October 2019

A Guide to Understanding Your Colina Stellar Care Group Insurance Coverage

COLINA

What's Inside?

Our Vision

To be recognized as a leading provider of innovative financial solutions which inspire trust and confidence, and enhance the well-being of our customers.

Our Policy of Service Excellence

Our customers deserve our best efforts as well as our respect and courtesy. Our five-point Policy of Service Excellence is our commitment to deliver on our promise of protection and integrity.

1. We are in business because of our customers. Our policy is to sustain the highest quality of customer satisfaction through personal accountability and professional commitment. We will strive to treat all customers we encounter with courteous and prompt service. We will deliver thoughtful, appropriate and timely solutions and suggestions to meet our customers' needs.

2. We offer confidence for life. Our policy is to be direct, open, and honest with you at every phase of our relationship – before, during, and after the purchase. In servicing your everyday needs, we will maintain your trust and confidence – knowing that it is your right as a customer to understand fully your contract, its terms, obligations and benefits.

3. We will listen to you. Our policy as a market-leading insurance company is to deliver products and services that exceed your expectations. To do this we will continue to solicit your feedback to improve how we address your changing needs and develop products that suit your unique circumstances.

4. We will respect you. Our policy is to safeguard your personal information and allow it to be used only for the purpose it was given to us and as required by law.

We will be responsive. Our policy is to answer your questions and resolve issues promptly and accurately. We will keep our commitments to provide information and documents, return a call or pay a visit. We will strive continually to exceed your expectations

About this guide

Welcome to your Colina Stellar Care membership guide.

We've prepared this guide to help you understand the important things you need to know about your employer-sponsored group insurance coverage. You can also find meanings to common healthcare terms.

This guide is for informational purposes only, and therefore does not supersede or replace any part of your employer's group insurance contract. The policies and procedures contained herein are in effect on the date published and are therefore subject to change.

Please read your Group Insurance Coverage Booklet in its entirely, which along with this guide, will help you understand your group insurance benefits, requirements for accessing healthcare, your financial responsibility and other obligations.

Customer Relations

If you have any questions about your health plan, please email them to

healthbenefits@colina.com

You may also call our Customer Relations Unit at 396-5100. Our Customer Service Representatives are available weekdays from 9am to 5pm and will be more than happy to assist you in getting answers to your health plan questions.

What is Group Insurance?

Group Insurance provides coverage to a defined group of people (typically employees of an organization) under a single master policy which is a contract between the Policyholder or Plan Sponsor (normally an Employer) and the insurance company. Colina Insurance Limited ("Colina") offers the following products to groups under our Stellar Care Suite of products:

a) Health Insurance: Medical, Vision and Dental

b) Life Insurance: Life and Accidental Death & Dismemberment

c) Disability Insurance: Long-term disability and Short-term disability

d) Critical Illness Insurance

Refer to your Group Insurance Coverage booklet to see which products your group insurance covers.

Who is eligible for coverage?

Covered persons may include eligible full-time employees working a minimum of 30 hours per week, Retirees, and Dependents, provided Retiree and Dependent coverage are chosen by your employer.

Who are eligible Dependents?

Eligible Dependents are classified as a Spouse or Child of an Employee with coverage under the group insurance policy.

- Dependent Child is an Employee's natural or legally adopted Child, Step-Child or Legal Ward who is:

- A resident of The Bahamas (or a non-resident if studying full-time at a registered educational institution outside The Bahamas);
- Unmarried;
- Dependent on the Employee for financial support; and
- Under age 19, any age if mentally or physically handicapped, or under age 26 if in full-time attendance at (or on vacation from) a high school, college, or university. As the maximum age for students may vary by health plan, refer to your Group Insurance Coverage Booklet for the maximum age applicable to your Dependent Child.

- Dependent Spouse is a person of the opposite sex resident in The Bahamas who is:
  - Married to the Employee through an ecclesiastical or civil ceremony; or
  - Not legally married to the Employee but cohabiting with the Employee in a husband and wife relationship which is recognized as such in the community, for at least two years

What is required to enroll?

- The Employee must submit completed and signed Enrollment Form(s) for himself and/or his Dependents within thirty-one (31) days of becoming eligible for coverage.
- If the Enrollment Form is received by Colina more than thirty-one (31) days after the date of eligibility, the enrollee is considered a late enrollee and Evidence of Insurability acceptable to the Company, for each of the persons to be covered, will be required. Additional requirements may be requested at the Underwriter's discretion.
- The table below displays the documents required as proof of eligibility when enrolling Dependents.

PROOF OF ELIGIBILITY REQUIREMENTS FOR DEPENDENT COVERAGE								
Insured/Covered Person	**Birth Certificate**	**Marriage Certificate**	**Legal Proof of Adoption**	**Legal Guardianship**	**Proof of Full-time Student**	**Proof of Disability**	**Divorce Decree**	**Proof of Address**
Legal Spouse		✓						
Divorced Spouse							✓	
Common-law/Domestic Partner								✓
Natural Child	✓							
Stepchild	✓	✓						
Adopted Child			✓					
Legal Ward	✓			✓				
Disabled Child age 19 and over						✓		
Child age 19 and over					✓			

When is Medical Underwriting required?

Small Groups (5 to 24 enrolled Employee)

- All enrollees will be required to furnish the following for Medical and Life coverage, and, in some instances, Long-term Disability coverage:
  - Completed individual Health Statements); and
  - HIV saliva test.
  - Additional requirements may be requested at the Underwriter's discretion.

Large Groups (25 or more enrolled Employee)

- Late enrollees and those applying for Life insurance in excess of the Non-Evidence Maximum (also referred to as the "Free Sum Assured Limit"), and, in some instances, Long-term Disability coverage, will be required to submit the following:
    - Completed individual Health Statements); and
    - HIV saliva test.
    - Additional requirements may be requested at the Underwriter's discretion.

Note that all medical requirements (Para-medicals, H.I.V. Saliva's etc.) for late enrollees are the expense of the applicant.

For all other enrollees, Medical Underwriting is typically not required.

When does coverage begin?

Employee

Employee coverage will begin on the latest of the following dates:

- The date on which the Employee first become eligible for insurance;
- The date on which the Employee's written application (in the form required by Colina) is signed, provided the application was received by Colina within 31 days of the Employee's eligibility date; or
- The date on which Colina approves the application.

Dependent

Dependent coverage will begin on the latest of the following dates:

- The date on which coverage for the relevant Employee becomes effective;
- The date on which the relevant Employee first becomes eligible for insurance, provided a written application for Dependent coverage (in the form required by Colina) is received by Colina within 31 days of such eligibility; or
- The date on which Colina approves the Dependent's application.

Special Provision for Newborn Children

An Employee who has Dependent coverage may elect to insure a Newborn Child from his or her date of birth, provided the enrollment application is completed and submitted to Colina within (31) days of his or her birth, and accompanied by the 1st month's premium.

When does coverage end?

Employee

Employee coverage will end on the earliest of the following dates:

- The date when the Policyholder notifies Colina that the Employee's employment has ended;
- The date on which the Policyholder notifies Colina that the Employee is no longer eligible for coverage;
- The date on which the Policy terminates;
- The date on which application for termination of the Employee's coverage is made;
- The end of the period for which the Employee's required premiums have been paid; or
- When the Employee's Lifetime Maximum benefit has been reached.

Dependent

Dependent coverage will end on the earliest of the following dates:

- The date on which the Employee coverage terminates;
- The date on which the Employee no longer has any eligible Dependents;
- The date on which application for termination of that Dependent's insurance under this Policy is made;
- The date on which 'the Policy terminates; or
- When a Dependent's Lifetime Maximum benefit has been reached.

Handicapped Children

Coverage for a mentally or physically handicapped child will continue as long as the coverage of the relevant Employee remains in effect, and the child continues to meet the following conditions:

- The child is handicapped; and
- The child depends on the relevant Employee for support.

