
## CORPORATE PROFILE

The Insular Life Assurance Company, Ltd., a financial conglomerate and market leader in the local life insurance industry, has been widely respected for providing service to the Filipino community for over 90 years. Living up to its commitment in responding to people's needs, the company added to its group of companies a subsidiary which specializes in delivering quality health care. Insular Life's total consolidated asset as of the end of 2001 is 31.1 billion Pesos.

The Insular Life Health Care, Inc. or I-Care, was formed in response to the widespread demand for timely, effective, comprehensive and yet affordable medical care thus, it is the only premier managed care company backed-up by a financial conglomerate offering superior and personalized services.

I-Care was registered with the Securities and Exchange Commission on October 14, 1991 and began operations on November 25 of the same year.

It has an authorized capital of P 100 million of which P 48 million is paid-up with an additional P 52.2 million paid-in capital in excess of par value.

The company takes pride in accrediting under its extensive network all the leading hospitals/clinics/laboratories throughout the country with only the best medical practitioners and specialists in its roster.

## CORPORATE PHILOSOPHY

Insular Life Health Care, Inc. is a Filipino company committed to the attainment of a high quality of life through superior and personalized health care services. We are dedicated to serving all our publics in the most satisfactory manner. Towards these ends:

We will provide efficient and effective health care services to as wide a membership base as possible.

We will establish ourselves as a market leader in the managed care industry.

We will continue to innovate and develop competitive health care plans responsive to the needs of the market.

We will promote the professional and personal growth of our employees, agents, and medical providers in recognition of their intrinsic values.

We will stand firm on our moral responsibility to the Filipino community by contributing to the betterment of society, the upliftment of the socio-economic condition of the vast majority and the preservation of human dignity.

In the pursuit of these goals, we are committed to uphold the highest standards of excellence, ethical conduct and social responsibility.

## SUMMARY OF PLAN BENEFITS FOR CORPORATE ACCOUNTS

**Plan A (Open Access to Accredited Hospital System)**
Under this Plan, a member may use any I-Care accredited Hospital nationwide.

**Plan B (preferred Hospital system)**

Under this plan, a member will have to select and strictly use hi preferred hospital except during genuine emergencies (as defined in the "Agreement" whereby he may use any hospital nearest him. If a member uses an accredited hospital, we afford him full coverage according to his benefits classification. If a member uses a non-accredited hospital, reimbursement of expenses will be governed by the Emergency provisions of the Agreement.

Plan features applicable to both Plan A & Plan B/ Out/In-patient Services

1. For primary care (non-emergency cases), entry point to accredited/preferred hospitals SHOULD BE THE COORDINATOR'S OFFICE. During off-clinic hours, and only for genuine emergency cases (as defined in the Agreement), a member may go to the Emergency Room for treatment. Unless stipulated in the Agreement, accredited clinics are not used for health care service availments.

2. Makati Medical Center (MMC) users will first have to pass through the I-Care Clinic (at the 1-Care Building in Makati City) and avail of its services. When the member requires services that are only available in MMC will he be referred to the hospital. During genuine emergencies (as defined in the Agreement), a member may use any hospital nearest him. If a member uses an accredited hospital, we afford him full coverage according to his benefits classification. If a member uses a non-accredited hospital, reimbursement of expenses will be governed by the Emergency Benefits provision of the Agreement.

3. Some accredited Metro Manila and provincial hospitals no longer have semi-private rooms or no longer admit HMO patients to semi-private rooms (e.g. Makati Medical Center, The Medical City, UST Hospital, Chong Hua Hospital, Mary Chiles General Hospital, and Dr. Jesus Delgado Memorial Hospital, Alabang Medical Center, St. Paul Hospital in Iloilo). For members who select the semi-private room accommodation plan and/or use hospitals without semi-private rooms for in-patient benefits, please be advised that these hospitals will automatically admit the member to the next higher room accommodation on a step-ladder basis. For genuine emergency cases (as defined in the Agreement), I-Care takes care of the difference in upgraded costs for the first 24 hours. After the first 24 hours, the member pays for the difference in upgraded costs prior to his discharge from the hospital. For elective cases, the member pays for the difference in upgraded costs from day one of his confinement prior to his discharge from the hospital. Please see provision "b" under Room and Board of In-Patient Benefits.

