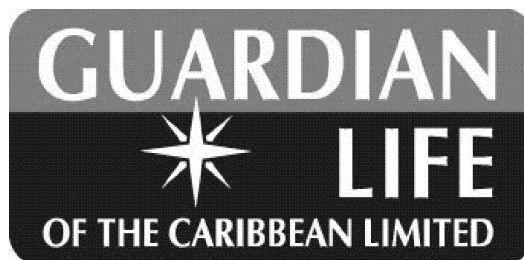


# Nem **Care** PROPOSAL



*Looking After Life*  
*A Member of the Guardian Holdings Group*

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## **Mission Statement**

*We commit to build on our tradition of integrity by being the dominant provider of personal financial services in the markets where we operate in terms of financial strength, quality service and professionalism, in a manner beneficial to our customers, agents, employees, shareholders and the wider community.*

## **Core Values & The Guardian Spirit**

*Integrity, Quality, Growth, Serving People*



**Guardian Life of the Caribbean Limited** introduced another health product, **NEMCare**, to the Caribbean Market.

NEMCare is committed to forging alliances with top health care providers and administrators worldwide.

Through its product NEMCare, Guardian Life of the Caribbean Limited will be offering a Preferred Provider Organization Plan to its members. The NEMCare network of Preferred Provider Organizations (PPOs) include qualified and experienced medical practitioners and specialist, hospitals, pharmacies and laboratories. When a PPO network provider is used there is very little out of pocket expenses.

An air ambulance benefit for Overseas Emergency Medical Treatment will also form part of the PPO plan.

**Under the NEMCare umbrella, there are 2 Health Plans available to you, they are:**

- ◆ Individual Health Plan
- ◆ Group Health Plan

**Individual & Group Health Plans**

The Comprehensive Major Medical benefit plans utilize a Preferred Provider Organization Network (PPO) to maximize benefits while offering the covered person/persons the choice of selecting non- Preferred Providers subject to a reduction in benefits.

## **Benefits of Our NEMCare Product**

- Choose your own health Care Providers
- Waive Deductibles for treatment within Network
- Minimum up-front payment for medical treatment
- Virtually eliminate claim forms for services received in Network
- Receive lifetime coverage at reduced benefits
- Dramatically reduce out-of-pocket cost
- Receive student coverage while attending school abroad



## NEMCare Covers

- A Choice of Major Medical Maximum Benefits:
  - BD\$250,000.00
  - BD\$500,000.00
  - BD\$1,000,000.00
  
- Preventative Care
- Immunizations
- Maternity And Postnatal Care
- In-Patient Services
- Outpatient Services including surgery
- Doctors/Specialists' Visits
- Emergency Treatment
- Ground and Emergency Air Ambulance
- Durable Medical Equipment Air Ambulance
- Laboratory Services
- Prescription Drugs
- Chemo/Radiation and Renal Dialysis Therapy
- Psychiatric Care, Substance Abuse and Mental Illness Treatment
- Private Nursing
- Dental
- Vision
- Emergency Overseas Benefit

The plans utilize pre-certification (Pre-certification of services is a feature that reviews medical appropriateness of certain procedures and utilization management procedures that must be followed to maximize benefits and avoid penalties.



# **GENERAL PROVISIONS**

## **EFFECTIVE DATE**

Health care benefits under this Plan are available to you effective the date your coverage has been approved.

## **ELIGIBILITY – EMPLOYEES**

All full-time employees under age 65, who are in active employment on the effective date, are eligible to join the Plan immediately. Other full-time employees who are employed after the effective date of the Plan will be eligible to join the Plan after completing their probationary period.

## **ELIGIBILITY – Actively at work age 65 and over and Retirees**

All fulltime employees who have attained the age of 65 years and are still actively at work or will retire on the attainment of age 65. Persons should be employed with the company for no less than 10 years. (this benefit is optional and should be requested by the company.) The major medical maxim will be reduced and the premium adjusted accordingly.

## **ELIGIBILITY – DEPENDENTS**

At the time of joining the Plan, **an employee may register his/her spouse** (a registered common-law wife or husband will be eligible). Any **unmarried children** (including legally adopted children and step-children) **must be under nineteen (19) years of age**. Unmarried dependant children, who **are full-time students at a university or any Institute of higher learning**, will be covered **up to age 25** upon receipt of application.