The relevant Employee will be required to provide the Company with Proof of Disability from a qualified professional.

Requirements for your Dependent(s) attending College or University

For continued coverage with Colina, you will be required to provide proof of full-time student status twice a year for your Dependent(s) ages 19 – 25, no later than January 31st to verify coverage for the Spring Semester, and no later than September 30th for the Fall Semester. Failure to provide proof of full-time student status will result in termination of your Dependent(s) coverage. As the maximum age for students may vary by health plan, refer to your Group Insurance Coverage Booklet for the maximum age applicable to your Dependent Child.

Role of the Group Plan Administrator

The Group Plan Administrator is usually an employee who is responsible for managing the group insurance plan and serves as a liaison between the employees and Colina. The responsibilities of the Group Plan Administrator include (but are not limited to) the following:

- To be knowledgeable about the group insurance plan
- Determining an Employee or Dependent eligibility for enrollment
- Enrollment of Employees and their Dependents
- Adding Dependents to an Employee's existing coverage
- Terminating Employee or Dependent coverage
- Notifying Colina of any changes to key Employee information e.g. occupation, salary, employment classification
- Completing the Plan Administrator's section of all forms (where applicable) and ensuring that all information is complete and accurate
- Ensuring that Employees are aware of their rights and obligations under the group insurance plan
- Acting as a key resource for Employee questions or enquiries pertaining to group insurance coverage
- Providing Employees with resource material e.g. benefit booklets, claim forms etc.
- Ensuring the timely submission of premium payments

Your Rights and Responsibilities as a Colina Member

As a Colina Member, you have certain rights and responsibilities that may be exercised or required of you throughout the duration of your coverage.

You have a right to:

- Be treated with courtesy and respect
- Be provided with information about your Colina health plan, its services and benefits, its providers.
- Know your rights and responsibilities as a Member.
- Privacy and confidentiality regarding your personal information, except if disclosure of that information is required by law.
- Discuss your medical records with your physician and receive, upon request, a copy of that record. Be informed of your diagnosis, treatment choices, and prognosis in terms you can reasonably expect to understand, and to participate in decision-making about your healthcare and treatment plan.
- File a formal complaint, as outlined in this guide, and expect a response to that complaint within a reasonable period of time.

You are expected to:

- Read carefully all questions on the Application for Insurance and disclose true and accurate information to prevent your or your Dependents coverage from being cancelled or claim from being denied.
- Read all information about your health benefits and ask for help if you have questions.
- Read and be aware of all material distributed by Colina explaining policies, procedures and protocols regarding services.
- Take your and your Dependents' Colina identification card with you at all times and use it when accessing medical care.
- Pay all applicable co-payments, deductibles, and coinsurance amounts required under your plan at the time service is rendered.
- Notify your group plan administrator about the following:
    - Changes or life events affecting your or your Dependents eligibility for coverage; and
    - Changes to your or your Dependents' personal data, including name, address, phone number, other health insurance carrier(s).
- Review your Explanations of Benefits (EOB) statements closely to ensure they accurately reflect the services you received.

Resolution of Complaints

All grievances or complaints should be directed to the Customer Relations Unit by calling

396-5100 or emailing them to healthbenefits@colina.com

At Colina, we aim to resolve all grievances amicably and as quickly as possible. Should you wish to appeal a decision communicated by the Customer Relations Unit, you may do so through Colina's formal complaints process by filing a written complaint addressed to:

Complaints Management

Colina Insurance Limited
308 East Bay Street
Second Floor
PO Box N-4728
Nassau, Bahamas
Email: Complaints@colina.com

Medical Coverage

Colina's medical products are managed care major medical products which provide all essential health benefits like emergency services, primary & specialist care, surgical services, hospitalization, overseas care, organ transplants, preventive care, prescription medication, maternity and newborn care and much more subject to the terms, conditions, limitations and exclusions of your employer's group insurance policy contract. One of the goals of managed care is to reduce cost and control the cost of health care for insureds by forming provider networks and contracting with providers and medical facilities to provide care for insureds at reduced costs.

Your Health Insurance ID Card

Each Covered Person has a unique ID number that allows healthcare providers to verify coverage. Your Health Insurance ID Card is your proof of insurance. Covered Persons are required to present this card when visiting a doctor, hospital or other Colina healthcare providers to receive medical services. Review your ID card as soon as you receive it and contact our Billings and Eligibility Unit at 396-5148 or 396-5145 to report any discrepancies in your personal information appearing on your card. Additional or replacement ID cards can be requested through your Plan Administrator.

Why should I use Colina's "In-network" or "Participating" providers?

Typically, if you visit a physician or other provider within Colina's network, the amount you will be responsible for paying will be less than what you will pay to a Non-Participating or Out-of-Network Provider. This is because Colina contracts with many doctors, hospitals, labs, pharmacies and other facilities who have agreed to accept a negotiated discount rate for their services.

Choosing a Medical Provider (within The Bahamas)

Colina has an extensive local provider network. When accessing medical care, we strongly encourage you to choose a "Participating" or "In-Network Provider" from our list of network providers in your Provider Booklet which can also be found on our website at www.colina.com in order to minimize your Out-of-Pocket costs. You may also contact our in-house Medical Unit at 396-5100 who will be happy to assist you with coordinating your care. If you choose to receive medical care from a "Out-of-Network" or "Non-Participating" provider, **Colina will only pay 50% of Usual, Customary, and Reasonable Charges (URC), after you have paid your applicable out-of-pocket expenses, and you will be responsible for the balance.**

Choosing a Medical Provider (outside of The Bahamas)

Colina also has an extensive overseas provider network. Prior to travelling overseas to obtain medical care, you will be required to contact our in-house Medical Unit at 396-5100 who will coordinate your care through our overseas Third Party Administrator (TPA), Sanus Health Corporation. If you choose to receive medical care from a 'Out-of-Network" or "Non-Participating" provider, **Colina will only pay 50% of Usual, Customary, and Reasonable Charges (URC), after you have paid your applicable out-of-pocket expenses, and you will be responsible for the balance.**

When is Pre-authorization/Pre-Certification required?

For certain procedures or services, your healthcare provider must receive prior approval from Colina. Procedures or services requiring Pre-certification or Pre-authorization from the Company, prior to services being rendered, are outlined in detail in your Group Insurance Coverage Booklet. Your provider office will typically obtain the required Pre-certification, however, it is ultimately the Covered Person's responsibility to ensure that the Pre-certification requirements have been met. We appreciate that there will be times when it will not be practical or possible for a Covered Person to contact us for prior approval, like in the case of emergency hospital admission. In circumstances like these, we require you to obtain Pre-certification within 48 hours after the date and time of admission, or as soon as reasonably possible thereafter.

If you fail to obtain Pre-certification, Colina will only pay 50% of Usual, Customary, and Reasonable Charges (URC), after you have paid your applicable out-of-pocket expenses, and you will be responsible for the balance.

The following services typically require prior approval from Colina:

- Hospital Admission
- Overseas Care
- Surgical Services
- Rehabilitation, Skilled Nursing Facility Confinements
- Home Health Care
- Diagnostic Procedures such as MRI, CAT Scans
- Air Ambulance or Air Transportation
- In-patient treatment
- Behavioral Health Disorders such as drugs or alcohol addiction
- Human Organ Transplants
- Certain medications
- Return/Repatriation of Deceased

When is a Referral required?

If you require specialist care locally or overseas, you must adhere to the following Referral rules.

Referrals are valid for one (1) month from the date of issue.

