NAGICARE ECGROUP HEALTH INSURANCE POLICY

NAGICO INSURANCE COMPANY LIMITED

(Hereinafter referred to as the Insurer)

Policyholder: **GOVERNMENT OF ANGUILLA**

Policy Number: **AGLH029/09**

Effective Date: **01 NOVEMBER 2009**

Policy Anniversaries: **01 JANUARY 2017 AND ANNUALLY THEREAFTER**

This Comprehensive Major Medical Group Health Policy is entered into between the Insurer and the Policyholder in consideration of the application of the Policyholder and the payment of premiums by the Policyholder.

The Insurer agrees to provide the benefits provided by this Policy to the Covered Persons in accordance with the provisions and conditions contained herein.

This Group Policy including any riders and endorsements, outlines the general provisions and conditions, provides definitions of terms for interpretation of the policy, gives a description of benefits, defines the insured and dependents eligibility, claims procedure, exclusions and limitations and gives a benefit schedule.

Signed at**The Valley, Anguilla**on this 17 day of May**, 2017**

Executed by:
NAGICO Insurance Company Limited

Branch Manager

Executed by:
The Policyholder

Permanent Secretary

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SECTION I: Definitions

Words and phrases used in the contract are defined below for purposes of interpreting the policy.

Accident
An inadvertent bodily injury suffered by the primary insured or dependent from sudden unforeseen and external causes. The event must be exact as to the time and place of occurrence.

Air Ambulance Transport
Emergency air transportation from a facility where the insured is staying to the nearest suitable hospital where treatment can be provided.

Alcoholism and Substance Abuse
The taking of alcohol or other drugs at dosages that:

- place a Covered Person's welfare at risk and/or
- cause the Covered Person to endanger the public welfare and/or
- constitute alcohol or drug dependence.

Amendment
An endorsement added to the policy that clarifies, explains or modifies the policy.

Anesthesiologist Fees
Charges for the administration of anesthesia during the performance of a surgical procedure or for medically necessary services for pain control.

Application
Completed forms supplied by the Insurer providing information about the policyholder and dependents and used to determine acceptance of risk. All documentation requested by the Insurer before effecting coverage forms part of the application.

Area of Validity
Means the following territories, ranked in the following order:-

(a) The territory of Anguilla ranking first;
(b) The territory of St. Maarten/St.Martin ranking second;
(c) The territories of the English-speaking Caribbean islands ranking third.

Benefits
Monetary payments made by the Insurer to service providers or reimbursement to insureds for expenses incurred with respect to coverage under the schedule of benefits and riders included in the policy. This also applies to dependents that are covered under the policy.

Co-insurance
Means the proportional arrangement by which the Company and the insured share a percentage of the covered medical expenses in each year, as specified in the Schedule of Benefits, after the annual deductible has been satisfied, if applicable.

Complications of Pregnancy
Termination of ectopic pregnancy or pregnancy to avoid medical complications of the mother. The following abnormalities or symptoms are also included: nephritis, necrosis, cardiac abnormalities, abortion of dead fetus,hyperemesis gravidarum, pre-eclampsia, and placenta previa. Miscarriage, occasional bleeding, prescribed bed rest, morning sickness are not considered complications of pregnancy.

Congenital disability
A disorder or illness present at birth or which is inherited from parents and manifests after birth.

Country of Residence
The country where the insureds and/or dependents reside for at least 7 months in any policy year, which is expected to be the Country of Anguilla.

Coverage
Eligible benefits provided by the policy as shown in the schedules of benefits.

Covered Person
Persons named and designated forcoverage in the Application for this Policy Contract and their eligible dependents, as defined herein, who are also named in the application for this Policy Contract, who have met eligibility requirements of the Policy Contract and for whom insurance is in force under the Policy.Individuals desirous of

joining the plan must be at least age 18 not older than the maximum age of 60.

Deductible
The amount of Eligible Expense a Covered Person must incur during each Policy Year before the Plan pays benefits. The Deductible may apply on an Individual and/or a Family basis.

Dependent
A primary insured's spouse under age 65 and unmarried dependent children under the age of 19, resident in the country where the contract is issued. Spouses that are legally separated will not be covered. Persons living in a common-law relationship for a minimum of 3 years can also be covered provided proof or legal documentation is provided to the Insurer. Stepchildren, legally adopted children and children for whom the insured is legally responsible can also be included. Coverage can also be extended to children over 18 years but less than 24 years attending a full time educational establishment provided that the documentation confirming the enrollment is submitted to the Insurer and approved.

Disability
Means sickness due to disease or accidental bodily injury necessitating medical treatment by a physician. All bodily injury sustained by a Covered Person in any one Accident shall be considered one disability. All bodily disorders existing simultaneously which are due to the same or related causes shall be considered one disability. A disability recurring within a period of 3 months shall be deemed to be a continuation of the same disability and not a new disability. Successive admissions or periods of hospital confinement of an employee due to the same or related causes shall be considered as the same period of confinement unless separated by the employee's return to active full-time work for at least 2 weeks. In the case of successive admissions or periods of hospital confinement of a dependent a new disability is established after a period of 3 months has elapsed following the day upon which the last treatment occurred unless expenses are not reimbursed because of exhaustion of the maximum benefit.

Donor
Means a live or cadaveric person donating an organ for the sole purpose of re-infusing, transfusing or transplanting into a Covered Person.

Effective Date
The date on which this Policy takes effect and covered persons first becomes eligible for benefits under the Policy.

Elective Surgery
Non-emergency surgery that is not medically necessary as defined in the policy. These surgeries are not covered under the plan.

Eligible Expenses/Covered Medical Expenses
Charges made to a covered person for supplies or services rendered which are the usual, customary and reasonable charges for those services and which are medically necessary for treatment of injury or illness.

Emergency
Accident or illness of sudden onset, which could reasonably result in placing a covered person's life or physical integrity in immediate danger and requiring urgent and immediate treatment deemed to be medically necessary.

Expenses Incurred
Purchases of supplies, treatment or services received at a point in time. An expense shall be deemed to be incurred on the day the purchase is made or the service rendered for which the charge is made.

Experimental or Investigative
The use of any treatment, procedure, facility, equipment, drug, drug usage device or supply which (1) is not considered a proven effective and reliable method by a consensus of the professional organizations in the international medical community and (2) is still being tested, studied or investigated to determine effectiveness.

Hospice
A licensed facility providing counseling, care, and medical services to terminally-ill patients.

Hospital

An institution engaged primarily in medical care and treatment to the ill and or injured person on an in-patient basis at the patient's expense and meets all the following requirements:

1. Conforms to the laws of the country in which it operates.
2. Maintains permanent, full-time facilities for the diagnosis, treatment, and care of sick or injured persons.
3. Has a staff of physicians in regular attendance.
4. Provides nursing care by registered nurses.
5. Has the necessary medical equipment, facilities and supplies for major surgery.

Hospital does not include rest homes, custodial care, nursing homes, homes for the elderly and treatment centers for alcoholism, drug addiction, or mental or nervous conditions. A psychiatric institution or "Mental Hospital" will be deemed a Hospital if it meets all the requirements of this definition except number 5.

Hospital Care

Period of confinement deemed medically necessary and certified by a physician as a result of a medical emergency, illness or accident.

Illness

A disease or disorder requiring medical treatment.

Injury

Bodily harm that is caused by and results from an Accident. All injuries sustained by a Covered Person in connection with any one Accident will be considered as one injury.

Intensive Care Unit, Cardiac Care Unit or Burn Unit

An accommodation or part of a Hospital which is established for a formal intensive care program and which, in addition to providing room and board, is exclusively reserved for critically ill patients requiring constant observation by a Physician, or at the direction of a Physician, by a registered nurse trained for service in such unit and which provides all necessary life-saving equipment, drugs and supplies in the immediate vicinity on a standby basis.

Maximum benefits

The maximum payable by the Insurer according to class as shown in the schedule of benefits.

Medically Necessary

Services or supplies ordered or provided by a hospital, physician or other provider not excluded under this plan, to treat or diagnose a sickness or injury and whichare:

1. Consistent with the symptom or diagnosis and treatment of the sickness or injury.
2. Not primarily for the convenience of the covered person, his physician, or other provider.
3. The most appropriate standard or level of service or treatment for the insured's diagnosis or symptoms.
4. Not part of a treatment plan that is considered experimental or for research purposes.

Mental or Nervous Disorder

Treatment or care for a mental disease or functional nervous disorder as recognized or defined by the local Medical Association or if there is no local Medical Association, by the Regulatory Authority.

Miscellaneous Hospital Expenses

Those charges for necessary medical or surgical treatment billed by the Hospital but excluding professional fees.

Most Common Semi-Private

The most common two-bed or three-bed room accommodation for the facility in which the services are rendered.

Newborn

A child who is less than 90 days old but whose existence is notified to the Insurer within 14 days of birth.

Nurse

A person who is a legally qualified and licensed Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.) or a Licensed Vocational Nurse (L.V.N) and duly registered to practice nursing in the jurisdiction where the services are given and who is not a relative of the insured.

Physician
A person who is licensed and registered to practice medicine in the jurisdiction where services are given, while acting within the scope of his practice.

Policyholder
The employer or the association or board of trustees or the union entering into contract with the insurer under the terms of this Policy and so named on the cover page of this Policy.

Pre-certification
Pre-certification means the approval in advance by the Company or its designate for medically necessary and covered services subject to eligible charges.

Pre-Existing Condition
Pre-Existing condition means a sickness or injury for which medical expense or medical treatment, consultation or advice, diagnostic testing or distinct symptoms were evident during the twenty-four(24) consecutive months immediately prior to becoming covered under the policy contract. The term "treatment" includes taking medicine prescribed by a physician.

Preferred Provider Network
A network of medical practitioners, hospitals, specialist clinics and pharmacies which have contracted with NAGICO to provide their services to plan members at preferred rates. Co-payments only apply to treatment by these preferred providers. The policyholder can be given access to names and addresses of contracted providers in both the local and foreign jurisdictions.

Pregnancy
Deemed to refer to any period of gestation, including not only those which result in childbirth but also to miscarriage and spontaneous abortion.

Prescription Drugs
Medications whose sale or use is legally restricted to the order of a physician, surgeon or dentist as set out and required by law in the insured's jurisdiction and dispensed by a licensed pharmacist, physician, surgeon or dentist.

Proof of Claim/ Proof of Loss
Records the formal statement concerning a loss for which a claim is submitted. It provides The Insurer with all information needed to determine whether the claim is reasonable and the extent of The Insurer's liability.

Reasonable and Customary Charge/Usual Customary and Reasonable Charge
The amount that is the usual, customary and reasonable charge for a covered service as defined in the contract and as determined by the Insurer. The R&C/UCR is the lowest of:

A. The individual provider's usual charge for specific services;
B. The customary charge for all providers of the same specialty in the same geographic region; and
C. The reasonable charge determined by the Insurer when services involve unusual circumstances or complicated conditions.

The common standard, however, is the amount that is most often charged for a covered service by a provider within the same geographic area or the Area of Validity herein before specified.

Second Surgical Opinion
A written report provided by a physician in active practice in the field of medicine pertinent to the proposed surgery. Such consulting surgeon must not be in close professional practice with the Physician who would perform the Surgical Procedure.

Sickness
A medical condition, diseaseor disorder for which an insured has incurred covered medical expense. Sickness does not include pregnancy, childbirth or abortions, but includes a medical emergency that results from complications of pregnancy.

Surgeon
A physician who is duly qualified and holds a lawful licence authorizing him to perform surgery in the jurisdiction in which the service is rendered.

Surgical Procedure
Any of the following:

1. the incision, excision, debridement or cauterization of any organ or body part,

except for Dental Services; or suturing of a wound;

2. the repair, revision, or reconstruction of any organ or body part;
3. the reduction by manipulating a fracture or dislocation and the application of cast or traction;
4. the endoscopic exploration for or removal of a stone or other object from the larynx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder, or ureter;
5. paracentesis, arthrocentesis, arthrodesis and all injectionsdirectly into a joint or bursa;
6. the induction of artificial pneumothoraxand the injection ofsclerosing solutions;
7. biopsy.
8. Injection treatment of hemorrhoids.

