I. KwikCare Health Subscription

This is a comprehensive medical insurance that covers inpatient, outpatient, and emergency services. Doctor-prescribed tests and consultations are also included up to the maximum benefit limit. It offers no-cash-out in accredited clinics & hospitals nationwide.

II. Schedule of Benefits

a. Inpatient Benefit

i. Room and board accommodation up to maximum benefit limit
ii. General nursing services
iii. Services of accredited physicians, specialists, surgeons, and anesthesiologists
iv. Anesthesia and its administration, dressing, sutures, casts, and other necessary medical supplies
v. Use of operating room and/or recovery room;
vi. Transfusion of blood, blood elements, and other intravenous fluids
vii. ICU confinements – subject to the maximum benefit limit
viii. Prescribed laboratory examination including complex diagnostic procedures such as but not limited to MRI, CT scan, and ultrasound;
ix. Chemotherapy, radiotherapy, physical therapy, speech therapy, and dialysis – subject to provisions on "Pre-existing Conditions", "Maximum Limit – Dreaded Diseases" and "Special Procedures – New Modalities of Treatment"
x. All other expenses directly related to the medical management of the illness/injury that resulted to a plan member's confinement including Admission Kit

b. Outpatient Benefit

i. Unlimited number of medical consultations and follow-up consultations;
ii. Referral to accredited specialists; pre- and post-natal consultations;
iii. Administration of vaccines (except for the cost of vaccine)
iv. Emergency treatment and minor surgeries not requiring hospitalization;
v. Prescribed laboratory/diagnostic examinations; for covered illness and injuries;
vi. Including emergency (first) dose of anti-rabies, anti-venom, and/or anti-tetanus;

c. Emergency Care

i. In any accredited hospital nationwide

- All expenses directly related to the medical management of the illness and/or injury that resulted to the member's emergency treatment shall be covered on a no-cash-out basis

d. Maximum Benefit Limit

Maximum Benefit Limit (MBL) per illness per policy year shall apply to Dreaded Diseases/Conditions and its complications.

Dreaded Disease refers to any illness or condition that is chronically, persistently, or presently life-threatening or may result to physical or functional loss of body parts such as but not limited to:

- blood dyscrasias
- benign/malignant new growths
- chronic cardio/cardiovascular diseases
- collagen/connective diseases
- diseases of the immune system
- chronic hepatobiliary diseases
- neuro-surgical/neurological conditions
- chronic pulmonary diseases
- chronic 3enitor-urinary diseases
- chronic gynecological conditions
- chronic gastrointestinal diseases
- endocrine abnormalities
- antibiotic/chemotherapy-resistant diseases/bacteremia/septicemia
- chronic opthalmo-otolaryngoloci diseases
- chronic musculo-skeletal diseases
- pathological/accidental fractures
- illnesses/injuries necessitating the use of Isolation Room/ICU or other intensive care facilities
- accidental injuries
- second and third-degree burns
- surgical procedures requiring the application/use of prosthesis for immediate treatment
- pre-existing illnesses/injuries subject to the pre-existing conditions

e. Special Procedures and/or New Modalities of Treatment

The following special procedures are payable and will form part of the entire medical expense relating to the medical management of a covered condition requiring such special procedures:

- Lithotripsy

- Arthroscopic procedures
- Laparoscopic procedures
- Laser therapy (excludes use for correction of vision/LASIK)
- Nuclear/radioactive isotope scans
- Cost of artificial limbs, joint prosthesis, and heart valve prosthesis
- Other new modalities of treatment for conditions with established etiologies and are used as alternatives to the conventional or traditional procedures
- Dialysis
- Chemotherapy
- Radiation oncology/therapeutic radiology
- Sclerotherapy
- Physical and speech therapy
- Angiography
- Tests involving the use of nuclear technologies (e.g., but not limited to Radionuclide Ventriculography, Thallium Stress Testing, Radionuclide/Thyroid Scan, Pyrophosphate Scintigraphy, Positron Emission Tomography, Radio Isotope Scanning)
- Thallium scintigraphy
- CT Scan/Magnetic Resonance Imaging
- Pulmonary perfusion scan
- Endoscopy
- Bone Densitometry Scan
- Anti-Nuclear Anti-Body (ANA)
- C-Reactive Protein (Rheumatic and its complications)
- Lupus cell exam
- Sleep therapy

f. Pre-existing Conditions/Illnesses

Any illness, injury, or condition is considered pre-existing if at any time prior to the effectivity of the master policy or member's coverage:

- Professional advice or treatment had been obtained for such illness, injury, or condition.
- Such illness, injury or condition was in any way evident to the member.
- The natural history of such illness, injury or condition can be clinically determined to have started whether or not the member is aware of such illness or condition.

