PARAMOUNT LIFE & GENERAL INSURANCE CORPORATION

Paramount Life & General Insurance Corporation
14th Floor, Sage House, 110 Rufino St., Legaspi Village
Makati, Philippines, Tel. No. 8842888
TIN 000-487-644-000

Group Medical Insurance Policy

Policy Number: GMI 0000228

Policyholder: CCT CREDIT COOPERATIVE

Effective Date: 11 OCTOBER 2019 TO 10 OCTOBER 2020

The **PARAMOUNT LIFE & GENERAL INSURANCE CORPORATION** (herein called the Company), subject to all conditions and provisions of this Policy, agrees to pay at its Home Office, the group insurance benefits as provided in the Schedule of Benefits section and to provide the other rights and privileges which are set forth in this Policy.

This Policy is issued in consideration of the Application of the Policyholder, a copy of which is attached to and made a part of the Master Policy and of the payment by the Policyholder of the premiums. The first premium is due on the Policy Effective Date. Subsequent premiums are payable as specified herein.

SIGNED AND SEALED at the Company's Home Office in Makati City, Philippines, as of the Policy Effective Date indicated above.

PARAMOUNT LIFE AND GENERAL INSURANCE CORPORATION

GEORGE T. TIU
President & COO

Documentary Stamps to the value of Php _____ have been affixed to the premium register where the policy is recorded.

IMPORTANT NOTICE

The Insurance Commissioner, with offices in Manila, Cebu and Davao is the Government official in charge of the enforcement of all laws relating to Insurance and has supervision over Insurance companies. He is ready at all times to render assistance in settling any controversy between an insurance company and a Policyholder relating to insurance matters.

Who May Be Insured

All individuals satisfying all of the following conditions shall be eligible for insurance under this Policy:

1. Any individual who has attained his 18th birth anniversary.
2. Any individual who is not more than 65 years old.
3. Any individual who is in good health and actively-at-work.
4. Enrolled by the Policyholder with the Company for coverage.

The term "DEPENDENTS" as used herein shall be limited to:

For Married Individuals

1. Legal spouse who is not more than 65 years old; and
2. Unmarried, legitimate, legitimated, legally adopted and acknowledged natural children, including natural children by legal fiction and stepchildren, who are wholly dependent upon the insured individual for support; and who are at least 14 days old but not more than 21 years old, not gainfully employed; and
3. Unmarried and unemployed illegitimate children who are at least 14 days old but not more than 21 years old, not gainfully employed, provided however, that:
   - The insured parent can present birth certificate to establish parentage; and
   - The illegitimate children are actually living under the care of the insured parent.

For Single Individuals

1. Unemployed parents of single individual who is not more than 65 years old; or
2. Unemployed and unmarried brothers and sisters who are 14 days old but not more than 21 years old, not gainfully employed.

Children of a single parent, 21 years old and below, unmarried and financially dependent on the individual becomes his qualified dependent upon declaration/endorsement by the Policyholder, parents or other sibling are then disqualified as his dependents.

Where both husband and wife are insured under the Policy, only the husband may apply for the insurance of their dependent-children. The wife shall be ineligible as a dependent. Likewise, where two or more unmarried siblings are insured under the Policy, only one of them may apply for the insurance of their dependent parent.

Minimum Participation Requirement

The minimum number required to participate under this Policy shall be in accordance with the following percentage in relation to eligible individuals:

NON-CONTRIBUTORY FUNDING – The Policyholder will pay the entire premium:

Requires one-hundred percent (100%) enrolment of all eligible individuals.

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CONTRIBUTORY FUNDING - The Policyholder and the individual will jointly pay the premium of the insurance or the individual will pay the entire premium of the insurance.

Requires at least seventy-five percent (75%) enrolment of all eligible individuals.

In the event the Policyholder failed to comply with the minimum participation requirement during the policy year, the Company shall continue to provide coverage to all individuals initially enrolled under this policy.