**OUT-PATIENT BENEFITS**
***ANNUAL PHYSICAL EXAMINATION*** *(To be availed at the I-Care Clinic in Makati City or at designated facilities upon full payment of membership fees for the current contact year)*

1. Taking of medical history
2. Physical examination
3. Chest X-ray
4. Laboratory medical examination
   - Complete Blood Count
   - Stool Examination
   - Urinalysis
5. Electrocardiogram for members 35 years of age and above
6. Pap smear for female members 35 years of age and above.

***PREVENTIVE HEALTH CARE*** *(to be availed at the I-Care Clinic, Accredited or Preferred Hospital)*

1. Immunization (does not include cost of vaccine and determination of susceptibility), whether in/out-patient post-exposure vaccination.
2. Consultation and advice on diet, exercise and other healthful habits
3. Periodic monitoring and management of health problems subject to program, provisions
4. Family planning counseling
5. Health education and wellness program
6. Medical information dissemination through clinics, newsletters, seminars, etc.

***OUT-PATIENT SERVICES***
(To be availed at the I-Care Clinic, Accredited or Preferred Hospital)

1. Consultation, including specialist's evaluation
2. First-aid treatment of injury or illness
3. Laboratory examination and all other diagnostic procedures prescribed by the I-Care Physician, subject to program provisions
4. Minor surgery not requiring confinement
5. Eye, ear, nose and throat care
6. Pre/post natal consultations

**IN-PATIENT BENEFITS**

1. Room and Board
   a. In case hospitalization arises either through the advise of the I-Care Medical Coordinator or by way of an "emergency" situation, I-Care shall secure the room chosen by its member using a "step-ladder" system (lowest to highest).
   b. For genuine emergency cases (as defined in the agreement), in the event that the room accommodation pre -selected by the member under

his I-Care package is not readily available, the member shall automatically be upgraded to the next higher room classification for the first TWENTY FOUR (24) HOURS and the ancillary price difference shall be borne by I-Care with absolutely no obligation on the pan of the member. After the first twenty-four (24) hours and there still is no room available under the member's original room classification, in the succeeding days of his confinement, the member shall pay for the difference in room rate as well as the difference in ancillary expenses between the higher room category and the original room category.

c. Room amenities vary according to actual hospital set-up.

2. Services of physicians and surgeons, including surgery
3. General nursing services
4. Use of operating room
5. Use of recovery room
6. Anesthesia and its administration
7. Drugs and medication for use in the hospital
8. Oxygen and its administration
9. Dressing standard plaster and cast
10. Transfusion of blood and other blood elements except donor-screening services
11. Chemotherapy/radio therapy (including out-patient)
12. ICU confinement (maximum of 14 days but not to exceed benefit limit)
13. Dialysis (maximum of 10 treatments but not to exceed maximum benefit limit inclusive of outpatient dialysis.
14. Physical therapy (maximum of 7 sessions but not to exceed benefit limit, inclusive of out-patient physical therapy)
15. Services and supplies related to the medical management of the patient subject to program provisions.
16. Other hospital charges deemed necessary by the I-Care accredited Physician in the treatment of the patient subject to program provisions.
17. Ambulance services (hospital to hospital transfers, limited to P 2,500 per conduction), if requested by an I-Care physician.

## EMERGENCY BENEFITS

No charge emergency care services administered in any I-Care accredited hospital/clinic for genuine emergency cases as defined in the agreement.

