TERMS OF REFERENCE

PROJECT: PROCUREMENT OF HEALTH CARE SERVICE PROVIDER FOR BASES CONVERSION AND DEVELOPMENT AUTHORITY (BCDA)

I. General Objectives

The Bases Conversion and Development Authority seeks to acquire the services of a Health Care Service Provider by selecting the **Lowest Calculated Responsive Bid**. BCDA, through the Health Care Service Provider, aims to: 1) provide efficient and appropriate health care services to its employees and their qualified dependents, and 2) provide the following services to all planholders with a maximum coverage benefit of P360,000.00/illness/year, exclusive of Philhealth benefits: a) Outpatient care; b) Preventive healthcare; c) In-patient care; d) Emergency cases; e) Network Access; f) Medico-legal cases; g) Ambulance Service; h) Dental Benefit; i) Financial Assistance; j) Special Concession; k) Extension of Coverage; and l) Pre-existing conditions coverage.

II. Duration of Contract

The Contract shall be for a period of one (1) year, effective **August 1, 2020 to July 31, 2021,** both for principal members and dependents, unless otherwise terminated pursuant to causes stated in the contract.

BCDA may opt to extend the Contract on a periodic **month-to-month basis not to exceed an aggregate period of one (1) year,** upon terms and conditions mutually acceptable to the parties concerned, in accordance with the Revised Guidelines on the Extension of Contracts for General Support Services issued by the Government Procurement Policy Board (GPPB Resolution No. 023-2007 dated 28 September 2007).

III. Approved Budget for the Contract

The Approved Budget for the Contract (ABC) is **FIVE MILLION FOUR HUNDRED THOUSAND PESOS (Php 5,400,000.00)** or (P40,000.00 x 135 principal members, as of 06 May 2020), inclusive of all applicable taxes and fees.

All bid prices (per principal member) for the duration of the contract shall be fixed. The number of principal members/planholders may increase or decrease at the discretion of BCDA depending on BCDA's requirements.

The above ABC is computed based on the number of principal members only. Premium rates for the Dependent Members shall be discussed only after the declaration of the Lowest Calculated Responsive Bid (LCRB) and issuance of Notice of Award. The proposed premium for the highest option for Dependent Members shall not exceed the proposed premium for Principal Members.

IV. Membership Eligibility for Health Care Coverage

The following persons shall be eligible for health care coverage of the Health Care Service Provider:

A. Principal Members

1. All bonafide employees of BCDA (married couples who are both employees of BCDA shall each be considered as principal members)

2. All bonafide employees of BCDA's subsidiaries which BCDA may, at its sole discretion, include as principal members (married couples who are both employees of the BCDA subsidiary shall each be considered as principal members)

3. Other individuals who render services to BCDA whom BCDA, at its sole discretion, may include as principal members as long as the Principal Members will not go beyond 135 or the premium paid will not exceed the ABC.

B. Dependents of the above-mentioned principal members, namely:

1. The lawful spouse;
2. All eligible (legitimate, illegitimate or adopted) children and stepchildren of the principal, from fifteen (15) days old to twenty one (21) years old;
3. Both parents below (65) years old, if the employee is single or a widow/er with no children;
4. All siblings from fifteen (15) days old to twenty one (21) years old, if the employee is single or a widow/er with no children;

The number of dependents shall in no way depend on the number of principal members.

V. Health Care Coverage and Benefits Required under the Contract

The Health Care Service Provider shall offer a health care package within the ABC/price per principal member which shall include the following benefits:

A. Maximum Coverage Benefit

1. Maximum Coverage Benefit of at least P360,000.00/illness/year, exclusive of Philhealth benefits, for Principal Members

2. Plan options for Dependent Members shall have Maximum Coverage Benefit, exclusive of Philhealth benefits, of at least:

- P360,000.00/illness/year
- P300,000.00/illness/year
- P250,000.00/illness/year
- P200,000.00/illness/year
- P125,000.00/illness/year

Principal member may opt to choose a different membership plan/package (Open Private and Semi-Private) and Maximum Coverage Benefit for each of his/her dependents.

