PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

CAYMAN ISLANDS GOVERNMENT
GROUP 30100 PLAN 3010001
CIVIL SERVANTS, PENSIONERS
Effective 1st July 2013

CONTENTS

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION : The Plan is a group health Plan and the administration is provided through a Third Party Claims Administrator.

PLAN NAME: Cayman Islands Government Group 30100 Plan 3010001 Civil Servants, Pensioners.

PLAN EFFECTIVE DATE: 1 February 2004.

PLAN YEAR ENDS: 30 June 2014.

EMPLOYER INFORMATION:

Civil Servants	Retirees
Cayman Islands Government C/O Portfolio of the Civil Service Government Administration Building George Town Grand Cayman, KY1-9000	Cayman Islands Government C/O Public Service Pensions Board Government Administration Building George Town Grand Cayman, KY1-9000

PLAN ADMINISTRATOR:

Cayman Islands National Insurance Company Ltd. ("CINICO")
Cayman Centre 1st Floor
P.O. Box 10112
Grand Cayman KY1-1001
Cayman Islands.

THIRD PARTY CLAIMS ADMINISTRATOR:

Cayman Islands National Insurance Company Ltd. ("CINICO")
(or such other entity as the Plan Administrator shall employ from time to time)

RESPONSIBLE PARTIES FOR CONTRACT AGREEMENT:

On behalf of CINICO Lonny Tibbetts CEO	On behalf of PoCS Gloria Mcfield-Nixon Chief Officer

DISCLOSURE OF PLAN DOCUMENT:

Once signed this plan document should be made available on the CINICO web-site and will be disclosed under the Freedom of Information Act.

(A) INTRODUCTION

This document is a description of the Cayman Islands Government Group 30100 Plan 3010001 Civil Servants, Pensioners (the Plan). It summarizes the rights and benefits for eligible Employees/Retirees and their Dependents. No oral interpretations can change this Plan.

Coverage under the Plan will take effect for an eligible Employee/Retiree and designated Dependents when they satisfy all of the Plan's eligibility and enrollement requirements.

Failure to follow the eligibility or enrollment requirements of the Plan may result in delays to coverage or non provision of coverage. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are summarised in the Plan.

The Plan will pay benefits only for the expenses incurred while the Plan Participant is eligible. No benefits are payable for expenses incurred before coverage begins or after coverage terminates. An expense for a service or supply is incurred only on the date the service or supply is furnished.

The Employer reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

CINICO may change/amend any or all parts of the Plan (including benefit coverage, deductibles, maximums, exclusions, limitations, definitions and eligibility), subject to consultation with and the approval of the Portfolio of the Civil Service (PoCS) on behalf of the Cayman Islands Government.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Plan Participants are limited to covered charges incurred before termination, amendment or elimination.

This Plan may be terminated by the PoCS or by CINICO, following written notice of six months.

Services that are 'In-Network' (Health Services Authority) or 'On Island with Referral' or 'Overseas Provider with Referral' will be covered according to the Schedule of Benefits on page 5 of the Plan, up to a lifetime maximum benefit of CI$5 Million. Approved coverage (in accordance with the schedule of benefits on page 5 of this plan) which exceeds this lifetime maximum is an assumed risk of the Government entity through whom the Plan Participant is eligible. On Island or Overseas Providers without Referrals will not be covered, unless coverage is for overseas emergency care only. For a list of benefits not covered see Plan Exclusions on pages 17, 19 and 21.

(B) SCHEDULE OF BENEFITS

MEDICAL CARE BENEFITS	In- Network (Health Services Authority)	On-Island or Overseas Providers without Referral•	On-Island or Overseas Providers with Referral within CINICO Preferred Provider Network	On-Island or Overseas Providers with Referral outside CINICO Preferred Provider Network
••**Maximum Lifetime Benefit Amount:** Cl $5 Million				
Covered Services: All covered expenses are payable subject to a fee schedule or negotiated rate				
Hospital Services				
Room and Board	100% of the semi-private room rate	No Coverage	100% of the semi-private room rate	90% of the semi-private room rate
Skilled Nursing Facility	100% of the facility's semi-private room rate	No Coverage	100% of the facility's semi-private room rate	90% of the facility's semi-private room rate
Physician Services				
inpatient visits	100%	No Coverage	100%	90%
Office visits	100%	No Coverage	100%	90%
Surgery	100%	No Coverage	100%	90%
Allergy testing	100%	No Coverage	100%	90%
Allergy serum & injections	100%	No Coverage	100%	90%
Home Health Care	$6000 maximum per month. in accordance with approved Home Health Care Plan			
Prescription Drugs	100%	No Coverage	100%	90%
Ambulance Service (Ground & Air)	100%	No Coverage	100%	90%
Occupational Therapy	100%	No Coverage	100%	90%
Speech Therapy	100%	No Coverage	100%	90%
Physical Therapy	100%	No Coverage	100%	90%
Durable Medical Equipment	100%	No Coverage	100%	90%
Prosthetics	100%	No Coverage	100%	90%
Orthotics	100%	No Coverage	100%	90%
Spinal Manipulation/Chiropractic	100% Maximum 20 visits per annum	No Coverage	100% Maximum 20 visits per annum	90% Maximum 20 visits per annum
Mental Disorders				
Inpatient	100%	No Coverage	100%	90%
Partial Hospitalization	100%	No Coverage	100%	90%
Outpatient	100%	No Coverage	100%	90%
Substance Abuse - Inpatient Detoxification Services Only	100%	No Coverage	100%	90%
Preventive Care - Includes office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory blood tests and Immunizations.				
Routine Well Adult Care	100%	No Coverage	100%	90%
Routine Well Newborn	100%	No Coverage	100%	90%

Care				
Routine Well Child Care	100%	No Coverage	100%	90%
Immunizations • Children to Adult		No Coverage	100% as ordered by a physician	90% as ordered by a physician
Organ Transplants	100%	No Coverage	100%	90%
Pregnancy	100%	No Coverage	100%	90%

* Overseas Medical Emergency Care only covered at a 100%

** Any benefit which exceeds the maximum lifetime benefit amount is an assumed risk of the Government Entity through whole the Plan Participant is eligible.

VISQN CARE BENEFITS

One eye examination per Plan Participant in a 24 month period, up to a maximum of $60 (or for Pilots - one eye examination in a six month period, or for Scenes of Crime Officers - one eye examination in a twelve month period).

One pair of prescription glasses in a 24 month period, up to a maximum of $300 (including frames), or equivalent in contact lenses.

DENTAL CARE BENEFITS

Class A (Preventative and Diagnostic)-100%
Includes - routine oral examinations, one bitewing once per calendar year, two full mouth x-rays every 24 months, four fluoride treatments per calendar year for Dependent children under 19 years old, two visits per calendar year for scaling and polishing of teeth, and emergency palliative treatment for pain.