Overseas Care

Colina must coordinate and approve all non-emergency overseas medical services. It is your responsibility to provide a Letter of Medical Necessity and Referral from a Specialist in The Bahamas to a Specialist overseas for a second opinion or for treatment not available locally. Should you require emergency care while travelling, please access the nearest medical facility and/or contact Sanus Health Corporation, using the number on the back of your ID card. If you fail to obtain a referral, prior to obtaining non-emergency medical services overseas, **Colina will only pay 50% of Usual, Customary, and Reasonable Charges (URC), after you have paid your applicable out-of-pocket expenses, and you will be responsible for the balance.**

Paramedical Services

To obtain the following services, we require a Referral from your attending physician, prior to obtaining medical services. If a Referral is not obtained, prior to obtaining medical services, **Colina will only pay 50% of Usual, Customary, and Reasonable Charges (URC), after you have paid your applicable out-of-pocket expenses, and you will be responsible for the balance.**

The following services require you to have a Referral:

- Chiropractic Care
- Physiotherapy
- Speech Therapy
- Masseurs Therapy
- Occupational Therapy

Our Care Management Program

Our team of medical professionals comprise of registered nurses and physicians with clinical and medical coding experience who ensure that you get the quality health care that you need. Our Care Management Program is made up of the following activities:

- Coordination of Care – our team of healthcare professionals are available to assist you with the following:
    - Questions about your health coverage
    - Information about Colina's Participating or In-Network providers
    - Coordinating your care

- Pre-Authorization/Pre-certification – we require that some services be approved prior to being rendered by a healthcare provider. Services requiring Pre-Certification or Pre-Authorization from the Company are outlined in detail under the Precertification Program in our employer's group insurance contract. In reviewing requests for services, our team of medical professionals evaluate medical necessity and use pre-set guidelines and protocols to make our decisions.

- Medical Case Management – Our team of medical professionals check on covered persons, while in hospital, to make sure they are getting the care they need. These experts use their clinical experience to evaluate the appropriateness and cost-effectiveness of medical care provided to our insureds and are able to coordinate all aspects of your care.

- Discharge Planning – our Case Managers help plan for your care after leaving the hospital. They can arrange follow-up and home care visits, equipment rentals and other services.

You may contact our team of medical professionals at 396-5106/5107, 396-5119, 396-5121 or by email at Group-MedicalUnit@COLINA.COM

What to do in the event of a local medical emergency?

In the event of a medical emergency, call 911 or go to the nearest private hospital emergency room. You will be required to make payment as stipulated in your Schedule of Benefits and according to the classification of the care administered. A Referral is not required for emergency care. The Pre-Certification Program requires that a Covered Person, or someone on his behalf, contact Colina as soon as possible, but no later than 48 hours after the date and time of Admission, or as soon as reasonably possible thereafter.

Preventative Healthcare

Preventative Healthcare is the care you receive such as annual check-ups, immunizations and screenings to prevent illnesses or diseases and help you stay healthy. Colina's health plans cover preventive services at 100%, up to the Calendar Year maximum benefit in the Schedule of Benefits found in your Group Insurance Coverage Booklet. This means that no Deductibles, Co-payments or Coinsurance applies.

How do Pre-existing Conditions affect your Coverage?

Most private group major medical plans include a Pre-existing Condition exclusion whereby they do not cover expenses, for a certain period of time, related to a medical condition that a Covered Person had before enrolling in a health plan. Why? If insurers did not exclude Pre-existing Conditions, most persons would wait until they became ill to obtain medical coverage. This would require insurers to charge extremely high premiums to cover the substantial medical bills for these individuals.

The period of time during which Pre-existing Conditions are not covered by a health plan is referred to as the Pre-existing Condition Exclusion Period. Colina's health plans have a 12-month Pre-existing Exclusion Period. This means that any expenses incurred by a Covered Person for, or as a result of, a Pre-existing Condition during the first 12 consecutive months of coverage will not be covered.

Note: Failure to disclose Pre-existing Conditions or necessary information to evaluate an application for insurance, where applicable, may result in Colina rescinding (voiding) your coverage and denying claims.

How does having more than one health plan work?

You, or any Dependent, may be covered under more than one health plan. Whenever there is more than one health plan, benefits payable under your Colina health plan will be coordinated with benefits payable under other health plans to ensure that the total reimbursement from all plans does not exceed 100% of Covered Services and that individuals do not profit from medical claims. This is referred to as Co-ordination of Benefits (COB).

In order to pay claims, the Insurer must determine which plan is Primary and which plan is Secondary, in accordance with the "Co-ordination of Medical Benefits Reduction" provision of your employer's group insurance contract which sets out the order in which claims are to be paid. The Primary plan will pay its share of the covered expenses first, and the Secondary plan will pay the difference, up to 100% of the covered expenses.

Your Lifetime Maximum

A Lifetime Maximum is the total or maximum dollar amount that Colina will pay in Medical benefits during the time a Covered Person is enrolled in a health plan. Each Covered Person (Employee and Dependents) has a Lifetime Maximum. Once your Lifetime Maximum is reached, your Medical coverage will end and Colina will no longer pay for Covered Services. It is important that you refer to your Group Insurance Coverage Booklet for the Lifetime Maximum applicable to your Medical coverage under your employer-sponsored group insurance plan for the purpose of monitoring it.

As an example, let's assume that Jane enrolled in her employer-sponsored group insurance plan with Colina in January 2010 and that the Lifetime Maximum of her Medical coverage was $2,000,000. At the end of December 2015, Colina had paid Covered Services for Jane totaling $1,900,000, leaving her with a remaining Lifetime Maximum of $100,000. In 2017, Jane underwent surgery and incurred Covered Services of $200,000. Because Jane only had $100,000 Lifetime Maximum remaining, Colina paid $100,000 of her Covered Services, and Jane was responsible for the balance of $100,000. Jane reached her Lifetime Maximum of $2,000,000 ($1,900,000 + $100,000) which ended her Medical coverage with Colina.

Annual Maximum

An Annual Maximum is the yearly limit, or maximum dollar amount, Colina will pay in Medical benefits for a Covered Person (age 70 years and older) during any given Calendar Year, which restarts at the beginning of a new Calendar Year until the Lifetime Maximum has been reached. Note – The portion of the Annual Maximum used in any Calendar Year is deducted from the Lifetime Maximum. The Annual Maximum applicable to Colina health plans is $250,000 for a Covered Person age 70 and older. Once your Annual Maximum is reached in a Calendar Year, Colina will no longer pay for Covered Services for the remainder of that Calendar Year.

As an example, let's assume that Richard attained age 70 on January 1, 2014. His Medical coverage had a Lifetime Maximum of $2,000,000 and Colina had already paid Covered Services for Richard totaling $1,500,000. Richard underwent surgery in May 2014 and incurred Covered Services of $300,000. Because Richard was now age 70, Colina paid $250,000 of his Covered Services, and Richard was responsible for the balance of $50,000. Richard had now used up $1,750,000 ($1,500,000 + $250,000) of his Lifetime Maximum and was not eligible for Covered Services for the remainder of 2014. On January 1, 2015 (the beginning of a new Calendar Year) Richard's Annual Maximum was reset to $250,000, which was also his remaining Lifetime Maximum. Richard underwent another surgery in August 2015 and incurred Covered Services of $260,000. Colina paid $250,000 of his Covered Services, and Richard was responsible for the balance of $10,000. Richard had also reached his Lifetime Maximum of $2,000,000 ($1,750,000 + $250,000) which ended his Medical coverage with Colina.

Other Benefit Maximums you should be aware of

Health plans usually have limits on specific benefits. Some benefits are limited by a specific number of days, visits, or specific dollar amount per Calendar Year. For example, your Medical Coverage with Colina limits Home Health Care and Private Nursing services to a specified number of visits, and Skilled Nursing and Hospice facilities to a specified number of days. It is important that you refer to your Group Insurance Coverage Booklet to know which benefits have limits.

Limited or Non-Covered Benefits

Like most major medical expense plans, your employer group insurance coverage with Colina is subject to Limitations and Exclusions. Exclusions describes specific treatments, conditions and situations that will not be covered by your health plan. Certain covered benefits also have a limit applied to them separately, which can be found in your health plan's Schedule of Benefits. Be sure to read your health plan exclusions which can be found in your Group Insurance Coverage booklet.

