Wise Financial Thinking for Life

CariCARE ADVANTAGE

This booklet describes your Group Insurance Plan in an easily understood manner. It is not a contract (does not create or confer any rights) and therefore is NOT BINDING.

The exact terms of the Plan are outlined in the more detailed provisions of the Policy Contract issued to your Company. In any cases of dispute the Policy Contract will supersede and be binding.

The Insurance Company reserves the right to amend, modify or terminate this policy or to change the method of underwriting without the consent of the Policy Holder.

2015

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General Provisions

Plan Benefits.

The Comprehensive Medical Benefit provides payment for a wide range of medical expenses (called Covered Expenses or eligible expenses). These expenses must be charged to you or your dependent while covered. These expenses must be as a result of:

- Sickness
- or Accidental Injury
- or Complication of Pregnancy. (Charges for Complications of Pregnancy are payable only for female employees and wives of male employees, not dependent children.)

These expenses must relate to the Covered Expenses under this Benefit.

Each covered person must satisfy an Individual Deductible each Calendar Year before any payment is made. Once the deductible has been satisfied the plan pays the percentage of Covered Expenses shown in the Schedule of Benefits for the rest of the year.

Maximum Benefit

The Maximum Benefit payable for you or any Dependent is shown in the Schedule of Benefits. You may use all or part of the Maximum Benefit.

Doctors Visits Benefit

This benefit provides for the reimbursement/payment of fees charged for medical visits by a legally licensed physician or specialist in connection with the treatment of a covered injury or sickness. Reimbursement/Payment will be made for fees charged for Office, Home or Hospital visits subject to the deductible

- No referral is required for a Specialist Visit.
- Psychiatric visits are reimbursed as a Specialist visit.

Physiotherapist Benefits

Payments will be made for these treatments as stated in the Schedule of Benefits and must be from a registered Physiotherapist.

General Provisions

Psychologist Benefits

Payments will be made for these treatments as stated in the Schedule of Benefits and must be from a registered Psychologist.

Individual Deductible

The Individual Deductible is the amount of Covered Expenses you must first satisfy each year before getting reimbursed.

The amount of the Individual Deductible is shown in the Schedule of Benefits.

Family Deductible

If three (3) Covered Family Members each satisfy the Individual Deductible in a year, then the Individual Deductibles for all Covered Family Members will be satisfied for the rest of the same year.

Carry-over Feature

Any Covered Expenses a person has incurred during October, November or December of a year which count toward that person's Individual Deductible for that year will also count toward that person's Individual deductible for the next year provided that the full deductible was not satisfied and no benefits have been paid after satisfying the deductible for the previous calendar year.

Common Accident Feature

If two (2) or more Insured Members of the same family are hurt in the same accident, only one Individual Deductible will have to be paid. This covers all of the combined daily expenses due to that accident during that year.

General Provisions

Covered Expenses

Covered Expenses are the actual cost to you of the Reasonable Charges for the services and supplies listed below. The service or supply must be:

- Medically necessary.
- Required for treatment.
- Recommended and approved by the attending physician.

Benefits are payable no matter where the service or supply is given subject to the rules of the plan.

Pre-existing Conditions

An Insured person may have received medical care or treatment for any injury or sickness at any time during the **3 months before your coverage starts** under this Plan. For large groups, coverage under this policy will be limited to the amount specified in the Schedule of Benefits for **twelve (12) months**.

Recurring Disability

All bodily disorders existing simultaneously, which are due to the same or related causes, will be considered one disability. A disability recurring within a period of three months will be considered a continuation of the same disability.
However, successive periods of hospitalization due to the same or related causes shall be considered as the same period of confinement unless you have been actively at work for at least two weeks, or in the case of a dependent unless separated by three months.

General Provisions

Co-ordination of Benefits

You or any Dependent may be covered under another group health plan. It may be sponsored by another employer who makes contributions or payroll deductions for it. It could be a government or tax-supported program.

Whenever there is more than one plan, the total amount of benefits paid in a Calendar Year under all plans cannot be more than the expenses charged for the Calendar Year.

One of the plans involved will pay the benefits first. (This is called the Primary Plan.) The other plans will then make up the difference up to the total reasonable expenses incurred. (These plans are called Secondary Plans.) NO plan will pay more than it would have paid without this provision.

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

- The plan has no Co-ordination of Benefits provision.
- The plan covers the person as an Employee.
- The plan covering the Insured as a dependent of a male Employee determines its benefits before a plan covering him as a dependent of a female Employee.
- When none of the above applies, the plan covering the person for the longest time pays first.
- Claims for dependent children MUST first be submitted via the Father's insurer
- First employee hired — Premium for Family Cover, with all dependents including spouse. An employee is not eligible for both individual employee coverage and dependent coverage of a spouse of the same organization.
- Second employee hired (who is the spouse) — No premium for Health, however, will be billed for all the Life 'coverages' as an Employee, i.e. Life, AD&D, Critical Illness

You will have to give information about any other plans when you file a claim.

General Provisions

Hospital Services

- Room and Board
  - ✓ Charges may be made for a ward, a semi-private room or an intensive care unit. The full amount of the Reasonable and Customary charges will be counted as Covered Expenses.
  - ✓ Charges may be made for a private room up to the Hospital's regular daily charge for a semi-private room.
- Other Hospital Services and Supplies
- Physician's or Surgeon's Services
- Services for Surgical procedures.
- Medical care and treatment
- Emergency Room Treatment
- Nursing Services of a trained nurse
- Emergency Transportation Services
- By professional ambulance, other than air ambulance, to and from a Hospital.
- X-ray and Laboratory Tests for diagnosis or treatment.
- Radiation Therapy
- Anaesthetics and charges for administering same.
- Medical Supplies recommending by the Attending Physician
- Prescribed drugs and medicines.
- Surgical supplies (such as bandages and dressings).

Hospital Services – continued

- An appliance which replaces a lost body organ or part or helps an impaired one to work. An example is an artificial limb or eye. Only the first charge for the first appliance is covered.
- Oxygen and charges for administering same. This includes rental of required equipment.
- Rental of a wheel-chair or hospital-type bed.
- Rental of a device to help breathing when paralyzed.
- Blood or blood plasma only if not donated

MATERNITY BENEFIT

This benefit applies only to female employees or female spouses of male employees who have enrolled with "Employee plus one" or "Family" coverage.