Class B (Basic Procedures)-100%
100%. Includes oral surgery, periodontics, endodontics, extractions, re-cementing and fillings (other than gold, or material more expensive than gold).

Class C (Major Procedures)-100%
Includes the installation and creation of crowns.

Class C (Major Procedures) - 50%
Dentures & Orthodontia. Installing, replacing or repairing removable dentures.

Not Covered
Gold restorations, including inlays, onlays and foil fillings, implants and bridgework

(c) DEFINED TERMS

The following terms have special meanings in the Plan and when used will be capitalized.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by Registered Nurses (R.N.s) and does not provide for overnight stays.

Chronic Illness Management is a system of coordinated health care interventions and communications for populations with conditions where patient self-care efforts are significant. It is the process of improving quality of life through the prevention/minimization of the effects of a disease/chronic condition, through integrative care.

Cosmetic Dentistry means dentally unnecessary procedures.

Cosmetic Surgery means medically unnecessary procedures.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent Child is as defined by Public Service Management Law and Personnel Regulations.

DomicIllary Care (aka Custodial Care) is care that is given to assist in daily activities (including personal hygiene) and can, according to generally accepted medical standards, be performed by persons who have no medical training. This care includes the room and board needed to provide such care. Examples of Domiciliary Care include providing help with walking, getting out of bed, bathing, dressing and/or feeding. It can also include supervision of medication which could normally be self-administered.

Durable Medical Equipment (DME) means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, and (c) is generally not useful to a person in the absence of an Illness or Injury. All DME is the property of CINICO.

Eligibility Board is a board convened to resolve eligibility issues. It includes a representative of PoCS, the Public Service Pensions Board (PSPB) and Cayman Islands Civil Service Association (CICSA).

Employee means a person with a valid current Cayman Islands Government employment agreement which stipulates the provision of medical benefits.

Employer is the Cayman Islands Government.

Enrollment Date is the first day of coverage under the Plan.

Experimental and/or investigational means services. supplies, care and treatment which do not constitute accepted medical practice within the range of appropriate standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies - at the time the services were rendered.

A Medical Board must make an independent evaluation of the experimental/non-experimental/investigational/non-investigational standings of specific technologies. The decisions shall be made in good faith and follow a detailed factual background investigation into the claim and the proposed treatment. The decision of the Medical Board will be final and binding on the Plan. The Medical Board will be guided by the following principles:

1. Whether furnished drugs or devices cannot be lawfully marketed without approval of the U.S. Food and Drug Administration or other national equivalent agencies from Cayman, Canada, the UK, and/or from within the region; or
2. Whether drugs, devices, medical treatments/procedures, or utilized patient informed consent documents, have been reviewed and approved by a treating facility's Institutional Review Board (or other body serving a similar function), or if US Federal Law or Cayman Islands law requires such review or approval; or
3. Whether reliable evidence shows that the drugs, devices, medical treatments or procedures are subject to on-going phase I or phase II clinical trials, research, experimental study or part of an investigational arm of on-going phase III clinical trials - or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
4. Whether reliable evidence shows that the prevailing opinion among experts regarding the drugs, devices, medical treatments or procedures is that further studies or clinical trials are necessary to determine maximum tolerated dose, toxicity, safety or efficacy as compared with a standard means of treatment or diagnosis.

'Reliable evidence' shall mean - only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility; the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility/by another facility studying substantially the same drug, device, medical treatment or procedure.

Family Unit is the covered Employee/Retiree and the family members covered as Dependents under the Plan.

Foster Child is as defined by Public Service Management Law and Personnel Regulations.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies: it is certified as a Home Health Care Agency: and it is licensed by the regulatory body in which it is located, where licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician and approved by the Chief Medical Officer which is reviewed at least every 180 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a Registered Nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services): physical, occupational and speech therapy services, medical supplies and laboratory services by or on behalf of the Hospital.

Hospital is an institution which is engaged primarily in providing medical care and the treatment of sick and injured persons on an inpatient basis at the patient's expense. It maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians. It continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of Registered Nurses (R.N.s) and is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

> A facility operating legally as a Psychiatric Hospital or residential treatment facility for mental health in which the facility operates;
>
> A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a Registered Nurse (R.N.); has a full-time Psychiatrist or Psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. This also incorporates Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Illegal Act shall mean the perpetration of any act or series of acts that could be prosecuted as a criminal offense.

Injury means an physical Injury to the body caused by external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. It has: facilities *tor* special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one Registered Nurse (R.N.) in continuous and constant attendance 24 hours a day.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of a person and managing the property and rights of the individual.

Lifetime is the period of time a Plan Participant is covered under the Plan.

Maternity Care means any medical services related to prenatal care, labor and delivery as well as postpartum care and treatment of complications.

Medical Board means a board convened to resolve medical issues. It includes the Chief Medical Officer/Chief Dental Officer, Plan Administrator and Medical Director of the Health Services Authority, or their designated representatives.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care. This includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary is care and treatment provided localy and overseas as approved by the Chief Medical Officer or Chief Dental Officer that is consistent with the patient's condition or accepted standards of good medical, optical and dental practice. It is medically proven to be effective treatment of the condition, and is not performed *tor* the convenience of the patient or provider of medical, optical and dental services. It is not conducted for research purposes. It is the most appropriate level of services which can be safely provided to the patient. The Chief Medical Officer or Chief Dental Officer approval of Medically Necessary care and treatment is valid for 90 days from date the referral is made.

Mental Disorder means any disease or condition (regardless of whether the cause is organic) that is classified as a Mental Disorder in the current edition of International Classification of Diseases published by the U.S. Department of Health and Human Services, or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Morbid Obesity is defined as a Body Mass Index (BMI) of *40* and above, or when Obesity reaches the point of significantly increasing the risk of related health conditions, such a difficulty in breathing, high blood pressure, heart disease, or other serious diseases that can result in significant physical disability or even death.

Obesity is defined as a Body Mass Index (BMI) of 30 and above, or 20% to 30% above the "ideal" body weight according to the standard life insurance tables.

Outpatient Care and/or Services is treatment (including services, supplies and medicines) provided and used at a Hospital under the direction of a Physician, to a person not admitted as a registered bed patient. This can also include services rendered in a Physician's office, laboratory or X-ray (or other scanning) facility, an Ambulatory Surgical Center, or within the patient's home.

Partial Hospitalization is an outpatient programme specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse. It is issued when there is reasonable expectation of improvement or when it is necessary to maintain a patient's functional level and prevent relapse.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.). Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Medical Social Worker, Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is registered and regulated by a government agency (or the responsible Health Practioners Council [Board] if practicing in the Cayman Islands), and is acting within the scope of his or her license.

