# Contract for Health Care Services

**THE PUBLIC IS INFORMED:**

This CONTRACT is executed between:

The **BASES CONVERSION AND DEVELOPMENT AUTHORITY**, a government instrumentality vested with corporate powers, created by virtue of Republic Act No. 7227, as amended, with office and postal address at the BCDA Corporate Center, 2/F Bonifacio Technology Center, 31st Street Corner 2nd Avenue, Bonifacio Global City, Taguig City, represented herein by its Executive Vice President, AILEEN ANUNCIACION R. ZOSA, who is duly authorized for this purpose under Item No. 178, page 27 of the BCDA Manual of Approval dated 22 November 2017, hereinafter referred to as "**BCDA**";

- and -

The **PHILIPPINE BRITISH ASSURANCE COMPANY, INC.**, a Corporation duly organized and existing under Philippine laws, with principal office at Penthouse, Morning Star Center Bldg., 347 Sen. Gil Puyat Avenue Extension, Makati City, represented in this act by its Assistant Vice President for Accident and Health, **ATTY. JENNIFER U. JUANILLO**, duly authorized for this purpose as evidenced by the Secretary's Certificate dated 17 May 2018, a certified true copy of which is hereto attached as Annex "A" and made an integral part hereof, hereinafter referred to as the "**CONTRACTOR**";

**BCDA** and the **CONTRACTOR** may hereinafter be referred to collectively as "PARTIES" and individually as "PARTY".

**- ANTECEDENTS -**

**BCDA** is mandated under Republic Act No. 7227, as amended by Republic Act No. 7917, to accelerate the sound and balanced conversion into alternative productive uses of the military reservations and their extensions, to raise funds by the sale of portions of Metro Manila military camps, and to apply said funds for the development and conversion into alternative productive uses of these properties.

In pursuance of its mandate, **BCDA** is committed to look after the welfare of its employees in order to maintain a healthy workforce to ensure productivity.

Pursuant to the Omnibus Rules Implementing Book V of Executive Order No. 292, each agency shall be responsible for the creation of an atmosphere conducive to the improvement of employee morale and towards this end, make provisions for the establishment of units responsible for the maintenance of employee health and welfare, among others.

**BCDA** is in need of a health care service provider to service the health care needs of its employees and for this purpose, conducted a bidding in compliance with Republic Act No. 9184 for the selection of a health care service provider.

Upon evaluation of the eligibility documents and bids, the Bids and Awards Committee (BAC) for Goods recommended that the Contract for Health Care Services be awarded to the **CONTRACTOR** since the proposal submitted by it has been found to be the most favorable and advantageous to **BCDA**.

The **BCDA** Executive Vice President approved the recommendation of the BAC for Goods and awarded the contract to the said **CONTRACTOR**.

**ACCORDINGLY**, for and in consideration of the foregoing premises, and for the stipulations and conditions hereinafter stated, the parties hereto hereby agree and bind themselves to the following:

## I. CONTRACT DOCUMENTS

A. The following documents shall form integral parts of this Contract as fully as if the contents of the said documents are reproduced, incorporated and set forth herein, and shall govern and control in full force and effect the rights and obligations of the Parties, except as otherwise modified by the terms and conditions of the Contract, or by mutual agreement of both Parties in writing, and by the provisions of relevant laws, codes, ordinances, rules and regulations of the government:

Annex "A" - **CONTRACTOR's** Secretary's Certificate;

Annex "B" - Bidding Documents;

Annex "C" - **CONTRACTOR's** Bid, including the Eligibility requirements, Technical and Financial Proposals and all other documents/statements submitted;

Annex "D" - Performance Security;

Annex "E" - Notice of Award with **CONTRACTOR's** "Conforme";

Annex "F" - Tax Clearance issued by BIR; and

Annex "G" - Other pertinent documents as may be required by **BCDA** and the Commission on Audit (COA).

B. All contract documents are and shall remain property of **BCDA**.

C. All documents which have been or may hereinafter be executed by the Parties shall likewise form integral parts of this Contract.

D. It is expressly agreed and understood that in case of conflict between this Contract and the provisions of the Contract Documents, the former shall prevail.

## II. DEFINITION OF TERMS

For purposes of this Contract, the following terms, words, and phrases shall mean and be understood as follows:

A. "**COORDINATOR**" - a licensed physician whose services have been engaged by the **CONTRACTOR** to provide, among others, the following services to Planholders: medical consultations and treatment, prescriptions, referrals to accredited specialist/s hospital, clinic, requests for laboratory examinations, and arrangement for services, including but not limited to, hospitalization.

B. "**ACCREDITED SPECIALIST**" - physicians engaged by the **CONTRACTOR** to provide specialty care and to whom the Coordinator may refer the Planholder.

C. "**ACCREDITED HOSPITAL**" - any public or private hospital contracted by the **CONTRACTOR** to provide medical and hospital services to Planholders under terms and conditions specified in this Contract.

D. "**ACCREDITED MEDICAL CLINIC**" - a duly licensed out-patient medical and Health Care facility as the **CONTRACTOR** may establish or designate for the purpose of providing out-patient care to Planholders. It shall also mean a private medical facility which is capable of providing complete medical, diagnostic and therapeutic facilities, and which the **CONTRACTOR** has an existing Mutual Accreditation Agreement with.

E. "**HEALTH PROFESSIONALS**" - duly accredited physicians, nurses, and allied health professionals who have been duly authorized by the **CONTRACTOR** to provide medical services to Planholders.

F. "**ID CARD**" - the Membership Identification Card issued by the **CONTRACTOR** to the Planholder. It contains, among others, the following information: name of the Planholder, ID number, card number, Planholder's signature and other membership information which the **CONTRACTOR** may deem necessary to include therein.

G. "**CONTRACT**": This Contract for Health Care Services executed by and between **BCDA** and the **CONTRACTOR** contains the effective date, benefits, coverage, claims, limitations and exclusion of benefits, mode of payment of membership fees, termination of coverage and other matters relevant to the relationship between the Planholder and **CONTRACTOR**. The application for membership duly submitted by the accepted Planholder, and the ID Card, form part of this Contract for Health Care Services, together with any and all endorsements, which may be incorporated thereto.