If you acquire a dependant after the effective date of your registration, you may enroll your dependent in the Plan without providing Evidence of Insurability. Application must be made within thirty-one (31) days of becoming eligible for dependent coverage. (Applicable to large groups only)

No medical examination or other evidence of insurability will be required of you or your dependents if you enroll for the membership within thirty-one (31) days after the date you become eligible. If you do not enroll within thirty-one (31) days from the date you become eligible, evidence of insurability covering you or your dependents will be required. **The full cost of such medical examination will be at your expense.**

Eligible members who are not in the country at the time of registration are required to join the Plan upon their return. If your dependent is confined at home, in a hospital, nursing home, or convalescent home or elsewhere due to sickness or injury on the date his/her coverage would otherwise become effective, his/her coverage will not become effective until he/she ceases to be so confined and is no longer disabled.



A dependent child who has attained the age of nineteen (19) and is physically or mentally incapable of maintaining himself, is eligible to be in the plan, provided evidence of such incapacity is furnished to the Company.

#### **CHANGE IN FAMILY STATUS**

To make sure your dependants are properly registered, you should report any changes in dependents promptly to the Company.

#### **RECURRING DISABILITY**

All bodily disorders existing simultaneously which are due to the same or related causes will be considered one disability. A disability recurring within a period of three (3) months will be considered a continuation of the same disability.

## **GENERAL INFORMATION**

### **TERMINATION OF COVERAGE**

#### **EMPLOYEE**

Your coverage will cease on the earliest of the following events:

- (1) On the date you terminate your employment.
- (2) On the date the Plan terminates.
- (3) On the date you die.
- (4) On the date you attain age 65.

#### **DEPENDANT**

Coverage for your dependents will cease on the earliest of the following events:

- (a) On the date your coverage terminates
- (b) On the date the dependent is no longer eligible, i.e. age 19 unless proof of attendance at University or any higher educational institution is provided. Coverage will then be provided up to age 25.
- (c) On the date the dependent becomes covered as an employee under the Plan.
- (d) On the date a dependent child gets married or enters into a common-law relationship.

## **ELIGIBLE EXPENSES**

Eligible expenses are restricted to the following items as per schedule:

- (1) Hospital/Nursing Home charges for Room & Board.
- (2) Hospital charges other than Room & Board, incurred as an inpatient, for necessary medical or surgical treatment e.g. medical supplies, operating room, injections.
- (3) Hospital charges incurred as an outpatient for necessary medical or surgical treatment or for pre-and post-admission testing when provided in accordance with the hospitals formally adopted programme.
- (4) Hospital or physician charges, incurred as an in-patient or outpatient, for the administration of anesthetics.
- (5) Professional services of a physician.
- (6) Professional services of a graduate registered nurse when medically necessary, who is not related to the employee nor ordinarily resident in the employees home.
- (7) Professional services of a licensed physiotherapist when recommended by a physician (except any such physiotherapist who is related to the employee).
- (8) Diagnostic procedures, radiology, oxygen and blood transfusions.
- (9) Charges for necessary licensed ground ambulance services to and from a local hospital.
- (10) Oxygen, rental of durable medical equipment (including wheel chairs) required for temporary therapeutic use.
- (11) Dental treatment (excluding orthodontia and periodontia), which is the direct result of an accidental injury to sound natural teeth and is rendered within 90 days of the accident.



- (12) Drugs, sera and injectibles available only by a prescription when prescribed by a physician.
- (13) Charges for routine nursery care for a child older than 14 days of age.
- (14) Regular ambulance service to and from a local hospital provided by a licensed ambulance service
- (15) Fees of a licensed dentist for accidental injury to natural teeth where services are performed within six months of the injury.
- (16) Expenses incurred for pregnancy, childbirth, miscarriage, pre-natal and post-natal care up to the limits show in the Benefits Schedule. However, in the case of severe complications any expenses for services rendered due to such complications will be considered under the Major Medical Maximum.
- (17) **MEDICAL TREATMENT ABROAD.** Unless it is proved to the satisfaction of the Company prior to treatment that such medical treatment is not available locally and that such treatment abroad was recommended by two physicians, at least one of whom shall be a Specialist Physician in that particular field of medicine to which the disability applies. Prior approval must be given, by the Company for payment of overseas treatment. If such overseas treatment does not meet the above conditions, the payment will be made according to local charges.
- (18) **EMERGENCY AIR AMBULANCE BENEFIT – (IF STATED ON THE SCHEDULE OF BENEFITS)**

If as a result of bodily injury or illness a Covered Person incurs expenses for Emergency Medical Air Transportation to an overseas destination for emergency medical treatment, provided injury or illness made the insured non-ambulatory and they required medical facilities or specialized treatment is not available in the country where the injury or illness occurred the Company agrees to the cost of such service.