1. In case of emergency treatment/confinement in a non-accredited clinic/hospital, I-Care shall reimburse up to 80% of the usual and customary fees which the I-Care preferred clinic/hospital would charge for such treatment/confinement in accordance with the Benefits Classification of the member; or P10,000.00 for clinic/hospital charges and P5,000.00 for professional fees (or a total of P15,000.00), whichever is less, provided that the illness or condition is covered under the contract and provided further that the member follows the Benefit Availment Procedures of I- Care

## MAXIMUM BENEFIT LIMIT (MBL)

The Maximum Benefit Limit (MBL) per person per illness or injury per year will depend on the member's Room Accommodation / Plan Category (which will be established at the start of the coverage period based on the client's requirements, e.g.. Officer, Supervisory, Rank & File, with or without dependents) and shall apply to dread and non-dread diseases.

MBLs may vary according to the client's requirements. However, as much as possible, the company applies the following standard MBLs for the following Room Accommodation / Plan Categories:

| Room/Plan | MBL | Room/Plan | MBL |
|---|---|---|---|
| **Suite** | P125,000 | **Plan 1000** | P125,000 |
| **Private** | 100,000 | **Plan 800** | 100,000 |
| **Semi-private** | 75,000 | **Plan 600** | 75,000 |
| **Ward** | 50,000 | **Plan 400** | 50,000 |

## OPTIONAL BENEFITS

### *DENTAL BENEFITS*

To avail of this out-patient benefit at the member's preferred dental clinic (for those who select strict preferred dental facilities) or at any dental clinic (for those who select open-door dental facilities) under the Filipino Doctors Health Alliance, 100% participation of all qualified enrollees (by category, i.e.. Officer / Supervisory / Rank & File, with or without their dependents) is required.

1. Any number of consultations during clinic hours
2. Annual examination and oral prophylaxis
3. Unlimited simple tooth extraction except surgery for impaction and complicated extractions involving re-administration of anesthesia. Complicated extractions involve the use of other dental instruments except the pliers)
4. Lesions, wounds, burns and gum or dental problems requiring dental management except surgeries.
5. Unlimited temporary fillings
6. Unlimited recementation of fixed bridges, jacket crowns, inlays and onlays
7. Dental education and counseling during consultations
8. Unlimited adjustments of dentures (limited to adjustment of clasp)
9. Two (2) permanent amalgam fillings (surfaces)

**(For open-door dental plan. add:**

10. Orthodontic & Aesthetic dental consultations
11. Emergency desensitization of hypersensitive teeth

### *LIFE (GROUP TERM) INSURANCE WITH INSULAR LIFE*

This is applicable only to employee-Principal members:

- Minimum of P10,000 in coverage
- Maximum of P50,000 in coverage

(To avail of this benefit, 100% participation of qualified employee-principals is required. Coverage over the above limits will need special approval)

In accordance with Insular Life Group Term Policy No. G-01494 dated 01 January 1992 and all of its succeeding endorsements, any individual with adverse medical findings shall automatically be covered for one-half (1/2) of coverage of a standard risk for deaths, due to natural causes and one hundred percent (100%) of coverage for deaths due to accident.

***MATERNITY BENEFIT (OPTIONAL)***

(All regular female employees must enroll but in no case less than 25)

1. Pre-natal and Post-natal diagnostic procedures at I-Care Clinic or accredited/preferred hospitals
2. Hospital care during pregnancy and delivery. Limits will depend on the needs of the corporate clients
   Examples :(Amounts inclusive of Item 1 & 3)
   - Caesarian P10,000
   - Normal 7,000
   - Miscellaneous 5,000
3. Ordinary nursing care for newborn baby while mother is confined, or for three days, whichever comes earlier.

Maternity Benefits shall be available only after the enrollee (principal or dependent member) has been continuously covered under the "Agreement" for a period of 280 days from date of initial enrollment except that in the event of pre-termination of pregnancy within the said period of 280 days, maternity benefit shall be available provided such pregnancy commences after the coverage of the enrollee becomes effective.