The benefit pays for Covered Charges made to the persons shown above while covered. The charges must be made due to pregnancy from conception through delivery.

Covered Charges

The following are covered charges:

- Hospital charges for Room and Board
- Hospital charges for Other Services and Supplies
- Charges made by a government operated clinic or delivery room for Other Services Supplied
- Charges made by a surgeon for performing one of the surgical procedures listed in the Schedule of Pregnancy Benefits shown in the Schedule of Benefits.
- Reasonable charges for ground ambulance to and from the Hospital, clinic or delivery room.
  (The charges must be made by a professional ambulance service.)
- Reasonable charges for anaesthetics and for the anaethesist.

There is a Maximum Benefit for one pregnancy per year. It is shown in the Schedule of Benefits. Twins would be considered one pregnancy.

After termination of an employee's coverage, benefits will be paid for a pregnancy that commenced while the person was covered except in cases where the Policy Contract terminates.

Maternity (continued) - Not Covered

Charges made in connection with Hospital confinement, which is not medically necessary.

Any charges in excess of the amount shown in the Schedule of Benefits for pregnancy.

No maternity benefit is payable for a pregnancy of an insured person whose pregnancy existed on or before the effective date of her insurance. However, female employees insured within 31 days of the effective date of the PLAN will be covered for pregnancies in existence on the effective date

General Provisions

Travel Benefits

Payment will be made for expenses incurred for Air Travel provided that such expenses are in connection with medical treatment that is not available locally and such treatment is recommended by two (2) Physicians, at least one of whom shall be a Consultant in the particular field of medicine pertaining to such sickness or injury.

Reimbursement for Commercial travel will be limited to the cost of two (2) economy airfares per calendar year, but NOT exceeding the plan maximum. "Cost of transportation by air" means the economy fare charged by a regular scheduled airline using the shortest route to the nearest hospital where the necessary medical treatment can be provided.

Medical Air Transportation Benefit (Air Ambulance)

This service affords the insured air transport outside the insured's country of residence for the purposes of obtaining medical care when this treatment is medically necessary and not available in your country of residence.

The Insurance Company must be notified for any services related to overseas treatment. If advance notification of overseas treatment is not furnished to the Insurance Company as required and the overseas treatment not certified, local benefit limits restrictions may apply.

Upon receipt of due proof that an insured person:

a. Requires necessary medical treatment in a country overseas as a result of sickness or injury insured under this Policy, the Insurance Company will provide a benefit covering expenses for transportation by air ambulance or commercial airline for the insured person to and from the nearest hospital where the necessary treatment is available. Transportation by Air Ambulance must be deemed medically necessary.

Air Ambulance - continued

or

b. Has incurred eligible expenses for necessary treatment by a physician overseas as a result of sickness or injury insured under this Policy the Insurance Company will pay a benefit equal to the cost of transportation by air (as defined later) of the insured person to and from the hospital where the necessary treatment was provided.

This benefit shall be limited as set out in the Benefit Schedule.

Necessary medical treatment will have to be recommended in writing by 2 physicians at least 1 of whom is a specialist in the particular field of medicine pertaining to the sickness or injury from which the insured person is suffering. Such proof must be submitted to the Insurance Company prior to the treatment except in the case where emergency treatment is required and the insured person is outside of their country of residence.

Where deemed medically necessary by a physician the Insurance Company will also provide at its own expense transportation by air ambulance for the spouse of the insured person or (in the case of a dependent child) the parent or guardian of such child to and from the hospital where the necessary treatment is being or is to be provided.

Where an insured person takes ill or is injured outside of his country of residence and is hospitalized for more than 7 days such insured person may select a relative to be flown by regular scheduled airline paying economy fare and using the shortest route to and from the nearest hospital where the necessary medical treatment is being provided.

General Provisions

Travel Benefits – continued

- **Emergency Air Transportation:-**
  Experience the overwhelming peace of mind knowing that medical emergencies will be covered according to the benefits in your schedule of benefits for an air ambulance. A medically staffed aircraft is on standby 24 hours a day for members.

- **Transportation of Escort:-**
  Arrangements will be for the member's spouse, family member or companion to accompany the individual in flight, should space permit.

- **Repatriation/ Recuperation:-**
  Should the patient and his treating physician determine that recuperation nearer home is feasible, air transportation will be provided.

- **Organ Retrieval:-**
  Should a member require a heart, heart/lung, liver, kidney, lung or pancreas transplant, the organ will be transported by Air Ambulance.

- **Organ Recipient Transportation:-**
  Should time or medical constraints require, the Air Ambulance would fly the organ recipient candidate.

- **Non-Injury Transportation:-**
  The member may select a family member to be flown round trip via common carrier to the city where the member is hospitalized for more than seven days.

- **Return Transportation:-**
  Included in member services is the arrangements and air transportation for the member's return home.

- **Minor Children Return:-**
  Accident or illness by a parent could result in minor children being stranded. The Air Transportation Benefit will cover the cost of air transportation back home. When necessary, an attendant will ensure their safe return home.

- **Mortal Remains:-**
  The Air Transportation Benefit will provide air transportation for the return of the member's remains whether as a result of accident or sickness.

Local Ground Ambulance Benefit

Upon receipt of due proof that an insured person has incurred expenses for a medically necessary Local Ground Ambulance, 100% of the cost will be reimbursed.

Preventative Care Benefit – (Not subject to the Individual deductible)

Employee and insured spouse only are eligible for this benefit with one exception being the "Child Immunization" benefit.

Upon receipt of due proof that an insured person has incurred eligible expenses for Preventative Care as specified in the Schedule of Benefits, the Insurance Company will pay a benefit equal to the fees actually incurred not exceeding the maximum amount stated in the Schedule of Benefits.

Acquired Immune Deficiency Syndrome (AIDS) –

Health Claims to a LIFETIME maximum of $50,000 are covered under this Plan.

Limitations on Covered Expenses for Mental and Nervous Disorders.

There are limits on Covered Expenses for Mental or Nervous Disorders

- The percentage of Covered Expenses payable by the Plan for confinement for Mental or Nervous Disorders is the same as any other sickness. It is shown in the Schedule of Benefits.
- The percentage of Coverage Expenses payable by the Plan for non-confinement Mental or Nervous Disorders is shown in the Schedule of Benefits.

