BIDS AND AWARDS COMMITTEE
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SUPPLEMENTAL / BID BULLETIN No. 2

Project	:	Procurement of 2020 Local Healthcare Coverage
Reference	:	PB-GS-13-2019
ABC	:	PhP 150,000,000.00
Date	:	10 December 2019

This supplemental/bid bulletin is issued to provide information to the prospective proponents/bidders on the following changes to the Bidding Documents:

I. **Technical Specifications (Section VII)** – The Technical Specifications (Section VII) of the Bidding Documents is superseded by ANNEX A of this Supplemental/Bid Bulletin No. 2 after considering inputs from the bidders and the Committee.

II. Utilization Report and Demographic Profile are available upon request.

The Bidding Documents is amended accordingly.

For the information and guidance of all concerned.

Sgd.
GENEROSO D.G. CALONGE
Ad Hoc BAC Chairperson

Technical Specification

2020 Local Healthcare Coverage

ANNEX A

I.	**BACKGROUND** The Department intends to procure Local Healthcare Coverage for the benefit of the Home Office personnel and their dependents to ensure their access to health and medical services under a comprehensive healthcare coverage.	
II.	**SCOPE** Provision of comprehensive local healthcare coverage to all Home Office personnel and their dependents from 01 January to 31 December 2020.	**Statement of Compliance**
III.	**DEFINITION OF TERMS** The following terms shall be defined as follows: a. **Home Office Personnel** – employees of the Department in the DFA Main Office, DFA-Aseana and DFA Consular Offices which include permanent, casual, contractual and home-based personnel b. **Principal Member** – an employee who is primarily covered by the policy, subject to the requisites of membership eligibility c. **Secondary Member** – a dependent of the principal, subject to requisites of membership eligibility as defined herein d. **Home-Based Personnel** – employees who are given regular *plantilla* positions. Such employees are considered permanent upon assumption of duty. e. **Healthcare Coverage Provider (Provider)** – an entity that provides access to health and medical services to members under a comprehensive healthcare coverage f. **Comprehensive Healthcare Coverage** – a type of healthcare coverage that provides access to comprehensive health and medical services through its local networks, wherein claims for health and medical expenses of members are: 1. Directly paid by the Provider to medical and health professionals/institutions; or 2. Reimbursed to members in case of payment to non-accredited health and medical professionals/ institutions g. **Co-Insurance** – a set percentage of the covered costs paid by the member. h. **Maximum Out-of-Pocket Limit (MOPL)** – accumulated amount in co-insurance paid by a member before the Provider	

pays one hundred percent (100%) of the health and medical expenses

i. **Annual Benefit Limit (ABL)** – maximum amount paid by the Provider for a member's health and medical expenses
j. **In-patient Services** – confinement in a health and/or medical institution for monitoring, treatment and/or recovery, including any treatment arising from or related to an illness or a condition requiring hospitalization such as, but not limited to, dialysis and chemotherapy
k. **Out-patient Services** – consultation, treatment, laboratory and other procedures from a health and/or medical professional/institution, without need of confinement
l. **Pre-existing Condition** – any illness or health condition, including known/unknown and diagnosed/undiagnosed congenital anomalies and conditions existing prior to and after the writing and signing of the Contract, and its complications

IV. PREMIUM PAYMENT CATEGORIES

For purposes of premium payments, the following categories shall be used:

Member Category	Definition
Single	principal member with no dependent
Duo	principal member with one dependent
Group/Family	principal member with more than one dependent

V. MEMBERSHIP ELIGIBILITY

The following persons shall be eligible as principal and secondary members:

a. **Principal Members**

1. All permanent employees at the Home Office and Consular Offices, including newly-assumed Foreign Service Officers,
2. Casual and contractual employees who are covered in the previous insurance year, and
3. Newly hired home-based personnel, casual and contractual employees after six (6) months of continuous service.

