GROUP POLICY

GENERAL PROVISIONS

ENTIRE CONTRACT: The Policy, the Coverage Summary, the Schedule of Benefits, the Application, and any Amendments, Riders, or Endorsements, make up the entire contract between the parties. All statements made by the Policyholder or by any individual Employee shall, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense to claim under this Contract, unless it is contained in a written instrument furnished to the Policyholder or a Covered Insured.

TERM OF THE POLICY: This Policy has a term of twelve (12) months renewable for a like term upon payment of the renewal premium.

BENEFITS TO WHICH COVERED INSUREDS ARE ENTITLED: The liability of the Company is limited to the benefits specified in the Contract. No person other than a Covered Insured is entitled to receive benefits under this contract. Such right to benefits and coverage is not transferable.

NOTICE: Means any notice required under this contract must be in writing. Any notice given by the Company will be mailed either to the Policyholder or to the Agent or Broker. Any notice given to the Company will be sent to the Company's administrative offices at: ***P.O. Box PW 5236, The D'Image Complex, Rock Farm, Anguilla AI 2640, British West Indies.***

CHANGES TO THE POLICY: The Company retains the right to amend the Policy without the consent of the Covered Insured or any person having a beneficial interest. Such amendment shall be without prejudice to any claim arising prior to the date of the change. The change will be valid only if made by a new Policy wording, Endorsement or Rider duly signed by an officer of the Company. Any changes to the Policy shall become effective thirty one (31) days after written notice of such change is mailed by the Company to the Policyholder, Broker or Agent.

GRACE PERIOD: After the first premium payment, a grace period of thirty one (31) days will be allowed for payment of each premium due. If the premium is not paid within the grace period, the Company will terminate this Policy on the due date of the unpaid premium. Benefits are not provided under the Policy during the grace period unless it is renewed.

RECORDS AND REPORTS: The Policyholder shall keep a record of the persons Covered Insured under the Policy containing for each person, the essential particulars of the insurance. The Policyholder shall periodically forward to the Company, on the Company's forms, such information concerning the persons eligible for the insurance under the Policy as may be relevant to the administration of the insurance and on the determination of the premium rates. Such records of the Policyholder relevant to the insurance shall be open for inspection by the Company at any reasonable time.

CLERICAL ERROR: Clerical error or delays in keeping records by the Company: (a) will not deny insurance which should otherwise have been granted; and (b) will not extend insurance which should otherwise have been terminated; and (c) will be subject to proper adjustment of premium not exceeding six (6) calendar months when an adjustment is needed.

PREMIUMS: Premiums under the Policy are payable by the Policyholder at offices of the Company or at offices agreed by the Policyholder and Company. Such premiums are due and payable as specified on the face page of the Policy, provided that by mutual agreement between the Policyholder and the Company the interval of payment may be changed, with appropriate adjustment, to provide for payment annually, semiannually, quarterly or monthly. The Company reserves the right to amend the premium at any date provided that thirty one (31) days notice is given in writing to the Policyholder.

CURRENCY: All payment of benefits made by the Company under the Policy shall be made in the same currency as that in which premiums were received unless otherwise arranged by mutual agreement between the Policyholder and the Company.

MISSTATEMENT OF AGE: If it is discovered that the Covered Insured's or Dependent's age has been misstated and the error has an effect on premium, an adjustment of the premium will be made and it will be determined whether coverage is valid under this Policy for the Covered Insured and Dependents.

THIRD PARTY ACT OR OMISSION: The Company shall not be liable for any injuries or damage resulting from acts or omissions by any officer or employee of the Company or of any Provider or other person furnishing services or supplies to the Covered Insured; nor shall the Company be liable for injuries or damage resulting from the dissemination of information for the purpose of claims processing or facilitating patient care.

FRAUD: If any claims presented under this Policy are in any respect fraudulent or if any fraudulent means or devices are used by the Covered Insured or anyone acting on his behalf, such as misrepresentation on the application form, omission of information or any attempts, through deceit, to obtain benefits for any person that otherwise would not be provided or payable, the Company will deny benefits and terminate the Policy. Termination will be effective as of the Effective Date of the Covered Insured's coverage under this Policy. The Company will refund premiums as indicated in the Refunds Provision less any benefit paid to or on behalf of the Covered Insured and any of his Dependents. If the value of the benefits paid exceeds the amount of premiums paid, the Covered Insured will pay the Company an amount equal to such excess.

PARTICIPATION REQUIREMENTS: When the provision of insurance under any Rider to this Policy stipulates that insurance is non-contributory the employees Covered Insured under such Rider must be no less than three (3) in number and one hundred percent (100%) of those eligible for insurance.

When the provision of insurance under any Rider to this Policy stipulates that insurance is contributory the employees Covered Insured under such Rider must be no less than three (3) in number and seventy five percent (75%) of those eligible for insurance.

APPLICABLE LAW: This contract is entered into, interpreted in accordance with, and is subject to the laws of ***Anguilla***. It is also agreed that 12:01 a.m. standard time in, ***Anguilla*** shall be deemed to be the effective time with respect to any date referred to in the Policy.

ARBITRATION: All disputes arising regarding this Policy or any matter that is related directly or indirectly to this insurance which cannot be resolved by the parties shall be settled exclusively through binding, non-appealable and confidential private arbitration. Notice requesting arbitration will be in writing and sent certified or registered mail, return receipt requested.

Each party shall choose one arbitrator and the two arbitrators shall choose an impartial third arbitrator who shall preside over the hearing. If either party fails to appoint its arbitrator within thirty one (31) days after being requested to do so by the other party, the latter, after ten (10) days notice by certified or registered mail of its intention to do so, may appoint the second arbitrator.

Within thirty one (31) days after notice of appointment of all arbitrators, the panel shall meet and determine timely periods for briefs, discovery procedures and schedules for hearings. The panel shall be relieved of all judicial formality and shall not be bound by the strict rules of procedure and evidence. The arbitration shall take place and shall consider the laws of ***Anguilla***. The decision of any two arbitrators when rendered in writing shall be final and binding. The panel is empowered to grant interim relief, as it may deem appropriate.

The panel shall interpret this Contract as an honorable engagement rather than as merely a legal obligation and shall make its decision considering the custom and practice of the applicable Insurance business as promptly as possible following the termination of the hearings.

TERMINATION OF INDIVIDUAL EMPLOYEES' INSURANCE: The Company retains the right to cancel, modify or rescind the Policy immediately;

- On the date the Employee's employment terminates;
- On the date the Employee is no longer eligible for insurance;
- On the date the Policy terminates;
  If an Employee ceases to be actively at work on a full time basis due to sickness or Injury his insurance will be continued until the end of the month following the month in which the sickness or disability, leave of absence, lay-off or part-time employment commenced;
- If statements on the application are found to be misrepresentations, incomplete or incorrect or if fraud has been committed, leading the Company to approve an application when, with the correct or complete information, the Company would have issued the Policy with restrictions or declined coverage; or by submission or falsification of any information including fraudulent claims is also grounds for rescission or cancellation of the Policy;
- If the Grace Period has ended without payment of the required premium;
- Upon written request from the Policyholder to terminate a Dependent coverage or to terminate the Policy on the last day of the period for which premium has been paid;
- As specified by the conditions of the Policy;
- If a Covered Insured resides temporarily or permanently outside the Caribbean for a period of more than three (3) months in any Policy period.

In the event a Policy terminates for any reason other than fraud, the Company would only be liable for treatment covered under the terms of the Policy that took place before the termination date of the Policy.

PRE-CERTIFICATION REQUIREMENTS: Pre-certification is required by the Company, in advance, for any non-emergency treatment. Surgery, diagnostic and other listed procedures performed during an Emergency, as determined by the Company, do not require pre-certification. However, the Company should be notified within two (2) business days of emergency services for those procedures listed herein, or as soon as reasonably possible, as determined by the Company.

Services Requiring Pre-certification:

- All non-emergency Inpatient admissions
- Surgical Procedures
- Transplants
- Operative and Diagnostic Endoscopies
- MRI Scans
- CAT Scans
- Therapy Services
- Restorative Services
- Psychiatric and Alcohol and Drug Abuse Services
- Private Duty Nursing Services
- Other Services and Supplies

OVERSEAS MEDICAL TREATMENT:
To maximize plan benefits for overseas medical treatment, it is recommended that the Covered Insured notify the Company for any overseas appointments or treatments at least five (5) business days prior to the appointment or treatment.

In the case of an Emergency, the Company should be notified within two (2) business days of emergency services or as soon as reasonably possible, as determined by the Company.

Coverage for overseas treatment would be provided through the Company's Preferred Providers Network and if accessed out of the Company's Preferred Provider Organization, would be subject to usual customary and reasonable charges applicable within the Company's network.

RIGHT TO RECOVER PAYMENTS IN ERROR: If the Company should pay for any contractually excluded services through inadvertence or error, the Company maintains the right to seek recovery of such payment from the Provider or Employee to whom such payment was made.

RIGHT TO ENFORCE CONTRACT PROVISION: If the Company shall choose to waive their rights under the Contract regarding a specific term or provision, it shall not be interpreted as a waiver of their right to otherwise administer or enforce this contract in strict accordance with the terms and provisions.