The Maximum Benefit payable for you or any Dependent is shown in the Schedule of Benefits. This maximum applies to each person's Lifetime.

CariCARE International Medical Card

Being a CariCARE Plan Member you are provided with an International Medical Card that affords you enhanced protection against Emergencies while travelling; or assistance for overseas treatment by Pre-Arrangement with the Insurance Company. Your card helps ensure that your eligible medical bills related to your emergency anywhere in the world are paid. A single phone call activates a series of events that lead to prompt and efficient medical care that can help you and your dependents in an emergency.

CariCARE INTERNATIONAL MEDICAL CARD

Worldwide 24 hours a day, 7 days a week

Details of Accessing the Network

(1) Overseas Identification

For medical emergencies while travelling overseas, the **CariCARE** International Card is to be used in the event of ***Emergency Situations ONLY.***

When emergency medical treatment is required, a telephone call should be made to one of the Emergency numbers at the back of the card. This will enable the Assistance Provider to give the needed help to the cardholder and also monitor progress on behalf of Sagicor Life Inc. on the particular case. The cardholder should therefore be aware that in the event that he decides to have some form of treatment, diagnostic or otherwise not of an emergency nature, their liability for Medical expenses incurred will be limited to the cost of said services in Trinidad and Tobago.

This emergency assistance is NOT available for vision care services i.e. the purchasing of spectacles and contact lenses and for dental services unless required dental treatment is as a result of an accident and as such would be reimbursed under your group health plan.

Presentation of the card without first calling may result in the non-acceptance of the Card by the Provider.
The CariCARE Card - the front of the card indicates:

(a) The Company's name,
(b) Name of Employee, and
(c) The Employee's code number.

Access to service while overseas

Should a life threatening medical emergency occur while abroad, you **MUST** at first, call one of the numbers printed at the back of your CariCARE Card.

The toll-free numbers are as follows:

– call direct/collect during normal business hours:

CARICOM	+1 246 467-7100
TRINIDAD	+1 868 628-2652 ext1264

-call toll free (24/7)

USA or CANADA	+1 877 540-0265

-call direct/collect

ALL OTHER LOCATIONS	+1 905 669-6797

This action triggers a process of events that ensures your medical needs will be addressed in an immediate and professional manner.

U.S. Providers

For eligibility and benefits: +1 877 540-0265
For claims: Aetna Provider Services at +1 800 414-0596
Claims submission: Aetna, PO Box 30259, Tampa, Fl 33630-3547
Payer ID#: 60054

EXCLUSIONS AND LIMITATIONS

No payment shall be made under any of the health benefits provided by this Policy for any claim resulting from any of the following:-

(1) Sickness, injury or disability for which the insured person is not under the continuing care of a physician.

(2) Expenses incurred as a result of:

a) Intentionally self-inflicted injury of any kind while sane or insane; any voluntary inhalation of gas or fumes or intake of poisonous substance;

(b) Bodily injuries resulting directly or indirectly out of or in the course of war or hostilities of any kind or any act incidental thereto whether war be declared or not and regardless of whether or not the insured was participating therein, any insurrection, strikes, riots, civil commotion or service in the armed forces of any country or international governmental body;

(c) The commission of or attempt to commit any criminal offence;

(d) Any occupational injuries or sickness for which the insured person's employer is liable.

(3) Expenses incurred for injury or sickness arising out of circumstances in which a person or body corporate is liable to the insured person whether such liability is insured under a policy of indemnity or not; expenses for any services, treatment or supplies incurred as a result of an injury where there is a right of recovery against the person or other party who caused the injury.

(4) Any examination or charge in connection with general dental care or other dental work (except in cases of accidental injury to sound natural teeth provided such dental work was performed within 90 days of the accident) or for any eye examination or for the purchase or fitting of eyeglasses or contact lenses or for any surgery to correct vision which can otherwise be corrected by lenses or for hearing aids or other artificial aids or the examinations in connection therewith.

(5) Travel for health or periodic health examinations or any examination required 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.

(6) Expenses relating to treatment of alcoholism or any drug addiction.

(7) Any expenses related to the inducement of pregnancy or to effect or treat impotence or loss of libido or to determine the cause of non-fertility.

(8) Expenses incurred for tubal ligation, vasectomies or any other means of birth control whether for contraception or other purposes.

(9) Cosmetic surgery or treatment, including treatment of complications of such treatment or surgery, when so classified by Sagicor, unless such surgery or treatment is to repair or alleviate damage to an insured caused by accidental bodily injuries sustained while insured under this Policy and of a nature covered by this Policy and such surgery or treatment commences within 90 days of such accident (unless proven not to have been possible within the 90 day period) or unless for the purposes of correcting congenital anomalies.

(10) 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 immunization.

(11) Expenses for any services or treatments rendered to an insured person to the extent of any benefits payable under any governmental plan of health insurance if at the time such services or treatments are rendered the insured person is eligible to enroll in or is insured by such a governmental plan.

(12) Charges for well baby care and hospital daily room and board and nursing care of a newborn infant before his discharge from hospital.

(13) Charges for treatment which the regulatory bodies consider experimental and which is not accredited by an international regulatory body.

(14) 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.

(15) Expenses for hospital sections or for any other service or supply for which the insured is not required to make payment or for which there is no cost for any other reason; expenses incurred for which no charge is or would have been made in the absence of insurance.

(16) Expenses for a dependent child relating to pregnancy, miscarriage, caesarean section or post-natal care.

(17) Any charges in excess of the usual, reasonable and customary charge for the service, treatment or supply provided or in excess of such charges as would have been made in the absence of this insurance.

(18) Charges for any treatment, supplies or services incurred before or commencing from any date before an insured's insurance commences under this Policy; any charge for any treatment, supply or service incurred after the termination date of any insured person's insurance except as specifically provided for under the terms of clause B5.

(19) Medical treatment abroad unless it is proved to the satisfaction of the Insurance Company prior to treatment that such treatment is not available locally and that such treatment abroad was recommended by two physicians, at least one of whom shall be a specialist in the particular field of medicine pertaining to the insured's sickness or injury. Expenses incurred due to this referral will be evaluated for benefit under the terms of this Policy based on the reasonable and customary limits of the nearest overseas source where the services are available.