Date of Eligibility

The eligibility date of the individuals shall be in accordance with the following:

Classification of Individuals	Eligibility Date
Those who, on the effective date of this Policy are already eligible under the Policy	Effective date of this Policy
Those who become eligible under the Policy after the effective date of this Policy.	The date they become insured under the Policy

Effective Date of Individual Insurance

The insurance of an individual shall take effect on:

The individual's eligibility date PROVIDED application for insurance is submitted to and received by the Company within thirty-one (31) days from the individual's eligibility date; OTHERWISE, the insurance shall take effect on the date the application is approved by the Company, PROVIDED, however, that no hospitalization benefits shall be payable for confinement due to existing illness or disability occurring within three (3) months from the date the individual's insurance takes effect EXCEPT for individuals who were insured on the effective date of this Policy.

Termination of Insurance

This Policy and the individual's insurance hereunder shall automatically terminate in the earliest of the following dates:

A. The Policy
   1. The date the premium falls due if written notice that this Policy will not be renewed is given to the Company by the Policyholder on or before said due date;
   2. The date of receipt by the Company of the Policyholder's written notice to terminate this Policy, if such notice is given during the grace period;
   3. The date next following the end of the grace period if premium is not paid.

B. The Individual Insurance
   1. The date this Policy terminates;
   2. The date the insurance of the individual under the Policy terminates;
   3. The date the individual attains his 66th birth anniversary;

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4. The date the individual ceases active work on account of temporary layoff or leave of absence without pay. His insurance however, shall be resumed immediately upon his return to active full-time work for the Policyholder and upon the payment of his premiums.
5. The date the individual ceases to be an active member of the Policyholder.

Dependent's Insurance

1. The date this Policy terminates;
2. The date the insurance under the Policy of the concerned individual terminates;
3. The date the dependent ceases to be qualified under the definition of the term dependents hereunder.

PART II. INSURANCE BENEFITS PROVISION

Reimbursement Conditions

The Company shall reimburse the actual, necessary, reasonable and customary hospital and medical expenses incurred by an individual hereunder, subject, to the maximum amounts specified in the SCHEDULE OF BENEFITS, the other provisions of this Policy and the following conditions:

1. That he shall have been disabled due to an accidental body injury; disease or sickness.

2. That by reason of such disability, he shall have been confined upon the recommendation of a duly licensed physician (M.D.) for at least six (6) hours in a legally constituted and operated hospital designated by the Company.

3. That due proof of hospital and medical expenses relative to such disability and confinement shall have been received and accepted by the Company.

The Company reserves the right to recover losses in the event the insured individual is injured by a third party by acting on behalf of the insured in seeking damage from the injuring party, provided, however that the excess of the amount or sum of money made by the Company with respect to the loss, damage and/or expenses shall be turned over to the insured after deduction of expenses of collection, judicial cost and attorney's fees, if any have been incurred.

The Company shall likewise reimburse an individual who had been separated from the Policyholder of his hospital and medical expenses as though his insurance had not been terminated, subject however to the same conditions set forth in the next preceding paragraph and to the two (2) additional conditions hereunder;

1. That such confinement is due to an accidental injury occurring or sickness or disease commencing before the termination of his insurance until the date of his confinement.

2. That he has been continuously disabled because of such injury, sickness or disease before the date of the termination of his insurance until the date of his confinement.

For purposes of the insurance under this Policy, successive hospital confinements, brought about by the same cause or interrelated causes, or by any or all medical complications thereof, but not separated from one another by an intervening period of at least fourteen (14) days of return to active full-time work for employees or one hundred eighty (180) days for dependents (from the date of discharge to

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the date of readmission), shall be regarded as confinements during any one period of disability. Accordingly, reimbursements already made for the previous confinements shall be taken into account in determining the reimbursable amount due for the second and subsequent confinements.

On the other hand, successive hospital confinements separated by an intervening period of at least fourteen (14) days of return to active full-time work for employees or one hundred eighty (180) days for dependents, even if brought about by disability arising from the same cause or interrelated causes or by any or all medical complications thereof the subsequent confinement shall be regarded as if it were brought about by an entirely new and different disability and expenses therefore shall be reimbursable independently of and separately from the previous confinements.

Description of Benefits

This Policy provides the following benefits for any covered disability, but not to exceed the maximum amounts shown in the SCHEDULE OF BENEFITS.

Room and Board. This consists of charges for room accommodation and subsistence for the number of days the individual is confined in a hospital.

Payment for Room and Board shall be made for the exact number of days as charged by the hospital, including any fractional part of a day.

Under this benefit the charges such as extra bed, extra tray, transfer room and similar extra charges are not reimbursable.

