2020 HOSPITALIZATION BENEFIT FOR SENATE EMPLOYEES
SCOPE OF WORK

I. **DEFINITION OF TERMS**

A. *ENROLLEE* – a person who is an employee-member of the Senate of the Philippines or shall be referred to as the FIRST PARTY, whether regular, casual, temporary, contractual or co-terminus regardless of age.

B. MEDICAL BENEFITS – the medical, surgical and dental services rendered by the HMO accredited doctors, and in HMO accredited hospitals and clinics which are consistent with the diagnosis and customary medical treatment of the condition and performed in the least costly manner required by the medical condition which shall be available for out-patient and in-patient services and at no cost to MEMBERS.

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 its HMO MEMBERS.

D. COORDINATOR – the officer-in-charge physician provided by the SECOND PARTY who acts as the primary 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. ACCREDITED PHYSICIAN – any physician in any accredited hospital or any clinic with whom the SECOND PARTY has an existing and valid agreement and where a member may avail of medical services.

F. ACCREDITED HOSPITALS/CLINICS – any hospital or any clinic with whom the SECOND PARTY has an existing and valid agreement and where a member may avail of medical services.

G. IDENTIFICATION CARD – Issued to the MEMBERS for their identification. It contains the member's name and signature; account number and effectivity date; validating signature; date of birth; type and room rate.

H. IN-PATIENT – A person receiving medical services/procedures who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of an accredited HMO physician until a discharge order has been issued by the HMO.

I. OUT-PATIENT - medical services/procedures rendered to a non-confined patient under the medical management of an accredited HMO physician.

J. EMERGENCY – any condition wherein a Member is in severe pain or is seriously ill or injured due to a sudden and unexpected occurrence which requires immediate medical or surgical intervention to alleviate the pain or to prevent the loss of life or limb or any vital part of the body.

K. CONVALESCENT CARE– Recover, regain, improve strength and health after an illness at home.

L. REHABILITATION CARE - The restoration of a person's ability to function as normally as possible after a disabling illness or injury.

M. CUSTODIAL OR MAINTENANCE CARE – Refers to 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.

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

O. COMPLEX AND/OR SPECIAL 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 therapeutic modalities listed in Article VIII, Section C of the Scope of Work.

P. JOB RELATED ILLNESSES/INJURIES – are illnesses/injuries suffered on the occasion, as a consequence, of the performance of a job.

Q. 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.

R. 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.

S. LETTER OF AUTHORIZATION – authorization issued by the HMO to cover medical confinements, procedures, or referrals to specialists.

T. OPEN-DOOR POLICY – where an enrollee/member can choose the accredited hospital where an employee-member will be admitted to avail of the HMO.

U. PRIVATE ROOM – refers to an air-conditioned private room of single occupancy accommodation with private toilet and bath.

II. ALL PRE-EXISTING DISEASES SHALL BE COVERED EXCEPT THE EXCLUSIONS ON LETTER I, PAGE 11 and 12 HEREOF.

III. COVERAGE SHALL INCLUDE THE INCUMBENT SENATORS AND ALL REGULAR, CASUAL, TEMPORARY, CONTRACTUAL AND CO-TERMINUS EMPLOYEES OF THE SENATE PAID OUT OF PERSONAL SERVICES (the list shall be submitted by the HRMS of the SENATE thru MDB to HMO), REGARDLESS OF AGE.

IV. THERE SHALL BE NO HOSPITAL ASSIGNMENT FOR COVERAGE OF HOSPITAL CONFINEMENT CASES. AN ENROLLEE CAN CHOOSE THE HOSPITAL FROM THE HMO'S NETWORK OF ACCREDITED HOSPITALS WHERE HE/SHE WISHES TO BE ADMITTED TO AVAIL OF THE SERVICES, PROVIDED PROCEDURES/GUIDELINES IN AVAILMENT ARE FOLLOWED.