Any other procedure not stated above may be considered a Surgical Procedure if deemed such by The Insurer.

Treatment
A personal interview between a Covered Person and a physician or a health care professional as defined in this Policy (but excluding a nurse). All treatments given on one day are deemed to be a single treatment.

Transplant
Medically necessary procedures involving transplanting tissue, an organ or part of an organ from a donor, dead or alive, to the recipient.

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SECTION II: General Provisions

Agent for Process
Legal process may be served on the Policyholder or any Covered Person.

Assignment
A Covered Person may assign benefit payments to a physician, hospital or any other provider of service under this Policy. The assignment must be received by the Insurer with the written proof of claim and such assignment.

Cancellation
This Policy can be cancelled by the Insurer, by way of a written notice to the Policyholder at least 31 days in advance of the cancellation date, and all liabilities terminate on the date of cancellation. Reasons for cancellation include:

- Failure to pay premium within 31 days of due date;
- Misuse of health care benefits;
- Failure to comply with contract requirements;
- Misrepresentation or fraud in procuring health care benefits;
- Falsification of any information, including claims or misstatement or omission of information on the insured's application forms or subsequently.

It is the responsibility of the Primary Insured to notify the Insurer, in writing, of any change in country of residence for Covered Persons within thirty (30) days of the change.

Clerical Error
Clerical errors or delays in processing for the Policy Contract by the Company or the Policyholder:

1. will not deny coverage which should otherwise have been granted; and
2. will not extend coverage which should otherwise have been terminated; and
3. will be subject to proper adjustment of premium when an adjustment is needed.

Co-ordination of Benefits
The insured or any Dependent may be covered under another health insurance plan. Whenever there is more than one plan in existence, the total amount of benefits paid in a Policy Year under all plans cannot be more than the expenses charged for the Policy Year. One of the plans will pay the benefits first. This is called the primary plan. The other plan(s) will then make up the difference up to the total reasonable expenses incurred. These plans are called the secondary plans. No plan will pay more than it would have paid without this provision.

In order to pay claims, NAGICO must establish which plan is Primary and which plan is Secondary. A plan will pay benefits first if it meets one of the following conditions:

- The plan has no Co-ordination of Benefits provision;
- The plan covers the person as aprimary insured;
- The plan covering achild as a dependent of a male Insured determines its benefits before a plan covering such child as a dependent of a female Insured;
- When none of the above apply, the plan covering the person for the longest time will pay first.

Conformity to Law
Any provision of this Policy Contract which conflicts with the law of the country or other sovereign which exercises jurisdiction over this Policy Contract shall be deemed amended to conform to minimum requirements of such law.

Construction of Terms
In this Policy Contract the singular number includes the plural and the plural includes the singular. Any word that refers to one gender includes all genders, unless the context requires one gender. Section headings are reading aids only and should not be used to construe the text.

Currency
Payments under this plan will be made in the lawful currency of the jurisdiction in which the Policy is issued, unless otherwise specified.

Discount / Case Management
Where our network providers have obtained discounts or reductions in fees by case

management, the fee associated with obtaining such discounts or reductionsshall be considered part of the claim benefits.

Duplication of Benefits
Benefits under this policy will not duplicate benefits of any other plan including workmen's compensation benefits, if available. The policy will pay its pro rata share of each claim. Where payments are made in excess of that required by the Policy the Insurer will be subrogated to the rights of the insured. Likewise where excess payments have been made under this provision by another party the Insurer shall have the right, exercisable alone and in its sole discretion to pay over its portion to any Insurer or organization.

Fraud
If a covered person attempts or succeeds through deceit, fraud or dishonest acts to obtain benefits for himself or for another person that otherwise would not be provided or payable, such member's coverage will terminate automatically without notice.

Freedom of Choice
Subject to the applicable terms of this Policy, the insured retains freedom of choice of doctors, hospitals and other health care professionals. Where treatment is available in Anguilla and the insured chooses to go outside of Anguilla, claims will be paid according to the usual, reasonable and customary rates in Anguilla.

If treatment is not available in Anguilla, but is available within any of the other tiers within the Area of Validity, and the insured chooses to obtain treatment within any of those tiers, then subject to the applicable terms of this Policy, claims will be paid according to the usual, reasonable and customary rates:

(a) In St.Maarten/St.Martin or
(b) In the other English Speaking Caribbean Islands where treatment was obtained in such islands, and was not available in Anguilla.

Pre-certification and our chief medical officer's referral are required.
If treatment is not available in the Area of Validity, the Insurer will settle claims up to a maximum not exceedingthe reasonable and customary charges of the jurisdiction selected by the insurer.
Where the insured is on business travel or on vacation and emergency care is necessary,claims will be paid based on the reasonable and customary charges of the respective jurisdiction in which the emergency occurs.

Grace Period
The 31 days period following the premium due date is called the grace period. This Policy will remain in force during that period. However, if the Policyholder does not pay the premium, or gives a written notice to termination within this period, this Policy will terminate as of the date for which premiums are due.

Incontestability
Statements included in the application form will be incontestable after the policy has been in force for a period of two years commencing from the effective date of any insured person's coverage. This provision does not apply to misstatement of age, or if the statement is fraudulent, or non-payment of premiums, or to any pre-existing condition, or to any claim in relation to which there has been non-disclosure or misrepresentation.

Insurance Data
The Policyholder agrees to give to the Insurer any such data as may be necessary for the correct implementation of this Policy's provisions and for premium rate calculations. The records of the Policyholder will be open to the Company for inspection at all reasonable times for any purpose relating to the provisions of this Policy Contract.

Local Law
Local laws in theterritory of Anguillawill take precedence over Policy provisions.

Misstatement of Age
If age has been understated the Policyholder will pay to the Insurer arrears of premium for the full time the insurance has been in force without interest. Likewise if age has been overstated the Insurer will refund to the policyholder any excess premium paid without interest.

Insurance Not Affected
This Policy does not replace and does not affect any requirements for National Insurance and or Social Security.

Payment of Premiums
Premiums are due and payable by the Policyholder on the effective date and on or before the first day of each subsequent month, at the Insurer's designated office. The monthly premium rates of this policy until changed in accordance with the terms of this policy are as shown in Schedule of Major Medical Premium Rates which forms part of this policy. The premium due will be the sum of the charges for the base plan and all riders attached thereto, in accordance with premium rates in effect at the time, and any premium adjustments and/or discount then in effect. The grace period will be allowed for payment of the premium due under the policy and if unpaid after that period the policy will lapse and no benefits will be payable. The Insurer will reinstate the Policy and coverage when all outstanding premiums are paid. The Company is not obligated to receive a modal premium other than in one sum from the Policyholder.

The liability of the Insurer under this Policy is conditional on the payment of premiums by the Policyholder as they become due.

No premium adjustment due to termination of an insured person's insurance (including dependents insurance benefits where applicable) shall exceed 4 complete Policy months.

Policy
This Policy together with any riders or endorsements and subsequent amendments thereto, and the applications of the Policyholder, will constitute the entire contract between the Insurer and the Policyholder. Any changes, modifications or alterations must be in writing and signed by a duly authorized officer of the Insurer for it to be valid. Words importing the singular shall include the plural and gender reference will include both sexes.

Policy Modification and Amendment
The Insurer can modify or amend this Policy from time to time at its sole discretion. The Insurer shall give at least 31 days advance written notice of such changes to the Policyholder.

Policy Renewal
This Policy is optionally renewable each year on its anniversary date at the option of the Insurer only, and may be renewed with the consent of the Policyholder upon payment of the amount of premium, before expiration of the applicable grace period, determined by the Insurer for new Policy Year.

Policy Termination for Non-Payment of Premium
The Policy will terminate automatically at 12:01 a.m. Standard Time on the date following the end of the Grace Period. The Primary Insured is liable for the payment of the premiums for coverage continued during the Grace Period.

Policy Year and Renewal of Policy
The Policy Year will be the 12 month period from the effective date to the policy anniversary date identified in the schedule of the policy. The policy will be renewed on each policy anniversary for a period of one year on such terms and conditions acceptable to Insurer and policyholder. The Insurer reserves the right not to renew the policy on the anniversary by giving 31 days notification in advance. The policyholder may terminate the plan by giving the Insurer 31 days' advance notice in writing.

Pre-existing Conditions
Pre-existing conditions may be covered provided the Insurer has agreed to do so in writing and the revised terms and conditions are accepted by the Insured and/orPolicyholder. This applies to disabilities which originated up to and including the 24 months prior to the effective date of a Covered Person's coverage and shall be excluded for the initial 24 consecutive months of coverage under the Policy.

Premium Rate Change
Premium rates are subject to change. On any premium due date, after the Effective Date, the Insurer has the right to change the premium or rate basis, provided the Policyholder has been

given at least 31 days prior written notice of such change.

At any time the Insurer agrees to change any terms or conditions of this Policy it reserves the right to change any premium rate and/or discount then in effect.
The insurer also reserves the right to change any premium rate and/or discount in effect if, in the Insurer's opinion, the insurer's liability is altered because of changes in the insured group or revisions in the insurance under the Policy or because of any change to any laws which affect liability under the Policy.

Reinstatement
If any premium is not paid for 60 days after the grace period, the Policy may only be reinstated at the option of the Insurer following the submission of a formal written reinstatement request to the Insurer together with acceptable evidence of insurability on a form satisfactory to the Insurer. The Insurer shall subsequently give formal written confirmation of reinstatement of the Policy.

Right to Receive and Release Information
The Insurer reserves the right to obtain information from any Insurer or person whom it deems necessary for the purpose of determining the applicability of and implementing the terms of the Policy. The Insurer may also with proper authorization release information requested.

Schedule of Benefits
The schedule of benefits sets out the relevant maximum benefits payable according to the classification chosen. Riders contain their own schedules and are part of this Policy.

Spendthrift Clause
To the full extent permitted by law, all rights and benefits under this Policy for a Covered Person shall be exempt from execution, attachment, garnishment, or other process in equity or at law for the debts or liabilities of any Covered Person, except that the laws of the jurisdiction where this Policy is issued shall take precedence.

Subrogation
The Insurer shall have the right of subrogation to an insured person's rights (including the right to institute legal proceedings in the insured person's name) to recover from a third party expenses and charges in respect of which the Insurer has paid benefits under this Policy. In such a case, the insured person shall fully cooperate with the Insurer in providing the Insurer with any information it may require and shall take no action that may prejudice the rights of the Insurer under this clause.

Termination of Coverage
The Insured and anyDependents' coverage under this Policy will terminate on the earliest of:

- The date the Policy is terminated by the Policyholder or the Insurer;
- The date the Insurer terminates the insurance of all persons in a given class;
- The date coverage under the Policy lapses;
- The date the Policyholder terminates the coverage of Insured andDependents by written notice to the Insurer;
- The date of death of the Insured or anydependents;
- On attainment of age 65 if retiree coverage is not selected.

In addition to the above, a Dependent's coverage under this Policy will terminate on the premium due date coincident with or first day of the next month following the date such person is no longer a Dependent, whichever is earlier.

Any termination will be without prejudice to any claim originating prior to the date of termination. If coverage is terminated, unearned premium will be computed and any unearned premium will be returned to the Policyholder.

No Waiveror Estoppel
The failure by the Insurer to insist upon compliance with or to enforce any provision of this Policy at any time or for any period or under any circumstances shall not operate to waive or modify such provision or any right at any time subsequently to insist upon compliance or to enforce all the terms and conditions hereof or in any manner whatsoever render any provision unenforceable as to any other time or as to any other occurrence.

