NON-DUPLICATION OF BENEFITS

The policy provides benefits in accordance with all of its provisions only to the extent that benefits are not provided by another valid and collectible insurance. If the Insured person is covered by another valid and collectible insurance, all benefits payable by such insurance will be determined as having primary status or on coordination or non-duplication of benefits provision. If the Insured person is insured under group or individual insurance, the Policy pays in accordance with the coordination or non-duplication of benefits provision of the Policy. Benefits paid by this policy will not exceed:

1. Any applicable policy maximums; and
2. 100% of the compensable expenses incurred when combined with benefits paid by another valid and collectible insurance.

EXCLUSIONS AND LIMITATIONS

Benefits will not be paid under the policy for any expenses which result from:

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 of 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, expenses for 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 charges 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.
39. Dental & Vision Care Benefits carried out during the first three (3) (or other period of time as specified in the schedule of dental & vision benefits) for insured persons. Orthodontic Services carried out during the first six (6) months after being enrolled on the plan are not eligible for reimbursement.

DEFINITIONS

Covered Medical Expenses are Usual, Customary and Medically necessary charges that are:

1. Not in excess of the maximum amount payable for services as specified in the schedule.
2. In excess of any deductible amount; and
3. Incurred while the Insured's coverage under the policy is in force.

Injury means bodily injury caused by an accident. The accident must occur while the covered person's insurance is in effect under this policy. A covered person must begin receiving services, supplies or treatment within 30 days from the time of accident in order for it to be considered a covered injury. All injuries sustained by one person in any one accident including all related conditions and recurrent symptoms of these injuries, are considered a single covered injury. The injury must be the direct cause of loss and must be independent of all other causes. The injury must not be caused by or contributed to by sickness.

Medical Emergency means the occurrence of a sudden, serious and unexpected sickness or injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in death, permanent placement of the covered person's health in jeopardy, serious impairment of bodily functions or serious and permanent dysfunction of any body organ or part. Expenses incurred for a medical emergency will be paid only for sickness or injury which fulfills the above conditions. These expenses will not be paid for minor injuries or minor sicknesses.

Medically Necessary means care which a physician has determined to be certifiably essential for the diagnosis or treatment of a sickness or injury. This determination must be based on objective results produced by an examination of the covered person's demonstrable symptoms. The Physician's treatment plan may be reviewed by an impartial third party whose determination will be binding on us and the insured.

Sickness means an illness or disease which first manifests itself while the policy is in force which results in a covered medical expense. All related conditions and recurrent symptoms of the same or similar conditions will be considered the same sickness. It also includes pregnancy.

Usual and Customary Charge means those charges for necessary treatment and services that are reasonable for the treatment of cases of comparable severity and nature. This will be derived from the mean charge based on the experience in a related area of the service delivered.

PRE-EXISTING CONDITION LIMITATION

No benefits are applicable to members who transferred from the Prior Plan. Benefits of EC$750.00 maximum will be paid for an Insured person's pre-existing conditions during the first twelve (12) months of coverage under this Plan. Pre-Existing conditions are defined as any injury sustained or a sickness for which an injured person noticed symptoms or was medically treated or was advised by a physician within the twelve (12) months immediately prior to his/her effective date of coverage under the policy.

CLAIM FILING PROCEDURES

In the event of an injury or sickness, in non-emergency situation, please note the following:

1. The Insured should report to their physician or hospital.
2. This Policy is established on a basis whereby claims expenses will be either billed by the Network provider to NAGICO or to the Insured.
3. A company claim form is required for filing a claim. Mail all medical and hospital bills to the address on the back of the brochure.
4. File claim within 30 days of injury or first treatment for a sickness. Bills should be received by the company within 90 days of service. Bills submitted after 90 days will not be considered for payment except in the absence of legal capacity.
5. For answers to queries or questions, please call NAGICO Medical Department at 1-758-452-3800.

OVERSEAS MEDICAL CARE ACCESS

With the continuous expanding medical interventions, NAGICO has created networks with medical organisations across the neighbouring and overseas countries that offer affordable treatment for planned and unexpected medical emergencies. Healthcare management that NAGICO has partnered with are **United Healthcare International, Sanus Health Corporation, Coomeva Medicina Prepagada and Innovative Quality and Consulting Inc.**

All Members and their dependents of St. Lucia Civil Service Association Medical Plan are covered for medical care overseas through our various overseas provider networks. Overseas care, only if not available locally, will be approved on the premise that such overseas care will be first sought in the overseas jurisdiction nearest to your island of domicile of St. Lucia. Reimbursement will be made on the basis of costs in same nearest jurisdiction.