A GUARANTEE FROM THE HMO THAT THE SERVICES SHALL BE PROVIDED TO SENATE EMPLOYEES BY THE FOLLOWING ACCREDITED HOSPITALS DURING THE TERM OF CONTRACT BUT NOT LIMITED TO:

A. ST. LUKE'S MEDICAL CENTER
B. MAKATI MEDICAL CENTER
C. MANILA DOCTOR'S HOSPITAL
D. PHILIPPINE HEART CENTER
E. MEDICAL CITY HOSPITAL
F. SAN JUAN DE DIOS HOSPITAL
G. CAPITOL MEDICAL CENTER
H. ASIAN HOSPITAL MEDICAL CENTER
I. MANILA ADVENTIST MEDICAL CENTER
J. CARDINAL SANTOS HOSPITAL

THERE MUST BE AT LEAST 4 ACCREDITED SPECIALISTS IN THEIR RESPECTIVE FIELD OF SPECIALIZATION IN THE 10 MAJOR HOSPITALS MENTIONED IN THE FOREGOING EXCEPT FOR THE PHILLIPINE HEART CENTER.

FOR YOUR OTHER ACCREDITED TERTIARY HOSPITALS IN METRO MANILA AND IN THE PROVINCES, PLEASE GIVE THE LIST OF THE HOSPITALS WITH THE LIST OF YOUR ACCREDITED SPECIALISTS.

HMO SHOULD NOTIFY THE SENATE THRU THE MDB FOR ANY CHANGES IN THEIR ACCREDITED HOSPITALS AND SPECIALISTS DURING THE CONTRACT PERIOD.

SUBMIT THE LIST OF SPECIALISTS WITH THE BID DOCUMENTS.

V. REGARDLESS OF WHETHER OR NOT THE PREMIUM HAS BEEN PAID, COVERAGE SHALL START ON JANUARY 1, 2020 UP TO DECEMBER 31, 2020. FOR THOSE CONFINED IN THE HOSPITAL AFTER THE EXPIRATION OF THE CONTRACT, THE COVERAGE SHALL CONTINUE UNTIL THE ENROLLEE IS DISCHARGED FROM THE HOSPITAL OR ARRANGEMENTS FOR CONTINUOUS COVERAGE WITH THE HMO FOR THE FOLLOWING YEAR IS MADE.

VI. FOR ENROLLEES WHO HAVE BEEN SEPARATED FROM THE SERVICE BEFORE THE CONTRACT PERIOD ENDS, A REFUND SHALL BE PAID BACK TO THE PHILIPPINE SENATE ON THE UNUSED PORTION OF THE PREMIUM.

THE START OF COMPUTATION FOR REFUND SHALL BE BASED ON THE NOTICE OF SEPARATION SUBMITTED BY HRMS OF THE SENATE THRU MDB TO THE HMO. DELISTING OF SEPARATED ENROLLEES BY THE HMO SHOULD BE RECKONED FROM THE DATE OF FORMAL NOTIFICATION BY HRMS.

VII. FOR NEW ENROLLEES DURING THE CONTRACT YEAR, THE COVERAGE SHALL START ON THE ACTUAL DATE OF THE ASSUMPTION OF DUTY OF THE PERSONNEL CONCERNED REGARDLESS OF WHETHER OR NOT THE PREMIUM HAS BEEN PAID. PREMIUM PAYMENT SHALL BE BASED ON THE FOLLOWING FORMULA:

$$\text{Subscription fee/day} = \frac{\text{Annual Subscription fee}}{\text{No. of days per year (365 or 366 if leap year)}}$$

$$\text{Remaining number of days} = \text{Expiry date} - \text{Date of inclusion or deletion}$$

Subscription fee = Subscription fee/day x remaining no. of days)
Result is rounded to the nearest hundredths

VIII. FOR CONFINED/HOSPITALIZED ENROLLEES, AN HMO LIAISON OFFICER SHOULD IMMEDIATELY VISIT THE EMPLOYEE AND ORIENT HIM/HER ABOUT THE CORPORATE HMO PROGRAM OF THE SENATE, SPECIFICALLY ON THE EXTENT OF THE COVERAGE.

