

**HEALTH CARE PROGRAM
DOJ EMPLOYEES MULTI-PURPOSE COOPERATIVE**

I. Premium

A. Premium without access to Top 6 Major Hospitals and Associated Clinics, and Healthway Clinics

Room & Board	Minimum Enrollees	Annual Premium					Benefit Limit
		1 to 4	5 to 11	12 to 65	66 to 70	71 to 75	
Ward	250 (onetime)	21,500.00	18,000.00	14,600.00	29,290.00	43,720.00	70,000 per illness
Semi Private		27,700.00	23,200.00	18,800.00	37,775.00	56,380.00	100,000 per illness
Regular Private		42,100.00	35,200.00	28,450.00	57,327.00	85,565.00	150,000 per illness
Open Private		50,200.00	42,000.00	34,000.00	68,377.00	102,050.00	200,000 per illness

B. Premium with access to Top 6 Major Hospitals and Associated Clinics, and Healthway Clinics

Room & Board	Minimum Enrollees	Annual Premium					Benefit Limit
		1 to 4	5 to 11	12 to 65	66 to 70	71 to 75	
Ward	250 (onetime)	24,050.00	20,150.00	16,300.00	32,800.00	48,965.00	70,000 per illness
Semi Private		31,000.00	26,000.00	21,000.00	42,000.00	63,135.00	100,000 per illness
Regular Private		47,100.00	39,450.00	31,850.00	64,000.00	95,845.00	150,000 per illness
Open Private		56,150.00	47,050.00	38,000.00	76,200.00	114,300.00	200,000 per illness

**Top 6 Major Hospitals (Asian Hospital Medical Center, Cardinal Santos Medical Center, Makati Medical Center, St. Luke's Medical Center - QC, St. Luke's Medical Center - Taguig, The Medical City)*

Note:

- a. Special accommodation for over-aged enrollees must not exceed 10% of the total eligible enrollees.
- b. Premiums and Benefits may be subject to change after 30 days.

II. Schedule of Benefits

Basis of Coverage	Coverage/ Limit
1. Ordinary Illness (sudden onset)	Subject to MBL
2. Pre-existing conditions	Covered at 100% participation of minimum enrollees otherwise, subject to 1 year contestability
3. Dreaded diseases	Subject to MBL for enrollees ages 1 to 65; Covered up to 5,000.00 per year for enrollees ages 66 to 75

A. In-Patient Care

Health Benefits	Coverage
1. Room and Board Accommodation	Covered
2. Use of operating room, Intensive Care Unit (ICU), isolation room (if prescribed by Attending Affiliated Physician) and recovery room.	Covered
3. Professional fees in accordance with 1COOPHealth schedule of rates per physician/specialist. a. Attending Physicians b. Surgeons c. Anesthesiologist d. Cardio-pulmonary clearances before surgery and cardiac monitoring during surgery except CP clearances for all elective surgical cases including OB and Gynecology.	Covered
4. Standard Nursing Services	Covered
5. Medicines for in-patient use	Covered

6. Blood products transfusions and intravenous fluids, including blood screening and cross matching if the Member patient is the recipient excluding expenses for donor screening services.	Covered
7. X-Ray, laboratory examinations, routine, diagnostic and therapeutic procedures incidental to confinement	Covered
8. Dressings, conventional casts (plaster of Paris) and sutures	Covered
9. Anesthesia and its administration	Covered
10. Oxygen and its administration	Covered
11. Standard Admission kit	Covered
12. All other items directly related in the medical management of the patient, as deemed medically necessary by the Attending Accredited Physician	Covered

Note:

- a. For enrollees who are PhilHealth members, the PhilHealth portion for which the enrollee is eligible shall be applied to or deducted from allowable charges.
- b. In case an enrollee is not a PhilHealth member, the PhilHealth portion must be paid by the enrollee directly to the hospital at the point of availment or upon discharge. 1COOPHealth will not pay or advance the costs of such benefits, nor be responsible for filing any claims under PhilHealth or ECC.