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SECTION III: Eligibility - Insureds

A. Covered Person

A Covered Person can be the Primary Insured named in the application or any eligible dependents, as defined herein and named in the application who are (1) formally accepted as insurable by the Insurer in accordance with the general underwriting standards of the Insurer, (2) for whom coverage is in force under the Policy, and (3) for whom premiums are paid and accepted by the Insurer.

The effective date of coverage for the Primary Insured shall be the first day of the month coincident with or next following the day that the Insurer approves the enrollment application and the evidence of insurability.

B.Eligible Dependents Provisions

1. Eligible Dependents

Only those eligible dependents, as defined herein, may be enrolled for coverage under this Policy. The insured is required to enroll his eligible dependents on a form satisfactory to the Insurer.

2. Eligibility Date

Dependents become eligible for cover when:

a) The Policyholder becomes covered;
b) At birth if a new born dependent child;
c) Upon adoption if a dependent child;
d) Upon legal marriage if a dependent spouse;
e) Upon legally fulfilling requirements for common-law-spouse.

3. Effective Date of Coverage

If the Insurer approves the enrollment form for dependent coverage, the dependent becomes a Covered Person. The effective date of such coverage will be the later of:

a) The first day of the month coincident with or next following the date the Insurer approves the enrollment application form after submission of evidence of insurability.
b) The first day of the month coincident with or during the month the Policyholder formally submits an enrollment application for and pays the required premium for a newborn within the 14 days from the moment of birth.

4. Effective Date Conditions

a. Coverage of a dependent can only take effect at the same time as or after the primary insured's coverage has been approved and is in effect.
b. If the person is not an eligible dependent on the date his coverage would become effective, that person will not become covered as a dependent of the Primary insured.
c. If a Primary insured has dependent coverage and acquires an additional dependent, that dependent automatically becomes covered on the date of the acquisition. The Policyholder should enroll such dependents on a form satisfactory to the Insurer.

1. Evidence of Insurability

The Primary insured must furnish satisfactory evidence of insurability on his dependents at his own expense if:

a. He enrolls his dependent newborn more than 31 days after birth, or
b. He wants to reinstate coverage that has lapsed because the required premiums were not paid.

If any dependent is totally disabled on the date the coverage would otherwise take effect, his coverage will not take effect until the date his physician certifies he is no longer totally disabled. Coverage for the disabling conditions will become available according to the rules of the pre-existing condition limitations.

2. All Dependents Covered

Unless covered under another medical insurance plan, such as an Individual Health plan, it is expected that all dependents eligible under this Policy and insurable in accordance with the Insurer's underwriting standards will be enrolled under this Policy.

3. Newborn Dependent

A newborn child would be fully covered if the policyholder notifies the Insurer within 31 days of the date of its birth, provided dependents coverage is in force and the Primary insured submits an application form satisfactory to the Insurerin respect of the newborn within 31 days of the birth date.

Ifthe Primary insured has eligible dependents but dependent coverage is not in force on the date he acquires a newborn child, and such insured does not enroll the child on a form satisfactory to the Insurer within 31 days of the birth date, the dependent coverage will become effective on the date the Insurer approves the enrollment form and any required evidence of insurability.

4.Dependents Coverage Change

Any increase in amount or addition of a type of dependent coverage, as a result of a change in classification, shall be effective on the first day of the month coincident with or next following the date of change. When a change in classification is received, the change in coverage will not become effective until the Insurer receives and approves any required evidence of insurability.Any reduction in amount or termination of a type of coverage as a result of a change in classification or dependents status will be effective on the first of the month coincident with or next following the date of change.

1. Dependents Termination Date

The coverage of any covered dependent shall automatically cease at the earliest of:

a) The end of the month in which the Primary insured terminates his coverage
b) The premium due date on which the Policyholder fails to make the required premium payment as specified in this Policy
c) The date the Policy is terminated
d) The date the dependent is no longer a dependent as defined in this contract.

2. Dependent Child Extension

As long as this Policy is in force, dependent child coverage will also remain in force if the child is:

a) Unable to maintain employment because of mental retardation or physical handicap and
b) Chiefly dependent on the Primary insured for support and care.

The Primary insured must furnish the Insurerwith proof that the child is so disabled and dependent on him within 31 days before the child attains maximum age limit. The Insurer may require further proof:

At any reasonable time during the first 2 years after the dependent child attains the maximum age limit and, once a year thereafter.

3. Dependent Re-enrollment

A previously Covered Dependent may be re-enrolled for Dependent Coverage if he is eligible, as defined. The dependent applicant must enroll for dependent coverage on the same basis for any eligible dependent. However, if re-enrollment is due to a Primary insured being re-enrolled, coverage becomes effective on the same basis as the Primary insured.

This page ends here!

SECTION IV: Description of Benefits

Payment of Benefits

Subject to the provisions, limitations and exclusions of this Policy Contract, the Covered Persons are entitled to benefits for covered services, treatments or supplies:

1. When deemed medically necessary as result of a covered illness or injury;
2. That are authorized or provided by a physician and are eligible under the terms of this Policy;
3. When payment for or reimbursement of eligible expenses is requested for services provided by professional providersand,
4. When incurred by a Covered Person during the period he is insured under this Policy.

All inpatient hospital admissions except in cases of emergency must be communicated to the Insurer for pre-certification in accordance with the requirements in the contract. Failure to do so will result in a reduction of benefits payable.

The insured person is given the option to seek the services of any provider and the benefits payable will be determined based on the Comprehensive Major Medical Benefits Schedule. The co-insurance and deductibles are shown in the schedule of benefits.

Deductible and Coinsurance

If a Covered Person incurs eligible expenses, benefits are payable only after the satisfaction of Deductible and Coinsurance requirements. A coinsurance may apply to specific types of expenses, while a Deductible will apply to all types of expenses unless where specifically excepted.

The Deductible is the amount of Eligible Expenses for which no benefits are payable under this Policy in one Policy Year. There is an Individual Deductible requirement that applies to each Covered Person and must be satisfied for each Policy Year. Additionally, there is a limit on how many individual Deductibles need be satisfied for a Policy Year by an insuredfamily. Both of these are set forth in the Schedule of Benefits. After the family Deductible limit is satisfied, no further medical Deductible is required for the remaining Covered Persons in the family.

An Eligible Expense is subject to any coinsurance that is required for that particular type of expense, if any such coinsurance requirement exists under the terms of this Policy. Any applicable coinsurance amounts are only as set forth in the Schedule of Benefits.

Maximum Benefit Amount

Benefits under this Policy will be payable upon receipt of satisfactory proof that the insured has incurred eligible expenses and in accordance with the benefit schedule but subject to the conditions, exclusions and limitations established in this Policy.

The maximumbenefit payable for the aggregate of the covered expenses incurred during the lifetime by an Insured shall not exceed the maximum specified in thisPolicy. The Schedule of Benefits states the level applicable to covered Members.

Eligible Expenses

1. The following medical services and supplies are covered at the rates agreed with providers or Usual Reasonable and Customary Charges for all others subject to the limits in the schedule of benefits:
2. A hospital or transplant center for room, board, and general nursing services for stay in the covered hospital room class of service. Other hospital services including operating room, intensive care unit, recovery room, the outpatient facility, prosthetic devices, surgical materials, drugs, blood transfusions and other similar services, except articles for personal use or those which are not of a medical nature or for services rendered by non-hospital personnel.
3. Physician charges, for any treatment, medical care, or surgical procedure.
4. Charges incurred for physiotherapy, chiropody, occupational and speech therapy, audiology, podiatry, orthopics

and osteopathy treatment administered by a duly registered professional and recommended by a duly registered Physician, Surgeon or Specialist. Any such charges shall be in accordance with this Policy's terms and conditions.

5. Private duty nursing services by duly licensed nurses that are not close relatives and prescribed by a physician up to the maximum benefit.
6. Ground ambulance service for treatment of emergency, illness or accident. Air ambulance services, air transportation or any other transportation service medically necessary and prescribed for treatment.
7. Emergency room treatment for accident or medical emergency.
8. Services, treatments, medical or surgical supplies as follows: x-ray testing for diagnostic purposes, x-ray therapy, , electrocardiograms, computerized scanning, laboratory testing, and any other tests or treatment of an illness or accident as long as they have been administered by a physician or under a physician's supervision.
9. Anesthesia and its administration, administered by a professional anesthesiologist.
10. Blood, blood plasma and other sanguineous products where such charges exceed any obtained credit by way of replacement of blood by donors.
11. Oxygen and its administration.
12. Drugs and medicines which must be prescribed by a physician and dispensed by a licensed pharmacist. Drugs available without a prescription will not be considered an eligible expense.
13. Expenses related to removal, preservation and transportation of an organ or tissue for which a transplant is being attempted.
14. Services rendered to a live donor during the removal process of an organ or tissue for purposes of performing a transplant.
15. Transplant on an insured including investigation of potential donors, services rendered to the donor at a hospital or transplant center required during the removal process of an organ or tissue for a transplant.
16. Surgery and other medical services related to the removal of an organ or tissue, for which a transplant is being attempted.
17. Services and material supplied for bone marrow culture, in relation to a tissue transplant being performed on an insured.
18. Services and materials related to maternity, including complications of pregnancy, of the primary insured or the covered spouse.
19. Preventative Care services as specified in the Policy.
20. Rental of a wheelchair, hospital bed or iron lung.
21. Dental treatment necessitated by and the direct result of accidental injury to sound natural teeth, which is rendered within 90 days of the date of the accident.

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SECTION V: MEDICAL CARE INSURANCE

MEDICAL PROVISIONS AND OR PRE-EXISTING CONDITIONS LIMITATION

i. **Surgical Expenses**

When two or more Surgical Procedures occur during the same operation, the Eligible Expenses for all charges are as follows:

a) When multiple, through the same incision, or bilateral Surgical Procedures that increase the time and amount of patient care performed, the Eligible Expenses are the UCR fee for the major procedure plus 50% of the UCR fee for each of the lesser ones.
b) When an incidental procedure is performed through the same incision, the Eligible Expense is the UCR fee for the major Surgical Procedure only. Incidental procedures include, but are not limited to, excision of a scar, appendectomy, lysis of adhesions.
c) When an assistant surgeon is required to render technical assistance at an operation, the Eligible Expense for such services shall be limited to a maximum of 25% of the UCR charge of the Surgical Procedure and shall be payable subject to the deductible and to the applicable coinsurance.

ii. **Cosmetic Services**

The Policy Contract will consider expenses for cosmetic surgery only for the following 2 situations:

a) The treatment begins within three (3) months of an accidental bodily injury sustained and treated while an Insured; or
b) The surgical correction of a congenital anomaly in a child who is a Covered Dependent and is born while covered under the Policy Contract.

Voluntary Second Surgical Opinion

The plan will cover the charges for the second (or third) opinion only if the following rules are observed:

a) The opinion is obtained before the actual surgical procedure is performed.
b) The second or third physician must not be in close professional practice with the physician who would perform the surgical procedure.
c) If a Covered person received 2 conflicting opinions, the plan will pay for medical expense incurred for obtaining a third opinion.

iii. **Dental Treatment**

The Policy Contract will consider expenses for the following oral Surgical Procedures:

a) Excision of wholly or partly un-erupted impacted teeth;
b) Open or closed reduction of a fracture or dislocation of the jaw.
c) Dental Services rendered by a Physician for treatment of Injury to natural teeth will be considered if: (a) the injury is caused by an accident sustained while a Covered Person,(b) treatment starts within 31 days of the accident, (c) all treatment is rendered within ninety (90) days of the accident; and d) all treatment is rendered while a Covered Person.

iv. **Temporomandibular Joint Syndrome (TMJ)**

Benefits for treatment of TMJ are payable to the policy year maximum amount,if any, stated in the Benefit Schedule but only for medical services, supplies or procedures related to surgical procedures for the excision or reduction of the temporomandibular joint disease.

v. **Pre-Existing Conditions Limitation**

Pre-Existing Condition means a sickness or injury for which medical expense or medical treatment, consultation or advice, diagnostic testing or distinct symptoms were evident during the twenty-four (24) consecutive months immediately prior to becoming covered under the Policy Contract. The term "treatment" includes taking medicine prescribed by a Physician. For that injury or sickness, expenses incurred will not be covered expenses, and benefits will only be payable for covered expenses incurred following the date the insured person has been covered under this Policy for 24 consecutive months.

vi. **Pre-Certification/Authorisation Requirement**

a) Pre-certification means that in order to obtain scheduled benefits under the Policy, the insured person must secure from the Insurer written pre-approval of the service, treatment or supply prior to incurral of expenses.

b) The insured person is required to obtain pre-approval from the Insurer for the below services, procedures or supplies:-

- Hospitalizations, both local and overseas;
- Surgical procedures, whether provided at a hospital, ambulatory surgical centre or in a physician's office;
- Diagnostic imaging; namely Magnetic Resonance Imaging, Magnetic Resonance Angiography
- Rehabilitation or skilled nursing care facility, private duty nursing;
- Organ transplants;
- Air transportation, whether by air ambulance or commercial airline;
- Inpatient treatment of mental health, nervous disorders and substance abuse;
- Allergy testing and sleep apnea testing.