Special Hospital Services. This benefit generally provides for payment of expenses incurred for hospital services. This benefit covers the following:

a. Operating room including anesthetics and oxygen and their administration;
b. X-rays examinations and echocardiography;
c. Laboratory examinations; and
d. Drugs, medicines, dressing and blood transfusions.

Benefits for hospital services are to be allowed only when the individual is confined in the hospital as a registered bed patient.

Charges for copies of hospital records, registration fees, newspapers, telephone calls, rent of radio or television and other similar charges are not covered.

Surgical Fee. This is the charge of the surgeon but not to exceed the amount corresponding to the particular surgery performed as determined by the SCHEDULE OF OPERATIONS. This benefit shall be payable even if no hospital confinement is involved, provided the surgery is performed by a legally qualified surgeon.

If two or more operative procedures are performed through a single incision, payment shall be made only for that one operation for which the largest amount of benefit is payable.

If the surgical operation performed is not shown in the SCHEDULE OF OPERATIONS the Company reserves the right to determine the maximum benefit thereof. A surgical operation of equivalent gravity and severity shall be used as the basis of the Company's settlement thereof. Only one surgeon's fee is payable, any other charges made by assistant surgeons are not payable.

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If specialized procedures and treatment are required or provided, the Company will pay up to the corresponding benefit or up to the limits stated in the SCHEDULE OF BENEFITS.

Doctor Calls. These are the daily charges of the attending physician for in-hospital visits or treatment calls to the individual during his confinement which can be determined by multiplying the doctor's rate per call by the number of days for which the individual was charged for the room and board while confined as a registered bed patient, but

Doctor Calls benefit shall not be paid for:

a. More than one treatment call on any calendar day; or
b. Treatment received for pregnancy or resulting childbirth, abortion or miscarriage or conditions which result from any one of these; or
c. Treatment received on the day of any surgical operation and during convalescence there from the individual is entitled to receive benefit from such surgical operation, regardless of whether or not the benefit for the doctor calls is greater than the surgical benefit.

Major Medical Insurance Benefits

The benefits hereunder shall apply only after the "Basic Benefits" as stated in the SCHEDULE OF BENEFITS shall have been paid. However, in all major medical services cases, a specified amount called the "CORRIDOR DEDUCTIBLE" as mentioned in the SCHEDULE OF BENEFITS shall be paid fully by the insured before his eligible expenses shall be considered for major medical insurance during any one disability.

Co-insurance. The Company will pay 80% of the covered expenses incurred while 20% will be absorbed by the insured individual.

Major Medical insurance covers the following expenses up to the maximum amounts stated in the SCHEDULE OF BENEFITS:

1. Room and Board;
2. Special Hospital Services;
3. Doctor calls;
4. Surgical fee and anesthesiologist's fee;
5. Post operative services;
6. Rental of wheel or iron lungs;
7. Prosthetic appliances;
8. Professional services performed by a registered nurse other than a nurse who is a relative or one who ordinarily resides in the insured's home and as prescribed by a physician;
9. Emergency transportation by a professional ambulance from place of disablement to nearest hospital;
10. Medical services and supplies performed or prescribed during confinement on account of the following complications of pregnancy;

    - Toxemia of pregnancy;
    - Eclampsia of pregnancy;
    - Extra-uterine pregnancy;
    - Hyperemesis gravidarum; or
    - Hydatidiform mole; and

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11. Medical services and supplies performed or prescribed during confinement on account of caesarian section and miscarriage/abortion, provided, however, that there is a prescribed Maternity Benefit under the Basic Benefits.
12. Out-patient benefits, if part of the medical program, such as consultation fees prescribed diagnostic tests and prescribed medicines.

Limitations

Expenses for any hospital confinement brought about by a cause or causes enumerated hereunder shall not be reimbursed:

1. The hospital confinement and the charges and operation, if any, upon which a claim is based the continuation of such confinement during the entire period thereof not recommended and/or approved by a legally qualified physician or surgeon (M.D.).

2. Charges for nursing or any other charges, fees or expenses not mentioned in the Schedule of Benefits and the other provisions of this group Policy.

3. Charges for room, board general nursing care and special hospital services which are not related to the diagnosis and treatment of the condition for which hospital confinement is required by the attending physician or surgeon.

