MediCard Healthcare Program Agreement
For Individual/Family – VIP

MediCard Philippines, Inc., (hereinafter referred to as "MediCard"), a duly organized and registered corporation, with principal office address at 8th Floor, The World Centre Building, 330 Sen. Gil Puyat Avenue, Makati City 1200, through the undersigned as its duly authorized representative, hereby confers this MediCard Healthcare Program Agreement – VIP (the "Agreement") to the PRINCIPAL MEMBER who agreed to engage the services of the former under the terms and conditions stipulated herein.

JULIAN C. MENGUAL
Chief Executive Officer

Conforme:

_____
Signature over printed name of Principal Member

_____
Date signed

TERMS AND CONDITIONS

I. DEFINITION OF TERMS

1. **ACCIDENT –** A visible, external, sudden and violent event occasioned by a physical or natural cause and occurring entirely beyond the MEMBER's control causing damage to the health of the MEMBER.

2. **ACCREDITED HOSPITAL -** A duly licensed hospital included in the list of accredited hospitals of MediCard with which MediCard has an existing and valid service agreement and where a MEMBER can avail of medical services pursuant to this Agreement.

3. **ACCREDITED MEDICAL CLINIC** - A duly licensed medical health care facility included in the list of accredited medical clinics of MediCard which has an existing and valid accreditation agreement with MediCard and where a MEMBER can avail of medical services pursuant to this Agreement.

4. **ACCREDITED PHYSICIAN/DOCTOR** - A duly licensed physician or specialist accredited by MediCard and named in the list of MediCard's accredited physician with whom MediCard has made arrangements to provide the required services under this Agreement.

5. **ANESTHESIOLOGIST -** A specialist duly licensed and registered to administer anesthetic agents and conduct other anesthesia procedures during medical operation.

6. **ATTENDING PHYSICIAN** - An Accredited Physician who is part of the medical staff of an Accredited Hospital or Accredited Medical Clinic, and legally responsible for the care given to a MEMBER while in the hospital or on out-patient basis.

7. **AUTHORIZED REPRESENTATIVE** - A person duly authorized by MediCard to approve the provision of medical services or claims reimbursements to a MEMBER.

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

9. **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:

    a. 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

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

10. **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 "Schedule A - Benefit Coverage".

11. **DEVELOPMENTAL, CONGENITAL CONDITION, BIRTH DEFECT** - A medical abnormality existing at the time of birth as well as neonatal physical or mental abnormalities developing thereafter because of causal factors or conditions present at the time of birth.

12. **DISABILITY** - An illness or injury and any symptoms, sequelae, or complication thereof requiring treatment. All injuries arising from the same event or series of continuous events are considered as one Disability.

13. **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.

14. **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.

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

16. **DURABLE MEDICAL EQUIPMENT** - As determined by the MediCard, medically prescribed items of medical equipment for repeated use, owned or rented, such as but not limited to crutches and wheelchairs which are placed in the home of a MEMBER to facilitate treatment and/or rehabilitation of illness or injury.

17. **EFFECTIVE DATE** - The date the Agreement commences as specified in this Agreement.

18. **ELIGIBLE EXPENSES** - Expenses incurred in the treatment of a covered illness or injury which are Medically Necessary and not exceeding the limits in "Schedule B – Membership Fees ".

19. **EMERGENCY CONDITION** - A life threatening or accidental injury or a sudden and unexpected onset of a condition or illness which at the time of the occurrence reasonably appears to have the potential of causing immediate Disability or death, or which requires the immediate action or alleviation of pain or discomfort. These illnesses or injuries require urgent medical or surgical care and attention which the MEMBER secures immediately after the onset or as soon as the care may be made available.

20. **EXPIRY DATE** - The date the Agreement is scheduled to terminate.

21. **HAZARDOUS JOB-RELATED ILLNESSES/INJURIES ARISING FROM NEGLIGENT ACTS** - illnesses/injuries suffered on the occasion, or as a consequence, of the performance of a job 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.

22. **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 MediCard accredited physician.

23. **INJURY** - Physical damage or trauma arising wholly and exclusively from an Accident or other events of violent or external, and visible nature.

24. **LETTER OF AUTHORIZATION (LOA)** - Letter of authorization duly issued by MediCard to, and signed by, the MEMBER which shall serve as the authority of the latter to avail of the medical services.

25. **MATERIAL INFORMATION** - An information is deemed material if its disclosure would have resulted in the (a) declination of the application for Membership of the applicant, (b) the assessment of a higher Membership Fee or (c) the inclusion of additional restrictions and exclusions to the benefits of the MEMBER under this Agreement.

26. **MAXIMUM BENEFIT LIMIT (MBL)** - The maximum limit that MediCard shall cover and assume per covered illness or lnjury (including related illnesses) of a MEMBER within the term of this Agreement. MBL is replenished upon renewal of the Agreement.

27. **MEDICAL BENEFITS** - The medical, surgical and dental services available as out-patient or in-patient benefits generally at no cost to MEMBERS if within the agreed scope of

coverage, whenever the need for them arises, and when rendered by and in MediCard accredited doctors, hospitals and clinics.

28. **MEDICAL DIRECTOR** (in an HMO set-up) - is a physician who is responsible in assuring healthcare delivery for health plans, products and services by leading, developing, directing and implementing medical and non-medical activities that impact health care quality, cost and outcomes in a financially responsible manner.

29. **MEDICALLY NECESSARY** - A medical service, as determined by MediCard, which is (a) consistent with the diagnosis and customary medical treatment of the condition, (b) in accordance with the standards of managed care and good medical practice, (c) not for the convenience of the MEMBER or the Accredited Physician, (d) performed in the most cost effective manner required by the medical condition and (e) consistent with the terms and conditions of this Agreement.

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

31. **MEDICARD 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 fee; termination of coverages; etc.

32. **MEDICARD IDENTIFICATION CARD** - The identification card issued to the MEMBERS for their identification. It contains the MEMBER's name, account number and validating signature.

33. **MEDICINE AND DRUGS** - Those for which a licensed medical practitioner has prescribed for dispensing, which are specifically required for the treatment of a covered illness or injury under this Agreement.

34. **MEMBER** - A Principal and/or Dependent who is eligible, has been accepted for Membership by MediCard after complying with the Eligibility provision, and is currently enrolled under this Agreement.

35. **MEMBERSHIP** - Refers to membership in MediCard, pursuant to this Agreement.

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

37. **PRIMARY ACCREDITED PHYSICIAN** - The officer-in-charge physician who acts as the family physician of the MEMBERS in their MediCard 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. This person must not be a relative of the MEMBER up to the third degree of consanguinity and affinity.

38. **PRIVATE NURSE** - A licensed nurse providing close observation and performing special treatments, which are certified as Medically Necessary by the Attending Physician.

39. **PROFESSIONAL FEES -** Fees paid to licensed medical professionals including but not limited to Occupational Therapists, Physiotherapists, Attending Physicians, Surgeons, Anesthesiologists, or Pathologists.

40. **ROOM AND BOARD ACCOMMODATION** - The pre-assigned type of hospital room and board by MediCard to the MEMBER based on the benefit and coverage of the health care plan under this Agreement.

41. **STATEMENT OF ACCOUNT (SOA)** - The statement of account duly issued by MediCard on or before the due date of payment reflecting Membership Fee and other monetary obligations, if any, payable by the Principal Member.

42. **SURGERY** - The branch of medicine dealing with manual or operative procedures for the correction of deformities and defects, repair of injuries, diagnosis and cure of certain diseases. This includes surgery performed in an out-patient setting for a covered Illness or Injury.

II. BENEFITS AND COVERAGES

All the benefits provided for in this Agreement are detailed in "Schedule A – Benefit Coverage", and subject to the following terms and conditions:

1. In case of Out-Patient, the MEMBER can go directly to the primary physician of any accredited hospital/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/clinic of his/her choice upon issuance by MediCard of the Out-Patient Consultation Form or Laboratory Request Form.

2. For In-Patient services, all limits are inclusive of room and board, operating room charges, professional fees and other incidental expenses relative to the procedure. A Letter of Authorization (LOA) together with other necessary documents shall be issued by MediCard prior to confinement. The maximum benefit limit and annual benefit limit shall be inclusive of consultations, diagnostic procedures and hospitalization. Before being discharged from the Hospital, a Member must fill up the prescribed discharge form and settle that portion of the medical bill not covered by the Agreement. That portion of the bill covered by the Agreement shall be settled directly by the HMO with the hospital and/or Attending Physician(s).

3. All procedures or benefits are subject to the limitations on pre-existing conditions as stated in this Agreement.

4. Non-emergency confinement or surgery (elective cases) shall be subject to prior review and approval by the MediCard review board. MediCard 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 MediCard.

5. In all circumstances of Emergency Care Services, MediCard reserves the right to validate whether treatment received is emergency in nature and/or the illness or condition is covered under the provisions of this Agreement.

6. In case a MEMBER is simultaneously covered under another health maintenance agreements with MediCard, the MEMBER shall not use the benefits of his other MediCard coverage (if any) simultaneously with the benefits of this MediCard Health Program Agreement, 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.

7. Hospitalization or in-patient coverage of a MEMBER will depend on his/her final diagnosis. All diagnostic procedures will only be covered if results are within inclusions of this Agreement.

8. All MediCard patient-MEMBERS are considered to be patients of the MediCard 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 the concerned accredited physician.