Dental Benefits

The Dental Expense Benefit will reimburse you and your dependents for the charges incurred for necessary dental care performed by a dentist or a qualified dental hygienist, up to the maximum stated in the Schedule of Dental Expense Benefits. Reimbursement will be made for charges in excess of the deductible and subject to the respective co-insurance factors. A charge will be considered to be incurred on the date the service is received, rather than on the date the charge is made.

Maximum Benefit & Deductible

The maximum benefit and deductible applies to each covered person in each calendar year.

Eligible Expenses:

Level 1 – Preventative

1. Oral examination including scaling and cleaning of teeth, but limited to one examination in any one six (6) month period.
2. Dental x-rays, except that bitewing x-rays are limited to any one set in any one six month period and full mouth x-rays are limited to one set in any twenty-four month period.

Level 2 – Restorative

1. Initial provision of amalgam, silicate, acrylic, synthetic, porcelain or composite restorations.
2. Replacement of amalgam, silicate, acrylic, synthetic, porcelain or composite restorations, provided that, unless an additional tooth surface is involved, a continuous period of at least twelve consecutive months has elapsed since the date on which the restoration was last provided or replaced.
3. Extractions.
4. Treatments for periodontal and other diseases of the gums and tissues of the mouth.
5. Initial provision and installation of space maintainers.
6. Drugs and medicines requiring written prescriptions and dispensed by a licensed pharmacist.
7. Oral surgery of a dental origin.

Level 3 – Major Restorative

1. Endodontic Treatment (including root-canal therapy).
2. Initial provision of crowns and gold inlay or gold onlays, provided that the tooth is broken down by decay or traumatic injury, so that the tooth structure cannot be restored by amalgam, silicate acrylic, synthetic, porcelain or composite restoration.
3. Replacement of gold inlays or gold onlays provided that the tooth is further broken down by decay or traumatic injury and only if:
   (a) the tooth structure cannot be restored with amalgam, silicate, acrylic, synthetic, and porcelain or composite restoration.
   (b) an additional tooth surface is involved or
   (c) a continuous period of at least twelve consecutive months elapsed since the date the gold inlay or onlay being replaced was last provided or replaced.
4. 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 individual's date of coverage.*
   (commonly referred to as Open Space Limitation)
5. Relining of, or any adjustments required to be made to new dentures provided that a period of at least twelve months has elapsed since the date the dentures were last provided.
6. Repair of dentures.
7. 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 individual's effective date of coverage.
8. Replacement of:
   (a) an existing full denture
   (b) an existing partial denture
   (c) an existing fixed bridgework.

   Provided that:
   (a) Such replacement or addition is required to replace one or more natural teeth at least one of which was extracted after the individual's effective date of coverage.
   (b) The existing or fixed bridgework was installed at least five years prior to its replacement and cannot be made serviceable.

Dental Benefit - Limitations and Exclusions

In addition to the General Limitations under the medical plan, no amount is payable under this benefit for charges incurred:

1. For education or training in, and supplies used for dietary or nutritional counseling, personal Oral hygiene or dental plaque control.

2. For procedures, appliances or restorations used to increase vertical dimension or to restore occlusion.

3. For replacement of dentures which are mislaid, lost or stolen.

4. For or in connection with orthodontic treatments, including correction of malocclusion.

5. For a course of dental care, which commenced prior to the effective date of an insured's individual insurance under this benefit, including charges for any crown, bridge or denture ordered prior to such date.

6. For devices and supplies which are for cosmetic purposes or for experimental treatment or for unnecessary care or treatments, including duplicate dentures or bridges and temporary crowns, bridges or dentures. Where a dental procedure is performed for both functional and cosmetic purposes, that part of the procedure performed for cosmetic purposes will be excluded.

7. For failure to keep scheduled dental appointment or for completion of any insurance forms

8. For vitality tests, study model or precision attachments.

9. For replacement of existing prosthetic devices unless the device is installed five or more years prior to replacement and in the opinion of the attending dentist is no longer serviceable.

10. For any extra charge made for metal dentures.

11. Expenses which are payable under any other plan or benefit, or under Workmen's Compensation or any similar legislation.

Dental Benefit - Limitations and Exclusions
Continued

1. Expenses incurred for Hospital Care other than benefits covered by the Plan.

2. Services and supplies which are not prescribed by a dentist or performed by a dentist or a dental hygienist.

3. For the waiting period as specified on the Schedule of Benefits for expenses incurred by the employees and their dependents

Orthodontia Benefit

Upon receipt of due proof that an insured person has incurred eligible expenses for necessary orthodontic care ordered by a dentist and administered by an orthodontist the Insurer will pay benefits equal to the eligible expenses actually charged not exceeding the maximum amount shown in the Schedule of Orthodontic Care Benefits which forms part of this Rider subject to such deductibles and co-insurance if any as shown in such Schedule.

No payment will be made under this benefit for charges incurred for:

(a) Orthodontic care rendered or supplied by a dentist employed by a Government or at the expense of a Government or agency thereof;

(b) The repair or replacement of an orthodontic appliance;

(c) Orthodontic care which is wholly cosmetic;

(d) Any appointment that an insured person fails to keep;

(e) A course of orthodontic care which commenced prior to the effective date of an insured person's insurance under this benefit;

(f) As a result of any dental disease, defect or injury arising out of or in the course of an insured person's employment;

(g) Orthodontic care for any insured and their dependent/s age 19 and over.

Vision Care Benefit

This benefit provides for the reimbursement of expenses incurred for necessary vision care treatment and supplies which are recommended by duly qualified and licensed Optician, Optometrist or Ophthalmologist up to the amounts shown in the Schedule of Benefits subject to the limitations listed below.

Limitations and Exclusions

1. See Schedule of Benefits for waiting period.

2. Examinations will be limited to **ONE** complete visual examination, including refraction per person during any one **Calendar Year** period.

3. Reimbursement will be made for two lenses during any one **Calendar Year** period.

4. Frames will be limited to one set per person during any one **Calendar Year** period.

5. Contact lenses limited to benefit maximum during any one **Calendar Year** period.

6. No payment will be made for sunglasses whether plain or prescription.

7. No payments will be made for charges incurred in connection with special procedures such as orthoptics or visual training or in connection with medical or surgical treatment of the eye.

8. No amount is payable under this benefit for charges which are excluded under the General Provision of the health insurance benefits.