REIMBURSEMENT OF PROVIDERS (PPO PLANS ONLY): The Covered Insured or the Provider may submit bills directly to the Company and, to the extent that benefits and indemnity are payable within the terms and conditions of this Contract, reimbursement will be furnished as follows:

- **Preferred Providers**
  Preferred Providers are members of the Company's Preferred Provider Organization Network and have a contractual arrangement with the Company for the provision of services to the Covered Insureds. Benefits will be provided as specified in the Schedule of Benefits for services, which have been performed by a Preferred Provider. The Company will compensate Preferred Providers in accordance with the contracts entered into between such Providers and the Company. No payment will be made directly to the Covered Insured for covered services rendered by any Preferred Provider.

- **Non-Preferred Providers**
  Non-Preferred Providers are not part of the Company's Preferred Provider Organization Network. The Company will provide benefits at the Non-Preferred Provider Coinsurance level specified in the Schedule of Benefits. Reimbursement for services to Non-Preferred Providers would be made to the Covered Insureds or if assigned by the Covered Insureds to the Non-Preferred Providers. If the Company determines that covered services were for Emergency care as defined herein, the Covered Insured will not be subject to the Deductible or Coinsurance penalties that would ordinarily be applicable to Non-Preferred Provider services. Emergency admissions must be certified within two (2) business days of admission, or as soon as reasonably possible, as determined by the Company.

TERMINATION OF POLICY AND RIDERS: All Riders shall terminate upon termination of the Policy. If on any premium due date the participation requirements are not complied with, the Company may thereupon terminate any Rider provided written notice of the Company's intention to effect such termination has been given to the Policyholder at least thirty one (31) days in advance. It is further provided that the Policyholder or the Company may terminate this Policy or any Rider to this Policy at any time by mailing to the other party written notice of such intention at least thirty one (31) days in advance of the termination date.

Once covered services are rendered by a Provider, the Company will not honor a Covered Insured's request not to pay for claims submitted by the Provider. The Covered Insured will have no liability to any person because of its rejection of the request.

EMERGENCY ADMISSION REVIEW (PPO PLANS ONLY): Covered Insureds are responsible for notifying the Company of a Non-Preferred Provider emergency admission for themselves or a Dependent within two (2) business days of the admission, or as soon as reasonably possible, as determined by the Company.

Failure to initiate Emergency Admission Review will result in a reduction in Hospital benefits of fifty percent (50%) of covered expense for Non-Preferred Provider services. Such penalty will be the sole responsibility of, and payable by, the Covered Insured.

If the Covered Insured elects to remain hospitalized after the Company and the attending Physician have determined that a Hospital level care is not medically appropriate, the Covered Insured will be financially liable for non-covered inpatient charges from the date of notification.

The Covered Insured, the Physician, or the Hospital may appeal the determination and submit information in support of the claim for inpatient benefits. A final determination, by the Company concerning eligibility for inpatient benefits will be made and the Covered Insured, Physician, and Hospital will be notified.

LARGE CLAIM MANAGEMENT: The Company may determine that a particular claim occurring under this Policy may require specific cost containment and case management. In the event that the Company determines that a particular claim meets the large case management requirements, the Company reserves the right to recommend and make payment for expenses that may not be covered under the terms of this insurance. Further, when in the Company's opinion, there are alternative treatments or procedures which may be more cost effective, the Company reserves the right to deny payment for expenses which are incurred which are over the amount the Company would pay if the recommendations of the Company had been followed.

DEFINITIONS

Certain words and phrases used in this contract are listed below, with the definition or explanation of the manner in which the term is used for the purpose of this contract. Masculine pronouns used in this document shall include masculine or feminine gender unless the contract indicates otherwise.

ACCIDENT means an unforeseen, unexpected, unintentional and fortuitous event due exclusively to an external cause of a violent nature beyond the control of the Covered Insured or Dependents, resulting, directly and independently of all other causes, in bodily trauma to the Covered Insured or Dependents and which occurs after the Effective Date of coverage and results in hospitalization of the Covered Insured or Dependents.

ANNUAL MEDICAL EXAMINATION means a medical examination that takes place outside of a Hospital as part of the Covered Insured's regular wellness examination, which is not for the purpose of the Diagnosis, and treatment of an Illness or Injury.

APPLICATION FORM or DECLARATION FORM means the form either written or via electronic transfer completed and signed by the Covered Insured to request insurance coverage under this Policy. It includes any medical history, questionnaires, and other documents requested by the Company prior to the issuance of the Policy.

CAESAREAN SECTION means the delivery of the fetus through an abdominal incision in conditions where the vaginal route is contraindicated.

CLOSE RELATIVE means the Covered Insured or spouse, parent, child, stepchild, brother, sister, mother-in-law, father-in-law, uncle, aunt or cousin of the Covered Insured.

COINSURANCE or COPAYMENT means the specific amount or percentages of the covered expenses, which must be paid by the Covered Insured. The actual percentages are shown on the Schedule of Benefits or as otherwise stated on the Policy.

COMPANY or WE, **US, or OUR** means Guardian Life of the Caribbean Limited.

COMPLICATIONS OF BIRTH means any disorder related to the birth of a newborn, not caused by genetic factors, manifested during the first thirty one (31) days of life, including, but not limited to hyperbilirubinemia (jaundice), cerebral hypoxia, hypoglycemia, prematurity, respiratory distress and birth trauma.

COMPLICATIONS OF PREGNANCY means ectopic pregnancy; or spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy also include, when pregnancy is not terminated (by delivery or otherwise), conditions which require Hospital confinement, whose diagnoses are distinct from pregnancy but are adversely affected by or caused by pregnancy, such as, but not limited to:

- acute nephritis; or
- nephrosis; or
- cardiac decompensation; or
- missed abortion, and similar medical and surgical conditions of comparable severity prior to delivery; and
- pre-eclampsia.

Complications of Pregnancy do not include occasional spotting; Physician prescribed rest during the period of pregnancy, or morning sickness.

CONFINEMENT means any admission and/or subsequent readmission(s) to a Hospital occurring within ninety (90) consecutive days. A new confinement begins when a Covered Insured has been discharged from a Hospital for more than ninety (90) days.

CONGENITAL DEFECTS means any condition, Illness, disorder or defect which is existing from the time of birth or before birth, regardless of its cause, and whether or not it has been first identified or diagnosed at birth, after birth, or in later years.

CONTRACT YEAR means the period that begins on the Effective Date shown on the coverage summary of this Policy and ends twelve (12) months after the Effective Date of this Policy.

COUNTRY OF RESIDENCE means the country declared in the application form or any other country in the Caribbean and where the Covered Insured and Covered Dependents must be present and residing for at least nine (9) months in any Policy period.

COVERED EXPENSES means the Usual Customary and Reasonable charges incurred by a Covered Insured for Medically Necessary treatments, services or supplies and/or prescribed drugs covered under this Policy. Covered Expenses are shown in the Schedule of Benefits and/or in the Coverage Summary of this Policy.

COVERED INSURED means a Covered Insured or his Dependent(s) who has satisfied the specifications of Eligibility and is entitled to coverage under this Policy and for whom the required premium has been paid.

CUSTODIAL CARE means care provided primarily for Maintenance of the patient or which is designed essentially to assist the patient in meeting activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease or bodily injury. Custodial Care includes but is not limited to help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications which do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively.

DEDUCTIBLE means the dollar amount of covered expenses which the Covered Insureds' are responsible to pay before Benefits are payable under this Policy. This amount will not be reimbursed under this Policy. Deductible amounts are shown in the Coverage Summary.

DEPENDENT means the Covered Insured's:

- Spouse; or the person living with the Covered Insured in a recognized husband and wife relationship and registered in the records of the Policyholder;
- Unmarried sons and daughters, under age nineteen (19), except if they are fulltime students at an accredited College or University, in which case the coverage will be extended up to age twenty five (25);
- Incapacitated Dependent over age twenty five (25) years and solely dependent on the Covered Insured.

DIAGNOSIS means the determination by a Physician or specialist of the nature of a disease or condition made from a study of the signs and symptoms of a disease or condition.

DURABLE MEDICAL EQUIPMENT means any equipment prescribed by a Physician designed for repeated use and which is Medically Necessary to improve the functioning of a malformation of the body, treatment of an Illness, or to prevent further deterioration of a Covered Insured's medical condition. "Duarable Medical Equipment" includes wheelchairs, hospital beds, respirators and such other items as determined by the Company.

EFFECTIVE DATE means that date on which coverage for a Covered Insured begins under the Policy as indicated in the Coverage Summary.

ELECTIVE means any care, service, treatment, or Surgery performed at the choice of the patient, for which there is no Medical Necessity, and/or which does not treat an Illness or Injury (such as care provided primarily as a convenience or to improve or preserve appearance).

EMERGENCY means the sudden and unexpected onset of a medical condition accompanied by acute signs or symptoms, which could reasonably result in placing the Covered Insured's life or physical integrity in immediate danger if medical attention is not provided immediately.

EMERGENCY MEDICAL SERVICES – the initial treatment of a sudden onset of a medical condition with acute symptoms of sufficient severity that in the absence of immediate medical attention could reasonably result in:

- permanently placing the Covered Insured's health in jeopardy;
- causing other serious medical consequences;
- causing serious impairment to bodily functions; or
- causing serious and permanent dysfunction of any bodily organ or part;
- causing loss of life or limb.

