

TERMS OF REFERENCE
(Issued on 13 January 2012)

ANNEX "A"

DEPARTMENT OF FOREIGN AFFAIRS
HEALTH INSURANCE CONTRACT FOR FOREIGN SERVICE PERSONNEL
(A major Medical/Comprehensive Insurance Package)

I. Membership Eligibility

The following persons shall be eligible for health care coverage:

- a. All permanent employees of the Department of Foreign Affairs and its attached agencies who are posted abroad.
- b. Dependents of the above mentioned employees, namely:
 - 1. The lawful spouse
 - 2. Children (legitimate, illegitimate, or adopted), stepchildren of the principal. This covers:

Children from birth up to at least 21 years of age;

Children over 21 years of age provided they are mentally, physically, or developmentally incapacitated and are primarily dependent on the principal for support;

Children from 21 to 26 years of age provided they are attending an accredited institution of higher learning on full time basis and are primarily dependent on the principal for support.

3. Dependent parent/s of single and married personnel.

- c. **Private staff/s on the full account and upon request of the principal.**

II. Pre-Existing Conditions

The health insurance provider shall cover all pre-existing illnesses or conditions of a member, including congenital anomalies and conditions, and its complications, subject to the maximum plan limit.

III. Health Coverage

The health care package shall cover the following benefits, subject to the following conditions:

- | | | |
|---------------------------------|---|----------------------|
| 1. Mode of payment | : | Monthly |
| 2. Territorial coverage | : | Worldwide |
| 3. Plan type | : | MAJOR MEDICAL |
| 4. Types of Membership coverage | : | Single/Family |

5. Room and Board Accommodation
 - In the Philippines : Private Room (Open)
 - Outside the Philippines : Private Room (Open),
except in selected Posts where
room accommodation is Semi-
Private
6. Limit for Outpatient Mental Illness/Substance Abuse Maximum: 50%
up to a maximum of \$1,000 per disability
7. Limit for Inpatient Mental Illness/Substance Abuse Maximum: 50% up
to a maximum of \$25,000 per confinement
8. Deductibles
 - For covered expenses incurred in the USA
 - Individual: max **US\$ 250 / year**
 - Family : max **US\$ 450 / year**
 - For covered expenses incurred outside the USA
 - Individual: max **US\$ 100/year**
 - Family: max **US\$ 200/year**
 - For covered expenses incurred in the Philippines: **no deductible**
9. Maximum Out of Pocket Limit : payment may be staggered or in
installments:
Individual: **US\$ 880/calendar yr**
Family: **US\$ 1,880/calendar yr**
10. Co-insurance Rate (In and Out Patient):
 - Covered expenses incurred in PHI : 100%
 - Covered expenses incurred outside PHI: 90%
11. **Maximum Annual Benefit : US\$2,000,000.00**

A. Hospitalization Benefits

In case a member requires hospitalization, s/he shall be entitled to avail of the authorized services in any hospital and by a physician of his choice, up to the maximum benefit limit.

Charges made by a hospital for room and board, professional services, other miscellaneous services and supplies for medical treatment of a member shall be covered by the health insurance provider, subject to the application of deductibles and co-insurance payments.

The insurance provider shall assign participating hospitals and physicians in all Posts and all areas under each Post's jurisdiction.

The insurance provider shall facilitate health care services for any member in and out of his/her Post of assignment. For this purpose, the insurance provider shall

furnish the Department with a list of all participating hospitals and physicians upon submission of the bid documents.

Reimbursement of expenses advanced shall be made in full within a month after claim is filed.

Charges covered by the healthcare insurance shall include but shall not be limited to:

1. Services of physicians, specialists, anesthesiologists, physiologists, Surgeon, and other medical professionals;
2. Nursing services;
3. Anesthesia and its administration;
4. Diagnostic X-ray and laboratory examinations, CT Scans, MRI;
5. X-ray, radium, and radioactive isotope treatment;
6. Transfusion of blood and blood substitutes;
7. Oxygen and other gases and their administration;
8. Rental of an oxygen breather or other durable equipment;
9. Physical therapy;
10. Orthopedic Procedure and Appliances used to correct disabilities;
11. Prosthetics therapy;
12. Prosthetic appliances;
13. Dressings;
14. Drugs and medicines for use in the hospital;
15. Dialysis up to the maximum benefit limit; and
16. Confinement in intensive care unit up to the maximum benefit limit.

