reduced.

L. **DOMICILIARY CARE** – Care provided because care in the patient's home is not available or unsuitable.

M. **COMPLEX DIAGNOSTIC EXAMINATIONS** – Procedures which may or may not be invasive in nature involving use of nuclear/radionuclide scans, digital imaging, fiberoptic/video endoscopy, markers/dyes and specific modalities listed in Article IV, subsection D.1.

N. **HAZARDOUS JOB RELATED ILLNESSES/INJURIES** – Illnesses/injuries suffered on the occasion or as a consequence, of the performance of a job attended with a high risk of suffering of physical injury or illness, or those brought about by negligence or non-use of protective measures in jobs requiring the handling of biological agents, radioactive substances, toxic chemicals and high voltage equipment.

O. **DISEASE** – Any illness, injury or adverse medical condition characterized by the abnormal functioning of a part, organ or system of the human body hallmarked by identifiable signs and symptoms, including all Disease Complications thereof.

P. **DISEASE COMPLICATION** – Any illness, injury or adverse medical condition that is caused by or is a consequence of an identifiable disease process.

II. MEMBERSHIP ELIGIBILITY

A. The following are eligible for Corporate Membership under this Agreement:

a. All PDIC employees who are on board the Corporation as of execution or hired during the effectivity of the Agreement

b. The President and Chief Executive Officer of the Corporation

c. Retired PDIC employees who are entitled to one (1) year Health Protection Program coverage after retirement from service to PDIC under the PDIC PRAISE policy

B. Underwriting cut-off dates in assigning effectivity date:

Due to the nature of the account being a Third Party Administration, HMO agrees to follow the effectivity date of membership of the additional enrollees specified in the transmittal provided by PDIC at anytime during the duration of the Agreement.

III. BENEFITS AND COVERAGES

HMO agrees to arrange for preventive, diagnostic and treatment services from HMO Medical Service Units and within HMO Accredited Hospitals or HMO Medical Centers to all qualified and accepted MEMBERS, subject to the following terms and conditions:

Care by HMO Medical Service Units/Teams

A. The following Preventive Health Care Services will be provided to MEMBERS by designated HMO Medical Service Units:

- Annual Physical Examination (APE) for MEMBERS below Vice President to include:
  - Complete Blood Count
  - Urinalysis (urine examination)
  - Fecalysis (stool examination)
  - Chest X-ray
  - Electrocardiogram (for members 35 years old and above, or if prescribed)
  - Pap smear (for women 35 years old and above, or if prescribed)
  - Eye Refraction
  - Prostate cancer screening (Prostate Specific Antigen) for male age 40 and above, or if prescribed
  - Mammography (for female 40 years old and above, or if prescribed)
  - Blood typing/chemistry (FBS, HDL, LDL, VLDL)

- Annual Executive Check-Up (AEC) for MEMBERS with the rank of Vice President and up
  - All items in the APE
  - Chest X-ray (PA-L view)
  - Blood chemistry – total cholesterol, triglycerides, SGOT, SGPT, BUN, CREA, Uric Acid, Serum Electrolytes (Na+, K+, Cl-, Ca++), Thyroid Function Test (TSH, FT3, FT4)
  - Treadmill Exercise Test
  - Gastroscopy
  - Proctosigmoidoscopy

Ultrasound of the whole abdomen (liver, gall bladder, pancreas, spleen, kidney)

- Management of Health Problems
- Routine Immunization (except cost of vaccines)
- Counseling on health habits, diets and Family Planning
- Record keeping of Medical History

Once a year, APE shall be conducted at the clinic of HMO or at the PDIC premises through a HMO Mobile Medical Team on a scheduled basis for a minimum of 50 Principal MEMBERS.

B. The following Out-Patient Services will be provided to MEMBERS in any HMO accredited hospital:

- Referral to specialists
- Regular consultation and treatment (except prescribed medicines)
- Eye, Ear, Nose and Throat treatment
- Treatment of minor injuries and surgery not requiring confinement
- X-ray and laboratory examinations prescribed by HMO physician
- Physical, occupational and speech therapy up to the annual benefit limit per MEMBER per year
- Laser treatment for all eye illnesses and injuries up to P30,000.00 per MEMBER per year
- Pre and post natal consultations excluding laboratory examinations
- First dose of anti-rabies, anti-tetanus and anti-venom
- Cauterization of warts including facial warts up to P1,000.00 per MEMBER per year
- Computed Tomography (CT) scan or Magnetic Resonance Imaging (MRI) study on any part of the body
- Echocardiography with or without contrast study, Doppler, or esophageal probe
- Nuclear imaging of any body organ
- Electromyography with Nerve Conduction Velocity Study
- Treadmill Stress Test or 12-Lead Electrocardiogram (12-L ECG)
- Mammography, Breast Ultrasonography
- Endoscopic and bronchoscopic examinations
- Chemotherapy or radiation/linear acceleration therapy, up to the annual benefit limit per MEMBER per year
- Dialysis up to the annual benefit limit
- Chest, abdominal or pelvic ultrasonography
- Endoscopic and bronchoscopic examinations
- Minor surgery/minor injury treatment (e.g., lipoma, cyst, mole)
- All diagnostic procedures prescribed by a HMO affiliated doctor or by a non-affiliated doctor, subject to the approval of the HMO

The MEMBER can go directly to the primary physician of any accredited hospital or at the Head Office clinic for out-patient consultation. The primary physician will request for laboratory or diagnostic examinations or refer the MEMBER to a specialist. The MEMBER may avail of services from any accredited hospital of his/her choice. All procedures or benefits are subject to the limitations on pre-existing conditions as stated in this AGREEMENT.