B. Emergency Care

Health Benefits	Coverage
1. In accredited Hospitals	Up to MBL
a. Physician's services	Covered
b. Emergency room fees	Covered
c. Medicines used for immediate relief during treatment	Covered
d. Oxygen, intravenous fluids and blood products	Covered
e. Dressings, conventional casts (plaster of Paris) and sutures	Covered
f. X-Rays, laboratory and diagnostic examinations, and other medical services related to the emergency treatment of the patient	Covered
2. In non-accredited Hospitals	Reimbursable up to 80% of hospital bills & professional fees based on 1COOPHealth rates
3. Outside the Philippines	Reimbursable up to 100% of the hospital bill and professional fees based on 1COOPHealth rates subject to inner limit of Php30,000.00 (in Php, subject to prevailing exchange rate at the time of availment)
4. Areas without accredited hospitals	<ul style="list-style-type: none"> a. 100% on room and board charges according to the Member's Room and Board accommodation. b. 100% on other hospital bills. c. 100% Professional fees based on 1COOPHealth rates.
5. Ambulance Land Transfer	Reimbursable up to 5,000.00 per conduction

C. Out-patient Care

Health Benefits	Coverage
1. Consultations and treatment prescribed by an accredited physician or specialist	Covered
2. Pre- and post-natal consultations	Up to fourteen (14) consultations per year
3. Treatment for minor injuries and minor surgery except out-patient medicines	Covered
4. Dressings, conventional casts (plaster of Paris) and sutures	Covered

5. Routine diagnostic examinations and therapeutic procedures prescribed by an Accredited Physician/Specialist provided however that the cost of diagnostic and therapeutic procedures covered shall be limited to a specific amount	Covered
6. Laser Eye therapy for retinal tear, retinal hole, retinal detachment and glaucoma except correction of refraction such as myopia, astigmatism and hyperopia as prescribed by an Accredited Physician/Specialist	Up to 10,000 per year
7. Electrocauterization of skin lesions such as plantar warts, flat warts, periungual warts, filiform warts and molluscum contagiosum, in any part of the body prescribed by an Accredited Physician/Specialist	Up to 5,000 per year
8. Sclerotherapy for varicose veins (except medicines and for cosmetic purposes) as prescribed by an Accredited Physician/Specialist	Up to 10,000 per year
9. Allergy Testing/ allergy screening and other related examinations prescribed by an Accredited Physician	Up to 4,000 per year
10. Speech therapy for stroke patients only. Note: Consultations shall be part of the limit and treated as sessions.	Up to 10,000 per year
11. Tuberculin test	Up to 1,000.00 per year

D. Preventive Care

Health Benefits	Coverage
1. Passive and active vaccines including anti-venom for tetanus, animal bites as well as snake bites and its administration	Up to 18,000 per year, cumulative
2. Wellness Program	Covered
3. Counselling on diets, health habits, family planning, etc.	Covered
4. Immunization and allergy desensitization (cost of vaccines, allergens and determinations of susceptibility are not included)	Covered
5. Recording and review of medical history	Covered
6. Periodic monitoring of health problems	Covered

E. Annual Physical Examination (APE)

Health Benefits	Coverage
1. Physical Examination	Covered
2. Complete blood count	Covered
3. Urinalysis	Covered
4. Fecalysis	Covered
5. Chest X-ray	Covered
6. ECG for 35 years old and above	Covered
7. Pap smear for female 35 years old and above	Covered
8. FBS	Covered
9. Cholesterol	Covered

Note:

- a. Member/ Cooperative must send a letter of request for an APE schedule to marketing@chmf.coop
 - i. For On-site APE – 10 days prior to the APE date
 - ii. For Walk-in APE – 5 days prior to the APE date
- b. APE can be utilized 3 months after enrollment.
- c. APE will be done in a designated accredited clinic of 1COOPHealth only.
- d. Rescheduling of APE will be allowed once only.

e. If in case of no accredited clinic in the area, 1COOPHealth can reimburse up to a maximum of P500.00, subject to the maximum benefit limit.