For any of the above, proof satisfactory to the Insurer must be submitted by the insured person or his designate, in writing from two physicians, one of which shall be a specialist in the field of medicine for which the care is required, not less than 72 hours before care is scheduled, that the insured person requires such care.
All services, procedures or treatments that are not emergencies shall be subject to this provision. For the purpose of this provision, any service, procedure or treatment which can be planned or scheduled in advance shall not be considered an emergency.

The covered person is responsible for making sure that the necessary information required by the Insurer is furnished. If pre-authorisation for non-emergencies is not obtained or notification for emergencies is not made, all benefits will be reduced to a 60% coinsurance payable by the Insurer where 80% would have applied.
In the case of emergencies, notification should be provided to the insurer within 48 hours of the emergency.

vii. **Overseas Treatment**

Expenses for medical treatment received abroad will be considered as having been incurred locally unless the following provisions are satisfied:

a) The diagnosis must be of such a nature so as to justify referral out of country or area of validity.

b) The required facilities for such treatment are not available in the place in which the injury or illness was contracted.

c) Such treatment is recommended by a specialist physician whose specialty is in the particular field of medicine to which the treatment applied.

d) Such treatment is approved by the Insurer's medical advisor prior to the date of departure of the covered person.

e) No alternative method of treatment is available locally.

Non-compliance with these requirements will result in the benefits being paid on the basis of the lowest of the reasonable and customary charges for such treatment in the country of domicile or the area of validity or the jurisdiction selected by the Insurer.

Benefits Exclusions and Limitations

All expenses incurred directly or indirectly for any of the following will be excluded and NAGICO will not be liable for their payment, except where otherwise stated or required by law:

1. Cosmetic or plastic surgery, or other services and supplies, to repair or reshape an essentially normal body structure for the improvement of an insured's appearance or self-esteem whether or not for psychological or emotional reasons, except for correction of damage caused by injury or in connection with a congenital defect, malformation or birth abnormality of a newborn child in accordance with Policy limits.
2. Expenses related to a pre-existing condition, except where coverage has been approved or to the maximum amount which may be specifically set

forth in the Schedule of Benefits.

3. Congenital or inherited disease expenses in excess of the maximum stated in the Schedule on Benefits.
4. Any care, injury or treatment while sane or insane due to self-inflicted illness or injury, suicide, failed suicide, alcohol use or abuse, or the use of illegal and controlled substances and including accidents resulting from the aforementioned criteria.
5. Injuries or illnesses suffered due to war, declared or not declared, act of war, rebellion, revolt, terrorism, strikes, riots, civil commotion, criminal action, or service in the military.
6. Expenses incurred as a result of the commission of or attempt to commit any criminal offence.
7. A sickness, injury or disability for which the insured person is not under the continuing care of a physician.
8. Travel for health or periodic health examinations or any examination for the use of a third-party, expensesfor any incidental personal comfort items and any medically unnecessary service or supply or for the treatment of any condition not causing sickness or not resulting from bodily injury.
9. Charges incurred for braces, prostheses, orthopedic appliances, mechanical equipment or artifacts designed to replace human organs, except when only recommended by a physician or surgeon for the treatment of traumatic injuries or illnesses and where the charges are for the initial purchase and fitting of the equipment.
10. Voluntary or induced illegal abortions, birth control supplies or devices.
11. Charges for recreational or educational therapy, services and supplies or for acupuncture, acupressure, hypnosis or biofeedback.
12. Rental or purchase of air conditioners, air purifiers, vaporizers, motorized transport equipment, escalators, elevators, swimming pools, waterbeds, exercise equipment or other personal or comfort items such as radios, television, barber or beauty equipment.
13. For treatment of sexual dysfunction or surgery to change gender or to improve or restore sexual function including but not limited to impotence and penile prosthesis for male or female. Voluntary sterilization or its reversal or for any type of birth control supplies or procedures, including abortions for social or psychological reasons or for infertility treatment, artificial insemination, in-vitro or in-vivo fertilizations or similar services or procedures for the purpose of impregnation.
14. Acquired immune deficiency syndrome (AIDS), including aids related complex (ARC), in excess of the maximum stated in the benefits schedule.
15. Care for the feet related to callus, flat foot, weak arches and weak foot.
16. Drugs not covered are: experimental or investigative, vitamins, dietary supplements, appetite suppressants, over the counter drugs or supplies, contraceptive drugs or devices and drugs prescribed for non-medical conditions.
17. Contagious diseases, requiring isolation or quarantine that have been reported as an epidemic.
18. Charges in excess of the maximum benefits, incurred after the policy terminates, greater than the reasonable and customary and for services or supplies that are not medically necessary.
19. Injury caused by, or as a result of active participation in private aviation, or professional training in any dangerous sport (such as motorcycle riding, mountain climbing, scuba diving, sky diving, skiing, or other similar activities) except if endorsed by the Policy.
20. Disabilities which commence before the effective date of the Policy, subject to any exclusion period and or benefit limitation.
21. Expenses due to any hospital confinement, injury or sickness for which benefits are payable under any other rider of this or any Policy, or which are not recommended by a physician.
22. Charges by an unlicensed physician.

23. Treatment of varicose veins by injection.
24. Maternity care for all conditions related to conception within 10 months following the commencement date of coverage for a female Primary Insured or female Dependent Spouse.
25. Expenses for treatment, operation or procedure for obesity, loss of weight, macromastia, or mastoplasty.
26. Charges for procedures that are unsafe, experimental or unapproved by a recognized regulatory body.
27. Charges rendered for professional services to a patient by any person who is ordinarily resident in the insured's home or who is a relative of the patient.
28. Expenses for any services, treatment or supplies rendered to an insured person to the extent of any benefits payable under a Workmen's Compensation or any government plan of health insurance if at the time such services, treatment or supplies rendered to the insured person is eligible to enroll or is insured by such a government plan.
29. Expenses for any services, treatment or supplies for which the insured is not required to make payment or for which there is no cost for any other reason; or expenses incurred for which no charge is or would have been made in the absence of insurance.
30. Expenses for a dependent child relating to pregnancy, miscarriage, abortion, normal delivery, caesarean section, pre-natal or post-natal care.
31. Expenses for any services, treatment or supplies as a result of an injury where there is right of recovery against a person who has caused the injury but only where such right of recovery is satisfactory by monetary payments.
32. Claims filed later than 90 days from the date the services, treatment or supplies were rendered.
33. Expenses for services or supplies which are not medically necessary for the diagnosis or treatment of an illness or injury, except as provided under Preventative Care Coverage.
34. Expenses for services, treatment and supplies covered by another health insurance carrier in accordance with the Co-ordination of Benefits Provision or for which another party is responsible.
35. Expenses for circumcision, unless it is pre-approved by the Insurer or is medically required to prevent an overall deterioration in physical condition.
36. Charges levied by a physician for his time spent travelling or for his transportation or for broken appointments or for completion of claim forms or for advice given by him via telephone or other means of telecommunication or for the administration of vaccines, antitoxins or injections for immunizations except as provided under the Preventative Care Coverage.
37. Expenses for allergy-testing and sleep apnea testing, except where pre-approved by the Insurer.
38. Preventative Care Treatment carried out during the first three (3) months (or other period of time as specified in the schedule of benefits) of continuous coverage for insured persons.

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SECTION VI: DENTAL CARE BENEFITS

This dental care rider forms part of this Policy.

(A) Application of General Provisions
Unless specifically stated to the contrary in this rider, the terms and conditions of the general provisions of this Policy shall where applicable apply to this rider.

(B) Premiums
The premium rates for this benefit at the effective date of this rider are set out in the Schedule of Dental Premium Rates, which forms part of this rider and shall continue in force until changed in accordance with the terms of the general provisions.

(C) Maximum Benefit:
As shown in the Schedule of Benefits in Appendix B.

(D) Diagnostic Services and Preventative Treatment:

1. Oral examination including scaling and cleaning of teeth but limited to one session every six month.
2. Dental x-rays, bitewing x-rays in any one 6-month period and full mouth x-rays being limited to one set in any 24-month period.
3. One application of fluorides and other anti-cariogenic substances in any one 12-month period.

(E) Basic Restorative Treatment and Basic Services:

1. Initial provision of amalgam, silicate, acrylic, synthetic, porcelain or composite restorations.
2. Space maintainers for children under age 18, including all adjustments made within 6- months of installation.
3. Replacement of amalgam, silicate, synthetic, porcelain or composite restoration.
4. Extractions (except for orthodontia).
5. Treatment for periodontal and other diseases of the gums and tissues of the mouth.
6. Oral surgery of a dental origin, including impacted wisdom teeth (except for orthodontia).
7. Fillings, other than gold.
8. General anesthesia given in connection with covered services.

(F) Major Restorative Treatment

1. Endodontic treatment (including root canal therapy.)
2. Initial provision of crowns inlays or onlays provided that the tooth is broken down by decay or traumatic injury.
3. Injury such that the tooth structure cannot be restored with an amalgam, acrylic, synthetic, porcelain or composite; also precision attachment for dentures.
4. Replacement of bridgework, dentures, crowns, inlays or onlays, provided that the tooth is further broken down by decay or traumatic injury, only if:
   The tooth structure cannot be restored with an amalgam, acrylic, synthetic, porcelain or composite.
   An additional tooth surface is involved.
   A continuous period of at least 12 consecutive months has elapsed since the date the crown inlay or onlay being replaced was last provided or replaced.
   Rebasing or relining of dentures, provided that a period of at least 12 months has elapsed since the date the dentures were provided.
5. Initial installation of full dentures, partial removable dentures or fixed bridgework provided that the appliance is required to replace one or more natural teeth at least one of which was extracted after the commencement of insurance of the insured person. This will include adjustment during the six-month period following installation. The denture or bridgework must include the replacement of the teeth which were extracted as above. Replacement of third molars (wisdom teeth) is not a covered expense.
6. Repair of dentures
7. Addition of teeth to existing dentures or fixed bridgework:
   Provided that:
   Such replacement or addition is to replace one or more natural teeth at least one of which was extracted after the commencement of insurance of the insured person and;
   The existing denture or fixed bridgework was installed five years prior to its replacement and

cannot be made serviceable.

Replacement or alteration of an existing full denture, an existing partial denture, or an existing fixed bridgework, which is necessary because of oral surgery:

Resulting from an accident;

For the repositioning of muscle attachments;

For the removal of a cyst, tumour, torus or redundant tissue.

The surgery must be performed while the insured or the dependents are covered. The replacement or alteration must be completed within 12 months from the day of the surgery.

The replacement or alteration of full or partial dentures or fixed bridgework which is necessary because of:

Structural change within the mouth and when more than five years have passed since the prior replacement;

The first replacement of an opposing full denture when the placement takes place after the insured or the dependents are covered under the provision for two years or more, or

The prior placement of an immediate or temporary denture when the replacement occurs within 12 months of placement of the immediate or temporary denture.