4. Any doctor's fee except fees of the surgeon for performing any operation mentioned in the provisions of this group Policy.

5. Charges for the use or acquisition of prosthetic appliances, such as artificial limbs, hearing aids, and others. This particular limitation does not apply under the Major Medical Benefits.

6. Hospital confinement or for charges or surgical fees incurred which result from:

   a. Any bodily injury sustained by the insured which he is in or about any airplane or aerial device except while traveling as a fare-paying passenger in a passenger airplane which is:

      1. Operated by a regular passenger airline;
      2. Operated by a duly licensed pilot; and
      3. Traveling on a scheduled passenger trip over an established passenger route.

   b. Any form disability, injury, sickness, sustained or contracted in riot, civil commotion, insurrection, or war, or service in any military, naval or air force of any country while such country is engaged in war, or police duty and a member of any military, naval or air organization.

   c. Any bodily injury self-inflicted intentionally whether the insured is sane or insane at the time of commission.

   d. Any dental treatment or surgery except dental operation resulting from an injury sustained by the insured in an accident.

   e. Treatment of any mental and nervous disease or disorder.

   f. Any treatment, which is purely for physical therapy or for recuperative purposes or confinement in a hospital or sanatorium or convalescent home for rest cure.

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g. Any treatment for tuberculosis, except surgical operations for removal of diseased portions of organs afflicted with tuberculosis, e.g. caecum, kidney, spine.

h. Any treatment or surgical operations for congenital deformities or defects, such as harelip, clubfoot, hernia, heart defect, birthmark, abnormal bone or muscular growth, cerebral palsy, and others.

i. Any confinement for physical checkup or diagnostic purposes.

j. Any communicable disease in epidemic proportion as declared by the government and any form of venereal disease.

k. Any cosmetic surgery except for treatment of injury sustained in an accident while insured.

l. Sterilization of either sex, such as castration, vasectomy, tubectomy, and tubal ligation.

m. Any process in determining the refractive errors of the eyes and their correction by glasses.

n. Any plastic surgery for any condition present on the effective date of the individuals insurance, such as bone or flesh transplanting;

7. Hospital confinement for charges or surgical fees incurred which result form pregnancy, resulting childbirth, miscarriage or caesarian section, prenatal or postnatal care. This particular limitation shall be applicable only where maternity and obstetrical benefits are not indicated in the Schedule of Benefits.

8. Resulting from any services or supplies for which no reimbursement or payment is required on account of the insured person receiving them.

9. Any hospital confinement or charges incurred for the treatment of Acquired Immuno Deficiency Syndrome (AIDS) or charges incurred for the examination immunization, and detection of human deficiency of human immuno deficiency virus and other related viruses.

10. Any hospital confinement for sickness or injuries incurred in the commission of criminal acts.

11. Confinement for charges or surgical fees incurred for the treatment of a pre-existing illness. An illness or condition shall be considered pre-existing if, during the period prior to the Effective Date of the Master Policy or the approval date of reinstatement in case of lapse, any of the following conditions are present:

    a. any professional advice or treatment was given for such illness or condition;
    b. such illness or condition was in any way evident to the member; or
    c. the pathogenesis of such illness or condition has started whether or not a member is aware of such illness or condition.

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The following conditions, among others, shall be considered pre-existing:

Cardio Vascular Disease
Cerebro Vascular Accident
Blood Dyscracias
Cirrhosis of the Liver
Cancer
Kidney Renal Failure
Systematic Lupus Erythematous
Multiple Sclerosis
Hepatitis B Infection
Decentral Nervous System Lesions

Pre-existing Conditions shall be covered only upon meeting the conditions stated below:

a. After twelve (12) months of membership without interruption provided
b. Such condition is properly declared on the application form and that no benefit were recovered herein based on said condition, and
c. Provided finally that the member concerned renews his memberships to another term immediately in the succeeding year without interruption.

PART IV. GENERAL PROVISIONS

Notice and Proof of Claims

Affirmative proof shall be furnished the Company within thirty (30) days from the termination of the hospital confinement upon which the claim is made. Failure to comply with this requirement, however, shall not invalidate the claim if it shall be shown that it was not reasonably possible to furnish such proof within the prescribed time; and that such proof was immediately furnished as soon as reasonably possible.