C. Care in HMO Accredited Dental Clinics

MEMBERS may avail of the dental care services from any of the accredited dental clinics, which shall include, but not limited to, the following:

- Once a year oral prophylaxis
- Consultations and oral examinations
- Unlimited simple tooth extractions, except surgery for impacted tooth
- Unlimited temporary fillings
- Gum treatment and adjustment of dentures
- Re-cementation of loose jackets, crowns, in-lays and on-lays
- Treatment of mouth lesions, wounds and burns
- Permanent amalgam filling up to one (1) surface per MEMBER per year
- Light cure permanent filling up to two (2) surfaces per MEMBER per year

D. Care in HMO Accredited Hospitals or HMO Medical Centers

1. The following hospitalization (In-Patient) services will apply when HMO physicians prescribe the hospitalization of MEMBERS in any HMO Hospitals or HMO Centers:

    - No deposit upon admission
    - Room & Board of any amount as long as it is within the category of Large Private. The HMO shall cover the excess or incremental charges above the MEMBER's room and board classification for the first 48 hours provided that the following conditions exist during admission: 1) There is no room available according to the MEMBER's classification; 2) The room and board assigned is the next higher available room and board of the MEMBER's classification; and 3) A certification of the unavailability of the MEMBER's room and board classification from the hospital admitting section must be secured before the date of discharge.
    - Use of operating and recovery rooms
    - Services of HMO specialist like anesthesiologists, internists, surgeons, etc.
    - Services and medications for general/spinal anesthesia or other forms of anesthesia deemed necessary for a surgical procedure
    - Transfusion of fresh whole blood, other blood products and intravenous fluids
    - X-ray and laboratory examinations
    - Administered medicines
    - Dressing, plaster casts, sutures and other items directly related to the medical management of the patient
    - Human blood products (e.g. platelets, packed RBC) and its processing/screening except gamma globulin up to the annual benefit limit per MEMBER per year
    - ICU or CCU confinements up to the annual benefit limit per MEMBER per year
    - Modern therapeutic modalities and interventional surgical procedures such as, but not limited to laparoscopic cholecystectomy/adrenalectomy and lithotripsy/ESWL up to the annual benefit limit each per MEMBER per year (once a year)
    - Orthopedic arthoscopy
    - Radioactive iodine therapy
    - Percutaneous ultrasonic nephrolithotomy up to the annual benefit limit per MEMBER per year (once a year)
    - CT Scan, MRI and ultrasound up to the annual benefit limit each per MEMBER per year
    - Laboratory/ancillary services for conditions whose pathogenesis or subsequent clinical improvement is not yet fully established in Medical Science up to the annual benefit limit per MEMBER per year
    - New modalities and/or diagnostic and treatment procedures for conditions with established etiologies and its use only as an alternative

to the conventional methods up to the annual benefit limit per MEMBER per year

- Chemotherapy or radiation/near acceleration therapy up to the annual benefit limit per MEMBER per year
- Radiotherapy up to the annual benefit limit per MEMBER per year
- Stereotactic brain biopsy up to the annual benefit limit per MEMBER per year
- Gamma knife surgery up to the annual benefit limit per MEMBER per year
- Congenital illnesses (e.g. AV malformation, Mitral Valve Prolapse, Indirect Inguinal Hernia) up to the annual benefit limit per MEMBER per year
- Slipped disc, scoliosis, spondylosis and spinal stenosis up to the annual benefit limit per MEMBER per year
- Hysteroscopic myoma resection up to the annual benefit limit per MEMBER per year
- Dilatation and Currettage (D&C)
- Transurethral microwave therapy (TUMT) of prostate up to the annual benefit limit per MEMBER per year
- Cryosurgery up to P1,000.00 per area up to the annual benefit limit per MEMBER per year (once a year)
- Work related illnesses/accidents, except those listed in exclusions, up to the annual benefit limit per MEMBER per year (For Principal MEMBERS only)
- Admission kit including bag
- Open heart surgery up to the annual benefit limit per MEMBER per year
- Dialysis, coronary or bypass surgery up to the annual benefit limit per MEMBER per year
- Psychiatric illness up to P50,000.00 per MEMBER per year on a reimbursement basis
- Echocardiography with or without study, Doppler, or esophageal probe covered up to the annual benefit limit per MEMBER per year
- Nuclear imaging of any body organs covered up to the annual benefit limit per MEMBER per year
- Electromyography with nerve conduction velocity study up to the annual benefit limit per MEMBER per year
- Treadmill stress test or 12-lead electrocardiogram up to the annual benefit limit per MEMBER per year
- Mammography, breast ultrasonography up to the annual benefit limit per MEMBER per year
- Endoscopic and bronchoscopic examinations up to the annual benefit limit per MEMBER per year
- Dialysis, up to the annual benefit limit per MEMBER per year
- Physiotherapy, speech therapy, or occupational therapy
- Human blood products (e.g. platelets, packed RBC) and its processing/screening except gamma globulin up to the annual benefit limit per MEMBER per year
- Organ transplant excluding the cost of organ and donor's expense up to the annual benefit limit per MEMBER per year
- The following complex diagnostic examinations up to the annual benefit limit each per MEMBER per year:

  a. Angiography (e.g. coronary, cerebral, retinal, pulmonary, GI, etc.)
  b. Serum chemistry panels (e.g. Chem 23, Spec M, etc.)
  c. Pulmonary perfusion scan

d. Tests involving use of Nuclear Technologies (e.g. Radionuclide Ventriculography/Thallium stress testing/Radionuclide (Isotope, Scanning, Pyrophosphate Scintigraphy, etc.)
e. 24-Hour Holter Monitoring, 2-D Echo and Doppler
f. Myelogram
g. Diagnostic Arthroscopy
h. Diagnostic Hysteroscopy
i. Adrenocortical Function, Plasma/Urinary Cortisol, Plasma Aldosterone, etc.
j. Bone densitometry scan (Dexascan)
k. Immunologic studies, Anti-nuclear antibody (ANA), C-Reactive Protein, Lupus cell exam
l. Genetic studies

- Professional fee of the assisting physician in surgical procedures
- Assistance in administrative requirements through the liaison officers
- All other items related to the management of the case

2. Above limits are inclusive of room and board, operating room charges, professional fees and other incidental expenses relative to the procedure. The maximum benefit limit shall be inclusive of consultations, diagnostic procedure and hospitalization. All procedures or benefits are subject to the limitations on pre-existing conditions as stated in this AGREEMENT.

3. Non-emergency confinement or surgery (elective cases) shall be subject to prior review and approval by the HMO review board. HMO reserves the right to direct the MEMBERS to other physicians or specialists for further opinions as needed so as to protect the interest of both the MEMBER and HMO.

4. In case a MEMBER is simultaneously covered under more than one corporate or group health maintenance agreements with HMO, the premiums for which are paid by the MEMBER'S employer and/or principal, the MEMBER, on a per confinement basis, shall only avail of the benefits accruing from one agreement. The MEMBER must choose which agreement will apply and his/her confinement will be governed by the terms and conditions and the limits of the agreement of his/her choice. The provision is without prejudice to the other benefits availed of by the MEMBER under another agreement which may apply for other confinements.

5. Hospitalization or in-patient coverage of a MEMBER will depend on his/her final diagnosis. All diagnostic procedures and miscellaneous charges directly related to the medical treatment and confinement such as but not limited to the following: Ice bag, hot water bag, thermometer, kidney basin, bed pan/urinal, medicine glass/cup/specimen cup, bed sheet, hospital gown, linen, pillow case, ID bracelet and distilled water for medicine dilution shall be covered. Compact Disk (CD) and Digital Video Disk (DVD) for diagnostic results shall only be covered if results are within inclusions of this Agreement.

6. Medicines and medical supplies prescribed and bought outside the hospital (because they are not available in the hospital) and used during the hospitalization period shall be covered.

7. A MEMBER may avail of the services of his/her doctor of choice who is not HMO affiliated in an accredited hospital, subject to prior approval of the HMO, under the following conditions: The HMO shall cover 100%

hospitalization fee and reimburse 80% of the doctor's professional fee based on what should have been paid to an affiliated doctor.

E. EMERGENCY CARE BENEFITS

1. Emergency care availed by the MEMBER in HMO accredited hospitals or HMO Medical Centers with an affiliated doctor is covered 100% by the HMO, which shall include, but not limited to, the following:

   - Doctor's services
   - Medicines used during treatment or for immediate relief
   - Oxygen and intravenous fluids
   - Dressings, casts, and sutures
   - Laboratory, x-ray and other diagnostic examinations directly related to the emergency management of the patient.

2. EMERGENCY CARE IN NON-HMO ACCREDITED HOSPITALS

   a. When a MEMBER is in immediate danger of losing a limb, eye or other parts of the body or is in severe pain that requires immediate relief and enters a non-HMO accredited hospital for treatment, HMO agrees to reimburse one hundred percent (100%) of the approved total hospital bills and professional fees, based on HMO's relative values for accredited hospitals.

   b. HMO shall pay the said amount when it is verified that HMO facilities were not used because to have done so would entail a delay resulting in death, serious disability or significant jeopardy to the MEMBER'S condition or the choice of hospital was beyond control of the MEMBER or the MEMBER'S family. Other expenses not covered in using non-HMO accredited hospitals for emergency care is follow up care.

   c. Emergency care availed in a non-affiliated facility or hospital for cases not falling in paragraphs a. or b. above shall be reimbursed by the HMO at 80% based on what should have been paid to an affiliated doctor and accredited hospital.

3. Ambulance services are covered on a reimbursement basis up to P2,500.00 per MEMBER per conduction.

4. EMERGENCY CARE IN FOREIGN COUNTRIES

   In cases of emergency where a MEMBER avails of services in a foreign territory, HMO shall reimburse one hundred percent (100%) of the approved total hospital bills and professional fees, based on what should have been paid to an affiliated doctor and accredited hospital, but not to exceed the amount of P30,000.00, Philippine currency.

5. EMERGENCY CARE IN AREAS WITHOUT ACCREDITED HOSPITALS

   For expenses incurred by a MEMBER in areas without accredited hospitals, HMO agrees to reimburse one hundred percent (100%) of the approved total hospital bills and of doctor's professional fees, based on what should have been paid to an affiliated doctor and accredited hospital.