Plan means Cayman Islands Government Group 30100 Plan 3010001 Civil Servants, Pensioners which is a benefits plan for eligible Employees and Retirees of the Cayman Islands Government and is described in this Plan Document. Reference will also be made to 'the Plan' and 'this Plan'.

Plan Administrator is CINICO who shall administer the Plan in accordance with its terms and establish its policies, interpretations, practices and procedures. The Plan Administrator shall have authority to construe and interpret the terms and provisions of the Plan.

Plan Member is an Employee or retired employee (Retiree) of the Cayman Islands Government who has entitlement to health care coverage under this agreement as defined by Schedule 1 of Personnel Regulations (as amended from time to time), or by such legislation as was in force at the time of their retirement.

Plan Participant is an Employee, Retiree or Dependent who is covered under this Plan.

Pregnancy is childbirth and conditions associated with maternity care.

Prescription Drugs and Prescribed Drugs. Prescription Drugs means any item that requires a licensed Physician to dispense medication for treating a medical condition. Prescribed Drug means any medication whereby a registered Physician has completed a prescription.

Recovery means monies paid to the Plan Participant by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injuries or Sickness whether or not said losses reflect health care charges covered by the Plan. Recoveries further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium,

wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

Refund means repayment to the Plan for health care benefits that it has paid toward care and treatment of the Injury or Sickness.

Retiree is a former Employee of the Employer who is retired, or who has reached mandatory retirement age.

Sickness is a person's Illness or disease.

Skilled Nursing Facility is a facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Nurse. Services to help restore patients to self-care in essential daily living activities must be provided; and
2. Its services are provided for compensation and under the full-time supervision of a Physician; and
3. It provides 24 hour nursing services by licensed nurses, under the direction of a full-time Registered Nurse (R.N.): and
4. It maintains a complete medical record on each patient; and
5. It is not, other than incidentally, a place for rest for the aged, drug addicts, alcoholics, mentally challenged, Custodial or educational care or a place for the care of Mental Disorders.

Skilled Nursing Facility also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Subrogation means the Plan's right to pursue and lien upon the Covered Person's claims for medical or dental charges against the other person.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Third Party means any Third Party including another person or a business entity.

(D) ELIGIBILITY

MAINTENANCE OF ELIGIBILITY INFORMATION

1. It is the responsibility of the Employer to notify the Plan Administrator of any changes to the Plan Participant data which affects eligibility as provided by the Employee.

2. It is the responsibility of the PSPB to notify the Plan Administrator of any changes to the Plan Participant data which affects eligibility as provided by the Retiree.

Determination of issues not explicitly covered under this Plan should be resolved by an Eligibility Board.

CLASSES OF PERSONS EUGIBLE FOR ENROLLMENT INTO THE PLAN

1. Employees and Dependents eligible for coverage as determined by the Employer. Currently determined under Section 9 of the PSML as "an employee, his spouse and dependent children, resident in the Cayman Islands, provided that the Cayman Islands Government is the employee's principal employer."

2. A Retiree of the Employer and their Dependents are eligible for coverage as determined by the Employer. Currently determined under Section 18 of the Personnel Regulations as "an employee, together with his spouse and dependent children, for the period from his retirement to his death, or in the case of his spouse from the time of his retirement to the death of the spouse, or in the case of dependent children from the time of retirement to the end of eligibility as a dependent child, provided that at the time the employee retired from government employment -
   (i) he is entitled to a pension under the Public Service Pension Law (2004 Revision): or
   (ii) if he was not a member of the Public Service Pension Scheme, he retired at an age where he would have been eligible for a pension under that scheme: and
   (iii) the government was the employee's principal employer for 10 consecutive years."

3. A Dependent Offspring of an Employee as determined by the Employer. Currently defined under the PSML and Health Insurance (Amendment) Law 2011 as "(a) eighteen years of age or over, **and** not a full time student at a university or other educational institution; **and** is (i) an offspring of both parties to a marriage; or (ii) an offspring who has been treated by both parties to a marriage as a child of the family and includes a step child, adopted child or foster child; or (iii) an offspring born out of wedlock: **and** (b) who for financial, medical or physical reasons is dependent on the employee for shelter or care".

4. Existing Plan Participants whose eligibility was conferred under previous eligibility criteria.

5. His Excellency the Governor and The Foreign and Commonwealth Office (FCO) support staff resident in the Cayman Islands.

6. Members of the Legislative Assembly.

7. Member of the Judiciary whose contractual arrangement specifies the provision of medical benefits through CINICO.

8. Dependents of Government Employees or Retirees whose dependent status has been determined by a ruling of the court.

9. Ex-employees whose eligibility for medical benefits through CINICO has been instructed by the Governor in Cabinet.

(E) MEDICAL CARE BENEFITS

MEDICAL BENEFITS

All benefits described in the Schedule of Benefits (please see page 5 of the Plan) are subject to the exclusions and limitations described more fully herein. Many of the terms referred to are capitalized and are defined within the Defined Terms section of this document (please see page 7 of the Plan). Medical Benefits apply to Plan Participants under this Plan.

BENEFIT PAYMENTS

Benefits will be paid for the covered charges of a Plan Participant. Payments will be made at the rates shown under reimbursement rate in the Schedule of Benefits of the Plan. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan. All amounts stipulated in this Plan Document are in Cayman Island dollars.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits (please see page 5 of the Plan).

COVERED CHARGES

Charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished. In respect of services not listed in the Schedule of Benefits or in the list of exclusions, contact should be made by the Plan Participant to the Plan Administrator.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center, including services for a Hospital Emergency Room or Medical Care Facility. Covered charges for semi-private room and board will be payable as shown in the Schedule of Benefits of the Plan. After 23 observation hours, a confinement will be considered an inpatient confinement.

(2) **Coverage of Pregnancy.** The fee schedule/negotiate rate charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

(3) **Physician Care.** The professional services of a Physician for surgical or medical services.

(4) **Other Medical Services and Supplies.** Services and supplies not otherwise included in the items above are covered as follows. This is not an exclusive list and the decision of the Chief Medical Officer will be obtained on services not referred to here:

(a) **Alopecia Including totalis secondary to chemotherapy.** Benefit provides for wig /cranial prosthesis limited to one time allowance of $400.

(b) Land or air **ambulance** service.

(c) **Anesthetic:** oxygen: blood and blood derivatives that are not donated or replaced: intravenous injections and solutions. Administration of these items is included.

(d) **Cardiac rehabilitation** as deemed Medically Necessary, provided services are rendered (a) under the supervision of a Physician: (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery: (c) initiated within 12 weeks after other treatment for the medical condition ends: and (d) in a Medical Care Facility as defined by this Plan.

(e) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(f) Initial **contact lenses** or glasses required following cataract surgery.

(g) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, dependent on the cost benefit of this choice and where the cost does not exceed a fair market value for the equipment at the time of purchase. Pre-approval by the Plan Administrator is required for the purchase option.