N.B. Lenses can be purchased on their own with the use of current frames. Frames, however, cannot be purchased independently without lenses.

Life Insurance

Life Insurance for You

Your Life Insurance Amount is as stated in the Schedule of Benefits.

In those instances where the Life Benefit is a percentage of salary, when your salary or wage changes, your Life Insurance Amount will be changed on the first day of the month after the change as long as the Insurance Company is notified in writing.

Any amount in excess of the Non Evidence Maximum has to be approved by the Insurance Company before coverage is effected.

If you are already insured under this plan for an amount equal or in excess of the non-medical maximum and you become eligible for more insurance, evidence of insurability will be required for the additional amount

Non-Evidence Maximum
The amount the Insurance Company will allow without medical evidence.

Reduction of Life Insurance

On your **65th** birthday, should your employment continue, your Life Insurance will be reduced by 50%. Your Life Insurance Benefit terminates at age 70.

Accidental Death & Dismemberment Benefit

Your Accidental Death Benefit can be equal to or less than your Life Insurance Amount and subject to the same requirements for evidence of insurability.

Your Accidental Death & Dismemberment Benefit terminates at age 65.

Death Benefit

If you die while covered, your Life Insurance Amount will be paid to your beneficiary. The Amount payable will be the eligible amount at the time of death. See Claims Information on Page 36 for more details.

Beneficiary

Your beneficiary is the person or persons who will be paid if you die while covered. A person becomes your beneficiary when registered as such with the Insurance Company.

You may change your beneficiary at any time by filling out a Change of Beneficiary Form. This form is available from your employer .

The form must be received and recorded by the Insurance Company before the change of beneficiary becomes effective.

Please ensure that there is a witness for your beneficiary designation where applicable.

Benefits if you become Totally Disabled

If you become Totally Disabled while covered and before your 60th birthday, your Life Insurance will continue for one year as long as you remain disabled. This insurance coverage will be at no cost to you. Waiver of premium commences after six months of continuous disability.

Your Life Insurance will then continue from year to year at no cost to you and without further premium payment while disability continues and your group plan remains in force. You must meet all of these conditions.

- You are totally disabled for at least 6 months.
- Medical evidence shows that disability will be permanent.
- Written proof of disability must be given to the Insurance Company three months prior to the anniversary date of the disability. The Insurance Company will not ask for proof more than once a year.

If you do not give proof of continuing disability when it is requested, your insurance will end on the anniversary of the date you last gave proof.

If disability stops, your Life Insurance will end 31 days after the date your disability stops unless both of the following happen:

- You return to active employment with your employer.
- The Employer pays the premium for you.

If the Plan has any reductions in Life Insurance occurring at a certain age or time; the reductions will apply to you even if you are disabled.

Life Conversion Clause

You may replace your **Group Life Insurance**, with one of the several individual policies of the Insurance Company without proof of good health if your coverage stops because your employment ends. **You must apply within 31 days after coverage ends**. The Individual Life policy chosen cannot exceed the level of Sum insured of your group life maximum, but can be less.

If you die within the 31-day conversion period the Insurance Company will pay your beneficiary the amount of life insurance you could have bought under the individual policy. The individual policy will not go into effect.

Assignment

You may NOT assign your Group Life Insurance benefits. This means you may not give or transfer your Group Life Insurance to anyone else.

Accidental Death & Dismemberment Benefit

For Accidental Death, Dismemberment and Loss of sight

If you have an accident while covered which results in any loss listed below within 365 days of the accident, the payment shown below will be made.

For Loss of Payment

Loss of Life	Full Sum Assured
Loss of sight in both eyes	Full Sum Assured
Loss of both hands or both feet	Full Sum Assured
Loss of use of both hands or both feet	Full Sum Assured
Loss of one hand and one foot	Full Sum Assured
Loss of use of one hand and one foot	Full Sum Assured
Loss of one hand and sight of one eye	Full Sum Assured
Loss of one foot and sight of one eye	Full Sum Assured
Loss of sight in one eye	½ Sum Assured
Loss of one hand or one foot	½ Sum Assured
Loss of use of one hand or one foot	½ Sum Assured
Loss of one thumb & any finger on the same hand	¼ Sum Assured

Loss of a hand means removal at or above the wrist joint.
Loss of a foot means removal at or above the ankle joint.
Loss of an eye means total loss of sight, which cannot be recovered.
Loss of thumb & index finger means severance at or above the knuckles joining the thumb & finger to the hand.

"Loss of use" means the total and irrecoverable loss of use for twelve (12) continuous months after which the benefit is payable, provided the loss of use is determined to be permanent.

The Accidental Benefit is shown in Schedule of Benefits. Only one Benefit, the highest, will be paid if you suffer more than one loss in an accident.

Benefits for loss of life will be paid to your beneficiary. This is in addition to your Life Insurance Benefit. Benefits for other losses will be paid to you. See Claims Information for more details.

Accidental Death Benefit - continued

Your beneficiary is the person or persons who will be paid if you die while covered. A person becomes your beneficiary when registered as such with the Insurance Company.

You may change your beneficiary at any time by filling out a Change of Beneficiary Form. This form is available from your employer.

Not Covered

No payment will be made for any loss caused or contributed to by one of the following:

- Disease, including Mental illness, or medical or surgical treatment for disease.
- Infection, except from an accidental cut or wound.
- Suicide or any attempt at suicide.
- War or international armed conflict.
- The commission of or any attempt to commit a criminal act.
- Travel or flight in any aircraft except solely as a passenger in a powered civil aircraft having a valid and current air-worthiness certificate and operated by a duly licensed or certified pilot while such aircraft is being used for the sole purpose of transportation only. Descent from any aircraft in flight will be deemed to be part of such flight.
- Poisoning in any form or inhalation of gas or fumes, if voluntary, occupation accidents exempted.
- Intentional use of legal or illegal drugs.
- Any injury covered by Workmen's Compensation Law or Act or similar legislation unless 24-hour coverage is indicated in the application.
- An accident which occurs while the blood alcohol level of the life assured is 80 milligrams or more per 100 milligrams of blood

- Participation in any submarine expedition or operation.
- Injuries arising whilst driving or riding in any race or participating in contact or aeronautical sports.
- Capital Punishment

However, successive periods of hospitalization due to the same or related causes shall be considered as the same period of confinement unless you have been actively at work for at least two weeks, or in the case of a dependent unless separated by three months.