(G) Orthodontic Treatment

Dental expenses for the necessary purchase, placement and adjustment of orthodontic braces, with the objective of correcting malocclusion of the teeth, shall be covered under the Policy (where applicable) for children under age 18. The maximum payable is stated in the Dental Benefits Schedule.

(H) Yearly Maximum

The maximum amounts of dental benefits payable for the combined types of covered dental expenses during any one policy year for Normal Dental Care and during each Covered Person's lifetime for Orthodontic Care are as shown in the Policy Schedule.

(I) Payments

Subject to the Exclusions which follow, payments are made in connection with covered dental expenses incurred while covered for the type of expenses described in the Dental Benefits Schedule after you have satisfied the applicable annual deductible, if any. Payments for each class of covered dental services will be the percentage in the Dental Benefits Schedule for that class up to the maximum amount.

(J) Pre-Determination

If charges for a dental course of treatment are expected to equal or exceed the Annual Policy Year Maximum, the dentist shall submit a pre-treatment claim form and send it to the Insurer along with the treatment plan (consisting of description of planned treatment, supportive x-rays and expected charges). The Insurer will review the treatment plan and inform the dentist how much will be considered covered dental expense and how much is expected to be payable, subject to the insured's eligibility for such benefits, when the charges are actually incurred.

(K) Incurred Date

The incurred date for the covered dental expenses is as follows:

1. Treatment: Incurred Date is date treatment is given.
2. Dentures: Incurred Date is date impression is taken.
3. Fixed Bridges and Crowns: The date the tooth is first prepared.
4. Root Canal Therapy: The date the tooth first opened by the dentist.
5. All other treatments: On the date the work is done.

Payment will be made only upon completion of the treatment.

(L) Alternate Treatment

If it is determined that there is a less expensive alternate procedure, service or course of treatment to correct a dental condition; and if the alternate treatment will produce a professionally satisfactory result; then the maximum covered dental expenses that will be considered for payment will be the charge for the less expensive treatment.

(M) Usual, Customary and Reasonable (UCR)

See definition in the 'Definitions' section in the beginning of this Policy.

(N) Dental Definitions

Covered Dental Expenses mean those costs you incur while covered for eligible medically-necessary dental services, treatments or supplies which are:

1. Normally recognized in the dentist's field of specialty as essential for the medically necessary treatment of the condition;
2. Performed or ordered by:
   A licensed dentist acting within the scope of his license; or
   A licensed physician performing dental services within the scope of his license; or
   A licensed dental hygienist acting under the supervision and direction of a dentist.
3. Not in excess of the usual, customary and reasonable fee for the services, treatments or supplies furnished.

(O) Benefits Exclusions and Limitations

1. Dental care which is not prescribed by a dentist or performed by a dentist.
2. Any treatment, service or supply not shown under Covered Services.
3. Normal Dental Care carried out during the first one (1) month (or other period of time as specified in the schedule of benefits) of continuous coverage for insured persons.
4. Orthodontic Care carried out during the first ten (10) months of continuous coverage for insured persons.
5. Replacement of dentures, bridges or other dental appliance which are mislaid, lost or stolen.
6. Devices and supplies which are for cosmetic purposes or for experimental treatment or for unnecessary care or treatment including duplicate dentures or bridges and temporary crowns, bridges or dentures and where a dental procedure is performed for both functional and cosmetic purposes, that part of the procedure performed for cosmetic purposes will be excluded.
7. Dental treatment with the exception of the necessary treatment due to an accident covered by the Policy.
8. Treatment of the teeth or gums for cosmetic purposes, including realignment of teeth;
9. Expenses incurred after coverage ends; however, prosthetics (an artificial replacement of one or more natural teeth), including bridges and crowns, which were fitted and ordered prior to the date coverage ends will be covered. An insured must receive the prosthetic device within 30 days after the coverage ends;
10. Prosthetics, including bridges and crowns, started or under way prior to the date the insured or his dependent became covered under this provision;
11. Rebasing or relining of a denture less than six months after the first placement, and not more than one rebasing or relining in any two year period;
12. Replacement of lost or stolen prosthetics;
13. A new denture or bridgework, if the existing denture or bridgework can be made serviceable;
14. Any expense paid in whole or in part by any other provision of a dental coverage plan under which a Covered Person is insured;
15. Pulp vitality tests study models or precision attachments;
16. Education or training in and supplies used for dietary or nutritional counseling, oral hygiene, dental plaque control.
17. Procedures, appliances and restorations used to increase vertical dimension or to restore occlusion.
18. Appointments for the completion of any insurance claims forms.
19. Dental appointments for which an insured person fails to keep.
20. Expenses for injury or illness resulting from insurrection or war, whether war be declared or not, or from injury or illness arising out of participation in riots, strikes or civil commotion, or the act of committing a felony.
21. Dental expenses incurred by dependent children on or after their 19th birthday, unless they are attending an educational institution on a full-time basis up to an including age 24.

22. Anything excluded under the General Exclusions.
23. Services or materials not listed in the Schedule of Dental Care Benefits.

(P) Benefits After termination

If a Covered Person's insurance under this rider terminates, the Insurer will pay the same amount for charges for any dental care as would be payable if such insurance had not terminated provided the procedure commenced prior to termination of insurance and payment of such dental care shall not extend beyond 90 days from the date of service.

(Q) Termination of Rider

1. This rider shall be terminated on the date of termination of this Policy.
2. The Policyholder may at any time terminate this rider by written notice to the Insurer. Such termination shall become effective on the date the written notice is received by the Insurer or the date specified on the written notice, whichever is later, but in no case shall the termination be effective before the end of the period for which premiums have already been paid.
3. The Insurer may terminate this rider at the end of any contract year by giving at least 31 daysprior written notice to the Policyholder.
4. In the event of termination of this rider for any reason, the Policyholder shall be liable to the Insurer for any and all unpaid premiums for the period during which the rider was in force from the last premium due date to the date of termination of this rider.
5. All benefits terminate on the effective date of termination of this rider.

This page ends here!

SECTION VII: VISION CARE BENEFITS

This vision care rider forms part of this Policy.

(A) Vision Definitions

1. **Optician** – a vision care professional duly certified and licensed to make optical apparatus and qualified to render services provided in the jurisdiction where such services are given.
2. **Optometrist** – a vision care professional duly certified and licensed to perform visual examinations and prescribe lenses to improve visual acuity and qualified to render such services in the jurisdiction where such services are given.
3. **Ophthalmologist** – a licensed doctor duly registered to practice medicine in the specialty of ophthalmology and qualified to render the treatment provided in the jurisdiction where such services are given.
4. **Vision care** – expenses incurred for vision care treatment, services rendered, supplied or performed by an ophthalmologist, optometrist or optician.

(B) Application of General Provisions

Unless specifically stated to the contrary in this rider, the terms and conditions of the general provisions of this Policy shall where applicable apply to this rider.

(C) Premiums

The premium rates for this benefit at the effective date of this rider are set out in the Schedule of Vision Premium Rates, which forms part of this rider and shall continue in force until changed in accordance with the terms of the general provisions.

(D) Eligible Vision Care Benefits

Covered Vision Care Charges, as defined, include only the Usual, Customary and Reasonable Vision Care charges incurred while insured. The Benefits payable for each type of Covered Vision Care Charges will be the percentage payable subject to the Deductible, Coinsurance Percentage and Policy Year Maximum shown under Benefit Summary.

Charges means those costs which are:

a) Medically necessary under accepted standards of optical practice as essential for the necessary treatment of the covered person's eye condition;
b) Performed or ordered by an ophthalmologist or optometrist acting within the scope of his license or by an optician;
c) Billed by the ophthalmologist, optometrist or optician who provided the service, treatment or supply; and
d) Not in excess of the prevailing rate for the service, treatment or supply furnished.

(F) Coinsurance Percentage

This Policy has a Coinsurance Percentage. The Coinsurance Percentage is shown in the Benefit Summary. After the Deductible, the Policy will pay Coinsurance Percentages of Eligible Expenses.

(G) Covered Vision Care Expense Benefits

1. One eye examination per year for up to maximum according to the class as stated in the schedule of benefits.
2. Reimbursement for glasses or contact lenses according to the class as stated in the schedule of benefits.
3. Frames will be limited to one set per person in a 24 months period.
4. Lenses are limited to one set (pair) per person in a 12 months period.
5. Contact lenses not medically necessary shall be limited to the amount shown in the benefit schedule.

The types of Covered Vision Care Charges are as follows:

1. Charges for Eye examination - includes the complete case history, a comprehensive analysis of the visual functions, the prescription for lenses where indicated, and verification and fitting of such lenses if prescribed;
2. Charges for Lenses - only if the lenses are prescribed as a result of an eye examination made while insured for Vision Care Benefits under this plan. The date on which the lenses are ordered shall be considered to be the date on which the charges are incurred and the lenses are furnished.
3. Charges for frames – only if the frame is to be used with lenses prescribed as the result of any eye examination which was made by a qualified vision provider while insured for Vision Care

Benefits under this Policy. The date on which the frame is ordered shall be considered the date on which the charge is incurred and the frame is furnished.

(H) Payment of Benefit

1. Upon receipt of due proof that a covered person has incurred eligible expenses for vision care, the Insurer will pay benefits equal to and not exceeding the maximum amount shown in the schedule of vision care benefits.
2. An expense or charge shall be deemed to be incurred on the date on which the vision care that gives rise to the expense or charge is rendered or obtained as the case may be.

(I) Benefits Exclusions and Limitations

1. No amount is payable for charges incurred for more than one (1):
   Complete visual examination including refraction during any 12 month period
   Set of prescription lenses during any one 12 month period
   Set of frames during any one 24 month period
   Pair of non-disposable contact lenses during any one 12 month period.
2. Charges that are not Covered Vision Care Charges or for procedures, services or supplies that are not specifically included as Covered Vision Care Charges;
3. Any portion of a charge in excess of the Policy Year Maximum Benefit, as defined;
4. Services or supplies which were furnished or rendered or for which charges were incurred prior to the effective date of Vision Care Benefits under this Plan, or after such Vision Care Benefits terminate;
5. Ortho-optics or vision training, sub-normal vision aids, aniseikonia lenses, coated lenses or any other special purpose vision aids;
6. Sun-glasses, whether or not requiring a prescription, safety glasses and safety goggles. Tinted lenses with a tint other than number 1 or number 2 are considered to be sunglasses for purpose of this exclusion;
7. Frames to be used with lenses which do not require a prescription;
8. Duplicate lenses or contact lenses, or duplicate frames;
9. Repair or replacement of broken, lost or stolen lenses, contact lenses or frames;
10. Medical or surgical treatment of the eyes, or for any prescribed drug or other medication;
11. Any procedure, service or supply which is payable under any medical expense benefit plan provided by your Employer, or provided through a medical department or clinic maintained by your employer;
12. Services or supplies rendered or furnished primarily for cosmetic purposes;
13. Services or supplies which are furnished or rendered in connection with an illness, injury, disease or condition contracted or resulting from an act of war, declared or not, civil disobedience, participation in a criminal act, riot, or nuclear or atomic explosion or accident.
14. Appointments for the completion of any insurance claim forms.
15. Appointments which an insured person fails to keep.
16. Treatment incurred as a result of any sickness or bodily injury arising out of or in the course of a covered person's employment.
17. Contact lenses unless medically required by a covered person:
18. Following cataract surgery or
19. If visual acuity in a covered person's better eye is not correctable to 20/70 by the use of conventional type lenses but can be corrected to 20/70 or better by the use of contact lenses.
20. Treatment services or materials if payment has been made for a pair of contact lenses during the last 12 months.
21. Vision Care carried out during the first one (1) month(or other period of time specified in the benefit schedule) of the continuous coverage.
22. Vision Care expenses incurred by dependent children beyond age 19 (or age 24 if pursuing higher education on a full-time basis).