The Company shall have the right to require as part of the proof of claim any other proof as regards the hospital confinement, hospital charges and fees incurred.

The Company shall likewise have the right to examine the person whose injury or sickness is the basis of a claim when and as often as it may reasonably require during the pendency of such claim.

Payment of Claims

Upon request of the insured individual and subject to receipt and acceptance by the Company of due proof of loss, the accrued hospitalization benefits of an individual shall be paid within two (2) weeks during any period for which the Company is liable. Any balance remaining unpaid at the termination of such period shall be paid immediately upon receipt and acceptance of due loss.

In case of death of an insured individual, the Company may pay any benefits remaining unpaid to the doctor and/or person submitting receipted bill showing payments of such fees or charges. Such payments shall fully discharge all liabilities of the Company under this Policy with respect to the deceased individual.

No court action shall be brought to recover on this Policy prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of this Policy, nor shall such

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action be brought at all unless brought within two (2) years from the expiration of the time within such proof of loss is required under this Policy.

Claims for expenses made or on behalf of an insured individual in any foreign currency shall be converted to Philippine Pesos at the official buying rate for such currency that is in effect in the Philippines at the commercial banks at the time of payment of such claim by the Insured Person. An Insured Person will be covered by the insurance up to ninety (90) days of staying outside the Philippines in a year.

Payment of Premiums

All premiums hereunder are payable in advance directly to the Home Office of the Company, or through other Officer as the Company may designate, except the premiums due during the first Policy year may be paid elsewhere through a duly authorized Agent of the Company in exchange for a Company receipt signed by the Agent.

The Policyholder shall be liable to pay the Company the pro-rata premium corresponding to the time the insurance hereunder has been kept continuously in force during the grace period after the premium due date upon which default occurred.

The Company shall furnish the Policyholder with premium statement for each premium due. The premium statement shall include the particulars about any additional individual to be insured, individual whose insurance is to be terminated, and/or premium adjustments, if any. Premium adjustments involving refund to the Policyholder by the Company of any unearned premiums shall be limited to the twelve (12) months immediately preceding the date of receipt by the latter of the evidence that such adjustment should be made.

Grace Period

A thirty-one (31) day grace period, without interest charge shall be allowed the Policyholder by the Company for the payment of every premium due after the first.

Non-Waiver Of Policy Provisions

Failure of the Company to insist upon compliance with any provisions of this Policy at any given time or under any given set of circumstances shall not operate to waive or modify such provisions, or in any manner whatsoever to render it unenforceable, as to any other time or as to any other occurrence, whether the circumstances are, or are not, the same.

Other Insurance

Expenses incurred by an insured individual that have been covered by and/or paid for by a health care company or another insurance company or similar agencies shall no longer be claimed from the Company. Any balance not covered or paid for, if still coverable under this Policy, may be subject for reimbursement by the Company. An insured individual insured by any other medical insurance shall inform and provide the Company with a copy of the medical insurance computation sheet, photocopy of hospital statement of account and certified true copy of official receipt of hospital bill.

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Suits against third parties

Nothing in this Policy shall the Company liable to respond or lay defense to any suits for damages which may be instituted by an insured individual against any physician or hospital nominated under this Policy, for reasons of neglect, malpractice, or other causes arising from his acts or omissions in the treatment or examination of any insured under the terms of this Policy.

Definition of Terms Used:

"Actively at work" - an employee shall be considered "actively at work" for the purposes of insurance if he reports for work on the day in question at his usual place of employment with his Employer and such usual place of employment is outside of his home and if when he so reports he is able to perform all of the usual and customary duties of his occupation on a regular, full-time basis. If an employee does not so report, or if his usual place of employment with his Employer is not outside of his home, he shall be considered "actively at work" if at any time on the date in question he is neither (i) hospital confined, nor (ii) disabled to a degree that he could not then have reported to a place of employment outside of his home and performed all of the usual and customary duties of his occupation on a regular, full-time basis.

"Insurance Age" – is the age of the individual on his latest birth anniversary.

"Disabled" – an individual shall be considered "disabled" if he is unable to perform any of the usual and customary duties of his occupation due to accidental bodily injury, disease or sickness.