EMPLOYEE means any regular, full time, permanent employee of the Policyholder who is regularly employed in an established job or position and works at least thirty (30) hours per week and accepted by the Company to be covered by the provisions of the Policy.

ESTIMATE means the assumed cost for the services or procedures to be conducted either by a Doctor, Surgeon or laboratory for the services to the patient for the treatment of a given Diagnosis or as part of an investigation in order to obtain a Diagnosis.

EXPERIMENTAL or **INVESTIGATIVE** means any treatment, procedure, equipment, drug, drug usage device or supply that fails to meet one or more of the following criteria:

- Controlled studies published in peer review medical literature demonstrate that such service or supply has a net beneficial effect on health outcomes for a specific Diagnosis; or under study, investigation, trial period or is limited to research; or
- Such service or supply is in accordance with generally accepted standards of medical practice in the United States of America;
- At the time such service or supply is received by a Covered Insured, it has been approved for the particular indication or application in question by the United States Food and Drug Administration (FDA) or other federal or state governmental agencies whose approval is required in the United States, regardless of where the medical expenses are incurred.

HOSPITAL means an institution:

- Operated in accordance with the laws pertaining to Hospitals of the area in which the Hospital is located;
- Which, for compensation from its patients and on an inpatient basis, is primarily engaged in providing diagnostic and therapeutic facilities for surgical and medical Diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of duly licensed Doctors of medicine;
- Which continuously provides twenty four (24) hours a day nursing service by registered nurses (R.N.); and
- Which is not, other than incidentally, a place for rest, a place for the aged, or a nursing or convalescent home or institution;
- Provides general hospital and major surgical facilities and services.

HOSPITAL INTENSIVE CARE UNIT means a section, ward or wing within the Hospital which is separated from other facilities and is operated exclusively for the purpose of providing twenty four (24) hour professional medical treatment for critically ill patients and is equipped with supplies and equipment for such medical treatment.

HOSPITAL ROOM means a semi-private Hospital Room.

ILLNESS means a bodily disorder or disease, which first manifests itself while the Policy is in force.

INCURRED means the date a Covered Insured receives the service or supply for which the charge is made.

INFECTIOUS DISEASE means a disease capable of being transmitted from person to person, with or without actual contact, and denoting a disease due to the action of a microorganism.

INJURY means bodily trauma resulting directly and independently of all other causes from an Accident occurring while coverage under this Policy is in force.

MAINTENANCE means continuation of care and management of the patient when the therapeutic goals of a treatment plan have been achieved, no additional functional improvement is apparent or expected to occur, and the provision of covered services for a condition ceases to be of therapeutic value.

MATERNITY CARE means care provided and billed by a Provider for any condition during and resulting from pregnancy, including delivery, prenatal and postnatal care, and complications of pregnancy (as defined), and as indicated in the Schedule of Benefits.

MEDICALLY NECESSARY or **MEDICAL NECESSITY** means services or supplies ordered and provided by a Hospital, Physician or other Provider which the Company determines:

- are appropriate to the Diagnosis or treatment of a Covered Insured's Illness or Injury;
- are consistent with accepted medical or professional standards of practice;
- are not primarily for the personal comfort or convenience of a Covered Insured, his family, his Physician or other Provider;
- are the most appropriate levels of services or supplies that can safely be provided to a Covered Insured; and
- in the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that a Hospital, Physician, or other Provider has prescribed, recommended, or approved a service or supply does not, in itself, make it Medically Necessary.

NERVOUS OR MENTAL DISORDER means those psychiatric Illnesses listed in the latest edition of:

- the Standard Nomenclature of Diseases and Operations of the American Medical Association; or,
- the Diagnostic and Statistical manual for Mental Disorders of the American Psychiatric Association.

Nervous or Mental Disorder does not include learning disabilities, attitudinal disorders, or disciplinary problems because these are not Illnesses.

ORGAN means a part of the human body that performs a specific function.

ORGAN TRANSPLANT PROVIDER NETWORK means a group of Hospitals and Physicians contracted on behalf of the Insurer for the purpose of providing organ transplant benefits to the Covered Insured.

OTHER HEALTH INSURANCE PLAN means a plan that provides insurance, reimbursement or service benefits for Hospital, Surgical or other medical expenses.

OUT OF POCKET LIMIT means the total co-insurance amount the Covered Insureds will pay for Covered Expenses after the Deductible as indicated in the Schedule of Benefits.

OUTPATIENT SERVICES means Medically Necessary services provided to a Covered Insured, who is not a registered in-patient in a Hospital, to prevent and treat injuries or Illnesses. Outpatient services shall include, but are not limited to:

- Comprehensive diagnostic and evaluation services;
- Outpatient care and treatment, pre-care, aftercare, emergency care, rehabilitation and habilitation, and supportive transitional services; and
- Professional consultation.

PHYSICIAN means only a Doctor or Surgeon who is a Doctor of Medicine and licensed by the duly constituted authority in the area in which service is rendered and when acting within the scope of such license. For the purpose of this Policy a Physician is not the Covered Insured's immediate family.

PRE-EXISTING CONDITION means a condition:

- Resulting from Illness or Injury for which a Covered Insured has received a Diagnosis, consultation, medical treatment, services, supply or drug prescription prior to the Effective Date of the Policy or its reinstatement; whether or not the Covered Insured was aware or diagnosed prior to the Effective Date of coverage or reinstatement of coverage;
- For which symptom, medical advice or treatment was recommended by or received from a Physician prior to the Effective Date of the Policy or its Reinstatement;
- For which symptom and/or sign of Illness, if presented to a Physician would have resulted in the Diagnosis of an Illness or medical condition whether or not the patient was aware of the condition.

Limitations -

- **New Groups:** This Limitation applies only during the first twelve (12) months of a Covered Insured's Coverage of Insurance;
- **Transferred Groups:** For Covered Insureds with pre-existing conditions, coverage is limited up to the Major Medical Maximum of the previous plan immediately preceding the current plan

PREFERRED PROVIDER NETWORK means a group of Hospitals and Physicians approved and contracted to treat Covered Insured Persons on behalf of the Company.

PREMATURITY or PREMATURE INFANT means the delivery of a fetus before thirty seven (37) completed weeks of gestation.

PRESCRIPTION DRUGS means medications whose sale and use are legally restricted to the order of a Physician and which can only be obtained with a Physician's written prescription, must be dispensed by a Physician or licensed Pharmacist and approved by the FDA in the USA or other applicable administrative organizations in the Caribbean and cannot be obtained over the counter at a pharmacy.

PROCEDURE or TREATMENT means a practice, a series of steps, or treatment to follow after a given Diagnosis is obtained.

PROFESSIONAL PROVIDER means a person or practitioner licenced where required and performing services within the scope of such licensure. The Professional Providers are:

- Physiotherapist
- Dentist
- Independent Clinical Laboratory
- Optometrist
- Physician
- Psychologist
- Chiropractor
- Surgeon

PROOF OF INSURABILITY means a health history and other proof as the Company may require, which the Company will use to determine if a person is acceptable to the Company to qualify for coverage under the Policy.

PROVIDER means, a person or entity licensed or certified as such by the duly constituted authority in the area in which the service is rendered and when acting within the scope of such licensure or certification; an Ambulatory Surgical Center or Hospital, Physician (M.D. or D.O.), a Dentist (D.D.S. or D.M.D.), a Nurse, Midwife or any other non-physician and non-dentist practitioner for whose services benefits are provided under this Policy.

RECONSTRUCTIVE SURGERY means Surgery that takes place immediately after or within ninety (90) days from a covered surgical procedure or Accident, and is Medically Necessary in order to maintain or restore normal bodily function. Reconstructive Surgery is not covered for congenital, hereditary or birth abnormalities for adults covered under this policy.

REHABILITATION (Institution for Prolonged Care) means a registered medical center with licensed nurses and Doctors that have been approved by the Company. This center gives specialized services to patients that have been released from a Hospital's intensive care unit requiring rehabilitation for their recovery and have been placed in this center as an alternative to staying hospitalized. This does not include hospice care.

REIMBURSEMENT (of medical expenses) means the amount of money refunded to the Covered Insured for Usual Customary and Reasonable covered expenses, as indicated in the Schedule of Benefits of this Policy.

RIDER means an endorsement added to the Policy that modifies the coverage.

SECOND SURGICAL OR MEDICAL OPINION means the medical opinion of a Physician approved and required by the Company.

SOUND NATURAL TOOTH means a healthy un-repaired tooth or a tooth of which a major portion remains after restorative work. A sound natural tooth is not carious, abscessed or defective. It does not include artificial items such as crowns or caps, braces or bands, jackets, inlays, bridges or dentures, which were installed before the date of the Injury. Repair or replacement of these items is not covered under this Policy.

SURGICAL EXPENSES/SURGERY means the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures. Payment for Surgery includes an allowance for related pre-operative and post-operative care. Treatment for burns, fractures and dislocations are also considered Surgery.