F. MEMBERS' FINANCIAL ASSISTANCE INCLUDING ACCIDENTAL DEATH & DISMEMBERMENT

HMO agrees to provide the heirs and/or assigns of such MEMBER, who is enrolled in this health care program in the event of death or injuries through natural causes or accidental means, the following amounts by way of financial assistance.

SCHEDULE OF MEMBERS' FINANCIAL ASSISTANCE

Natural Death	P 10,000.00
Accidental Means	20,000.00
Loss of both hands	10,000.00
Loss of both feet	10,000.00
Loss of sight (both eyes)	10,000.00
Loss of one hand & one foot	10,000.00
Loss of one hand & sight of one eye	10,000.00
Loss of one foot & sight of one eye	10,000.00
Loss of one hand or one foot	5,000.00
Loss of sight of one eye	5,000.00

Provided, that the death or injury results from causes that are covered and are not under the exclusions or uncovered pre-existing conditions as stated in this AGREEMENT.

G. Congenital illnesses shall be covered up to the covered aggregate benefit limit.

H. Psychiatric illnesses shall be covered up to a maximum limit of P50,000.00 on a reimbursement basis.

IV. MEMBERS SATISFACTION SERVICE

A. All questions or concerns of MEMBERS about the medical services and benefits shall be directed to HMO Head Office. MEMBERS should give complete information so that the Members Assistance Personnel at HMO Head Office and/or the appropriate staff or Administrative Personnel can work with the MEMBER to resolve the MEMBER'S concern in a timely manner.

B. Emergency Hotlines that operate on a 24 hour/day 365 day/year basis to respond to inquiries shall be available at the following telephone numbers:

Tel. No. : _______________ (for Out-patient)
_______________ (for In-patient)
_______________ (for Dental)
Mobile : _______________

C. Open door policy. Direct access to a network of accredited hospitals/clinics nationwide and satellite medical clinics.

V. PHILHEALTH

It is hereby declared and agreed that hospitalization benefits due under the PHILHEALTH program are assigned to and integrated with the HMO program such

that any of the HMO benefits due under this AGREEMENT shall be net of the MEMBER'S PHILHEALTH benefits.

VI. GENERAL PROVISIONS FOR ROOM ACCOMMODATION

If a MEMBER occupies a room with a rate higher than what he/she is entitled to, he/she shall share in the medical expenses according to the following formula:

a. If a MEMBER occupies a room one category higher than what he/she is entitled to, the MEMBER shall pay for the incremental cost on hospital expenses and professional fees and the excess on room & board.

- Incremental cost for hospital expenses:
  (Total hospital bills minus total room and board charges minus disapproved charges) multiplied by 30%

- Incremental cost for professional fees:
  Medical case: Actual Charges – HMO Rate
  Surgical case:
    Ward to Private Room: Actual Charges – HMO Relative Value
    Private Room to Suite: Actual Charges – HMO Relative Value

The above provisions shall be subject to the exception mentioned in Article III Section D.

VII. CLAIMS AND REIMBURSEMENTS

A. REIMBURSEMENT PROCEDURE

All claims for reimbursement shall be submitted or forwarded to the HMO Head Office within thirty (30) calendar days after discharge from the hospital, except if it can be shown in writing that it was not reasonably possible to furnish such documents within thirty (30) calendar days. All reimbursable benefits must be paid one (1) week after filing and submission of all required documents.

In maternity-related cases/confinements, filing will be allowed for a maximum of sixty (60) calendar days.

Required documents in availing reimbursement:

1. Emergency confinement in non-accredited hospital attended by a non-accredited doctor
   - Duly filled-out claim form
   - Clinical Abstract
   - Medical Certificate to include complete final diagnosis
   - Surgical/Operative report if an operation was done
   - Original Official Receipt paid to hospital and doctor
   - Hospital Statement of account and corresponding charge slips
   - Police report if due to accident or medico-legal case
   - Incident report why MEMBER was confined in a non-accredited hospital

2. Emergency confinement in an accredited hospital attended to by a non-accredited doctor
   - Duly filled-out claim form

- Clinical Abstract
- Medical Certificate to include complete final diagnosis
- Original Official Receipt paid to hospital and doctor
- Hospital statement of account and corresponding charge slips
- Police report if due to accident or medico-legal case
- Incident report or proof that HMO accredited doctor was not available during the time of confinement

3. Out-Patient emergency consultation/treatment by a non-accredited doctor in areas where there are accredited hospitals/clinics.
   - Medical Certificate to include complete final diagnosis
   - Original Official Receipt paid to hospital and doctor
   - Hospital Statement of account and corresponding charge slips
   - Police report if due to accident or medico-legal case
   - Incident report why MEMBER was confined in a non-accredited hospital

4. Out-Patient emergency or non-emergency consultation/treatment by a non-accredited doctor in areas where there is no accredited Hospital/Clinic.
   - Medical Certificate to include complete final diagnosis
   - Original Official Receipt paid to hospital and doctor
   - Incident report
   - Police report if due to accident or medico-legal case

5. For MEMBERS Financial Assistance
   - HMO I.D.
   - Affidavit of next of kin or marriage agreement
   - Death Certificate (certified true copy)
   - Attending Physician's Statement (duly notarized)
   - Certificate of employment of principal MEMBER
   - Police report (in case of an accident)

B. RECONSIDERATION OF DENIED REQUEST FOR PAYMENT

If a request for payment is denied, the MEMBER or the MEMBER'S authorized representative may appeal the decision by filing a written request with the HMO Head Office within thirty (30) days after receiving a negative decision. The request must set forth why the MEMBER believes that the decision was in error. The MEMBER may examine pertinent documents not subject to "privileged communication" or disclosure and may submit additional written statements for consideration of the appeal.