The six-month probationary period shall not apply to regular, casual and contractual employees who have been given home-based *plantilla* positions, provided that said

	casual and contractual employees are covered in the previous insurance year. b. **Secondary Members** Dependents of principal members shall be considered as secondary members, provided that the following requirements are met: 1. **Spouse** – Principal member's legal husband or wife. In the case of Muslim marriages where the principal member has more than one (1) wife, the elected wife. 2. **Child** – a person with whom the principal member has legal parental obligations to fulfill, which includes the following: i. Unmarried children twenty-three (23) years old and below, and those who turn 24 years old during the effectivity of the contract shall still be covered; ii. Children over twenty-three (23) years old who are mentally, physically, or developmentally incapacitated, and primarily dependent on the principal member for their support; and iii. Children who are born during the effectivity of the contract. Married couples who are both employees of the DFA shall be individually considered as principal members.	
VI.	**QUALIFICATIONS OF THE PROVIDER** The Provider shall: a. Be a well-established health insurance company and provider of health and medical services for at least five (5) years.	
	b. Have affiliates able to, or a mechanism that allows the health and/or medical professional/institution to, directly bill the Provider so that members shall not be billed except for the applicable co-insurance which the member shall pay directly to the health and/or medical professional/institution.	
	c. Have direct billing system arrangements with local hospitals for in-patient expenses and, where applicable, out-patient expenses.	

d. Have the following arrangements in places where it has no affiliates:

1. Reimburse the coverable consultation and treatment fees when the health and/or medical professionals/institutions do not accept letters of guarantee subject to IX(d); or
2. Secure arrangements with other providers to facilitate access to and provision of necessary health and medical services and the processing and reimbursement of claims.

e. Have affiliations with and/or existing offices in major hospitals and medical centers all over the country, particularly in the Metro Manila area, and locations of Consular Offices.

For Metro Manila, affiliations shall include, but shall not be limited to, the following: Asian Hospital and Medical Center, St. Luke's Medical Center Global City, St. Luke's Medical Center Quezon City, Adventist Medical Center Manila, Makati Medical Center, The Medical City, Cardinal Santos Medical Center, Sta. Lucia Health Care Centre, Our Lady of Lourdes Hospital, Capitol Medical Center, Inc., Manila Doctors Hospital, University of the East Ramon Magsaysay Memorial Medical Center, Inc., FEU-NRMF Medical Center, UST Hospital, Manila East Medical Center, San Juan de Dios Educational Foundation, Inc. Hospital, Chinese General Hospital and Medical Center, Victor R. Potenciano Medical Center.

VII. COVERAGE

Annual Benefit Limits – The local coverage shall have the following limits:

Member Category	Annual Benefit Limit
Single	PhP 1,500,000.00
Duo	PhP 2,000,000.00* (shared limit; individual limit is PhP 1,700,000.00)
Group/Family	PhP 3,000,000.00 (shared limit; individual limit is PhP 1,700,000.00)

Pre-existing Conditions – All pre-existing illnesses or conditions of a member, either known/unknown or diagnosed/undiagnosed prior to and during the effectivity of the contract, shall be covered.

	Benefits – The following are the major categories of healthcare and medical services under the Schedule of Benefits (**Annex B)** of the DFA Healthcare Coverage: A. In-patient Benefits B. Maternity Benefits C. Out-patient Benefits D. Annual Physical Exam* E. Out-patient Prescribed Medicines F. Emergency Care (including professional ambulance service) G. Dental Benefits (minor and major) H. Optical Benefits I. Financial Assistance (for principal members) 1. Loss of Life Indemnity 2. Additional Indemnity for Loss of Life by Accident 3. Accident Disability and Dismemberment Benefit J. Other Benefits (Maximum Benefit Utilization) Unless explicitly stated in the Exclusion List **(Annex C)**, all healthcare and medical services are included in the DFA Local Healthcare Coverage. * The specifics and implementation of Annual Physical Exam are indicated in ANNEX F	
VIII.	**CO-PAYMENT TERMS** The following co-payment provisions shall operate in a sequential order: a. **Co-Insurance** – A member shall be subject to a ten percent (10%) co-insurance on in-patient healthcare and medical expenses. b. **Maximum-Out-of-Pocket Limit** – In no case shall a member pay for more than Php 50,000.00 in accumulated co-insurance.	
IX.	**DUTIES OF THE PROVIDER** The Provider shall:	
	a. Issue new membership cards to members indicating validity or the duration of the contract to facilitate access to services. The membership cards will be processed upon receipt by the Provider of the Notice to Proceed (NTP) based on the master list provided by the Department and issued within thirty (30) calendar days upon receipt of the master list and subsequent updates thereto. In case a member's card has not been issued, the policy number shall be sufficient proof of membership.	