(J) Benefits after Termination

If a Covered Person's insurance under this rider terminates, the Insurer will pay the same amount for charges for any dental care as would be payable if such insurance had not terminated provided the procedure commenced prior to termination of insurance and payment of such dental care shall not extend beyond 90 days from the date of service.

(K) Termination of Rider

1. This rider shall be terminated on the date of termination of this Policy.
2. The Policyholder may at any time terminate this rider by written notice to the Insurer. Such termination shall become effective on the date the written notice is received by the Insurer or the date specified on the written notice, whichever is later, but in no case shall the termination be effective before the end of the period for which premiums have already been paid.
3. The Insurer may terminate this rider at the end of any contract year by giving at least 31 days prior written notice to the Policyholder.
4. In the event of termination of this rider for any reason, the Policyholder shall be liable to the Insurer for any and all unpaid premiums for the period during which the rider was in force from the last premium due date to the date of termination of this rider.
5. All benefits terminate on the effective date of termination of this rider.

This page ends here!

Section VIII: Claims Procedure

(A) Notice of Claim
Where expenses are incurred for treatment of illness or injury covered by the Policy, the insured or dependent is required to give written notice on forms satisfactory to the Insurer within 90 days of its occurrence or happening. Failure to give notice within such time shall invalidate such claim unless it can be shown not to have been reasonably possible to give such notice within 90 days and that notice was given as soon as reasonably possible.

In no event shall the Insurer consider any notice received later than 1 year from the time the notice is required.

(B) Claim Forms
The Insurer will provide the necessary forms for completion, and written proof of expenses incurred for treatment must be furnished by the insured or dependent before payment of claims by the Insurer.

(C) Examination
The Insurer shall have the right to make a medical, dental or vision examination, as applicable, of any person with respect to whom a claim is being made under the Policy. In addition, the Insurer has the right and opportunity to do an autopsy in case of death where it is not prohibited by law.

(D) Time of Payment
Benefits payable under the plan will be made within 60 days of receipt of all relevant documentation, provided that premium payments are current. Where premiums are in arrears, benefit payments will be suspended until premiums are brought up to date.
Reimbursement shall only be made in respect of the amount actually charged to and payable by an insured for treatment or services covered under the Policy. If the charges are in excess of any fixed maximum allowed under the Policy, the Insurer shall only pay up to the maximum payable for such charges.

(E) Legal Action
No action at law or in equity shall be brought to recover under this Policy prior to the expiration of 120 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of two years after the time written proof of loss is required to be furnished.

(F) Payee
Expenses incurred by insured persons for which the necessary documentation has been furnished to the Insurer will be payable to the Primary Insured; any accrued benefits unpaid at the Primary Insured's death will be payable to the designated beneficiary if any or to the Primary Insured's estate.

(G) Appeal / Review of a Claim
If a claim is denied, in whole or in part, the Insurer will furnish a notice to the Primary Insured in which it will specify the reason or describe any additional information required to perfect the claim. Upon your written request within sixty (60) days after notice is received, the Insurer will re-evaluate the claim in question and give a final written decision on the re-evaluation within sixty(60) days to one hundred and twenty (120) days, after such request is received.

This page ends here!

SCHEDULE OF MEDICAL PREMIUM RATES
STAFF

Active Employee under 60... EC$360.94

Active Dependent spouseunder 60.. EC$360.94

Active/Retired Employees Age 60 to 69.. EC$381.15

Active/Retired Dependent Spouse Age 60 to 69.................................. EC$381.15

Retired Employees age 70 & over...EC$436.68

Dependent Children under 19..EC$85.31

Dependent Children age 19 to 24..EC$171.66

Appendix A - Comprehensive Major Medical Benefit Schedule

COMPREHENSIVE MAJOR MEDICAL COVERAGE	EC$ GOLD
Lifetime Benefit Maximum (Employees under age 65)	EC$1,000,000.00
Lifetime Benefit Maximum (Employees age 65 and over)	EC$500,000.00
Annual Maximum Benefit (Employees under age 65)	EC$400,000.00
Annual Maximum Benefit (Employees age 65 and over)	EC$150,000.00
Deductible per Year	EC$250.00
Deductible per Family	2

LOCAL BENEFIT PAYMENT	
Out-Patient Benefit Payment: Coinsurance Percentage	80% of 1st EC$100,000.00 100% thereafter
Out-of- pocket:	EC$20,000.00

OVERSEAS BENEFIT PAYMENT	
Pre-certified Overseas Treatment Within Managed Care Network or Emergency treatment	90% of the R & C Charges in Overseas Territory
Pre-certified Overseas Treatment Outside of Managed Care Network	80% of the R & C Charges in Overseas Territory specified by NAGICO
Not approved nor Pre-certified	50% of the R & C Charges based on lesser of the Area of Validity or the Overseas Territory specified by NAGICO

PRE-EXISTING CONDITIONS LIMITATION: **12** months waiting period applies to new enrollees.

INTERNAL PLAN LIMITS (applies toward Lifetime Major Medical Maximum)	
AIDS or AIDS-related illnesses	
Lifetime Benefit Maximum	EC$50,000.00
Annual Benefit Maximum	EC$10,000.00
Benefit Payment: (After Deductible) Coinsurance Percentage	80%of the R & C Charges

ORGAN TRANSPLANTS	
Lifetime Maximum (Employees under age 65) Lifetime Maximum (Employees Age 65 & over)	EC$200,000.00 EC$100,000.00

Benefit Payment: (After Deductible) Coinsurance Percentage	80%of the R & C Charges
DAILY ROOM AND BOARD LIMIT	
Local (After Deductible)	80% of the R & C Charges
Overseas (After Deductible)	80% of the R & C Charges
Intensive Care (After Deductible)	80% of the R & C Charges

OVERSEAS ACCOMODATION (15 days maximum per year)	
Benefit Payment: Coinsurance Percentage	80%up to EC$270.00 per day

SURGICAL BENEFIT	
Benefit Payment: Coinsurance Percentage	80%of the R & C Charges

OTHER HOSPITAL SERVICES	
Benefit Payment: (After Deductible) Coinsurance Percentage	80%of the R & C Charges

SPECIALIST BENEFIT (by referral only) Gynaecologists and Paediatricians do not require referrals	
Benefit Payment (1 visit per day) (Local Specialist) Coinsurance Percentage	80% up to EC$202.50
Benefit Payment (1 visit per day) (Visiting Specialist) Coinsurance Percentage	80% up to EC$202.50

DOCTOR'S VISIT BENEFIT (Home, Office or Hospital)	
Benefit Payment (1 visit per day maximum) Local Coinsurance Percentage	80% up to EC135.00
Overseas Coinsurance Percentage	See Overseas Benefit

PRESCRIPTION DRUGS BENEFIT	
Benefit Payment Local Coinsurance Percentage Overseas Coinsurance Percentage	80%of the R & C Charges See Overseas Benefit

DIAGNOSTIC EXPENSE BENEFIT	
Benefit Payment LocalCoinsurance Percentage Overseas Coinsurance Percentage	80%of the R & C Charges See Overseas Benefit

EMERGENCY DOCTOR'S VISIT BENEFIT (Maximum per consultation – 1 visit per day)	
Benefit Payment Local Coinsurance Percentage Overseas Coinsurance Percentage	80%of the R & C Charges See Overseas Benefit

MATERNITY BENEFIT (Blanket Cover)	
Normal Delivery Caesarean Section Miscarriage	EC$4,000.00 EC$5,000.00 EC$1,000.00
Benefit Payment (After Deductible)	80% of the R & C Charges
Pre-natal care and extra-uterine pregnancy included in above maximums. Ten (10) months waiting period applies to new enrollees. Any other complications shall be treated as any other illness.	

PRIVATE DUTY NURSING (20 days maximum per year)	
Maximum per 8-hour shift – Private residence (day)	80% up to EC$70.00
Maximum per 8-hour shift– Private residence (night)	80% up to EC$100.00
Maximum per 8-hour shift – Hospital (night)	80% up to EC$120.00
Pre-approval necessary. Maximum days limits applicable to in-patient and out-patient care.	

MENTAL HEALTH AND SUBSTANCE ABUSE	
Lifetime Benefit Maximum (Applicable to Out-patient & Hospital Care)	EC$25,000.00
Maximum per Treatment (1 visit per day)	
Benefit Payment – In-patient	80% of the R & C Charges
Benefit Payment – Out-patient	50% of the R & C Charges

PSYCHIATRIC BENEFIT	
Lifetime Benefit Maximum	EC$25,000.00
Annual Benefit Maximum	EC$5,500.00
Benefit Payment (1 visit per day)	50% up to EC$202.50

CHIROPRACTICE CARE, PHYSIOTHERAPY AND OTHER HEALTHCARE PROFESSIONALS (20 days maximum per year)	
Annual Benefit Maximum	EC$2,700.00
Benefit Payment (1 visit per day)	80% up to EC$135.00

GROUND TRANSPORT (Local Ambulance & Emergency)	
Annual Benefit Maximum	EC$134.00
Benefit Payment(2trip per day)	80% of the R & C Charges

MEDICAL AIR AMBULANCE (Pre-Approval MANDATORY)must be medically necessary	
Benefit Payment	100% of the R & C Charges
Maximum trips per year	2

MEDICAL AIR TRANSPORTATION BENEFIT (Pre-Approval Necessary)	
Annual Maximum Benefit	EC$3,000.00
Benefit Payment: Economy Airfare	80% of the R & C Charges

CONGENITAL BIRTH DEFECTS (initial cover up to the first 14 days maximum)	
Benefit Payment (After Deductible) Coinsurance Percentage	80% of the R & C Charges

PREVENTATIVE CARE COVERAGE	
Annual Preventative Care Benefit	80% up to a max.
N.B: This benefit is meant to cover annual preventative care treatment comprising:	
a. Annual Physical Examination which includes blood pressure check, respiratory check, complete urinalysis, lipid profile, blood profile (consisting of FBS, CBC, haemoglobin and ESR tests) and ECG per Insured Person.	EC$720.00
b. Annual Gynaecology & Pap Smear Test for each Female Employee or covered Female Spouse of a Male Employee	EC$350.00
c. Local Dietician & Nutritional Counselling.	EC$100.00
d. Annual PSA test for each Male Employee or covered Male Spouse of a Female Employee over age 40.	EC$108.00
e. Vaccinations prescribed by the family doctor or specialist.	EC$150.00
f. Annual Mammogram for each Female Employee or covered Female Spouse of a Male Employee, from age 30.	EC$297.00
THREE (3) MONTHS WAITHING PERIOD APPLIES **NOT SUBJECT TO ANNUAL DEDUCTIBLE**	

SCHEDULE OF DENTAL CARE PREMIUM RATES

FOR ACTIVE EMPLOYEES UNDER AGE 65

Active Employee under 60.. EC$36.75

Active Dependent spouseunder 60... EC$36.75

Active/Retired Employees Age 60 to 69... EC$36.75

Active/Retired Dependent Spouse Age 60 to 69..................................... EC$36.75

Retired Employees age 70 & over...EC$36.75

Appendix B - Dental Care Schedule

DENTAL CARE BENEFITS	
Normal Dental Care Benefit	
Maximum per Year	EC$1,000.00 (plus 2 Preventative Examinations)
Deductible per Year	EC$135.00
Benefit Payment (After Deductible):	
Level – 1 Preventative Services	80% of the R & C Charges, if done by Health Authority; 50% of R & C Charges, if service done elsewhere
Level – 2 Minor Restorative Services	80% of the R & C Charges, if done by Health Authority; 50% of R & C Charges, if service done elsewhere

N.B:

a. Dependent children only covered up to age 18, or age 24 if pursuing higher education.
b. Maximum of two (2) preventative examinations, of six months apart, per calendar year.
c. Orthodontia benefits and major restorative services are not included.
d. Three (3) months waiting period after enrolment before making benefit claims applies for new members.
e. All benefits are based on Reasonable & Customary Charges.