Pre-certification of medical treatment overseas is required prior to accessing care. A written medical report from a specialist, in the field of medicine, relevant to the illness or injury must be provided to NAGICO, at least three (3) working days prior to the planned date of travel, for our Company's chief medical advisor's review and formal confirmation of approval.

IN THE EVENT OF EMERGENCY

In the unfortunate event of a medical emergency overseas or domestic, Members should contact the healthcare provider, or your plan administrator or NAGICO by calling the telephone numbers listed on the back of their NAGICO medical insurance card.

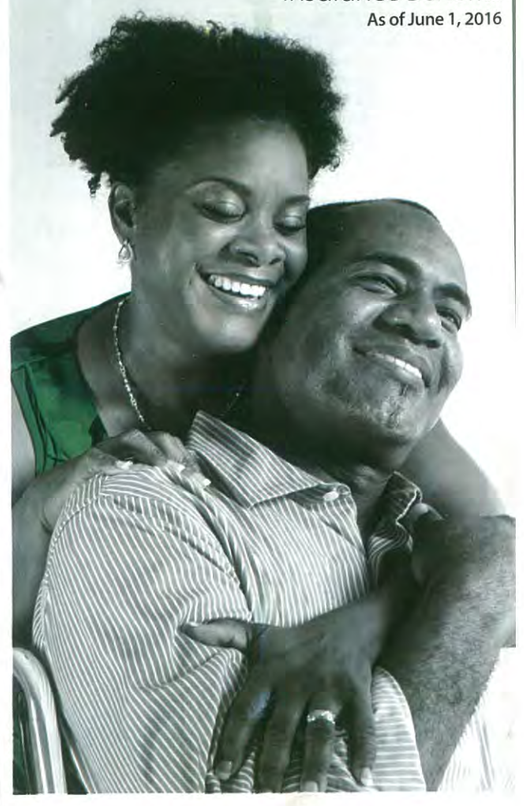
NAGICO St. Lucia Branch Office
NAGICO Building
P. O. Box 2766
Rodney Bay, LC 01, 401
Gros Islet, St. Lucia

INJURY & SICKNESS

St. Lucia Civil Service Association

Members' Health Insurance Benefits

As of June 1, 2016



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NA2031.15

ELIGIBILITY

All St. Lucia Civil Service Association regular and full-time Members at least age 18 as at June 1, 2016 plan commencement date are eligible for coverage under the Plan. All Primary Members who have been enrolled in the previous plan as well Members not previously enrolled will not be required to provide evidence of insurability to be eligible for coverage under the new Plan. All new members hired after June 1, 2016, at least age 18 but not older than age 60 will not be required to present evidence of insurability provided that he/she enrolls within 31 days of first becoming eligible and he/she is not terminally ill or hospitalized on the day the insurance would normally commence. Additionally, all Members must complete the necessary enrollment application form and submit same to the office of the St. Lucia Civil Service Association in order to join the Plan.

DEPENDENT ELIGIBILITY

Eligible Members may also insure their dependents. Eligible dependents are the spouse and unmarried dependent children of the Insured. Dependent child/children is/are covered up to age 19 with an extension to age 24 when proof of full-time enrollment in an accredited university of higher learning is submitted. Dependent eligibility expires concurrently with that of the Insured Member. Dependent coverage must be applied for by completing the dependents section of the necessary application form and by paying the required premiums.

EFFECTIVE/TERMINATION DATES

The Master Policy became effective at 12:01 a.m., June 1, 2016. The policy is a one-year renewable term policy. Coverage will become effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy will be due for renewal June 1, 2017 and annually thereafter unless terminated. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. The Insureds and any dependents' coverage under the Policy will terminate on the earliest of: the date the Policy is terminated by the group policyholder; the date the Insurer terminates the insurances of all persons in a given class; the date coverage under the Policy lapses; the date the Insured terminates the coverage of any dependents by written notice to the Insurer, the date of death, disability or retirement of the Insured, whichever is earlier; the date the insured or dependent has not fulfilled the 7 months resident requirement in St. Lucia; and the attainment of age 65, unless Retiree's coverage was previously elected where applicable.