		If previously issued, the Provider shall comply with the arrangement for updating existing membership cards as mutually agreed upon in writing by the Department and the Provider.	
	b.	Furnish each principal member, together with the membership card, a manual on the Department's health care and medical coverage, including information on the procedures for availing themselves of benefits and claims.	
	c.	Ensure that members may directly access any accredited hospital, physician, specialist, or appropriate care provider, for health and medical services without prior verification with or approval of the Provider.	
	d.	Have an online facility for its issuance or shall fully reimburse the fees of the accredited health and/or medical professional/institution, in cases where the Provider's representative is not present to issue a LOA.	
	e.	Guarantee that members who avail themselves of healthcare services from a specialist health professional, when none is accredited, is reimbursed fifty percent (50%) of the actual expenses or the industry standard, whichever is higher. For all other non-accredited health and/or medical professional/institution, members shall be reimbursed for coverable charges subject to industry standards. The Provider shall provide a list of accredited health and/or medical professional/institution upon award of the Contract.	
	f.	Reimburse members for coverable charges in case of emergency confinement in a non-affiliated hospital.	
	g.	Guarantee that, in the event that the room prescribed under the coverage is unavailable upon admission for confinement, a member is admitted to the next higher-level room without additional expense until the prescribed room becomes available. This shall be applicable for both emergency and non-emergency cases requiring confinement.	
	h.	Bear bank charges and other related costs should reimbursement be necessary,	
	i.	Notify the Department of changes in the list of affiliated health and/or medical professionals/institutions, provided that none of the institutions listed in VI (e) shall be removed from the list for the duration of the contract.	
	j.	Settle claims for reimbursement within fifteen (15) calendar days from receipt of complete claim documents.	
	k.	Accept claims for reimbursement from a member for up to three (3) months from the availment of medical service or purchase of prescribed medicines, provided that the member has given,	

	within thirty (30) calendar days from the availment or purchase, written notice to the Provider's liaison officer that a claim is forthcoming.	
	l. Submit a quarterly Utilization and Claims Experience Report of the Department in a spreadsheet file, on or before the 15th day of the first month of the following quarter, which shall contain at least the following: 1. Claims demographics including summary of un-enrolled members 2. Summary of approved claims by member category 3. Summary of disallowed claims and their bases 4. Top fifteen (15) providers for out-patient and in-patient care by member category 5. Top fifteen (15) illnesses by member category 6. Top fifteen (15) utilizers by member category 7. Claims for Loss of Life Indemnity 8. Claims for additional Indemnity of Loss of Life by Accident 9. Claims for accidental Disability and Dismemberment Benefit 10. Any other information that may be required by the Department.	
	m. Submit monthly Raw Data of Utilization Reports in spreadsheet file, on or before the 15th day of the following month, following the prescribed format in ANNEX D. The reporting of monthly Incurred But Not Yet Reported (IBNR) claims shall follow the formula below: IBNR = average monthly utilization X 2 The reports in (l) and (m) above shall be the basis for the issuance by Human Resource Management Office (HRMO) of the monthly certificate of acceptance and completion. The monthly certificate is a condition to payment. Submit an updated Utilization and Claims Experience Report and Raw Data of Utilization Report six (6) months after the end of the contract year. Such report shall be the basis of the release of the Certificate of Final Acceptance and Completion for the Contract. Ensure the accuracy of the reports submitted to the DFA. Submitting reports which are false, forged, altered, or otherwise lacking in authenticity, with or without the intent to create false	