Treatment needed as a result of someone else's fault

Your employer's group insurance contract contains a Subrogation clause which allows Colina to recover the cost of medical treatment, in the event a Covered Person suffers an injury or sickness as a result of the fault or neglect of a third party e.g. a motor vehicle accident, work injuries, slips and falls etc. Colina will pay the Covered Person's medical expenses and pursue reimbursement directly from the liable third party or from the Covered Person, if such person received payment from the liable third party.

Understanding Cost-Sharing:

Deductibles, Coinsurance, Co-pays and Out-of-Pocket Maximums.

Most group health insurance plans require members to pay some of the cost of covered health care services. This is called "Cost Sharing" or "Out-of-Pocket" costs. Cost Sharing varies with different types of health plans, but most will have a Copayment, Coinsurance, Deductible or Out-of-Pocket Maximum amount. How much is paid by the insurance company, and how much is your responsibility, depends on your health plan's Cost Sharing arrangement. Colina's group health insurance plans are no exception and are subject to the following Cost-Sharing requirements.

Deductible – the dollar amount you pay towards certain Covered Services each Calendar Year before your insurance plan starts paying any of the cost, or before the Co-insurance kicks in. Deductibles are not applicable to services requiring a Co-payment, which means that you do not have to satisfy your Deductible before making a Co-payment. **Co-payments and Co-insurance amounts do not go towards your Deductible. Refer to your health plan's Schedule of Benefits to see what Deductible you have and the benefits to which it applies.**

Illustrative Example: Company ABC Group Health Insurance Plan

Deductible: $1,500 . Coinsurance 20% . Out-of-Pocket Maximum $5,000

On February 1, Jane had a routine out-patient surgical procedure which resulted in Covered Services totaling $1,500. Since Jane had not yet met her Deductible for the Calendar Year, she was required to pay the full $1,500 of her Covered Services. **Jane has now met her Deductible for the remainder of the Calendar Year.**

Jane Pays	Colina Pays	Amount Towards Deductible	Amount Towards Out-of-Pocket Max.
$1,500	$0	$1,500	$0

Co-payment – a fixed amount you pay to a healthcare provider at the time of service which can vary depending on your health plan and the services you receive. **Co-payments do not go towards your Deductible nor your Out-of-Pocket Maximum amount.** Refer to your health plan's Schedule of Benefits to see which benefits Co-payments are applicable and the amounts.

Illustrative Example: Company ABC Group Health Insurance Plan

Deductible: $1,500 . Coinsurance 20% . Out-of-Pocket Maximum $5,000

On April 1, Jane visited her doctor for a routine check-up which resulted in Covered Services totaling $200. Since Jane's medical coverage only requires a Covered Person to pay a Co-payment of $50 for a routine check-up, Jane was only required to pay $50 and Colina was required to pay the balance of $150. As indicated in the example above, Deductible's are not applicable to services requiring a Co-payment, and, besides, Jane had already met her Deductible on February 1. **Jane's Co-payment of $50 does not go towards her Out-of-Pocket Maximum.**

Jane Pays	Colina Pays	Amount Towards Deductible	Amount Towards Out-of-Pocket Max.
$50	$150	$0	$0

Co-insurance – the shared cost between the Covered Person and the insurance company for specified Covered Services. Co-insurance percentages vary between plans and is usually expressed as a percentage split, where the Covered Person pays a certain percentage and the insurance company pays the rest. **Co-insurance begins after your Deductible is met and goes towards your Out-of-Pocket Maximum amount.** Once your Out-of-Pocket Maximum is reached in a Calendar Year, you will not be required to pay a Co-insurance amount for the remainder of the Calendar Year. Refer to your health plan's Schedule of Benefits to see what your Co-insurance percentage is.

Illustrative Example: Company ABC Group Health Insurance Plan

Deductible: $1,500 . Coinsurance 20% . Out-of-Pocket Maximum $5,000

On August 1, Jane underwent extensive diagnostic screening which resulted in Covered Services totaling $3,000. Since Jane had already met her Deductible of $1,500 on February 1, the Co-insurance kicked in and she was only required to pay a Co-insurance amount of $600 (20% of $3,000), up to the Out-of-Pocket Maximum of $5,000, while Colina was required to pay a Co-insurance amount of $2,400 (80% of $2,400). **Jane's Co-insurance payment of $600 was applied towards her Out-of-Pocket Maximum of $5,000.**

Jane Pays	Colina Pays	Amount Towards Deductible	Amount Towards Out-of-Pocket Max.
$600	$2,400	$0	$600

Out-of-Pocket Maximum – the most that you will be required to pay out of pocket for in-network expenses during a Calendar Year. **Only your Co-insurance payments go towards your Out-of-Pocket Maximum amount.** Once you have paid the maximum Out-of-Pocket amount, your insurance should pay 100 percent of your Covered Services for the remainder of the Calendar Year. Refer to your health plan's Schedule of Benefits to see what your Out-of-Pocket Maximum amount is .

Illustrative Example: Company ABC Group Health Insurance Plan

Deductible: $1,500 . Coinsurance 20% . Out-of-Pocket Maximum $5,000

On November 1, Jane was admitted to a rehabilitation facility which resulted in Covered Services totaling $30,000. Since Jane had already met her $1,500 Deductible on February 1, and had already paid a Coinsurance of $600, on August 1, towards her $5,000 Out-of-Pocket Maximum, she was only required to pay the difference of $4,400 ($5,000 - $600), and not the full $6,000 ($30,000 * 20%), in order to meet her Out-of-Pocket Maximum for the Calendar Year. Colina was required to pay $25,600 ($30,000 - $4,400). **Jane has met both her Deductible and Out-of-Pocket Maximum for the Calendar Year, and will only be required to pay Co-payments, for the remainder of the Calendar Year, where applicable.**

Jane Pays	Colina Pays	Amount Towards Deductible	Amount Towards Out-of-Pocket Max.
$4,400	$25,600	$0	$4,400

How to file a claim?

Choosing a "Participating Provider" from our provider networks eliminates the need for you to file a claim. However, if you choose to receive care from a "Non-Participating Provider", you will have to pay the provider in full for services and subsequently file a claim with us for reimbursement. We aim to settle claims within 7-10 business days.

To file a claim for reimbursement, simply follow these steps:

- Have your physician or the medical facility complete the claim form and ensure that the following areas are completed.
    - Patient Name
    - Date(s) of Service
    - Type of Service(s)
    - Diagnosis Codes
    - Procedure Codes
    - Amount Paid for the Service
    - Total Charges for the Service
- Only original documents will be accepted for processing
- Under no circumstances should liquid paper be used on a claim form
- Changes made to the form must be crossed out and initialed.
- Payment receipts should be submitted along with your claim

All claims must be submitted within six (6) months from the date of service. Claims submitted outside of this time frame will be denied for untimely filing.

Understanding how your benefits are processed

Each time Colina processes a claim submitted by you or your healthcare provider, we explain how we processed it in the form of an Explanation of Benefits (EOB).

The EOB is not a bill. It simply explains how your benefits were applied to that particular claim. Each time you receive an EOB, review it carefully to make sure you received the service(s) being billed. If you observe any discrepancies between your EOB and the services you received from your healthcare provider, contact our Customer Relations Unit immediately.at 396-5100.

The following is an illustrative example of Colina's Explanation of Benefits (EOB) statement.