SCHEDULE OF PREVENTATIVE CARE COVERAGE

Preventative Care Coverage - 100% of the R & C Charges, to an annual maximum of EC$750.00 per family.

This benefit is meant to cover the following annual preventative care benefit:

a. Annual Physical Examination which includes blood pressure check, complete urinalysis, lipid profile, blood profile (consisting of FBS, CBC, Haemoglobin and ESR tests) and ECG for the Primary Member.
b. Annual Gynaecology & Pap Smear Test for each Female Member or covered Female Spouse of a Male Member.
c. Annual Mammogram for each Female Member or covered Female Spouse of a Male Member, from age 35.
d. Annual Proctology or Prostate Examination for each Male Member or covered Male Spouse of a Female Member, from age 40.
e. Routine Well Baby Immunisation for each dependent up to age 8.
f. Annual Glaucoma Test for the Primary Member.
g. Three (3) months waiting period before making benefit claims applies to new members. Not subject to annual deductible.

SCHEDULE OF MEDICAL EXPENSE BENEFITS

1. **Three-Year Renewable Medical Benefit** of EC$500,000.00 for all Insured Members under age 65 & EC$250,000.00 Maximum Medical Lifetime Benefit for all Insured Members age 65 & Over/Retirees.
2. **Annual Deductible** of EC$200.00 per Insured Member per Calendar Year (applicable to all benefits with the exception of Doctor's Visit Benefit & Prescription Drugs Benefit); Annual Maximum of 3 Deductibles per Family per Calendar Year.
3. **Local Benefit (for Out-patient and In-patient)** - After Deductible, NAGICO will cover 80% of first EC$40,000.00 of the R & C Charges and 100% thereafter.
4. **Overseas Benefit: - (1) Pre-certified Overseas Treatment within Managed Care Network or Emergency treatment** will be paid at 90% of the first EC$50,000.00 of R & C Charges in Overseas Territory and 100% thereafter, after the deductible is applied; **(2) Pre-certified Overseas Treatment outside of Managed Care Network** will be paid at 80% of the first EC$100,000.00 of R & C Charges in Overseas Territory specified by NAGICO and 100% thereafter, after the deductible is applied; **(3) Overseas Treatment Not approved nor Pre-certified** will be paid at 80% of R & C Charges based on the lesser of Area of Validity or 60% in Overseas Territory specified by NAGICO, after the deductible is applied.
5. **Carry Over Provision** - Last three (3) months of Calendar Year.

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
Coinsurance Percentage ..... After deductible, 80% of the R & C Charges

ORGAN TRANSPLANTS
Lifetime Benefit Maximum (Members under age 65) ..... EC$250,000.00
Lifetime Benefit Maximum (Members age 65 and Over/Retirees) ... EC$125,000.00
Coinsurance Percentage ..... After deductible, 80% of the R & C Charges

DAILY ROOM & BOARD LIMIT
Local (Caricom) ..... After deductible, 80% up to EC$400.00
Overseas (Non-Caricom) .. See Overseas Benefit; 80% up to EC$2,000.00 after deductible
Intensive ..... After deductible, 80% subject to not exceeding 2.5 times the Average Semi-Private R & C Room Rates

SURGICAL BENEFIT
Benefit Payment ..... After deductible, 80% of the R & C Charges
Coinsurance Percentage ..... See Overseas Benefit above

SPECIALIST BENEFIT (by referral only) (After Deductible)
Gynaecologists & Paediatricians do not require referrals
Benefit Payment ..... 80% of the R & C Charges up to EC$150.00; One (1) visit per day
Coinsurance Percentage ..... See Overseas Benefit above

DOCTOR'S VISIT BENEFIT *(Home, Office & Hospital)* (One (1) visit per day)
Benefit Payment – Home ..... 80% of the R & C Charges up to EC$120.00
Benefit Payment – Office ..... 80% of the R & C Charges up to EC$130.00
Benefit Payment – Hospital ..... 80% of the R & C Charges up to EC$150.00