SYMPTOM means a sensation or feeling that the Covered Insureds may experience and consider not to be normal. Such feeling or sensation may be in the form of pain or change in bodily fluids. This symptom will not be considered an Illness or a medical condition until a licensed Physician or Specialist gives a Diagnosis. This Diagnosis would need to be an eligible benefit approved and covered under the Policy.

TRANSPLANT means the Medically Necessary procedure, performed while a Covered Insured's coverage under this Policy is in effect, during which:

- One or more Organs are surgically moved from a donor (living or deceased), to a Covered Insured as the recipient; or
- Tissue is surgically moved to a Covered Insured, from:
    - a donor (living or deceased); or
    - the same Covered Insured.

USUAL CUSTOMARY and REASONABLE CHARGE (UCR) means the charge or fee determined by the Company to be the general rate charged by others who render or furnish such treatments, services or supplies to persons who reside in the same area; and whose injuries or Illnesses is comparable in nature and severity.

The Usual Customary and Reasonable charge for a treatment, service, or supply that is unusual, or not often provided in the area, or that is provided by only a small number of Providers in the area, will be determined by the Company. The Company will consider such factors as: complexity; degree of skill needed; type of specialist required; range of services or supplies provided by a facility; and the prevailing charge in other areas.

The term "area" means a city, a county or any greater area, which is necessary to obtain a representative cross section of similar institutions or similar treatment.

ELIGIBILITY

ELIGIBLE COVERED INSURED: To be eligible for coverage under this Policy the Covered Insured must be:

- Actively at work on the Effective Date of this Policy;
- Actively at work on the date he completes the waiting period if employed after the Effective Date of this Policy;
- Actively at work on the date he commences employment if employed after the Effective Date of this Policy and the waiting period has been waived as a condition of employment;
- Be in good health and not confined to a Hospital or nursing home on the Effective Date of coverage.

An Employee who is not actively at work on the date he would otherwise become eligible for insurance shall not be eligible for insurance until he returns to active work.

When the provision of Insurance stipulates that insurance under any rider is non-contributory:

- Each Employee eligible for insurance under this rider shall become a Covered Insured on the date he became eligible, provided he is actively at work on a full time basis. If he is not actively at work, coverage would be deferred until he returns to full time work.

When the provision of Insurance stipulates that insurance under any rider is contributory:

- If a request to participate is made by the Employee after the date he becomes eligible but within thirty one (31) days of his eligibility, he shall be covered from the date of request;
- If a request to participate is made by the Employee after the end of the thirty one (31) day period immediately following the first day he is both eligible and actively at work on a fulltime basis, the Employee should furnish evidence of insurability satisfactory to the Company. If the Company determines such evidence to be satisfactory, the Employee shall be covered from the date communicated by the Company;
- An Employee who must furnish evidence of insurability satisfactory to the Company as a condition to become covered, and whose service with the Policyholder terminates without such evidence having been given, shall continue to be subject to the same requirements if he is subsequently re-employed.

ELIGIBLE DEPENDENT: To be eligible for coverage, the following individuals will be considered Dependent(s) under this Policy if they reside with the Covered Insured and they are:

- The Covered Insured's spouse;
- The Covered Insured's unmarried children under age nineteen (19);
- The Covered Insured's unmarried children from age nineteen (19) to twenty five (25) years old, who are full-time students in an accredited university or college in or outside their country of residence, and receive financial support from the Covered Insured.

DEPENDENT(S) INSURANCE: A Dependent of a Covered Insured Employee shall become covered as a Dependent on the earliest of the following dates:

- An Employee who has a Dependent will become eligible for Dependent insurance on the date he becomes eligible for Employee insurance under this Policy;
- An Employee with no Dependent on the date he becomes eligible for Employee insurance under this Policy shall become eligible for Dependent insurance on the date he acquires a Dependent;
- On the date the Employee applies in writing for Dependent insurance under this Policy if such application is made within thirty one (31) days of the date on which the Employee becomes eligible for Dependent insurance;
- On the date of approval by the Company of evidence of insurability satisfactory to the Company for each Dependent for whom coverage is requested if the Employee applies in writing for Dependent insurance more than thirty one (31) days after the Employee becomes eligible for Dependent insurance.

EFFECTIVE DATE OF COVERAGE: The Covered Insured's coverage under this Policy begins at 12:01 a.m. standard time at the Covered Insured's residence on the Effective Date shown on the Coverage Summary of this Policy.

EFFECTIVE DATE AND ENROLLMENT FOR NEWBORN CHILDREN: Coverage will be effective on the child's date of birth:

- Provided that a child is born to the Covered Insured or Covered Insured's Dependent spouse after the Effective Date of the Policy and covered under the Maternity Benefit;
- Provided that the required application form has been completed and submitted to the Company within thirty one (31) days following such child's date of birth and any required premiums paid.

If the Covered Insured fails to enroll a newborn eligible Dependent within thirty one (31) days of eligibility as described above, the Dependent will be considered a new Dependent and will be required to provide evidence of insurability.

Newborn children born as a result of fertility treatment will not be covered automatically, the Covered Insured must submit an Application to enroll the new Dependents and it will be subject to proof of insurability.

CONTINUATION OF INCAPACITATED CHILD: If an unmarried child is incapable of self-support because of mental or physical incapacity and is dependent on the Employee for over half of his support, the Employee may apply to the Company to continue coverage of such child under this Contract upon such terms and conditions as the Company may determine. Coverage of such Dependent child shall terminate upon his or her marriage. Continuation of benefits under this provision will only apply if the child was eligible as a Dependent and mental or physical incapacity commenced prior to the limiting age shown in this contract. The child must be unmarried, incapable of self-support and the disability must have commenced prior to attaining 19 years of age. The disability must be certified by the attending Physician. Furthermore, the disability is subject to annual medical review. In a case where a handicapped child is over 19 years of age and joining the Company for the first time, the handicapped child must have been covered under the prior Company and submit proof from the prior Company that the child was covered as a handicapped person.

BENEFITS PAYABLE

Benefits for covered expenses will be payable at the percentage/rates as indicated in the Schedule of Benefits, after the Deductible amount has been satisfied. Benefits are subject to all provisions, conditions, definitions, benefit limitations and exclusions of this policy. The Maximum Benefits stated by the Policy would include the fees incurred in the negotiations and/or contractual fees incurred to reduce the cost of such services.

INPATIENT MEDICAL SERVICES:

- Room and Board: An average semi-private room, as designated by the Hospital;
- A Special Care Unit such as Intensive Care or Coronary Care, when such a designated unit with concentrated facilities, equipment and supportive services are required to provide an intensive level of care for a critically ill patient and prescribed by an attending Physician. This benefit is paid in lieu of the Room and Board limit;
- Nursing Facilities for a newborn are included in Room and Board benefit;
- Meals including special meals or dietary services as required are included in the Room and Board limit.

MISCELLANEOUS HOSPITAL SERVICES: Benefits are payable for all ancillary services usually provided and billed for by Hospitals (except for personal convenience items) including but not limited to the following:

- Use of operating, delivery, recovery, or other specialty service rooms and any equipment or supplies therein;
- Casts, surgical dressing, and supplies, devices or appliances surgically inserted within the body;
- Oxygen and oxygen therapy;
- Administration of Blood and Blood plasma, including the processing of Blood from donors; Blood or Blood plasma as provided within this Contract;
- Anesthesia and the supplies and use of anesthetic equipment;
- Physical Therapy, Cardiac Therapy, Occupational Therapy, Respiratory Therapy and Speech Therapy when administered by a person who is appropriately licensed and authorized to perform such services;
- All drugs and medications (including intravenous injections and solutions) for use while in the Hospital and which are released for general use and are commercially available to Hospitals;
- Pre-admission testing.

EMERGENCY ROOM ACCIDENT/EMERGENCY ROOM MEDICAL SERVICES: Outpatient services and supplies provided by a Hospital or Facility Provider and/or Professional Provider for Emergency treatment of a Medical Emergency or traumatic bodily injury resulting from an Accident shall be covered if services are performed within two (2) days of (a) the Medical Emergency, or (b) the date the Accident occurred.

A Medical Emergency shall include heart attacks, loss of consciousness or respiration, cardiovascular accidents, convulsions, or other such acute medical conditions as determined by the Company.

SURGICAL EXPENSE AND ANAESTHESIA BENEFIT: Charges incurred for the services of a qualified Surgeon for the performance of a surgical operation, except pregnancy and the anaesthesiologist fees necessary for that Surgery. This benefit includes inpatient pre-operative and all postoperative care, normally provided by the Surgeon as part of the surgical procedure

ORAL SURGERY

Dental or oral surgery will be covered only for surgical removal of impacted teeth which are partially or completely covered by bone. Hospitalization for dental surgery would only be covered if the Covered Insured has a non-dental disorder and hospitalization is Medically Necessary.

DENTAL SERVICES RELATED TO ACCIDENTAL INJURY

Dental Services which are required as a result of Accidental Injury to the jaws, sound natural teeth, mouth or face occurring on or after the Covered Insured's Effective Date and if service is rendered within ninety (90) days of covered Accident.
Injury as a result of chewing or biting shall not be considered an Accidental Injury.

