SCHEDULE OF BENEFITS

CLASSIFICATION	GROUP LIFE	ACCIDENTAL DEATH & DISMEMBERMENT
ALL STAFF	NOT COVERED	NOT COVERED

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SCHEDULE OF BENEFITS

GENERAL MAJOR MEDICAL BENEFITS	*BENEFIT MAXIMUMS/LIMITS*
Maximum Lifetime Benefit	
For Active Employees under age 65	$1,000,000.00
For Active Employees over age 65 & Retirees	$ 250,000.00
Internal Plan Limits per insured (*applies toward Lifetime Major Medical Maximum*)	
Lifetime Benefits for:	
Transplants for Active Employees under age 65	$ 250,000.00
Transplants for Active Employees over age 65 & Retirees	$ 100,000.00
AIDS or AIDS-related Illnesses	$ 50,000.00
Psychiatric Care (Applicable to Out-patient & Hospital Care)	$ 25,000.00
Congenital Disorders (New Born)	$ 250,000.00
Deductible per Calendar Year	
Per Each Individual Insured	$ 200.00
Per Family	2
Co-Insurance Payment: ***Local Benefit***	
On the first $40,000 per Calendar Year	75%
Thereafter to the Maximum	100%
Co-insurance Payment: ***Overseas Benefit***	
Pre-certified Overseas Treatment within Managed Care Network or Emergency treatment	80% on the 1st $50,000., 100% thereafter
Pre-certified Overseas Treatment outside of Managed Care Network	75% on the 1st $200,000., 100% thereafter
Not approved or Not Pre-certified	40% - no stop loss will apply
Carry Over Provision	Last 3 months of Calendar Year

BENEFITS SUBJECT TO THE DEDUCTIBLE & THE CO-INSURANCE	*BENEFIT MAXIMUMS/LIMITS*
Pre-existing Condition (Maximum per Disability)	$ 750.00
Daily Room & Board	
Local (Caricom)	$ 400.00
Overseas (Non-caricom)	$ 2,000.00
Intensive Care	2.5 times Average Semi-Private Room Rate
Private Duty Nursing	
Maximum per 8-hour Shift – In private residence (Day)	$ 70.00
Maximum per 8-hour Shift – In private residence (Night)	$ 100.00
Maximum per 8-hour Shift – In hospital (Night)	$ 120.00
Psychiatric Benefit	
Out-patient Care	50%
Maximum per Treatment	$ 50.00
Maximum Treatments per Calendar Year	20
Hospital Confinement	75%
Physiotherapy and other Health-care Professional Groups - Maximum Allowable Expense	$ 40.00

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SCHEDULE OF BENEFITS

BENEFITS SUBJECT TO THE DEDUCTIBLE & THE CO-INSURANCE (Cont'd)	*BENEFIT MAXIMUMS/LIMITS*
Doctor's Visit	**Maximum Allowable Expense**
Office Visit	$ 90.00
Home Visit	$ 90.00
Hospital Visit	$ 90.00
Specialist Visit by Referral Only	$ 150.00
Emergency Doctor's Visits Benefit (Home and Hospital)	$ 225.00
Local Ground Ambulance	75% of R & C Charges
Surgical Expense	75% of R & C Charges
Other Hospital Services	75% of R & C Charges
Miscellaneous Expense	75% of R & C Charges
Prescription Drugs	75% of R & C Charges
Diagnostic Expense	75% of R & C Charges
Medical Air Transportation Benefit *(Economy Airfare)*	75% of R & C Charges
Maximum benefit per Calendar Year	$ 3,000.00
Maximum trips per Calendar Year	**See * below**
Maternity Benefit	
Normal Delivery (Inclusive of Pre-natal payment)	Treated as any other illness
Caesarean Section (Inclusive of Pre-natal payment)	Treated as any other illness
Miscarriage (Inclusive of Pre-natal payment)	Treated as any other illness
Pre-natal	Treated as any other illness
Complications including Extra-Uterine pregnancy are treated as any other illness	

BENEFITS NOT SUBJECT TO THE DEDUCTIBLE NOR THE CO-INSURANCE	*BENEFIT MAXIMUMS/LIMITS*
Medical Air Transportation Benefit *(Emergency Air Ambulance)*	100%
Maximum trips per Calendar Year	**See * below**
Preventative Care	
Annual Physical Examination Benefit for employees only	$ 150.00
Annual GYN and Pap Smear test for each female employee/spouse	$ 65.00
Mammogram for each female employee/spouse over age 40	$ 125.00
Annual Proctology/Prostate Examination for each male employee/spouse over age 40	$ 65.00
Routine Well Baby Immunizations for each dependent child under age 5	$ 100.00

NOTES:
****Only 2 trips per Calendar Year are covered under the Medical Air Transportation Benefit.***
Prescription Drugs – Reimbursement/Payment limited to "prescribed drugs" as set out and required by law in the insurer's jurisdiction.
R & C means Reasonable & Customary.

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SCHEDULE OF DENTAL BENEFITS

Maximum per calendar year	$1,500.00
Deductible per calendar year	$ 50.00

Amount of Benefit:

Level 1 – Preventative	80%
Level 2 – Restorative	50%
Level 3 - Major Restorative	50%

SCHEDULE OF VISION BENEFITS

Complete Examination	$ 50.00
Lenses Each:	
Single Vision	$ 55.00
Bi-Focal	$ 62.50
Tri-Focal	$ 75.00
Lenticular	$ 90.00
Contact (Medically Required)	$200.00
Contact (Not Medically Required)	$100.00
Frames	$200.00

This benefit provides for the reimbursement of expenses incurred by necessary vision care treatment and supplies which are recommended by a duly qualified optician, optometrist or ophthalmologist up to the amounts shown in the schedule of benefits.

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