9. For purposes of determining the amount utilized by the MEMBER of his/her "per disease, per year limit," it shall be understood that any Disease Complication shall share the same limit as the primary disease which caused it, and any amount expended for the treatment of the Disease Complication shall be included in the total amount expended for the said primary disease for the year. Similarly, the exclusion of a primary disease from coverage by MediCard shall cover any Disease Complication that may have been caused by the said excluded primary disease. This provision shall be applicable to all benefits provided by MediCard under this Agreement, especially those provided for under this "Schedule A – Benefit Coverage". Note that this Section is applicable only for Accounts which limit is MBL.

III. PRE-EXISTING CONDITIONS PROVISIONS

1. Any illness, injury or any adverse medical condition shall be considered pre-existing if prior to the effectivity date of membership, the pathogenesis or onset of such illness, injury or adverse medical condition has started as determined by MediCard's Medical Director or accredited physicians. The determination of the pre-existing condition shall not be limited to one (1) year from the effectivity date of membership.

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. Cataracts/Glaucoma
   e. ENT conditions requiring surgery
   f. Bronchial Asthma/Allergy/Urticaria
   g. Tuberculosis
   h. Chronic Cholecystitis/Cholelithiasis (gall bladder stones)
   i. Acquired Hernias
   j. Prostate disorders
   k. Hemorrhoids and Anal Fistulae
   l. Benign Tumors
   m. Uterine Myoma, Ovarian Cyst, Endometriosis
   n. Buergher's Disease
   o. Varicose Veins
   p. Arthritis
   q. Migraine Headache
   r. Gastritis/Duodenal or Gastric Ulcer

3. Pre-existing condition as defined in Sections 1 and 2 shall only be covered after twelve months from effectivity date of membership, except as otherwise stated in Schedule "A" of this Agreement; provided however, that there is no failure to disclose, misrepresent or conceal, material information in the original Application or Application for reactivation. Notwithstanding the disclosure by the Member of a pre-existing condition, MediCard may permanently exclude from coverage a specific medical condition, illness or injury upon written notice to the MEMBER.

4. It is understood that the foregoing benefits shall likewise be applicable to "dreaded diseases" as defined under Article XII, Section 2 of this Agreement.

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

6. Diagnostic procedures undertaken to determine the existence of a Pre-existing Condition is a covered expense provided that the result of diagnostic procedure is negative for the existence of the pre-existing condition.

IV. CLAIMS AND REIMBURSEMENTS

1. REIMBURSEMENT PROCEDURE

All claims for reimbursement must be submitted or forwarded to MediCard 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.

Required documents in availing reimbursement:

a. 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

b. 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 MediCard accredited doctor was not available during the time of confinement

c. 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

d. 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
   - Incident report
   - Police report if due to accident or medico-legal case

2. 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 MediCard 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" (as discussed in Rule 130, Section 24 of the Rules of Court) 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 MediCard decision and the reason for such decision.

3. FRAUDULENT CLAIMS

If any claim under this Agreement is in any respect fraudulent, all benefits payable and/or paid in relation to that claim shall be forfeited and if deemed appropriate, recoverable, respectively.

4. PHYSICAL EXAMINATION AND AUTOPSY

MediCard shall have the right and opportunity to examine the MEMBER when and as often as it may reasonably require during the pendency of claim hereunder, and the right and opportunity to make an autopsy in case of death, where it is not forbidden by law.

5. BENEFIT PAYMENT

a. All benefits payment shall be in PHILIPPINE PESO.

b. If a MEMBER incurs Eligible Expenses during the effectivity of this Agreement, MediCard will pay benefits in accordance with "Schedule A - Benefit Coverage" of this Agreement. MediCard will pay the Eligible Expenses after application of any stipulated co-payment or other deductions that may apply.

c. Benefits will not exceed the total medical expenses when combined with other health care or medical coverage in force or organizations or which are provided free of charge in government or private facilities.

d. MediCard reserves the right to deny Claims for Reimbursement if the procedures and requirements have not been strictly complied with.

6. PAYMENT OF CLAIMS

All benefits that pertain to a MEMBER will be paid by check to the order of Principal Member, unless the Principal Member requests otherwise, or HMO, in its discretion, considers it preferable to make the payment in another manner. In case of death of a MEMBER, any benefit due but remaining unpaid shall be paid to the first surviving class of the following classes of successive preference of beneficiaries: the MEMBER's (a) widow or widower; (b) surviving children; (c) surviving parents; (d) surviving brothers and sisters; and (e) executors or administrators.

V. EXCLUSIONS AND LIMITATIONS

1. HOSPITALIZATION

a. All confinement shall be upon recommendation of the MEMBER's MediCard accredited Physician, or the MediCard Medical Director or the Emergency Room Resident Physician of the MediCard Accredited Hospital who decides to admit MediCard patient-MEMBER in cases of life threatening emergencies.

b. Hospital bills for the following hospital services shall be charged to the account of the MediCard patient-MEMBER: services of a private nurse or doctor, use of extra

food and/or bed, T.V., electric fan, video/audio disc player, ID bracelet, thermometer and all other items not directly related to the medical management of the patient.

c. Hospitalization and treatment outside the Philippines is not covered except where there is a coverage for "Emergency Care Services in Foreign Countries", explicitly indicated in "Schedule A - Benefit Coverage" of this Agreement.

d. MediCard is not responsible and will not recognize any hospital bills incurred by a MEMBER in hospitals not accredited by MediCard, except for emergency care services under the terms provided in this Agreement.

e. 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 MediCard attending physician, or without MediCard's express written report shall not be shouldered by MediCard.

2. OUT-PATIENT SERVICES

a. Prescribed medicines on an out-patient basis are not provided by MediCard-owned Clinics or Medical Service Units.

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

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

3. EXCLUSIONS

Except as otherwise provided in this Agreement, the following shall be excluded in the coverage given by MediCard:

a. Services which a MEMBER receives from a non-MediCard Physician, non-MediCard Accredited Hospital or other provider of care, Accredited Physician in non-MediCard Accredited Hospital or other provider of care, except as described in the emergency care in non-MediCard hospitals, as provided for in this Agreement;

b. Hereditary and/or congenital defects of whatever form;

c. Sensorineural hearing impairments except those acquired during time of membership;

d. Plastic and reconstructive surgery for cosmetic purposes and for physical congenital deformities and abnormalities;

e. Dermatological care for aesthetic purposes such as electrocautery or chemical treatment for skin tags, xanthelasma, milia, keloids, scars, etc. on any exposed area of the body;

f. Guillain-Barre syndrome, multiple sclerosis, demyelinating disease, Parkinson's disease, Alzheimer's disease, Myasthenia gravis, epilepsy, seizure disorder and other autoimmune neurologic diseases;

g. Slipped disc, scoliosis, spinal stenosis and spondylosis;

h. AV malformation and aneurysms which are considered congenital except only those unequivocably proven to be acquired secondarily;

i. Corrective eye surgery for error of refraction including laser surgery for correction of myopia and hypermyopia;

j. Psoriasis, vitiligo;

k. Experimental medical procedures, acupuncture, acupressure, reflexology and chiropractics;

l. Services to diagnose and/or reverse infertility or fertility and virility/potency (erectile dysfunction);

m. Open heart surgeries, angioplasties, valvuloplasties, permanent pacemaker insertion, intracoronary thrombolysis, balloon valvuloplasties, transvenous endocardial biopsy, percutaneous intraaortic balloon pump insertion, balloon atrial septostomy, previous craniotomy sequelae, organ transplantation and complication and other surgeries related to the heart;

n. Diagnostics for hypersensitivity and desensitization treatment;

o. Purchase or lease of durable medical equipment, oxygen dispensing equipment and oxygen except during hospital confinement under the Hospital Confinement Benefit;

p. Corrective appliances and artificial aids and prosthetic devices;

q. Human blood products like platelets, packed RBC, plasma, gamma globulin, etc. and its processing;

r. Psychiatric and psychological illnesses including neurotic and psychotic behavior disorders;

s. Treatment for alcoholic intoxication and drug addiction or overdose reaction to use of prohibited drugs including illnesses directly related to it and other injuries attributed as a result of it;

t. Rehabilitation treatment, physical, speech, occupational and hormonal therapies;

u. Developmental disorders, metabolic diseases, sleep and eating disorders;

v. Sexually transmitted diseases such as Hepatitis B, condyloma, gonorrhea, syphilis, herpes, etc. and their attendant complications;

w. Pelvic inflammatory disease, tubo-ovarian abscess, pyosalpingitis, etc.;

x. HIV/AIDS;

y. Hazardous job-related illnesses and/or injuries;

z. Physical examinations required for obtaining or continuing employment, insurance or government licensing, health permit, requirement in school and other similar purposes;

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

ab. Treatment of self-inflicted injuries or injuries attributable to the MEMBER'S own misconduct, gross negligence, use of alcohol and/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;

ac. Maternity care and other conditions as a result of pregnancy unless specifically provided;

ad. Custodial, domiciliary care, convalescent and intermediate care;

ae. Oral surgery for purposes of beautification, temporomandibular joint disease (TMJ) surgery done by dental practitioner;

af. Circumcision, except for correction of Phimosis;

ag. Treatment of injuries sustained in a motor vehicle accident if the MEMBER or his guardian fails or refuses to execute the Deed of Subrogation specified in Article XII, Section 16 of this Agreement;

ah. Professional fees of medico-legal officers;

ai. Diagnosis of unknown etiology or the absence of any organic dysfunction;

aj. Cost of vaccines for active and passive immunization except as otherwise provided for in this Agreement;

ak. Laboratory examinations for screening sexually related illnesses and injuries; and

al. Any condition or illness waived upon membership except as otherwise provided for in this Agreement.