IX. IN CASE OF DOUBT IN THE INTERPRETATION OF THE TERMS AND CONDITIONS OF THE CONTRACT, THE SAME SHALL BE RESOLVED UPON AGREEMENT OF BOTH PARTIES (SENATE and HMO), TAKING INTO CONSIDERATION THE WELFARE OF THE EMPLOYEE/ENROLLEE.

X. HMO MUST BE ACCREDITED BY THE INSURANCE COMMISSION

A. OUT-PATIENT SERVICES

The following shall be provided to the enrollee free of charge and without limit subject to the exclusions listed in letter I, page 11-12 hereof:

1. Any number of consultations to an accredited HMO physician to include medicines applied/given/*used* during such consultations. ONLY MEDICINES PRESCRIBED AFTER THE CONSULTATION SHALL BE CHARGED TO THE ENROLLEE.

2. Any surgery and therapeutic procedures that do not require hospitalization, including materials used in such procedures. ONLY MEDICINES PRESCRIBED AFTER THE PROCEDURE SHALL BE CHARGED TO THE ENROLLEE.

3. Necessary laboratory tests and diagnostic procedures as may be requested by accredited physicians shall be done at the accredited HMO hospital/clinics. All laboratory requested by the accredited physician must be honored by the HMO.

4. Eye refraction shall be done by accredited ophthalmologist/optometrist/optical shop.

5. Cauterization of warts except for cosmetic purposes.

6. Referral to non-accredited specialist or sub-specialist by an accredited physician in a hospital/clinic where there are no accredited specialist or sub-specialist shall be covered in full (100% of the actual rate, not HMO rate) under a reimbursement

plan. It is inherent that the enrollee prior to the procedure shall seek the approval of the HMO. Once approved, the HMO shall issue a Letter of Approval immediately not exceeding seven (7) calendar days. The Letter of Approval shall be the basis for the agreement and shall form as an attachment to the reimbursement claims.

7. There shall be 100% reimbursement of actual hospital bill for consultations in places where there are no clinic or hospital affiliations, e.g. in provinces.

8. The HMO shall honor referral of Senate Medical/Dental doctor to accredited medical/dental specialist based on the HMO's guidelines on referrals.

B. IN-PATIENT SERVICES

In the event any enrollee suffers from an ailment requiring confinement in a hospital, as determined by the HMO accredited physician/medical staff or by the emergency room resident/attending physician, the following shall be provided to enrollee free of charge and without limit, subject to the exclusion and limitations listed in Sections I & J:

1. A private air-conditioned room of single occupancy accommodation with toilet and bath, regardless of existing room rate of any accredited hospital listed in the HMO's directory. Downgrading shall not be allowed. (E.g. private room to a semi-private room or ward)

2. In cases where there are no available private rooms, an upgrading of room shall be allowed at no extra cost to the enrollee. The HMO should exert all effort in reserving/obtaining a private room where the confined enrollee could stay after the first 24 hours of upgrading. Provided however, it is still the HMO who shall shoulder the extra cost until a private room is available and written notice is given to the enrollee. If a private room becomes available thereafter, the enrollee is obligated to transfer otherwise he/she shall shoulder all extra costs from date of receipt of written notice.

3. Professional services of HMO designated physicians/surgeons/ anesthesiologist or any specialist called in for needed surgery/referral.

4. Drugs, medications, blood components e.g. plasma, platelet, packed RBC, fibrinogen and intravenous fluids used while confined in hospital.

5. Use of operating/recovery room, ICU, CCU, and other special units.

6. Laboratory and other diagnostic procedures as requested by the HMO's designated physicians/surgeons/anesthesiologist/ specialist.

7. Oxygen and its administration.

8. Other supplies directly used in the treatment of the covered ailment/injury.

The Medical Director of the Philippine Senate or the designated member of his staff has the right to visit any enrollee while confined in the hospital. He may coordinate with the HMO's attending physician in extending services to the enrollees, and he shall reserve the right to examine the medical records, ask copies thereof as the occasion demands, or otherwise inquire into the clinical circumstances of the case in the interest of the enrollee.