**LATEST MODALITIES OF TREATMENT** (examples of)

1. Laparoscopic Cholecystectomy (LapChole) is covered up to MBL. All other laparoscopic procedures for therapeutic purposes (except LapChole, Hysteroscopic D&C of up to P 5,000 per session and Hysteroscopic Myomectomy of up to MBL) are covered up to P 20,000 per session.
2. Lithotripsy (limited to one session per year) up to P 30,000.
3. Magnetic Resonance Imaging (MRI) / Magnetic Resonance Angiogram (MRA) / Computerized Tomography (CT Scan) / Magnetic Resonance Spectroscopy are covered up to P 5,000 per session.
4. All nuclear medicine procedures (e.g.. Thallium Scintigraphy, Radioactive isotope Scan, Hexamibi, etc.) are covered up to P 5,000 per session.
5. Cryosurgery is covered up to MBL.
6. Electrocautery of Warts is covered up to P 1,000/ year
7. Endoscopic Procedures is covered up to MBL for diagnostic purposes; and P 5,000 per session for therapeutic purposes (except FESS)
8. Functional Endoscopic Sinus Surgery (FESS) is covered up to MBL.
9. Gamma Knife is covered up to MBL.
10. Percutaneous Ultrasonic Nephrolithotomy (PUN) with Electro Shock Wave Lithotripsy are covered up to P30.000 (one session per year).
11. Stereotactic Brain Biopsy is covered up to P 20,000 .per session.
12. Transurethral Microwave Therapy of Prostate is covered up to P 30,000 per session.
13. Laser eye procedures (one session per eye per year) is covered up to P 5,000 except Photorefractive Keratectomy.
14. Speech Therapy - maximum of seven sessions, not to exceed the MBL inclusive of out-patient speech therapy
15. Positron Emission Tomography Scan (PET Scan) up to P 5,000 per session
16. Sleep Studies up to P 5,000 per year
17. Pain Management up to P 3,000 per year

**DREAD DISEASE (examples of)**

Coverage is subject to the Maximum Benefit Limit per person per illness or injury per year.

1. Neurological Disorder
2. Blood dyscracia
3. Collagen/Immunological disorder
4. Liver Cirrhosis
5. Chronic Pulmonary/Renal disorder
6. Cardiovascular disorder
7. Cancer
8. Any condition which necessitates the use of Intensive Care Unit subject to other limitations.
9. Accidental injuries
10. Other conditions causing partial or total organ damage or failure.

**PRE-EXISTING CONDITIONS (PEC)**

A. An illness or condition shall be considered pre-existing if before the Effective Date of the Agreement:
   1. Any professional advice or treatment was given for such illness or condition prior to effective date of coverage.
   2. Such illness or condition was in any way evident to the member prior to effective date of coverage.
   3. The pathogenesis of such illness or condition has already started prior to effective date of coverage (which the member may not be aware of)

B. After the member has been continuously covered with I-Care for 12 months and the agreement is renewed, PECs are covered provided that the PEC is not considered part of the "Permanent Exclusions to Health Care Coverage." and that such PEC was declared by the member in the original application. Genuinely unknown (and therefore undeclared) PECs will be covered provided these are not concealment cases. In case an application is disapproved due to an adverse medical condition, an applicant may still avail of the I-Care program by executing a "waiver"

relinquishing or limiting coverage for the particular adverse condition.