4. LIMITATION IN SERVICES: MediCard is not responsible for the following:

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

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

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

d. Sudden change of hospital policies.

VI. MEMBERSHIP ELIGIBILITY

1. The following are eligible for Membership under this Agreement:

a. Principal Member:

Any person at least 18 years old up to 60 years of age.

b. Qualified Dependent Member:

For Married Principal Member

b.1 Legal spouse up to 60 years of age.
b.2 Legitimate and/or legally adopted children 30 days old and up to 21 years of age who are not gainfully employed and unmarried.

For Single Principal Member

b.1 Parents up to 60 years of age.
b.2 Brothers and sisters 30 days old and up to 21 years of age.

For Single Parent Principal Member

Children 30 days old and up to 21 years of age.

2. **HIERARCHY RULE FOR DEPENDENTS.** The choice of enrolling dependents must follow a hierarchy. This means that for married principal member, the spouse must be enrolled first followed by the eldest child, second child and so on. For single principal member, the parents must be enrolled first followed by eldest brother/sister and so on.

   If the Principal Member is married, his/her parents, brothers or sisters are no longer eligible as Qualified Dependents unless expressly provided for in this Agreement.

VII. PHILHEALTH/ECC PROVISION

It is hereby declared and agreed that hospitalization benefits due under the PHILHEALTH and/or Employee Compensation Commission (ECC) program are assigned to and integrated with the MediCard program such that any of the MediCard benefits due under this Agreement shall be net of the MEMBER's PHILHEALTH and/or Employee Compensation Commission (ECC) benefits. MediCard will not pay or advance the costs of such benefits, nor be responsible for filing any claims under PHILHEALTH and/or ECC.

VIII. EFFECTIVITY AND DURATION OF THIS AGREEMENT

1. This Agreement shall take effect on the date specified in Schedule B – Standard Membership Fee upon signing by the parties thereof and upon receipt by MediCard of the full membership fee, and will be in force and effect for a period of one (1) year.

2. This Agreement terminates upon expiration of the one-year period unless the same is renewed under such terms as may be agreed upon by both parties. Such agreements to be signified in writing as an amendment to this Agreement, or a new Agreement may be issued to replace the expired agreement.

3. Any aggrieved party may pre-terminate this Agreement for cause (i.e. any act of bad faith, breach of agreement, etc.), save in cases cited below, upon service of thirty (30) days notice to the other. MediCard shall have the right to immediately terminate this Agreement in the event that: (a) any material misrepresentation; or warranty made by the MEMBER is false or untrue; or if the MEMBER commits any act with the intent to defraud MediCard; or (b) the MEMBER's non-payment of appropriate fees and other obligations subject to agreed payment terms.

4. **Free Look Provision.** The MEMBER may terminate this Agreement by giving a written notice within fifteen (15) days from his/her receipt of the contract. The MEMBER may cause the termination of this Agreement provided the membership ID Cards and this Agreement are surrendered to MediCard within the same period. If payment was made by the MEMBER, the amount shall be returned in full to the MEMBER. MediCard shall thereafter terminate the membership and the termination provision of this Agreement shall apply. Failure to terminate this Agreement within the period set shall be understood as an acceptance of all terms and conditions provided hereunder. Any availment of a MEMBER within the fifteen (15) - day period shall also mean acceptance by the MEMBER of all the terms and conditions of this Agreement.

5. The MEMBER may terminate this Agreement for justifiable reasons at any time by giving a written notice to MediCard at least thirty (30) days prior to the intended termination date. The MEMBER may only terminate this Agreement if it is not in default in the

performance of its obligations or it has not violated any of its warranties and representations. Starting on the termination date, MediCard shall be free from all liabilities to the MEMBER. This shall be without prejudice to the right of MediCard to collect Client's obligations which have become due and demandable.

6. Membership coverage shall automatically terminate when: (a) the MEMBER has fraudulent availment or material misrepresentation or misstatements for the purpose of availing the benefits; or (b) when the MEMBER fails to observe the terms and conditions of this Agreement with utmost good faith.

7. In all cases, termination shall be without prejudice to the right of MediCard to collect MEMBERS obligations which have become due and demandable. All medical expenses incurred after the date of termination of the MEMBER's coverage shall be charged to the MEMBER.

8. The termination of this Agreement will not hold MediCard responsible to provide the medical and health care services described herein to such enrolled MEMBER, who are still confined in any of the MediCard 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 MediCard.

9. In case of pre-termination under Article VIII, Section 3 hereof, where the MEMBER is the aggrieved party entitled to a refund, maximum benefit limits as well as other benefits with limits will be pro-rated according to the number of months where applicable premiums were made. All benefits availed beyond determined limits will be deducted from refundable fees, or will be billed to the MEMBER, as the case may be. The provision of Article IX, Section 8 shall apply.

10. In case of renewal, the MEMBER cannot avail the benefits under this Agreement unless the Membership Fee is fully paid and the MEMBER has no outstanding obligations with MediCard.

IX. PAYMENT TERMS AND CONDITIONS

1. **MEMBERSHIP FEE.** The Principal Member with respect to this Agreement, agrees to pay MediCard the full membership fee as specified in "Schedule B – Membership Fees".

2. **PAYMENT OF MEMBERSHIP FEE.** The Membership Fee are considered due on the effective date of this Agreement. Upon renewal, the MEMBER is however, given a grace period of thirty (30) days from the due date, which is the date the effectivity of this Agreement lapses, to pay the full membership fee.

   Should there be any dispute, contest or conflict regarding the SOA on any substantial matter pertaining thereto, the MEMBER shall pay the undisputed portion of the Statement of Account (SOA) on or before the due date stated therein, notwithstanding such dispute, contest or conflict, unless the MEMBER shows proof of significant error on any substantial matter stated in the SOA. For this purpose, significant error means an error that would affect at least 25% of the total amount due. Upon resolution of the dispute, contest or conflict, the adjustment, if any, shall be reflected in another statement of account to be given within seven (7) days from the date that dispute, contest or conflict was settled by the MEMBER and MediCard. In this regard, a full payment of such adjusted SOA shall be made within fifteen (15) days from the time of receipt of such adjusted SOA.

   The absence of any written notice to MediCard regarding dispute, contest or conflict in the details contained in the SOA within seven (7) days from receipt thereof shall constitute MEMBER's absolute agreement thereto.

3. **DELINQUENCY, GRACE PERIOD AND LAPSATION PROVISIONS.**

   a. This Agreement shall automatically lapse and be void, without need of any notice, if the membership fee remains unpaid after thirty (30) days from the due date, which is the grace period for payment of membership fee.

   b. During the thirty (30) days period, all the benefits and privileges of membership under this Agreement shall be suspended until such time that the membership fee are settled.

   c. All claims incurred during the grace period shall be reimbursed to the MEMBER, after the membership fee due is paid, which reimbursable amount should be based on MediCard relative rates.

4. **APPLICATION OF PAYMENT.** All payments received by MediCard from the MEMBER shall be applied to the SOAs, in the order of respective due dates, starting from the earliest. Payment will be applied to the interest or penalty first before applying it to the principal amount.

5. **EFFECTS OF NON-PAYMENT OF MEMBERSHIP FEES.** Non-payment of the Membership Fees due after the grace period shall entitle MediCard to:

   a. Suspend all services under this Agreement or services to MEMBERS whose Membership Fees have not yet been received, until full payment of all Membership Fees due, including penalty charges equivalent to five percent (5%) a month or a fraction thereof on the unpaid Membership Fees due, computed from due date; and

   b. Terminate this Agreement without prejudice to collecting the amount due and the corresponding penalty charges that have accrued thereon.

6. **REACTIVATION OF AGREEMENT.** A Member whose coverage has lapsed may apply to reactivate his or her coverage within fifteen (15) calendar days from the end of the grace period by (a) submitting a written request for reactivation; (b) paying the Membership Fee due with arrears, including the penalty charge per Member; (c) for modes of payment other than annual, paying in advance the Membership fee due for the next period.

   Suspension of benefits under this Agreement shall be in force until such time the Member shall have paid in full all fees required in reinstatement of his or her coverage.

   If, after fifteen (15) days from the end of the grace period, all fees required in reactivation of coverage have not yet been paid and settled, MediCard shall have the right to disapprove reactivation. However, Member may re-apply subject to approval of MediCard. Claims incurred during the suspension shall not be reimbursed even after the lifting of suspension.

7. **REFUND/CREDIT OF MEMBERSHIP FEE.** If a member's coverage is terminated or cancelled, the unused pro rata Membership Fee paid shall be refunded to the MEMBER, only if no availment has been made by the MEMBER prior to the termination or cancellation. The schedule of refund is provided below:

If the Agreement/Membership has been in force for	Percent of refund from the paid Annual Membership Fees
Not more than one (1) month	80%
More than one (1) month but less than three (3) months	70%
At least three (3) months but less than six (6) months	40%
Six (6) months or more	No refund

Note: A processing fee of P50.00 shall be deducted from the refundable amount.

Furthermore, there shall be no refund of membership fees in the event that the MEMBER has availed of any benefit under this Agreement.

If the Membership Fees are unpaid prior to cancellation or termination of membership, MEMBER shall settle the pro rata membership fee, inclusive of penalty charges if applicable.