"Disability" – shall mean any accidental bodily injury, disease or sickness which prevents an individual from performing any of the unusual and customary duties of his occupation. Pregnancy shall no be considered as a disability.

"Actual, necessary, reasonable and customary expenses" - shall mean the real and essential which a prudent person would consider to be reasonably priced in the particular are concerned in the light of the disability being treated.

The masculine pronoun whenever used in this Policy shall include feminine and the singular shall include the plural unless the context clearly indicates a different meaning.

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SCHEDULE OF OPERATIONS
Expressed as a Percentage of the Maximum Surgical Benefit
(For Basic Medical Benefit Only)

Description of Operation	Maximum Benefit (%)
ABDOMEN	
Operations involving cutting into abdominal cavity:	
Appendectomy	50.00
Gastro-Enterestomy: gastrectomy:	
Resection of Bowel	87.50
Removal of spleen, removal of gallbladder.	75.00
Any other laparotomy (except as specified below)	66.67
(Two or more surgical procedures performed through the same abdominal incision will be considered as one operation).	
ABCESS-Incision and Treatment	
Superficial abcesses; boils (each, limited to 2 in any one disability)	3.33
CarbuNcle, Cellulitis, paroncychia	10.00
Deep abscesses: Ischiorectal, peritonsillar; Bartholin Gland, Intramuscular abscess	15.00
AMPUTATION	
Finger or toe (each)	7.50
Thigh or knee	62.50
Arm, forearm, entire hand, leg or entire foot	50.00
BREAST	
Amputation, Single	50.00
Amputation, radical for cancer	75.00
Removal of cysts or benign tumors (one or more)	25.00
Abscesses, deep (furuncles excepted) (one or more)	10.00
CHEST	
Complete thoracoplasty, or removal of portion of lung	100.00
Other cutting into thoracic cavity for diagnosis of treatment (tapping excepted)	50.00
Induction of artificial pneumothorax	12.50
Refills of pneumothorax, each (limit of ten during one disability)	5.00
DISLOCATION-Reduction and Treatment of:	
Hip or knee joint (Patella excepted)	17.50
Shoulder, elbow or ankle joint	15.00
Lower jaw, collar bone or wrist	7.50

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EXCISION or FIXATION BY CUTTING - Removal of:

Shoulder or hip joint	75.00
Knee joint	62.50
Elbow, wrist, ankle joints	50.00
Diseased portion of long bones including curettage	25.00

EAR, NOSE, THROAT

Mastoidectomy, one side	50.00
Both sides	75.00
Tonsillectomy, or tonsils and adenoids (cutting operations only)	15.00
Sinus operation, radical	50.00
Submucuos resection (entire procedure)	37.50
Any other cutting operation (Polyps, adenoids)	7.50
Cutting operation on larynx or trachea (tracheotomy)	37.50
Bronchoscopy with removal of foreign body or biopsy	25.00
Bronchoscopy for purposes of diagnosis	20.00

EYE

Removal of cataract	75.00
Any other cutting operation into eyeball (through cornea or sclera or operation on eye muscles)	50.00
Operation for detached retina	100.00
Any other cutting operation on eyeball	10.00
Enucleation, eyeball	37.50

FRACTURE, REDUCTION & TREATMENT

Thigh, pelvis, vertabrae (coccyx excepted)	37.50
Leg (one or two bones), kneecap, upperarm	25.00
Lower jaw (alveolar processes excepted), skull, collar bone, shoulder blade or forearm (one or two bones)	12.50
Wrist, hand, ankle, or foot or sternum	13.33
Nose, finger or toe, each	5.00
Ribs or vertebral processes (one or more)	
Coccyx or upper jaw	12.50

The amounts shown above are for simple or multiple fractures. For compound fracture, the maximum will be one and one half times the amount for a simple fracture. For a fracture requiring an open operation with bone grafting, bone splinting, or metallic fixation at point of fraction, the maximum will be twice the amount for a simple fracture.