The following are automatically considered pre-existing conditions if occurring at any time within the first six (6) months after the effectivity date of the member's coverage whichever is later:

- asthma, pleural effusion, or other chronic airway obstruction conditions;
- benign cyst/tumor and malignant conditions;
- chronic gynecologic conditions;

- hemorrhoids and other chronic colonic and ano-rectal illnesses;
- disease tonsils requiring surgery, cataracts and other ophthalmo-otolaryngologic conditions;
- pathological abnormalities of nasal septum and turbinate;
- sinus condition requiring surgery;
- chronic neurologic conditions;
- calculus cholecystitis/cholelithiasis and/or urolithiasis;
- chronic conditions of the genitourinary system;
- polyps, ulcers, liver cirrhosis and other chronic gastrointestinal diseases;
- endocrine illnesses;
- seizure disorders;
- moderately to far advanced tuberculosis;
- chronic musculo-skeletal malignancies
- malignancies of the blood and bone marrow
- hypertension, coronary artery disease/myocardial ischemia, cerebro-vascular accident and other chronic cardiac diseases
- collagen/connective tissue diseases;
- diseases of the immune system.

III. Age Eligibility and Hierarchy of Dependents

Principal Plan Members - regular, full-time employees up to 65 years old (coverage automatically ends on the day before the employee celebrates his 66th birthday or retires from employment whichever is earlier.

Coverage for minors (0-17 years old) will only be enrolled as an immediate dependent of an employee. Minor dependents must be fully dependent to the employee, unmarried, and unemployed.

Immediate Dependents

i. For Married Employees

- Start with the LEGAL SPOUSE who is not more than 65 years old (coverage automatically ends on the day before the spouse celebrates 66th birthday);
- Followed by CHILDREN who are single, unemployed and at least 30 days up to 22 years old (coverage automatically ends on the day before the children celebrate their 23rd birthday).
- Legally adopted children can also be covered. Stepchildren who are yet to be adopted legitimately.

ii. For Single Parent Employees

- Starts with CHILDREN who are single, unemployed at least 30 days old up to 22 years old (coverage automatically ends on the day before the children celebrate their 23rd birthday).

- Followed by PARENTS up to 65 years old (coverage automatically ends on the day before the spouse celebrates 66th birthday);

iii. For Single Employees

- Start with PARENTS up to 65 years old (coverage automatically ends on the day before the parents celebrate their 66th birthday);
- Followed by SIBLINGS who are single, unemployed and at least 30 days old up to 22 years old (coverage automatically ends on the day before the siblings celebrate their 23rd birthday);

b. PhilHealth

The KwikCare Health Subscription Plans are designed to be "on top of the PhilHealth". As such, PhilHealth should be filed prior to discharge.

Should the plan member (or his duly authorized representative) be unable to submit accomplished PhilHealth Form to the appropriate section/person in the hospital where he is confined within prior appropriate time prior to discharge, any amount that would have been charged to and paid by PhilHealth will be settled by the plan member. This is regardless of the room accommodation at the time of his and/or his enrolled dependent's confinement.

IV. Room Accommodation (more than the Room & Board limit)

a. During Emergency Confinement

Should the plan member stay in a room higher than his/her Room and Board limit as a result of unavailable room equal to his Room and Board limit, eligible expenses on the first 24 hours of stay will be covered.

Should the plan member decide to stay further once an available room equal to or less than his Room and Board limit becomes available, the plan member will have to pay for the excess, ineligible expenses and/or corresponding incremental costs prior to discharge.

b. During Non-Emergency Confinement

Should the plan member stay in a room higher than his Room and Board limit, the plan member shall pay for any excess, ineligible expense and/or corresponding incremental costs incurred prior to discharge.

c. Excesses, Ineligible Expenses, and/or Incremental Costs

Prior to discharge from the hospital, the plan member should settle any of the following:

- Excess in the limits of the plan;
- Ineligible expenses such as but not limited to extra food, extra bed, etc);
- Incremental costs on professional fees, diagnostic tests, drugs and medicines, etc) resulting from taking a room and board accommodation more than the limit of the plan.