ASSISTANT SURGEON

Services by an assistant Surgeon who actively assists the operating Surgeon in the performance of covered Surgery. The condition of the Covered Insured or the type of Surgery must require the active assistance of an Assistant Surgeon as determined by the Company. Such services shall be limited to twenty percent (20%) of the Usual Customary and Reasonable Surgeon fees.
Surgical services are not covered when performed by a Surgeon who himself performs and bills for another surgical procedure during the same operative session.

SECOND SURGICAL OPINION

Consultations for Surgery to determine the Medical Necessity of an Elective surgical procedure. Elective Surgery is Surgery, which is not of an Emergency or life threatening nature. Services must be performed and billed by a Surgeon other than the one who initially recommended performing the Surgery. One additional consultation, as a third opinion, is eligible in cases where second opinion disagrees with the first recommendation. In such instances the Covered Insured will be eligible for a maximum of two (2) such consultations involving the elective surgical procedure in question, but limited to one (1) consultation per consultant.

MEDICAL BENEFITS – OTHER:

- In Hospital: If as a result of a disability, a Covered Insured incurs expenses for professional attendance and treatment by a Physician while confined in Hospital, for causes other than pregnancy, the Company shall make reimbursement for such expenses up to the maximum amount per visit and per disability set forth in the Schedule of Benefits;
- Office Visits: Professional attendance and treatment in the Physician's office or clinics up to the limits in the Schedule of Benefits;
- Home Visits: Professional attendance and treatment at the home of the Covered Insured up to the limits in the Schedule of Benefits.

DIAGNOSTIC SERVICES: The following Diagnostic Services when ordered by a Physician are covered:

- Diagnostic X-ray, consisting of radiology, ultrasound, and nuclear medicine;
- Diagnostic laboratory and pathology tests;
- Diagnostic medical procedures consisting of ECG, EEG, and other diagnostic medical procedures approved by the Company;
- Allergy testing, consisting of percutaneous, intracutaneous and patch test and immunotherapy.

THERAPY SERVICES: Benefits shall be provided for the following services prescribed by a Physician and performed by a licensed therapist, which is used in treatment of an Illness or Injury.

CHEMOTHERAPY

Chemotherapy means the treatment of malignant disease by chemical or biological anti-neoplastic agents. Such chemotherapeutic agents are eligible if administered intravenously or intramuscularly (through intra-arterial injection, infusion, perfusion or subcutaneous, intracavitary and oral routes). The cost of drugs, approved by the Federal Food and Drug Administration or a similar authority and only for those uses for which such drugs have been specifically approved by the Federal Food and Drug Administration (FDA) as anti-neoplastic agents is covered, provided they are administered as described in this paragraph.

DIALYSIS

The treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body by hemodialysis, peritoneal dialysis, hemoperfusion, or chronic ambulatory peritoneal dialysis (CAPD).

RADIATION THERAPY

The treatment of disease by X-ray, radium, or radioactive isotopes, including the cost of radioactive materials supplied and billed by the Provider.

PHYSICAL THERAPY

Includes treatment by physical means, heat, hydrotherapy or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss or body part.

CARDIAC REHABILITATION THERAPY

Refers to a medically supervised rehabilitation program designed to improve a patient's tolerance for physical activity or exercise. Such therapy is covered for a patient recovering from myocardial infarction or a coronary bypass procedure, or who has been diagnosed with coronary disease, angina pectoris, valvular heart disease, exercise triggered cardiac arrhythmia or such other conditions as determined by the Company.

RESPIRATORY THERAPY

Includes the introduction of dry or moist gases into the lungs for treatment purposes. Coverage will also include services by a respiratory therapist.

OCCUPATIONAL THERAPY
Includes treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary task of daily living. Coverage will also include services rendered by a registered, licensed occupational therapist.

MATERNITY SERVICES:(LIMITED TO COVERED EMPLOYEES AND THE COVERED INSURED SPOUSES OF COVERED EMPLOYEES)

OBSTETRICAL/MATERNITY CARE
Services rendered in the care and management of a pregnancy of a Covered Insured is a Covered Expense as specified in the Schedules of Benefits. Benefits are payable for (1) facility services provided by a Hospital and (2) professional services performed by a Physician. Benefits payable for a delivery shall include pre-and post–natal care. Maternity care Inpatient benefits will be provided for forty eight (48) hours for vaginal deliveries and ninety six (96) hours for caesarean deliveries, except where otherwise approved by the Company.

NEWBORN CARE
The newborn child of the Covered Insured or the spouse of The Covered Insured shall be entitled to benefits provided by this Contract from the date of birth up to a maximum of thirty one (31) days. Such coverage within the thirty one (31) days shall include care, which is necessary for treatment of medically diagnosed congenital defects, birth abnormalities prematurity and routine nursery care. Enrolment must be completed within thirty one (31) days to continue coverage in the event of congenital treatment.

PSYCHIATRIC CARE:

INPATIENT TREATMENT
Benefits are provided, subject to the Benefits Period limitations stated in the Schedules of Benefits, for an inpatient admission for treatment of Mental Illness

Covered services include treatment such as: psychiatric visits, psychiatric consultations, individual and group psychotherapy, electro convulsive therapy, psychological testing and psychopharmacologic management.

OUTPATIENT TREATMENT
Benefits are provided, subject to the Benefits Period shown in the Schedule of Benefits, for an Outpatient treatment of Mental Illness. Covered Services include treatments such as: psychiatric visits, psychiatric consultations, individual and group psychotherapy, electroconvulsive therapy, psychological testing, psychopharmacologic management, and psychoanalysis.

OUTPATIENT PRIVATE DUTY NURSING SERVICES:

Benefits will be provided for Outpatient Services for private duty nursing performed by a Licensed Registered Nurse (R.N.) when ordered by a Physician. All nursing services must be Medically Appropriate/Medically Necessary as determined by the Company and start immediately after the patient is discharged from Hospital.

BENEFITS ARE NOT PAYABLE FOR:

- Nursing care which is primarily custodial in nature; such as care that primarily consists of: bathing, feeding, exercising, homemaking, moving the patient and/or giving oral medication;

- Services provided by a nurse who ordinarily resides in the Covered Insured's home or is a member of the Covered Insured's immediate family;

PROSTHETIC DEVICES
Expenses incurred for prosthetic devices for an Illness or Injury that occurs on or after the Covered Insured's Effective Date. Expenses for prosthetic devices are subject to medical review by the Company to determine eligibility and Medical Appropriateness/Medical Necessity.

Such expenses may include, but not be limited to:

- The purchase, fitting, necessary adjustments and repairs of prosthetic devices and supplies which replace all or part of the function of an inoperative or malfunctioning body Organ.
- No Benefits are payable for replacements of a prosthetic device.
- Expenses incurred for the purchase and fitting of hearing aids as indicated in the Schedule of Benefits.

PRESCRIPTION DRUGS/MEDICINES: Benefits will be provided for Medically Necessary medications prescribed by a Physician's written prescription dispensed by a licensed Pharmacy and which by law must be dispensed with a prescription order.

Benefits will not be payable for:

- Drugs used for Experimental or Investigative purposes;
- Drugs used for cosmetic purposes;
- Drugs which are used for treatment of infertility and birth control and for loss of or to improve/enhance Libido;
- Health foods, dietary supplements;
- Vitamins, unless they require a prescription and are Medically Appropriate/Medically Necessary for the treatment of a specific Illness, as determined by the Company;
- Drugs dispensed to a Covered Insured while a patient in a Hospital, nursing home or other institution;
- Administration or injection of drugs.

GROUND AMBULANCE BENEFIT: Ground Ambulance services which are approved by the Company and determined Medically Necessary for transport of the sick or Injured to the nearest Hospital provided that transportation by any other method would result in loss of life or limb.

AIR AMBULANCE BENEFIT: Benefits are provided for emergency air evacuation on an air ambulance to the nearest suitable medical facility for treatment of a covered condition for which treatment cannot be provided locally and the attending Physician considers the situation to be life threatening and transportation by any other method would result in loss of life or limb. Emergency air evacuation must be approved by the Company's Physician.

AIRFARE EXPENSE BENEFIT: If stated in the Schedule of Benefits and as a result of bodily injury or illness, any Covered Insured necessarily incurs expenses for air transportation for medical treatment outside of their country of residence and provided that such treatment has been approved by the Company's Medical Consultant.

The cost of transportation by air means the amount charged by a regular scheduled airline using the shortest route to the nearest place where the necessary medical treatment can be provided.

OTHER COVERED EXPENSES:

- **Organ Transplant** – coverage for transplant of human organs and tissues is provided only within the Company's Transplant Network. This benefit includes – Physician's services, inpatient hospital or transplant medical center expenses, surgical procedures for live donors, ancillary costs, inpatient medications and take-home supplies, outpatient evaluation, and follow-up care. The only organ transplants covered under this Policy, are the following:

    - Heart, Heart and Lung, Single Lung, Double Lung, Kidney, Kidney and Pancreas, Liver, Cornea, Bone and Skin Grafts, Small Intestine;
    - Allogenic and Autogous, Bone Marrow, except those performed for the treatment of a Congenital Condition(s), including a genetic disease or defect;

- **Reconstructive Surgery** – coverage is provided for Reconstructive Surgery that takes place immediately after or within ninety (90) days from a covered surgical procedure or Accident, and is Medically Necessary in order to maintain or restore normal bodily function. Reconstructive Surgery is not covered for congenital, hereditary or birth abnormalities for adults covered under this policy;

- **Emergency Dental Treatment** – coverage is provided for treatment necessary to restore or replace sound natural teeth, damaged or lost as a consequence of a covered Accident that results in Hospitalization, provided that it takes place within the first ninety (90) days of the covered Accident;

- **Repatriation of Mortal Remains** – in the event a Covered Insured person dies outside of his/her country of residence, the costs of legal procedures and the necessary preparations for the transportation as well as the transportation of the body or ashes to the nearest airport in his/her country of residence. All arrangements must be pre-approved and coordinated by the Company for this coverage to take effect and as noted in the Schedule of Benefits.