H. "**CONVALESCENT CARE**", "**INTERMEDIARY CARE**" and/or "**REHABILITATION CARE**" - care to help restore a Planholder's ability to function as normally as possible after a disabling illness or injury.

I. "**CUSTODIAL OR MAINTENANCE CARE**" - care furnished primarily to provide room and board (which may or may not include nursing care, training, personal hygiene, and other forms of self or supervisory care); or care furnished to a person who is physically or mentally disabled, or both, and when any of the following conditions are present.

   1. the person is not under any specific medical, surgical or psychiatric treatment to reduce the existing disability to the extent medically necessary to enable the patient to live outside an institution providing such care; or

   2. when despite such treatment, there is no reasonable possibility that the disability will be reduced or diminished.

J. "**DOMICILIARY CARE**" - care provided in a Planholder's residence.

K. "**DUE DATE**" - the date when Membership Fees should be received by the **CONTRACTOR** office as determined by the agreed mode of payment. For annual mode of payment, this pertains to the Effective Date of the Contract. For other modes of payment, this refers to the Effective Date and all the first days of the period covered by the mode of payment.

L. "**EFFECTIVE DATE**" - the date agreed upon by the Parties as stated in Article IX (A) of this Contract.

M. "**IN-PATIENT MEDICAL SERVICES**" - medical services provided to a Planholder confined in an Accredited Hospital under the services of a Health Professional. It includes accommodation, medicines and supplies, professional services, laboratory, diagnostic examinations and/or ancillary procedures normally furnished and charged by the Accredited Hospital to a registered bed patient.

N. "**OUT-PATIENT SERVICES**" - medical services provided to a Planholder in the office or clinic of a Health Professional. It includes consultations, treatment and requests for laboratory, diagnostic examinations and/or ancillary procedures, but not as an in-patient.

O. "**EMERGENCY CONDITION**" - an illness or injury of unexpected onset that manifests acute symptoms with sufficient severity or pain, which at the time of occurrence, in the absence of immediate medical attention, could reasonably appear to have the potential of causing: (1) serious bodily dysfunction; (2) immediate disability; and/or (3) death.

P. "**PLANHOLDER**" - the principal member or his/her enrolled dependent/s

   1. "**PRINCIPAL MEMBER**" - an employee of **BCDA** and its subsidiaries, or any individual who render services to **BCDA** whom **BCDA**, at its sole discretion may include, who are enrolled under Private Plan covered by this Contract.

   2. "**DEPENDENT**" means:

a. The lawful spouse;
b. All eligible (legitimate, illegitimate or adopted) children and stepchildren of the principal, from fifteen (15) days old to twenty-one (21) years old;
c. Both parents below sixty-five (65) years old, if the employee is single or a widow/er with no children;
d. All siblings from fifteen (15) days old to twenty-one (21) years old, if the employee is single or a widow/er with no children.
e. All dependents who are enrolled with **BCDA's** health care service provider for the previous contract period regardless of age and civil status.

Q. "**SOPHISTICATED PROCEDURE**" - Treatment procedure/s or diagnostic examination/s for which there are no comparable conventional or traditional equivalents or counterparts.

R. "**NEW MODALITIES**" - New treatment procedure/s add or examination/s that have been generally accepted as medically necessary for the diagnosis and/or treatment of specific medical conditions, and for which there are no comparable conventional or traditional equivalents or counterparts.

S. "**SCREENING TEST**" - A test for a particular disease done on members who have no signs and symptoms of the disease.

T. "**CONGENITAL DISORDERS**" - Conditions that maybe manifested at birth or recognized until later in life, which are medically considered to be the result of either genetic abnormalities, errors of intrauterine morphogenesis or development, or a chromosomal abnormality.

U. "**PHIC**" - the Philippine Health Insurance Corporation (a.k.a. Philhealth) established under Republic Act No. 7875, otherwise known as the "National Health Insurance Act of 1995".

V. "**SERVICE AREA**" - the territorial jurisdiction of the Republic of the Philippines.

W. "**MEDICO-LEGAL CASE**" - any medical case or situation involving a covered member where a Medical Report is required by law to be submitted by the attending doctor, hospital or clinic to the police authorities.

X. "**MAXIMUM COVERAGE BENEFIT**" - notwithstanding any provisions to the contrary, the aggregate liability of the **CONTRACTOR** for all benefits under this Contract, per illness per contract year, not to exceed the limits specified in Annex "C". The Maximum Coverage Benefit shall include all covered expenses incurred in undergoing the treatment for an illness or injury, inclusive of Philhealth (PHIC) benefits.

Y. "**EXCESS IN ROOM AND BOARD**" - the actual difference in room rates for transfer to a Room and Board accommodation higher than the Planholder's room category.

Z. "**INCREMENTAL RATE CHARGES**" - the adjustment in charges for hospital ancillary services, professional fees, medicines, operating room and supplies resulting from the transfer by a Planholder to a Room and Board Accommodation not included in his enrolled program and higher than his allowable benefit. It shall be computed as follows:

1. An additional Thirty Percent (30%) for one step-up transfer shall be charged on top of the Original Charges to a Room and Board accommodation higher in category than the Planholder's allowable benefit (except a Suite Room) (i.e. from Ward to Semi-Private; Semi-Private to Private).

2. An additional Fifty Percent (50%) for two step-up transfer shall be charged on top of the Original Charges to a Room and Board accommodation higher in category than the Planholder's allowable benefit (except a Suite Room) (i.e. from Ward to Private).

## III. PRINCIPAL MEMBERSHIP

A. Eligibility for Principal Membership

1. All employees of **BCDA** and its subsidiaries, which **BCDA** may include at its sole discretion, are eligible for principal membership in the Private Plan under this Contract.

2. **BCDA**, at its sole discretion, may include other individuals who render services to **BCDA** as principal members.

3. It is a pre-requisite that all enrollees must be members of the PHIC in good standing before they are included as Planholders under this Contract. However, in case, there are Planholders enrolled who are not PHIC members, such Planholders shall pay and be accountable for the PHIC portion of the total hospital bills and professional fees as determined by the hospital.

4. The number of employees/principal members may increase or decrease at the discretion of **BCDA** depending on the manpower complement of **BCDA**.

5. **BCDA** reserves the right to include or delete Planholders upon notification to the **CONTRACTOR**, subject to the same terms and conditions herein provided.

