iii. Drugs: Patient's name, name of prescribing doctor, date, prescription number, the name of the drug (itemized ifthere is more than one) and the corresponding cha rges. This also applies to repeat prescriptions.

iv. Vision: Date of examination and itemization of charges.

v. Dental: Itemization of charges.

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. 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, prescr ibed drugs, injections and other treatment recei ved 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 di rect 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 chi ldren up to age 19 or 25 if attending school ful ltime.

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 here in differ from those in the Master Contract, the latter will prevail. The Plan is designed to give valuable assistance in meeti ng 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 on line
2. Submit claims and supporting i nvoices using the portal
3. Review their Explanation of Benefits

MEMBER CARD

This plan does not carry a swipe card option. However, members will receive a member card that can be presented at:

1. Any listed medical institution when completing any eligible service where they will only pay their part of the cost.
2. Any listed pharmacy location when purchasing eligible prescriptions where they will only pay 20-25% of the cost.

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.

57-61 Abercromby Street, Port of Spain, Trinidad

Sangster's Hill Mall, Scarborough, Tobago

Corner Queen and Green Streets, Arima

62RHAND (627-4263) | memberrelations@rhand.org.tt

www.rhand.org.tt/insurance/#group-health

RHAND Group Health Insurance Plan

Terms, conditions and schdule of benefits 66 Plus

SCHEDULE OF BENEFITS 66 to 99

(All benefits quoted in TT dollars unless otherwise specified)

Maxiumum Benefit	$500,000
Benefit Period	Lifetime
Calendar Year Deductible	$500 per Person
Deductible per Family (max. 2)	$1,000 per Family
Co-Insurance	80%-20%
Pre-existing Conditions (new member)	**NIL** (1st 24 months)

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	$500
Overseas Maximum- Non Caricom	$3,500
Maximum no. days per Disability	31
Co-Insurance	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	$250
Home/Hospital	$300
Maximum no. of Visits per Day	1
Maximum no. of Visits per Disability	31
Specialist Consultation (upon referral)	
Office/Hospital/Home	$400
Maximum no. of Visits per day	1
Maximum no. of Visits per Disability	10
Co-Insurance	80%-20%
Prescribed Drugs Benefit	80%-20%
Diagnostic/XRAY/Lab	80%-20%
Physio/Occupational/Speech Therapy (upon referral)	
Maxiumum per Visit	$150
Maximum no. Visits per Day	1
Maxmum no. Visits per Calendar Year	10
Co-Insurance Factor	80%-20%

SCHEDULE OF BENEFITS 66 TO 99

(All benefits quoted in TT dollars unless otherwise specified)

Eligible Expenses Per Calendar Year

Psychologist/Psychiatrist (upon referral)	
Maximum per Visit	$200
Maximum no. Visits per Day	1
Maximum no. Visits per Calendar Year	20
Co-Insurance Factor	80%-20%
Chiropractic Benefit (upon referral) *(Must be a member of the Chiropractic Association of T&T)*	
Maximum per Consultation	$200
Maximum no. Visits per Day	1
Maximum no. Visits per Calendar Year	20
Co-Insurance Factor	80%-20%
Acupuncture Benefit (upon referral) *(Shall only be covered when performed by a licensed physician)*	
Maximum per Consultation	$200
Maximum no. Visits per Day	1
Maximum no. of Visits per Calendar Year	20
Co-Insurance Factor	80%-20%
Preventative Care Benefits	
Annual Maximum	$1,000
Airfare Benefit	
Maximum Benefit	$10,000
Maximum no. of Trips per Calendar Year	2
Co-Insurance Factor	80%-20%
Air Ambulance Benefit	
Maximum Benefit	US$25,000
Maximum no. of Trips per Calendar Year	2
Co-Insurance Factor	100%
Local Ground Ambulance	100%
Internal Lifetime Plan Limits *(Not subject to Deductible/No Co-Insurance)*	
Organ Transplants	$250,000 (subject to UCR)
Mental/Nervous Disorder	$25,000
HIV/AIDS	$50,000
Covid 19 & Hospitalization	$150,000
Durable Medical Equipment	80% subject to UCR to a max. of $20,000
Radiotherapy/Chemotherapy/Dialysis (per calender year)	$25,000 (subject to UCR)

SCHEDULE OF BENEFITS 66 TO 99

(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	$75
Private Residence-Night	$100
Hospital-Night	$120
Maximum no. of days per Disability	30
Repatriation of Mortal Remains	
Lifetime Maximum	$20,000

VISION & DENTAL CARE BENEFITS

VISION CARE	
Maximum Benefit per Calendar Year	$2,500
Deductible per Calendar Year	$150
Co-Insurance Factor	80%-20%
Contact Lenses (Not medically approved)	Included in Vision Max.
Waiting period (new members)	3 months
DENTAL CARE	
Maximum Benefit per Calendar Year	$3,000
Deductible per Calendar Year	$150
Co-Insurance	80%-20%
Waiting period (new members)	3 months

MONTHLY PREMIUMS

Retiree Only	**$398.47**
Retiree and One	**$746.35**
Retiree and Family	**$1,151.48**

REQUIREMENTS FOR SUBMISSION OF A CLAIM

It is the responsibili ty of the plan member to ensure that claim 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 ha ve to obtain the missing information from doctors, nursing homes and pharmacies.

Your co -operation on the foregoing is greatly appreciated.

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 Policy-holder'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 docto r, date of service, type of procedures (itemized if there is more than one) and corresponding charges