GROUP CRITICAL ILLNESS

Group Critical Illness represents one of the most comprehensive packages of living benefits available in the Caribbean today. It is a living benefit that allows the insured to enjoy the benefits.

If you the insured, are diagnosed with any of the diseases covered by the plan, Sagicor Life Inc will pay **Tax Free, 100% of the sum assured** directly to you after a survival period of thirty (30) days for all the Critical Illnesses except if stated otherwise in the Critical Illness definition.

The proceeds of this benefit can then be used to cover anything from enjoying an exotic holiday, helping offset the medical costs associated with the treatment of the disease, making the rest of your life more comfortable, to providing for loved ones. It is totally up to you!

INSURED CONDITIONS:

The program includes coverage for the following Conditions, except as determined by the Exclusions governed by the Terms of the Policy Contract:

1) **LIFE-THREATENING CANCER** means the Diagnosis by a Medical Doctor of a malignant tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

The following forms of cancer are excluded:

i) pre-malignant lesions, benign tumours or benign polyps;
ii) any skin cancer other than malignant melanoma invading into the dermis or deeper;
iii) tumours in the presence of any human immuno-deficiency virus (HIV);
iv) non-invasive cancer in situ;
v) stage A prostate cancer;
vi) Dukes' stage A colon cancer;
vii) stage 1 Hodgkin's disease;
viii) intraductal non-invasive carcinoma of the breast; and
ix) stage 0 or 1 transitional cell carcinoma of the urinary bladder.

There is a 90-day Waiting Period before cancer coverage begins. There shall be no coverage under the Insured Condition definition of Life-threatening Cancer, if the Diagnosis of Cancer is made within the Waiting Period, or if any symptom or medical problem, which initiated any investigation leading to the Diagnosis of Cancer, commenced within the Waiting Period.

CRITICAL ILLNESS - continued

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2) **HEART ATTACK** means the Diagnosis by a Medical Doctor of the death of a portion of the heart muscle. This is as a result of inadequate blood supply to the relevant area. The diagnosis must be based on all of:

i) chest pain, and
ii) new electrocardiographic (ECG) changes, and
iii) elevation of cardiac enzymes above normal levels.

3) **CORONARY ARTERY BY-PASS SURGERY** means heart surgery on the recommendation of a Medical Doctor certified as a Cardiologist to correct narrowing or blockage of one or more coronary arteries with bypass grafts. Techniques that involve Non-Invasive procedures, such as balloon angioplasty, laser relief of an obstruction and/or other intra-arterial procedures are not covered.

4) **STROKE** means the Diagnosis by a Medical Doctor of a cerebrovascular incident, caused by infarction of brain tissue, hemorrhage, or embolisation from an extra-cranial source, excluding a Transient Ischemic Attack (TIA). In addition, the Medical Doctor must provide evidence that the Insured Person has suffered a permanent, measurable neurological deficit, which has persisted for at least 30 days.

5) **MULTIPLE SCLEROSIS (MS)** means an unequivocal Diagnosis of MS by a certified Neurologist. The Diagnosis must be based on at least two episodes of well-defined neurological abnormalities, with at least one episode lasting for a continuous period of at least six months and confirmed by modern imaging techniques.

6) **KIDNEY FAILURE (RENAL FAILURE)** means the Diagnosis by a Medical Doctor of permanent and irreversible failure of both kidneys (end stage renal disease) requiring regular dialysis or necessitating kidney transplantation.

7) **MAJOR ORGAN TRANSPLANT** (as recipient) means failure of a vital organ necessitating, and undergoing the receipt by transplant surgery, of one or more malfunctioning organs or tissues, with organs or tissues from a donor considered suitable under generally accepted medical procedures. The following transplants are covered: liver, kidney, lung, entire heart, or bone marrow.

8) **PARALYSIS** means the Diagnosis by a Medical Doctor, of the complete and permanent loss of use of two or more limbs as a result of paralysis for a continuous period of 180 days or more.

9) **DEAFNESS** means the Diagnosis by a Medical Doctor certified in Otolaryngology, of the permanent loss of hearing in both ears with an auditory threshold of more than 90 decibels.

10) **BLINDNESS** means the Diagnosis by a Medical Doctor certified in Ophthalmology of the permanent and uncorrectable loss of sight in both eyes. The corrected visual acuity must be either worse than 20/200 in both eyes, or the field of vision must be less than 20 degrees in both eyes.

"Diagnosis" means the certified written diagnosis of an Insured Condition by a Medical Doctor licensed and practicing medicine in the country of issue. The Date of Diagnosis shall be the date the Diagnosis is established by the Medical Doctor, as supported by the medical records.

"Life support" means the Insured Person is under the regular care of a Medical Doctor and is being kept alive through nutritional, respiratory and/or cardiovascular support even though irreversible cessation of all functions of the brain has occurred.

"Medically necessary" and **"medical necessity"** means that a medical service, supply or medicine is necessary and appropriate for, and consistent with, the diagnosis or treatment of an illness or injury based on generally accepted current medical practice. Without limiting the generality of the foregoing, a medical service, supply or medicine will be considered medically necessary if:

I. It is an appropriate and essential treatment for the insured's diagnosis or symptoms;

II. It is not in excess (in scope, duration or intensity) of that level of care which is needed to provide safe, adequate and appropriate treatment;

III. It is not part of a treatment plan that is considered to be experimental or for research purposes;

IV. The diagnosis or treatment of the illness or injury is in accordance with generally accepted current medical practice, based on consultation with an appropriate service;

V. It does not involve the use of any drug or substance not formally approved by the United States Food and Drug Administration, even if such approval is not required;

VI. It is not provided primarily as a convenience to the patient or the provider of care.

"Survival period" means the minimum number of consecutive days (excluding the number of days of Life Support), immediately following the Date of Diagnosis or Surgery, which the Insured Person must survive before a Critical Illness Benefit Amount may become payable. The Survival Period is 30 days unless a longer period is specified in the definition of a Critical Illness Insured Condition. A Critical Illness Benefit Amount is not due and does not accrue during a Survival Period.

PAYMENT OF BENEFITS

Upon receipt of due proof that an Insured Person has contracted a critical illness the
Insurer will pay a lump sum benefit not exceeding the maximum amount shown in the Schedule of Critical Illness Benefits.