A **Claim #** 05292019ds20087

B **Patient Name** JANE DOE

C **Member Name** JOHN DOE

D **Group Name** ABC COMPANY

E **Member ID** 0076638

Member PID 1376368702

F **Provider Name** LIMITED 123

T

Payment Summary	
VAT Payment (Estimated)	$0.00
Total Paid to Provider (VAT Inclusive, if applicable)	$448.00

G	H	Payment Details							Insured's Responsibility			
		I	J	K	L	M	N	O	P	Q	R	S
Dates of Service	Procedure Code	Submitted Charges	Over R&C/ Saving	Amount Not Covered	Amount Covered	Discount	Amount paid by another insurer	Amount paid by your Health Plan	Deductible	Copay	Coinsurance	Patient's Total Responsibility
05/07/19 - 05/07/19	92004	$120.00	$0.00	$0.00	$120.00	$0.00	$0.00	$120.00	$0.00	$0.00	$0.00	$0.00
05/07/19 - 05/07/19	V2020	$173.96	$0.00	$0.00	$173.96	$0.00	$0.00	$173.96	$0.00	$0.00	$0.00	$0.00
05/07/19 - 05/07/19	V2300	$280.00	$0.00	$173.96	$106.04	$0.00	$0.00	$106.04	$0.00	$0.00	$0.00	$0.00
Total		$573.96	$0.00	$173.96	$400.00	$0.00	$0.00	$400.00	$0.00	$0.00	$0.00	$0.00

Amounts displayed in the tables above are Value Added Tax (VAT) exclusive

U

EOB REMARKS		
94	Processed in Excess of charges.	92004
648	Netpay reduced - Maximum Coverage reached.	V2300

V

Additional Info
VISION-MAX

COLINA

Colina Insurance Limited
12 VIllage Road, P.O. Box N4728
Nassau, New Providence, The Bahamas
TIN: 100049718 ***T***:242-396-5100 ***F***:242-396-5125

If you have questions about your claim(s), please contact our Customer Service Unit at 396-5104 or 396-5110.

Understanding your Explanation of Benefits

A **Claim #:** This number identifies the claim that either you or your healthcare provider submitted to Colina. You can reference this number to query the claim.

B **Patient Name**: Name of Covered Person who received the service.

C **Member Name:** Name of the employee (subscriber).

D **Group Name:** Name of the employer.

E **Member ID:** A unique number assigned by Colina that identifies the patient as a Covered Person. This should match the Member ID number on the patient's insurance card.

F **Provider Name:** Name of the healthcare provider who submitted the claim.

G **Date of Service:** The beginning and end date(s) the healthcare provider indicated the service(s) billed were received by the patient.

H **Procedure Code:** The procedure code(s) submitted by the healthcare provider to identify the service(s) received by the patient. To look up the description of a Procedure Code on your Explanation of Benefits, visit www.aapc.com and enter the Procedure Code in the AAPC Coder Search field.

I **Submitted Charges:** The fee(s) charged by the healthcare provider for the service(s) provided to the patient.

J **Over R&C/Savings:** Amounts billed by your healthcare provider above Reasonable and Customary charges that are not covered by the patient's health plan. Reasonable and Customary (R&C) charges are the normal range of fees for services and supplies provided by similar healthcare providers in a given geographical area.

K **Amount Not Covered:** A charge that is not covered by the patient's health plan.

L **Amount Covered:** A charge that is covered by the patient's health plan.

M **Discount:** The discount negotiated by Colina which reduces the fee charged by the healthcare provider for the service(s) provided to the patient.

N **Amount paid by another insurer** – The amount paid by another insurance carrier, if applicable.

O **Amount paid by your Health Plan:** The amount the health plan paid for the services provided to the patient.

P **Deductible:** The amount of covered charges the patient is required to pay before benefits will be paid by Colina

Q **Copay:** a fixed amount you pay to a healthcare provider at the time of service which can vary depending on your health plan and the services provided.

R **Coinsurance:** The percentage of the Amount Covered the patient is required to pay at the time of service.

S **Patient's Total Responsibility:** The total amount the patient is required to pay the healthcare provider at the time of service. This includes any copays, deductibles or coinsurance, if applicable.

T **Total Paid to Provider:** The total amount Colina paid the healthcare provider.

U **EOB Remarks:** Provides explanations on payment details for submitted charges.

V **Additional Info:** Provides additional information on payment details for submitted charges.

Your right to request to convert your medical coverage

When an Employee's group health coverage with Colina ceases, the Employee is entitled to request to convert to a new individual medical policy covering him and his Dependents, except when termination of the group health coverage occurs under circumstances defined within the "How you lose your rights to request conversion" section below.

When a Dependent Child's group health coverage with Colina ceases due to i) the child becoming married if said child has achieved the age of majority or ii) the child being 19 or older and no longer being in full-time attendance at (or on vacation from) a high school, college or university, the Employee is entitled to request to convert that child's group health benefit to a Colina individual health insurance policy except, when termination occurs under circumstances defined within the "How you lose your rights to request conversion" section below.

The new individual health insurance policy shall be of a type determined by Colina to provide equal or lesser benefits as compared to the benefits of the Employer's plan. Should the Employee wish to convert to an individual health insurance policy determined by Colina to provide richer benefits, Medical Underwriting will be required and issuance of the new individual policy will be subject to Company approval.

This conversion right may be exercised, provided written application for the individual policy and payment of the applicable first premium is made to Colina within thirty-one (31) days after termination of the group health coverage.

How you lose your rights to request conversion

Rights to conversion is lost when group insurance coverage ceases due to:

- Non-payment of premiums
- Master group contract terminates
- Fraud/misrepresentation in evidence of Group Insurance Health Statement or any other materials.

Dental Coverage

If your Employer has chosen Dental insurance coverage for you and your Dependent(s), Colina will only pay benefits for covered dental expenses in accordance with the Schedule of Benefits found in your Group Insurance Coverage Booklet and other applicable provisions of your Employer's group insurance policy.

Cost Sharing, Limitations, Exclusions

Dental benefits are subject to Co-insurance, Deductible, and Annual Maximums. Lifetime Maximum and Exclusions, as outlined in your Dental Schedule of Benefits.

Pre-authorization

For certain covered dental expenses, your provider must receive Pre-authorization or prior approval from Colina, prior to services being rendered, are outlined in detail in your Group Insurance Coverage booklet

Preventative Care

Dental insurance coverage covers 100% of reasonable and customary covered dental services for preventative care, in accordance with the Schedule of Benefits found in your Group Insurance Coverage Booklet and other applicable provisions of your Employer's group insurance policy.

Waiting Period

Dental insurance coverage has a 12-month waiting period for specific benefits. Refer to your Schedule of Benefits found in your Group Insurance Coverage Booklet to see which benefits are subject to a 12-month waiting period.

Termination Age

Dental coverage terminates at age 75 or retirement, whichever occurs first.

Vision Coverage

If your Employer has chosen Vision insurance coverage for you and your Dependent(s), Colina will only pay benefits for covered vision expenses in accordance with the Schedule of Benefits found in your Group Insurance Coverage Booklet and other applicable provisions of your Employer's group insurance policy. Vision insurance coverage covers 100% of covered vision services up to the Calendar Year maximum benefit in your Schedule of Benefits found. This means that no Deductibles, Co-payments or Co-insurance apply.

Waiting Period

Vision insurance coverage has a 3-month waiting period. This means that Covered Persons must wait 3 months, after enrollment, to access Vision benefits.

Termination Age

Vision coverage terminates at age 75 or retirement, whichever occurs first.

Disability Coverage

Your Employer's health plan may also include disability insurance coverage. Disability coverage pays you a monthly benefit, for a covered illness or injury, when you are unable to work for a period of time because of a total disability. Colina will only pay benefits for covered disability expenses in accordance with the Schedule of Benefits found in your Group Insurance Coverage Booklet and other applicable provisions of your Employer's group insurance policy.

- Short-term disability: pays you a portion of your income if you become temporarily disabled due to a covered illness or injury that leaves you out of work for a short period of time.
- Long-term disability: pays you a portion of your income if you become totally disabled due to a covered illness or injury and unable to work for an extended amount of time.