Upon completion of the procedure, the MEMBER will receive a written notice stating the final HMO decision and the reason for such decision.

VIII. EXCLUSIONS AND LIMITATIONS

A. HOSPITALIZATION

1. All confinement shall be upon recommendation of the HMO's accredited Physician, or the HMO Medical Director, or in cases of life threatening emergencies, the Emergency Room Resident Physician of the hospital who decides to admit the MEMBER.

2. Hospital bills for the following hospital services shall be charged to the account of the MEMBER: services of a private nurse or doctor, use of extra food and/or bed, T.V., electric fan and VCD/DVD player.

3. Hospitalization and treatment outside the Philippines is not covered except during emergency cases as stated in Article III Section E.4 of this AGREEMENT.

4. HMO is not responsible and will not recognize any hospital bills incurred by a corporate health program holder in hospital not accredited by HMO, except for emergency care services under the terms provided in this AGREEMENT and subject further to the provisions of Article III Section B.

5. Cost of hospitalization, medical services, medicine and other expenses incurred as a result of a MEMBER'S decision to avail of such hospitalization, medical services, treatment or procedure, not prescribed or contrary to what has been prescribed by the attending HMO provider, or without HMO's express written report shall not be shouldered by HMO.

B. OUT-PATIENT SERVICES

1. Prescribed medicines on an out-patient basis are not provided by HMO Medical Center or Medical Service Units, except when used for out-patient chemotheraphy and for emergency room or hospitalization use.

2. The absolutely no charge out-patient medical and health care services are provided only during clinic hours of Medical Service Units.

3. Second opinions and cost of treatment incurred in non-accredited hospital or clinic should the MEMBER unilaterally decide to seek such recourse.

C. EXCLUSIONS

1. Cosmetic surgery and dermatological procedures for purposes of beautification, except constructive surgery to treat a functional defect due to disease or accidental injury.

2. Drug addiction, substance abuse and acute or chronic alcoholism.

3. Acquired Immune Deficiency Syndrome (AIDS) and AIDS related disease.

4. Treatment of self-inflicted injuries attributable to the MEMBER's own misconduct, gross negligence, use of alcohol or drug, vicious or immoral habits, participation in act of crime, violation of a law or ordinance, unnecessary exposure to imminent danger or hazard to health, and hazardous sports related injuries.

5. Injuries or illnesses resulting from participation in war like or combat operations, riots, insurrection, rebellion, strikes, and other civil disturbances.

6. Rest cures, custodial, domiciliary or convalescent care.

7. Sterilization, circumcision, artificial insemination, sex transformation, diagnosis and treatment of infertility.

8. Experimental medical procedures such as acupuncture and reflexology.

9. Corrective appliances, artificial aids, prosthetic devices and durable equipment.

10. Sleep and eating disorders.

11. Services of special nurse or doctor and extra food, bed, electric fan, television and other appliances.

12. Hospitalization and treatment outside the Philippine territory except during emergency cases as provided for in the provisions under emergency care in foreign countries.

13. Hospitalization and treatment in non-accredited hospital except during emergency cases as provided for in the provisions under emergency care benefits.

14. Prescribed out-patient medicines, except when used for out-patient chemotherapy and for emergency room or hospitalization use.

15. Corrective eye surgery for error of refraction.

16. Psoriasis and vitiligo.

17. Hypersensitivity testing and desensitization treatment.

18. Physical examination required for obtaining or continuing employment, insurance or government licensing.

D. LIMITATION IN SERVICES: HMO is not responsible for the following:

1. Delay or failure to render services due to major disasters, brownouts or epidemics affecting facilities or personnel.

2. Unusual circumstances such as complete or partial destruction of facilities, war, riots, disability of a significant number of HMO personnel or similar events which result in delay to provide services.

3. Conditions for which a MEMBER has refused recommended treatment for personal reasons, for which HMO physicians believe no professionally acceptable alternative treatment exists.

4. Sudden change of hospital policies.

IX. PRE-EXISTING CONDITIONS PROVISIONS

1. Any illness, injury or any adverse medical condition shall be considered pre-existing if during the entire period prior and within the first twelve (12) months from the effectivity date of this AGREEMENT:

   a. Any professional advice or consultation and/or treatment was made or given as a result of such illness, injury or adverse medical condition; or

   b. The MEMBER was aware or should reasonably have been aware of the signs or symptoms of such illness, injury or adverse medical condition; or

c. The pathogenesis or onset of such illness, injury or adverse medical condition has been started during the contestability period for membership in this Corporate Health Program as determined by HMO's Medical Director or accredited physicians.