Other procedures that shall be covered if medically necessary include, but are not limited to the following:

Adenoidectomy	Joint Replacement	Oophorectomy
Blepharoplasty	Laminectomy	Panniculectomy
Bunionectomy	Laparotomy	Prostectomy
Cataract Surgery	Mastectomy	Salpingectomy
Cholecystectomy	Meniscectomy	Strabotomy
Coronary Bypass	Nasal Polypectomy	Submucous Resection
Hemorrhoidectomy	Nasal Reconstruction (non-cosmetic)	Thyroidectomy
Hysterectomy	Circumcision	Appendectomy
Tonsillectomy	Inguinal Herniography	Paratomy
Varicose Vein Treatment	Bariatric Surgery	Accupuncture
Chiropractic procedures	Drug and alcoholism rehabilitation	
Psychiatric and psychological therapy and rehabilitation including post-trauma counseling		

Covered expenses:

1. Second surgical opinion – the surgeon must personally examine the insured person, and
2. Diagnostic X-ray and laboratory examinations in connection with such opinion.

B. Outpatient Benefits

In case a member requires outpatient services, s/he shall be entitled to avail of authorized services in any hospital and by the physician of his choice, up to the

maximum benefit limit. In case a member avails of the services of participating hospitals and physicians, deductibles and out of pocket expenses shall not apply.

During any 12 month period, charges shall be covered at 100%.

1. Annual Physical Examination

- a. Complete Blood count
- b. Blood Chemistry (Spec M-23), including but not limited to the following:
 1. Fasting Blood Sugar
 2. Electrolyte Potassium
 3. Lipids: Total Cholesterol HDL, LDL, VLDL Cholesterol Triglycerides
 4. Kidney Function: Urea and Creatinine
 5. Liver Function: SGOT (AST), SGPT (ALT)
 6. Alkaline Phosphatase
 7. Total Bilirubin
 8. Total Protein, Albumin, Globulin
 9. Bone Disease: Calcium and Alkaline Phosphatase
 10. Gout: Uric Acid
- c. Thyroid Function: TSH-IRMA
- d. Hepatitis Screening: HBsAG, Anti-HBc
- e. Routine Urinalysis
- f. Routine Fecalalysis including stool for occult blood
- g. Cardiac Work-up
 1. 12 lead ECG
 2. Treadmill Stress Test
- h. Chest X-ray
- i. Abdominal Work-up
 1. Upper Gastrointestinal Series
 2. Ultrasound of Liver, Gallbladder, and Pancreas
 3. Barium Enema
 4. Proctosigmoidoscopy
- j. Electrocardiogram for members
- k. Pap smear for female members
- l. Ultrasound of the prostate for male members
- m. Mammography/ultrasound and similar procedures for female members
- n. HPV/DNA Testing to determine cervical cancer
- o. Blood Typing
- p. HIV/AIDS Test (at the option of member)
- q. and other procedures as may be required or requested by the attending physician.

2. Outpatient Services

- a. Consultations, including specialists' evaluation
- b. First aid treatment of injury or illness
- c. Minor Surgery
- d. Emergency medicines including anti-tetanus for immediate relief of symptoms
- e. All necessary x-rays, CT scans, MRI, Laboratory tests and diagnostic/medical examinations.
- f. Eye, ear, nose and throat care (including eyeglasses, corrective lenses, up to US\$300.00, and other vision care related services)
- g. Management treatment of fractures, including the required plaster cast
- h. Dialysis, chemotherapy, radiotherapy and similar cancer treatment procedures

- i. Electrocautery of warts and moles
- j. Charges made by any facility licensed to furnish treatment of mental or psychiatric illness or functional nervous disorder, for care and treatment.
- k. Charges made by any facility licensed to furnish treatment of alcoholism or drug addiction, for care and treatment.
- l. Charges made by an affiliated physician or Clinical Psychologist for professional services.
- m. Vaccinations
- n. Charges for yearly Pap test
- o. Charges for routine prostate screening for males
- p. Charges for routine mammography screening for females
- q. Charges incurred in spas and wellness centers for therapeutic purposes (as prescribed by physician)
- r. Acupuncture and acupressure treatment for therapeutic purposes
- s. Wellness counseling

3. Maternity Benefits

All members may avail of maternity benefits up to the maximum benefit limit. All members may avail of all maternity and maternity-related services in any hospital and by any physician, up to the maximum benefit limit.

Coverage for all female employees and dependent female spouses includes, but shall not be limited to:

1. Pre-natal and Post-natal consultations with an OB-GYNE, including all OB-GYN required laboratories
2. Hospital Care during pregnancy
3. Cost of actual delivery
4. Pre-delivery hospital admission during delicate pregnancies upon recommendation of an affiliated physician

4. Baby/Pediatric Care

Benefits are payable for routine charges incurred by the insured member's newborn child not subject to deductible or co-insurance. These shall include, but not limited to: a) hospital charges for routine nursery care during the mother's confinement, not to exceed four days; b) physician's charges for circumcision; c) physician's charges for visits to the newborn child in the hospital; and d) benefits for hearing loss screening tests provided by a hospital before discharge.