Pre-existing Condition Exclusion Period

No payments will be made for any period of total disability commencing during the first 12 months of coverage of an Employee, if the total disability was directly or indirectly the result of an illness or injury, in accordance with the Schedule of Benefits found in your Group Insurance Coverage Booklet and other applicable provisions of your Employer's group insurance policy.

Waiver of Premium

Disability insurance coverage contains a Waiver of Premium benefit that waives the requirement to pay premiums when a Covered Person is receiving disability benefits.

Termination Age

Disability coverage terminates at age 65 or retirement, whichever occurs first.

Employee & Dependent Life Coverage

If your Employer has chosen Life Insurance coverage for you and your Dependent(s), in the event of your death, Colina will pay the proceeds of your Life Insurance benefit to your named beneficiary(ies) or trustee, upon receipt of proof of claim satisfactory to the Company, and in accordance with the Schedule of Benefits found in your Group Insurance Coverage Booklet and other applicable provisions of your Employer's group insurance policy. The Employee is automatically the beneficiary for their Dependent(s) Life insurance benefit, if applicable.

Naming a beneficiary for your Group Life coverage

Employees are required to name a beneficiary(ies), on their application for insurance, for the proceeds of their Life insurance benefit. An Employee can name any person or entity they choose as a beneficiary. In cases where the Employee is designating more than one beneficiary, the percentage that is being designated for each beneficiary is also required and should add up to 100 percent.

We encourage you to review your beneficiary designation periodically to ensure that it is consistent with your wishes. You can change your beneficiary(ies) at any time or whenever you experience a life event such as marriage, divorce, birth of a child, or death.

An Employee designating an estate as beneficiary should consider the following:

- Probating a deceased person's estate can be costly, time consuming, and can be avoided if proceeds are payable to a named beneficiary.
  - Insurance proceeds payable to the estate are subject to claims from creditors, whereas proceeds payable to a named beneficiary may be protected from creditors.
  - The granting of probate can take months, from the date of the filing of the application.

When designating a minor child(ren) as beneficiary(ies), who has not reached the age of majority as defined by legislation, we recommend appointing a Trustee to receive the death benefit on behalf of your minor child(ren). Otherwise, benefits payable will remain with Colina until your minor child(ren) attain the age of majority.

Your right to request to convert your Group Life coverage.

If an Employee's Life Insurance terminates or reduces and such Employee is under age 65, then the Employee will be entitled to request to convert any amount of insurance, up to the amount of life Insurance coverage lost, to an individual policy issued by Colina without providing evidence of insurability, except when termination of the Group Llife coverage occurs under any of the following circumstances.

- Non-payment of premiums by your Employer
- Termination of your Employer's Master group contract
- Fraud or misrepresentation was detected on your Group Insurance Health Statement or any other materials.

To request to convert to an individual policy, you will be required to submit a written application for the individual policy to the Company and pay the first premium within thirty-one (31) days of the date of termination or reduction of your insurance. Your plan administrator will advise you of the amount of insurance that may be converted.

Living Benefit Insurance

Your Life Insurance coverage also has a Living benefit for Employees diagnosed by a physician as totally disabled as a result of a terminal illness. The Employee is required to make written application, in a form satisfactory to Colina for payment of a Living Benefit which is subject to the applicable provisions of your Employer's group insurance policy. Your plan administrator will advise you of the amount of your Living benefit.

Waiver of Premium

Your Life Insurance coverage has a Waiver of Premium benefit which allows your Employer to continue coverage for an Employee who was diagnosed as being totally disabled prior to attaining age 65. Premiums for the amount of Life Insurance applicable to such Employee will be waived after six months of continuous total disability.

Benefit Reduction

Employee Life coverage will reduce by 50% at age 65 and by a further 25% at age 70.

Termination Age

Employee Life coverage terminates at age 75 or retirement, whichever occurs first.

Basic requirements for filing a death claim

To assist your beneficiary(ies) or trustee with prompt settlement of your death benefit, the following basic requirements must be submitted when notifying Colina of a death claim.

- Original Death Certificate or certified copy of original
- Completed Claimant's Statement.
    - If more than one beneficiary, each beneficiary must complete a separate Claimant's Statement.
    - If beneficiary is a company, corporate seal and two (2) authorized signatures are required on Claimant's Statement.
- If beneficiary is 'Estate' court executed probate documents or Letters of Administration.
- Completed Physician's Certificate (on reverse side of Claimant's Statement)
- Any of the following valid national photo IDs for the deceased insured and beneficiary.
    - Passport
    - Driver's License along with a Birth Certificate
    - Voter's Card
- Employer's Certificate for Group Life policies only (to be completed by the Group Administrator)
- Letters of Guardianship approved by the court, if parent or guardian is claiming for a minor.

Employee Accidental Death & Dismemberment (AD&D) Coverage

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If your Employer has chosen Employee Accidental Death & Dismemberment (AD&D) insurance coverage, Colina will also pay you or your beneficiary(ies) a set amount of money if your death or dismemberment is a direct result of an accident while you were covered under your Employer's group insurance plan, upon receipt of proof of claim satisfactory to the Company, and in accordance with the Schedule of Benefits found in your Group Insurance Coverage Booklet and other applicable provisions of your Employer's group insurance policy.

Benefit Reduction

Employee Accidental Death & Dismemberment (AD&D) coverage Life coverage will reduce by 50% at age 65 and by a further 25% at age 70.

Termination Age

Employee Accidental Death & Dismemberment (AD&D) coverage terminates at age 75 or retirement, whichever occurs first.

Critical Illness Coverage

Critical Illness insurance provides coverage for a defined set of critical illnesses like cancer, heart attack, stroke and kidney failure. If your Employer has chosen Critical Illness insurance coverage, Colina will pay a Covered Person a pre-determined lump sum, once diagnosed as having one of the specified critical illnesses, in accordance with the Schedule of Benefits found in your Group Insurance Coverage Booklet, and other applicable provisions of your Employer's group insurance policy. The Covered Person may use the lump sum at his/her discretion.

Pre-existing Condition Exclusion Period

No payments will be made for a covered condition that was diagnosed prior to the effective date of the Covered Person's Critical Illness insurance.

Waiting Period

Critical Illness insurance is subject to a waiting period which must be satisfied by Covered Persons before making a claim. The waiting period is 90 days for cancer and 30 days for any other critical illnesses from the effective date of coverage.

Survival Period

Covered Persons are required to survive a specified number of days, starting from the date of diagnosis, in order to have a valid claim. The survival period is 30 days.

Glossary of terms

Accident – a sudden, unintentional and unexpected occurrence caused by external, visible means and resulting in physical injury.

Accidental Bodily Injury – an injury caused solely be external, violent and accidental means independently of all other causes.

Accidental Dental Benefits – dental benefits which are necessary due to injury to sound natural teeth as a result of a covered Accident.

Active Full-Time Employment – working full-time for the Policyholder with a minimum of 30 hours per week including an Employee who is: i) on vacation; or ii) on a paid leave of absence where disclosed by the Policyholder and approved in writing by the Company.

Active Part-Time Employment – working part time for an employer with a minimum of 20 hours per week.

Actively At Work – being actually at work at the usual place of employment (or other location to which the Employer requires Him to travel). He must be physically and mentally fit to perform the essential duties of His normal occupation (or other work that the Employer may temporarily assign). Such an Employee is considered to be Actively at Work on weekends, vacations and statutory holidays.

Age Limit – the attained age stated in the Schedule of Benefits at which coverage terminates.

Air Transportation – air transportation services charges up to maximum outlined in the Schedule of Benefits when Medically Necessary. The services must be approved by the Company.

Allowable Charge – charges for services rendered or supplies furnished by a health provider, which would qualify as covered expenses and for which the plan will pay in whole or in part, subject to any deductible, co-insurance or table of allowance included in the plan.

Ambulance – services of a registered ambulance provider for an urgent, serious medical condition.