PREVENTATIVE CARE SERVICES: The following preventative care services are covered as noted in the Schedule of Benefits:

ANNUAL MEDICAL EXAMINATION
Routine Medical examination or health checkup limited to one examination per policy year (not necessarily for Diagnosis and treatment of an Illness or Injury) as stated in the Schedule of Benefits.

VACCINATIONS/IMMUNIZATIONS
Coverage is provided for pediatric vaccinations/immunizations up to age five (5).

SCREENING MAMMOGRAMS
Coverage is provided for screening mammograms annually as stated in the Schedule of Benefits subject to the following:

- One baseline mammogram for any female age 35 years to 39 years of age;
- One mammogram every other year for any female 40 through 49 years of age;
- One mammogram every policy year for any female age 50 years of age or older;
- One mammograms per policy year when ordered by a Physician for any Covered female who is at risk for breast cancer. "At risk" means
  - A personal history of breast cancer;
  - A personal history of biopsy-proven benign breast disease;
  - A family history of breast cancer; or
  - The female has not given birth prior to the age of 30.

PROSTATE CANCER SCREENING
Coverage is provided for the routine prostate cancer screening, known as a prostatic specific antigen (PSA) test, annually as stated in the Schedule of Benefits subject to the following:

- One test each Policy year for a Covered male age 45 and over;
- One test each Policy year for a male age 40 to 44 if ordered by a Physician.

LIPID PROFILE
Coverage is provided for annual Lipid Profile tests as stated in the Schedule of Benefits.

ANNUAL PAP SMEAR
Coverage is provided for annual Pap Smear tests as stated in the Schedule of Benefits.

ANY OTHER SCREENING EXAMINATION as stated in the Schedule of Benefits.

COMMENCEMENT OF BENEFITS AND WAITING PERIODS:

- **Organ Transplant**, will be covered after the Covered Insured has been continuously covered under this Policy for a period of twelve (12) consecutive months;

- **Newborn Dependent Children – Covered Expenses** incurred by a newborn child become payable on the child's date of birth provided that such child has been enrolled in this Policy within the thirty one (31) days following the child's date of birth.

PROCEDURES FOR CLAIMS SUBMISSION AND PAYMENT

CLAIM PAYMENT: Benefits under this Policy will only be accepted and processed if proof of claim is submitted to the Company within ninety (90) days of occurrence. **No benefits will be paid for claims presented to the Company after ninety (90) days from the date of services were rendered or supplies were furnished.**

In order to process a claim payment the Company must receive:

- A Claim form for each Covered Insured fully completed, including Diagnosis, signed by the attending Physician;
- The original itemized bills or receipts for treatment or service, prescription and pharmacy bills (photocopies of receipts are not acceptable). Such bills must include the name of the patient, the date of service and be in the currency of the country where services are performed;
- Any additional documentation requested by the Company necessary for the review and/or payment of the claim within the terms of this Policy;
- Documents submitted not in the language of the Policy must be translated prior to submission.

COORDINATION OF BENEFITS: The benefits provided by this Policy will not duplicate the benefits of any other group plan, statutory plan or any insurance plan for which the Covered Insured may be eligible. When a Covered Insured is also covered for any such duplicate benefits, the benefits under this Policy will be reduced to an amount which when added to such duplicate benefit will equal to one hundred percent (100%) of medical expenses incurred. Where benefits are payable by more than one plan, benefits will be payable as follows:

- The plan covering the Covered Insured as an Employee will determine its benefits before a plan which covers such person as a Dependent;
- The plan covering the Covered Insured as a Dependent of a male Employee determines its benefits before a plan covering him as a Dependent of a female Employee;
- If the above do not establish an order of priority, the plan which has covered the Covered Insured for the longer period of time determines the benefits first.

RELEASE OF MEDICAL RECORDS: Each Covered Insured shall authorize any Hospital, Physician or other party providing services or supplies for which the Covered Insured is claiming benefits under this Policy to release to the Company any and all information or records relating thereto. It is the Covered Insured's responsibility to pay for any charges related to said release of information or records.

RIGHT OF EXAMINATION: The Company, at its own expense, shall have the right to have a Covered Insured, for whom a claim is pending under this Policy, examined by a Physician of the Company's choice when and as often as the Company may reasonably require.

SUBROGATION: The Company shall have the right of subrogation to a Covered Insured's rights, including the right to bring suit in the Covered Insured's name, for health care expenses for which the Company paid benefits when a Covered Insured has the right to recover the same expenses from another responsible party, including a liability company or any person or organization causing the Injury or the need for care, but excluding any insurer of a health insurance policy issued to the Covered Insured.

Each Covered Insured shall fully cooperate with the Company in its efforts to obtain payment of reimbursement, including providing the Company with any information that may be required by the Company to obtain said payment or reimbursement and/or completing and submitting any consent form, release, assignment or other document that may be required by the Company to obtain said payment or reimbursement.

The Covered Insured shall take no action that will prejudice the rights or interests of the Company under this Policy.

LEGAL PROCEEDINGS: No action at law or in equity shall be brought to recover under this Policy prior to the expiration of sixty (60) days after proof of claim has been furnished in accordance with the requirements of the Policy, nor shall any such action be brought at all unless commenced within two (2) years from the expiration of the time within which proof of claim is required hereby.

LIMITATIONS AND EXCLUSIONS

No benefits are payable under this Policy for charges incurred for treatment, services, or supplies including consequences derived or related to the following:

1. Routine physical examinations, evaluations and immunizations, observations or diagnostic studies which are a part of a routine physical examination or health check-up, or well child care exams including but not limited to, vaccinations, except as otherwise provided in this Policy and is indicated in the Covered Insured's Schedule of Benefits.

2. Mental health or chemical dependency exams, evaluations for such purposes as obtaining or continuing employment, insurance, government licensure, school admission, or for participation in sports; or evaluation and treatment of learning disabilities; educational or learning problems; or the issuance of medical policies and medical statements. Treatment to improve and maintain memory loss or the progress of its medical condition including but not limited to the normal process of aging. Treatment related to chronic fatigue syndrome, sleep apnea or sleep disorder.

3. Mental health disorder unless specified in the Schedule of Benefits.

4. Routine eye examinations or eye refraction, surgery or laser surgery to correct refractive errors, eye glasses, or contact lenses, routine hearing examinations, hearing aids, or their fitting, or cochlear implants unless specified in the Schedule of Benefits.

5. Dental or orthodontic care, treatment, or surgery of the teeth or gums, whether or not in connection with a jaw condition, except as indicated in the Schedule of Benefits.

6. Medical or dental services or supplies for the treatment of jaw joint problems, including but not limited to, temporomandibular joint syndrome (TMJ), craniomandibular disorders or other conditions of the joint linking the jaw bone, the skull and the complex of muscles, nerves and other tissues in relation to that joint.

7. Podiatric care including, but not limited to, the treatment of weak arches, weak, strained or flat feet, corns, calluses, bunions or toenails, symptomatic complaints of the feet, congenital foot disorders, orthopedic shoes or other supportive devices for the feet, such as, but not limited to, arch supports and orthotic devices and shoe inserts of any kind, or any other preventative services and supplies.

8. Chiropractic care unless specified in the Schedule of Benefits.

9. Prosthesis or the use of corrective devices or medical appliances that is not Medically Necessary or not implanted during surgery.

10. Any voluntary induced termination of pregnancy, unless imminent maternal demise exists.

11. Prematurity, congenital defects or conditions, birth abnormalities and/or defects, hereditary conditions, except as otherwise provided herein for newborn coverage as indicated in the Schedule of Benefits.

12. Pregnancy of a Dependent child.

13. Pregnancy including resulting childbirth, abortion or miscarriage, except as provided under Maternity Benefits.

14. Any kind of fertility treatment, examinations, tests, including hormone treatment, and any related procedures, as well as expenses for pregnancy, delivery, prenatal and postnatal care, complications of Pregnancy or newborn routine care; except as provided under the Maternity Benefits.

15. Any non-disclosed pre-existing conditions in the application form, or conditions arising from treatments or conditions not covered under this Policy. Non-disclosed pre-existing, conditions will result in claim denial, or cancellation of the Policy. Pre-existing conditions are defined and explained in this Policy.

16. Aircraft injuries except when the Covered Insured or Dependent(s) are traveling as fare-paying passengers on a commercial airline, except as otherwise provided in this Policy and as indicated in the Schedule of Benefits.

17. Weekend charges incurred for a Hospital confinement that starts on a Friday, Saturday or Sunday, unless:

    - the attending Physician certifies that such weekend admission is Medically Necessary; or
    - such weekend Hospital Confinement is in connection with a surgery scheduled for the next day that follows the date of admission (Saturday, Sunday or Monday).