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GENITO-URINARY TRACT

Cystoscopy	12.50
Removal of kidney	100.00
Cutting into or fixation of kidney	75.00
Removal of tumors or stones in kidney, ureter or bladder:	
By open operation (e.g. Ureterolithotomy)	66.67
By crushing of cautery (through cystoscope)	25.00
Removal of entire prostate (complete procedure)	75.00
Removal of part of prostate: By endoscopic Means	50.00
Varicocele, cutting operation	25.00
Vasectomy (for disease only)	25.00
Epididymectomy	25.00
Hydrocele, excision or incision and treatment of sac (tapping excepted)	25.00
Orchidectomy	25.00
Complete removal of uterus tubes and ovaries	100.00
Hysterectomy	66.67
Removal of uterine polyps or cysts, one or more	12.50
Cauterization of cervix	12.50
Bartholin's gland, radical excision	12.50
Plastic operation of vagina and perineum (not including post-partum)	37.50
Dilation and curettage (non-puerperal)	12.50

GOITER, NECK

Thyroidectomy (complete procedure inclusing ligation of thyroid arteries, to be treated as one operation)	75.00
Ligation of thyroid arteries not followed by thyroidectomy:	
One or more at one operation	23.33
Two or more stage operations	50.00
(Complete procedure to be treated as one operation)	
Neck surgery	37.50

HERNIA - Cutting operation and/or injection treatment (Complete procedure)

Single hernia	50.00
More than one hernia	62.50

JOINT

Incision into (tapping excepted)	12.50
Semilunar cartilage, removal of	16.67

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LIGAMENTS OR TENDONS	
Cutting operation, lengthening or transplanting	25.00
Suturing, single	17.50
Suturing, multiple	25.00
TAPPING (Each limited to two during one disability)	
Abdomen, chest or bladder (other than catheterization)	10.00
Eardrum, joint or spine	6.67
RECTUM	
External hemorrhoids only	12.50
Internal hemorrhoids or Internal and External	25.00
Fistula in ano, radical operation	12.50
Prolapse of rectum	22.00
Proctoscopy and/or Signoidoscopy	12.50
SKULL	
Cutting into cranial cavity for tumor or abscess	100.00
Trephining or decompression, for fracture	35.50
Carotid Angiography	37.50
SPINE OR SPINAL CORD	
Operation involving removal of portion of vertebrae (e.g. laminectomy), processes excepted	100.00
Removal of processes (one or more)	50.00
Coccyx, removal of	25.00
TUMORS OR CYSTS	
Cutting operation for removal of malignant tumors:	
Involving internal organ or organs	66.67
Superficial, face, lip, skin	16.67
Benign tumors (one or more)	12.50
Removal of warts, moles, ingrowing toenails, Sebacceous cysts (one or more)	5.00
Pilonidal cyst (radical removal)	16.67
Bursae (radical removal)	13.33
Ganglion	10.00
VARICOSE VEINS	
Cutting operation and/or injection (complete procedures on all veins involved)	30.00

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PARAMOUNTCare

October 11, 2019

Mr. Allan L. Legaspi
General Manager (Peer Servant)
CCT CREDIT COOPERATIVE
5TH Floor Enchelon Tower, 2100 A. Mabini St.

RE: GROUP MEDICAL INSURANCE

Dear Mr. Legaspi,

Thank you for considering Paramount Life & General Insurance Corporation as your partner in providing Group Medical Insurance program for the employees **CCT CREDIT COOPERATIVE.**

Before we finalize our policy contract, we have presented below plan features for your approval:

SCHEDULE OF BENEFIT

PLAN DESCRIPTION	
BASIC MEDICAL BENEFIT*	
Maximum Limit	50,000
Room & Board Limit, max of 31 days	Ward up to Php600
Hospital Miscellaneous Services	As charged
Surgical Fee based on schedule of operation	10,000
Anesthesiologist's Fee, 35% of eligible surgical fee	3,500
Doctor's Fee, mas of 31 days	600
Specialist's Fee, max. of 7 days	600
OUT-PATIENT BENEFIT	
Annual Benefit Limit	1,000
Consultation Fee per day	As charged
X-ray/laboratory tests	As charged
BASIC LIFE	
Amount of cover	20,000

ANNUAL PHYSICAL EXAM (for Principal members only) through MedAsia accredited clinics for APE Php500.00 only

Physical Examination
Complete Blood Count (CBC)
Fecalysis
Urinalysis
Chest X-ray

PREMIUM COST

Annual Premium	
Per Employee with Membership Card	2,600.00

Philhealth Benefit - In addition to Philhealth

Effective Date – **October 11, 2019 to October 10, 2020**

Should you find everything in order as discussed, please affix your signature on the space provided below to confirm acceptance of the foregoing terms.