C. Examples of PECs (inclusive of complications)
   1. Hernias
   2. All tumors and malignancies involving any body organ or system
   3. Endometriosis, Dysfunctional Uterine Bleeding
   4. Hemorrhoids
   5. Diseased tonsils requiring surgery
   6. Pathological abnormalities of the nasal septum and turbinates
   7. Hyperthyroidism / Goiter
   8. Cataract
   9. Sinus condition requiring surgery
   10. Asthma/Chronic Obstructive Pulmonary Disease
   11. Liver cirrhosis
   12. Tuberculosis
   13. Anal fistulae
   14. Cholelithiasis/Cholecystitis
   15. Calculi of the urinary system
   16. Gastric or duodenal ulcer
   17. Hallux valgus
   18. Diabetes mellitus
   19. Hypertension
   20. Collagen disease/auto immune disease
   21. Cardio-vascular disease
   22. Hormonal dysfunction
   23. Seizure disorder

D. The following health conditions may be covered (either fully or up to certain amounts) provided pre-existing conditions of an account are likewise covered.
   1. Organ transplants and/or open heart surgery/ angioplasty and all services (e.g., coronary angiogram) related thereto (except organ and donor services)
   2. AIDS and AIDS-related diseases except when sexually transmitted
   3. Congenital abnormalities and conditions are covered up to P10,000.
   4. Chronic glomerulonephritis, gullain-barre syndrome
   5. Physical deformities (e.g., scoliosis, spinal stenosis, vitiligo, psoriasis, etc.). Only consultations are covered.

## PERMANENT EXCLUSION (examples of)

1. Care by non-accredited Physician and / or in a non-preferred or non-accredited hospital/clinic except in emergencies wherein the emergency provision of the agreement will apply.
2. All pregnancy related conditions requiring medical/surgical care and screen tests related thereto.
3. Sterilization of either sex or reversal of such, artificial insemination, sex transformations or diagnosis and treatment of infertility, and circumcision.
4. Rest cures, custodial, domiciliary or convalescent care.
5. Cosmetic surgery, dental/oral surgery, and dermatological procedures for the purpose of beautification except reconstructive surgery to treat a dysfunctional defect due to disease or accident.
6. Psychiatric disorders, psychosomatic illnesses, hyperventilation syndrome, adjustment disorders, anxiety disorders, alcoholism and its complications or conditions related to substance or drug abuse, addiction and intoxication.
7. Sexually transmitted diseases.
8. Medical and surgical procedures which are not generally accepted as standard treatment by the medical profession.
9. Procurement or use of corrective appliances, artificial aids, durable equipment, and orthopedic prosthesis and implants.
10. Surcharges resulting from additional personal (luxuries/accommodation) request or service including special nursing services.
11. Physical examination required for obtaining employment, medical certification, insurance or a government license, and procedures for purely diagnostic / screening purposes including among others, procedures conducted prior to hormonal replacement therapy
12. Injuries or illnesses due to military, paramilitary, police service, high risk activities, or suffered under conditions of war.
13. Reimbursement of procedures obtained through government programs
14. Injuries or illnesses, which are self-inflicted, caused by attempt at suicide or incurred as a result of or while participating in a crime or acts involving the violation of laws or ordinances
15. Out-patient/take-home medicines
16. Valvular Heart Disease or Rheumatic Heart Disease 17 Medico-legal consultations
17. When a member is discharged against medical advice
18. Blood/Organ Donor screening / other screening procedures
19. All hospital charges and professional fees after the day and time hospital discharge has been duly authorized and professional fees of Assistant Surgeons
20. All conditions and complications requiring dental care
21. All confirmatory tests used to document health conditions not covered under the program
22. Hypersensitivity tests
23. Hospital Admission Kits

## MEMBERSHIP ELIGIBILITY

1. Membership fees are based on a specific number of, principal enrollees that were culled from the client's employee census.
2. If membership fee is employer-employee shared or employee-paid, we require at least 75% participation of employee-principals.
3. Accommodation/Benefits Plan of Principal Members must follow a uniform category (e.g., officers at Private room, rank-and-file employees at Semi-Private room,

etc.) pre-established by the client at the start of the program

A. Principal members:
At least 18 years to less than 65 years old

B. Dependents: (Following hierarchy guidelines)
For single employees: Parent(s) first who is/are less than 65 years old and not gainfully employed; followed by the eldest sibling down to the youngest who is/are 15 days to less than 21 years old, unmarried and not gainfully employed.