Annual Maximum – the maximum amount your health plan will pay for covered benefits for a Covered Person during any given calendar year. It is your responsibility to pay for any medical expenses in excess of your Annual Maximum until your health plan calendar year starts over. Refer to your health plan's Schedule of Benefits to see your Annual Maximum amount and at what age it becomes applicable.

Application – a written application (including any medical records, questionnaires or other documents provided to or requested by the Company) in such form as the Company may require made by a Covered Person for coverage under one or more of the Benefits provided by this Policy.

Benefit – the insurance provided by Sections A, B, C or D of this Policy (as the context may require) and "Benefits" means all such coverage.

Calendar Year – the 1st day of January to the 31st day of December (both days inclusive) in any given year.

Close Relative – the Individual, the Individual's spouse and children, brothers, sisters and parents of the Individual and of the Individual's spouse.

Co-insurance – the percentage of Allowable Charges specified in the Schedule of

Benefits that a Covered Person must pay for a Covered Service.

Colina Transplant Network – a group of hospitals or physicians contracted on behalf of the insurer or through their representative agent for the purpose of providing organ transplant benefits to the insured.

Complications of Pregnancy means:

1. conditions that require Hospital Confinement, when diagnoses are distinct from pregnancy but are adversely affected by or caused by pregnancy, such as, but not limited to:
    a) acute nephritis; nephrosis
    b) gestational of diabetes
    c) cardiac decompensation
    d) missed abortion, hydatidiform mole and;
2. when pregnancy is terminated:
    a) non-elective caesarean section
    b) ectopic pregnancy that is terminated; or

COMPLICATIONS OF PREGNANCY will not include false labour; occasional spotting; physician prescribed rest during the period of pregnancy; morning sickness and similar conditions associated with the management of a difficult pregnancy that do not constitute a nosologically distinct Complication of Pregnancy.

Confined to Hospital – formally admitted to a Hospital.

Congenital Defect – a physical, developmental, functional or structural defect, disorder or illness acquired during conception or the fetal stage of development as a result of either genetic or environmental factors, whether or not the condition is manifested or diagnosed before birth, at birth, after birth or years later.

Contributory – Employees are required to contribute to the cost of the Benefits provided.

Non-contributory – Employees are not required to contribute to the cost of the Benefits provided.

Co-payment – the amount of the Allowable Charges specified in the Schedule of Benefits that a Covered Person must pay for a Covered Service.

Covered Person – an Employee or a Dependent in respect of whom insurance is provided under this Policy. If the Covered Person is a Dependent Child, the Employee in respect of whom insurance is provided under this Policy is deemed responsible for any action required of the Covered Person under this Policy.

Covered Services – charges of health care providers which are allowable under the policy.

Custodial Care – assistance with the activities of daily living that can be administered by non-medical/nursing trained personnel.

Deductible – the dollar amount of Eligible Expenses specified in the Schedule of Benefits a Covered Person must meet each Calendar Year before the Company pays benefits.

Dental Care Plan – a dental plan which provides specified dental benefits which are outlined in a Schedule of Benefits.

Dentist – a Doctor of Dental Surgery or a Doctor of Dental Medicine licensed to practise and prescribe where services are provided and who is practising within the scope of His license.

Dependent – a Spouse or Child of an Employee with Coverage under this Policy.

Dependent Child – an Employee's natural or legally adopted Child, step-Child or legal ward who is

a) A resident of The Bahamas (or a non-resident if studying full-time at a registered educational institution outside The Bahamas);
b) Unmarried;
c) Dependent on the Employee for financial support: and
d) Under age 19 (or any age if mentally or physically handicapped); or under age 26 and in full-time attendance at (or on vacation from) a high school, college, university).

Dependent Spouse – a person of the opposite sex resident of The Bahamas who is:

a) married to the Employee through an ecclesiastical or civil ceremony; or
b) Not legally married to the Employee but cohabiting with the Employee in a husband and wife relationship which is recognised as such in the community, for at least two years.

If a court order requires that an Employee provide Coverage for an ex-Spouse and the Employee acquires another Spouse, legal or common-law, the new Spouse will not be eligible for Coverage until the court order expires. This Policy does not provide Coverage for concurrent Spouses.

Division – a segment of one company which has group insurance under this policy.

Donor – a person (living or deceased) whose organs or tissues are surgically removed with the purpose of transplanting them to a Covered Person as the Recipient.

Drug – medicines which have been approved for use in the United States of America by the Food and Drug Administration (FDA).

Durable Medical Equipment – equipment that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally useful to a person in the absence of Illness or Injury

Elective – in connection with a Transplant, a treatment, service, procedure, or surgery which:

1. is not Medically Necessary, as defined in this Policy; and
2. is not the only means by which the Covered Person may reasonably be expected to live a normal life in spite of his sickness or condition.

Eligible Expenses – the cost of services and expenses falling within clause 66.1 above.

Emergency – a sudden acute medical condition with severe symptoms which could reasonably result in placing the patient's life or limb in danger if medical attention is not provided immediately

Emergency Admissions – medically necessary admission for treatment due to an emergency.

Employee - a resident of The Bahamas, employed by the Employer on a permanent full-time basis for not less than 30 hours per week. If the Employer is a sole proprietorship or a partnership, the proprietor or a partner shall be considered to be an Employee of the Employer for the purpose of this Policy, providing He is engaged on a full-time basis in the business of the Employer.

Endogenous Morbid Obesity- 100 or more pounds over ideal weight, as determined by The Metropolitan Height & Weight Tables for Men and Women, which are caused by some metabolic abnormality.

Evidence of Insurability - a statement or proof of a person's physical condition or occupation affecting his acceptance for insurance.

Experimental or Investigative means that, with regard to a Transplant, a medical or surgical procedure, treatment, course of treatment, equipment or drug or medicine:

1. Is not widely accepted as safe, effective and appropriate for the treatment of a sickness or injury by a consensus of the recognized professional organizations of the international medical community;
2. Has not been proven in an objective way to have therapeutic value or benefit;
3. Is medically questionable with respect to effectiveness; and
4. Is under study, investigation, in a trial period, or any phase of a clinical trial (including research protocols).

The Company may be contacted to determine if, with regard to a Transplant, a particular procedure, treatment, device, drug or drug therapy is considered to be Experimental or Investigative.

Explanation of Benefits (EOB) – a statement sent by the insurer to the insured person explaining what medical treatment and/or services were paid for on their behalf and the amount they are responsible for. An EOB contains useful information to help you track your healthcare expenses and medical services received in the past.

Exclusions – services not covered under a health insurance plan. The insured is expected to pay the full cost of non- covered services out of their own pocket

Family - spouse and children who are covered under the plan.

Full-Time Employment - working full-time for an employer with a minimum of 30 hours per week.

Geriatric Care - care for the aged.

Home Health Care Agency - a plan for care and treatment of a person in his home. To qualify, the plan must be established and approved in writing by a Physician who certifies that the Person:

a) would require Hospital Confinement as a registered bed patient without the care and treatment specified in the plan.

Hospice - an agency which provides a coordinated plan of home and inpatient care to a terminally ill person whose life expectancy is six months or less.

Hospice Services- a team of professionals and volunteer workers who provide care to reduce or abate pain or other symptoms of mental or physical distress, and meet the special needs arising out of the stress of the terminal illness, dying and bereavement.

Hospital Confinement means:

a) Any period for which a charge for room and board by a hospital, or
b) Any period during which a Covered Person incurs Covered Medical Expenses as a result of surgery performed at a hospital on an out-Patient basis.

Illness – a sickness, disorder, pathology, abnormality, ailment, disease or any other medical, physical or health condition, including Complications of Pregnancy (as defined) identified in a medical examination. Illness does not include learning disabilities, attitudinal disorders or disciplinary problems.

Immediate Family – a person who is the spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, mother-in-law, brother-in-law, or sister-in-law of the Employee.