F. Dental Care

Health Benefits	Coverage
1. Annual dental examination & consultation	Covered
2. Oral prophylaxis	Twice a year
3. Simple tooth extractions	Up to 2 teeth per day
4. Temporary fillings	Up to 2 surfaces per day
5. Permanent fillings	Two (2) surfaces per year
6. Simple adjustment of denture	Covered
7. Emergency dental treatment	Covered
8. Dental nutrition and dietary counselling	Covered
9. Restorative and prosthodontic treatment planning	Covered
10. Desensitization of hypersensitive teeth	Covered

Note:

- a. Dental care benefits for members aged 66 to 75 years old shall not be covered.
- b. If in case of no accredited clinic in the area, 1COOPHealth can reimburse dental services up to a maximum of P250.00 per procedure, subject to a maximum benefit limit.

G. Benefits covered whether out-patient or in-patient (shared limit for OP and IP; Professional fees, Hospital Bills and other incidental expenses relative to the procedure shall form part of the limit)

The following procedures and modalities are subject to the inner limits when specified, otherwise Actual Cost, subject to MBL.

a. Routine Procedures (whether OP or IP)

Health Benefits	Coverage
1. Blood chemistries	Covered
2. Chest X-Ray	Covered
3. Complete Blood Count (CBC)	Covered
4. Fecalysis	Covered
5. Urinalysis	Covered

b. Diagnostic Procedures (whether OP or IP)

Health Benefits	Coverage
1. 12-Lead Electrocardiogram (ECG)	Covered
2. 24-hour Electroencephalogram (EEG) monitoring	Covered
3. 24-hour Holter Monitoring	Covered
4. Adrenocortical Function	Covered
5. Anti-nuclear antibody, C-Reactive Protein, Lupus Cell Exam	Covered
6. Arterial blood gas	Covered
7. Arthroscopic procedures, orthopedic arthroscopy	Covered
8. Audiograms and tympanograms	Covered
9. Bone Densitometry Scan (Dexascan)	Covered
10. Bone Mineral Density Studies	Covered
11. Cardiac Stress Tests (Thallium and Dipyridamole Stress Tests)	Covered
12. Computed Tomography (CTScans)	Covered
13. Diagnostic Radiographs:	
a. Biliary tract: Cholecystogram and Cholangiogram	Covered
b. Chest, ribs, sternum and clavicle	Covered
c. Digestive: Plain film of the abdomen, Barium Enema, Upper Gastrointestinal (GI) Series, Lower GI Series, Small Bowel series	Covered

d. Face (including sinuses), Head and Neck	Covered
e. Urinary: Kidney, Ureter and Bladder	Covered
f. X-ray of the extremities and pelvis	Covered
g. X-ray of the spine (cervical, thoracic lumbosacral)	Covered
14. Diagnostic Ultrasounds:	
a. 2D-Echo with Doppler	Covered
b. Abdomen	Covered
c. Duplex Scan	Covered
d. Digestive and urinary systems	Covered
e. Ultrasound of the Lungs	Covered
15. Electroencephalogram (EEG) Monitoring	Covered
16. Electro myelography and Nerve conduction Velocity studies	Covered
17. Endoscopic Procedures	Covered
18. Fluorescein Angiography	Covered
19. Impedance Plethysmography	Covered
20. Magnetic Resonance Angiography (MRA)	Covered
21. Magnetic Resonance Imaging (MRI)	Covered
22. Mammogram and Sonommamogram	Covered
23. Myelogram	Covered
24. Nuclear Radioactive Isotope Scan	Covered
25. Pap Smear	Covered
26. Perfusion Scan	Covered
27. Plasma Urinary cortisol, Plasma Aldosterone	Covered
28. Polysomnograms (Sleep Recording)	Covered
29. Pulmonary Function Tests	Covered
30. Radioisotope Scans and Function Studies:	
a. Cardiac	Covered
b. Gastrointestinal	Covered
c. Liver	Covered
d. Parathyroid Bone, Pulmonary (Perfusion/ Ventilation Lung scans)	Covered
e. Renal	Covered
f. Thyroid Scans	Covered
g. Total Body Scans	Covered
31. Radionuclide Ventriculography	Covered
32. Surface Electromyography (SEMG)	Covered
33. Thallium Scintigraphy	Covered
34. Treadmill Stress Test (TMST)	Covered
35. M-mode Echocardiogram	Covered
36. Video gastroscopy	Covered