2. Without necessarily limiting the following enumeration, the following are automatically considered as pre-existing conditions if consultation or treatment is sought within the first twelve (12) months of coverage:

   a. Any dreaded diseases as defined in this Agreement except letters k and l
   b. Hypertension
   c. Goiter (Hypo/Hyperthyroidism)
   d. Cataract/Glaucoma
   e. ENT conditions requiring surgery
   f. Diseased tonsils requiring surgery
   g. Bronchial Asthma/Allergy/Urticaria
   h. Tuberculosis
   i. Cholecystitis/cholelithiasis (gall bladder stones)
   j. Acquired Hernias
   k. Prostate disorders
   l. Hemorrhoids and Anal Fistulae
   m. All Benign Tumors
   n. Uterine Myoma, ovarian cyst, Endometriosis
   o. Buergher's Disease
   p. Varicose Veins
   q. Arthritis, chronic back pain (e.g., scoliosis, lumbago), slipped disc, spinal stenosis and spondylosis
   r. Migraine headache
   s. Gastritis/Duodenal or Gastric Ulcer
   t. Diabetes mellitus
   u. Collagen and connective tissue diseases
   v. Cardiovascular diseases
   w. Other pre-existing illnesses

3. All "pre-existing conditions" shall be deemed covered by HMO up to the annual benefit limit per MEMBER per year.

4. It is understood that the foregoing benefits shall likewise be applicable to "dreaded diseases" as defined under Article XI of this Agreement.

5. If there is a stipulated maximum limit on selected procedures or benefits, the coverage should be within both pre-existing conditions coverage and the stated maximum limit.

X. DREADED DISEASES

1. "Dreaded diseases" are potentially or actually life threatening conditions. They may also be illnesses that may require unusually or uncustomary prolonged or repeated hospitalization and may likewise require intensive care management. These are enumerated but not limited to the illnesses/conditions in Section 2 of this Article.

2. The following are considered dreaded diseases:

   a. Cerebrovascular Accident (stroke)

b. Central Nervous System lesions (Poliomyelitis/Meningitis/Encephalitis/neurosurgical conditions/spinal cord lessions)
c. Cardiovascular Disease (Coronary/Valvular/Hypertensive Heart Disease/Cardiomyopathy)
d. Chronic Obstructive Pulmonary Disease (Chronic Bronchitis/Emphysema), Restrictive Lung Disease)
e. Liver Parenchymal Disease (Cirrhosis, Hepatitis, New Growth)
f. Chronic Kidney/Urological disease (Urolithiasis, Obstructive uropathies, etc.)
g. Chronic Gastrointestinal Tract Disease requiring bowel resection and/or anastomosis
h. Collagen disease (Rheumatoid Arthritis, Systemic Lupus Erythematosus)
i. Diabetes Mellitus and its complications
j. Malignancies and Blood dyscrasias (Cancer, Leukemia, Idiopathic Thrombocytopenic Purpura)
k. Injuries from accidents or assaults, frustrated homicide or frustrated murder;
l. Complications of an apparent ordinary illness including Multi Organ Dysfunction Syndrome (MODS) and Systemic Inflammatory Reaction Syndrome (SIRS) (e.g. sepsis due to pneumonia, typhoid ileitis, kawasaki disease, cerebral malaria, etc.)
m. Single or multiple organ dysfunction and failure
n. Conditions that may require dialysis
o. Chronic pain syndrome (greater than six weeks)
p. Any illness other than the above which would require Intensive Care Unit confinement

3. HMO shall pay for the hospitalization services, as herein defined, of a MEMBER for "dreaded disease" up to the stated maximum amount or limit as specified in Annex "A" per illness per year.

4. "Dreaded diseases" which are pre-existing in accordance with this AGREEMENT are to be governed by the provisions of Article XI.

XI. CORPORATE HEALTH PROGRAM MEMBERSHIP REQUIREMENT

A. PDIC undertakes to submit to HMO the following:

1. List of its employees who will be enrolled as MEMBER to the Corporate Health Programs.

2. From time to time, a list of new employees at PDIC's option, for inclusion to the list mentioned in Article XII, Section (A), No. 1 above so that the corporate membership subject to this AGREEMENT will apply to them. The date of effectivity of membership of the new/additional enrollees stated in the new list shall apply.

B. HMO undertakes to furnish PDIC the following:

1. Membership application forms to be filled out by PDIC employees if required;
2. HMO Identification Card
3. This AGREEMENT

XII. AGREEMENT PRICE

Service Charge & Membership fee

In consideration of the services rendered by HMO as herein provided, HMO shall be paid an Administrative Service Fee of ______________(_____%) of the actual utilization cost of the MEMBERS and the Annual Membership Fee in the amount of ___________________ PESOS (P________) for each MEMBER as specified in Annex "A".

XIII. PAYMENT OF ACTUAL COST OF HEALTH BENEFITS AND SERVICES

PDIC shall pay HMO the amount covered by the billing notice within ten (10) working days from receipt thereof. Should certain amounts in the bill be contested in good faith, then the parties shall first strive to amicably settle the dispute among themselves before invoking Article XXI.

XIV. NON-TRANSFERABILITY PROVISIONS

This Corporate Health Program can neither be transferred nor assigned by the MEMBER to any other person.

XV. OTHER BENEFITS

1. The parties have agreed that the application forms and medical evaluations for covered MEMBERS are deemed waived.

2. AMBULANCE SERVICES

   Access to ambulances with the following schedules of benefits:

   a. 24-hour Emergency Hotline for health, medical and first aid advisories.*
   b. Emergency Quick Response (EQR) Service*
      - use of ambulance
      - use of life-saving equipment, medicines and supplies until properly endorsed to receiving emergency room hospital personnel
   c. Inter-Facility Transfer (IFT) Service*
      - use of ambulance from hospital to hospital only

   Examples:
      - MEMBER needs to be brought to another hospital for a diagnostic examination not available in the hospital where he/she is currently confined.
      - MEMBER is initially confined in a non-accredited hospital (emergency case) and is requesting to be transferred to an accredited hospital.