Injectable Drugs – medicines which are given by injections.

Injuries– physical damage to the body resulting from Accidents.

Insured – an Employee or a Retiree who is covered under the Policy or a Dependent of an Employee or a Retiree who is covered under the Policy.

Intensive Care – continuous and closely monitored health care that is provided to critically ill patients.

Inpatient – a person who is receiving medical treatment that requires hospital stay in excess of 24-hours.

Institution of Higher Learning means any of the following accredited institutions:

a) State university or college or community college;
b) Licensed private college or university; or
c) Post-high school vocational, technical or similar licensed training school

Limitation: The definition of Institution of Higher Learning does not include high schools, vocational high schools, correspondence schools or schools not providing an entire course progression. If a Covered Person takes certain specialised coursed (for example, adult education courses), He will not be considered to be enrolled in an Institution of Higher Learning.

Licensed Chiropractor – a trained health care professional who is registered with the appropriate governing body to practise chiropractic medicine.

Licensed Occupational Physiotherapist – a trained health care professional who is registered with the appropriate governing body to practise occupational physical therapy.

Licensed Clinical Psychologist – a trained health care professional who is registered with the appropriate governing body to practise clinical psychology.

Licensed Occupational Therapist – a trained health care professional who is registered with the appropriate governing body to practise occupational therapy.

Licensed Practical Nurse – a trained health care professional who is registered with the appropriate governing body to practise practical nursing.

Life Insurance – the applicable amount, based upon the provisions of the policy, the Company agrees to pay to the beneficiary of record immediately upon receipt of due proof of the death of the Covered Person while insured.

Lifetime Maximum Benefit – means maximum medical amount payable on each Covered Person during the lifetime of the policy.

Living Benefit – a benefit of up to $25,000 or fifty percent, whichever is less, of the amount of Life Insurance applicable to an employee who is terminally ill and it is morally certain will die within 12 months.

Material Fact – a fact that would influence or affect the judgment of a reasonable or prudent underwriter in deciding whether to insure a Covered Person in respect of any of the benefits provided by this Policy, and if so on what terms or for what premium, or which is otherwise material as a matter of law.

Medical Provider – a person or place that gives you medical care. Providers include doctors, hospitals, retail clinics, urgent care centers, and other healthcare professionals and facilities.

Medically Necessary – a service or supply which is necessary and appropriate for diagnosis or treatment of an illness or Injury based upon generally accepted current medical practice.

Mental or Nervous Disorders – a mental or emotional disease or disorder which generally denotes a disease of the brain with predominant behavioural systems. Any of various conditions characterized by impairment of an individual's normal cognitive or behavioural functioning,

Non-Participating Provider – a provider which does not have a participating contract with the Company or their representative.

Officer – a director or secretary of the Company or any person with actual authority to enter into policies of insurance on behalf of the Company.

Organ – a grouping of tissues into a distinct structure, which performs a specific function in the human body.

Orthotics – an external device intended to correct any defect of form or function of the human body.

Out-patient – a person who is receiving medical care in a doctor's office, clinic, day surgery center or hospital whose treatment requires a stay of less than 24 hours.

Paramedical Practitioner – a licensed Chiropractor, Clinical Psychologist, Occupational Therapist, Physiotherapist, Podiatrist, Speech Therapist.

Participating Provider – an approved provider which has a participating contract with the Company or their representative.

Pharmacist – a person licensed to prepare and dispense drugs and medicines and who is practising within the scope of His licence.

Physician – a Doctor of Medicine (M.D.) licensed to practise medicine, and is practising within the scope of his licence.

Plan – any policy or government sponsored program that provides insurance, reimbursement or service benefits for Hospital, surgical or other medical expenses. This includes, but is not limited to:

a) individual or group Major Medical health insurance policies;
b) group health care service contracts and health maintenance organization agreements, or other group practice or pre-payment coverage;
c) service provided or payment received under laws or programs of any national, state or local government.

If coverage is provided on a service basis, the reasonable cash value of the services under such

coverage will be taken as the cost of the service.

Pre-Existing Condition - any Illness or Injury (including pregnancy, Complications of Pregnancy, or pregnancy-related conditions), or any complication resulting from such Illness or Injury:

1. which existed on or before the commencement of a Covered Person's coverage under this Policy; or
2. for which a Covered Person received medical or surgical treatment or advice within the 12 month period before the commencement of their coverage under this Policy; or
3. for which symptoms were present, on or before the commencement of their coverage under this Policy, whether or not the symptoms were related to the condition.

Pre-Admission Certification - the approval in advance by the Company that the Admission is Medically Necessary.

Pre-Certification - the approval in advance by the Company based upon medically recognized criteria, whether or not a test, procedure, service, or an elective Admission to a Hospital is Medically Necessary.

Prescription Drugs - medicines whose sale and use are legally restricted to the order of a physician.

Preventive Care - care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examinations, immunization and well-person care.

Primary Insurance - The insurance company that has first responsibility for payment of a claim.

Provider Healthcare Network - the cumulative group of Healthcare Providers approved to be in the Company's Healthcare Network.

Referral - A written recommendation by an insured's primary care physician or a specialist that the insured see another physician or specialist.

Registered Nurse - a person who is trained and registered by the appropriate Medical Authority to practise Nursing.

Registered Nursing Assistant - a person who is trained and registered by the appropriate Medical Authority and assist in the care of patients. They work under the direction and supervision of registered nurses (RNs) and licensed practical nurses (LPNs) and other medical staff and are not ordinarily resident in the Covered Person's home or related to the Covered Person by blood or marriage.

Replacement of a Denture - the substitution of a different full or partial removable denture for one previously used, whether or not the previous denture was lost, stolen or not being used at the time of the substitution, unless such substitution was necessitated by the removal of natural teeth.

Retiree - an individual who is a minimum of 55 years old; and was engaged in Active Full-Time Employment with the Policyholder for a minimum of 10 consecutive years.

Room and Board - daily room charges as billed by a hospital for the cost of accommodation, meals and general nursing care.

Service Area - the geographic area from which the health care plan draws the majority of its users.

Schedule of Benefits – a list of the various services covered under a health insurance plan, outlining the responsibility of the Company and the insured persons.

Sickness – a disease or disorder.

Skilled Nursing Facility – a facility that provides 24-hour nursing services by Registered Nurses on duty; and provides convalescent and long-term illness care with continuous nursing and other health care services by, or under the supervision of, a staff of one or more Physicians and Registered Nurses.

Spouse – husband or wife who is covered under the policy

Surgery – the incision through manual or instrumental means to correct disease, deformity or injuries and the treatment of diseases and conditions which require or are amenable to operative procedures.

Tissue – an aggregate of similar cells and cell products forming a finite structural material with a specific function, in a multicellular organism.

Trained Clinical Nurse – a person formally educated, legally licensed and trained to care for the sick or infirmed.

Transplant – a Medically Necessary procedure, performed while a Covered Person's coverage under this Policy is in effect, during which; one or more Organs are surgically re-moved from a Donor (living or deceased) and transplanted into a Covered Person as the Recipient.

Transplant Medical Centre – a Hospital which meets the Provider Healthcare Network criteria to be considered a Transplant Medical Centre. Such criteria include, but are not limited to the following requirements:

1. The Centre provides comprehensive Transplant services;
2. The Centre requires a minimum of 2 years Transplant Surgeon Certification;
3. The Centre has:
    a) the ability to provide continuity of care;
    b) Medicare certification; and
    c) Satisfactory Transplant experience; and
4. The Centre is affiliated with the United Network of Organ Sharing (UNOS).

Usual Customary and Reasonable – charges of health care providers that are consistent with charges from similar providers for identical or similar services in a given locale.

Walk-In Clinic – medically licensed, private facility, providing preventive, diagnostic and treatment services for conditions in need of prompt care that are not life threatening.

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