c. Therapeutic Procedures

Health Benefits	Coverage
1. Chemotherapy	Covered
2. Arthrocentesis	Covered
3. Continuous Positive Airway Pressure (CPAP) titration for sleep study	Covered
4. Dialysis	Covered
5. Physical/Occupational therapy	Up to twelve (12) sessions
6. Therapeutic Radiology:	

a. Brachytherapy	Covered
b. Cobalt	Covered
c. Linear Accelerator Therapy	Covered
d. Radioactive Cesium	Covered
e. Radioactive Iodine	Covered
f. Thoracentesis	Covered
7. Cataract Surgery except cost of lens	Up to 30,000 per year

H. Additional Procedures and Modalities (shared limit for OP and IP; Professional fees, Hospital Bills and other incidental expenses relative to the procedure shall form part of the limit)

The following procedures and modalities are subject to the inner limits when specified, otherwise Actual Cost, subject to MBL.

Health Benefits	Coverage
1. Angiography/ Angiogram	Up to 20,000 per year
2. Angioplasty/ Coronary Artery Bypass Graft	Up to 20,000 per year
3. Cryosurgery	Covered
4. Gamma Knife Surgery	Covered
5. Hysteroscopic Myoma Resection	Covered
6. Hysteroscopically-guided procedures	Up to 20,000 per year
7. Laparoscopic Cholecystectomy	Up to 30,000 per year
8. Unilateral Laparoscopic Adrenalectomy	Up to 20,000 per year
9. Bilateral Laparoscopic Adrenalectomy	Up to 30,000 per year
10. Other Laparoscopic procedures	Up to 20,000 per year
11. Lithotripsy	Up to 30,000 per year
12. Percutaneous Ultrasonic Nephrolithotomy	Up to 30,000 per year
13. Stereotactic Brain Biopsy	Up to 50% of MBL
14. Conventional Hemorrhoidectomy	Covered
15. Scalpel Hemorrhoidectomy	Covered
16. Stapled Hemorrhoidectomy	Covered
17. Mammotome/ Vacuum Assisted Breast Biopsy	Covered
18. 4D Ultrasound except for maternity-related cases	Covered
19. Esophageal Manometry	Covered
20. Intensified Modulated Radiotherapy	Not covered
21. Botox which is not cosmetic in nature nor for beautification purposes	Not covered
22. Positron Emission Tomography (PET) scan	Covered
23. Photodynamic Therapy	Not covered
24. Arthroscopy with Meniscectomy	Up to 20% of MBL
25. Transurethral Microwave Therapy for Prostate	Up to 30,000 per year
26. Other medically necessary modalities not mentioned above and those for which there are no comparable, conventional or traditional counterparts.	Up to 5,000.00 per procedure per year

Note:

- The above procedures are subject to limitations and exclusions of the contract.

I. Additional Benefits

The following procedures and modalities are subject to the inner limits when specified, otherwise Actual cost, subject to MBL.

Health Benefits	Coverage
1. Motor Vehicular Accidents	Covered

2. Provoked and Unprovoked Assault, including domestic violence, whether initiated by the Member or by a known or unknown third party	Not covered
3. Scoliosis, slipped disc, spondylosis & spinal stenosis including necessary procedures, except physical therapy sessions, whether congenital, pre-existing, development or acquired.	Up to 20,000 per year
Note: Physical therapy sessions shall form part of the Physical therapy/ occupational therapy limits.	
4. Congenital conditions except physical therapy sessions and developmental disorders.	Up to 20,000 per year
Note: Physical therapy sessions shall form part of the Physical therapy/ occupational therapy limits.	
5. Congenital Hernia	Subject to congenital conditions limit
6. Chronic Dermatoses (Consultations only)	Covered
7. Scabies (Consultations only)	Covered
8. Hepatitis B including vaccines and screening	Not covered
9. Human Immunodeficiency Virus (HIV)	Covered; subject to limitations and HIV guidelines
10. Herniorrhaphy	Covered
11. Work-related conditions covered by ECC (for Principal only)	Covered

Note:

- a. Motor vehicular accidents for overage (66-75) drivers shall not be covered.
- b. The above procedures are subject to limitations and exclusions of the contract.

