

REQUIREMENTS FOR SUBMISSION OF A CLAIM

The procedures outlined below must be strictly adhered to in the best interest of all members concerned.

1. Member's Statement must be fully completed (all questions answered) and signed by the member and the spouse, if spouse is the patient.
2. Credit Union's Statement must be completed and signed by the Plan Administrator and stamped with the Policyholder's stamp.
3. Attending Physician's Statement (reverse side of medical form) must be completed by the doctor, giving details of the treatment and fees. It is necessary that the diagnosis, the name of the injection and drugs be clearly stated, as this information is vital for settlement.
4. It should also be noted that the patient's name on the reverse side of all claim forms (medical/dental/vision) must always be stated by the attending physician / dentist / optometrist / ophthalmologist ONLY and NOT BY THE INSURED. Failure to comply with the foregoing will result in the claim(s) being declined.
5. A receipt must be submitted for drugs supplied or tests done by the doctor in excess of twenty-five dollars (\$25.00). Receipts must also be submitted for Anaesthetist's fees, Obstetrician's fee and all Surgical Procedures. Referral to a Specialist by the Attending Physician must be indicated on the claim form or in a letter.
6. The time limit for submission of a claim is ninety (90) days from the date of loss. If treatment must continue beyond this period, written notice must be submitted with full details.
7. Supporting receipts/bills must be attached showing the following detailed information:-
 - (I.) Hospital:- The number of days spent and itemization of all charges incurred during the period of confinement. Also a breakdown of the medications / drugs used with corresponding charges.
 - (II.) X-rays and Lab Tests:- Patient's name, name of referring doctor, date of service, type of procedures (itemized if there is more than one) and corresponding charges.
 - (III.) Drugs:- The patient's name, name of prescribing doctor, date, prescription number, the name of the drug (itemized if there is more than one) and the corresponding charges. This also applies to repeat prescriptions.
 - (IV.) Vision:- Date of examination and itemization of charges.
 - (V.) Dental:- Itemization of charges.

REQUIREMENTS FOR SUBMISSION OF A CLAIM

It is the responsibility of the plan member to ensure that claims submitted are accompanied by relevant and accurate documentation. Failure to do so will result, in many instances, in an increase in the time taken to process and settle the claim, as we would have to obtain the missing information from doctors, nursing homes and pharmacies.

Your co-operation on the foregoing is greatly appreciated.

EXCEPTIONS AND LIMITATIONS

1. Disability originating prior to the effective date of the insured's coverage - will be covered after the first 12 months of coverage, unless an exclusion is applied.
2. Any charges in excess of the usual reasonable and customary charge for the services, treatment or supply provided.
3. Injury or illness resulting from civil insurrections or war.
4. Cosmetic or plastic surgery unless necessitated by accidental injury.
5. General health examinations or the supply or fitting of spectacles, hearing aids and Psychological services unless stated in Schedule of Benefits.
6. Self-Inflicted injury while sane or insane; treatment of chronic alcoholism, drug addiction, allergy or nervous or mental disorders.
7. Any operation or treatment performed so as to induce pregnancy or to determine the cause of non-fertility, any birth control methods.
8. Medical treatment abroad unless it is approved to the satisfaction of the Insurer prior to treatment that such treatment is not available locally.
9. Injury or illness covered under Workmen's Compensation or similar laws arising out of the Insured's occupation.

OUT-OF-HOSPITAL TREATMENT

The cost of doctor's visits, prescribed drugs, injections and other treatment received out of hospital should be paid by the individual. The client will then be reimbursed by Beacon up to the amount of benefit under the plan.

IN-HOSPITAL TREATMENT

If you wish Beacon to make direct payment to the hospital or surgeon, please ensure that the appropriate assignment of Benefits on the claim form is completed and forwarded with all other documentation.

Written notice of loss must be given to Beacon within 30 days after the ailment or injury occurred and affirmative proof of loss must be submitted within 90 days from date of loss for which claim is made.

Failure to comply with this policy condition will result in your claim being time-barred.

All claim forms must be completed and all relevant questions answered.