B. Membership Fees

The Schedule of Membership Fees is shown in Annex "C". Membership Fees shall be paid by **BCDA** to the **CONTRACTOR** on or before the Due Date. Payments shall be made at any of duly authorized payment centers or authorized collectors of the **CONTRACTOR**. The **CONTRACTOR** shall issue an Official Receipt for any payment made by **BCDA**.

Delay in the payment of Membership Fees exceeding thirty (30) days shall give the **CONTRACTOR** the right to suspend the benefits and privileges of the Planholders in delay.

C. Addition and Deletion of Principal Plan Holders

The coverage of the additional Principal Members shall be on the date of regularization of his employment with **BCDA**. Written notice thereof shall be given to the **CONTRACTOR** within thirty (30) days before or after regularization.

For Planholders enrolled by **BCDA** after six (6) months from the effective date of this Contract, their Plan Fees and Maximum Coverage Benefit shall be computed on a pro-rata basis proportionate to the remaining months of their membership.

Formula: MCB/12 Months x Remaining months of membership
= PRO-RATED MCB

PF/12 Months x Remaining months of membership
= PRO-RATED PF

Should the Contract or any Membership covered thereby be pre-terminated, **BCDA** shall be entitled to a refund of Membership Fees in accordance with the following schedule:

| If Contract/Membership has been in force for: | % of Annual Membership Fees to be Refunded |
|---|---|
| Not more than one month | 80% |
| More than 1 month but less than 2 months | 70% |
| More than 2 months but less than 3 months | 60% |
| More than 3 months but less than 4 months | 50% |
| More than 4 months but less than 5 months | 40% |
| More than 5 months but less than 6 months | 30% |
| Six months or more | No Refund |

Provided, however, that a) fees paid for processing applications shall not be refundable; and b) neither the Planholders nor any of their Dependents have availed themselves of any of the health care benefits under the Contract during the period of coverage.

D. ID Card

The **CONTRACTOR** will provide free replacement of Planholder's membership card once during the contract period in case of loss or damage.

The membership card of an employee should bear the name of his/her specific agency in which he/she belongs, i.e. Bases Conversion and Development Authority.

The membership card shall be made available to all members within ten (10) working days upon enrollment.

## IV. DEPENDENTS

A. Eligibility for Dependent Membership

Principal Planholders may enroll their Dependents as defined in this Contract. **BCDA** may, subsequent to the signing of this Contract, request for the inclusion of additional Dependents, or deletion of current Dependents. The number of Dependents shall in no way depend on the number of Principal Members.

B. Enrollment Period

Enrollment period for dependents is limited to thirty (30) days from the date of effectivity of membership of the Principal Member. After the period specified above, the **CONTRACTOR** may no longer receive, evaluate and accept any designation or application of qualified dependents from any principal member.

Additional dependents may be accepted after the thirty (30) day enrollment period in cases of newborn child, newly married spouse and dependent of newly regularized and/or promoted employees, provided they are enrolled within thirty (30) days of eligibility (e.g. childbirth, marriage, regularization of employment status or job promotion).

C. Hierarchy of Dependents

In the event that not all Dependents of a Principal Member are enrolled, the following decreasing order of preference must be followed:

1. in case of unmarried Principal Members: (i) children; (ii) parents; (iii) siblings;
2. in case of married Principal Members: (i) lawful spouse; (ii) children, from the eldest to the youngest

"DEPENDENT" means:

1. In the case of an unmarried Principal Member, 1st priority - (eldest to youngest) all eligible (legitimate, illegitimate or adopted) children and stepchildren of the principal, from fifteen (15) days old to twenty-one (21) years old; 2nd priority - father below sixty-five (65) years of age; 3rd Priority - mother below sixty-five (65) years of age; and 4th priority - (eldest to youngest sibling) all siblings from fifteen (15) days old to twenty-one (21) years old (There shall be no substitution in the abovementioned hierarchy, except where a dependent is already covered in a plan under a separate health care provider).

2. In the case of a married Principal Member, 1st priority - his/her legitimate spouse who is below sixty-five (65) years of age; 2nd priority - (eldest to youngest children) all eligible (legitimate, illegitimate or adopted) children and stepchildren of the principal, from fifteen (15) days old to twenty-one (21) years old (There shall be no substitution in the abovementioned hierarchy, except where a dependent is already covered in a plan under a separate health care provider).

3. Dependents of Principal Members who were enrolled with **BCDA's** previous health care service provider regardless of age and civil status

D. Addition and Deletion of Dependents

The effectivity date of the inclusion of additional Dependents shall be the date of approval by the **CONTRACTOR** of their application. The effectivity of all deletions in the list of Dependents shall be upon approval by the **CONTRACTOR**.

## V. BENEFITS

A. Covered Services

The **CONTRACTOR** shall provide to Principal Members and their Dependents within the Service area, the health care services listed herein, and **BCDA** shall pay the **CONTRACTOR** the Membership Fees listed in Annex "C", subject to the terms and conditions stated herein.

B. Maximum Coverage Benefit

Notwithstanding any provisions to the contrary, the aggregate liability of the **CONTRACTOR** for all benefits under this Contract per illness per contract year, including the out-patient benefit and prescribed medicines limit, not to exceed the limits specified in Annex "C". The Maximum Coverage Benefit shall include all covered expenses incurred in undergoing the treatment for an illness or injury, exclusive of Philhealth (PHIC) benefits.

C. Out-Patient Benefit

1. Any reasonable number of consultations, during regular clinic hours. Expenses for prescribed medicines, nebulization kit and nebules used in nebulization, are not covered and shall be for the sole account of the Planholder;
2. Eye, ear, nose and throat (EENT) care;
3. Treatment for minor injuries such as lacerations, mild burns, sprains, strains, fractures, etc., excluding the cost of medicines;
4. X-rays, laboratory examinations and diagnostic procedures prescribed by the Hospital Coordinators and accredited specialists;
5. Referrals to affiliated specialists;
6. Minor surgical procedures not requiring confinement; and
7. Total of fourteen (14) pre & postnatal consultations excluding laboratory work-ups.