B. Out-Patient Benefit

1. Any reasonable number of consultations, during regular clinic hours. Expenses for prescribed medicines, nebulization kit and nebules used in nebulization**,** are not covered and shall be for the sole account of the Planholder;
2. Eye, ear, nose and throat (EENT) care;
3. Treatment for minor injuries such as lacerations, mild burns, sprains, strains, fractures, etc., excluding the cost of medicines;
4. X-rays, laboratory examinations and diagnostic procedures prescribed by the Hospital Coordinators and accredited specialists;
5. Referrals to affiliated specialists;
6. Minor surgical procedures not requiring confinement; and
7. Total of fourteen (14) pre & postnatal consultations excluding laboratory work-ups.

C. Preventive Healthcare

1. Immunization, excluding the cost of vaccines;
2. Medical management of health problems;
3. Health education and counseling on diets and exercises;
4. Family planning counseling;
5. Record keeping of medical history;

6. Annual Physical Examination (APE) for all principal members and dependents can be availed at any accredited HMO clinics within the first quarter of the effectivity date. The APE shall include the following:

a. Physical Examination;
b. Chest X-ray;
c. Medical History;
d. Eye Refraction;
e. Stool Examination (Fecalysis);
f. Urine Examination (Urinalysis);
g. Complete Blood Count (CBC);
h. Electrocardiogram (ECG) for Planholders above twenty- one (21) years old
i. Blood chemistry consisting of FBS, Creatinine, Lipid Profile and SGPT for Planholders thirty -five (35) years of age and older, and
j. Pap Smear for females thirty-five (35) years of age or older; or if medically indicated and prescribed by accredited HMO health professional

In areas where there is no accredited clinic, the planholder can reimburse the actual cost of the above procedures.

7. Ambulatory Laboratory Services –. Patients who are required by the accredited physician to have a regular blood exam on a quarterly basis can avail of the procedure at ActiveOne.

E. In-Patient Care

1. Room and Board, but not to exceed the amount per schedule.

a. PRIVATE PLAN**:** Room and Board Accommodation up to a maximum of Open Private Room per day of confinement;

Open Private Room Accommodation shall not be subject to a stepladder policy in securing a room in an Accredited Hospital.

b. SEMI-PRIVATE PLAN**:** Room and Board Accommodation up to a maximum of Open Semi-Private Room per day of confinement

Principal members shall automatically be covered under Private Plan. Dependents shall have the option to choose between Private and Semi-Private Plans.

2. Use of Operating and Recovery Rooms;

3. The following medical procedures are covered subject to pre-existing condition provisions, exclusions and limitations and all antecedent expense, as charged subject to the Maximum Coverage Benefit (MCB):

a. 24 Hour Holter Monitoring
b. 2D Echo with Doppler
c. Angiography
d. Arthroscopic Knee Surgery Procedure/Arthroscopic Procedure/ Orthopaedic Surgery
e. Benign Prostatic Hypertrophy Treatment
f. Bone Mineral Density/Densitometry Scan (Dexascan)
g. Brachytheraphy
h. Cataract Surgery ex*cluding cost of lens*
i. Chemotherapy/Radiotherapy
j. Cryosurgery
k. CT Scan
l. EEG Electroencephalography
m. Electromyography, Nerve Conduction Velocity Studies

n. Endoscopy including one video
o. Eye Laser Therapy (for cataract extraction, retinal detachment and glaucoma, e*xcept for correction of error of refraction such as myopia, astigmatism & hyperopia)*
p. Flourescein Angiogram
q. Gamma Knife Surgery
r. Herniorraphy *acquired cases*
s. Hysterescopic myoma resection/procedures
t. Hysterospically Guided D&C
u. Laparoscopic Procedures
v. Laser Tonsillectomy
w. Lithotripsy (ESWL)
x. Mammography & Sonomammogram
y. M-Mode Echocardiogram
z. MRI
aa. Myelogram
bb. Nuclear Radioactive Isotope Scan
cc. Open Heart Surgery *including Angioplasty.* Procedure is covered, not the materials used during the surgery
dd. Organ transplants except donors expenses. Procedure is covered, cost of the organ is not included
ee. Orthopedic Surgery
ff. Out-patient Chemotherapy. Medicine used for Outpatient chemotherapy is covered on a reimbursement basis
gg. Out-Patient Dialysis *renal or peritoneal*
hh. Out-Patient Physical/ Speech Therapy
ii. Percutaneous ultrasonic nephrolithotomy
jj. Position Emission Tomography (PET Scan)
kk. Pulmonary Perfusion Scan
ll. Pyrosphoshate Scintigraphy
mm. Sclerotheraphy
nn. Sleep Study unless directly related to an organic illness
oo. Stereotactic Brain Biopsy
pp. Stereotactic Radiosurgery
qq. Thallium Scintigraphy
rr. Trans urethral Microwave Therapy
ss. Ultrasound *except pregnancy related*
tt. Ventilation & Perfusion Lung Scan
uu. Visual Perimetry

The Health Care Service Provider shall cover latest modalities of treatment or new medical technologies up to the maximum limit of the plan.

