Health Maintenance Organization

CORPORATE HEALTH PROGRAM CONTRACT AGREEMENT

KNOW ALL MEN BY THESE PRESENTS:

In consideration of the foregoing premises and in accordance with the following stipulations herein set forth, here are the agreed terms

- **DEFINITION OF TERMS**
  - **MEMBER –** An enrollee who has complied with all the requirements of membership under the HMO program and is hereby entitled to its medical benefits. Unless otherwise specified, all members are entitled to all benefits.
  - **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.
  - **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 HMO MEMBERS.
  - **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 to specialists, orders x-ray and other laboratory tests, prescribes medicines and arranges for hospitalization if needed.
  - **HMO ACCREDITED HOSPITALS/CLINICS –** Hospitals and clinics accredited by HMO, where the designated physician assigns MEMBERS for hospitalization and check-up.
  - **HMO CORPORATE HEALTH 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.

- **HMO IDENTIFICATION CARD –** Issued to EMBERS for their identification. It contains the member's name, account number and validating signature.
- **IN-PATIENT –** A person who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of an HMO physician.
- **OUT-PATIENT –** A person receiving medical services under the direction of an HMO physician, but not as an in-patient.
- **CONVALESCENT CARE OR REHABILITATION CARE –** The restoration of a person's ability to function as normally as possible after a disabling illness or injury.
- **CUSTODIAL OR MAINTENANCE CARE –** Care furnished primarily to provide room and board (which 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:
    - Who is not under specific medical, surgical or psychiatric treatment so as to reduce the disability to such extent necessary as to enable them to live outside an institution providing such care; or
    - When, despite such treatment, there is no reasonable likelihood that the disability will be so reduced.
- **DOMICILIARY CARE –** Care provided because care in the patient's home is not available or unsuitable.
- **COMPLEX DIAGNOSTIC EXAMINATIONS –** Procedures which may or may not be invasive in nature involving use of nuclear/radionuclide scans, digital imaging, fiber optic/video endoscopy, markers/dyes and specific modalities.
- **HAZARDOUS JOB RELATED ILLNESS/INJURIES –** Illness/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.
- **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.
- **DISEASE COMPLICATION –** Any illness, injury or adverse medical condition that is caused by or is a consequence of an identifiable disease process. A disease complication shares the same limit as the primary disease which caused it.

- **MATERIAL MISREPRESENTATION OR NON-DISCLOSURE**

  Failure to disclose or misrepresentation of any material information by company or any applicant for membership under this agreement, whether intentional or not, shall entitled HMO to terminate this Agreement, and/or terminate the membership of the member concerned, respectively, at the option of HMO, effective immediately upon receipt of company and/or of such member of a notice of termination for this case. Information is deemed material if:

  - It is among those required to be answered or supplied in the corporate and/or individual application and/or medical examination forms of HMO at the time of application;
  - It would have revealed the existence of a pre-existing condition of a "dreaded disease"
  - It would be determinative of an "exclusion" or
  - It would have resulted in the disapproval of the application of company and/or the member for membership, or the assessment of a higher membership fees which may already have been paid to HMO, as well as any and all benefits which may be provided, under this Agreement before the termination.

- **MEMBERSHIP ELIGIBILTY**

  - The following are eligible for Corporate Membership under this Agreement:
    - All company employees who are on board the Corporation as of execution or hired during the effectivity of the Agreement
    - The President and Chief Executive Officer of the Corporation
    - Retired company employees who are entitled to one (1) year HPP coverage after retirement from service to company under their policy
  - 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 company at any time during the duration of the Agreement.

- **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:

EMERGENCY CARE BENEFITS

- In cases of emergency where the member avails of the services of HMO Accredited Hospitals or HMO Medical Centers, the following are provided free of charge up to the annual benefit limit:
    - Doctor's services
    - Medicines used during treatment of 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.
- EMERGENCY CARE IN NON-HMO ACCREDITED HOSPITALS
    - 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 (100%) of the approved total hospital bills and of professional fees, based on HMO relative values for accredited hospitals, up to the annual benefit limit.
    - 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 the 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.
- Ambulance services are covered on a reimbursement basis up to P2,500.00 per member per year.

- 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 of professional feels, based on the HMO relative value and in Philippine currency, but not to exceed to the amount of P30,000.00

- MEMBER'S 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 MEMBER'S 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.

The request for members' financial assistance must be filed within sixty (60) days from the occurrence of death or accident

- **MEMBERS SATISFACTION SERVICE**

  - 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.

  - An Emergency Assistance Response Service (E.A.R.S) that operates on a 24 hour/day 365 day/year basis to respond to inquiries shall be available at the following telephone numbers:

    Tel No. : 884-9999

    Toll Free Nos. : 1800-1888-9001

    Text HMO : Key in specific information or request on your mobile phones and send to: (0917) 8512648 for Globe subscribers;

    (0908) 8841814 for Smart subscribers and (0923) 8388979 for Customer Management Group.