D. Preventive Healthcare

1. Immunization, excluding the cost of vaccines;
2. Medical management of health problems;
3. Health education and counseling on diets and exercises;
4. Family planning counseling;
5. Record keeping of medical history;
6. Annual Physical Examination (APE) for all Planholders (principal members and dependents) can be availed of starting on the 2nd to 3rd month after the effectivity date to be conducted at the ActiveOne located at 2/F Bonifacio Technology Center, 31st St., cor. 2nd Avenue, Bonifacio Global City, Taguig. The APE shall include the following:

    a. Physical Examination;
    b. Chest X-ray;
    c. Medical History;
    d. Eye Refraction;
    e. Stool Examination (Fecalysis);
    f. Urine Examination (Urinalysis);
    g. Complete Blood Count (CBC);
    h. Electrocardiogram (ECG) for adults thirty-five (35) years old & above; or if medically indicated and prescribed by accredited HMO health professional; and

i. Pap Smear for females thirty-five (35) years of age or older; or if medically indicated and prescribed by accredited HMO health professional

Planholders can also avail the APE benefit at any accredited HMO clinics. In areas where there is no accredited clinic, the planholder can reimburse the actual cost of the above procedures.

7. Ambulatory Laboratory Services – Patients who are required by the accredited physician to have a regular blood exam on a quarterly basis can avail of the procedure at the ActiveOne.

E. In-Patient Care

1. Room and Board, but not to exceed the amount per schedule.

   a. PRIVATE PLAN: Room and Board Accommodation up to a maximum of Open Private Room per day of confinement;

      Open Private Room Accommodation shall not be subject to a stepladder policy in securing a room in an Accredited Hospital.

   b. SEMI-PRIVATE PLAN: Room and Board Accommodation up to a maximum of Open Semi-Private Room per day of confinement

      Principal members shall automatically be covered under Private Plan. Dependents shall have the option to choose between Private and Semi-Private Plans.

2. Use of Operating and Recovery Rooms;

3. The following medical procedures are covered subject to pre-existing condition provisions, exclusions and limitations and all antecedent expense, as charged subject to Maximum Coverage Benefit:

   a. 24 Hour Holter Monitoring;
   b. 2D Echo with Doppler;
   c. Angiography;
   d. Arthroscopic Knee Surgery Procedure/Arthroscopic Procedure/Orthopaedic Surgery;
   e. Benign Prostatic Hypertrophy Treatment;
   f. Bone Mineral Density/Densitometry Scan (Dexascan);
   g. Brachytheraphy;
   h. Cataract Surgery excluding cost of lens;
   i. Chemotherapy/Radiotherapy;
   j. Cryosurgery;
   k. CT Scan;
   l. EEG Electroencephalography;
   m. Electromyography, Nerve Conduction Velocity Studies;
   n. Endoscopy including one video;
   o. Eye Laser Therapy (for cataract extraction, retinal detachment and glaucoma, except for correction of error of refraction such as myopia, astigmatism & hyperopia);
   p. Flourescein Angiogram;
   q. Gamma Knife Surgery;
   r. Herniorraphy acquired;
   s. Hysterescopic myoma resection/procedures;
   t. Hysterospically Guided D&C;
   u. Laparoscopic Procedures;
   v. Laser Tonsillectomy;
   w. Lithotripsy (ESWL);
   x. Mammography & Sonomammogram;
   y. M-Mode Echocardiogram;
   z. MRI;
   aa. Myelogram;
   bb. Nuclear Radioactive Isotope Scan;
   cc. Open Heart Surgery including Angioplasty;

dd. Organ transplants except donors expenses;
ee. Orthopedic Surgery;
ff. Out-patient Chemotherapy;
gg. Out-Patient Dialysis renal or peritoneal;
hh. Out-Patient Physical/ Speech Therapy;
ii. Percutaneous ultrasonic nephrolithotomy;
jj. Position Emission Tomography (PET Scan);
kk. Pulmonary Perfusion Scan;
ll. Pyrosphoshate Scintigraphy;
mm. Sclerotheraphy;
nn. Sleep Study unless directly related to an organic illness;
oo. Stereotactic Brain Biopsy;
pp. Stereotactic Radiosurgery;
qq. Thallium Scintigraphy;
rr. Trans urethral Microwave Therapy;
ss. Ultrasound except pregnancy related;
tt. Ventilation & Perfusion Lung Scan; and
uu. Visual Perimetry.

The **CONTRACTOR** shall cover latest modalities of treatment or new medical technologies up to the maximum limit of the plan.

Procedures stated above that requires confinement shall be inclusive of the room and board charges, professional fees, and other incidental expenses relative to the procedures.

Provided that:

a. Included in the maximum liability limits listed above are expenses that are incurred due to:
   i. undergoing the medical procedures, such as hospitalization expenses and professional fees;
   ii. any condition or complication related to the treated illness or to the procedures above mentioned;
   iii. any recurrence of the treated illness or a repetition of said procedures; and
   iv. pre and post-procedure work-ups.

b. In cases where a patient opts to avail of the use of a more expensive sophisticated procedure or treatment (ex. Lithotripsy, laser treatment) when an equally effective surgical procedure is available, the **CONTRACTOR** shall be amenable to the choice of the patient.

c. The availment of special treatment procedures such as Laparoscopic Procedure, Lithotripsy and Arthroscopy are covered regardless of number of availment provided that the procedures are medically indicated and prescribed by accredited HMO health professional.

4. Professional Fees for:

   a. Attending Physicians;
   b. Anesthesiologists;
   c. Surgeons; and
   d. Specialists, when necessary

5. Drugs, medicines and injectables; inhalation therapy

6. Blood transfusions, including human blood products (except gamma globulin), and intravenous fluids;

7. X-rays, laboratory examinations, and diagnostics test ordered by the Health Care Attending Physicians;

8. Dressing, casts (except fiberglass supplies), and sutures;

9. Sports-related injuries incurred during officially-sanctioned sports activities shall be covered up to the Maximum Coverage Benefit. Injuries of the same nature incurred during unofficial sports activities shall be covered up to Thirty Thousand Pesos (P30,000.00);

10. Admission kit shall be covered;

11. All illnesses or conditions, whether work-related or not, of all planholders (whether principal member or dependent), covered up to Maximum Coverage Benefit, subject to Article VII. General Exclusions and Limitations of this Contract;

12. Congenital illnesses/conditions and developmental pediatric disorders of all planholders covered up to a maximum of Fifty Thousand Pesos (P50,000.00);