PRESCRIPTION DRUGS BENEFIT (Over the counter medication not covered)
Benefit Payment ..... 80% of the R & C Charges
Coinsurance Percentage ..... See Overseas Benefit above

DIAGNOSTIC EXPENSE BENEFIT
Benefit Payment ..... After deductible, 80% of the R & C Charges
Coinsurance Percentage ..... See Overseas Benefit above

EMERGENCY DOCTOR'S VISIT BENEFIT
(Home/Hospital) (Maximum per consultation – 1 visit per day)
Local Coinsurance Percentage ..... After deductible, 80% of the R & C Charges up to EC$350.00

MATERNITY BENEFIT *(Blanket Cover)*
An initial ten (10) months waiting applies to all new female members and all female dependent spouses of any new member.
Benefit Payment - Normal Delivery ..... EC$2,000.00
Benefit Payment - Caesarean Section ..... EC$3,000.00
Benefit Payment - Miscarriage ..... EC$1,000.00
Coinsurance Percentage ..... After deductible, 80% of the R & C Charges

Pre-natal care is included in above maximums. Complications including extra-uterine pregnancy are treated as any other illness.

PRIVATE DUTY NURSING *(Pre-approval necessary)*
20 Max days' limits applicable to in-patient & outpatient care. Max per 8-hour shift
Private Residence - Day (After Deductible) ..... 80% of R & C Charges up to EC$100.00 per day
Private Residence - Night (After Deductible) ..... 80% of R & C Charges up to EC$120.00 per night
In Hospital - Night (After Deductible) ..... 80% of R & C Charges up to EC$150.00 per night

MENTAL HEALTH AND SUBSTANCE ABUSE
(Applicable to outpatient & hospital Care)
Lifetime Benefit Maximum ..... C$25,000.00
Annual Benefit Maximum ..... EC$1,500.00
Maximum per Treatment – One (1) visit per day ..... Up to EC$60.00
Benefit Payment – In-patient ..... After deductible, 80% of R & C Charges
Benefit Payment – Out-patient ..... After deductible, 50% of R & C Charges

EXTENDED CARE FACILITY
Annual Benefit Maximum ..... EC$3,000.00
Benefit Payment – One (1) visit per day ..... After deductible, 80% of R & C Charges up to EC$70.00

HOME HEALTH /HOSPICE CARE
Annual Benefit Maximum ..... EC$3,000.00
Benefit Payment – One (1) visit per day ..... After deductible, 80% of R & C Charges up to EC$70.00

MISCELLANEOUS EXPENSE BENEFIT
Coinsurance Percentage ..... After Deductible, 80% of the R & C Charges

PHYSIOTHERAPY & OTHER HEALTH CARE PROFESSIONALS
Annual Benefit Maximum ..... EC$1,500.00
Benefit Payment – One (1) visit per day ..... After deductible, 80% of R & C Charges up to EC$60.00

GROUND TRANSPORT (Local Ambulance & Emergency)
..... EC$400.00
Annual Benefit Payment ..... After deductible, 80% of the R & C Charges

MEDICAL AIR TRANSPORTATION BENEFIT *(Pre-Approval Necessary)*
Annual Benefit Maximum ..... EC$4,000.00
Benefit Payment (Economy Airfare) .. After deductible, 100% of the R & C Charges

MEDICAL AIR AMBULANCE BENEFIT *(Pre-Approval MANDATORY)*
Annual Benefit Maximum ..... Two (2) trips per year
Benefit Payment ..... After deductible, 100% of the R & C Charges

CONGENITAL BIRTH DEFECTS
Lifetime Maximum Benefit ..... EC$100,000.00
Benefit Payment ..... After deductible, 80% of the R & C Charges

SCHEDULE OF LIFE BENEFITS

This cover is for Members only. All current and future Members will not be required to present evidence of insurability at enrollment provided that he/she enrolls within 31 days of the eligibility period.

Basic Life Insurance Benefit – EC$25,000.00 per Member.
Life Benefit - In the event of a Member's death from any cause, except death by suicide within 2 years of the effective date of the Member's coverage, NAGICO Insurances will pay the amount of life insurance shown in the Schedule of Benefits to the covered Member's named beneficiary. The Life Benefit reduces by 50% on the attainment of age 65 and terminates at age 70, if still employed.