Procedures stated above that require confinement shall be inclusive of the room and board, operating room charges, professional fees and other incidental expenses related to the procedures.

Provided that:

a. Included in the maximum liability limits listed above are:
1. expenses incurred in undergoing the medical procedures, such as hospitalization expenses and professional fees;
2. expenses due to any condition or complication related to the treated illness or to the procedures mentioned above;
3. expenses due to any recurrence of the treated illness or a repetition of said procedures; and
4. expenses due to pre and post-procedure work-ups.

b. In cases where a patient opts to avail of the use of a more expensive sophisticated procedure or treatment (ex. Lithotripsy, laser treatment) when an equally effective surgical

procedure is available, the health care service provider shall be amenable to the choice of the patient.

c. The availment of special treatment procedures such as Laparoscopic Procedure, Lithotripsy and Arthroscopy are covered regardless of number of availment provided that the procedures are medically indicated and prescribed by accredited HMO health professional.

4. Professional Fees for:

a. Attending Physicians;
b. Anesthesiologists;
c. Surgeons; and
d. Specialists, when necessary

5. Drugs, medicines and injectables; inhalation therapy

6. Blood transfusions, including human blood products (except gamma globulin), and intravenous fluids;

7. X-rays, laboratory examinations, and diagnostics test ordered by the Health Care Attending Physicians;

8. Dressing, casts (except fiberglass supplies), and sutures;

9. Sports-related injuries incurred during officially-sanctioned sports activities shall be covered up to the Maximum Coverage Benefit. Injuries of the same nature incurred during unofficial sports activities shall be covered up to Thirty Thousand Pesos (P30,000.00);

10. Admission kit shall be covered;

11. All illnesses or conditions, whether work-related or not, of all planholders (whether principal member or dependent), covered up to Maximum Coverage Benefit, subject to the exclusions and limitations as stated in the draft Contract;

12. Congenital illnesses/conditions and developmental pediatric disorders of all planholders covered up to a maximum of Fifty Thousand Pesos (P50,000.00)

13. AIDS secondary to accidental blood transfusion or needle injection shall be covered by the Health Care Service Provider;

14. Slipped disc, spondylosis, spinal stenosis and scoliosis shall be covered up to the Maximum Coverage Benefit;

15. Cauterization of Warts including Facial area shall be covered up to the Maximum Coverage Benefit with no limit per visit. Genital warts caused by Sexually Transmitted Disease (STD) shall not be covered;

16. Allergy Testing shall be covered up to Seven Thousand Five Hundred Pesos (P7,500.00)/year and Tuberculin Test covered up to Six Hundred Pesos (P600.00)/year when prescribed and not to be done during Annual Physical Examination;

17. Pre-existing illness/conditions of principal members at the start of membership shall be covered up to Maximum Coverage Benefit. Dependents enrolled with the current health care service provider shall also be covered up to Maximum Coverage Benefit. For newly enrolled dependent members, pre-existing coverage is up to Twenty Thousand Pesos only (P20,000.00) during the first three (3) months; after the three (3) month period, pre-existing coverage shall be up to the Maximum Coverage Benefit;

18. Reimbursement of the Professional fee of Neurologist based on rate of the Health Care Service Provider;

19. All other items deemed necessary by the attending physician for the medical management of the patient.

Notwithstanding the above provisions, the Health Care Service Provider shall be liable for hospital and medical expenses and fees of the Health Professionals only up to the Maximum Coverage Benefit per year per illness or condition, including: a) complications thereof; b) Intensive Care Cases (ICU/CCU) and their equivalent; and c) pre-confinement and post-confinement work-up on an out-patient basis.

D. Emergency Cases

1. Emergency Room Treatment: In emergency cases inclusive coverage of the following:

a. professional fees;
b. medications used for immediate relief of symptoms;
c. nebulization;
d. dressings;
e. sutures for wounds;
f. cast *(except fiberglass supplies)*;
g. first dose of anti-tetanus serum (ATS);
h. administration of anti-tetanus vaccine (inclusive of cost of vaccine, professional fees and other related materials and fees);
i. first dose and administration of anti-rabies vaccine (inclusive of cost of vaccine, professional fees and other related materials and fees) for all planholders. Succeeding treatment and vaccination required shall be covered up to the maximum amount of Php5,000.00 per treatment;
j. diagnostic examinations; and
k. Other medical services related to the emergency management of the treated planholder: 100% actual charges for covered items only.