13. AIDS secondary to accidental blood transfusion or needle injection covered up to the Maximum Coverage Benefit;

14. Slipped disc, spondylosis, spinal stenosis and scoliosis shall be covered up to the Maximum Coverage Benefit;

15. Cauterization of Warts including Facial area shall be covered up to the Maximum Coverage Benefit with no limit per visit except genital warts caused by Sexually Transmitted Disease (STD);

16. Allergy Testing shall be covered up to Seven Thousand Five Hundred Pesos (P7,500.00)/year and Tuberculin Test covered up to Six Hundred Pesos (P600.00)/year when prescribed and not to be done during Annual Physical Examination;

17. Pre-existing illness/conditions of principal members at the start of membership shall be covered up to Maximum Coverage Benefit. Dependents enrolled with the current health care service provider shall also be covered up to Maximum Coverage Benefit. For newly enrolled dependent members, pre-existing coverage is up to Twenty Thousand Pesos only (P20,000.00) during the first three (3) months; Afterwards, pre-existing coverage shall be up to the Maximum Coverage Benefit;

18. Reimbursement of the Professional fee of Neurologist based on the rate of the **CONTRACTOR**;

19. All other items deemed necessary by the attending physician for the medical management of the patient.

Notwithstanding the above provisions, the **CONTRACTOR** shall be liable for hospital and medical expenses and fees of the Health Professionals only up to the Maximum Coverage Benefit per year per illness or condition, including: a) complications thereof; b) Intensive Care Cases (ICU/CCU) and their equivalent; and c) pre-confinement and post-confinement work-up on an out-patient basis.

F. Emergency Cases

1. Emergency Room Treatment includes:

   a. professional fees;
   b. medications used for immediate relief of symptoms;
   c. nebulization;
   d. dressings;
   e. sutures for wounds;
   f. cast (except fiberglass supplies);
   g. first dose of anti-tetanus serum (ATS);
   h. administration of anti-tetanus vaccine (inclusive of cost of vaccine, professional fees and other related materials and fees);
   i. first dose and administration of anti-rabies vaccine (inclusive of cost of vaccine, professional fees and other related materials and fees). Succeeding treatment and

vaccination required shall be covered up to the maximum amount of P5,000.00 per treatment;

j. diagnostic examinations; and
k. Other medical services related to the emergency management of the treated planholder: 100% actual charges for covered items only.

2. Emergency Care in Accredited Hospitals

If the emergency health care was administered in an Accredited Hospital whether as in-patient or out-patient and the illness or conditions is covered under the Plan, the Planholder shall be entitled to full coverage provided that: (a) the Planholder or his representative notifies the **CONTRACTOR** within 24 hours after the emergency has commenced and a prescribed referral was issued by an Authorized Physician; and (b) professional services are provided by Accredited Physicians.

In the event that any of the foregoing conditions are absent, the Planholder shall pay the cost of his medical care, including any amount his Physicians may charge as professional fee, the **CONTRACTOR** shall, thereafter, reimburse the Planholder of up to 100% of the actual cost of coverable benefits availed of, but not to exceed 100% of what the **CONTRACTOR** would have incurred in providing such benefits according to the Plan.

3. Emergency Care in Non-Accredited Hospital

When a planholder requires immediate medical attention, necessitating the use of facilities of a non-accredited hospital, the **CONTRACTOR** shall reimburse at actual cost up to the Maximum Coverage Benefit per emergency case.

This shall be applicable only when the use of accredited hospitals shall entail a delay that may result in death, serious disability or significant jeopardy to his/her life. The **CONTRACTOR** shall pay the corresponding hospitalization according to the amount had the patient been treated in a duly accredited facility subject to the provision stated below, except for follow-up care. The final diagnosis shall be evaluated and approved by the **CONTRACTOR**.

However, if the planholder who was confined during the emergency case in a non-accredited hospital cannot be transferred due to seriousness of the condition, the **CONTRACTOR** shall cover the payment for the same on a reimbursement basis, up to the Maximum Coverage Benefit in accordance with the type of plan.

4. Official Business Trip Abroad

The **CONTRACTOR** shall cover the Planholder's emergency case expense during official business trips abroad of employees, based on the schedule of emergency case in non-accredited hospitals up to the Maximum Benefit Coverage on a reimbursement basis.

5. Areas where there are no Accredited Specialist at the Accredited Hospitals:

In areas with no Accredited Specialist at the Accredited Hospital, for reasons outside the control of the **CONTRACTOR**, such as when there is no specialist to accredit, the **CONTRACTOR** shall cover 100% of the treated members hospital bills and reimburse the professional fees based on the member's Plan and Relative Value Unit (RVU), subject to the Maximum Coverage Benefit.

6. Areas without Accredited Hospital:

In areas with no accredited hospitals/facilities, the **CONTRACTOR** will reimburse the member 100% of the cost of the health services availed of, based on the member's existing Plan, up to the Maximum Coverage Benefit.

G. Network Access

All members are entitled to choose, at their own convenience, any Accredited Hospital, where they want to be treated and where they may consult with any Coordinator(s) in said Hospital, which includes Makati Medical Center (MMC), St. Luke's Medical Center (SLMC-Quezon City), The Medical City, Cardinal Santos Medical Center (CSMC), Asian Hospital Medical Center (AHMC), and St. Luke's Medical Center-Global City (SLMC-Global City).

H. Medico-legal Cases

1. All those classified as medico-legal cases, whether in-patient or out-patient, shall be subject to reimbursement, provided that the duly accomplished required documents are submitted.

2. Requirements for No Fault Injuries must be submitted to the **CONTRACTOR** not later than sixty (60) days from date of discharge.