(h) Treatment specifically and limited to **erectile dysfunction** where medically necessary as determined and prescribed by the Chief Medical Officer.

(I) **Home Health Care** services as prescribed by a Physician. Includes part-time or intermittent nursing care; part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

0) Charges for **Immunizations.**

(k) **Laboratory work.**

(I) Treatment of **Mental Disorders** and **Substance Abuse.** Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

Psychiatrists (M.D.), Psychologists (Ph.D.), Counselors (C.S.W.) or Medical Social Workers may bill the Plan directly. Other licensed mental health practitioners must be under the direction of these professionals and must bill the Plan through them.

(m) Injury to or care of **mouth, teeth** and **gums.** Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be covered charges under Medical Benefits, only if the care is for the following oral surgical procedures:

(I) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
(II) Emergency repair due to Injury to sound natural teeth;
(Iii) Surgery needed to correct injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth;
(Iv) Excision of benign bony growths of the jaw and hard palate;
(v) External incision and drainage of cellulitis;
(vi) Incision of sensory sinuses, salivary glands or ducts;
(vii) Removal of impacted teeth;
(viii) Reduction of dislocations and excision of temporomandibular joints (TMJs).

Charges will be covered under the dental services section for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(n) **Morbid Obesity.** Care and treatment for services deemed appropriate and approved by Chief Medical Officer.

(o) **Nutritional Counseling.** When prescribed by a Physician relative to disease management.

(p) **Occupational therapy** by a licensed Occupational Therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function.

(q) **Organ transplant.** Charges incurred for the care and treatment due to an organ or tissue transplant including on-going anti-rejection medication.

(r) The initial purchase, fitting and repair of **orthotlc appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

(s) **Orthoptlcs** charges for orthoptics (eye muscle exercise).

(t) **Physical therapy** by a licensed Physical Therapist. The therapy must be in accord with a Physician's medical assessment.

(u) **Maternity Care** (see Defined Terms from page 7 of this Plan).

(v) **Prescription Drugs** prescribed by a Physician.

(w) **Repatriation of the Deceased.** In the event that a Plan Participant dies whilst receiving treatment overseas, the costs incurred in repatriating the deceased to the Cayman Islands or if recruited from overseas, the country of residence. This does not include funeral expenses.

(x) **Routine Preventive Care.** Covered charges listed in the Schedule of Benefits are payable for routine Preventive Care.

(I) Charges for **routine well adult care.** Routine well adult care is care by a Physician that is not for an Injury or Sickness.
(II) Charges for **routine well child care.** Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

(y) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

(z) **Reconstructlve Surgery.** Correction of abnormal congenital conditions, reconstructive mammoplasties and other medically necessary procedures will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(I) reconstruction of the breast on which a mastectomy has been performed,
(II) surgery and reconstruction of the other breast to produce a symmetrical appearance, and
(III) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

(**aa)** **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches when under medical supervision.

(ab) **Speech therapy** by a licensed practitioner. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral

cavity, throat or nasal complex (other than a frenectomy) of a person: (ii) an Injury: (iii) stroke, anurism etc.

(ac) **Spinal Manipulation/Chiropractic services** by a licensed Physician (see defined terms).

(ad) **Sterilization** procedures.

(ae) **Substance Abuse and Overdose.** Expenses for Substance Abuse treatment and for treatment of an overdose.

(**af)** **Surgical dressing,** casts and other devices used in the reduction of fractures and dislocations.

(ag) Coverage of **Well Newborn Nursery/Physician Care.**

(I) Charges for routine nursery care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if a parent is a Plan Participant who was covered under the Plan at the time of the birth and the newborn child is an eligible Dependent and is neither injured nor ill.

Charges for covered routine nursery care will be applied toward the Plan of the newborn child.

(II) Charges for routine Physician care. The benefit is limited to the fee schedule/ negotiated rate charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

(ah) Diagnostic **x-rays and other Imaging services.**

(5) As approved by Chief Medical Officer and referred to an overseas Hospital on a non-emergency basis, the Plan Participant is entitled to free air transportation based on economy travel to and from the overseas Hospital; and, if being treated as an outpatient. to the reimbursement of any accommodation cost not to exceed $120 US (before tax) per day. This includes the equivalent air/accomodation costs associated with a companion where the Plan Participant requires a legal guardian, is a minor, or is disabled (including travel within the Cayman Islands).

(6) Any other treatment as approved as Medically Necessary by the Chief Medical Officer.

NON-COVERED MEDICAL SERVICES

For all Medical Benefits shown In the Schedule of Benefits (please see page *5* of the Plan), a charge for the following Is not covered:

(1) **Convalescent care.** Services or supplies provided mainly as a rest cure.

(2) **Educational or vocational testing.** Services for educational or vocational testing or training.

(3) **Exercise programmes.** Exercise programmes for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

(4) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational, not Medically Necessary or performed for administrative purposes.

(5) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. However, refer to the Vision Care Benefits (please see page 19 of the Plan). This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.

(6) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of the Plan Participants Illegal Act, or their participation in a riot or public disturbance. This exclusion does not apply if the Injury or Sickness resulted from a medical (including both physical and mental health) condition or as a victim of an Illegal Act.

(7) **Illegal drugs or medications.** Services, supplies, care or treatment to a Plan Participant for Injury or Sickness resulting from that Plan Participant's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Substance Abuse and Overdose treatment as specified in this Plan. This does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(8) **Infertility.** Care, supplies, services and treatment for infertility, artificial insemination, or in vitro fertilization.

(9) **Obesity.** Care and treatment of Obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Specifically excluded are charges for bariatric surgery, included but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals. Medically Necessary charges for Morbid Obesity will be covered.

(10) **Overseas Travel** where pre-approval has not been granted by the Chief Medical Officer.

(11) **Marital or pre-marital counseling.** Care and treatment for marital or pre-marital counseling.

(12) **No charge.** Care and treatment for which no charge was made.

(13) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

(14) **No Physician order.** Care, treatment, services or supplies not ordered and approved by a Physician: or treatment, services or supplies when the Plan Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(15) **Non-traditional.** Non-traditional medical services, treatments and supplies which are not specified under this Plan, unless approved by the Chief Medical Officer.

(16) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, first-aid supplies and nonhospital adjustable beds.

(17) **Private duty nursing.** Charges in connection with care, treatment or services of a private duty nurse.

(18) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Plan participant's home or is related to the Plan Participant as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law. Applications for payment for relative care givers must be granted by the Medical Board.

(19) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Plan Participant's physical condition or wear and tear not due to misuse on the brace; to make the original device no longer functional, or upon the approval of the Chief Medical Officer.

(20) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(21) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

(22) **Speech Therapy.** Any treatment due to a learning or Mental Disorder.