C. BENEFITS FOR SPECIAL DIAGNOSTIC AND THERAPEUTIC PROCEDURES.

Whether as in-patient or outpatient, the enrollee shall be entitled to any of the following procedures: (In out-patient cases, coordination with the HMO prior to the procedure should be done)

1. Immunologic Laboratory Examinations:

a. Hepatitis profile, e.g. HbeAg, HBS Ag., Anti-HBc, IgM, Anti-HAV gM etc.
b. ANA Profile, e.g. Anti-Nuclear-Antibody, Anti-Native-DNA, Anti-Sm,
c. Anti-SSA, Beta-HCG, AMA, etc.
d. Thyroid Profile, e.g., FT3, FT4, TSH, etc.
e. TORCH Profile, e.g. Anti-Toxoplasma Gondi IgM, Anti-Rubella Anti-Cytomegalo-Virus Ig, etc.
f. FAT, Widal Test, ASO Titer, Serum Ig-G., Alpha-Feto Protein, etc.
g. FTA, ABS, VDRL, etc.

2. Computer-based Laboratory Procedures

a. Ultrasonography of any organ, transvaginal sonography
b. 3D Imaging
c. C-T Scan of entire body
d. C-T Scan of body organs or regions
e. M-Mode Echocardiography
f. Echocardiography with Contrast Study
g. Echocardiography with Doppler and Contrast Study
h. Echocardiography with Esophageal Probe
i. Echocardiography with Doppler Only
j. Magnetic Resonance Imaging (MRI)
k. Mammography
l. Treadmill Stress Test
m. Angiography
n. Holter Monitor

3. Chemotherapy, radiotherapy, physiotherapy and dialysis shall be covered up to a maximum limit of the underlying dreaded disease condition.
4. Newest modalities/newer alternative procedure of treatment to include among others but not limited to confinements covering Lithotripsy for Urolithiasis, Endoscopic Cholecystectomy, Laparoscopic Pelvic Operation, and other newer modalities, including any complication thereof, are covered up to a maximum of One Hundred Eighty Thousand Pesos (Php 180,000.00) each if the enrollee opts for the procedure in lieu of the conventional surgery. Notwithstanding the availment of the new modality, any employee of the Senate may avail also of the conventional procedure at no cost within the contract period.

D. EMERGENCY CARE BENEFITS

Emergency out-patient or in-patient services shall be provided the enrollee when he/she is brought to the Emergency Room of the hospital. It is understood that for purposes of emergency cases admission, it is enough that admission be authorized by an attending resident physician on duty, not necessarily an HMO accredited physician.

1. Emergency Care in an Accredited Hospital

Whether as in-patient or out-patient to include ER consultations after the regular clinic hours of HMO accredited physicians. All

expenses for services (professional fees, hospital fees, laboratory and other diagnostic services, referrals, medicines and other drugs including anti-tetanus vaccine and anti-rabies vaccine, first dose only) used in the treatment of the enrollee shall be free of charge.

2. Emergency Care in a Non-Accredited Hospital in areas where there is no HMO accredited hospitals.
Whether as in-patient or out - patient, the HMO shall reimburse 100% of the charges (actual charges) incurred by an enrollee who received emergency treatment/care.

3. Emergency Care in a Non-Accredited Hospital in Areas where there are HMO Accredited Hospitals, and/or Emergency Care in an Accredited Hospital utilizing the services of a Non Accredited Physician.

Whether as in-patient or outpatient, the HMO shall reimburse 80% of the approved covered fees and charges to an enrollee who has received and paid for emergency treatment. However, the 80% (HMO rate) shall be based on computations had the patient been confined in an accredited hospital within the area where enrollee has been confined/treated and attended to by an HMO accredited physician/surgeon/anesthesiologist/specialist.

4. Emergency Care in Hospitals/Clinics Abroad

Whether as in-patient or out-patient, the HMO shall reimburse 80% of the approved covered fees and charges to an enrollee who has received and paid for emergency treatment in hospitals/clinics abroad. However, the 80% (HMO rate) shall be based on computations had the patient been confined in an accredited hospital and attended to by an HMO accredited physician/surgeon/anesthesiologist/specialist.