I. Ambulance Service

The **CONTRACTOR** shall provide ambulance service based on the following benefits:

1. Emergency call and medical telephone advisory service;
2. Ambulance conduction/service based on the limits stipulated below per conduction:

| HOSPITAL | AREA COVERED | MAXIMUM LIMIT |
|---|---|---|
| Accredited to Accredited | Metro Manila | Outright coverage subject to MCB |
| Accredited to Accredited | Province to Manila | P5,000.00 per conduction |
| Non-Accredited to Accredited | Metro Manila | Outright coverage subject to MCB |
| Non-Accredited to Accredited | Province to Manila | P5,000.00 per conduction |

3. Use of equipment in the ambulance such as defibrillator ECG monitor, suction machine, physician specialists, etc;
4. Medical services/doctor's fees; and
5. Medical supplies (i.e. oxygen, medicine and other consumables)

J. Dental Care

1. Any number of consultations with an accredited dentist;
2. Treatment of dental related pain excluding cost of prescribed medicines;
3. Simple tooth extractions, except surgery for impactions;
4. Gum treatment excluding the cost of prescribed medicines;
5. Recementation of jacket crown, inlays and onlays;
6. Treatment of lesions, wounds and burns;
7. Unlimited temporary fillings;
8. Annual dental examination;
9. Adjustment of dentures;
10. Relief and/or prescription for acute dental pain;
11. Emergency desensitization of hypersensitive teeth;
12. Orthodontic consultation;
13. Aesthetic dental consultation;
14. Permanent fillings (light cure only) covered up to four (4) surfaces per year;
15. Twice (2x) a year oral Prophylaxis.

K. Financial Assistance

The **CONTRACTOR** shall provide financial assistance of Fifty Thousand Pesos (P50,000.00) in case of natural or accidental death of a principal member.

L. Unavailability of Room Covered and Excess in Room and Board and Incremental Rate Charges

If upon admission in an emergency situation, there is no room available conforming to the limitations and restrictions of a member's plan except Suite Room, the **CONTRACTOR** shall upgrade to the next higher room during emergency cases covered until the room according to their plan becomes available.

M. Point of Service

In non-emergency cases in an accredited hospital, reimbursement of the professional fee of non-accredited physician shall be 100% of the rate of the **CONTRACTOR** for outpatient or in-patient cases while medical and laboratory tests prescribed by the non-accredited physician are automatically covered. In a non-accredited hospital, professional fees, medical procedures and laboratory tests are reimbursable at 100% of the rate of the **CONTRACTOR**.

N. Special Concession

Upon signing of this Contract, the CONTRACTOR shall authorize BCDA's Company Physician to issue requests and Letters of Authorization for laboratory procedures (such as but not limited to urinalysis, fecalysis, chest x-ray, complete blood count and blood chemistry) and issue referral slips to any accredited specialists at any accredited hospital.

O. Designation of Liaison Officer

The **CONTRACTOR** shall designate a liaison officer who shall serve as the point person for the concerns of **BCDA** and its planholders.

P. Extension of Coverage

All members who will be disqualified due to age eligibility or change of principal planholder's civil status within the contract period will not be removed from the program and shall be allowed to use the card and avail his/her benefits until the expiration/termination of Contract.

Q. Experience Fund

Should the **BCDA** show cost effective utilization performance for the contract year, the **CONTRACTOR** agrees to pay a refund, which will be credited to the renewal billing. It will be computed on the third (3rd) month after the expiry of the contract (15th month). If the contract is renewed, refund shall be credited to the renewal billing, and if not, it shall be paid to **BCDA**. Refund will be based on the following computation:

Experience Refund = [(Annual Membership Fees x 30%) less (Actual Utilization of benefits + IBNR)] x 50%

R. Utilization Report

**BCDA** shall require the **CONTRACTOR** to provide a detailed annual utilization data, based on the required fields including the name of member and patient. **BCDA** warrants that this request for medical reports/utilization data is done with the full consent of members. **BCDA** shall hold the **CONTRACTOR** free and harmless from any liability whatsoever, should any member accuse the **CONTRACTOR** of breach of confidentiality in any civil, criminal or administrative proceedings.

The **CONTRACTOR** shall submit to **BCDA** a quarterly report on utilization within one (1) month after each quarter.

## VI. PRE-EXISTING CONDITIONS

A. Definition of Pre-Existing Conditions

An illness or injury is considered to be in existence prior to the effective date of the Planholder coverage in any of the following cases:

1. When any professional advice or treatment has been obtained for such illness or injury prior to the said effective date of coverage.
2. Such illness or injury is evident to the Planholder before the effectivity date of his/her membership.
3. The natural history of such illness or injury can be clinically determined to have started prior to the effectivity date of coverage.

The following conditions, among others, when occurring during the first year of coverage after the effective date, are considered pre-existing:

(a) Acquired hernias;
(b) Benign new growths or tumors (like sebaceous cysts, lipoma, Epidermal inclusion cysts etc.);
(c) Bronchial Asthma;
(d) Buergher's disease;
(e) Chronic ENT conditions requiring surgery (Nasal Polyposis, Chronic Otitis Media, Vocal Fold Polyp/nodules);
(f) Eye disorders like cataracts and glaucoma;
(g) Fatty liver;
(h) Gallbladder diseases like cholecystitis, cholelithiasis;
(i) Gastric & duodenal ulcers;
(j) Gynecological conditions(endometriosis, myoma, ovarian cysts);
(k) Hemorrhoids and anal fistula;
(l) Hypertension, atherosclerosis, dyslipidemia;
(m) Neurological disorders like Paralysis;
(n) Osteoarthritis, gout, hyperuricemia;
(o) Peptic Ulcer Disease;
(p) Primary Koch's Infection/Tuberculosis;
(q) Prostate diseases like benign prostatic hypertrophy;
(r) Thyroid disease (Nodular Nontoxic Goiter, Hypothyroidism, Hyperthyroidism);
(s) Varicose veins; or
(t) Any dreaded diseases, if present upon enrollment.

The following are considered dreaded diseases:

(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;
(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); or
(p) Any illness or condition other than the above which would require Intensive Care Unit confinement or which may be chronically, persistently or presently life threatening or may result to physical or functional loss of body parts as determined by the attending/accredited physician (subject to the exclusions and limitations of this Contract).

B. Pre-Existing Coverage

Pre-existing illness/conditions of principal members at the start of membership shall be covered up to Maximum Coverage Benefit. Dependents enrolled with the current health care service provider shall also be covered up to Maximum Coverage Benefit. For newly enrolled dependent members, pre-existing coverage is up to Twenty Thousand Pesos only (P20,000.00) during the first three (3) months. Afterwards, pre-existing coverage shall be up to the Maximum Coverage Benefit, unless specifically waived by the Planholder at the onset of membership, or if the illness or injury falls under the provisions on exclusions and limitations stated in this Contract.