R & C=REASONABLE AND CUSTOMARY

SCHEDULE OF VISION CARE PREMIUM RATES

Active Employee under 60.. EC$49.88

Active Dependent spouseunder 60... EC$49.88

Active/Retired Employees Age 60 to 69.. EC$49.88

Active/Retired Dependent Spouse Age 60 to 69.................................... EC$49.88

Retired Employees age 70 & over...EC$49.88

Appendix C - Vision Care Schedule

VISION EXPENSE BENEFITS	
BENEFITS	
Eye Examination	80% of benefit not exceeding EC$136.00
Lenses	
Single (each)	80% of benefit not exceeding EC$154.00
Bi-Focal (each)	80% of benefit not exceeding EC$330.00
Multi-Focal (each)	80% of benefit not exceeding EC$375.00
Deductible per Year	EC$135.00
Frames	80% of benefit not exceeding EC$135.00
Contact Lenses	80% of benefit not exceeding EC$206.00

N.B:

a. Frames are limited to 1 set per 24 months period.
b. Lenses are limited to 1 set per 12 months period.
c. Eye examinations are limited to 1 visit per year.
d. 3 months waiting period after enrolment before making benefit claims applies for new members.
e. This Benefit provides for reimbursement of expenses incurred for necessary vision care treatment and supplies which are provided or recommended by a duly qualified Optician, Optometrist or Ophthalmologist up to the amounts shown in the above schedule.

R & C=REASONABLE AND CUSTOMARY

GROUP LIFE INSURANCE POLICY

APPLICATION OF GENERAL PROVISIONS

1.1 Unless specifically stated to the contrary in this Group Life Policy the General Provisions of the Group Health Policy shall (where applicable) apply to this Group Life Policy and wherever the word "**Policy**" appears in the Group Health Policy the words "**Group Life Policy**" shall be substituted there for.

1.2 If any provision of this Group Life Policy is inconsistent with any provision of the Group Health Policy the provision of this Group Life Policy shall supersede and prevail over the Group Health Policy.

1.3 The following terms wherever used herein shall be construed as follows:

Experience means the ratio of claims incurred to premiums with respect to this Group Life Policy and other Plans in the Insurer's group life portfolio.

Insured or **insured person** means an employee who is insured for life insurance benefits under the provisions of this Group Life Policy.

Group Life Policy means this group life policy as amended from time to time and any endorsements hereto.

Group Health Policy means the group health policy to which this Group Life Policy is attached.

2 PREMIUMS

2.1 The monthly premium rates at the effective date of this Group Life Policy are set out in Part 1 of the Schedule of Group Life Premium Rates which forms part of this Group Life Policy and shall continue in force until changed in accordance with the terms of this clause.

.:Premium rates shown in Part 1 of the Schedule of Group Life Premium Rates are guaranteed until the first Group Life Policy anniversary and may be revised at such anniversary or on any premium due date thereafter (but not more than once in any contract year) on the Insurer giving at least 31 days' prior written notice to the employer.

2.3 The premium for the amount of insurance in force on the effective date of this Group Life Policy and thereafter shall be determined at the average rate per $1,000 ("**the average rate**") specified in Part 2 of the Schedule of Group Life Premium Rates. The average rate shall be determined as of the effective date of this Group Life Policy and on any subsequent Group Life Policy anniversary by:

(a) dividing the total premium payable for all insured persons at the relevant ages for the amount of insurance then in force on such insureds' lives as of such date as specified under the actual rate per $1,000 set out in Part 2 of the Schedule of Group Life Premium Rates by 1,000th of the aggregate amount of such insurance and

(b) making such adjustments by way of reduction or increase as may be determined by the Insurer to be warranted by the experience of this Group Life Policy or by reason of any change in the risk assumed hereunder.

2.4 All premiums are payable by the employer to the Insurer at the office designated by the Insurer. Premiums are due and payable in advance on the effective date and on the first day of each succeeding month thereafter while this Group Life Policy is in force. The Insurer is not required to accept a monthly premium other than in 1 payment from the employer.

2.5 Unless otherwise provided herein premiums shall be paid in respect of an insured person who becomes insured hereunder from the first day of the contract month immediately following the date the insurance takes effect.

2.6 Premiums in respect of an insured person who ceases to be insured under this Group Life Policy shall be payable in full for the month during which the insurance terminates.

2.7 If premiums are payable other than monthly the appropriate adjustment shall be made for insurance which has commenced, terminated or changed between premium due dates. Each premium payment hereunder shall include any adjustment in past premiums arising from those changes which have not previously been taken

into account.Provided however that no premium adjustment shall be made for a period exceeding 4 calendar months.

ELIGIBILITY FOR INSURANCE

3.1 An employee will become eligible for insurance under this Group Life Policy on the terms and conditions stated in the application form.

3.2 The employer may by filing written notice with the Insurer elect that the previous service of a former employee who is re-employed within 6 months shall apply towards the waiting period in determining the date on which such employee shall be eligible for insurance. In the absence of such election such employee shall be classified as a new employee in determining his eligibility.

4 COMMENCEMENT OF INSURANCE

4.1 If the benefits provided by this Group Life Policy are based on non-contributory insurance and the premium is to be paid on the employee's behalf by the employer such employee shall become insured on the date he becomes eligible for insurance provided the employer applies for insurance within 4 months of the date on which the employee becomes eligible but if the employer fails to apply for insurance within such period the employee will become insured on the actual date of the application.

4.2 If the benefits provided by this Group Life Policy are based on contributory insurance an eligible employee who has agreed to make his required contribution towards the cost of his insurance and who makes application for insurance to the Insurer through the employer on a form prescribed by the Insurer and signed by the employee shall become insured on the earliest of the following dates:

(a) on the date he becomes eligible for insurance if on or before such date the employee applies in writing for insurance under this Group Life Policy;

(b) on the date the employee applies in writing for insurance under this Group Life Policy if such application is made within 31 days of the date on which he becomes eligible for insurance; or

(c) on the date of approval by the Insurer of satisfactory evidence of insurability furnished at the expense of the employee if:

(i) the waiting period has been waived or

(ii) the employee applies in writing for insurance under this Group Life Policy more than 31 days after the date on which he becomes eligible for insurance or

(iii) the employee makes request for reinstatement of his insurance which was terminated for a period longer than 6 months.

4.3 If the employee is not engaged in active work on the date his insurance would otherwise have become effective under this Group Life Policy such insurance shall not become effective until the employee returns to active work.

5 TERMINATION OF INSURANCE

5.1 Subject to clause **5.4** an employee's insurance under this Group Life Policy shall cease at the earliest of the following events:

(a) on the date of termination of employment with the employer;

(b) on the date he is no longer eligible for insurance;

(c) on the date he ceases to be in good standing where the Policyholder is an association, board of trustees, board of management or union;

(d) on the date he no longer contributes towards the cost of his insurance where benefits are provided on a contributory basis;

(e) on the date he retires;

(f) on the attainment of age 70;

(g) on the date this Group Life Policy terminates.

5.2 Cessation of active work by an employee shall be deemed to be termination of employment except that if the employee ceases to be actively at work due to:

(a) sickness or injury or retirement (where retired persons are a class eligible for insurance) his insurance may be continued by continued payment of premiums until he recovers or his employment is terminated whichever is the earlier;

(c) temporary lay-off strike leave of absence suspension or vacation (in this clause called **"the event"**) his insurance may be continued at the option of the employer but not beyond the end of the 3rd contract month following that in which the event commenced.

5.3 Any maximum period of continuation provided may be extended by written agreement between the employer and the Insurer.

5.4 If in the application form retired persons are insured hereunder the insurance of a retiree under this Policy shall terminate on the earliest of the following events:

(a) on the date he is no longer eligible for insurance;

(b) on the date he ceases to be in good standing where the Policyholder is an association, board of trustees, board of management or union;

(c) on the date he no longer contributes towards the cost of his insurance where benefits are provided on a contributory basis;

(d) on the date he enters the armed forces of any country on a full-time basis;

(e) on attainment of age 70 or his death (whichever is stated in the application form);

(f) on the date he dies;
(g) on the date this Policy terminates.

6 **SCHEDULE OF BENEFITS**

6.1 Subject to the terms and conditions set out in this Group Life Policy the amount of insurance for which an employee is insured will be determined by his classification under the Schedule of Group Life Benefits which forms part of this Group Life Policy subject to the provisions of excess insurance.

6.2 This Group Life Policy does not provide for participation in the distribution of any surplus which may be declared by the Insurer from time to time.

7 **EXCESS INSURANCE**

7.1 Evidence of insurability satisfactory to the Insurer is required from an employee applying to be insured for an amount exceeding the maximum amount shown in the Schedule of Group Life Benefits and referred to therein as **"Non-Evidence Maximum"**. If such evidence of insurability is not satisfactory to the Insurer the employee will be insured for the Non-Evidence Maximum.

7.2 Where an employee who is insured for an amount equal to or in excess of the Non-Evidence Maximum is eligible for an increase in such amount he must submit further evidence of insurability to the Insurer. If such evidence of insurability is not satisfactory to the Insurer the employee shall remain insured for the amount for which he was insured immediately prior to submitting evidence of insurability.

7.3 Where the Non-Evidence Maximum is increased an employee who is insured for the Non-Evidence Maximum because the Insurer is not satisfied of his insurability for a greater amount shall remain insured for the amount for which he was insured immediately before the increase unless he can provide further evidence of insurability satisfactory to the Insurer.

8 **EMPLOYEE CERTIFICATE**

8.1 The Insurer will from time to time issue to the employer for delivery to each employee insured hereunder an individual certificate stating the group life and accidental death and dismemberment benefits (if any) to which such employee is entitled.

8.2 A certificate issued to an employee (whether by reason of inadvertence error or otherwise) who

is not or has ceased to be entitled to insurance under this Group Life Policy shall be null and void.

8.3 An employee certificate shall not constitute part of this Group Life Policy and if there is any inconsistency or conflict between the terms of the certificate and this Group Life Policy the terms of the Group Life Policy shall supersede and prevail.

9 CHANGE IN AMOUNT OF INSURANCE

9.1 The employer must report promptly in writing to the Insurer the names of all insured persons who are eligible for an increase or decrease in the amounts of their insurance due to changes in classification or salary together with the data necessary to compute such increase or decrease.

9.2 If at any time a change in an employee's classification or salary warrants a change in the amount of insurance for such employee the increase or decrease shall become effective on the date the change in classification or salary becomes effective subject to the terms of the application and the provisions in this Group Life Policy relating to eligibility and commencement of insurance.

9.3 Subject to the foregoing provisions if this Group Life Policy is amended after its effective date an insured person shall become insured for such amended amount of benefits on the effective date of the endorsement.

9.4 No increase in the amount of an insured person's insurance may be made retroactively without the approval of the Insurer.

10 REDUCTION IN INSURANCE

When an insured person attains the age of 65 the amount of insurance for which he shall be covered will be reduced by 50% of the amount for which he was insured immediately preceding his 65th birthday.

11 EXCEPTIONS AND LIMITATIONS

No payment will be made under this Group Life Policy for claims resulting directly or indirectly from suicide while sane or insane within 1 year of the commencement of insurance hereunder in which event the Insurer's liability will be limited to a refund without interest of the premiums paid by or on behalf of the insured.

12 PAYMENT OF BENEFIT

Upon receipt of proof satisfactory to the Insurer of the death of an insured person the Insurer will pay to his designated beneficiary or otherwise as provided in clause **13** a benefit equal to the amount of group life insurance in force on the life of such insured person in accordance with the Schedule of Group Life Benefits.

13 BENEFICIARIES

13.1 An insured person may designate a beneficiary to receive any benefit payable hereunder by reason of his death. Such designation may be changed in writing in a form satisfactory to the Insurer without the consent of such beneficiary but subject to any statutory restriction.