It is further provided that the Company would pay for the cost of such if the Company's Medical Consultant authorizes treatment to a Medical Facility in another country. Provided also that travel on a commercial air carrier even on a stretcher accompanied by a staff member is impossible, and the illness or injury requires the special in-flight medical care provided on an Air Ambulance aircraft with special medical equipment and supplies on board with specially trained medical personnel.

The Company's authorized Air Ambulance carrier is **air Ambulance Professionals Limited.**



## **INELIGIBLE EXPENSES**

### **The plan will not pay for: -**

- (1) Expenses incurred when not under the care of or authorized by a physician or charges of an institution/physician for whose service payment is not required in the absence of a medical plan.
- (2) Expenses incurred as a result of: -
  - (a) Intentionally self-inflicted injuries while sane or insane;
  - (b) riot, civil commotion, insurrection, war or any act incident thereto, whether war be declared or not provided that the registered member was participating;
  - (c) Occupational injuries or sickness covered by Workmen's Compensation or Occupational Disease Law.
- (3) Expenses incurred for which no charge is or would have been made in the absence of a medical plan.
- (4) Administrations of vaccines or infections for immunization whether administered by a physician or other health care professional except under the Preventative Health Care Benefit.
- (5) In-Vitro fertilization or any treatment or operation to induce pregnancy.
- (6) Tubal ligation or resection if preferred for the purpose of sterilization vasectomies or any other means of Birth Control for contraception.
- (7) Cosmetic or Plastic Surgery except to the extent required for the repair of damages or the alleviation of damage to any member of the Medical Plan caused by accidental bodily injuries and provided that Surgery is performed **within 6 months of such accident** or the correction of congenital abnormalities, or abnormalities in a child who is a covered dependent and is born while covered under the Plan.
- (8) Periodic Health Examinations or Examinations required by a third party, medically unnecessary services, treatment of any condition not causing sickness or not resulting from bodily injury.
- (9) Charges levied by a physician for his/her time spent traveling, broken appointments, his/her transportation cost, or for advice given by him/her by telephone or other means of telecommunication.
- (10) Pregnancy of a dependent child.
- (11) Treatment for infertility / Loss of Libido



## **MATERNITY EXPENSE BENEFIT**

This benefit applies only to female employees and enrolled wives and in the case of common-law relationships, enrolled spouses of employees. It does not apply to dependent children.

This benefit provides for the payment of eligible expenses incurred as a result of pregnancy (which term includes resulting childbirth, miscarriage or abortion) subject to the following conditions and the amount shown in the Schedule of Benefits' page.

Eligible maternity expenses include hospital, surgical and medical expenses incurred for pre-natal care, delivery fees, hospitalization and obstetrical operations, if necessitated by pregnancy.

## **CO-ORDINATION OF BENEFITS**

If you or any of your dependents are covered under any Group Plan, the benefits will be co-ordinated with this Plan so as to provide maximum benefits to cover the expenses incurred. The coverage, which is determined to be primary, will pay its normal benefits, and the secondary coverage will pay the lesser of either its normal benefits or 100% of the total coverage.

The co-ordination of benefits provision operates to reduce benefits under this coverage only if the claimant would otherwise receive benefits, which exceed 100% of the expenses claimed under all coverage.

### **RECOVERIES**

In the event that the Dependent uses our Preferred Provider Network and the company is the secondary carrier, recovery of benefits used would be claimed from the primary carrier.

### **SERVICES THAT REQUIRE PRECERTIFICATION**

Pre-certification of services is a feature that reviews medical appropriateness of certain procedures. The Company requires that the following services are authorized by the Company prior to scheduling:

- All non-emergency In-patient Admissions
  - Outpatient Surgical Procedures
  - Transplants
  - Operative and Diagnostic Endoscopies
  - MRI Scans
  - CAT Scans
  - Out-patient Therapies
  - Private Duty Nursing



- Psychiatric, Substance Abuse and Serious Mental Illness Treatment
- Rental of Durable Medical Equipment
- Prosthesis

## **EMERGENCY**

Surgery, diagnostic and other listed procedures performed during any emergency, as determined by the Company, do not require Pre-Certification.