## VII. GENERAL EXCLUSIONS & LIMITATIONS

A. Non-Transferability of Benefits

The health care benefits under this Contract are personal to the Planholder. Under no circumstance whatsoever shall they be transferred or assigned to another person.

B. Philhealth Benefits

1. Philhealth Members

Benefits under Philippine Health Insurance Corporation (Philhealth) shall first be deducted before applying any of the benefits due a Planholder under this Contract. Hence, Planholders who are Members of Philhealth and/or ECC shall, before discharge, submit to the admitting hospital all documents necessary to avail themselves of the benefits under the said medical insurance program. Failure to do so shall make the Planholder liable for any unclaimed Philhealth and/or ECC benefit. The **CONTRACTOR** is therefore under no obligation to pay or advance the cost of the benefit under Philhealth.

2. Non-Philhealth Members

Planholders who are not members or beneficiaries of Philhealth shall be liable to pay the applicable Philhealth portion of the hospital expenses and professional fees.

3. Deed of Subrogation

A Planholder shall be entitled to the Emergency Care services for injuries sustained in a motor vehicle accident caused by the willful act or negligence of a third party provided that the Planholder, or his legal guardian (if Planholder is a minor), executes a Deed of Subrogation assigning to the **CONTRACTOR** whatever rights or causes of action that he or his ward may have against the third party or his insurer by reason of the said accident, up to the extent of the value of the services **CONTRACTOR** has so rendered.

4. No Liability

The **CONTRACTOR** may not be held liable for any defaults, failures to assist, or delays in the delivery of services herein provided which are due to causes beyond its control, including, but not limited to, acts or any order of government, fires, floods, epidemics, complete or partial destruction of hospital or medical facilities, civil disturbances, strikes and other labor disputes, unduly severe weather, or incidents of war. The **CONTRACTOR** shall, however, continue to exert its best efforts to provide health care services to the Member insofar as circumstances will allow.

5. Refusal to Comply with Treatment

The **CONTRACTOR** shall have no obligation to continue providing health care coverage to Planholders who refuse to comply with any treatment or procedure recommended by a Health Professional, nor shall it be under any obligation to continue providing health care coverage to Planholders who refuse to be discharged from confinement after his/her attending Health Professional has recommended the discharge.

6. Hospital Policy

Hospital care services shall be subject to the rules and regulations of the Accredited Hospital.

7. Exclusions and Limitations

No health care benefits shall be paid for the following:

a. Custodial Care;
b. Domicilliary Care;
c. Convalescent Care;
d. Intermediary Care;
e. Cosmetic treatment surgery; reconstructive surgery to treat congenital deformities and abnormalities, except reconstructive surgery necessary to treat a functional defect resulting from an accidental injury;
f. Unless otherwise provided, maternity care and other conditions resulting from pregnancy;
g. Physical examinations and psychological testing necessary complications for employment, school, Insurance or licensing purposes;
h. Experimental medical procedures and acupuncture;
i. Services to diagnose and reverse infertility or fertility;
j. Purchase or lease of medical equipment, oxygen dispensing equipment, and oxygen, except during covered in-patient care;
k. Long term rehabilitation and psychiatric care;
l. Functional disorders of the mind; alcoholism; and substance addiction or abuse;
m. Treatment of injuries or illness resulting from war, or any combat related activities while in military service;
n. Treatment of injuries or illnesses resulting from attempted suicide or self-destruction, regardless of whether Planholder was sane or insane;
o. Treatment of injuries attributable to the Planholder's own misconduct, gross negligence, intemperate use of drugs or alcoholic liquor, vicious or immoral habits (e.g., sexually transmitted diseases like AIDS, gonorrhea and syphilis, if proven to be acquired through sexual promiscuity), participation in the commission of a crime whether consummated or not, violation of a law or ordinance, and unnecessary exposure to any imminent danger or hazard to health:
p. Oral surgery for purposes of beautification;
q. Treatment of injuries resulting from riots, strikes, and other civil disturbances in which the Planholder is a willing participant; and
r. All procedures for screening purposes are not covered.

## VIII. PAYMENT OF CLAIMS

A. Claims Procedure

All claims for reimbursements together with the accomplished documents or requirements (see list below) must be submitted or forwarded to the **CONTRACTOR's** Head Office within sixty (60) calendar days after the discharge from the hospital. Failure to do so shall invalidate the claim.

1. Emergency confinement in non-accredited hospital attended by a non-accredited doctor

a. Duly filled-up claim form signed by Planholder and the attending physician
b. Clinical Abstract
c. Medical Certificate to include complete final diagnosis
d. Surgical/Operative report if an operation was done
e. Original Official Receipt paid to hospital and doctor
f. Hospital Statement of account and corresponding charge slips
g. Police Report if due to accident or medico-legal case

2. Emergency confinement in an accredited hospital attended to by a non-accredited doctor

a. Duly filled-up claim form signed by Planholder and the attending physician
b. Clinical Abstract

c. Medical Certificate to include complete final diagnosis
d. Original Official Receipt paid to hospital and doctor
e. Hospital Statement of account and corresponding charge slips
f. Police Report if due to accident or medico-legal case
g. Incident report stating the reason why the Planholder was not admitted under the services of an accredited doctor

3. Out-Patient emergency consultation / treatment in areas where there are accredited hospitals/ clinics

a. Duly filled-up claim form signed by Planholder and the attending physician
b. Medical Certificate to include complete final diagnosis
c. Original Official Receipt paid to hospital and doctor
d. Incident report
e. Police Report if due to accident or medico-legal case

4. Out-Patient emergency or non-emergency consultation / treatment in areas where there are no accredited doctors / hospitals / clinics

a. Duly filled-up claim form signed by Planholder and the attending physician
b. Medical Certificate to include complete final diagnosis
c. Original Official Receipt paid to hospital and doctor
d. Incident report
e. Police Report if due to accident or medico-legal case

B. Right to Examine Planholder

While the claim is pending, the **CONTRACTOR** shall have the right to physically examine the Planholder who alleges the injury or illness for which a claim is made.

C. Payment of Claim

Payment of the claim shall be made personally to the Planholder, or in case the Planholder is a minor, to the principal Planholder. In case of death of the Planholder, payment shall be made to the **BCDA**, which hereby agrees to hold such payment in trust for the heirs of the Planholder and to dispose of the same in accordance with law.