Conditions for the entitlement of this Benefit are as follows:

I. The illness must be diagnosed or confirmed by a Medical Doctor, using modern investigative techniques.

II. The Insured Person must give written notice to the Insurer within three months of the date of diagnosis of illness and must, at the Insured Person's own expense, provide reports covering clinical, histological, radiological and laboratory evidence, as the Insurer may require.

III. The Insured Person will, at the request of the Insurer,consent to be examined by a Medical Doctor of the Insurer's choice, prior to the admission of a claim. The decision of the Insurer's Chief Medical Officer will be final.

IV. The Insured Person shall have survived for a period of 30 days commencing from the time of diagnosis except in situations where the specific illness involved requires a longer survival period as set out in this Policy.

V. The illness must not be caused directly or indirectly, wholly or partly, by the Exceptions and Limitations shown under Section 6 set out below.

EXCEPTIONS AND LIMITATIONS

No amount of benefit shall be payable if a Critical Illness results either directly or indirectly from any one or more of the following causes:

i. Period of illness which commences during the first 24 months of an Insured Person's coverage, if the illness results from any sickness or injury for which the Insured Person was treated by or attended to by a Medical Doctor during the 24 month period prior to the Effective or

ii. An intentionally self-inflicted injury or sickness, or attempted suicide, whether the Insured Person is sane or insane; or

iii. Committing or attempting to commit a criminal offense whether inside or outside of the country of issue, under the laws in the jurisdiction where the offense takes place; or

iv. The use of any drug, poisonous substance, intoxicant or narcotic other than as prescribed and administered by or in accordance with the instruction of a legally licensed Medical Doctor; or

v. The misuse of alcohol; or

vi. Any insured condition first diagnosed prior to the effective date of coverage;

vii. Where a claim is made in respect of an Insured Person who has been, or is at any time found to be infected by any human immuno-deficiency virus (HIV), or acquired immune deficiency syndrome (AIDS), or any similar condition or syndrome.

viii. Where no untrue statement has been made or pertinent information has been withheld by an Insured in the submission of evidence of insurability for this rider.

ix. **CANCER** - If within 90 days following the later of the effective Date or the date of the last reinstatement of the coverage:-

The Life Assured is diagnosed with Cancer as defined in the policy,

i. Any sign or symptom of any type of cancer becomes first manifest, or

ii. Any medical testing or investigation was initiated which subsequently leads to a **diagnosis of any type of Cancer,**

And further, if an Insured Person has claimed on one of the Insured Conditions as defined in the Rider, and then gets another illness or injury also defined in this Rider while the Policy is still in force, the Insured Person shall not be eligible to receive another lump sum payment, since a claim has already been made by the said Insured Person. Therefore, premium payment is no longer required for this Insured Person.

Auto- Adjudication

On-Line Claiming at the Provider

Sagicor Life Inc. has taken another step towards providing you with a superior service experience by launching our **"Online Claims Settlement".** This new and simple-to-use facility allows you to use your **CariCARE** card at numerous providers to transact business with immediate claims settlement with just a simple “Swipe”.

Here are the simple steps involved when you visit any of these vendors to carry out your transaction:

. You will enter a provider’s office, and recognize the signage, as shown below or ask if they are on Sagicor’s system of on-line claims settlement

· Submit a picture ID together with your CariCARE card, which already contains your name and plan information on the magnetic strip as shown in Illustration 2.

. The provider will swipe the card, input the details of the transaction and submit the claim on-line.

· The computer system will display to the provider, the total expense, less the deductible (where applicable), less the payment by the insurer and what the client’s portion of the expense is.

· You will pay your portion only.

· Two copies of the transaction will then be generated: a client copy and the other which the client will sign and leave at the provider as the provider’s copy.

· The provider will subsequently receive payment directly from Sagicor.

· In the unlikely event of any transactional issues arising, you may be asked to pay for the service in the traditional manner.

If you have a C.O.B. (coordination of benefits) arrangement available to you with another insurer, you should NOT use this facility. Please pay for the service in the traditional manner, for the claim to be submitted to the other insurer.

Claiming Process

Traditional (Paper) Claims

Claim Forms are available from your employer or the Sagicor/Group Web/Online Documents website. This Form should be thoroughly completed and accompanied by all relevant information relating to that claim.

Health Benefits

To claim health benefits you must give the Insurance Company written proof of your loss within 90 days of the service. If it is not possible to file the claim within 90 days, the Insurance Company should be notified of the pending claim.

It is important to keep separate records for each person in your family since maximum amounts; deductible amounts and other provision apply separately to each person.

- All original bills, receipts must accompany your completed claim form and Must include the following:
    - Patient's name,
    - Date of service
    - Prescription #
    - Doctor's name
    - Name and Cost of medication

The Insurance Company has the right to examine anyone filing a claim.

Health Benefits

All benefits will be paid to you within 10 working days after the Insurance Company receives satisfactory proof of loss.

How to Appeal a Claim

You will be notified in writing by the Insurance Company if a claim or any part of a claim is denied.

- If you are not satisfied with the explanation of why the claim was denied you may ask to have your claim reviewed.
- If you think you have more information that can help your claim you can send it with your request.

You can ask for and receive copies of documents important to the claim. In some cases approval may be needed to release confidential information such as medical records. You may submit issues and comments in writing.
A decision will be made within 60 days after receipt of request for review or the date all information required from you is given.

The Insurance Company will notify you in writing about the decision on your review. The reasons for the decision will be stated in a manner you can understand.

Life and AD&D Claims

Life and Accident Death Benefits

Your Employer should be notified as soon as possible after a death.

The Insurance Company can request an autopsy in connection with a claim for death under the Accidental Benefit, except where it is not permitted by law.

Other claims for losses under the Accidental Benefit should be filed within 365 days from the date of the loss, if it is not possible to file the claim within 365 days, the Insurance Company should be notified of the pending claim.

Waiver of Premium

The Insurance Company should be notified as soon as possible after you have become disabled or not more than twelve (12) months thereafter.

Death and Accidental Death

Your Life Insurance and Accident Death Benefit may not be paid in one amount. You can get more information about this from your Employer. These benefits will be paid to your beneficiary immediately after the Insurance Company receives due proof of death.
Payment of any part of the insurance for which there is no beneficiary named at your death will be made to your estate.