X. MEMBERSHIP

1. **DEADLINE FOR ENROLLMENT OF DEPENDENTS:**

   a. For dependents who meet the eligibility requirements within the Agreement period - 30 days from the date dependent becomes eligible for membership (copy of birth certificate or marriage agreement must be submitted).

   b. Any additional dependents other than the above can be enrolled upon the renewal of AGREEMENT.

   c. After the lapse of the periods specified above, MediCard shall no longer receive, evaluate and accept any designation or application to be a Qualified Dependent of a Principal Member.

2. **UNDERWRITING CUT-OFF DATES IN ASSIGNING EFFECTIVITY DATE:**

Date of Receipt of Application/Endorsement	Effectivity Date
11th to 25th of the month	1st of the following month
26th to 10th of the month	16th of the same month

3. New enrollees who are approaching age of ineligibility must be enrolled at least six (6) months counting from the date of effectivity up to the date that the enrollees become ineligible for them to be accepted as MEMBERS (i.e. If age of eligibility is up to 60 years old, only applicants who are 60 years and 6 months old and younger will be accepted for membership). All pre-existing conditions/maximum benefit limits will be computed on a prorated basis.

4. Renewing MEMBERS who will become age ineligible within the next renewal agreement year will be allowed to renew regardless of the remaining months that the MEMBER will remain eligible. However, pre-existing conditions/maximum benefit limits will be computed on a prorated basis (i.e. If age of eligibility is up to 60 years old, a renewing MEMBER who is 60 years and 9 months old will still be renewed). All pre-existing conditions/maximum benefit limits will be computed based on the following formula:

$$\frac{\text{Total months that MEMBER remains eligible}}{12} \times \text{PEC/MB limit} = \text{Pro-rated limit}$$

5. Enrolled MEMBER who will reach the age of ineligibility can still be accommodated until the end of the contract period, provided that, within thirty (30) days prior to reaching the age of ineligibility, the MEMBER will pay the membership fees for the remaining months that he is considered ineligible.

6. In relation to his/her dependents, the MEMBER shall be known as the Principal and he/she shall be deemed to have undertaken to comply with all the requirements and obligations of individual regular membership under the Agreement on behalf of said dependent/s, particularly the payment of the required fees, dues and charges.

7. **MEMBERSHIP REQUIREMENT**

   a. The MEMBER undertakes to submit to MediCard the following:

      Valid Identification Card

b. MediCard undertakes to furnish the MEMBER the following:

b.1 Membership application forms to be filled by the MEMBERS;

b.2 MediCard Identification Card

b.3 this Agreement

c. 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.

8. **UPGRADING/DOWNGRADING OF PLAN.** Upgrading or downgrading of MEMBER's plan shall not be allowed during the contract period. Changes in plan, including upgrading or downgrading of plan is allowable only during the renewal of this Agreement subject to the approval of MediCard.

XI. MATERIAL MISREPRESENTATION OR NON-DISCLOSURE

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

a. it is among those required to be answered or supplied in the corporate and/or individual application and/or medical examination forms of MediCard at the time of application;

b. it would have revealed the existence of a pre-existing condition under Article III or of a "dreaded disease" as defined under Article XII, Section 2;

c. it would be determinative of an "exclusion" as defined under Article V; or

d. it would have resulted in the disapproval of the application of the PRINCIPAL MEMBER and/or the MEMBER for membership, or the assessment of a higher membership fee for the benefit/s applied for with MediCard in accordance with the prevailing practice of MediCard at the time the misrepresentation or non-disclosure was discovered.

In case of invalidation of the agreement due to fraudulent non-disclosure or misrepresentation of any material information by the MEMBER, he/she shall not be entitled to a return of membership fees which may have been paid already to MediCard, as well as any and all benefits which may be provided under this Agreement. Furthermore, MediCard may also demand for reimbursement of the cost of services rendered or amount already refunded to the member plus administration fee; however, in the event that there is no fraud, MediCard shall return the membership fees paid less cost of previous services rendered by MediCard and all amounts already refunded to the MEMBER including administration fee.

XII. GENERAL PROVISIONS

1. **ENTIRE AGREEMENT.** This Agreement together with its Annexes and the Applications for Membership altogether constitute the entire agreement between MediCard and the MEMBER, and no statement, promise or inducement made by or through any other party not contained herein shall be binding or valid. All statements and information contained in the MEMBER's Application Form shall be deemed representations and warranties made by the MEMBER himself for purposes of applying the provisions of this Agreement. The Conforme Letter, Renewal Agreement or any agreement between the Parties shall constitute as execution of this Agreement by the Parties. This Agreement supersedes all prior undertakings, arrangements, representations, agreements, whether

valid or verbal between the Parties. All services and benefits arising out of this Agreement are valid only in the Philippines. Any amendment to this Agreement must be approved by MediCard and shall form part of this Agreement. Unless agreed by the Parties in writing, no such alteration or endorsement shall affect any agreement issued prior thereto. This Agreement shall be governed by and construed in accordance with the laws of the Republic of the Philippines. It is hereby agreed that the venue for actions arising out of this Agreement shall be in Makati City, Philippines.

2. **DREADED DISEASES.** 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 following illnesses/conditions which are considered as dreaded disease:

   a. Cerebrovascular Accident (stroke)
   b. Central Nervous System lesions (Poliomyelitis/Meningitis/Encephalitis/ neurosurgical conditions)
   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 (except Type A), New Growth)
   f. Chronic Kidney/Urological disease (Urolithiasis, Obstructive uropathies, etc.)
   g. Chronic Gastrointestinal Tract Disease requiring bowel resection and/or anastomosis
   h. Collagen diseases (Rheumatoid Arthritis, Systemic Lupus Erythematosus)
   i. Diabetes Mellitus and its complications
   j. Malignancies and Blood dyscrasias (Cancer, Leukemias, Idiopathic Thrombocytopenic Purpura)
   k. Injuries from accidents or assaults, frustrated homicide or frustrated murder; subject to police report
   l. Complications of an apparent ordinary illness including MODS and SIRS (e.g. sepsis due to pneumonia, typhoid ileitis, Kawasaki disease, cerebral malaria, etc.)
   m. Single or multiple organ dysfunction and failure (MODS and MOF)
   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

   MediCard shall pay for the consultation and hospitalization services, as herein defined, of a MEMBER for "dreaded disease" up to the stated maximum amount or limit as specified in “Schedule B – Membership Fees”, “per illness per year” or “per member/per family unit per year”, whichever is applicable.

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

3. **DOWNGRADING OF ROOM ACCOMMODATION.** Availment of a room accommodation lower than the MEMBER's Room and Board Accommodation can be done at the option of the MEMBER but there shall be no refund or offsetting for the cost difference in room accommodation and other related medical benefits.

4. **GENERAL PROVISIONS FOR ROOM ACCOMMODATION**

   If a MEMBER occupies a room higher than what he/she is entitled to, during confinement except during emergency care, he/she shall share in the medical expenses according to the following formula:

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

   Computation:
   (Rate of room occupied minus maximum room and board benefit) multiplied by
   (No. of days confined)

b. 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: MRV* Actual Room – MRV* Assigned Room
     Surgical case:
       Ward to Private Room: MRV* Private – MRV* Ward
       Private Room to Suite: MRV* Suite – MRV* Private

       *Note: *MRV – MediCard Relative Value*

c. If at the time of the confinement the Accredited Hospital has no available room in accordance with the MEMBER's Room and Board Accommodation and the MEMBER is entitled under this Agreement to avail of the next higher room available, he/she may avail the said benefit in accordance with "Schedule A - Benefit Coverage", Article VI.

5. **EXCESS CHARGE.** Services availed by a MEMBER in excess of the coverage or allowable limit shall be settled by the MEMBER directly with the hospital. Failure of the MEMBER to settle the excess charges shall necessitate MediCard to bill the MEMBER, all excess charges with corresponding twenty percent (20%) service fee, payable within fifteen (15) calendar days from receipt of billing. Otherwise, a corresponding penalty of one percent (1%) per month will be incurred. If the bills remain unpaid after thirty (30) calendar days, the concerned MEMBER shall cease to be entitled for coverage until after bills have been settled in full.

6. **NON-TRANSFERABILITY PROVISIONS.** This Agreement or any of the benefits hereunder can neither be transferred nor assigned by the MEMBER to any other person. Any purported assignment or delegation of this Agreement is null and void and can be considered as breach of this Agreement.

7. **AUTHORITY TO EXAMINE MEDICAL RECORDS.** The MEMBER hereby represents and warrants that, at the time of the effectivity of this Agreement and effectivity of coverage, it has authorized MediCard and any of its authorized representatives to obtain, examine and process the MEMBER's personal information, including the medical records of their hospitalization, consultation, treatment or any other medical advice in connection with the benefit/claim availed under this Agreement;

   The MEMBER shall hold MediCard free and harmless from and against any and all suits or claims, actions, or proceedings, damages, costs and expenses, including attorney's fees, which may be filed, charged or adjudged against MediCard or any of its directors, stockholders, officers, employees, agents, or representatives in connection with or arising from the use by MediCard of the MEMBER's medical records and other personal information pursuant to this Agreement.

8. **MISCELLANEOUS PROVISION.** It is hereby understood that, to be entitled to the benefits under this Agreement, the MEMBER hereby waives his/her consent to the

disclosure and processing of his/her medical/health information which is determinative for the assessment of his/her coverage and necessary for the treatment of his/her illness. MediCard, its Medical Service Units/Teams and its Accredited Hospitals/Clinics are hereby released from any liability by reason of such disclosure.