Accidental Death & Dismemberment (AD&D) Benefit – EC$25,000.00 per Member.
AD&D Benefit - This benefit provides for the payment of a stated sum as shown in the Schedule of Benefits in the case of the accidental loss of life, one or both limbs or sight, and is subject to the limitations. The Accidental Death and Dismemberment Benefit terminates on the attainment of age 65, if still employed.

Loss of Life	100%
Loss of Sight of Both Eyes	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of One hand and One Foot	100%
Loss of One Hand and Sight of One Eye	100%
Loss of One Foot and Sight of One Eye	100%
Loss of Sight of One Eye	50%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of thumb and any finger on the same hand	25%

"Loss of Foot" means severance at or above the ankle joint; "Loss of Hand" means severance at or above the wrist joint; "Loss of Eye" means entire and irrecoverable loss of sight of the eye; "Loss of Thumb and Finger" means severance at or above the knuckles joining the thumb and Finger to the hand. The Accidental Death and Dismemberment Benefit terminates on the attainment of age 65, if still employed. The Accidental Death & Dismemberment Benefit covers each Insured Member whilst on and off the job and losses reported up to three hundred and sixty-five (365) days maximum after the accident. No Benefit shall be paid under the Accidental Death and Dismemberment provisions for the following: 1) Losses occurring more than one hundred and eighty (180) days after the accident. 2) Losses resulting directly or indirectly from: 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; Suicide or intentionally self-inflicted injury while sane or insane; Travel or flight in any aircraft except solely as a passenger in a licensed civil aircraft; Intentional misuse of drugs; The commission of, or any attempt to commit a criminal act; Poisoning in any form or inhalation of gas or fumes, if voluntary, occupation accidents excepted; Any injury covered by Workmen's Compensation Law or Act of similar legislation unless twenty-four (24) hour coverage is indicated in the application; 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; An accident which occurs while the blood alcohol level of the life assured is 80 milligrams or more per 100 milligrams of blood.

The Accidental Death and Dismemberment benefits may be payable in addition to any payment under the Life Insurance Benefit.

SCHEDULE OF DENTAL AND VISION BENEFITS

DENTAL CARE BENEFITS

Normal Dental Care Benefits
Maximum per Calendar Year ..... EC$1,000.00
Deductible per Calendar Year ..... EC$50.00

Benefit Payment (After Deductible)
Level 1 – Preventative Services ..... 100% of R & C Charges
Level 2 – Minor Restorative Services ..... 80% of R & C Charges
Level 3 – Major Restorative Services ..... 80% of R & C Charges

Orthodontia Benefit (Up to age 18)
Lifetime Maximum ..... EC$1,000.00
Deductible per Calendar Year ..... EC$50.00
Benefit Payment (After Deductible) ..... 60% of R & C Charges

N.B:

a. Dependent children only covered up to age 19, or age 24 if pursuing higher education.
b. Maximum of two (2) preventative examinations, of six months apart, per calendar year.
c. Full mouth x-rays limited to one (1) set in a twenty-four (24) months period.
d. Fluorides and other anti-cariogenic substances limited to one (1) application in a twelve (12) months period.
e. Three (3) months waiting period after enrollment before making benefit claims applies for new members.
f. Six (6) months waiting period after enrollment before making Orthodontic benefit claims applies to new members.
g. All benefits are based on Reasonable & Customary Charges.

VISION EXPENSE BENEFITS

Examinations, Frames and Lenses
Annual Benefit Maximum ..... EC$1,000.00
Deductible per Calendar Year ..... EC$50.00
Benefit Payment (After Deductible) ..... 80% of R & C Charges

N.B:

a. Not medically necessary contact lenses will be limited to EC$200.00 maximum in a twelve (12) months period.
b. Frames are limited to 1 set per twenty-four (24) months period.
c. Lenses are limited to 1 set per twelve (12) months period.
d. Eye examinations are limited to one (1) visit per year.
e. Three (3) months waiting period after enrollment before making benefit claims applies to new members.
f. This Benefit provides for reimbursement of expenses incurred for necessary vision care treatment and supplies which are recommended by a duly qualified Optician, Optometrist or Ophthalmologist up to the amounts shown in the above schedule of benefits.
g. All benefits are based on Reasonable and Customary Charges.