J. Telemedicine Consultations thru 1COOPTelehealth

Health Benefits	Coverage
1. Phone call consultation (on-duty doctors)	Covered
2. Video consultation (on-duty doctors)	Covered

K. Financial Assistance given to the beneficiary of the member in case of death

Health Benefits	Coverage
1. Natural Death	P 10,000.00
2. Accidental Death	P 20,000.00

Note:

- a. Coverage for financial assistance shall be contestable for a period of one (1) year from the date of enrollment if death is caused by any of the following:
 - i. Dreaded diseases ii.
 - Terminal diseases iii.
 - Chronic diseases

L. Special coverage for Covid-19 confirmed cases

Health Benefits	Coverage
1. Out-patient, Emergency and In-patient care	Up to P 10,000.00 per year
a. RT-PCR Test	Up to P 2,000.00 per test
b. Rapid Antigen Test	Up to P 1,000.00 per test

Note:

- a. Members who were found to be infected of COVID-19 virus before the effectiveness of the policy will not be covered.
- b. Special coverage for Covid-19 patients shall be covered for **symptomatic patients only**.
- c. Not covered for screening test purposes.

M. Optical Benefits

1. At Executive Optical (EO)

Health Benefits	Coverage
1. Free Eye Check-ups (Computerized Eye Refraction and Color Blindness Test)	Covered
2. Guaranteed discounts on exclusive signature frames and sunglasses purchases shall be given from the Suggested Retail Price (SRP)	Up to 30% discount; except on Oakley, Rudy Project, Mango and Spyder & Oakley brands
3. Free cleaning and minor repair services	Covered

Note:

- a. Discounts shall not be applicable to lenses, contact lenses, solutions and accessories. Discounts shall not also be used in conjunction with any other existing promotion.
- b. Purchase of items/goods in connection with the availment will be honored in ALL the branches of OPTICAL nationwide except the OPTICAL's Landmark branches and Bazaar branch in Zamboanga City.

2. At Ideal Vision

Health Benefits	Coverage
1. Discount on regular price frame and sunglasses	Up to 20% discount
2. Discount on regular price finished lenses	Up to 10% discount
3. Discount on consigned items, except Bolon, Cartier Maui Jim, Oakley, Ray-ban and Swissflex	Up to 10% discount
4. Additional discount on sale items except those items which are already marked down	Up to 10% discount
5. Free eye examination: <ul style="list-style-type: none"> a. Computerized Eye Examination using AUTOREFRACTOMETER b. Visual Acuity Test for thorough Evaluation c. Color Perception Test using ISHIHARA Method 	Covered

3. At Vision Express

Health Benefits	Coverage
1. Computerized Eye Refraction	Covered
2. BUY 1 GET 1 FREE (BOGO) eyewear on over 50+ designer eyewear brands	Covered
3. Discount on ALL regular items on over 50+ designer eyewear brands on a single purchase of frames and sunglasses	Up to 15% discount
4. Discount on Shamir and Tokai Lens	Up to 15% discount
5. Discount on Bausch & Lomb Contact Lenses	Up to 10% discount
6. Discount on prepacked Tony Morgan London PC Glasses	Up to 15% discount
7. "VISION EXPRESS DEAL" - Complete package for P990, which includes TONY MORGAN frame worth P 1,990 with 1.5 HCM single vision lenses and freeaward-winning 7-step eye exam.	Covered
8. Additional benefits: <ul style="list-style-type: none"> a. Free custom fitting & adjustment b. Free Ultrasonic cleaning services c. Replacement of screws and nose pads for frames availed from the OPTICAL following the approved OPTICAL policies and procedures 	Covered