5. Transfer in Emergency Cases

Transfer from a hospital (accredited or non accredited) to an accredited hospital shall be arranged by the HMO. If immediate transfer is contraindicated, all expenses shall be shouldered by the HMO, including subsequent enrollee's transfer (to include use of ambulance).

E. NON-EMERGENCY IN-PATIENT BENEFITS

In cases of confinement for non-emergency illness, an enrollee should be entitled to in-patient benefits even if attended to by a

non-HMO accredited doctor in an accredited hospital. The confinement in such case shall be arranged by the enrollee with the HMO in advance. It is inherent that the enrollee prior to the confinement shall seek the approval of the HMO. Once approved, the HMO shall issue a Letter of Approval immediately not exceeding seven (7) calendar days. The Letter of Approval shall be the basis for the agreement and shall form as an attachment to the reimbursement claims. All fees (doctors and hospital) applicable under the circumstances should be based on 80% of HMO rates.

F. ALL MEDICAL SUPPLIES USED DURING OUTPATIENT CONSULTATIONS, EMERGENCY CARE AND DURING CONFINEMENT, TOGETHER WITH ADMISSION KIT SHALL BE COVERED BY THE HMO.

G. MATERNITY BENEFITS

The HMO shall provide maternity benefits for women enrollees. "Maternity" shall mean any cause or condition arising out of or during anyone's pregnancy, childbirth, miscarriage or abortion, or any complications arising from the same. The coverage shall be limited to one pregnancy only.

Maternity benefit shall also include all pre-natal, post-natal care and laboratory and diagnostic procedures requested by HMO accredited physicians.

If the enrollee during the delivery and confinement availed the services of our HMO's network physicians and hospitals, the following maximum limit for maternity benefits shall be as follows:

CEASARIAN HYSTERECTOMY ----------80,000.00
CEASARIAN SECTION ----------70,000.00
LAPAROTOMY SEC. TO ECTOPIC PREGNANCY--- 60,000.00
NORMAL DELIVERIES TO INCLUDE ASSISTED DELIVERIES (Forceps, Vacuum extraction, etc.) ----------60,000.00
COMPLETION OF ABORTION BY CURETTAGE -----30,000.00

If the employee during delivery and confinement, opts to avail of the services of a physician / OB-GYNE outside the HMO's network of physicians, a reimbursement up to the maximum amount provided under the following procedures shall be made:

CAESARIAN HYSTERECTOMY ----------30,000.00
CAESARIAN SECTION ----------25,000.00
LAPAROTOMY SEC. TO ECTOPIC PREGNANCY---20,000.00
NORMAL DELIVERIES TO INCLUDE ASSISTED DELIVERIES (Forceps, Vacuum extraction, etc.) ----------15,000.00
COMPLETION OF ABORTION BY CURETTAGE -----10,000.00

Reimbursement claims of services rendered by physicians / OB-GYNE outside the HMO's network shall be subject to the submission of necessary receipts and documents.

The reimbursements shall be based on actual hospital expenses and professional fees, not on the HMO's prevailing rates.

H. ANNUAL PHYSICAL EXAMINATION (APE)

As soon as the employee is enrolled/ covered, he/she is entitled to the APE. The HMO in coordination with the Senate Medical Bureau shall schedule an APE, which includes the following:

1. History and Physical Examination
2. Laboratory to include:
   a. CBC, differential count
   b. Urinalysis
   c. Stool examination
   d. Chest x-ray using big film 11 x 14
   e. Pap's smear for female employees regardless of age, with consent of the employee-member
   f. ECG for 35 years old and above/or those with indication regardless of age
   g. Blood Chemistry 35 years old and above/or those with indication regardless of age to include FBS, Uric acid, Cholesterol, HDL, LDL, Triglycerides, BUN, Creatinine
3. Immunization, excluding cost of vaccine
4. Consultation and advice on diet, exercises and other health habits
5. Family planning, counseling
6. Monitoring of health problems

A mobile laboratory and X-ray shall be provided by the HMO in the Senate premises. It shall undertake the APE every 3rd and 4th Thursdays of February, June and October. APE can also be availed at the HMO's designated/accredited clinic. To prevent disparity in diagnosis, laboratory results interpreted by the Mobile Clinic doctors should be reviewed by HMO doctors before submission to the Senate Medical/Dental Bureau. For enrollees

based outside Metro Manila, the above services shall be made available at any of the HMO's designated/accredited clinics or hospitals. Results must be submitted to the Senate Clinic within one (1) week after the APE so that any medical condition can be attended to immediately. Physical examination and laboratory findings that would need immediate attention must be reported at once to the Senate physicians.