9. **CONFIDENTIALITY.** The MEMBER shall not use or reproduce, directly or indirectly any Confidential Information for the benefit of any person, or disclose to anyone such Confidential Information without the written authorization of MediCard, whether during or after the term of this Agreement, for as long as such information retains the characteristics of Confidential Information.

   "Confidential Information" means any data or information, that is proprietary to MediCard and not generally known to the public, whether in tangible or intangible form, whenever and however disclosed, including, without limitation: (i) personal information, treatments or operations undergone by its members; (ii) trade secrets, confidential or secret formulae, special medical equipment and procedures; (iii) medical utilization reports, directly or indirectly useful in any aspect of the business of MediCard; (iv) any vendor, names, customer, member and supplier lists; (v) marketing strategies, plans, financial information or projections, operations, sales estimates, business plans and performance results relating to the past, present or future business activities of MediCard; (vi) all intellectual or other proprietary or material information of MediCard; (vii) all forms of Confidential Information including, but not limited to, loose notes, diaries, memoranda, drawings, photographs, electronic storage and computer print outs; (viii) any other information that should reasonably be recognized as confidential information of MediCard. All information which the MEMBER acquires or becomes acquainted with during the period of this Agreement, whether developed by MediCard or by others, which the MEMBER has a reasonable basis to believe to be Confidential Information, or which is treated, designated and/or identified by MediCard as being Confidential Information, shall be presumed to be Confidential Information. Confidential Information need not be novel, unique, patentable, copyrightable or constitute a trade secret in order to be designated as Confidential Information.

10. **FUTURE TAXES, LEVIES AND GOVERNMENT IMPOSITION.** If during the effectivity of this Agreement, the fees and benefits are made subject to new taxes, levies or fees, or such law, regulation or its equivalent resulted to changes in the formula or manner of computing taxes thereby resulting in additional obligations on the part of MediCard, any additional amount due shall automatically be charged to the MEMBER in addition to the fees stated therein. Future taxes, levies or fees referred herein are only those that affect the quoting of Membership Fee (Ex. 12% VAT), other future taxes, levies or government impositions that do not affect the quoting of Membership Fee are therefore excluded.

11. **ARBITRATION.** Any difference arising between the MEMBER and MediCard shall be referred to an arbitrator to be appointed by the parties to the dispute. If the parties are unable to agree on a single arbitrator, two (2) arbitrators shall be appointed (one by each party). In the event of further disagreement, the arbitrators shall select an umpire. If the difference between the parties requires medical knowledge (including any question regarding the appropriate maximum indemnity for any medical service or an operation not listed in the schedule of surgical fees) the arbitrators at the discretion of MediCard, may be registered medical practitioners and the umpire in such an instance, shall be a consultant Specialist, Surgeon, or Physician. Determination of an award shall be a Condition Precedent to Any Liability or right of action against MediCard.

12. **AUTHORIZED SIGNATORY.** The Parties hereby represent that their respective representatives had been duly authorized by the Board of Directors to sign, execute and deliver this Agreement.

13. **SEPARABILITY.** If any term or provision of this Agreement is declared invalid, illegal or unenforceable under Philippine laws, such invalidity, illegality or unenforceability shall not affect or render unenforceable any other term or provision of this Agreement.

14. **NOTICES.** All notices, demands and other communications required or permitted hereunder shall be made in writing and sent to the Parties addresses indicated herein.

15. **MEMBERS SATISFACTION SERVICE**

    a. All questions or concerns of MEMBERS about the medical services and benefits shall be directed to the MediCard Head Office. MEMBERS must provide complete and necessary information so that the Customer Management Assistant, Customer care Officers and/or other appropriate staff or Administrative Personnel can work with the MEMBER to resolve the MEMBER's concern in a timely manner.

    b. 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.	: 8841-8080
Toll Free Nos.	: 1800-1888-9001
Text MediCard	: Key in specific information or request on your mobile phones and send to: (0917) 8512648 for Globe subscribers; (0908) 8841814 for Smart subscribers and (0922) 3822943 for Customer Management Group.

    c. Open door policy. Direct access to a network of one thousand fifty-two (1,052) accredited hospitals/clinics nationwide, three (3) mall-based clinics, nine (9) hospital-based clinics, fifteen (15) referral desks and sixteen (16) free-standing clinics including a Head Office Clinic.

16. **RIGHT OF SUBROGATION.** MediCard 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 through a motor vehicle. Provided, however, that the MEMBER executes an agreement to subrogate to MediCard whatever rights the MEMBER may have by reason of such accident or event that gave rise to such claim to the extent of the value of the services so rendered and that the MEMBER will undertake to assist MediCard in the successful recovery of the losses. The agreement to subrogate form is available at MediCard Head Office.

17. **CIVIL CODE ARTICLE 1250 WAIVER**. The provisions of Article 1250 of the Civil Code of the Republic of the Philippines (Republic Act No. 386) which reads, "In case an extraordinary inflation or deflation of the currency stipulated should supervene, the value of the currency at the time of establishment of the obligation shall be the basis of payment", shall not apply in determining the extent of liability under the provisions of this Agreement.

18. **IMPORTANT NOTICE**. The Insurance Commission, with offices in Manila, Cebu and Davao, is the government office in charge of the enforcement of all laws related to Health Maintenance Organization (HMO), and has supervision over HMOs. It is ready at all times to assist the general public in matters pertaining to HMO. For any inquiries or complaints, please contact the Public Assistance and Mediation Division (PAMD) of the Insurance Commission at 1071 United Nations Avenue, Manila with telephone numbers 632-85238461 to 70 and email address publicassistance@insurance.gov.ph. The official website of the Insurance Commission is www.insurance.gov.ph.

Schedule A – VIP Package Benefit Coverage

I. PREVENTIVE HEALTH CARE SERVICES. The Preventive Health Care Services will be provided to MEMBERS by designated MediCard Medical Service Units.

HEALTH CARE BENEFITS	COVERAGE/LIMIT
1. Annual Physical Examination (APE) shall be conducted once a year at designated MediCard Clinics. APE shall include the following:	
a. Complete Blood Count	up to the maximum benefit limit per member per year
b. Urinalysis (urine examination)	
c. Fecalysis (stool examination)	
d. Chest X-ray	
e. Electrocardiogram (for members 40 years old and above, or if prescribed)	
f. Pap smear (for women 40 years old and above, or if prescribed)	
2. Management of Health Problems	up to the maximum benefit limit per member per year
3. Routine Immunization (except cost of vaccines)	up to the maximum benefit limit per member per year
4. Counselling on health habits, diets and Family Planning	up to the maximum benefit limit per member per year
5. Record Keeping of Medical History	up to the maximum benefit limit per member per year

II. **OUT-PATIENT CARE SERVICES.** Out-Patient Services will be provided to MEMBERS in any MediCard accredited hospitals/clinics.

HEALTH CARE BENEFITS	COVERAGE/LIMIT
1. Referral to specialists	up to the maximum benefit limit per member per year
2. Regular Consultations and treatment (except prescribed medicines)	up to the maximum benefit limit per member per year
3. Eye, Ear, Nose and Throat treatment	up to the maximum benefit limit per member per year
4. Treatment of minor injuries and surgery not requiring confinement	up to the maximum benefit limit per member per year
5. X-ray and laboratory examinations prescribed by MediCard physician	up to the maximum benefit limit per member per year
6. Physical and speech therapy	up to ten (10) sessions within the maximum benefit limit per member per year
7. Laser treatment for glaucoma and retinal detachment	up to P20,000.00 per member per year
8. Cataract extraction (including phacoemulsification) excluding the cost of lens	up to the maximum benefit limit per member per year
9. Cauterization of warts including facial warts	up to P1,000.00 per member per year
10. First dose of anti-tetanus	up to P1,000.00 per member per year
11. Tuberculin test (excluding screening)	up to P800.00 per member per year
12. Consultations for Chronic Dermatoses (except Psoriasis)	up to the maximum benefit limit per member per year
13. Consultations for Scabies	up to the maximum benefit limit per member per year

ADDITIONAL BENEFIT FOR OUT-PATIENT SERVICES

No-charge consultations from primary care physicians and the following specialists shall be provided at MediCard-owned clinics:

a. General Surgeon
b. Obstetrician Gynecologist
c. Pediatrician
d. Family Medicine
e. General Practitioner
f. General Internist

MEMBERS can also avail of the free consultations even for conditions which are classified under general exclusions or pre-existing conditions which are not covered. Furthermore, MEMBERS can avail of discounts at MediCard-owned clinics for cases which are not covered.