  - Open door policy. Direct access to a network of accredited hospitals/clinics nationwide, satellite medical clinics, mall-based clinics, referral desks and a Head Office Clinic.

- **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.

- **MOTOR VEHICLE LIABILITY**

  HMO medical and hospital services are extended to a member if the member's bodily injuries and fractures are claimed to have been caused by any act or omission of a third party thru motor vehicle. HMO agrees to waive the execution of subrogation from provided that the company will pay HMO the hospital expenses as well as the professional fees with an eighteen percent (18%) administrative fee and

provided further, that the company will not raise the defense of claiming the said expenses to the third party.

- **GENERAL PROVISIONS FOR ROOM ACCOMODATION**

  If a member occupies a room higher that what he/she is entitled to, he/she shall share in the medical expenses according to the following formula:

  - If a member occupies a higher priced room of the same category, the member shall pay for the excess on room & board.
  - 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.

- **CLAIMS AND REIMBURSEMENTS**

  - REIMBURSEMENT PROCEDURE

    All claims for reimbursement must be submitted or forwarded to HMO Head Office within thirty (30) calendar days after discharge from the hospital. Failure to do so shall invalidate the claim, 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 fifteen (15) working days 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:

    - Emergency confinement in non-accredited hospital attended by a non-accredited doctor
      - Duly filled-up 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

- Emergency confinement in an accredited hospital attended to by a non-accredited doctor
  - Duly filled-up claim form
  - Clinical Abstract
  - Medical Certificate to include complete final diagnosis
  - Original Official Receipt paid to the 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 confinement

- 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 the doctor
  - Incident report
  - Police report if due to accident or medico-legal case

- 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 the doctor
  - Incident report
  - Police report if due to accident or medico-legal case

- For Members Financial Assistance
    - HMO ID
    - 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)

- 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 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.

- **EXCLUSIONS AND LIMITATIONS**

- HOSPITALIZATION
    - All confinement shall be upon recommendation of the corporate health program holder's HMO accredited Physician, or the HMO Medical Director or the Emergency Room Resident Physician of the HMO Accredited Hospital who decides to admit HMO patient-member in cases of life threatening emergencies.
    - Hospital bills for the following hospital services shall be charged to the account of the HMO patient-member: services of a private nurse or doctor, use of extra food and/or bed, T.V., electric fan and VCD/DVD player.

- Hospitalization and treatment outside the Philippines is not covered except during emergency cases.
- HMO is not responsible and will not recognize any hospital bills incurred by a corporate health program holder in hospitals not accredited by HMO, except for emergency care services under the terms provided in this Agreement.
- 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.

- OUT-PATIENT SERVICES
  - Prescribed medicines on an out-patient basis are not provided by HMO Medical Center or Medical Service Units.
  - The absolutely no charge out-patient medical and health care services are provided only during clinic hours of Medical Service Units.
  - Second opinions and cost of treatment incurred in non-accredited hospital or clinic should the member unilaterally decide to seek such recourse.
- EXCLUSIONS
  - Cosmetic surgery and dermatological procedures for purposes of beautification, except constructive surgery to treat a functional defect due to disease or accidental injury.
  - Drug addiction, substance abuse and acute or chronic alcoholism
  - Acquired Immune Deficiency Syndrome (AIDS) and AIDS related diseases
  - Treatment of self-inflicted injuries attributable to the member's own misconduct, gross negligence, use of alcohol or drugs, 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.
  - Injuries or illnesses resulting from participation in war like or combat operations, riots, insurrection, rebellion, strikes, and other civil disturbances
  - Rest cures, custodial, domiciliary or convalescent care

- Sterilization, circumcision, artificial insemination, sex transformation, diagnosis and treatment of infertility
- Experimental medical procedures such as acupuncture, reflexology
- Corrective appliances, artificial aids, prosthetic devices and durable equipment.
- Sleep and eating disorders
- Services of special nurse or doctor and extra food, bed, electric fan, television and other appliances.
- Hospitalization and treatment outside the Philippine territory except during emergency cases as provided for in the provisions under emergency care in foreign countries.
- Hospitalization and treatment in non-accredited hospital except during emergency cases as provided for in the provisions under emergency care benefits.
- Prescribed out-patient medicines, except when used for out-patient chemotherapy and for emergency room or hospitalization use
- Corrective eye surgery for error of refraction
- Psoriasis and vitiligo
- Hypersensitivity testing and desensitization treatment
- Physical examination required for obtaining or continuing employment, insurance or government licensing

- LIMITATION IN SERVICES: HMO is not responsible for the following:
  - Delay of failure to render services due to major disasters, brownouts or epidemics affecting facilities or personnel.
  - 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.
  - Conditions for which a member has refused recommended treatment for personal reasons, for which HMO physicians believe no professionally acceptable alternative treatment exists.
  - Sudden change of hospital policies.