However, the Company should be notified within two (2) business days of emergency services for those procedures listed herein.

## **PREFERRED PROVIDER ORGANIZATION**

The Company provides a network of preferred providers for convenient access to medical services for plan members. This Preferred Provider Organization offers a selection of Doctors, Dentist, Pharmacist, Opticians, Laboratories, X-Ray Units and Hospitals. When a network provider is used there is a co-payment.

The list of Providers is attached. This list will be reviewed and updated periodically.

When visiting any of the network providers you are required to present your Medical Identification Card and also an additional form of identification (i.e. ID Card, Passport, Driver's License).

**You are required to pre-certify non-emergency hospital admissions. The company would notify you of the covered amounts and your co-payment.**

### **HOW TO CLAIM**

For out of Network visits special Medical Claim Forms are available from your Plan Administrator. Your doctor should complete the back of the claim form indicating services provided for **each symptom**, date of service and fee for the service. The front of the Medical Claim form should then be completed by you and submitted to the Company for reimbursement.

For In-Network visits you are to sign for the service and the Doctor completes and sends the claim forms to us.



## **DENTAL CARE BENEFITS**

Eligible expenses incurred by you or your dependent, if applicable, are covered only when the dentist's proposed course of treatment has been submitted to and reviewed by the Company and returned to the dentist showing the covered amounts.

A Treatment Plan is the dentist's report that (a) itemizes the recommended services; (b) shows the charge for each service, and (c) when requested by the Company, is accompanied by supporting pre-operative X-rays.

Pre-determination of benefits permits the review of the proposed treatment in advance and allows for resolution of any questions before, rather than after the work has been done. Additionally, both you and the dentist will know in advance what is covered and payable under the Plan.

### **BENEFIT PROVISION**

The benefit will reimburse you for Covered Dental Charges for necessary dental care and treatment by a legally qualified dentist, subject to the maximum benefit stated in the Benefit Schedule.

### **MAXIMUM BENEFIT**

The Maximum Benefit applies to each covered person in each calendar year.

### **ELIGIBLE EXPENSES**

Eligible expenses shall be:

#### **LEVEL 1 – Preventive**

1. Oral examinations including scaling and cleaning of teeth, but limited to one examination in any one (1) six-month period.
2. Dental X-Rays.
3. Application of fluorides and other anticariogenic substances, but limited to one (1) application in any one (1) 12-month period

#### **LEVEL 2 – Restorative**

1. Initial provision of amalgam, silicate, acrylic, synthetic, porcelain or composite restorations.
2. Replacement of amalgam, silicate, acrylic, synthetic, porcelain or composite restorations, provided that, unless an additional tooth surface is involved, a



continuous period of at least 12 consecutive months has elapsed since the date on which the restoration was last provided or relapsed.

3. Extractions (except for orthodontia).
4. Treatment for periodontal and other diseases of the gums and tissues of the mouth.
5. Initial provision and installation of space maintainers.
6. Drugs and medicines requiring the written prescription of a dentist and dispensed by a licensed pharmacist.
7. Oral surgery of a dental origin (except for orthodontia).

### **LEVEL 3 – Major Restorative**

1. Endodontic Treatment (including Root Canal Therapy).
2. Initial provision of crowns and gold inlays and onlays, provided that the tooth is broken down by decay or traumatic injury, so that the tooth structure cannot be restored with an amalgam, silicate, acrylic, synthetic, porcelain or composite restoration.
3. Replacement of gold inlays or onlays provided that the tooth is further broken down by decay or traumatic injury and only if:
  - (a) The tooth structure cannot be restored with an amalgam, silicate, acrylic, synthetic, porcelain or composite restoration.
  - (b) An additional tooth surface is involved, or
  - (c) A continuous period of at least 12 consecutive months elapsed since the date the gold inlay or onlay being replaced was last provided or replaced.
4. Initial installation of full dentures, partial dentures, or fixed bridgework provided that the appliance is required to replace one or more natural teeth at least one of which was extracted after the individual's effective date of coverage.
5. Relining of, or any adjustments required, to be made to new dentures provided that a period of at least 12 months has elapsed since the date the dentures were last provided.
6. Repair of dentures.



7. Addition of teeth to existing dentures or fixed bridgework provided that such addition is required to replace one or more natural teeth, at least one of which was extracted after the individual's effective date of coverage under Level 3 (Open Space Limitation).
8. Replacement of:
  - (d) An existing full denture.
  - (e) An existing partial denture.
  - (f) An existing fixed bridgework.