D. Reconsideration of Claim

If a claim for reimbursement is disapproved, or if a question arises from the amount reimbursed by the **CONTRACTOR**, the Planholder shall submit to the **CONTRACTOR** a written request for reconsideration not later than sixty (60) calendar days from receipt of the disapproved claim advice or questioned reimbursement. The **CONTRACTOR** shall resolve the request for reconsideration within thirty (30) days upon its receipt.

## IX. EFFECTIVITY

A. Effectivity Period

This Contract shall take effect on June 1, 2018 at 12:00 a.m., Philippine time, and shall terminate at exactly 11:59 p.m. of May 31, 2019, unless pre-terminated as provided in this Contract. It is understood that the reckoning point of time shall be that as reflected in **BCDA's** head office.

B. Extension

**BCDA** may opt to extend the Contract on a periodic month-to-month basis not to exceed an aggregate period of one (1) year, upon terms and conditions mutually acceptable to the parties concerned, in accordance with the Revised Guidelines on the Extension of Contracts for General Support Services issued by the Government Procurement Policy Board (GPPB Resolution No. 023-2007 dated 28 September 2007).

C. Termination

This Contract may be pre-terminated by either party subject to the provisions stated herein by serving a written notice to the other party at least thirty (30) days prior to the specified date of pre-termination.

In case of pre-termination, Maximum Coverage Benefits as well as other benefits with limits will be prorated according to the number of months where applicable membership fees were paid. All availments beyond determined limits will be deducted from refundable fees, or will be billed to **BCDA**, as the case may be.

D. Performance Appraisal

Performance of the **CONTRACTOR** shall be subject to an appraisal system to be administered bi-annually. Based on the assessment, BCDA may preterminate the contract for failure by the **CONTRACTOR** to perform its obligations, in line with the Guidelines on Termination of Contracts issued by the Government Procurement Policy Board (GPPB Resolution No. 018-2004 dated December 2004).

## X. PERFORMANCE SECURITY

Prior to the signing of the Contract, the **CONTRACTOR** shall post in favor of **BCDA** a Performance Security to guarantee the **CONTRACTOR's** faithful performance of all obligations and undertakings under this Contract. The Performance Security shall be in an amount equal to a percentage of the total contract price in accordance with the following schedule:

| FORM OF PERFORMANCE SECURITY | AMOUNT OF PERFORMANCE SECURITY |
|---|---|
| A. Cash or cashier's/manager's check issued by a Universal or Commercial Bank | Five percent (5%) of the total contract price |
| B. Bank draft/guarantee or irrevocable letter of credit issued by a Universal or Commercial Bank.<br><br>If issued by a foreign bank, it shall be confirmed or authenticated by a Universal or Commercial Bank | Five percent (5%) of the total contract price |
| C. Surety bond callable upon demand issued by a surety or insurance company duly certified by the Insurance Commission as authorized to issue such security. | Thirty percent (30%) of the total contract price |

## XI. FINAL PROVISIONS

A. OGCC Review

This Contract shall be subject to the review of the Office of the Government Corporate Counsel (OGCC) whose review, comments and amendments shall be incorporated herewith.

B. Arbitration and Venue of Action

Any dispute arising out of or in connection with this Agreement shall be submitted for arbitration guided by the Arbitration Laws of the Philippines. Venue of the arbitration proceedings shall be in the Philippines. All actions arising from this Contract shall be filed exclusively in the proper courts of Taguig City.

C. Non-Waiver of Rights

The failure of one party to insist upon a strict performance of any of the terms, conditions and covenants hereof shall not be deemed a relinquishment or waiver of any right/remedy that said

party may have, nor shall it be construed as a waiver of any subsequent breach of the same or other terms, conditions or covenants. No waiver by any one party or any of its rights under this Contract shall be deemed to have been made unless expressed in writing and signed by that party.

D. Representation and Warranties

The parties warrant that they have not offered or given, and will not offer or give to any employee, agent, or representative of either party, any gratuity, with a view toward securing any business from one another, or influencing such persons with respect to terms, conditions or performance of any contract with each other.

E. Separability Clause

If any term or condition of this Contract is held invalid or contrary to law, the validity of the other terms and conditions hereof shall not be thereby affected.

**SIGNED BY THE PARTIES** this 26 June 2018, in Taguig City, Philippines.

| | |
|---|---|
| **BASES CONVERSION AND DEVELOPMENT AUTHORITY** | **PHILIPPINE BRITISH ASSURANCE COMPANY, INC.** |
| By: | By: |
| **AILEEN ANUNCIACION R. ZOSA**<br>Executive Vice President | **ATTY. JENNIFER U. JUANILLO** |

BCDA Bases Conversion and Development Authority
Organization Development & Management Department
FB2018 – 1049

WITNESSES:

# ACKNOWLEDGMENT

Republic of the Philippines)
City/Municipality of Taguig City ) S.S.

BEFORE ME, a Notary Public in and for the City of Taguig City, personally appeared:

| Name | Gov't issued ID's/ CTC No. | Date/Place of Issue |
|---|---|---|
| Bases Conversion and Development Authority | TIN: 002-291-694-000 | Taguig City |
| **AILEEN ANUNCIACION R. ZOSA** | Passport# EC1784672 | 11 June 2014/DFA-NCR Central |
| Philippine British Assurance Company, Inc. | TIN: 000-803-300-000 | |
| **ATTY. JENNIFER U. JUANILLO** | PRC #0027598 | |

Both known to me and to me known and who have been identified by me through their competent evidence of identity mentioned above to be the same persons who executed the foregoing Contract for Heath Care Services and acknowledged to me that the same is their free act and deed and the entities they represent for the uses and purposes herein stated.

I further certify that the foregoing instrument consists of twenty (20) pages including this page and that each and every page thereof has been signed by the PARTIES and by their witnesses and sealed with my notarial seal.

SIGNED AND SEALED this JUL 06 2018 in Taguig City, Philippines.

GUALBERTO J. QUZON, JR.
Notary Public for Taguig City, Philippines
Appointment No. 22 Until 31 December 2019
2/F BTC 21st St., BGC, Taguig City, 1634
PTR No. A-3774071/Taguig City/16 January 2018
Roll of Attorneys No. 48062/IBP Lifetime Member No. 04862
MCLE Compliance No. V-0003517/14 January 2015

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