- **PRE-EXISTING CONDITIONS PROVISIONS**

  - 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:

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

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

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

  - 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:

    - Any dreaded diseases as defined in this Agreement except letters k and l

    - Hypertension

    - Goiter (Hypo/Hyperthyroidism)

    - Cataracts/Glaucoma

    - ENT conditions requiring surgery

    - Bronchial Asthma/Allergy/Urticaria

    - Tuberculosis

    - Chronic Cholecystitis/cholelithiasis (gall bladder stones)

    - Acquired Hernias

    - Prostate disorders

    - Hemorrhoids and Anal Fistulae

    - Benign Tumors

    - Uterine Myoma, ovarian cyst, Endometriosis

    - Buergher's Disease

    - Varicose Veins

- Arthritis
- Migraine headache
- Gastritis/Duodenal or Gastric Ulcer

- All “pre-existing conditions” shall be deemed covered by HMO up to the annual benefit limit per member per year.
- It is understood that the foregoing benefits shall likewise be applicable to “dreaded diseases”
- If there is a stipulated maximum limit on selected procedures or benefits, the coverage should be within both the pre-existing coverage and the stated maximum limit.

- **CORPORATE HEALTH PROGRAM MEMBERSHIP REQUIREMENT**
  - company undertakes to submit to HMO the following:
    - List of its employees who will be enrolled as members to the Corporate Health Programs.
    - From time to time, a list of new employees at COMPANY’s option, 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.
  - HMO undertakes to furnish PDIC the following:
    - Membership application forms to be filled by PIC employees if required;
    - HMO Identification Card
    - This Agreement
  - The Identification Cards merely provide information about the Member and do not constitute this Agreement and neither do they guarantee the delivery of the benefits herein contained.

- **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 Eighteen Percent (18%) of the actual Utilization Cost of the Principal Members and the Annual Membership Fee of Employees: TWO HUNDRED FIFTY PESOS (P250.00) for each Member.

- **PAYMENT OF ACTUAL COST OF HEALTH BENEFITS AND SERVICES**

  company shall pay HMO the amount covered by the billing notice within the ten (10) working days from receipt thereof. Should certain amounts in the bill be contested in good faith, such dispute, controversy or claim arising out of or relating to this Agreement, or the breach, termination or invalidity thereof, shall be settled by arbitration in accordance with Republic Act Number 876, as amended by Republic Act Number 9285. The number of arbitrators shall be one (1).

  It is understood, however, that any invoiced item shall be paid by company within ten (10) working days from the receipt of billing.

- **SUSPENSION OF SERVICES AND BENEFITS**

  If the amount billed to company, whether contested or not, remains unpaid within (10) working days from the date of receipt of the billing, HMO shave have the option to suspendcompany from receiving services and benefits that are entitled to them under this Agreement.

  Likewise, if company's outstanding unpaid balance reaches P3,400,000.00 in one (1) month, said amount must first be settled by company. Otherwise, all services and benefits shall cease to be given to company's enrolled members.

- **NON-TRANSFERABILITY PROVISIONS**

  This Corporate Health Program can neither be transferred nor assigned by the member to any other person, nor can the company assign or transfer this corporate membership to any company.

- **DELIQUENCY, GRACE PERIOD AND LAPSATION PROVISIONS**

  - This Agreement shall automatically lapse and be void, without need of any notice, if the Corporate membership fee remains unpaid after thirty (30) calendar days from the due date, which is the grace period for payment of membership fees.
  - If the Corporate membership fee remains unpaid after thirty (30) calendar days from the due date of payment, the Corporate members shall no longer be entitled to HMO benefits. As such, the Corporate membership shall be considered lapsed.
  - During the 30-day grace period within which company and/or its members are given time to update their account, all benefits will still be covered, except for emergency care and hospital confinement which will cease to be covered after fifteen (15) calendar days from the date the payment of the membership fees is due.

- **EFFECTIVITY AND DURATION OF THIS CONTRACT**

  - This Agreement shall take effect on based on you Entry Date upon signing 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 company shall provide each 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 of one (1) year. Thus, all eligible members are entitled to fresh full coverage of P600,000.00 starting based on you Entry Date.

- 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. 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.

- Membership of the individual shall automatically cease upon termination of employment with the company.

- The termination of this Agreement will not hold HMO responsible to provide the medical and health care services described herein to such enrolled member of company, 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 be HMO.

- 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.