18. Any Hospital admission more than forty eight (48) hours before a planned surgery, unless authorized by the Company.

19. Treatment of any Injury or Illness for which the Covered Insured, or Dependent are not under the regular care of a Physician or which is not authorized or prescribed by a Physician.

20. Treatment in any governmental, or non-governmental facility in which the Covered Insured(s) would be entitled to free care.

21. The following drugs, medicines or supplies, even if prescribed by a Physician:

    - Experimental or Investigative;
    - Over-the-counter (OTC) drugs or supplies including but not limited to, Vitamins, dietary supplements, Baby formula, appetite suppressants, hair regenerative or anti-photo aging drugs; cosmetics, or health and beauty aids; Nystatin, Minoxidil, Viagra, Tretinoin (Retin A) or Nicorette gum;
    - Contraceptive drugs or devices, prescription or otherwise, even if prescribed for other than contraceptive purpose;
    - Drugs prescribed for conditions which are not covered under this Policy.

22. Custodial care, rest cures, periods of quarantine or isolation, long term or maintenance care or therapy for chronic conditions, services, supplies or treatment in any long term care facility, spa, hydro clinic, rehabilitation institutions, sanitariums, institutions for rest or custodial care, nursing home or home for the aged, or institutions that are not a Hospital, domiciliary care and home health care. Long term or maintenance care includes maintenance of chronic conditions, injuries or Illness when response to treatment has reached the maximum therapeutic level, no additional functional improvement can be demonstrated or anticipated and continuation of the service will be of no therapeutic value to the Covered Insured.

23. Elective or cosmetic surgery or medical treatment for improvement of appearance or self-esteem, also including keloid removal; unless necessitated by Injury, deformity or Illness which first occurs while the Covered Insured is covered by this Policy. Elective surgery also includes nasal deformities or deviated septum or medical conditions related to them except as a result of an Accident covered by this Policy. Breast reductions regardless of the Physician's recommendation of medical necessity, except in connection with Breast Reconstructive Surgery after a covered Mastectomy. The maximum amount payable by the Company for cosmetic, reconstructive or plastic surgery will not exceed $6,000 during the lifetime of the Covered Insured.

24. Obesity or Weight control surgery, or any form of food supplement in connection with weight control.

25. Any treatment of alcoholism or drug addiction, including treatment or complications arising there from, but not limited to, Injury or Illness sustained while under the influence, wholly or partly, and any charges for rehabilitation center for the treatment of drug/alcohol addiction except as indicated in the Schedule of Benefits

26. Male or female sterilization, reversal of sterilization, sex change, sexual transformation, birth control, infertility, artificial insemination, sexual dysfunction, or inadequacies, or any drug related to them, even if prescribed for other purposes.

27. Any condition related to Acquired Immune Deficiency Syndrome (AIDS), HIV positive, AIDS Related Complex (ARC) or any venereal or sexually transmitted disease; or any treatment of Chagas' disease; or any complications arising there from unless stated in the Schedule of Benefits.

28. An Injury or Illness due to:

    - Martial law or state of siege, or any event or causes which determine the proclamation or maintenance of martial law or state of siege;
    - Participation in civil commotion or an illegal act, mutiny, riot, strike, military or popular uprising, insurrection, rebellion, military or usurped power; including resultant imprisonment;
    - Any act of any person acting on behalf of or in connection with any terrorist organization;
    - War or any act of war declared or undeclared.

29. Experimental or investigative treatments or research oriented and not scientifically or medically recognized for a prescribed treatment or for accepted medical standards.

30. Any consequence happening or arising from a nuclear accident, incident, explosion or radioactive fallout.

31. Epidemics which have been placed under the direction of public authorities.
32. Charges which exceed the Usual Customary and Reasonable for a treatment, service, or supply for the geographical area.
33. Any charges in connection with the purchase or rental of Durable Medical Equipment or corrective devices unless specified in the Schedule of Benefits.
34. Personal comfort items, such as radio, television, telephone, barber or beauty supplies, rental or purchase of air conditioners, humidifiers, vaporizers, exercise equipment and similar devices.
35. Organ transplant when alternative treatment procedures are equally effective to treat the condition.
36. A transplant that includes artificial or mechanical equipment or artifacts designed to replace human Organs.
37. Transportation other than local licensed ambulance service or as specified on the Schedule of Benefits.
38. Injury or Illness covered under Workmen's Compensation or similar laws arising out of the Covered Insured's occupation; Injury caused by, or as a result of an active participation in private aviation or professional training in any dangerous sport (such as, but not limited to: motorcycle riding, mountain climbing, scuba diving, skiing, or similar hazardous activities).
39. Any care, services or treatment by a Close Relative.
40. For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services.
41. For treatment of an Emergency Medical or Emergency Accident treatment sustained during the commission of a felony by a Covered Individual.
42. Any care for autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation which extends beyond traditional medical management or for environmental or social change.
43. For medical supplies such as but not limited to thermometers, ovulation kits, early pregnancy or home pregnancy testing kits.

VISION CARE RIDER

This Vision Care Rider forms part of this Policy.

DEFINITIONS AND INTERPRETATION

It is noted that the definitions and interpretations in the General Provisions of this 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:

"Optician" – means 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.

"Optometrist" – means 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.

"Ophthalmologist" – means 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.

"Eligible Expenses" – means expenses incurred for vision care recommended as necessary by an ophthalmologist , optometrist or optician that are reasonable and customary in the area in which the Covered Insured person resides.

"Vision Care" – means expenses incurred for vision care treatment services, or supplies rendered, supplied or performed by an ophthalmologist, optometrist or optician.

PAYMENT OF BENEFIT

Guardian Life of the Caribbean Limited will reimburse the Covered Insured up to the maximum stated in the Schedule of Benefits for eligible reasonable and customary expenses incurred subject to the limitations stated hereunder.

EXCEPTIONS AND LIMITATIONS

No amount is payable under this Rider for charges incurred for:

- More than one (1)
  - complete visual examination including refraction during any one - twelve (12) month period;
  - set of prescription lenses during any one - twelve (12) month period;
  - set of frames during any one – twelve (12) month period;
- Sunglasses whether plain or prescription;
- Special procedures for orthoptics visual training, subnormal vision or medical or surgical treatment of the eye;
- Treatment incurred as a result of any sickness or bodily injury arising out of or in the course of an Covered Insured person's employment;
- Replacement of lost or broken lenses and/or frames, duplicate glasses or lenses or lenses or frames;
- Services or materials not listed in the Schedule of Vision Care Benefits.

DENTAL CARE RIDER

This Dental Care Rider forms part of this Policy.

ELIGIBLE EXPENSES

Eligible expenses are limited to the following:

Diagnostic Services and Preventative Treatment

- Oral examination including scaling and cleaning of teeth but limited to one session every six (6) months;
- Dental X-rays, bitewing X-rays in any one – six (6) month period and a full month;
- X-rays being limited to one set in any one – twelve (12) month period;
- One application of fluorides and other anticariogenic substances in any one – twelve (12) month period.

Basic Restorative Treatment and Basic Services

- Initial provision of amalgam, silicate, acrylic, synthetic, porcelain or composite restorations;
- Replacement of amalgam, silicate, synthetic, porcelain or composite restorations;
- Extractions (except for orthodontia);
- Treatment for periodontal and other diseases of the gums and tissues of the mouth;
- Initial provision and installation of space maintainers;
- Oral surgery of a dental origin (except for orthodontia).

Major Restorative Treatment

- Endodontic treatment (including root canal therapy);

- Initial provision of crowns, gold inlays or onlays provided that the tooth is broken down by decay or traumatic Injury so that the tooth structure cannot be restored with an amalgam silicate acrylic synthetic porcelain or composite;

- Replacement of crowns, gold inlays or onlays provided that the tooth is further broken down by decay or traumatic Injury and only if:

    - the tooth structure cannot be restored with an amalgam acrylic synthetic porcelain or composite;
    - an additional tooth surface is involved; or
    - a continuous period of at least twelve (12) consecutive months has elapsed since the date the crown, inlay or onlay being replaced was last provided or replaced;

- Initial installation of full dentures partial 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 Covered Insured person;

- Relining of or any adjustments required to be made to new dentures provided that a period of at least twelve (12) months has elapsed since the date the dentures were last provided;

- Repair of dentures;

- Addition of teeth to existing dentures or fixed bridgework provided that such addition is required to replace one or more natural teeth at least one of which was extracted after the commencement of insurance of the Covered Insured person;

- Replacement of:
    - an existing full denture
    - an existing partial denture; or
    - an existing 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 Covered Insured person and;
    - the existing denture of fixed bridgework was installed at least five (5) years prior to its replacement and cannot be made serviceable.

Orthodontic Treatment

Expenses incurred for orthodontic care recommended as necessary by an Orthodontist.