2. Emergency Care in Accredited Hospital

If the emergency health care was administered in an Accredited Hospital whether as inpatient or out-patient and the illness or conditions is covered under the Plan, the Planholder shall be entitled to full coverage provided that (a) the Planholder or his representative notifies the Health Care Service Provider Office within 24 hours after the emergency has commenced and a prescribed referral was issued by a Health Care Service Provider Authorized Physician, and (b) professional services are provided by Accredited Physicians.

In the event any of the foregoing conditions are absent, the Planholder shall pay the cost of his medical care, including any amount his Physicians may charge as professional fee, the Health Care Service Provider shall, thereafter, reimburse the Planholder of up to 100% of the actual cost of coverable benefits availed of, but not to exceed 100% of what the Health Care Service Provider would have incurred in providing such benefits according to the Plan.

3. Emergency Care in Non-Accredited Hospital

When a planholder requires immediate medical attention, necessitating the use of facilities of a non-accredited hospital, the Health Care Service Provider shall reimburse at actual cost up to the Maximum Coverage Benefit per emergency case.

This shall be applicable only, when the use of accredited hospitals shall entail a delay resulting in death, serious disability or significant jeopardy to his/her life. The Health Care Service Provider shall pay the corresponding hospitalization according to the amount had the patient been treated in a duly accredited facility subject to the provision stated below, except for follow-up care. The final diagnosis shall be evaluated and approved by the Health Care Service Provider.

However if the planholder confined during emergency case in a non-accredited hospital cannot be transferred due to seriousness of the situation/condition, the Health Care Service Provider shall cover through reimbursement basis up to the Maximum Coverage Benefit according to the type of plan.

4. Official Business Trip Abroad

The Health Care Service Provider shall cover the Planholder's emergency case expense during official business trips abroad of principal members, based on the schedule of emergency case in non-accredited hospitals up to the Maximum Coverage Benefit on a reimbursement basis.

5. Areas where there are no Accredited Specialist at the Accredited Hospitals:

In areas with no Accredited Specialist at the Accredited Hospital, for reasons outside the control of the Health Care Service Provider, such as when there is no specialist to accredit, the Health Care Service Provider shall cover 100% of the treated members hospital bills and reimburse the professional fees based on the member's Plan and Relative Value Unit (RVU), subject to the Maximum Coverage Benefit.

6. Areas without Accredited Hospital:

In areas with no accredited hospitals/facilities, the Health Care Service Provider will reimburse the member 100% of the cost of the health services availed, based on the member's existing Plan, up to the Maximum Coverage Benefit.

E. Network Access

All members are entitled to choose, at their own convenience, any Accredited Hospital where they want to be treated and wherein they may consult with any Coordinator in said Hospital which should include *Makati Medical Center (MMC), St. Luke's Medical Center (SLMC-Quezon City), The Medical City, Cardinal Santos Medical Center (CSMC), Asian Hospital Medical Center (AHMC),* and *St. Luke's Medical Center-Global City (SLMC-Global City).*

F. Medico-legal Cases

Definition of Medico-legal case: any medical case or situation involving a covered member where a Medical Report is required by law to be submitted by the attending doctor, hospital or clinic to the police authorities.

1. All medical utilization whether, in-patient or out-patient, classified as medico-legal in nature shall be for reimbursement, subject to the complete submission of duly accomplished requisite documents for the said case.

2. Requirements for No Fault Injuries must be submitted to the Health Care Service Provider Head Office not later than sixty (60) days from date of discharge.