Expenses of well baby and pediatric care check-ups and immunizations, including cost of vaccines, shall be covered up to the maximum benefit limit. Charges incurred for routine preventive care and immunization of an insured dependent child will be considered covered medical expense even though such charges are not the result of an injury or sickness.

C. Emergency Benefits (to include outside-of-post emergency services)

In case a member requires emergency services, he shall be entitled to avail of needed services in any hospital and by the physician of his choice up to the maximum benefit limit.

1. Emergency ground or air ambulance shall be provided by the insurance provider at the soonest possible time, which shall not exceed one (1) hour from the time request is made to the provider through its toll free international hotline. Charges for professional ground or air ambulance service to the nearest hospital best equipped to render treatment for an emergency medical condition, whether such hospital is accredited or not, shall be covered. In the event that the nearest hospital best equipped to render treatment is in a country **other** than Post of assignment of the member, costs for the return transportation of the member, including one (1) companion, to his/her Post of assignment shall be covered.

2. Members whose illness or injury cannot be treated in the country of assignment, are entitled to professional ambulance service, both air and land, to the nearest health facility properly equipped and staffed to provide such treatment up to maximum of \$50,000.00 for said ambulance services for all cases, including return transportation cost of one companion.

3. If a member requires emergency service while outside of his/her post of assignment, the emergency treatment/procedure shall be done at the nearest hospital where the emergency service could be given. The health insurance provider's coordinator shall settle the bill of the emergency service availed of, up to the limit of the approved rates as if the emergency service was obtained in a participating hospital and by a participating physician. In all cases, emergency services obtained in participating hospitals and participating doctors shall not be subject to deductibles and out of pocket expenses.

4. If a member obtains emergency service from any hospital and/or any physician located within his post of assignment, the health insurance provider shall settle directly with the hospital or physician, without requiring the application of deductibles and out of pocket expenses. In the event that the member voluntarily opts to advance payment for the cost of the emergency service, the health insurance provider shall reimburse the member of actual charges.

5. The health insurance provider shall make arrangements for evacuation/repatriation of dependent children and spouse who are left unattended at Post.

D. Extended Care Facility

Benefits are payable for charges billed and for an extended care facility if they are incurred while a person is confined to the facility and is insured for these benefits. Covered expenses are as follows:

- a. The daily room and board charge for each day of confinement computed at the facility's average charge for semi-private rooms;
- b. The facility's other charges incurred for medical care on a day for which room and board benefits are covered by the insurer; and
- c. Cost of one (1) extra bed for companion.

An extended care facility means an institution which is not a hospital, as defined, but which is primarily engaged in providing on an inpatient basis {a} skilled nursing care and related services for patients who require medical or nursing care; or {b} rehabilitation services for the rehabilitation of injured or sick persons.

IV. Special Benefits

1. Air transportation benefit – The insurance company will pay for roundtrip commercial air transportation to and from the Philippines, for the insured and one family member, if the insured chooses to receive treatment of a specified condition in the Philippines, especially for members assigned in countries where the medical insurance provider is not allowed to operate by the host government or in countries facing sanctions imposed by the UN/US.

2. The health insurance provider shall make arrangements for the compassionate or humanitarian visit of one family member or any person of choice by a single member who is hospitalized at Post or in countries outside his/her Post of assignment.

3. Coverage of charges made by a registered nurse for private professional nursing services if recommended by an affiliated physician within the schedule of fees established by the insurer for the period covered.

4. Coverage of all new modalities of treatment or diagnostics and alternative or non-conventional medicine, such as, but not limited to the following: Laparoscopic Cholecystectomy, Lithotripsy, MRI, Nuclear or Radioactive Isotope Scans, Hysteroscopic Myoma Resection, Unilateral Laparoscopic Adrenalectomy, Bilateral Laparoscopic Adrenalectomy, Transurethral Microwave Therapy of Prostate, Hysteroscopically-guided D&C, Percutaneous Ultrasonic Nephrolithomy, Uterolithotripsy, Stereotactic Brain Biopsy, Cryosurgery, Sleep Study, Sclerotherapy, Pelvic Laparoscopy (for endometriosis), Gamma-Knife surgery, Physical and Speech Therapy, laser Treatment for Glaucoma, Cataract, Retinal Detachment and Sleep Apnea.

5. Cost of prescription medicine (including maintenance drugs) including contraceptives, vitamins and mineral supplements.

6. Cost of vaccines, including anti-flu, pneumonia, HPV (**for 12 years old and above; provided that for 40 years old and above, applicable only if medically necessary**) and H1N1 and other relevant vaccines and allergens up to the maximum benefit limit.* Substantial Compliance shall be at least 80% of the stated benefit.

7. Prevention and treatment of animal bites – passive immunization for and treatment of animal bites up to the maximum benefit limit.