I. DENTAL EXAMINATION

As part of the membership fees, the following services should be made available from HMO dental clinics and any of the accredited dental clinics:

1. Oral prophylaxis – 2 x a year
2. Temporary filling
3. Treatment of pain, treatment of gum and treatment of mouth lesions, wounds and burns
4. Dental extractions except surgery for impaction
5. Recementation of inlays, outlays and jacket crowns
6. Simple adjustment of dentures
7. Annual dental examination
8. Any number of consultation including dental education and counseling
9. Surgery care treatment following accidental injury to teeth
10. All other dental services are available at discounted prices for enrollees account if prior arrangement is made with the HMO accredited dentist
11. Simple dental X-ray

J. EXCLUSION FROM COVERAGE

All services (diagnosis and treatment) prior to documentation of the illness shall be covered. However, after the illness has been properly documented/ diagnosed and was found to be included in the list of exclusions, the start of non-coverage shall be the date the enrollee was notified verbally and in writing about the exclusion. This should apply to in-patient confinement, out-patient and emergency room consultations.

The following are excluded from coverage:

1. Adverse medical conditions arising from treatment by non-accredited physicians
2. Plastic and reconstructive surgery for cosmetic purposes
3. Experimental medical procedures and acupuncture
4. Services to diagnose and reverse fertility or infertility

5. Organ transplant procedures
6. Psychiatric care
7. Rest cases, custodial, domiciliary, convalescent and intermediate care
8. Executive check-up except when confinement is for purely diagnostic purposes and prescribed by the HMO physician and approved by the HMO Coordinator
9. Treatment for alcoholism, drug addiction or abuse
10. Treatment of conditions which are attributable to the enrollees' own misconduct, negligence, intemperate use of drugs or alcoholic beverages resulting in the impairment of faculties, vicious or immoral habits, direct participation in the commission of a crime as declared by a regular court of law whether consummated or not, violation of law or ordinance, and unnecessary exposure to imminent danger or hazard to health except in the lawful performance by the enrollee member of his duties
11. Human blood products and (vaccines) except those listed in letter B, In patients services number 4
12. Artificial aids and prosthetic devices
13. Orthopedic hardware used in nailing, pinning and bracing
14. Purchase or lease of durable medical equipment, oxygen dispensing equipment and oxygen (except what is used during covered in-patient care). In cases where these equipments are not available in the hospital where the enrollee is confined and it was decided that these equipment are to be rented from outside sources, payment for the rental shall be shouldered by the HMO
15. Extra hospital goods and services such as:
    a. Service of a private nurse
    b. Use of extra bed, television, electric fans, VCR and other amenities
    c. Extra food tray
16. P.E. required for obtaining or continuing employment, insurance or government licensing.
17. Financial responsibility for medical services covered by Philhealth.
18. Supplemental charges beyond the enrollee's program limit in room rate and accompanying rate difference for professional fees, diagnostic procedures, laboratory examinations and all other ancillary medical services as set by the hospital.

K. LIMITATIONS IN SERVICES

It is understood and agreed that the dreaded disease shall be covered by a maximum of THREE HUNDRED THOUSAND PESOS (P 300,000.00) per illness or disease per year. Limitations in services shall commence after the illness has been properly

documented/diagnosed and employee was notified verbally and in writing about the inclusion (limitations in services).
The following are considered dreaded diseases:

1. Cerebrovascular Accident (Stroke)
2. Cardiovascular Diseases (Cardiomyopathy/Coronary/Valvular)
3.Central Nervous System Diseases
(Poliomyelitis/Encephalitis/Meningitis/ Neurosurgical conditions)
4. Chronic Obstructive/Restrictive Lung Diseases
5. Chronic Nephrological/Urological Diseases
6. Collagen Diseases (Rheumatoid Arthritis, Systemic Lupus Erythematosus)
7. Malignancies and New Growth
8. Blood Dyscrasias (Hemophilia, Leukemia)
9. Chronic Endocrine, i.e. Diabetes Mellitus and its complications
10. ICU confinements
11. Congenital Anomalies and Conditions
12. Liver Cirrhosis
13. Multiple Organ Failure
14. Serious accidental injuries including 2nd (more than 20%) and 3rd degree burns, serious injuries to extremities that may lead to amputation, intracranial and spinal cord injuries, injuries to vital internal organs like kidney, liver, spleen, pancreas and the like, requiring intensive care.
15. Sexually transmitted diseases including gonorrhea, syphilis and AIDS

L. CLAIM FOR REIMBURSEMENTS

After complete submission of affirmative proof of outpatient consultation, referral to specialist/sub-specialist, hospital confinement and laboratory examinations/ procedures on which a claim is based, the HMO shall reimburse to the enrollee the approved claim within thirty (30) calendar days from receipt of proper documents. The claim document shall include original or certified true copy or fax copies of the following:

1. Receipt of payment;
2. Medical Certificate issued by the Attending Physician.

M. MOTOR VEHICLE LIABILITY

The 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 a motor vehicle. Provided, however, that the member executes an agreement to subrogate to the HMO whatever

rights the member may have by reason of such accident to the extent of the value of the services so rendered. The agreement to subrogate form should be made available at the HMO Head Office. However, this provision will not take effect if the injuries incurred were due to the employees' fault and negligence as indicated in the police report.

N. INFORMATION DISSEMINATION AND ORIENTATION

The HMO shall conduct thorough information dissemination and orientation program, regarding their services. This should include a manual of guidelines, rules and regulations specific for the Senate.

O. ADMINISTRATIVE SUPPORT

In the administration of the hospitalization program, administrative support shall be extended to the Senate by the HMO. The HMO shall assign one (1) of its personnel to liaise between the Senate and the HMO every day from 8:00 A.M. to 7:00 P.M., Monday to Thursday at no cost to the Senate. The assigned liaison officer shall be authorized by the HMO to issue LOAs, and referrals for convenience on the part of the enrollees. LOA's validity must be extended up to seven (7) days.

Membership IDs should be processed within seven (7) working days from receipt by the HMO of the application forms or the list of qualified personnel.

The Senate ID shall serve as sufficient proof for availment of the benefits in case the HMO ID is lost or is pending processing, provided that the employee is included in the list submitted by the Senate HRMS to the HMO.

The HMO shall submit a quarterly utilization report of the availment of services/benefits, which should include the name of the enrollee, the illness and treatment given, and the amount spent.

The HMO should provide a 24 hour/day 365 day/year membership assistance hotline, to be clearly indicated in the HMO ID.

The HMO who do not have a concierge or HMO office in the hospital should provide a hospital coordinator available from 9-5, Mondays – Saturdays in major hospitals in Metro Manila to issue LOAs.

P. ADDITIONAL BENEFITS

HMO should state specific additional benefits to be offered to the enrollee.

Q. PERFORMANCE SECURITY

The HMO to post/submit within ten (10) days from receipt of the Notice Of Award a Performance Bond properly executed and payable to the Senate of the Philippines for the whole year of 2020, in an amount equivalent to One Hundred Percent (100%) of the total winning bid.

Failure of the HMO to submit the required performance bond within the specified period shall render the award null and void.

This is to certify that I have read and understood all information contained in the approved Terms of Reference, Scope of Work, Specifications and Bid Bulletin/s and that I agree to abide by the provisions thereof.

I hereby commit to comply with all the Terms of Reference, Scope of Work, Specifications and Bid Bulletin/s. if found to be false either during bid evaluation or post-qualification, the same shall give rise to automatic disqualification of our bid.

CONFORME:

_____ _____

Name of Company Contact Person

_____ _____

Address Contact Numbers

BY:

SIGNATURE: _____
NAME IN PRINT: _____
DESIGNATION: _____
DATE: _____