(23) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(24) **Travel or accommodations.** Charges for domestic travel or accommodations, (except for ambulance charges as defined as a covered expense) unless precertified. Precertification for air travel from Cayman Brae or Little Cayman to Grand Cayman will be given by the Cayman Brae Medical Officer in charge (MoiC) for the patient only, and for a chaperone in circumstances where the Cayman Brae MoiC deems it necessary (i.e. child, elderly, mental disorder).

(25) **War.** Any loss that is due to a declared or undeclared act of war.

Any exclusion above will not apply to the extent the coverage of the charge is required under any law.

Note: Non-Covered services related to Vision and Dental Care are shown In the Vision Care Benefits and Dental Benefits Sections.

(F) VISION CARE BENEFITS

Vision care benefits apply when vision care charges are incurred by a Plan Participant for services that are recommended and approved by a Physician or Optometrist.

BENEFIT PAYMENT

Benefit payment for a Plan Participant will be made as described in the Schedule of Benefits (please see page 5 of the Plan).

VISION CARE CHARGES

Charges are for the vision care services and supplies based on the Schedule of Benefits. Benefits for these charges are payable up to the maximum benefit amounts shown in the Schedule of Benefits for each vision care service or supply.

VISION CARE BENEFITS

One eye examination per Plan Participant in a 24 month period. up to a maximum of $60 (or for Pilots one eye examination in a six month period, or for Scenes of Crime Officers. one eye examination in a 12 month period).

One pair of prescription glasses in a 24 month period up to a maximum of $300 (including frames) - or equivalent in contact lenses. Lenses may be single vision, bi-focal, tri-focal. progressive, lenticular (including special treatment if deemed medically necessary by an optician, optometrist or ophthalmologist).

NON-COVERED VISION SERVICES

No benefits will be payable for the following:

(1) **Before covered.** Care, treatment or supplies tor which a charge was incurred before a person was covered under this Plan.

(2) **No prescription.** Charges for lenses ordered without a prescription.

(3) **Orthoptlcs.** Charges for orthoptics (eye muscle exercises) as this a service is a covered Medical Benefit.

(4) **Training.** Charges for vision training or subnormal vision aids.

(G) DENTAL BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

MAXIMUM BENEFIT AMOUNT

The maximum dental benefit amount is shown in the Schedule of Benefits.

DENTAL CHARGES

Dental charges are the usual and reasonable charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rota charge will be considered to be incurred as each visit or treatment is completed.

COVERED DENTAL SERVICES

Referrals to the periodontal, orthodontic and surgical specialists need prior approval through the Chief Dental Officer (COO) and need to be part of an overall treatment plan.

Class A Services:
Preventative and Diagnostic Procedures

The limits on Class A services are for routine services. If dental need is present, this Plan will consider reimbursement for services performed more frequently that the limits shown.

1. Routine oral exams.
2. One bitewing x-ray series once per calendar year.
3. Two full mouth x-rays every 24 months, includes panoral radiographs.
4. Four fluoride treatments each calendar year for covered Dependent children under the Plan who are under 19 years old.
5. Sealants on the occlusal surface of a permanent posterior tooth for Dependent children every 2 years.
6. Scaling and polishing of teeth limited to two visits per year.
7. Oral hygiene instruction including tooth-brushing, dietary and plaque control advice.

Class B Services:
Basic Dental Procedures

1. Dental x-rays not included in Class A, such as endodontics and surgery cases.
2. Oral surgery. This is limited to the removal of teeth, the preparation of the mouth for dentures and the removal of tooth-generated cysts of less than¼ inch, biopsy, trenectomy, soft tissue cysts.
3. Endodontics (root canals).
4. Extractions. This service includes local anesthesia and routine post-operative care.
5. Re-cementing crowns.
6. Fillings, other than gold or material more expensive than gold.
7. General anesthetics, upon demonstration of Medical Necessity.
8. Antibiotic drugs.
9. Emergency palliative treatment for pain. This includes temporary fillings, antibiotics, pain killers, extractions, denture repair, denture relines, repair of crowns and radiographs.

Class C Services:
Major Dental Procedures

1. Gold restorations, including inlays, veneers, onlays and foil fillings - not covered.
2. Installation and creation of crowns.
3. Installing precision attachments for removable dentures - **50%.**
4. Addition of clasp or rest to existing partial removable dentures - **50%.**
5. Repair of removable dentures - **50%.**
6. Rebasing of removable dentures - **50%.**
7. Replacing an existing removable partial or full denture or adding teeth to an existing removable partial denture to replace newly extracted natural teeth - **50%.** However, this item will apply only if one of these tests is met:
   (a) The existing denture was installed at least five years prior to its replacement and cannot currently be made serviceable.
   (b) The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within five years from the date the temporary denture was installed.
8. Any implants and bridgework - not covered (only when the Chief Dental Officers deems it to be necessary as a special exception).

ALTERNATE TREATMENT

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the usual and reasonable charge for an amalgam filling. The patient will pay the difference in cost.

NON-COVERED DENTAL SERVICES

Charges for the following are not covered:

1. **Administrative costs.** Costs of completing claim forms or reports or for providing dental records.

2. **Before coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.

3. **Broken appointments.** Charges for broken or missed dental appointments.

4. **Excess charge.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the usual and reasonable charge.

5. **Felonious behavior.** Charges for services received as a result of Injury or Sickness caused or contributed to by engaging in an Illegal Act or occupation, by committing or attempting to commit any crime, assault or other felonious behavior, or by participating in a riot or public disturbance.

6. **Hygiene.** Oral Hygiene, plaque control programmes or dietary instructions.

7. **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

8. **No listing.** Services which are not included in the list of covered dental services.

9. **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

10. **Not Medically or Dentally Necessary.** Care and treatment that is not Medically or Dentally Necessary.

11. **Occupational.** Care and treatment of an Injury or Sickness that. in either case, is occupational - that arises from work for wage or profit. including self-employment.

12. **Personalization.** Personalization of dentures.

13. **Plan design.** Charges excluded or limited by the Plan design as stated in this document.

14. **Replacement.** Replacement of lost or stolen appliances.

15. **Self-Inflicted.** Any loss due to an intentionally self inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

16. **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet. including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

(H) ENROLLMENT REQUIREMENTS

ENROLLMENT REQUIREMENTS

In order for a Plan Member to be enrolled in the Plan they must comply with the enrollment procedures outlined by the PoCS for Employees, or PSPB with regard to Retirees. Current procedures are included in Appendix A of the Plan.

EFFECTIVE DATES

A Plan Member will be covered under this Plan as of the first day that they satisfy the:

1) The Eligibility Requirements of the Plan (see page 12 of the Plan):
2) The Enrollment Requirements of the Plan (please see Appendix *5* of the Plan).

A Dependent's and Dependent Offspring's coverage will take effect on the day that it is demonstrated (a) that the eligibility requirements are met; and (b) the Plan Member is covered under the Plan: and (c) the enrollment requirements are met.