THE GROUP MEDICAL INSURANCE PLAN

Your Medical Insurance Plan will provide the benefits specified in accordance with the terms of the Group Policy.

Dependent coverage is also available to spouses, legally married or common-law and children up to age 19 or 25 if attending school fulltime.

This leaflet summarizes the main provision under your Medical Plan and is intended to inform you of the benefits to which you are entitled. It does not create any contractual obligations upon the Company and should the provisions given herein differ from those in the Master Contract, the latter will prevail.

The Plan is designed to give valuable assistance in meeting the financial difficulties you may encounter as a result of accident or sickness.

It is important that you are fully conversant with the scope of the benefits provided under your Plan, since any amount charged for medical attention over the amount of benefit provided by the Plan will be paid by you.

MEDICAL EMERGENCY WHILE OVERSEAS

Member to call Olympus Managed Health Care toll free number stated at the back of their medical card for assistance.

Employee must make contact with their employer advising of emergency within 24 hours of the Emergency.

Olympus will contact Beacon to verify coverage and Benefits and will provide Beacon with the necessary updates on Patient's condition.

Employer can contact Broker or Beacon Insurance for updates.

GROUP HEALTH PORTAL

All registered members will be able to

1. Enrol online
2. Submit claims and supporting invoices using the portal
3. Review their Explanation of Benefits

SUPERPHARM

All registered members will only pay 20% of the cost on eligible prescription drugs that are purchased at Superpharm pharmacies. Beacon will pay 80%. The member will be required to present their Beacon card with valid ID at any Superpharm store to access this benefit.

DISCLAIMER

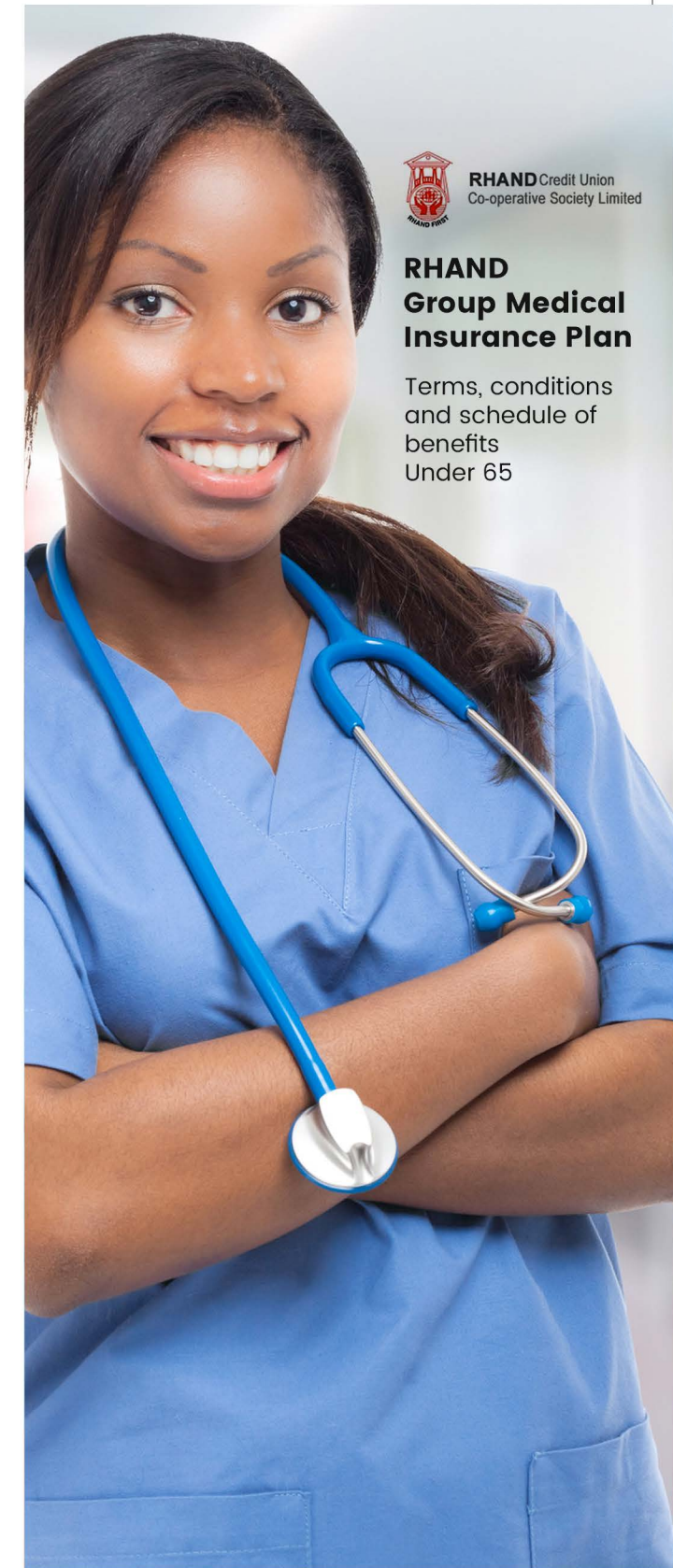
This leaflet is intended only to provide information to you in a convenient form. It does not in any way modify or change the meaning of the text of the actual Insurance Contract under which this Plan is funded. The complete policy contract set forth the Terms and Conditions and governs any rights and obligations you may be exposed to.