   Note: HMO will initially accommodate cost of EQR and IFT Services and later on bill MEMBER if there is any difference or excess over the coverage given by HMO for ambulance services, or if the case is not covered (e.g self-inflicted injuries, alcoholic intoxication, attempted suicide, etc.). MEMBER shall give his/her name, company name and account number, and sign the HMO-Lifeline form.

   d. 20% discount on regular rate of Air Medical Evacuation & Airlift Services
   e. 20% discount on regular rate of Provincial Land Conduction

f. 15% discount on regular rate of Home Care Services*

Note: Outright payment of discounted fees should be made to the ambulance service provider for letters d to f.

*__COVERAGE AREA:__ Metro Manila and adjacent provinces: Antipolo, Cainta & Taytay, Rizal; Bacoor, Cavite; Meycauayan, Obando & San Jose del Monte, Bulacan; San Pedro, Laguna.

3. HMO agrees to accommodate the annual executive check-up of Vice Presidents and up, to be arranged by HMO at any accredited hospital, on a fee for service basis.

4. In cases of non-availability of room according to plan during confinements, a MEMBER may avail of the next higher room available up to small suite room until a room according to plan is available, provided a certification from the hospital admitting section must be secured before the date of discharge to that effect.

5. MATERNITY ASSISTANCE PROGRAM

   HMO agrees to provide maternity assistance for all female MEMBERS, subject to the reimbursable limits on the table below:

Type of Delivery	*Rate of Reimbursement*
Caesarean Delivery	P8,000.00
Normal Delivery	P4,000.00
Miscarriage/Abortion	P2,000.00

   **Above benefit is not subject to administrative fee*

   The above benefits are subject to the provisions on room accommodation, claims and reimbursement provision of this AGREEMENT and may be availed once during the contract period.

6. HMO agrees to provide fast relief medicines worth P2,000.00 per month for the whole PDIC.

7. HMO shall provide two (2) accredited HMO physicians subject to the approval of PDIC, to be assigned at the PDIC clinic, each to report three (3) days a week at eight (8) hours per day. HMO shall advance the salaries of the physicians with an hourly rate of P400.00 and no administrative fee shall be charged for the services of the physicians.

   The HMO authorizes the PDIC Company Nurse and the said physicians to issue referral forms for diagnostic and laboratory examinations and consultations. In case a MEMBER will avail of out-patient services in accredited hospitals, he/she does not need to pass through the Coordinator and can directly avail of the prescribed diagnostic and laboratory examination.

8. HMO shall provide two (2) Physical Fitness Programs for the MEMBERS including the engagement of physical fitness instructors, subject to the approval of PDIC, for two (2) hours each program to be conducted twice a week. The HMO shall advance the salaries of the instructors with a rate of P1,500.00 per session and no administrative fee shall be charged for the services of the instructors.

9. POINT OF SERVICE PROGRAM

   Point of service benefit allows MEMBERS to avail of services from non-accredited doctors and hospitals subject to the reimbursement limits on the table below:

Type of Availed Services	***Rate of Reimbursement***
In-patient	
Approved hospital bills**	100% based on MRV* up to the annual benefit limit
Professional Fees	
Out-patient	
Consultation	100% based on MRV* up to the annual benefit limit
Approved laboratory examinations**	

*MRV-HMO Relative Value – based on what it would have cost HMO if an accredited physician rendered the service in an accredited hospital.
**As if prescribed by the HMO physician.

10. HMO shall provide the Human Resource Department of PDIC monthly and quarterly utilization reports and top utilizers on or before the 15th day after the referred month or quarter.

XVI. OTHERS

1. Any service availed in excess of the prescribed limit shall be billed to the MEMBER through PDIC. In order to assure payment, an appropriate form shall be provided by HMO and signed by the MEMBER stating that the excess bill shall be paid by him/her.

2. Reimbursement forms shall be provided by HMO at PDIC clinic, distribution of which shall be facilitated by the PDIC nurse, or any person designated by the Human Resources Department of PDIC who shall also be tasked to coordinate regularly with HMO.

3. All billings shall be forwarded through PDIC Human Resources Department or PDIC nurse upon reaching the P280,000.00 limit.

4. Reimbursement for laboratory and diagnostic examinations, if any, shall be paid within seven (7) working days from the submission of complete documents.

5. Quarterly orientation lectures about health updates/discussions on relevant health topics shall be conducted by HMO upon PDIC's request.

6. HMO must be willing to accredit clinics and/or doctors subject to its standard requirements and procedures on accreditation of clinics or doctors.

XVII. PERFORMANCE SECURITY

The form of Performance Security and the amount thereof shall be in accordance with any of the following schedules:

Form of Security	***Minimum Amount in Percentage of the Total Contract Price***
Cash, manager's/cashier's check issued by a Universal or Commercial Bank.	Five percent (5%)

Bank draft/guarantee or irrevocable letter of credit issued by a Universal or Commercial Bank: Provided, however, that it shall be confirmed or authenticated by a Universal or Commercial Bank, if issued by a foreign bank.	Five percent (5%)
Surety Bond callable on demand issued by a surety or insurance company duly certified by the Insurance Commission as authorized to issue such security.	Thirty percent (30%)
Any combination of the foregoing	Proportionate to share of form with respect to the total amount of security

XVIII. CONSTRUCTION

This AGREEMENT together with any addendum, annex and the Applications for Membership altogether constitute the entire agreement between HMO and PDIC, and no statement, promise or inducement made by or through any other party not contained herein shall be binding or valid.