	impression by such reports, shall be a basis for blacklisting the Provider in future DFA biddings. Samples of Utilization and Claims Experience Report and Raw Data of Utilization Report shall be submitted as part of the Bid Documents for the reference of the Bids and Awards Committee.	
	n. Designate a company officer who shall be the focal person for all matters related to the Department's policy. The company officer must have sufficient authority to decide policy issues for the company. The Contractor shall indicate their recommended company officer in the Bidding Documents for the approval of the Department.	
	o. Assign a liaison officer to be stationed at the DFA Main Building during office hours who can also be reached through mobile phone and by email 24/7. It shall also provide the liaison officer with the necessary office equipment and supplies. The liaison officer shall be authorized to issue letters of authorization (LOAs) for DFA employees and/or dependent members.	
	p. Maintain a 24-hour hotline for verification of membership and inquiries on health and medical services.	
	q. Assign one retainer physician at the Department during hours as agreed upon by both parties. The retainer physician shall be authorized to issue LOAs for Department employees and/or dependent members.	
	r. In the event that a new Consular Office is opened during the validity of the Contract, provide the Department the names and contact details of all accredited health and/or medical professionals/institutions in the area of the new office within a period of thirty (30) calendar days from its opening.	
	s. Organize at least two (2) on-site annual physical examinations. The specifics and implementation of the on-site APEs are indicated in Annex F.	
	t. Submit all books, records and files relevant to the auditing of the Department's medical claims during scheduled and spot visits of the Department's representatives to the Provider's office.	
X.	**ENROLLMENT AND UN-ENROLLMENT OF MEMBERS** The Department shall immediately notify in writing the Provider through its designated representative in the Department of the date of effectivity of the enrollment and un-enrollment of members. The Provider shall confirm in writing the date of effectivity of such enrollment and un-enrollment of members for billing purposes.	
XI.	**BID OFFERS**	

	The bid offer shall be quoted in Philippine pesos only. The Provider shall also submit a price breakdown following the prescribed format in Annex E.	
XII.	**TERMS OF PAYMENT** a. The Provider shall submit twelve (12) equal monthly billings, based on the annual premiums of the enrollment at the beginning of the year, one week after receipt of the Notice to Proceed (NTP). b. The Department shall make monthly payments for the premiums by bank transfer from the Land Bank of the Philippines through a List of Due and Demandable Accounts Payable (LDDAP) within thirty (30) working days upon submission of complete documents, and subject to the following additional conditions: 1. The payment for January 2020 shall be upon the release of Notice of Cash Allocation (NCA) from the Department of Budget and Management (DBM). 2. The billings for November and December 2020 shall be subject to adjustment based on the actual enrollment and un-enrollment of members to avoid over payment.	
XIII.	**SUSPENSION OF SERVICES** a. The Provider shall not unilaterally suspend services due to late payment of premiums for reasons beyond the Department's control. b. The Provider shall give thirty (30) working days' notice by registered mail to the Department of any intention to suspend services. c. In case of suspension, services shall be restored immediately after the payment of all past due premiums.	
XIV.	**CONTRACT DURATION** This Local Healthcare Coverage of DFA Personnel shall be for a period of one (1) year, which shall begin on 01 January 2020 and end on 31 December 2020. Coverage becomes effective on the date of enrolment, but not before the effective date of the present contract. The contract enters into effect on 01 January 2020 at 00:00 hour for a period of twelve (12) months.	
XV.	**EXTENSION OF CONTRACT**	

	Should no new contract on local healthcare coverage for the following year be awarded by the end of this contract term, the Department has the option to extend the contract for up to three (3) months without any surcharge or extension fee. All other terms shall be applicable to the extended contract, except for the schedule of benefits which shall be applied on pro-rated terms. Under Republic Act 9184 otherwise known as the Government Procurement Act, no contract shall be extended for more than one (1) year.	
XVI.	**CONFLICT BETWEEN TECHNICAL SPECIFICATIONS/TERMS OF REFERENCE AND INSURANCE POLICY** In case of conflict between the Technical Specifications/Terms of Reference of the Contract and the standard healthcare or insurance policy of the Provider, the Technical Specifications/Terms of Reference shall prevail.	

Note:

Bidder must state compliance to each of the provisions in the Terms of Reference/Technical Specifications, as well as to the Schedule to Requirements. The **STATEMENT OF COMPLIANCE** must be signed by the authorized representative of the Bidder, with proof of authority to sign and submit the bid for and in behalf of the Bidder concerned. If the Bidder is a joint venture, the representative must have authority to sign for and in behalf of the partners to the joint venture. All documentary requirements should be submitted on or before the deadline for the submission of bids.