G. Ambulance Service

Coverage of cost of Ambulance Service by land based on the limits stipulated below per conduction:

HOSPITAL	AREA COVERED	MAXIMUM LIMIT
Accredited to Accredited	Metro Manila	Unlimited
Accredited to Accredited	Province to Manila	P5,000.00 per conduction
Non-Accredited to Accredited	Metro Manila	Unlimited
Non-Accredited to Accredited	Province to Manila	P5,000.00 per conduction

H. Dental Care

1. Any number of consultations with an accredited dentist;
2. Treatment of dental related pain excluding cost of prescribed medicines;
3. Simple tooth extractions, except surgery for impactions;
4. Gum treatment excluding the cost of prescribed medicines;
5. Recementation of jacket crown, inlays and onlays;
6. Treatment of lesions, wounds and burns;
7. Unlimited temporary fillings;
8. Annual dental examination;
9. Adjustment of dentures;
10. Relief and/or prescription for acute dental pain;
11. Emergency desensitization of hypersensitive teeth;
12. Orthodontic consultation;
13. Aesthetic dental consultation;
14. Permanent fillings (light cure only) covered up to four (4) surfaces per year;
15. Twice (2x) a year oral Prophylaxis.

I. Financial Assistance

The Health Care Service Provider shall provide financial assistance of Fifty Thousand Pesos (P50,000.00) in case of natural or accidental death of a principal member.

J. Unavailability of Room Covered

If upon admission in an emergency situation, there is no room available conforming to the limitations and restrictions of a member's plan except Suite Room, then Health Care Service Provider shall upgrade to the next higher room during emergency cases covered until the room according to their plan becomes available.

K. Point of Service

In non-emergency cases in an accredited hospital, reimbursement of the professional fee of non-accredited physician shall be 100% of the rate of the Health Care Service Provider for outpatient or in-patient cases while medical and laboratory tests prescribed by the non-accredited physician are automatically covered. In a non-accredited hospital, professional fees, medical procedures and laboratory tests are reimbursable at 100% of the rate of the Health Care Service Provider.

L. Special Concession

Upon signing of the Contract, the Health Care Service Provider shall authorize the BCDA Company Physician to issue request and Letter of Authorization for laboratory procedures (such as but not limited to Urinalysis, Fecalysis, Chest X-ray, Complete Blood Count and Blood Chemistry) and issue referral slip to any Accredited Specialist at any Accredited Hospital.

M. Designation of Liaison Officer

The Health Care Service Provider shall designate a liaison officer who shall serve as the point person for the concerns of BCDA and its planholders.

N. Extension of Coverage

All members, whether principal or dependent, who will be disqualified due to age eligibility or change of principal planholder's civil status within the contract period will not be removed from the program and shall be allowed to use his/her card and avail of his/her benefits until expiry of contract.

O. Experience Refund

Should the BCDA show cost effective utilization performance for the contract year, Health Care Service Provider agrees to pay a refund, which will be credited to the renewal billing. It will be computed on the third (3rd) month after the expiry of the contract (15th month). If the contract is renewed, refund shall be credited to the renewal billing, and if not, it shall be paid to BCDA. Refund will be based on the following computation:

Experience Refund = [(Annual Membership Fees x 30%) less
(Actual Utilization of benefits + IBNR)] x 50%

P. Utilization Report

BCDA shall require the **CONTRACTOR** to provide a detailed annual utilization data, based on the required fields including the name of member and patient. **BCDA** warrants that this request for medical reports/utilization data is done with the full consent of members. **BCDA** shall hold the **CONTRACTOR** free and harmless from any liability whatsoever, should any member accuse the **CONTRACTOR** of breach of confidentiality in any civil, criminal or administrative proceedings.

The CONTRACTOR shall submit to BCDA a quarterly report on utilization within one (1) month after each quarter.

Q. Pre-Existing Coverage

Pre-existing illness/conditions of principal members at the start of membership shall be covered up to Maximum Coverage Benefit. Dependents enrolled with the current health care service provider shall also be covered up to Maximum Coverage Benefit. For newly enrolled dependent members, pre-existing coverage is up to Twenty Thousand Pesos only (P20,000.00) during the first three (3) months; after the three (3) month period, pre-existing coverage shall be up to the Maximum Coverage Benefit.

VI. General Considerations

A. Membership Card

1. The Health Care Service Provider will provide free replacement of planholder's membership card once during the contract period in case of loss or damage.

2. The membership card of an employee should bear the name of his/her specific agency in which he/she belongs, i.e. Bases Conversion and Development Authority or the name of the BCDA subsidiary in the event of its inclusion.

3. The membership card shall be made available to all members within ten (10) working days upon enrollment.

B. Membership Inclusion and Cancellation

Should the Agreement or any Membership covered thereby be pre-terminated, the Planholder shall be entitled to a refund of their Membership Fees in accordance with the following schedule:

If Agreement/Membership has been in force for:	% of Annual Membership Fees to be Refunded
Not more than one month	80%
More than 1 month but less than 2 months	70%
More than 2 months but less than 3 months	60%
More than 3 months but less than 4 months	50%
More than 4 months but less than 5 months	40%
More than 5 months but less than 6 months	30%
Six months or more	No Refund

Provided, however, that a) fees paid for processing applications shall not be refundable; and b) neither the Planholders nor any of their Dependents have availed themselves of any of the health care benefits under the Agreement during the period of coverage.