Accidental Dismemberment and Loss of Sight

All other benefits for a loss from an accident will be paid to you after the Insurance Company receives satisfactory proof of loss.

Who is Eligible for Coverage

Employees

You are eligible if you are a full-time Employee (see Glossary).

Employees who join the organization are immediately eligible for enrolment, regardless of probationary status.

Temporary employees are not covered by the Plan.

Dependents

Your eligible Dependents are:

- Your spouse – Legally married or common law.
- Your unmarried children under 19.
- Your unmarried children age 19 but younger than age 23 who are registered students in regular full-time attendance at a recognized school or university.

Your dependents must reside in the same household and be registered on the records of the Employer.

Eligible children include stepchildren and legally adopted children

If husband and wife are both eligible as Employees, only one may cover their dependents.

Enrolment Eligibility - continued

When Coverage Starts:

Employee

Coverage starts on the later of:

- The Effective Date of this Group plan, if you started work on or before this Date.
- The first day of the month you have joined the organization as a Full Time Employee
- The date when immediate coverage is requested on your behalf and approved by the Insurance Company.

If you are away from work on the date coverage should start; coverage will not start until you return to full-time work.

Dependents Coverage

You must enroll for the coverage for your Dependents (see how to enroll Your Dependents).

Coverage starts on the latest of:

- The date you become covered.
- The first day of the month in which you acquired your first Dependent.
- The date you enroll for the Dependent coverage.
- The date your dependents are approved by the Insurance Company for coverage.

If a dependent is confined in a hospital or other institution when coverage should start, the Comprehensive Medical benefit will not start until:

- The Insurance Company is given proof that the Dependent has completely recovered.

How to Enroll Your Dependents

If you do not have a dependent when you become covered, you may enroll for the Dependents benefits when you acquire your first Dependent.

For Large Groups the Insurance must be notified within thirty-one days of having a new dependent.

For Large Groups proof of insurability acceptable to the Insurance Company of each of the persons to be covered must be given if you enroll them after thirty-one days from the time they become eligible.

Proof of insurability also must be given if you stop your Dependents coverage and then want to enroll them again.

If the proof of insurability of any one of your Dependents is not acceptable to the Insurance Company, that person will not be considered as a Dependent under the Plan. No benefit will be paid under this Plan for that person.

Change in Family Status

To make sure your dependents are properly insured you should report promptly to the company any change in dependents - if you marry or have a child, for example, or if you are divorced or there is a death in your immediate family, or if a child marries - so as to avoid loss of protection or on the other hand, payment of more than is necessary for protection.

Termination of Coverage

Your Coverage

Coverage will stop on the earliest of the following:

- Upon termination of employment.
- On the date the policy terminates.
- On the date the insured dies.
- On the attainment of age 65 unless specified otherwise in your Schedule of Benefits.

Your Dependents Coverage

Coverage for all of your Dependents stops when your coverage stops or when you stop making contributions.

Coverage for an individual Dependent stops if one of the following happens:

- The Dependent becomes covered as an Employee under this plan.
- The Dependent stops being an eligible Dependent.

Handicapped Children

A mentally or physically handicapped child's health coverage will not stop due to age. It will continue as long as your Dependents coverage continues and the child continues to meet the following conditions

- The child is handicapped.
- The child is not capable of self-support.
- The child depends mainly on you for support.

You must give the Insurance Company proof that the child meets these conditions when requested. The Insurance Company will not ask for proof more than once a year.

Accident Benefit

The Insurance Company will pay:

- Accidental Benefits if the accident happened while covered. The loss must be due to the accident. The loss must happen within 365 days after the accident.

Comprehensive Medical Benefit

The Insurance Company will pay:

- Benefits for the 12 month period after coverage stops, as long as the following conditions are met:

    1. The person is Totally Disabled due to the same cause for the entire time from when coverage stops.

    2. The expenses are not payable under any other group plan.

Benefits are payable only for charges made for the accidental injury, sickness or pregnancy which caused the Total Disability.

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Glossary

(These definitions apply when the following terms are used in this Certificate)

Calendar Year: A period of one year beginning with a January 1.

Covered Family Members: You, your eligible Spouse and Dependent children who are covered under this plan.

Complications of Pregnancy: The following are considered Complications of Pregnancy:

a. Any complication that requires intra-abdominal surgery after pregnancy ends.
b. Pernicious vomiting.
c. Toxemia with convulsions which requires confinement in a hospital.

Full-Time Employee: A person on the payroll of the Employer and regularly employed by the Employer on a full-time basis for a minimum of one year. Employee must be working a minimum of 30 hours per week.

Hospital: An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an in-patient basis at the patient's expense and which fully meets all of the following three tests.

1. It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified physicians; and

2. It continuously provides on the premises 24 hour a day nursing service by or under the supervision of registered graduate nurses ; and

3. It is operated continuously with organized facilities for operative surgery on the premises.

Illness: "Illness" or "sickness" means a disease or medical condition that does not arise out of and is not caused by nor contributed to nor as a consequence of any disease or medical condition that arises out of or in the course of employment or occupation for compensation or profit. The term **"sickness"** will include Complications of Pregnancy (as defined).

Mental or Nervous Disorder: Neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Nurse: A person who is a licensed Nurse of Senior Training, a licensed Certified Nurse or a licensed Partially Trained Nurse.

Other Services and Supplies: Services and supplies furnished to the individual and required for treatment, other than the professional services of any physician and any private duty or special nursing services (including intensive nursing care by whatever name called).

Physician: A person who is licensed to practice Medicine in the jurisdiction where the service is provided.

Reasonable and Customary Charges: An amount measured and determined by comparing the actual charge with the charges customarily made for similar services and supplies to individuals of similar medical condition in the locality concerned.

Room and Board: Room, board, general duty nursing, intensive care by whatever name called, and any other services regularly furnished by the hospital as a condition of occupancy of the class of accommodations occupied, but not including professional services of physicians nor special nursing services rendered outside of an intensive care unit by whatever name called.

Total Disability (With respect to Life Insurance): Your complete inability to engage in any occupation or employment for which you are or become qualified by reason of education, training or experience and you are not in fact engaged in any occupation or employment for pay or profit.

Total Disability (With respect to Health Coverage): Your complete inability to perform any and every duty pertaining to your occupation or employment.