Bidders must state here either "Comply" or "Not Comply" against each of the individual parameters of each Specification stating the corresponding performance parameter of the equipment offered. Statements of "Comply" or "Not Comply" must be supported by evidence in a Bidders Bid and cross-referenced to that evidence. Evidence shall be in the form of a manufacturer's un-amended sales literature, unconditional statements of specification and compliance issued by the manufacturer, samples, independent test data etc., as appropriate. A statement that is not supported by evidence is subsequently found to be contradicted by the evidence presented will render the Bid under evaluation liable for rejection. A statement either in the Bidders statement of compliance or the supporting evidence that is found to be false either during Bid evaluation, post-qualification or the execution of the Contract may be regarded as fraudulent and render the Bidder or supplier liable for prosecution subject to the provisions of **ITB** Clause 3.1 (a)(ii) and/or **GCC** Clause 2.1 (a)(ii)

Conformé:

[Signature/s]

[Name of Bidder’s Authorized Representative/s]

[Position]

[Date]

LOCAL HEALTHCARE COVERAGE
SCHEDULE OF BENEFITS

Annex B

I.	**ANNUAL BENEFIT LIMIT (ABL)**		**REMARKS**
	Single	PhP 1,500,000.00	
	Duo	PhP 2,000,000.00	Shared limit; PhP 1,700,000.00 individual limit
	Group/Family	PhP 3,000,000.00	Shared limit; PhP 1,700,000.00 individual limit All benefits, except Financial Assistance and Maximum Benefit Utilization, shall be subject to ABL.
II.	**CO-PAYMENT TERMS**		
	Co-Insurance	90/10	All in-patient healthcare and medical expenses
	Maximum Out-of Pocket Limit	PhP 50,000.00	Cumulative; per member
III.	**BENEFITS**		**All benefits shall be subject to MOPL and ABL**
A.	**IN-PATIENT BENEFITS**		In addition to PhilHealth
	Room and Board	Open Private (single occupancy)	
	All Covered Medical Expense Limits	as charged	In cases of organ transplant procedures, the medical expenses of donors (even if policy members) shall not be covered
B.	**MATERNITY BENEFITS**	as charged	Subject to co-insurance; applicable only to principal members (regardless of marital status) and dependent spouses Includes out-patient services, such as pre- and post-natal consultations and laboratory tests Actual delivery
C.	**OUT-PATIENT BENEFITS**		In addition to PhilHealth, when applicable
	Annual Benefit (per person)	PhP 300,000.00	
	Dialysis	PhP 5,000.00	Per session; in addition to PhilHealth rate
D.	**ANNUAL PHYSICAL EXAM**		Principal members only; shall be availed at any hospital or clinic accredited by the Provider
E.	**OUT-PATIENT PRESCRIBED MEDICINES**	PhP 150,000.00	Shared limit; includes prescribed vitamins and minerals
F.	**EMERGENCY CARE**	as charged	Includes all items and services as needed in the treatment of the patient
G.	**DENTAL BENEFITS (minor and major)**	PhP 5,000.00	Shared limit

H.	**OPTICAL BENEFITS**	PhP 5,000.00	Shared limit; error of refraction, eyeglasses and contact lens as prescribed
I.	**FINANCIAL ASSISTANCE (for principal members)**		
	Loss of Life Indemnity	PhP 1,000,000.00	
	Additional Indemnity for Loss of Life by Accident	PhP 1,000,000.00	
	Accidental Disability and Dismemberment (long scale)	PhP 1,000,000.00	Maximum amount
J.	**OTHER BENEFITS**		
	Maximum Benefits Utilization	PhP 250,000.00	First 20 members to exceed ABL are entitled to additional benefit of PhP 250,000.00

Exclusion List
Annex C

EXCLUSIONS

FINANCIAL ASSISTANCE

For Loss of Life Indemnity, Additional Indemnity for Loss of Life by Accident, and Accidental Disability and Dismemberment Benefit

No benefits are payable if the death or loss results from suicide or intentionally self-inflicted injury

BENEFITS (In-patient, Out-patient)

Subject to the Terms of Reference, no benefits are payable for the following:

- treatment arising from or is in any way connected with attempted suicide or any injury or illness inflicted upon one's self
- treatment in nature clinics, health spas and nursing homes
- charges for residential stays in a hospital, which are arranged wholly or partially for domestic reasons, where treatment is not required, or where the hospital has effectively become the place of domicile or permanent abode
- treatment needed because of, or relating to, infertility or any type of fertility treatment, including complications arising out of such treatment, with the exception of the investigation of infertility to the point of diagnosis
- treatment by way of the intentional termination of pregnancy, unless two medical practitioners certify in writing that the pregnancy was to endanger the life or mental ability of the mother
- sex change operations or any treatment needed to prepare for or recover from these operations (e.g., psychological counselling) including complications arising out of such treatment
- treatment that arises from, or is any way connected with injury, sickness or disability as a result of taking part in a sporting activity on a professional basis, solo scuba-diving, or scuba-diving at depths below 30 meters unless the diver is PADI qualified (or equivalent) for that depth
- expenses relating to any form of plastic, cosmetic or reconstructive surgery treatment, including medical procedures, unless it is of medical necessity as a direct result of the patient having an accident or because of other surgery, which in itself would have been covered under the policy.

- Treatment for developmental disorders including functional disorders of the mind, such as but not limited to Attention-Deficit Disorder (ADD)/Attention-Deficit Hyperactivity Disorder (ADHD), Autism Spectrum Disorders, Central Auditory Processing Disorder (CAPD), Cerebral Palsy, Down Syndrome, Neural Tube Defects, and Mental Retardation.

- Illness, injury or death attributable to the member's own misconduct, gross negligence, intemperance or participation in the commission of a crime, violation of law or ordinance.

- Any treatment which are not recommended and performed by a Physician as being medically necessary including any charges for non-medical services such as telephone, radio, television, extra bed, extra food, toilet articles and the like, private duty nurse or physician.

- Except when conducting official business or in the line of duty, the following cases are also excluded in the coverage:

    - Injuries arising from war, invasion, act of foreign enemy, hostilities or warlike operations (whether declared or undeclared), mutiny, riot, civil commotion, strike, civil war, rebellion, revolution, insurrections, conspiracy, military or usurped power, martial law or state of siege, or any of the events or causes which determine the proclamation or maintenance of martial law or state of siege, seizure, quarantine or customs regulations; or nationalization by or under the order of any government or public or local authority; or any weapon or instrument employing atomic fission or radioactive force whether in time of peace or war.

    - Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.

ANNEX D

RAW DATA OF UTILIZATION REPORT FORMAT

Claim Number	Member ID	Claim Type	Membership Type	Sex	Start Date	End Date	Treatment Date	Provider	Diagnosis	Coverage	Received Date	Date Processed	Claimed Amount	Surcharge (if any)	Co-insurance (if applicable)	PhilHealth (if applicable)	Paid/ Reimbursed Amount	Check No./ Transaction Reference No.	Paid Date

PRICE BREAKDOWN FORM

ANNEX E

A. Premium Schedule

A	B	C	D (B + C)	E	F (D x E)	G (F x 12)
Premium Category	Indicative Number of Regular, Casual and Contractual Personnel[1]	Indicative Number of Home-based Personnel to be enrolled in 2020 [2]	TOTAL Indicative Number of Members	Monthly Premium Per Member	Total Monthly Premiums	Gross Annual Premium
Single	794	181	~~901~~ 975			
Duo	242	73	~~274~~ 315			
Group	560	167	~~635~~ 727			
	1,596	421	2,017	XXX	XXX	

B. Price Bid Breakdown

Item	Price
Projected Medical Expenses	
Financial Assistance Premium *(for principal members; inclusive of life indemnity, accidental death and dismemberment)*	
Risk Premium (if applicable)	
Administrative Costs	
Applicable Taxes	
Agent's Fee (if applicable)	
Total Bid Price [3]	

[1] *The indicative number of regular, casual and contractual personnel is based on the 31 August 2019 census provided by Cocolife.*

[2] Per Section V.3. of the Technical Specifications, home-based personnel will only be eligible after six (6) months of continuous service.
The breakdown of the home-based personnel per premium category is a projection based on the premium category breakdown of members currently covered by the local healthcare.

[3] *The Total Bid Price must be equal to the Gross Annual Premium.*