RETROACTIVE ENROLLMENT

Retroactive enrollment is permitted up to a maximum of 90 calendar days.

ENROLLMENT REQUIRMENTS FOR NEWBORN CHILDREN

A newborn child of a Plan Member is automatically enrolled in this Plan for 90 days from birth. Charges for covered benefits !including nursery care), will be applied toward the Plan of the newborn child. If proper documentation is not received within the first 90 days from birth, coverage for the newborn will terminate on the 91st day. Coverage will be reinstated upon receipt of the relevant documentation.

CHANGE IN FAMILY CIRCUMSTANCE

The Plan permits a change of benefit coverage during the plan year if a qualified change in family circumstance occurs. The procedures for making changes to family circumstances will be determined by the Employer or in the case of Retirees the Public Service Pensions Board (PSPB). Plan Members are, by law, responsible for notifying the Employer or PSPB when family circumstances affecting eligibility for medical coverage change.

EMPLOYER/PSPB LIABILITY

Where the potential Plan Member has met the eligibility and enrollment requirements of the Plan but the Employer/PSPB has failed to comply with the enrollment requirements of the Plan on their behalf, the liability for medical expenses incurred in that period by the Employee/Retiree and their Dependent will be met by the Plan Members Employer (the Ministry/Portfolio/Department)/PSPB.

TERMINATION OF COVERAGE

The Plan Participants coverage under the Plan will terminate on the earliest of these dates:

1) The date the Plan is terminated.
2) The first day of the month following the date they cease to be eligible under the plan.

The Plan Administrator is required to provide Plan Members with the opportunity of purchasing up to 3 months additional coverage under the Plan, once eligibility for this plan automatically ends.

A former Employee who is re-hired after a break of more than 6 months, will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements.

(I) ADMINISTRATIVE PROCEDURES

RESPONSIBILITIES FOR PLAN ADMINISTRATION

A Plan Participant should contact the Plan Administrator to obtain additional information (free of charge) about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

Duties of the Plan Administrator (CINICO)

1) To administer the Plan in accordance with its terms.
2) To interpret the Plan, and refer any ambiguities, inconsistencies or omissions to the Eligibility or Medical Board.
3) To prescribe and communicate procedures for filing a claim for benefits and to review claim denials.
4) To keep and maintain the Plan documents and all other records pertaining to the Plan.
5) To appoint a Third Party Claims Administrator or to pay claims internally.
6) To delegate to any person or entity such powers, duties and responsibilities (in relation to the administration of claims), as it deems appropriate.
7) To provide Plan Participant communication literature and whatever instruments deemed necessary to administer the plan.

Additional Service Expectation of Plan Administrator

1) The Plan and a summary of the Plan to be negotiated & agreed annually, prior to the commencement of the fiscal year to which it relates.
2) The provision of management report on trends and salient issues from preceding six months, to be provided twice annually.
3) The provision of a dedicated claims line with a well publicized contact number.
4) The provision of a short communication document summarizing the contents of this document for distribution to Plan Members, updated on an annual basis.
5) Publishing, as part of this agreement, their service level agreement including time-frame for claims and quality checks for suppliers.
6) For Emergency Medical Treatment Overseas la) provide and publish 24 hour emergency phone numbers for pre-certification within 48 hours: lb) provide an alternate certification route in the event of an indicent which prohibits pre-certification within the 48-hour time line.
7) Make publically available for Plan Participants the list of medical institutions within CINICO's Preferred Provider Network (for the time being) in respect to approved medical referrals (within the Cayman Islands and overseas).
8) The provision of cards: A CINICO card will be provided for each Plan Participant on joining the scheme and when appropriate on a change of circumstance. Lost or stolen cards will be available at a charge of $10 to the Plan Participant. Malfunctioning cards will be replaced free of charge.

DISPUTE RESOLUTION

Dispute resolution in relation to this Plan and its administration, will be conducted at the lowest possible stage of the following three stages:

Stage 1: Resolution at operational level - between authorised representatives of the Risk and Appeals Committee of CINICO.
Stage 2: Resolution at strategic level - Chief Officer Ministry of Health, Chief Officer PoCS and the Chairman of CINICO.
Stage 3: Resolution at external level - the Health Insurance Commission.

PLAN FUNDING & BILLING- Please see separate billing document.

CLAIMS PROCEDURE

CINICO designs and agrees with the client a claims procedure, including an appeals mechanism. It also designs and agrees methods of publicizing the procedure to Plan Members.

- Employees must submit claims within 180 days of the date the charges were incurred;
- CINICO will acknowledge claims within 48 hours of receipt;
- Decisions on claims to be settled within 30 calendar days. Any decisions which exceed this time to be reported within quarterly reports provided to PoCS.

Where a Plan Member has had to self pay, they must submit a receipt for reimbursement.

CASE MANAGEMENT SERVICES - Overseas referral

The following is the procedure which must be adhered to in order to avoid denial of reimbursement from the Plan following an overseas referral. These procedures must be adhered to whether this Plan is considered the primary or secondary payer.

Overseas referral process

(1) CINICO to agree process for overseas referral with Chief Medical Officer.
(2) All overseas care must be pre-certified.
(3) Patients are required to sign a medical release form before traveling overseas.
(4) Plan Participants are permitted to choose any facility for overseas care.
    (a) If the facility of choice is outside of the CINICO Preferred Provider Network, the Plan Participant will be responsible for 10% of billed charges.

COORDINATION OF BENEFITS

The Plan Member must provide additional information, relating to themselves and dependents, to permit co-ordination of benefits. CINICO is to co-ordinate benefits to minimize costs to the Plan.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes, will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

Any under/over-payment occurring under the adminstration of this Plan will be refunded/paid to the relevant individual or institution once the error has been identified during the next invoice period.

LEGAL SECTION

SUBROGATION AND THIRD PARTY RECOVERY

When this Provision Applies The Plan Participant may incur health care charges due to injuries caused by the act or omission of a third party, or a third party or a third party's insurer may be responsible for payment. In such circumstances, the Plan Participant may have a claim against that third party, or insurer, or both for payment of the health care charges. Accepting benefits under the Plan for such incurred health care expenses automatically assigns to the Plan any rights the Plan Participant may have to recover payments from any third party or insurer. This subrogation right allows the Plan to pursue any claim which the Plan Participant has against any third party, or insurer, whether or not the Plan Participant elects to pursue that claim. The Plan may make a claim directly against the third party or insurer, but should the Plan elect not to pursue a claim, the Plan has a lien on any amount recovered by the Plan Participant whether or not designated as payment for health care expenses. This lien shall remain in effect until the Plan is repaid in full.