8. Life/Accidental and Disability/Dismemberment Insurance

1. Life Insurance – Insurance (including casket, embalment, and repatriation of mortal remains) – **US\$ 100,000.00**

2. Accidental Death and Disability/Dismemberment Benefit, including without limitation, all vehicular accidents, fire and acts of terrorism – **US\$100,000.00**

When insured employee suffers any of the following loss or loss of use within 120 days of and solely as the result of an injury or disease that occurs while insured, the health insurance provider will pay the sum corresponding to the indicated percentage of **US\$100,000.00**. Sum for:

Loss of:	Percentage of:
Life	US\$100,000.00
Both hands or Feet	100%
Sight of both eyes	100%
One Hand and One foot	100%
Hearing in both Ears	100%
Speech	100%
One Hand or One Foot	100%
Sight of One Eye	100%
Tongue Full	100%
Other body parts	100%
Per thumb	50%
Per Ear	50%
Tongue (partial)	50%
Per Finger/Toe	10%

9. The health insurance provider shall cover any dental service or procedure to be availed of anywhere in the world up to a maximum limit of US\$2,000.00.

VI. Other Conditions

1. The health insurance provider must have hospital and medical services worldwide and must have participating hospitals and physicians in Metro Manila and at all Posts and their areas of Jurisdiction, a list of such participating hospitals and physicians is required from the insurance provider pursuant to Section III (A) (Hospitalization Benefits) of this Terms of Reference. In countries where the medical insurance provider does not have any participating hospitals and physicians, a local health insurance provider must be affiliated in order to facilitate the processing of needed medical service and/or reimbursement of claims. In the event that a new Philippine Foreign Service Post shall be opened during the validity of the health insurance contract, the insurer shall inform the Department of Foreign Affairs of the name and contact details of all hospitals where services may be availed of especially of participating hospitals and doctors in that city within a period of thirty (30) days from its opening. The Department shall inform the insurance provider of any plans to open a new Philippine Foreign Service Posts at least sixty (60) days prior to the deployment of its personnel to that post.
2. The health insurance provider shall submit within 15 days after the end of every quarter, the utilization and claims experience of the Department of Foreign Affairs and its attached agencies. The claims utilization report for submission to DFA-OPAS should include full details of all claims filed, processed, paid and pending, name of the insured, date of claim, diagnosis, treatment, amount, status of claim, among others.
3. The failure of the health insurance provider to submit each claim utilization report after each quarter shall result in a penalty equal to US\$1,000.00 per day of delay.
4. The health insurance provider shall furnish all members with identification cards prior to their assignment or at their Foreign Service Post. For employees at post who apply for coverage with the insurer, for themselves and for their dependents, the identification cards shall be issued within a period of thirty (30) days from the insurer's receipt of the application. The passport should be sufficient proof of coverage pending issuance of insurance I.D.

5. The health insurance provider shall furnish the Department an audio-visual presentation in CD format that covers, among others, benefits in the health insurance package, availment procedures and necessary forms. The provider shall also provide each principal member with a manual on the health care package that would be transmitted together with ID cards.
6. The health insurance provider shall designate an accounts/customer relation officer exclusively for this contract. This officer shall hold office at the DFA OPAS.
7. The health insurance provider shall make available a seven-day, 24-hour international toll free hotline for membership verification, queries, and notices of emergencies. The health insurance provider shall likewise indicate an email address and mobile phone number to which queries by members may be directed: provided, that replies to these queries shall be made within 24 hours from the insurer's receipt of queries.
8. If the health insurance provider is headquartered in a foreign country, it should have a local affiliated health insurance provider that shall be authorized to represent and bind the principal in relation to the Department of Foreign Affairs.
9. All provisions in the contract between the Department of Foreign Affairs and the health insurance provider shall be interpreted in accordance with, and shall be subject to Philippines laws and jurisprudence. In case of disagreement, the matter shall be referred to an appropriate court in Pasay, Philippines, to the exclusion of all other courts, whether local or foreign.
10. The contract period under this procurement shall be one year. **The Department has the option to extend the contract on a monthly basis without any surcharges and extension fees.** Further, no penalties shall be imposed by the insurer arising from late payment of premiums not due to the fault of the Department of Foreign Affairs. In this regard, failure on the part of the Department to pay the premiums due to health insurance provider at no fault of the Department shall oblige the health insurance provider to continue to provide coverage to the members and their dependents for a period at least of 6 months.
11. To facilitate the payment of premiums, the Department of Foreign Affairs and the health insurance provider shall agree on the place and modality of payment.
12. The health insurance provider shall submit a monetary incentive directly to the members who, due to good health, found no need to avail of the services offered under the insurance contract. The incentive package may be in monetary terms.
13. This Foreign Service insurance coverage shall commence once the employee is enroute to the Post.

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