XIX. EFFECTIVITY AND DURATION OF THIS AGREEMENT

1. This AGREEMENT shall take effect on __________________ upon signing by the parties thereof and upon receipt by HMO of the first periodic corporate membership fee, and will be in force and effect for a period of one (1) year. The Health Protection Program (HPP) of PDIC shall provide each PDIC employee health benefits/services, including dental services, out-patient and hospitalization benefits/services up to a maximum amount of SIX HUNDRED THOUSAND PESOS (P600,000.00), Philippine Currency, for the period covering one (1) year starting _______________ up to _________________. Thus, all eligible MEMBERS are entitled to fresh full coverage of P600,000.00 starting _______________.

2. This AGREEMENT terminates upon expiration of the one-year period unless the same is renewed and/or extended on the day immediately upon its expiration under such terms as may be agreed upon by both parties. Such agreements to be signified in writing as an amendment and/or extension to this AGREEMENT, or a new agreement may be issued to replace the expired agreement. However, any aggrieved party may pre-terminate this AGREEMENT for cause (i.e. any act of bad faith, breach of agreement, etc.) upon service of thirty (30) days notice to the other.

3. Membership of the individual shall automatically cease upon termination of employment with the PDIC, subject to Article II, A.c.

4. The termination of this AGREEMENT will not hold HMO responsible to provide the medical and health care services described herein to such enrolled MEMBERS, who are still confined in any of the HMO Accredited Hospitals or undergoing emergency treatment in non-accredited hospitals at the time of the termination of this AGREEMENT. However, only the hospital charges applicable up to the time of termination of the AGREEMENT will be paid by HMO.

5. All HMO patients are considered to be patients of the HMO Medical Director handled by his authorized designates. As such, coverage or non-coverage of certain illness not listed herein shall be upon his discretion after proper consultation with concerned medical specialist.

XX. VENUE OF ACTIONS

The parties hereby agree that any action arising out of this AGREEMENT shall be instituted exclusively in the proper courts of Makati City, Philippines.

PHILIPPINE DEPOSIT INSURANCE CORPORATION
TIN : __________

By:

____

Date : _____________
Place: _____________

Signed in the Presence of:

__________________________ __________________________

____
TIN : __________

By:

____

Date : _______________
Place: _______________

Signed in the Presence of:

__________________________ __________________________

ANNEX "A"

SCHEDULE OF MEMBERSHIP FEES

Annual Membership Fee : P________ per head (inclusive of VAT)
Administrative Service Fee : _______________ percent (_______%)

With MMC, TMC, AHMC, SLMC-QC, SLMC-Global, CSMC, MDH and CMC

Room & Board	***Annual Benefit Limit (for all benefits availed per member per year)***
Large Private	P600,000.00

MMC	*Makati Medical Center*	***SLMC-QC***	*St. Luke's Medical Center – Quezon City*
TMC	*The Medical City*	***SLMC-Global***	*St. Luke's Medical Center – Global City*
AHMC	*Asian Hospital & Medical Center*	***CSMC***	*Cardinal Santos Medical Center*
MDH	Manila Doctors' Hospital	**CMC**	Capitol Medical Center

Notes: Non-Philhealth members must pay initially an additional P1,500.00 per head or shall pay the corresponding portion during confinements and out-patient surgical procedures.

ACKNOWLEDGMENT

REPUBLIC OF THE PHILIPPINES)
MAKATI CITY) S. S.

BEFORE ME, a Notary Public, in and for the City of Makati, this _____ day _______________________, personally appeared:

Name	**Identification Doc. & No.**
	PDIC ID No. 1341

known to me to be the same person who executed the foregoing instrument and who acknowledged to me that the same is his/her free and voluntary act and deed as well that of the entity which he/she represents and that he/she is duly authorized for the purpose.

The foregoing instrument, consisting of twenty-three (23) pages including the page on which this acknowledgment is written and Annex "A" hereof, has been signed on each and every page by the parties and the witnesses.

WITNESS MY HAND AND SEAL on the date and in the place abovewritten.

Doc. No. _____;
Page No. _____;
Book No. _____;
Series of _____.

ACKNOWLEDGMENT

REPUBLIC OF THE PHILIPPINES)
______________________) S. S.

BEFORE ME, a Notary Public, in and for _____________________, this _____ day of ______________________, personally appeared:

Name	**Government ID & No.**	**Expiry Date**

known to me to be the same person who executed the foregoing instrument and who acknowledged to me that the same is his/her free and voluntary act and deed as well that of the entity which he/she represents and that he/she is duly authorized for the purpose.

The foregoing instrument, consisting of twenty-three (23) pages including the page on which this acknowledgment is written and Annex "A" hereof, has been signed on each and every page by the parties and the witnesses.

WITNESS MY HAND AND SEAL on the date and in the place abovewritten.

Doc. No. _____;
Page No. _____;
Book No. _____;
Series of _____.