Enrollment period for qualified and eligible dependents is limited to thirty (30) days from the date of effectivity of membership of the employee. Additional dependents may be accepted after the thirty (30) day enrollment period in cases of newborn child, newly married spouse and dependent of newly regularized and/or promoted employees, provided they are enrolled within 30 days of eligibility (e.g. childbirth, marriage, regularization of employment status or job promotion).

C. Claims Procedure

All claims for reimbursement must be submitted or forwarded to the head office of the Health Care Service Provider within sixty (60) calendar days from the date of availment.

D. Performance Appraisal

Performance of the Health Care Service Provider shall be subject to an appraisal system to be administered bi-annually. Based on the assessment, BCDA may preterminate the contract for failure by the Health Care Service Provider to perform its obligations, in line with the Guidelines on Termination of Contracts issued by the Government Procurement Policy Board (GPPB Resolution No. 018-2004 dated 22 December 2004).

VII. Performance Security

Prior to the signing of the Contract, the Health Care Service Provider shall post in favor of BCDA a Performance Security to guarantee the Health Care Service Provider's faithful performance of all obligations and undertakings under the Contract. The Performance Security shall be in an amount equal to a percentage of the total contract price in accordance with the following schedule:

A. Cash or cashier's/manager's check issued by a Universal or Commercial Bank. Five percent (5%);

B. Bank draft/guarantee or irrevocable letter of credit issued by a Universal or Commercial Bank; Provided, however, that it shall be confirmed or authenticated by a Universal or Commercial Bank, if issued by a foreign bank. Five percent (5%);

C. Surety bond callable upon demand issued by a surety or insurance company duly certified by the Insurance Commission as authorized to issue such security. Thirty percent (30%).

D. Any combination of the foregoing. Proportionate to share of form with respect to total amount of security.

VIII. Qualification, Bid Evaluation, Awarding and Other Conditions

A. Eligibility and Declaration of Winning Proponent

Only the bids of proponents declared as eligible based on the **Checklist for Requirements for Bidders** attached in the Bid Documents shall be opened.

The eligibility requirements envelope shall be opened first and the **Technical Specifications Compliance Form** (see **Section VII** of the Bid Documents) shall be evaluated for compliance; thereafter, the financial bid/s of the eligible proponent/s who have passed the technical specifications shall be opened for evaluation.

The eligible proponent with the **Lowest Calculated Bid** (i.e., has complied with all technical specifications and has submitted the lowest price) shall undergo the post-qualification process.

After passing the post-qualification process, the proponent with the **Lowest Calculated Bid (LCB)** shall be declared as the proponent with the **Lowest Calculated Responsive Bid (LCRB)** and shall thereafter be declared as the winning proponent.

B. Other Conditions Regarding Evaluation

1. BCDA reserves the right to reject any or all proposals, or to waive any defect or informality thereon or minor deviations, which do not affect the substance and validity of any or all of the proposals.

   BCDA reserves the right to reject the proposal of any proponent who:

   a. does not offer the required services as provided for in this Terms of Reference;
   b. is discovered to have suppressed, disclosed or falsified information; or
   c. failed to satisfactorily perform/complete any contract previously taken.

2. BCDA reserves the right to review other relevant information affecting the proponent or the proposal before the approval of the contract. Should such review uncover any misrepresentation made in the proposal documents, or any change in the situation of the proponent which affects the substance of his proposals, BCDA may disqualify the proponent from obtaining the award/contract.

3. Any attempt by a bidder to influence the BAC or its authorized representatives in the evaluation of the bids or contract award decisions shall result in the rejection of its bid or revocation of award as the case may be, and the application of other sanctions and remedies provided by law."

C. Immediate Coverage

The winning Heath Care Service Provider shall commit to provide immediate coverage starting **August 1, 2020** pending finalization and execution of the contract.

D. Contract Signing

Within ten (10) calendar days after the approval of the award by the President and CEO, the winning bidder shall sign a Contract for Health Care Services, which shall be subject to the review and approval by the Office of the Government Corporate Counsel (OGCC).