EXCEPTIONS AND LIMITATIONS

No amount is payable under this Rider for charges incurred for:

- Dental care which is not prescribed by a dentist or performed by a dentist;
- Replacement of dentures, bridge or other dental appliance which are mislaid, lost or stolen;
- A course of dental care which commenced prior to the Effective Date of commencement of insurance of a Covered Insured person under this Rider (including charges for any crown bridge ordered prior to such date);
- 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;
- Pulp vitality tests, study models or precision attachments;
- Expenses payable under Workmen's Compensation or any similar legislation;
- Replacement of existing prosthetic devices unless the device has been installed five (5) or more years prior to replacement and in the opinion of the attending dentist is no longer serviceable;
- Services or materials not listed in the Schedule of Dental Care Benefits;
- Orthodontia which is wholly cosmetic.

Schedule of Benefits – Guardian Life of the Caribbean – Smart Choice Plan

IMPORTANT: This Schedule of Benefits should be read in conjunction with the Group Health Policy and is subject to the definitions, benefit limitations, exclusions and to all other provisions of the Group Health Policy. Covered medical expenses are based on the usual customary and reasonable charges incurred by you or your Dependents while insured hereunder for Medically Necessary treatment of an Illness or Injury.

IMPORTANT: Failure to pre-certify in accordance with the pre-certification requirement will result in an additional 20% penalty for Preferred Providers, and 20% for Non-Preferred Providers. This penalty is in addition to any other Coinsurance or Deductible stipulated in the Schedule of Benefits and applies in full notwithstanding any applicable maximum out of pocket expenses.

IMPORTANT: The Per Insured and Per Family Deductibles are applied to the covered medical expenses before the Coinsurance factors. The resulting net amount (after applications of Deductibles and Coinsurance) is always subject to any stipulated maximum dollar limit payable by Underwriters for the applicable medical treatment or condition. Family includes the Covered Insured, Spouse and any Dependents.

IMPORTANT: Once the Underwriters limit has been exhausted in respect of a specific treatment or condition then any further expenses relating to that treatment or condition are no longer covered, irrespective of any maximum out of pocket cap.

All currency is in EC$	**Non - Preferred Provider**	**Preferred Provider USA & Worldwide**	**Preferred Provider Anguilla, St Maarten/St Martin**
Lifetime Maximum	$1,344,100		
Per Insured per year Deductible	$250	$250	$250 Waived in the Anguilla, St Maarten/St Martin
Family Year Deductible (2 Family members to satisfy)	$500	$500	$500
Dental Services per Insured Person per Annual Insurance Period Deductible, if applicable	$135	$135	$135
Dental Services per insured family per Annual Insurance Period Deductible (2 Family members to satisfy) if applicable	$270	$270	$270
Co-Insurance factor Anguilla, St Maarten/St Martin			See Below
Co-Insurance factor USA & Worldwide	See Below	See Below	
Maximum out of pocket cap per individual each year for covered medical treatment	No Cap	$5,376	$2,688
Maximum out of pocket cap per Family	No Cap	$10,752	$5,376
Non pre-certification penalty	20%	20%	20%

Covered Medical Expenses and Coinsurance Factors

All currency is in EC$	Percentage of Covered Expenses payable by Underwriters		
	Non-Preferred Provider	**Preferred Provider - USA & Worldwide**	**Preferred Provider - Anguilla, St Maarten/St Martin**
Hospital Treatment including: Semi-private room - after 60 days of confinement, the Extended Care Facility Benefit applies Surgeon's / Physicians fees Assistant Surgeon's fee (20% of Surgeons fee) **Pre-certification Required**	75%	80%	80%
Extended Care Facility After a period of confinement, a maximum of $134 payable per day up to a maximum of 120 days	75%	80%	80%
	Subject to a lifetime maximum of $16,129		
Rehabilitation Facility **Pre-Certification required**	75%	80%	80%
Home Health Care/Hospice Care After a period of confinement, a maximum of $134 payable per day up to a maximum of 120 days	75%	80%	80%
	Subject to a lifetime maximum of $16,129		
Emergency Room including non-emergency treatment in emergency room	75%	80%	80%
Out Patient Diagnostic Testing benefit MRI, CT Scans, Endoscopy, Cardiovascular Studies and any other Diagnostic Procedures **Pre-certification Required**	75%	80%	80%
Prescription per item	75%	80%	80%
Doctors and Specialist Visits	75%	80%	80%
Second Surgical Opinion (no deductible)	75%	80%	80%
Preventative Care Services-subject to an overall maximum of $2,688 per policy year for the following services:			
• **Annual Routine Medical Exam**	100%	100%	100%
• **Screening Mammogram**	100%	100%	100%
• **Prostate Cancer Screening**	100%	100%	100%
• **Annual Pap Smear**	100%	100%	100%
• **Routine Diagnostic Lab Test & Other Routine Screening Exams**	80%	80%	80%
• **Vaccinations/Immunizations up to age 5 years old**	100%	100%	100%

All currency is in EC$	Non-Preferred Provider	Preferred Provider - USA & Worldwide	Preferred Provider - Anguilla, St Maarten/St Martin
Airfare Benefit Maximum two trips per year	100%	100%	100%
	Subject to a maximum of $3,000 per policy year		
Private Duty Nursing - $134 per day, maximum of 30 days per year	75%	80%	80%
Pre-certification required	**Subject to a maximum amount of $4,032 per policy year**		
Hearing Test/Examination Consultation/Office Visit Hearing Test Hearing Aid	 50% 75% 75%	 60% 80% 80%	 60% 80% 80%
Organ Transplants including Pre and Post Operative Treatments	75%	80%	80%
Pre-certification Required	**Subject to a lifetime maximum amount $201,615**		
Air Ambulance	100%	100%	100%
Pre-certification required	**Subject to a maximum amount of $67,205 per policy year**		
Ground Ambulance @ $202per trip	100%	100%	100%
	Subject to a maximum amount of $404 per policy year		
Birth Abnormalities, Congenital Conditions, Premature Birth, or Other Defects in newborn children	75%	80%	80%
	Subject to a maximum amount for any insured child of $134,410		
All Treatment for AIDS, HIV, ARC	75%	80%	80%
Pre-certification Required	**Subject to a maximum amount of $13,441 per policy year and lifetime maximum of $53,764**		
Chemotherapy	75%	80%	80%
Pre-certification Required			
Radiotherapy	75%	80%	80%
Pre-certification Required			
Physical Therapy- up to 20 one hour sessions per annual insurance period – maximum $135 per session	75%	80%	80%
Psychiatric Care, including prescription drugs - Limited to 20 treatments per annum with a maximum of $202 per office visit	50%	50%	50%
	Subject to a maximum amount of $6,721 per policy year and lifetime maximum of $26,882		
Durable Medical Equipment **By prescription only**	75%	80%	80%
Alcoholism and Substance Abuse	75%	80%	80%
	Subject to a maximum of $6,721 per policy year and lifetime maximum of $26,882		

All currency is in EC$	**Percentage of Covered Expenses payable by Underwriters**
Dental Care Benefits: Diagnostic/preventative Basic restorative Major Replacement Orthodontia	 80% (deductible waived) 80% (deductible waived) 80% (deductible applies) **Subject to a maximum of $2,688 per policy year per insured person** 80% (deductible applies) **Subject to a lifetime maximum benefit payable per member of $2,688**
Vision Care Benefits: per person, per year $1,075 Eye Examination - one per year Lenses (All types) - one pair per year Frames - one pair per year Contact Lenses	 80% 80% 80% 80% **Subject to a maximum of $1,075 per policy year per insured person**

Maternity Benefits

The Underwriter will pay covered Maternity Benefits for a Covered Insured or Spouse up to a maximum of $10,753 per pregnancy, for services, including doctors fees, Hospital fees and hospitalisation relating to prenatal care, postnatal care, delivery, complication of pregnancy, and charges relating to well baby nursery care.

All currency is in EC$	**Percentage of Covered Expenses payable by Underwriters**
Pre and Post Natal Care Office visits	80%
Doctors Fees: Normal delivery **Pre-certification required**	80%
Caesarean Section **Pre-certification required**	80%
Ectopic or other complications **Pre Certification Required**	80%
Hospital Fees: Maternity **Pre-certification required**	80%
	Subject to a maximum of $10,753 per pregnancy

METHOD OF APPEAL- REVIEW OF A DENIED CLAIM:

If a claim is denied, in whole or in part, Insurers will advise you and will specify the reason or describe any additional information required to complete the claim. All appeals should be submitted in writing, within 45 days after from the date the explanation of benefits was issued. Underwriters will re-evaluate the claim in question and give a final written decision on the re-evaluation within 45 days, or 90 days, if additional information is required, after such request is received. If, after the expiration of 90 days, the additional information is not received, the appeal will be considered closed and no determination will be made at that time.

No action at law or in equity against Insurers may be brought before 60 days have passed since written proof of loss has been furnished. No such action may be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

COMPLAINTS PROCEDURE:

If you have a complaint, please contact our Compliance Officer by one of the following methods:

In writing:	Compliance Officer Alliance Insurance Services Limited P.O. Box PW 5236 Rock Farm, Anguilla British West Indies
By email:	info@aisanguilla.com
By telephone:	1 264 498 7788

Your complaint will be logged in our Register of Complaints. The Compliance Officer will discuss the complaint with the Department Manager and an investigation will take place. A response to your complaint will be prepared in writing and sent to you within 15 days. If we require more time to address your complaint due to complications or the involvement of a third party, you will be advised accordingly.