	Regular Private		***Large Private***	***Suite up to Plan 8000***
	With P200,000.00 maximum benefit limit	With P250,000.00 maximum benefit limit		
▪ Laboratory examinations	Up to 30%		Up to 40%	Up to 50%
▪ Maternity-related laboratory and ultrasound	Up to 30%			

III. **DENTAL CARE SERVICES.** MEMBERS may avail of the following dental care services from any of the accredited dental clinics:

HEALTH CARE BENEFITS	**COVERAGE/LIMIT**
1. Twice a year oral prophylaxis	up to the maximum benefit limit per member per year
2. Consultations and oral examinations	up to the maximum benefit limit per member per year
3. Simple tooth extractions, except surgery for impacted or ankylosed tooth, etc.	up to the maximum benefit limit per member per year
4. Temporary fillings	up to the maximum benefit limit per member per year
5. Gum treatments for cases like inflammation or bleeding	up to the maximum benefit limit per member per year
6. Recementation of loose jackets, crowns, in-lays and on-lays	up to the maximum benefit limit per member per year
7. Treatment of mouth lesions, wounds and burns	up to the maximum benefit limit per member per year
8. Adjustment of dentures	up to the maximum benefit limit per member per year
9. Emergency out-patient dental treatment	up to the maximum benefit limit per member per year
10. Temporomandibular Joint (TMJ) consultations	up to the maximum benefit limit per member per year
11. Restorative and Prosthodontic consultations	up to the maximum benefit limit per member per year
12. Dental nutrition and dietary counselling through chairside instruction	up to the maximum benefit limit per member per year
13. Dental Health Education	up to the maximum benefit limit per member per year

<table>
<tr><td>14. Pre and post natal dental consultations</td><td colspan="4">up to the maximum benefit limit per member per year</td></tr>
<tr><td rowspan="2">15. Light cure filling</td><td colspan="2">Regular Private</td><td rowspan="2">Large Private</td><td rowspan="2">Suite up to Plan 8000</td></tr>
<tr><td>P200,000.00 maximum benefit limit</td><td>P250,000.00 maximum benefit limit</td></tr>
<tr><td>none</td><td>one (1) surface</td><td>two (2) surfaces</td><td>five (5) surfaces</td></tr>
<tr><td rowspan="2">16. Root canal</td><td colspan="2">Regular Private</td><td rowspan="2">Large Private</td><td rowspan="2">Suite up to Plan 8000</td></tr>
<tr><td>P200,000.00 maximum benefit limit</td><td>P250,000.00 maximum benefit limit</td></tr>
<tr><td>none</td><td>none</td><td>none</td><td>P5,000.00</td></tr>
</table>

V. IN-PATIENT CARE SERVICES. The following hospitalization (In-Patient) services shall apply when MediCard physicians prescribe the hospitalization of MEMBERS in any MediCard Accredited Hospitals:

HEALTH CARE BENEFITS	COVERAGE/LIMIT
1. No deposit upon admission	up to the maximum benefit limit per member per year
2. Room & Board according to type of enrollment	up to the maximum benefit limit per member per year
3. Use of operating theatre and Recovery Room	up to the maximum benefit limit per member per year
4. Services of MediCard specialist like anesthesiologists, internists, surgeons, etc.	up to the maximum benefit limit per member per year
5. Services and medications for general/spinal anesthesia or other forms of anesthesia deemed necessary for a surgical procedure	up to the maximum benefit limit per member per year
6. Fresh whole blood transfusions and its processing/screening and intravenous fluids	up to the maximum benefit limit per member per year
7. X-ray and laboratory examinations	up to the maximum benefit limit per member per year
8. Administered medicines	up to the maximum benefit limit per member per year
9. Dressings, plaster casts, sutures and other items directly related to the medical management of the patient-MEMBER	up to the maximum benefit limit per member per year
10. ICU confinements	up to the maximum benefit limit per member per year
11. Human blood products (e.g. platelets, packed RBC) and its processing/screening except gamma globulin	up to the maximum benefit limit per member per year
12. Admission kit including wee bag	up to the maximum benefit limit per member per year
13. Chemotherapy	up to ten (10) sessions within the maximum benefit limit per member per year

14. Radiotherapy:	up to ten (10) sessions within the maximum benefit limit per member per year
a. Intensified Modulated Radiotherapy	
b. Three-Dimensional Conformal Radiotherapy (3DCRT)	
c. Tomotherapy	
d. Brachytherapy	
15. Dialysis:	up to ten (10) sessions within the maximum benefit limit per member per year
a. Continuous Renal Replacement Therapy (CRRT)	
16. Laparoscopic procedures (once a year):	up to P20,000.00 per member per year
a. Single Incision Laparoscopy Surgery (SILS)	
17. Lithotripsy/ESWL (once a year)	up to P20,000.00 per member per year
18. Hysteroscopic procedures (once a year)	up to P20,000.00 per member per year
19. Stereotactic brain biopsy/ Stereotactic breast biopsy (once a year)	up to P20,000.00 per member per year
20. Gamma knife surgery (once a year)	up to P20,000.00 per member per year
21. Percutaneous ultrasonic nephrolithotomy (once a year)	up to P20,000.00 per member per year
22. Transurethral Microwave Therapy (TUMT) of the prostate (once a year)	up to P20,000.00 per member per year
23. Arthroscopically-guided procedures	up to P20,000.00 per member per year
24. CT Scan, MRI and ultrasound guided excisions:	up to P20,000.00 per member per year
a. CT Guided Percutaneous Discectomy	
25. Endoscopically-guided excisions/ treatments/ procedures	up to P20,000.00 per member per year
26. Intradiscal Electrothermal Therapy (IDET)	up to P20,000.00 per member per year
27. Laser/ Coblation Tonsillectomy	up to P20,000.00 per member per year
28. Endovenous Laser Therapy/Endovenous Laser Ablation/ Radiofrequency Ablation (except for cosmetic purposes)	up to P20,000.00 per member per year
29. Coblation Procedures	up to P20,000.00 per member per year
30. Ductoscopy (Breast) guided excisions/ treatment/ procedures	up to P20,000.00 per member per year
31. Endoscopic Ultrasound guided excisions/ treatments/ procedures	up to P20,000.00 per member per year
32. Infrared Coagulation Hemorrhoidectomy	up to P20,000.00 per member per year

33. Mammotome/ Vacuum Assisted Breast Biopsy	up to P20,000.00 per member per year
34. Stereotactic Radiation Therapy/ Stereotactic Radiosurgery	up to P20,000.00 per member per year
35. Thyroplasty (implant not covered)	up to P20,000.00 per member per year
36. Transarterial Hemorrhoidal Dearterialization (THD)	up to P20,000.00 per member per year
37. Ultroid Hemorrhoid Management	up to P20,000.00 per member per year
38. Any other modern therapeutic procedure not mentioned above	up to P20,000.00 per member per year
39. Magnetic Resonance Imaging (MRI)/ Magnetic Resonance Angiography (MRA):	up to P5,000.00 per member per year
a. Tractography/Diffusion Tensor Imaging	
b. Superparamagnetic Iron Oxide (SPIO) enhanced MRI	
40. CT Scan:	up to P5,000.00 per member per year
a. Multislice/ multidetector/ spiral/ multirow CT	
b. Ultrafast Electron Beam Computed Tomography	
41. Ultrasound:	up to P5,000.00 per member per year
a. Intravenous Ultrasound/ Intravascular Ultrasound	
b. Contrast Enhanced Ultrasound	
42. Robotic Surgery/ Robotically-assisted Surgery	up to P5,000.00 per member per year
43. Photodynamic Therapy	up to P5,000.00 per member per year
44. Acoustic Radiation Force	up to P5,000.00 per member per year
45. Capsule Endoscopy	up to P5,000.00 per member per year
46. New modalities and/or diagnostic and treatment procedures for conditions with established etiologies and its use is only an alternative to the conventional methods	up to P5,000.00 per member per year
47. Laboratory/ancillary services for conditions whose pathogenesis or subsequent clinical improvement is not yet fully established in Medical Science	up to P5,000.00 per member per year
48. Other medically necessary modalities not mentioned above and those for which there are no comparable, conventional or traditional counterparts	up to P5,000.00 per member per year

<table>
<tr><td>49. Positron Emission Tomography (PET) Scan</td><td colspan="4">up to P5,000.00 per member per year</td></tr>
<tr><td>50. Stapled Hemorrhoidectomy</td><td colspan="4">up to P5,000.00 per member per year</td></tr>
<tr><td>51. Cryosurgery</td><td colspan="4">up to P5,000.00 per member per year</td></tr>
<tr><td rowspan="2">52. Slipped disc</td><td colspan="2">Regular Private</td><td rowspan="2">Large Private</td><td rowspan="2">Suite up to Plan 8000</td></tr>
<tr><td>P200,000.00 maximum benefit limit</td><td>P250,000.00 maximum benefit limit</td></tr>
<tr><td></td><td>P5,000.00</td><td>P10,000.00</td><td>P20,000.00</td><td>P30,000.00</td></tr>
<tr><td>53. The following complex diagnostic examinations:</td><td colspan="4" rowspan="2">up to P5,000.00 per member per year</td></tr>
<tr><td>a. Angiography (e.g. coronary, cerebral, retinal, fluorescein, pulmonary, GI, etc.)</td></tr>
<tr><td>b. Serum chemistry panels (e.g. Chem 23, Spec M, etc.)</td><td colspan="4" rowspan="7">up to P5,000.00 per member per year</td></tr>
<tr><td>c. Pulmonary perfusion scan</td></tr>
<tr><td>d. Tests involving use of Nuclear Technologies (e.g. Radionuclide Scan/Ventriculography, Thallium stress testing, Pyrophosphate Scintigraphy, Myocardial Perfusion Scanning, etc.)</td></tr>
<tr><td>e. Electromyography, Nerve Conduction Velocity Studies</td></tr>
<tr><td>f. 24-Hour Holter Monitoring, 2-D Echo and Doppler</td></tr>
<tr><td>g. Treadmill Stress Test</td></tr>
<tr><td>h. Myelogram</td></tr>
<tr><td>i. Diagnostic Endoscopy including one of video:</td><td colspan="4" rowspan="2">up to P5,000.00 per member per year</td></tr>
<tr><td>i.1 Multiphoton endoscopy</td></tr>
<tr><td>j. Diagnostic Arthroscopy</td><td colspan="4" rowspan="4">up to P5,000.00 per member per year</td></tr>
<tr><td>k. Diagnostic Hysteroscopy</td></tr>
<tr><td>l. Adrenocortical Function, Plasma/Urinary Cortisol, Plasma Aldosterone, etc.</td></tr>
<tr><td>m. Mammogram and Sonomammogram</td></tr>
<tr><td>n. Bone densitometry scan (Dexascan)</td><td colspan="4" rowspan="4">up to P5,000.00 per member per year</td></tr>
<tr><td>o. Immunologic Studies:</td></tr>
<tr><td>o.1 Anti-nuclear antibody (ANA)</td></tr>
<tr><td>o.2 C-Reactive Protein</td></tr>
<tr><td>o.3 Lupus cell exam</td><td colspan="4">up to P5,000.00 per member per year</td></tr>
</table>