#### **DEFINITION OF ELIGIBLE CHARGE**

An eligible charge is a charge the dentist makes to you for a covered dental service furnished to you or a covered dependent, provided the service: -

1. Is in the List of Dental Services shown under Level 1,2 or 3
2. Is part of a Treatment Plan as described above, and
3. Is not excluded by the section "Charges Not Covered"
4. Charge will be considered to be incurred on the date the service is received, rather than on the date the charge is made

#### **CHARGES NOT COVERED**

In addition to the general limitation under the Medical Plan, no amount is payable under this Benefit for charges incurred as follows: -

1. Services or supplies, which are not prescribed by a dentist or performed by a dentist or dental hygienist.
2. For education or training in, and supplies used for dietary or nutritional counseling, personal or oral hygiene or dental plaque control.
3. For procedures, appliances and restorations used to increase vertical dimension or to restore occlusion
4. For replacement of dentures which are mislaid, lost or stolen.
5. For or in connection with orthodontic treatments, including correction of, malocclusion unless orthodontic treatment is included in the Benefit Schedule.



6. For a course of dental care, which commenced prior to the effective date of an insured individual's insurance under this Benefit, including charges for any crown, bridge or denture ordered prior to such date.
7. For devices and supplies which are for cosmetic purposes or for experimental treatment or for unnecessary crown, bridges or dentures. Where a dental procedure is performed for both functional and cosmetic purposes, that part of the procedure performed for cosmetic purposes will be excluded.
8. For failure to keep scheduled dental appointments or for completion of any insurance form.
9. For pulp vitality tests, study models or precision attachments.
10. For replacement of existing prosthetic development devices unless the device has been installed five (5) or more years prior to replacement and in the opinion of the attending dentist is no longer serviceable.
11. For any extra charge made for metal dentures



## **ORTHODONTIA BENEFIT**

Upon receipt of due proof that a member incurred expenses for necessary orthodontic care by a dentist or dental surgeon, the Plan will refund the charges as specified in the Schedule of Benefits.

No payment will be made under this benefit for charges incurred for:

- (a) Orthodontic care rendered or supplied by a dentist employed by a Government or at the expense of a Government or agency thereof;
- (b) The repair or replacement of an orthodontic appliance;
- (c) Orthodontic care which is wholly cosmetic;
- (d) Any appointment that an insured person fails to keep;
- (e) A course of orthodontic care which is commenced prior to the effective date of an insured person's insurance under this benefit;
- (f) As a result of any dental disease, defect of injury arising out of or in the course of an insured person's employment.

### **HOW TO CLAIM**

For out of Network visits special Dental Claim Forms are available from your Plan Administrator. Your dentist should complete the back of the claim form indicating services provided for **each tooth**, date of service and fee for the service. The front of the Dental Claim form should then be completed and submitted to the Company for reimbursement.

For In-Network visits you are to sign for the service and the Dentist completes and sends the claim forms to us.



## **VISION CARE BENEFIT**

### **BENEFIT**

This benefit pays the amounts stated in the Benefit Schedule of eligible optical examinations and/or optical supplies performed by or prescribed by a legally qualified ophthalmologist or optometrist subject to the maximum amounts specified in the Benefit Schedule.

### **CHARGES NOT COVERED**

No amount is payable under this Benefit for charges: -

1. Which are excluded under the General Provisions of the Health Care Benefit Schedule.
2. Incurred for more than: -  
One (1) complete visual examination, including refraction, during any one 12-month period.  
  
Two (2) lenses during any one 12-month period.  
  
One (1) set of frames during any 24-month period.
3. For sunglasses, whether plain or prescription.
4. For extra charge made for plastic lenses.
5. Incurred in connection with special procedures such as orthoptics or visual training or in connection with medical or surgical treatment of the eye.

Charges payable under this benefit for contact lenses shall be limited to charges which are incurred by an individual following cataract surgery or if visual acuity in his/her better eye is not correctable to 20/70 by the use of conventional types of lenses but can be corrected to 20/70 or better by the use of contact lenses.

### **HOW TO CLAIM**

For out of Network services you must ensure that the bill submitted shows the cost of the following services separately:

- (a) Examination.
- (b) Lenses & type of lens supplied, i.e. single, bifocal etc.
- (c) Frames.