RHAND Credit Union
Co-operative Society Limited

RHAND Group Medical Insurance Plan

Terms, conditions and schedule of benefits
Under 65



SCHEDULE OF BENEFITS 65 AND UNDER

(All benefits quoted in TT dollars unless otherwise specified)

Maximum Benefit	\$1,000,000
Benefit Period	3 year renewable
Calendar Year Deductible	\$250 Per Person
Deductible per Family	\$500 Per Family
Carry Over Provision	Last 3 months of Calendar Year

Pre-Existing Conditions (new members)	1st 12 months
Maximum	\$2,500

Eligible Expenses Per Calendar Year

The Beacon Insurance Company shall pay **80% of eligible expenses** per disability after satisfaction of the calendar year deductible and subject to Usual, Customary & Reasonable charges, which shall include:

Hospital Daily Room and Board Limit

Local Maximum- Caricom	\$700
Overseas Maximum- Non Caricom	\$4,000
Maximum no. days per Disability	31
Co-Insurance Factor	80%-20%

Intensive Care Unit

Local Maximum- Caricom	\$1,000
Overseas Maximum- Non Caricom	\$4,000
Maximum no. days per Disability	31
Co-Insurance Factor	80%-20%

Miscellaneous Hospital Expenses

80%-20%

Surgical Benefit

Disability Maximum	80% of UCR
Anesthesia Benefit	25% of UCR

Doctor's Visits

Office	\$300
Home	\$350
Hospital	\$400
Maximum no. of Visits per day	1
Maximum no. of Visits per Disability	31
Co-Insurance Factor	80%-20%

Specialists' Visits

Office/Hospital/Home	\$450
Maximum no. of Visits per day	1
Maximum no. of Visits per Disability	10
Co-Insurance Factor	80%-20%

SCHEDULE OF BENEFITS 65 AND UNDER

(All benefits quoted in TT dollars unless otherwise specified)

Eligible Expenses Per Calendar Year

Physiotherapy (upon referral)	80% UP TO
Maximum per Visit	\$150
Maximum no. Visits per Day	1
Maximum no. Visits per Calendar Year	20

Psychologist (upon referral)

Maximum per Visit	\$200
Maximum no. Visits per Day	1
Maximum no. Visits per Calendar Year	20
Co-Insurance	80%-20%

Prescribed Drugs (Controlled/Antibiotics)

80%-20%

Diagnostic/XRAY/Lab

80%-20%

Maternity/Obstetrical

(Subject to Deductible/No Co-Insurance)

Normal Delivery	\$7,500
Caesarean Section	Payable as Surgery
Dilation and Curettage/Miscarriage	\$3,000
Pre-natal Maximum (inc. in Maternity Max)	\$3,000
Waiting Period (new members)	10 months