V. Limitations

Unless a specific endorsement is made, the program excludes coverage of the following:

1. Care by Non-Accredited Physician in either Accredited or Non-Accredited Hospitals, except in emergencies wherein the Emergency Provision of the Agreement shall apply;
2. Care by an Accredited Physician in a Non-Accredited Hospital or Clinic;
3. Additional hospital charges and professional fees resulting from taking a room category higher than that specified in the member's benefit schedule;
4. Additional personal comfort items (e.g., telephone, television, additional food trays, admission kit, and such other items of the same nature)
5. Procurement or use of corrective appliances, prosthesis, artificial aids, and durable equipment such as but not limited to the following: stents, prolene mesh, pins, screws, plates, wires, VP shunts, clips, hearing aids, intraocular lens, eyeglasses, contact lenses, balloons, valves, braces, crutches, pacemaker;
6. All pregnancy-related conditions and complications relating to the mother and unborn child, requiring medical and surgical care, regardless of time/date of occurrence (during the actual time of pregnancy or thereafter);
7. All sexually transmitted diseases;
8. Circumcision, sterilization of either sex or reversal of such, artificial insemination, sex transformation, or diagnosis and treatment of infertility'
9. Rest cures, custodial, domiciliary, and convalescent care. These pertain to care in a skilled accredited facility or an institution that meets certain standards for medical care and includes nursing care and therapeutic services following hospital confinement;
10. Cosmetic procedure and surgery and oral surgery solely for purpose of beautification, except reconstructive surgery to treat functional defects due to disease or accidental injury;
11. Blood screening, blood typing, cross-matching for potential donors in relation to blood donation and transfusion;

12. Weight reduction programs, surgical operation, or procedure for treatment of obesity, including but not limited to gastric stapling;
13. Dental examination, extractions, fillings and general dental attention and conditions and all complications arising there from, including oral surgery and prosthodontics procedures following accidental injury to teeth for purposes of beautification. Exceptions are treatment to the extent necessary for repair and or restoration of function of the covered person caused solely by accidental injuries;
14. All forms of behavioral disorders whether congenital or acquired; developmental or psychiatric disorder; psychosomatic illness;
15. Any injury, illness or condition which the Member may suffer after he/she has taken intoxicating drugs or alcoholic beverage as evidenced by clinical history or alcoholic breath duly determined by the examining physician/ medical personnel and/or as indicated in the police report and other official medical documents conditions or illnesses resulting from Alcoholism and Drug Addiction;
16. Medical or surgical procedures that are experimental in nature and those that are not generally accepted as standard medical treatment by the medical profession, that may include but is not limited to, Chiropractic Services, Acupuncture, and Reflexology;
17. Allergens used for hypersensitivity testing regardless of if administered as an outpatient or inpatient procedure;
18. All expenses incurred by the Member in the process of donating organs;
19. Treatment of injuries or illnesses resulting from the voluntary participation of a Member in any hazardous sport or activity that may include but is not limited to: bungee jumping, scuba diving, hang-gliding, mountain climbing, parachuting, surfing, rock climbing, airsoft, paint balling, boxing, wrestling, martial arts (such as taekwondo, judo, karate, etc.), gymnastics, motor sports (drag racing, jet skiing), wakeboarding, water skiing and all such other voluntary activities which pose a grave danger to life and limb, except those related to or directly connected with the Member's occupation as declared in the application for health care coverage under the Agreement;
20. All injuries or conditions that are self-inflicted or inflicted on the Member with his or her consent, or injuries or conditions attributed to participation by the Member in any activity where the Member utilizes procedures, techniques, instruments or products that substantially increase the risk of harm or damage;
21. Physical examinations, certification of results/fitness and other related services required for obtaining or continuing employment, insurance application, government licensing, travel clearances, school clearances, sports and competition clearances, company promotions or not related to the health maintenance of the client;

22. Treatment of injuries or illnesses due to military service or suffered under conditions of war;
23. Executive check-ups and confinement which are for purely diagnostic purposes except as specified in the Agreement;
24. Treatment of injuries or illnesses wherein the care or reimbursement of services is provided by law or a government program, up to the stipulated limits;
25. Treatment of any injury which is proven to be attributable to the Member's own misconduct such as negligence, intemperate use of drugs or alcoholic liquor, direct or indirect participation in the commission of a crime, whether consummated or not, violation of a law or ordinance, unnecessary exposure to imminent danger or hazard to health, infections or complications as a result of tattoos and piercing of the ear or any body part, whether self-inflicted or done by a third party, or attempted suicide or self-destruction, whether sane or insane. Self-inflicted fireworks related injuries are included in the general exclusion list;
26. All cases of assault perpetrated by the Member including domestic violence which result in harm or injury to the Member perpetrator; Charges by physicians and health professionals, whether or not accredited by PHILCARE, on the difference between their charged rate and PHILCARE standard professional fees for specific medical services;
27. Take-home medicines, preventive and /or non-therapeutic drugs, such as but not limited to vitamins, supplements, hormonal preparations, medicines, or drugs during confinement which are not available in the Philippines, immunizing agents and all other medicines/drugs not approved by the Bureau of Food and Drugs (BFAD);
28. Outpatient medicines, with the exception of intravenous chemotherapy medicine and those administered during an emergency treatment;
29. Vaccines whether elective or administered during an emergency treatment unless covered by the plan;
30. All hospital charges and Professional Fees incurred after the day and time the discharge from the hospital has been duly authorized;
31. Diagnosis and Treatment of Error of Refraction (EOR) conditions such as myopia, astigmatism, and the like and its complications (e.g. retinal detachment), including laser treatment for the purpose of corrective eye refraction;
32. Outpatient Pain Management is not covered except in cases of emergency. In- Patient Pain Management necessitating specialized pain management team and/or the use of specialized equipment are likewise not covered;
33. Complications arising from non-covered procedures and surgery;