Thank you and best regards.

Sincerely yours,

NAOME LUCERNAS
Account Executive

WITH MY CONFORMITY:

CCT CREDIT COOPERATIVE

MR. ALLAN L. LEGASPI
CCT, General Manager (Peer Servant)

MINDANAO ALLIANCE FOR SELF HELP SOCIETY – SOUTHERN PHILS. EDUCATIONAL COOPERATIVE CENTER

MS. BERNADETTE O. TOLEDO, CPA
MASS-SPECC, Chief Executive Officer

MASS-SPECC
COOPERATIVE DEVELOPMENT CENTER

coop International Co-operative Alliance

PARAMOUNT LIFE & GENERAL INSURANCE CORPORATION

POLICY SCHEDULE

CCT CREDIT COOPERATIVE
5th Floor Enchelon Tower,
2100 A. Mabini St.

GROUP MEDICAL INSURANCE
POLICY NUMBER GMI- 000228
DATE ISSUED
PERIOD OF INSURANCE
FROM October 11, 2019
TO October 10, 2020

Schedule of Benefits

The benefits under this Policy are in addition to the benefits under the Employees Compensation and State Insurance Fund but are superimposed on the PhilHealth benefits under the National Health Insurance Act of 1995 (Republic Act No. 7875). This Policy shall reimburse covered expenses up to the maximum benefit limits which are not payable under the said National Health Insurance Act of 1995. In no instance, however, shall the total payment under this Policy and the PhilHealth benefits exceed the actual incurred expenses.

PLAN DESCRIPTION	
BASIC MEDICAL BENEFIT*	
Maximum Limit	50,000
Room & Board Limit, max of 31 days	Ward up to Php 600
Hospital Miscellaneous Services	As charged
Surgical Fee based on schedule of operation	10,000
Anesthesiologist's Fee, 35% of eligible surgical fee	3,500
Doctor's Fee, max of 31 days	600
Specialist's Fee, max. of 7 days	600
OUT-PATIENT BENEFIT	
Annual Benefit Limit	1,000
Consultation Fee per day	As charged
X-ray/laboratory tests	As charged
BASIC LIFE	
Amount of cover	20,000

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ANNUAL PHYSICAL EXAM (for Principal members only) through MedAsia accredited clinics for APE Php 500.00 only

Physical Examination
Complete Blood Count (CBC)
Fecalysis
Urinalysis
Chest X-ray

***MAXIMUM BENEFITS DURING ANY ONE PERIOD OF DISABILITY**

PRE-EXISTING CONDITIONS, covered up to Maximum Limit per head

Note:
* Member's eligibility age is 18 - 65 years old.

For Board of Directors, current officers and pioneer members, eligibility age is up 70 years old. Beginning age 71 until 75 years old coverage will reduce to 50% for both medical & life cover. Exit age is 76 years old.

* For non-accredited hospitals and doctors, Paramount shall reimburse medical expenses based on the existing benefit.

Premium Rates
On the Policy Effective Date, the annual premium rate/s shall be:

The Company reserves the right to establish new premium rates at the beginning of any renewal year or whenever the terms of this Policy are changed.

Classification	**Premium**
Principal	Php 38,062.62
In & Out Patient Benefit, Basic Life, APE & NAF	Inclusive
SUB-TOTAL	38,062.62
Documentary Stamp	100.00
Premium tax	761.25
Local Government Tax	76.13
TOTAL AMOUNT DUE	**39,000.00**

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Benefits

Subject to the provisions of the sections entitled "REIMBURSEMENT CONDITIONS" and "DESCRIPTION OF BENEFITS", and other provisions of this Policy, the Company shall reimburse the actual, necessary and reasonable customary expenses which an individual may have incurred up to the maximum amounts specified in the SCHEDULE OF BENEFITS.

WITH MY CONFORMITY:

CCT CREDIT COOPERATIVE

ALLAN L. LEGASPI
CCT, General Manager
(Peer Servant)

MINDANAO ALLIANCE FOR SELF HELP SOCIETY – SOUTHERN PHILS. EDUCATIONAL COOPERATIVE CENTER

BERNADETTE O. TOLEDO, CPA
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