o.4 Enhanced Luciferase Complementation / Luciferase Immunoprecipitation Assay	up to P5,000.00 per member per year
o.5 Enzyme-linked Immunosorbent Spot (ELISPOT) Assay	
o.6 ESAT-6 and CFP-10 Antigens	
o.7 QuantiFERON Tuberculosis (QFTB)	
p. Genetic Studies:	up to P5,000.00 per member per year
p.1 Alpha Globin/Globulin	
p.2 Beta Globin/Globulin Genotyping	
p.3 BCR-ABL by Quantitative Real-time Polymerase Chain Reaction (QRT-PCR, RT-PCR	
p.4 Duolink In-Situ Fluorescence Hybridization (DISH)/Array Comparative Genomic Hybridization (aCGH)	
p.5 Epidermal Growth Factor Receptor (EGFR) Mutation Assay/Test	
p.6 Fluorescence In-Situ Hybridization (FISH)	
p.7 JAK-2 Mutation	
p.8 Karyotyping	
p.9 KRAS Testing	
p.10 Philadelphia chromosome	
p.11 Polymerase Chain Reaction (PCR) for katG and rpoB	
p.12 Polymerase Chain Reaction Single Strand Conformation Polymorphism (PCR-SSCP)	
p.13 Reverse Transcription Polymerase Chain Reaction (RT-PCR)	
q. Magnetic Resonance Spectroscopy	up to P5,000.00 per member per year
r. Platelet Aggregation Test	
s. 3D/4D ultrasound (except for maternity cases)	
t. Ductoscopy (Breast)	
u. Endoscopic Ultrasound	
v. Peritoneal Dialysis Adequacy Test	

w. Peritoneal Equilibration Test	up to P5,000.00 per member per year
x. Spinal Angiogram	
y. Any other complex diagnostic procedure not mentioned above	
54. Professional fee of the assisting physician in surgical procedures	up to the maximum benefit limit per member per year
55. Assistance in administrative requirements through the liaison officer	up to the maximum benefit limit per member per year
56. All other items related to the management of the case	up to the maximum benefit limit per member per year

VI. EMERGENCY CARE SERVICES.

HEALTH CARE BENEFITS	COVERAGE/LIMIT
1. **EMERGENCY CARE IN MEDICARD ACCREDITED HOSPITALS/CLINICS** In cases of emergency where the MEMBER avails of the services of MediCard Accredited Hospitals/ Clinics, the following will be provided: a. Doctor's services b. Medicines used during treatment or for immediate relief c. Oxygen and intravenous fluids d. Dressings, plaster casts, and sutures e. Laboratory, x-ray and other diagnostic examinations directly related to the emergency management of the patient-MEMBER	up to the maximum benefit limit per member per year
2. **EMERGENCY CARE IN NON-MEDICARD 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-MediCard accredited hospital for treatment. b. MediCard shall pay the said amount when it is verified that MediCard 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-MediCard Accredited Hospitals for emergency care is follow up care.	MediCard agrees to reimburse eighty percent (80%) of the approved total hospital bills and of professional fees, based on MediCard relative value for accredited hospitals, up to the maximum benefit limit.
3. **EMERGENCY CARE IN FOREIGN COUNTRIES** In cases of emergency where a MEMBER avails of services in a foreign territory.	MediCard shall reimburse one hundred percent (100%) of the approved total hospital bills and of professional fees, based on the MediCard relative value and in Philippine currency, up to P30,000.00.

4. Ambulance services (land transport) are covered on a reimbursement basis up to P2,500.00 per member per year.
5. In cases of non-availability of room according to plan during emergency case, MEMBER may avail of the next higher room available except suite room within the first twenty-four (24) hours of confinement upon admission. All incremental costs incurred after the first twenty-four (24) hours shall be for the personal account of the MEMBER, except when the Accredited Hospital issues a certification of non-availability of the MEMBER's room and board accommodation.

VII. OTHER BENEFITS & CONSIDERATIONS

1. 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***			
	Regular Private		***Large Private***	***Suite up to Plan 8000***
	With P200,000.00 maximum benefit limit	With P250,000.00 maximum benefit limit		
In-patient				
Approved hospital bills**	80% up to P30,000.00	80% up to P50,000.00	80% up to P75,000.00	80% up to P100,000.00
Professional Fees	70% based on MRV* up to the maximum benefit limit	75% based on MRV* up to the maximum benefit limit	80% based on MRV* up to the maximum benefit limit	100% based on MRV* up to the maximum benefit limit
Out-patient				
Consultation Fee	Five (5) consultations at P250.00 per consultation	Ten (10) consultations at P300.00 per consultation	Fifteen (15) consultations at P350.00 per consultation	Unlimited consultations at P350.00 per consultation
Approved laboratory/diagnostic examinations**	80% up to P5,000.00	80% up to P10,000.00	80% up to P12,000.00	100% up to P20,000.00

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

Note: The above benefits are subject to the provisions on room accommodation, claims and reimbursement provision of this Agreement.

2. LIFELINE 16-911 MEDICAL, INC.

Access to LIFELINE: Eight (8) ambulances and four (4) emergency motorbikes complement the Lifeline Quick Response Services. The schedules of benefits are as follows:

a. Access to Lifeline's 24-hour Emergency Hotline **16-911** 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 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: MediCard 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 MediCard for ambulance services, or if the case is not covered (e.g. self-inflicted injuries, alcoholic intoxication, attempted suicide, etc.). MEMBER shall give his name, company name and account number, and sign the MediCard-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 Lifeline Arrows 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.

The foregoing benefit is subject to the continuance of the memorandum of agreement between the MediCard and LIFELINE 16-911 MEDICAL, INC.

3. Member is also entitled to benefits based on the table below:

HEALTH CARE BENEFITS	COVERAGE/LIMIT			
	Regular Private		***Large Private***	***Suite up to Plan 8000***
	With P200,000.00 maximum benefit limit	With P250,000.00 maximum benefit limit		
3.1 Executive Check-Up at MediCard free-standing Clinics (for Principal Member and one (1) enrolled adult dependent)	Primary Package	Expanded Package	Expanded plus choice of one (1) test: Kidney Functions, Liver Functions, Thyroid Functions or Diabetes Functions	Expanded plus choice of two (2) tests:
3.2 Out-Patient medicine reimbursement, provided that, official receipts and prescription from an accredited doctor are submitted.	P3,000.00	P4,000.00	P5,000.00	P8,000.00
3.3 Additional limit for accidents	P50,000.00	P100,000.00	P150,000.00	P200,000.00
3.4 Diamond Peel/Facial/Revitale or Thermolift to be done at MediCard Skin and Body Clinic:	Diamond Peel up to three (3) sessions	Diamond Peel up to three (3) sessions or Facial up to	Diamond Peel or Facial up to five (5) sessions; &	Diamond Peel up to ten (10) sessions or Facial up to

		two (2) sessions	Revitale or Thermolift up to two (2) sessions	five (5) sessions; & Revitale or Thermolift up to five (5) sessions
3.5 Weight Management/Nutrition Program at MediCard Lifestyle Centre				
3.6 Use of MediCard Lifestyle Centre – Fitness Center (exclusive of personal trainer)				
3.7 Use of MediCard Lifestyle Centre – Conference Room (maximum of four (4) hours)	One-time	Twice (2x) a year		Three times (3x) a year

4. Assist America services shall be provided as stipulated in the Service Certificate (Schedule "C").

VIII. PRE-EXISTING CONDITIONS COVERAGE. This shall be based on the year of membership as follows:

For Regular Private Plan with P200,000.00 maximum benefit limit:

Year of membership	Amount of Coverage
1st year	Up to P5,000.00 per illness per member per year
2nd year of continuous membership onwards	Up to P5,000.00 per illness per member per year provided that the pathogenesis or onset of such illness, injury or adverse medical condition started prior to membership or during the first twelve (12) months from the effectivity date of membership; otherwise, up to the maximum benefit limit per illness per member per year

For Regular Private Plan with P250,000.00 maximum benefit limit:

Year of membership	Amount of Coverage
1st year	Up to P10,000.00 per illness per member per year
2nd year of continuous membership onwards	Up to P10,000.00 per illness per member per year provided that the pathogenesis or onset of such illness, injury or adverse medical condition started prior to membership or during the first twelve (12) months from the effectivity date of membership; otherwise, up to the maximum benefit limit per illness per member per year

For Large Private Plan:

Year of membership	Amount of Coverage
1st year	Up to P15,000.00 per illness per member per year
2nd year of continuous membership onwards	Up to P15,000.00 per illness per member per year provided that the pathogenesis or onset of such illness, injury or adverse medical condition started prior to membership or during the first twelve (12) months from the effectivity date of membership; otherwise, up to the maximum benefit limit per illness per member per year

For Suite up to Plan 8000:

Year of membership	Amount of Coverage
1st year	Up to P20,000.00 per illness per member per year
2nd year of continuous membership onwards	Up to P20,000.00 per illness per member per year provided that the pathogenesis or onset of such illness, injury or adverse medical condition started prior to membership or during the first twelve (12) months from the effectivity date of membership; otherwise, up to the maximum benefit limit per illness per member per year

IX. We do not offer MEMBERS' FINANCIAL ASSISTANCE in our package; we just endorse it to a third party namely: Prudential Guarantee and Assurance, Inc. and First Life Guarantee Life Assurance Company, Inc.; MEMBER will contract with them directly.