Airfare Benefit

Maximum per Trip	80% UP TO \$10,000
Number of Trips per Calendar Year	2

Emergency Air Ambulance Benefit

Maximum no. of Trips per Calendar Year	\$25,000USD
Co-Insurance Factor	2
	100%

Preventative Care Benefits

Benefit Maximum	\$1,500
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Local Ground Ambulance

100%

Internal Lifetime Plan Limits

(Not subject to Deductible/No Co-Insurance)

Organ Transplants	50% Major Medical
	Max. subject to UCR
Mental & Nervous Disorder	\$25,000
HIV/AIDS	\$50,000
Congenital Birth Defects	\$250,000

Durable Medical Equipment

80% subject to UCR

Radiotherapy/Chemotherapy/Dialysis

80% subject to UCR

SCHEDULE OF BENEFITS 65 AND UNDER

(All benefits quoted in TT dollars unless otherwise specified)

Eligible Expenses Per Calendar Year

Private Duty Nursing	Max. per 8 hour shift
Private Residence-Day	\$100
Private Residence-Night	\$150
Hospital-Night	\$200
Maximum no. of days per Disability	30

Acupuncture Benefit

(Shall only be covered when performed by a licensed physician)

Maximum per Visit	\$200
Maximum no. Visits per Day	1
Maximum no. of Visits per Disability	20
Co-Insurance Factor	80%-20%

Chiropractic Benefit

(Must be performed by a member of the Chiropractic Association and referred by a licensed Physician)

Maximum per Visit	\$200
Maximum no. Visits per Day	1
Maximum no. Visits per Disability	20
Co-Insurance Factor	80%-20%

Repatriation of Mortal Remains

\$20,000TTD

VISION & DENTAL CARE BENEFITS

VISION CARE

Maximum Benefit per Calendar Year	\$3,000
Deductible per Calendar Year	\$100
Co-Insurance Factor	80%-20%
Contact Lenses not medically required	Included in Benefit
	Maximum
Waiting period (new members only)	3 Months

LIMITATIONS

- 1 Examination during any 12 consecutive months
- 1 Pair of Contact Lenses or Conventional Lenses and/or Frames during any 12 consecutive months
- 1 Set of Frames during any 24 consecutive months

DENTAL CARE

Maximum Benefit per Calendar Year	\$4,000
Deductible per Calendar Year	\$100
Orthodontic (Limited to children up to age 19)	
Lifetime Maximum	\$4,000
Orthodontic Annual Maximum	\$2,000
Co-Insurance Factor	80%-20%
Waiting Period (new members only)	3 Months

GROUP LIFE, ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Coverage per Member	\$50,000
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MONTHLY HEALTH & LIFE PREMIUMS

Member Only	\$229.50
Member and One	\$394.50
Member and Family	\$589.50

If you are injured in an accident and within 90 days of the accident suffer death, dismemberment or loss of sight, the Insurance Company will pay you or your beneficiary the Amount of Insurance benefit shown in the Table of Losses.

The Amount of Insurance shown under the Table of Losses, is known as the "Principal Sum". The term "Principal Sum" means the amount of Group Accidental Death and Dismemberment Insurance benefit as shown in the Schedule of Insurance Benefits.

Description of Losses Incurred	Amount of Insurance Benefit
Loss of Life	The Principal Sum will be paid to your beneficiary
Loss of: Two hands Or two feet, Or the sight of two eyes, Or one hand & one foot, Or one foot & the sight of one eye Or one hand & the sight of one eye	The Principal Sum will be paid to member
Loss of: One hand, Or one foot, or the Sight of one eye	One-half the Principal Sum will be paid to member
Thumb or index finger	25% of Principal Sum will be paid to member
Two or more toes of the same foot; Or two or more fingers of the same hand	25% of Principal Sum will be paid to member
Loss of Use of One Arm	75% of Principal Sum will be paid to member
Loss of Use of One Hand	Two-thirds of Principal sum will be paid to member
Paraplegia (total paralysis of both lower limbs)	The Principal Sum will be paid to member
Hemiplegia (total paralysis of upper and lower limbs on one side of the body)	One-Half of Principal Sum will be paid to member