13.2 Any such designation shall take effect on the date it is made without prejudice to any action taken or payment made by the Insurer before evidence of such designation is received by the Insurer at its head office.

13.3 Unless otherwise specifically provided in a beneficiary designation benefits shall be paid by the Insurer in the following manner:

(a) If no beneficiary has been designated the benefits shall be paid to the estate of the deceased.

(b) If a beneficiary has been designated the benefits shall be paid to such beneficiary.

(c) If a beneficiary has been designated and such beneficiary predeceases the insured person the benefits shall be paid to the estate of the insured person.

(d) If more than 1 beneficiary has been designated and any of them predeceases the insured person the benefits shall be paid to the surviving beneficiary (if any) and if more than 1 the surviving beneficiaries.

13.4 Where an insured person dies leaving more than one beneficiary the benefits shall be paid to the surviving beneficiaries in the proportion

designated by the insured person and if not so designated in equal shares.

15 WAIVER OF PREMIUM - TOTAL DISABILITY

15.1 Upon receipt of proof satisfactory to the Insurer either before the discontinuance of premium payments in respect of an insured person or within 12 months thereof that:

(a) such insured person before attaining the age of 60 and before termination of his employment became totally disabled and

(b) such total disability existed continuously for a period of at least 6 months

the Insurer will continue the insured person's insurance under this Group Life Policy with effect from the end of the initial 6 month period of continuous total disability without the payment of premiums (herein called **"waiver of premium"**) in respect of such insured person during the continuance of such total disability for a period of 1 year from the date when the insured person became totally disabled and for additional periods of 1 year each during the continuance of such total disability provided that during the 3 months immediately preceding each year for which such insurance has been continued the employee submits due proof to the Insurer of his continued total disability.

15.2 The amount of life insurance which will be continued in force in accordance with the foregoing provisions shall be the amount for which the insured person was insured on the date of discontinuance of premium payments for him except that if the Schedule of Group Life Benefits provides for a reduction in the amount of life insurance by reason of the attainment of a specified age or provides for termination of insurance upon retirement (hereinafter together called **"the event"**) the amount of life insurance being continued shall be automatically reduced or terminated as the case may be in accordance with the Schedule of Group Life Benefits when the event occurs provided however that the attainment of age 65 shall be deemed to be retirement date for the purposes of waiver of premium.

15.3 The amount of insurance for which an insured person is insured shall not be increased while a waiver of premium relating to his insurance hereunder is in effect.

15.4 Notwithstanding the requirements set out above for a waiver of premium if due proof is furnished to the Insurer at its head office that:

(a) premium payments for such insured person's insurance were discontinued while he was totally disabled and

(b) the insured person qualified or would have qualified if the disability had existed continuously for a period of at least 6 months for a waiver of premium as provided above except that the proof required by the terms hereof had not yet been received (or if received had not yet been approved) by the Insurer and

(c) the insured person died during the uninterrupted continuance of such total disability and within 12 months following the date of discontinuance of premium payments for his insurance hereunder

the Insurer will pay the benefits for which the insured person was covered.

15.5 Total disability insurance will not apply to an insured person who has intentionally self-inflicted an injury which results in his total disability.

15.6 Total disability insurance of an insured person shall terminate immediately at the earliest of the following dates:

(a) the date the insured person ceases to be totally disabled;

(b) the date on which his insurance would normally cease if he was not totally disabled or the age of 65 whichever is the earlier;

(c) the end of any period for which insurance has been continued hereunder during which the insured person fails to furnish proof of continuance of total disability;

(d) the date the insured person refuses to be examined by a physician or other health care professional designated by the Insurer as herein provided;

(e) the date this Group Life Policy terminates.

16 MISSTATEMENT OF AGE

If the age of an employee has been misstated the amount of insurance payable hereunder shall be the amount of insurance as set out in the Schedule of Group Life Benefits to which such employee is entitled based on his true age and an equitable premium adjustment shall be made.

17 ASSIGNMENT

The benefits provided under this Group Life Policy may not be assigned.

18 RENEWAL OF GROUP LIFE POLICY

18.1 This Group Life Policy may be renewed by the Insurer at the end of each contract year for a further term of 1 year subject to receipt of the first premium due for renewed contract year. The premium for the renewed contract year will be based upon the premium rates determined by the Insurer.

18.2 The Insurer reserves the right to review this Group Life Policy in all respects and may decline to renew this Group Life Policy at the end of any contract year. Without prejudice to the generality of the foregoing the Insurer may decline to renew this Group Life Policy if the number of employees insured at that time is less than the percentage specified in the application.

19 TERMINATION OF GROUP LIFE POLICY

19.1 The employer may at any time terminate this Group Life Policy by written notice to the Insurer. Such termination shall become effective on the date such written notice is received by the Insurer or on the date specified in the written notice whichever is later but in no case shall termination be effective before the end of the period for which premiums have already been paid.The Insurer may terminate this Group Life Policy at the end of any Policy year by giving at least 31 days prior written notice to the employer and without prejudice to the generality of the foregoing the Insurer may terminate this Group Life Policy by giving at least 31 days' prior written notice to the employer if:

(a) the number of employees insured is less than the percentage specified in the application;

(b) the employer fails to furnish promptly any information which the Insurer may reasonably require orwithout good or sufficient cause to duly perform or observe in good faith any obligations on the part of the employer to be performed or observed under this Group Life Policy.

19.3 In the event of termination of this Group Life Policy for any reason the employer shall be liable to the Insurer for any and all unpaid premiums for the period during which this Group Life Policy was in force with respect to any employees covered hereunder pro-rated from the last premium due date to the date of termination of this Group Life Policy.

19.4 Subject as set out herein all benefits terminate on the effective date of termination of this Group Life Policy without prejudice to the rights of employees with respect to anything occurring while this Group Life Policy was in force.

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SCHEDULE OF GROUP LIFE PREMIUM RATES

Average Rate Group Life Insurance EC$6.83

Average Rate AD&D Insurance EC$1.26

AD & D BENEFITS

SCHEDULE OF GROUP LIFE BENEFITS

Flat Benefit – EC$50,000.00

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS RIDER

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS RIDER

This Accidental Death and Dismemberment Benefits Rider forms part of the Group Life Policy.

DEFINITIONS AND INTERPRETATIONS

Subject as hereinafter set out the definitions and interpretations in the Group Life Policy shall where applicable apply to this Rider and in addition thereto the following terms wherever used in this Rider shall be construed as follows:-

Accidental injury means bodily injury sustained solely through external violent and accidental meansresulting in a loss of foot hand eye or thumb and finger.

Loss of eye means entire and irrecoverable loss of sight of the eye.

Loss of foot means severance at or above the ankle joint.

Loss of hand means severance at or above the wrist joint.

Loss of thumb and finger means severance at or above the knuckles joining the thumb and finger to the hand.

Group Life Policy means the group life policy to which this Rider is attached.

APPLICATION OF POLICY

Unless specifically stated to the contrary in this Rider the provisions of the Group Life Policy shall (where applicable) apply to this Rider.

PREMIUMS

The monthly premium rates for this benefit at the effective date of this Rider are set out in the Group Life Policy and shall continue in force until changed in accordance with the terms of the Group Life Policy.

PAYMENT OF BENEFIT

Upon receipt of proof satisfactory to the Insurer that an insured person has suffered a loss specified in the Schedule of Accidental Death and Dismemberment Benefits which forms part of this Rider and is hereinafter called **"The Schedule of A D & D Benefits"** the Insurer will pay to such insured person (or in the case of loss of life to his designated beneficiary or otherwise as provided in the Group Life Policy) subject as set out below the maximum amount shown in the Schedule of A D & D Benefits applicable to such insured person at the time of the accidental injury provided however that the maximum amount payable under this benefit in respect of all losses suffered shall not exceed the maximum amount for which an insured person is covered.

EXCEPTIONS AND LIMITATIONS

No payment will be made under this benefit for:

loss occurring more than 365 days after the accident resulting in the accidental injury;

loss resulting directly or indirectly from:

a) Physical or mental infirmity, illness or disease of any kind existing before or commencing after an accidental injury, or medical or surgical treatment thereof; ptomaine or bacterial infection other than septic infection occurring simultaneously with and solely in consequence of an external and visible bodily injury or wound accidentally sustained.

b) Suicide or intentionally self-inflicted injury while sane or insane.

c) Insurrection, or participation in a riot or war (whether declared or undeclared).

d) Travel or flight in any aircraft except solely as a ticket holding passenger in a licensed civil aircraft.

e) Intentional misuse of drugs.

f) The commission of, or any attempt to commit a criminal act.

g) Poisoning in any form or inhalation of gas or fumes, if voluntary, occupation accidents excepted.

h) Any injury covered by Workmen's Compensation Law or Act of similar legislation unless twenty-four (24) hour coverage is indicated in the application.

i) Injuries resulting in death where there is no visible contusion or wound on the exterior of the body, drowning and internal injuries revealed by autopsy excepted.

j) An accident which occurs while the blood alcohol level of the life assured is 80 milligrams or more per 100 milligrams of blood.

<u>TERMINATION OF RIDER</u>

This Rider shall be terminated on the date of termination of the Group Life Policy.

The employer may at any time terminate this Rider by written notice to the Insurer. Such termination shall become effective on the date such written notice is received by the Insurer or on the date specified in the written notice whichever is later but in no case shall termination be effective before the end of the period for which premiums have already been paid.

The Insurer may terminate this Rider at the end of any contract year by giving at least 31 days prior written notice to the employer and without prejudice to the generality of the foregoing the Insurer may terminate this Rider by giving at least 31 days' prior written notice to the employer if:

(a) the number of employees insured is less than the percentage specified in the application;

(b) the employer fails to furnish promptly any information which the Insurer may reasonably require orwithout good or sufficient cause to duly perform or observe in good faith any obligations on the part of the employer to be performed or observed under this Rider.

In the event of termination of the Group Life Policy for any reason the employer shall be liable to the Insurer for any and all unpaid premiums for the period during which this Rider was in force with respect to any employees covered hereunder pro-rated from the last premium due date to the date of termination of this Rider.

Subject as set out herein all benefits terminate on the effective date of termination of the Group Life Policy without prejudice to the rights of employees with respect to anything occurring while the Group Life Policy was in force.

This rider shall terminate for all employees on the attainment of age 65.

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ACCIDENTAL DEATH AND DISMEMBERMENT RIDER

SCHEDULE OF ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

PERCENTAGE OF SUM ASSURED

Accidental Injury	%
Loss of life	100
Loss of sight of both eyes	100
Loss of both hands or both feet	100
Loss of 1 hand and 1 foot	100
Loss of 1 hand and sight of 1 eye	100
Loss of 1 foot and sight of 1 eye	100
Loss of sight of 1 eye	50
Loss of 1 hand or 1 foot	50
Loss of 1 thumb and any finger on the same hand	25

NAGICO INSURANCES

NAGICO Insurance Company Limited

Insured Name: **Government of Anguilla**

Policy Number: **AGLH029/09** Effective Date: January 1st 2017

Endorsement No: **1 – Attached to and forming part of the Policy # AGLH029/09**

(1)Notwithstanding anything contained in the policy to the contrary, it is hereby understood and agreed that the benefits provided under this policy shall be amended to read and extended to all active/retired employees or persons named in the policy form signed and was submitted to the Company by the Government of Anguilla.

It is also understood and agreed that coverage terminates on cessation of employment or until death once the retirement coverage is accepted.

(2) It is hereby understood and agreed that employees who present morbidity risk factors at the time of application not meeting established standard underwriting requirements eligible for coverage will be subject to extra morbidity rating and or appropriate underwriting conditions will be so placed on such illnesses.

All other terms and conditions of the policy remain unchanged.

In witness whereof, NAGICO INSURANCE COMPANY LIMITED, has caused this endorsement to be executed to become effective January 1st, 2017.

Sign for and on behalf of NAGICO

Authorized Signature

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