Schedule B – VIP Membership Fees

(A separate page will be reissued reflecting the actual Room and Board and Membership Fees after payment.)

Template only:

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

Classification	*Annual Membership Fee*			
	Regular Private		*Large Private*	*Suite up to Plan 8000*
	Maximum Benefit Limit			
	P200,000.00	**P250,000.00**	**P300,000.00**	**P500,000.00**
Principal Member Only	P_____.00	P_____.00	P_____.00	P_____.00
Principal + 1 dependent	P_____.00	P_____.00	P_____.00	P_____.00
Principal + 2 dependents	P_____.00	P_____.00	P_____.00	P_____.00
Principal + 3 dependents	P_____.00	P_____.00	P_____.00	P_____.00
Principal + 4 dependents	P_____.00	P_____.00	P_____.00	P_____.00
In excess of 4 dependents (per dependent)	P_____.00	P_____.00	P_____.00	P_____.00
Principal Member (61 to 65 years old)	P_____.00	P_____.00	P_____.00	P_____.00

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

Notes:

1. Above rates are inclusive of 12% VAT.
2. The room and board plan of the Dependent Members should not be higher or better than the plan of their Principal Member. Dependents plan of each Principal should be uniform.

Schedule C – Assist America

assist america®

Service Certificate

MediCard has arranged through an agreement with Assist America Asia Limited, 20/F Printing House, 6 Duddell Street, Central, Hong Kong (hereinafter known as "AAAL") to make available to employers the following Assist America services.

Members of the **VIP Plan** are eligible for the services described herein, namely those employees covered under the provisions of medical insurance provided through MediCard.

Now, therefore, AAAL agrees to provide Participants the Assist America services as described below under Service membership # 63-AL-MDC-06083. All services described below, subject to certain limited exclusions as set forth in this Certificate, are provided by AAAL when Participants are travelling 150 kilometres or more away from his/her primary, legal residence or in another country which is not his/her country of residence for less than 90 days. All services must be arranged by AAAL. No claims for reimbursement are accepted.

AAAL's Assist America program makes the following benefits available to Participants:

Medical Consultation, Evaluation and Referral: Participants have access to an Operations Center with multilingual staffs on duty 24 hours a day, 365 days a year. Medical personnel are available for medical consultation, evaluation and referrals to Western-trained physicians.

Hospital Admission Guarantee: AAAL will validate a Participant's medical insurance, as applicable or advance funds to a medical facility, to facilitate Participant's admittance to a foreign medical facility, as necessary. The Participant must repay any emergency hospital admittance deposit paid by AAAL within 45 days. Participants, through their health plan or other means, are responsible for costs incurred for medical services rendered by the treating medical facility.

Emergency Medical Evacuation: When an adequate medical facility is not available proximate to where the Participant is located, as determined by the AAAL physician and the consulting physician, AAAL will arrange an emergency evacuation, with medical supervision, by an appropriate means to the nearest medical facility capable of providing the required care at no cost to the Participant.

Medical Repatriation: When medically necessary, as determined by the AAAL physician and the consulting physician, repatriation under medical supervision at no cost to the Participant, to the Participant’s legal residence or to a medical or rehabilitation facility near Eligible Participant’s residence, at such time as the Participant is medically cleared for travel via commercial carrier, provided the repatriation can be accomplished without compromising the Participant’s condition. If the time period to receive medical clearance to travel by common carrier exceeds fourteen days from the date of discharge from the hospital, an appropriate mode of transportation may be arranged, such as an air ambulance. Medical or non-medical escorts may be provided as necessary.

Medical Monitoring: Monitoring of Eligible Participant’s condition by medical personnel who will (i) stay in regular communication with the attending physician and/or hospital and (ii) relay necessary and legally permissible information to family members.

Transportation to Join Patient: Provide a designated family member or personal friend with an economy, round-trip, common carrier transportation to the major airport closest to the place of hospitalization, provided the Participant is travelling alone and is projected to be hospitalized for more than seven consecutive days. It is responsibility of the family member or the friend to meet all visas and document requirement, if applicable.

Prescription Assistance: AAAL will aid in replacing a prescription when possible and legally permissible and upon consulting with the Eligible Participant's attending physician. Participant is responsible for the cost of the prescription.

Care of Minor Child(ren): When a minor child(ren) is left unattended as the result of a Participant's medical emergency, AAAL will provide the child(ren) with one-way economy

common carrier the place of residence of the minor child(ren). An attendant will escort the child(ren) if required.

Emergency Message Transmission: AAAL will receive and transmit emergency messages to/from home.

Return of Mortal Remains: In the event of a Participant's death, AAAL will arrange and pay for the return of mortal remains at no cost to the Participant. AAAL will render any assistance necessary in the transport including locating a local, licensed funeral home, mortuary or direct disposition facility to prepare the body for transport, completing all documentation, obtaining all legal clearances, procuring consular services (for death overseas), providing death certificates, purchasing the minimally necessary casket or air transport container, as well as transporting the remains, including retrieval from site of death and delivery to receiving funeral home.

Interpreter and Legal and Referrals: AAAL will provide the Participant with referrals to interpreters, counsellors or legal personnel, as requested.

Emergency Cash Coordination: AAAL will assist in coordinating the transfer of emergency cash. Source of funds is the responsibility of Participant.

Lost Luggage or Document Assistance: AAAL helps Eligible Participants locate lost luggage, documents, personal belongings or assist with travel tickets replacement.

Pre-trip Information: AAAL will provide other support assistance services, such as Web-based country profile that includes visa requirements, immunizations and inoculation recommendations, embassy and consulate information, country-specific details and security advisories as well as other pertinent information for travel destinations.

Fulfillment/Communication Material: AAAL will provide Identification Cards for Participants with the telephone numbers necessary to access an Operations Center.

The Company and Participant hereby acknowledge that AAAL's obligation to provide or contract for the above services is subject to the following conditions/exclusions:

Conditions:

AAAL will not provide services in the following instances:

- ♦ Travel undertaken specifically for securing medical treatment
- ♦ Injuries resulting from participation in acts of war or insurrection
- ♦ Commission of an unlawful act(s)
- ♦ Attempt at suicide
- ♦ Incidents involving the use of drugs unless prescribed by a physician
- ♦ Transfer of Participant from one medical facility to another medical facility of similar capabilities and providing a similar level of care

AAAL will not evacuate or repatriate a Participant:

- ♦ Without medical authorization
- ♦ With mild lesions, simple injuries such as sprains, simple fractures, or mild sickness which can be treated by local doctors and do not prevent the Participant from continuing his/her trip or returning home
- ♦ With a pregnancy with a term of over six months
- ♦ With mental or nervous disorders unless hospitalized

Exclusions:

- ♦ Travel by a Participant's spouse when it is for the benefit of the spouse's employer (spouse business travel)
- ♦ Trips exceeding 90 days from legal residence without prior notification to AAAL. (Separate purchase of Expatriate coverage is available)
- ♦ Students at home/school campus address (as they are not considered to be in travel status)

Legal actions arising hereunder shall be barred unless written notice thereof is received by AAAL within one (1) year from the date of event giving rise to such legal action.

While assistance services are available worldwide, transportation response time is directly related to the location/jurisdiction where an event occurs. AAAL is not responsible for failing to provide services or for delays in the delivery of services caused by strikes or conditions beyond its control, including by way of example and not by limitation, weather conditions, availability of airports, flight conditions, availability of hyperbaric chambers, communications systems, or where rendering of service is limited or prohibited by local law or edict.

All consulting physicians and attorneys are independent contractors and not under the control of AAAL. AAAL is not responsible or liable for any malpractice committed by professionals rendering services to a Participant.

The Company must reimburse AAAL for any service rendered upon its request that is beyond the scope of this Certificate.

The Company is responsible for distributing Identification Cards (as described above) to Participants. The Company's failure to maintain in-force the insurance policy cited above will invalidate the described program as to the Participant and AAAL will have no obligation to provide any service to the Participant.

The Company hereby acknowledges its appointment of MediCard to be available to verify a Participant's participation under this Certificate ("Designee"). There may be circumstances under which AAAL reasonably believes that a sick or injured person is a Participant but cannot verify participation through the Designee, and, in the opinion of that person's then attending physician, an evacuation or repatriation is medically imperative. In such an event, the Company acknowledges its responsibility to verify participation at the earliest possible time but in no event shall the verification be later than 72 hours from AAAL's initial verification inquiry. AAAL will not hold the Company financially responsible for services rendered pending verification during the 72-hour period.

AAAL is not affiliated with the provider of the Company's Medical Health Service Program cited above, and such provider shall not be held liable or responsible for any acts or omissions by AAAL in connection with or arising under the rendering of services described herein.

Assist America Asia Limited or its authorized representative assist america® is a registered service mark of Assist America, Inc.