For married individuals: Spouse first who is less than 65 years old; followed by the eldest child down to the youngest, 15 days to less than 21 years old, unmarried and not gainfully employed.

## DEPENDENT'S COVERAGE

Participation and Enrollment:

If Dependents' Coverage is Employer-paid, we require 100% participation of employee-principals enrolling at least two (2) immediate dependents each following our hierarchy guidelines.

If Dependents' Coverage is Employer-Employee-Shared or Employee-paid, we require at least 75% participation of employee-principals enrolling at least two (2) immediate dependents each following our hierarchy guidelines.

In both instances above, if the minimum participation requirement is not met (because of employees who may have only one or no eligible dependent/s), we may still offer Dependents' Coverage. Applications will be individually underwritten subject to acceptance or denial as the case may be. It is understood that a re-quote of dependents' rates based on the actual number of enrollee-dependents may be done, if necessary.

Dependents should be enrolled simultaneously with principal members.

Newly married spouse, newly born child/sibling should be enrolled within 31 days from date of qualification as a dependent.

Accommodation/Benefits Plan of Dependents must follow a uniform category pre-established by the client at the start of the program; and must be equal to or lower than the Principal's accommodation/benefits plan.

## PHILHEALTH/ECC

Our program is integrated with benefits under Philhealth and/or Employees Compensation Commission (ECC); therefore such Philhealth and / or ECC benefits to which the member is entitled to shall be deducted from the claim cost in the computation of benefits under our program, unless agreed otherwise through a special endorsement in the contract. All covered members are assumed to be Social Security System (SSS) members. In case a member and/or any dependent is not an SSS member, he shall be charged the amount equivalent to the Philhealth benefit in case he is hospitalized. I-Care shall pay only all hospital bills in excess of the Philhealth benefits. Philhealth benefits may not be used to cover excess charges or services not entitled to coverage.

## ENROLLMENT/APPROVAL OF APPLICATION

An applicant applying for coverage is required to accomplish an enrollment form otherwise there will be no coverage despite having paid a deposit for membership fees. Changes in the application may be done prior to the underwriting process or the issuance of the ID card. Exceptions, if any, will be handled on a case-to-case, non-precedent setting basis. It is understood that I-Care reserves the absolute right to approve or disapprove any application for membership. In case an application is disapproved due to an adverse medical condition, an applicant may still avail of the I-Care program by executing a "waiver" relinquishing or limiting coverage for the particular adverse condition. Non-compliance of underwriting requirements within me prescribed period -will mean the exclusion from coverage of the condition for which an underwriting requirement has been prescribed. It will likewise mean the non-issuance of the member's ID card. While the member's health care program is in effect, hospitals will have to call the I-Care Office before providing services for a member without an ID card. In case of pre-termination of coverage or resignation/deletion of members, the client should return the ID card(s) of members. Any misuse of the ID card by a member will be for me account of the client and/or the member.

## MEMBERSHIP FEE/BILLING STATEMENT

Membership fee is due and payable on Effective Date of the Agreement. Payment should be on or before Due Dates corresponding to a mode pre-selected by the client. Non-receipt (by the client) of a billing notice does not constitute a valid reason for non-payment of membership fees. Non -payment of Membership Fees for 31 days from Due Date will automatically void the "Agreement". Benefits under the "Agreement" are allowed only if membership fees have been paid PRIOR to availing of such benefits. If for any reason the I-Care membership is pre -terminated, the member must surrender to I-Care his ID card

## EFFECTIVITY DATE OF COVERAGE

Effective date of coverage will be any day preferred by the corporate client after receipt (and evaluation) of the Corporate Application receipt of the initial deposit for membership fees; and/or after underwriting requirements, if any, have been complied with by the corporate client