The Plan Participant:

1. automatically assigns to the Plan his or her rights against any third party or insurer when this provision applies: and
2. shall repay to the Plan the benefits paid to him or her, or on his or her behalf, out of any recovery made from the third party or insurer in respect of the specific coverage provided by the Plan.

Amount Subject to Subrogatton or Refund The Plan Participant agrees to recognize the Plan's right to subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all recoveries and funds paid by a third party to a Plan Participant relative to Injury or Sickness for which the third party or insurer is responsible to pay. These rights include a priority over any claim for health care charges, attorney fees, or other costs and expenses. Accepting benefits under the Plan tor incurred medical or dental expenses automatically assigns to the Plan any and all rights the Plan Participant may have to recover payments from any Responsible Third Party.
Notwithstanding its priority to funds, the Plan's subrogation and refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for health care charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan is required to file suit in order to recover payment for medical or dental expenses recovered by a Plan Participant from a third party or insurer and not thereafter repaid to the Plan in accordance with these provisions.

For the avoidance of doubt, the Plan Participant (a) shall not be liable to repay the Plan any amount in excess of the amount, if any, recovered by the Plan Participant from the third party or insurer: and (b) shall not be liable to repay the Plan for any amounts recovered from the third party or insurer that are not directly related to the specific coverage provided by the Plan.

When a right of recovery exists, the Plan Participant will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of subrogation as a condition to having the Plan make payments. In addition, the Plan Participant will do nothing to prejudice the right of the Plan to subrogate.

Conditions Precedent to Coverage The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Plan Participant if a Plan Participant refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights.

Recovery from another plan under which the Plan Participant Is covered This right of refund also applies when a Plan Participant recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator The Plan Administrator has a right to request reports on and approve of all settlements, provided that approval of any settlement in respect of benefits paid to or on behalf of any Plan Participant shall entitle the Plan to recover only the amount agreed. For the avoidance of doubt, the Plan shall hold the Plan Participant wholly exempt and fully indemnified in respect of any shortfall in the settlement recovery against benefits it has paid to, or on behalf of, the Plan Participant.

Notice of Other Coverage As a condition of receiving benefits under this programme, the Employee must notify the Claims Administrator of:

1. Any legal action or claim against another party for a condition or injury for which the Plan paid benefits: and the name and address of that party's insurance carrier.
2. The name and address of any insurance carrier providing personal injury protection (PIP), underinsured motorist, uninsured motorist, or any other insurance under which the Employee is or may be entitled to recover compensation.
3. The name and address of any other group insurance plan under which the Employee is covered.

FALSE OR MISLEADING STATEMENTS

If any benefits under the plan are paid in error due to false or misleading statements knowingly and willfully made by the Plan Participant or any person on his behalf, the Plan shall be entitled to recover those amounts from the Plan Participant. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if it is required to file suit in order to secure repayment of such benefits erroneously paid.

REIMBURSEMENT/RECOVERY

The Plan has the right to recover amounts it paid that exceed the amount for which it was liable. Such amounts may be recovered from the employee or any other payee, including a provider. Such amounts may also be deducted from future benefits of the employee or any of his or her dependents (even if the original payment was not made on that enrollee's behalf) when the future benefits would otherwise have been paid directly to the employee or to a provider that does not have a contract with the Plan.

LIABILITY

Neither the Employer, nor the Plan Administrator nor the Third Party Claims Administrator, nor their agents or employees shall be liable for any of the following:

I . Situations such as epidemics, disasters, or other causes or conditions beyond their control that prevent Plan Participants from obtaining the benefits of this contract.

2. The quality of service or supplies received by Plan Participants since all those who provide care do so as independent contractors.

3. The regulation of the amounts charged by any provider outside of the CINICO Preferred Network, since all those who provide care do so as independent contractors.

4. Any fault, act , omission, negligence, misfeasance or malpractice on the part of any hospital, or other institution , any agent or employee thereof, or on the part of any physician, health

care professional, pharmacist or other person participating in or having to with the care or treatment of the Plan Participant.

5. Amounts in excess of the actual cost of services and supplies.

6. Amounts in excess of this Plan's maximums. This includes recovery under any claim of breach.

7. General damages including, without limitation, alleged pain, suffering or mental anguish.

8. Inaccurate and unapproved descriptive materials. The Plan Administrator will indemnify, defend and hold the Claims Administrator harmless from any claims, damages, judgments and expenses (including attorney's fees) based on or arising out of, directly or indirectly, descriptive materials written, created, designed or printed by any third party when such descriptive materials are used without the Plan Administrator's prior review and written approval and inaccurately reflect any of the terms, conditions and/or provisions of this contract.

The term "descriptive materials" includes, without limitation any type of circular, leaflet, booklet, summary, handbook, letter or form that describes in whole or in part any of the terms, conditions and/or provisions of this contract.

WAIVER AND ESTOPPEL

No term, condition or provision of the Plan shall be waived and there shall be no estoppels against the enforcement of any provision of the Plan, except by written direction of the Plan Administrator. No such waiver shall be deemed a continuing waiver unless specifically stated. Each waiver shall operate only as a specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

DISCLOSURE AND PRIVACY

The enrollment application authorizes any provider to release information about the Employee that is required to process applications or claims to the Claims Administrator when requested. The enrollment application also authorizes any person or organization, including an insurance company, to release to the Claims Administrator any information that is or may reasonably be material to a claim for benefits under this programme.

For the purposes of determining the applicability of and implementing the terms of this Plan or of any other Plan, the Plan Administrator or Claims Administrator may without the consent of, or notice to, any person release to any individual, insurance company or other body corporate any information which the Plan Administrator or Claims Administrator deems necessary to be released for the purposes of reviewing, settling or adjudicating any claim for benefits under this Plan.

Benefits under this plan will not be provided if the Employee does not permit access to material records or fails to furnish to the Plan Administrator or Claims Administrator such information as may be necessary to implement this provision.

The Plan Administrator or Claims Administrator shall not disclose personal information about the Employee for any purpose other than that of carrying out the Plan Administration functions and as required by the laws of the Cayman Islands .

NOTICES

All payments or notices of any kind to Employees, Participants, beneficiaries or Plan Officials may be mailed to the address for that person last appearing on the records of the Plan Administrator. When such a notice is mailed by first class mail, it is deemed to have been:

a. Duly delivered into the custody of postal officials on the date post marked; and

b. Duly received by the addressee five (5) calendar days after being deposited, postage prepaid, Mail.

When such a notice is delivered in person, it is deemed to have been received on the same day as delivery. Each Plan Member must keep the Employer/PSPB notified of his current address. If there is any doubt about the accuracy of an address, the Plan may give notice , by registered mail, to any such Plan Member's last recorded address, that payments and other mail are being withheld pending receipt of a proper mailing address from that person.

ASSIGNMENT

All rights to the benefits of this Plan are available only to enrollees. The Plan will not honor any attempted assignment, garnishment, attachment or transfer of any right of this Plan.