34. All diseases declared as epidemic by the Department of Health and any other recognized health agencies.
35. Medico Legal Fees – these are professional fees of a medico-legal consultant to whom the patient is referred primarily for the issuance of a medical certificate for legal purposes including performance of autopsies.
36. Procedures and/or services considered screening methods; and
37. Congenital anomalies and conditions and their complications;
38. Access to Healthway Clinics;
39. Access to Manila Adventist Medical Center, Notre Dame De Charles Hospital, and Philippine Orthopedic Institute.

VI. Terms and Conditions

a. Availment of the medical benefits for this program has a waiting period of fifteen (15) days from the date of purchase. There will be no coverage during the fifteen (15) days waiting period except for the emergency accidental cases that are injuries sustained from vehicular accidents (with police report), acts of nature, struck by falling objects, drowning, and burns.

   Cashless availment through PhilCare's accredited networks only; reimbursement is not applicable.

b. Log-in credentials will be provided after fifteen (15) days from the date of purchase following the waiting period rule.
c. In cases of any emergency confinement due to accidental cases you may coordinate with PhilCare's hotline **8802-7333 loc 19216 or 19224** or Kwik.insure's Customer Service, **0917 659 2023 & 0917 651 2023** which is available every day, 9:00 am to 6:00 pm.
d. Pre-existing conditions will be covered by 100% of the maximum benefit limit for consultations and emergency cases (life-threatening cases such as but not limited to heart attack, stroke, severe asthma attack, sudden paralysis, elevation in blood pressure, and seizure disorders) only. Coverage for emergency cases is for expenses within the emergency room and is limited to doctor fees, treatment, and medicine. Surgical operations and room & board related to pre-existing conditions are excluded even if they are brought about by emergencies.
e. Pre-existing conditions with needed procedures, laboratory and diagnostic tests will be covered after six (6) months of continuous subscription.
f. Should a member fail to continuously pay for six (6) consecutive months, the waiting period for the pre-existing condition coverage start date will be reset.

   Example:
   - First month: August 1, 2023

- Fails to pay on the 5th month: January 1, 2024
- Reactivates account: January 10, 2024
- Pre-Existing Condition Coverage will start on July 10, 2024, given six (6) months of consecutive payments

g. For corporate accounts enrolled prior to August 15, 2023
   - Current enrollees (principal & dependents) – pre-existing conditions will be covered 100% of the maximum benefit limit for outpatient, inpatient, and emergency cases. This includes but not limited to consultations, laboratory, and diagnostic tests.
   - Additional enrollees (principal & dependents) – pre-existing conditions will be covered 100% of the maximum benefit limit for outpatient, inpatient, and emergency cases. This includes but not limited to consultations, laboratory, and diagnostic tests.
   - In cases of lapse in payment, once account is reactivated, the new Terms & Conditions will be applied when the account is reactivated.

     Example:
     - Enrollment date: June 1, 2023
     - Expiry date: September 1, 2023 (no payment was made)
     - Payment date: September 15, 2023
     - Reactivation date: September 15, 2023
     - Terms and Conditions of August 15, 2023, will apply.

h. For corporate accounts enrolled on August 15, 2023, onwards
   - Pre-existing conditions will be covered by 100% of the maximum benefit limit for consultations and emergency cases (life-threatening cases such as but not limited to heart attack, stroke, severe asthma attack, sudden paralysis, elevation in blood pressure, and seizure disorders) only. Coverage for emergency cases is for expenses within the emergency room and is limited to doctor fees, treatment, and medicine. Surgical operations and room & board related to pre-existing conditions are excluded even if they are brought about by emergencies.
   - Pre-existing conditions with needed procedures, laboratory and diagnostic tests will be covered after six (6) months of continuous subscription.

i. For individual accounts enrolled prior to August 15, 2023
   i. Current enrolled principals and dependents:

- Pre-existing conditions will be covered 100% of the maximum benefit limit for outpatient, inpatient, and emergency cases. This includes but not limited to consultations, laboratory, and diagnostic tests.

ii. Additional dependents enrolled on August 15, 2023, onwards:
- Pre-existing conditions will be covered by 100% of the maximum benefit limit for consultations and emergency cases (life-threatening cases such as but not limited to heart attack, stroke, severe asthma attack, sudden paralysis, elevation in blood pressure, and seizure disorders) only. Coverage for emergency cases is for expenses within the emergency room and is limited to doctor fees, treatment, and medicine. Surgical operations and room & board related to pre-existing conditions are excluded even if they are brought about by emergencies.
- Pre-existing conditions with needed procedures, laboratory and diagnostic tests will be covered after six (6) months of continuous subscription.

iii. In cases of lapse in payment, once account is reactivated, the new Terms & Conditions will be applied when the account is reactivated.

Example:
- Enrollment date: June 1, 2023
- Expiry date: September 1, 2023 (no payment was made)
- Payment date: September 15, 2023
- Reactivation date: September 15, 2023
- Terms and Conditions of August 15, 2023, will apply.

j. For individual accounts enrolled on August 15, 2023, onwards

i. For current enrollees and additional dependents:
- Pre-existing conditions will be covered by 100% of the maximum benefit limit for consultations and emergency cases (life-threatening cases such as but not limited to heart attack, stroke, severe asthma attack, sudden paralysis, elevation in blood pressure, and seizure disorders) only. Coverage for emergency cases is for expenses within the emergency room and is limited to doctor fees, treatment, and medicine. Surgical operations and room & board related to pre-existing conditions are excluded even if they are brought about by emergencies.
- Pre-existing conditions with needed procedures, laboratory and diagnostic tests will be covered after six (6) months of continuous subscription.

k. All terms and conditions are subject to change in accordance with the Group Master Policy provisions from PhilHealth Care, Inc.

VII. Excluded Nature of Business

a. Government Associations, Government Agencies, Government Financial Institutions, Government and Government-Owned and Controlled Corporations, and companies related to Government.
b. Health Services (including veterinary clinics, dental clinics, and schools related to hospitals).
c. Non-legally established groups, groups formed for the purposes of acquiring insurance and open groups.
d. Hazardous occupations are not covered such as, but not limited to blasters, stuntmen, pilots, armed forces, police, odd job laborers, mining, etc.
e. Agricultural sectors
f. Unemployed
g. Employees of associations, cooperatives, non-profit organizations will be allowed if provided proof or certification from the authorized signatory that coverage is an employee benefit.

VIII. Documentary Requirements

- **Employed Individuals and Enrolled Dependents**
  - Valid Government ID
  - Company ID
  - Payslip (if applicable)
  - Certificate of Employment

- **MSMEs, corporation, and start-up businesses**
  - Certificate of Registration
  - BIR 2306
  - Company Address
  - Barangay Permit (for sari-sari store)
  - Proof of Active Membership in Online Selling Platforms (Lazada, Shopee, Sarisuki, etc.)

- **Freelancers and gig workers (delivery riders, drivers, etc.)**
  - AML Compliance Certification
  - Counterpart Certificate of Business Registration Outside Philippines
  - Certificate of Employment
  - Proof of Remittance from Employer
  - Proof of active project contract with client
  - Proof of active membership in any ride-hailing or logistics apps

- **Household Helpers, Workers, and Drivers**
    - Proof of Employment – letter of confirmation from employer

IX. Premium

KwikCare Health Plans	Maximum Benefit Limit	Monthly Premium
KwikCare Health Starter	Php50,000.00	Php995.00
KwikCare Health Standard	Php100,000.00	Php1,250.00
KwikCare Health Max	Php150,000.00	Php1,495.00

- Dental (Optional) – Php350.00 (one-time payment – annual coverage);
- Premium is non-refundable;
- Rates are not applicable for over-aged enrollees;
- Rates are inclusive of pre-existing conditions up to MBL;
- Rates inclusive of NAF, exclusive of dental costs & other fees;
- Enrollee without PhilHealth coverage (including those with incomplete monthly payments) may opt to:
    - Enroll voluntarily under PhilHealth;
    - Pay for the PhilHealth portion of the bill when confined;
    - Pay an additional Php3,600.00 premium per head for processing of PhilHealth.