At its option and in accordance with the laws of the Cayman Islands in which the Plan Document was issued, the Plan may pay the benefits of this programme to the employee, provider, other carrier, or other party legally entitled to such payment. Such payment will discharge the Plan's obligation to the extent of the amount paid so that the Plan will not be liable to anyone aggrieved by its choice of payee unless such payment is made in error or unless a competent Court orders otherwise.

MODIFICATIONS

The enrollee shall not be entitled to rely on any oral statement from an employee of the Plan Administrator or Claims Administrator (including but is not limited to an oral statement from a customer service representative) where such oral statement purports to:

1. modify or otherwise affect the benefits, general limitations, exclusions, or other provisions of the Plan, or
2. Increase, reduce, waive or void any coverage's or benefits under the Plan.

In addition, the enrollee shall not be entitled to rely on such oral statement(s) in the prosecution or defense of a claim under the Plan.

GOVERNING LAW

The Plan will be construed and enforced in accordance with the laws of the Cayman Islands.

(J) ADOPTION OF THE PLAN DOCUMENT

Adoption
The PoCS. on behalf of the Cayman Islands Government hereby adopts this Plan Document as the written description of its employee welfare benefit plan (the "Plan"). This Plan Document replaces any prior statement of the Plan and is effective on the date shown below.

Purpose of the Plan
The purpose of the Plan is to provide certain benefits for eligible participants. The benefits provided by the Plan are as listed in the **General Plan Information** section.

Conformity with Law
If any provision of this Plan is contrary to any law to which it is subject. such provision contained in this Plan is hereby declared null and void in such much as it is necessary to conform to such law.

Participating Employers
Employers participating in this Plan are as stated in the section entitled **General Plan Information.**

Acceptance of the Plan Document
IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument (pages 1 - 29 inclusive) to be executed, effective as of 1st July, 2013.

Cayman Islands Government Group 30100 Plan 3010001

Signed by:

Signed by:	
Chief Exective Officer on behalf of CINICO	Acting Chief Officer on behalf of PoCS
Date: 30/8/2013	Date: 30th August 2013
Witness Signature:	Witness Signature:

Appendix A

CURRENT ENROLLMENT PROCEDURES

New Employees and their Dependents

1. Eligibility for Plan benefits for Employees and Dependents will be negotiated as part of the recruitment and selection process and documented in the Employee Agreement.
2. The required supporting documentation must be provided by the Employee as part of their pre/new employment administration.
3. The Ministry/Portfolio/Department must ensure entry of relevant information into the HRIRIS system on commencement of employment.
4. Information regarding Plan eligibility will be automatically transferred electronically to CINICO's NHIS database, and CINICO will produce and distribute CINICO cards for the Employee and Dependent(s).

Existing Employees and their Dependents

1. Employees must notify their Department immediately of changes to their circumstance or that of their Dependents impacting eligibility for Plan benefits. This is required under Schedule 1 Section 13(1) (b) of the Personnel Regulations. The table below identifies the supporting documentation needed to support each request. A **Change Of Circumstance Form** must be completed and submitted in each case.
2. The Ministry/Portfolio/Department must consider whether the request requires a variation to the employee's terms and conditions and must issue an amendment to the Employee Agreement where a contractual change is being authorized.
3. The Ministry/Portfolio/Department must ensure the update of relevant information into the HRIRIS system with immediate effect.
4. Updated HRIRIS information regarding Plan eligibility will be automatically transferred electronically to CINICO's NHIS database and CINICO will produce/distribute/deactivate CINICO cards as appropriate.

Change of Circumstance	Supporting Documentation
Marriage	Marriage Certificate and Spouse's Birth Certificate
Becoming a step-parent	Marriage Certificate and child's Birth Certificate
Birth of Child	Child's Birth Certificate DNA test results where a male employee is not listed as the parent of the child on the Child's Birth Certificate.
Adoption of Child	Adoption Certificate Child's Birth Certificate (If adoption is accompanied by a name change see name change section below)
Child aged 18 to 23 in full-time education	Proof of enrolment in full-time course at school/university
Marriage of child aged 18 to 23 in full-time education	Marriage Certificate
Child under 18 commencing employment	Letter from employer identifying child is covered for medical benefits under the employer
Death of Spouse of Child	Death Certificate
Divorce	Dissolution of Marriage Certificate (If divorce is accompanied by a name change see name change section below)
Name Change	Copy of Deed Poll
Change of Postal Address	Nothing in addition to the Change of Circumstance Form

Dependent Offspring of Existing Employees (optional at the expense of the member and with prior approval).

1. Employees must request eligibility for Plan benefits for Dependent Offspring from the Ministry/Portfolio /Department.
2. The Ministry/Portfolio/Department (in conjunction with PoCS) must consider whether or not a Dependent Offspring can be added to the Employee's Plan in accordance with the policy of the PoCS.
3. The Ministry/Portfolio/Department must ensure entry of relevant information into the HRIRIS system (including salary deductions where appropriate).
4. Updated HRIRIS information regarding Plan eligibility will be automatically transferred electronically to CINICO's NHIS database and CINICO will produce and distribute CINICO cards as appropriate.

Terminated Employees and their Dependents/Dependent Offspring

The Employer will be responsible for maintaining and timely furnishing to CINICO, current and accurate Plan eligibility.

1. Changes affecting the status of any of the Plan Participants must be submitted to CINICO within 10 business days after the Employer becomes aware of any such change.
2. CINICO will not be responsible for errors or omissions arising out of the failure to maintain current and accurate eligibility data held on HRIRIS.
3. In the event of retrospective changes in status of more than 30 days, CINICO reserves the right to seek recovery of paid claim(s) from the Ministry/Portfolio/Department.

New Retirees and their Dependents

1. On the retirement of a Plan Participant from the Civil Service (who was entitled to a Pension, or was already a member of the Public Service Pension Scheme that he/she can now claim under, and the Government was their principal employer for at least 10 consecutive years), PSPB will enter the pensioner's details (and their Dependents) onto the NHIS database.
2. In cases where the eligibility conditions detailed above appear not to have been met, the pensioner may be referred to PoCS to determine whether PSPB should still add them to the NHIS database. PSPB will only act in these cases on the written instruction of PoCS.
3. Once CINICO cards have been received, PSPB will contact the pensioner for pick up.

Amending Retiree (pensioner) and Dependent Details

1. Upon notification of changes to a Retiree's circumstances and on receipt of required documentation, PSPB will make the necessary amendments to the NHIS database.
2. If the amendment requires new CINICO card(s) to be issued, then PSPB will contact the Retiree/pensioner on receipt of the card(s) to arrange pick up.
3. If the maximum age is reached for Retiree's Dependents, or notification is received that their Dependents have ceased to be in full time education, then their Dependents will be end dated by PSPB on the NHIS database.