Sagicor Life

Group Health Insurance FAQs

FREQUENTLY ASKED QUESTIONS

Q IS A NEW SWIPE CARD ISSUED ANNUALLY?

No, while a new benefit card is issued on renewal, the swipe card does not have an expiry date and should be retained.

Q IS THERE A COST FOR HEALTH CARDS?

Yes. The cost is $300 each for replacement benefit and swipe cards.

Q CAN I MAKE A CLAIM IF THE DRUG LIMIT ON THE SWIPE CARD HAS BEEN EXHAUSTED?

Yes, if this is a provision under your health plan.

Q WHAT IS A DEDUCTIBLE?

An out-of-pocket expense that must be paid by the insured before the major medical benefit is payable.

Q WHY IS PRE-AUTHORIZATION REQUIRED FOR SPECIAL PROCEDURES?

Some Benefits under your Sagicor Health Plan require you to get approval and in the case of large expenses, it allows you and your Provider to know what will be covered.

Q WHY ARE OVER-THE-COUNTER DRUGS EXCLUDED?

The plan was not designed to facilitate the purchase of drugs and medication which are easily accessed over the counter, but rather those which are prescription items.

Q WHY ARE OVERSEAS PROVIDERS NOT PAID BY THE INSURANCE COMPANY?

This is a JAMAICAN dollar contract. Coverage will only be extended if the treatment of condition does not exist in Jamaica. In this instance, the benefit will be paid on a reimbursement basis and limited ti the cost of care accessed in Jamaica.

Q WHY ARE DEPENDENT CHILDREN EXCLUDED FROM MATERNITY COVERAGE?

This benefit is intended for female dependent spouse ONLY.

Q DO DENTAL AND OPTICAL BENEFITS GO INTO MAJOR MEDICAL?

Not all dental and optical benefit go into major medical. Benefits are provided under a rider attached to the medical plan with a specific limit:

Root Canal : This benefit will be covered from the medical benefit and not the Dental dollar maximum amount.

Crowns (as a result of root canal): Benefit will be paid from the medical benefit. Cosmetic conditions, eg. Restoration of shape and appearance are not covered. The number of crowns is limited to (two) 2 per year.

*Crowning is not covered under the Executive Health Plus plan

Q ARE ALL GROUP HEALTH INSURANCE POLICIES THE SAME?

No. With Group Insurance the employer selects the type of plan and terms of coverage for the company.

Q CAN AN INDIVIDUAL CONTINUE TO HAVE COVERAGE AFTER TERMINATION OF EMPLOYMENT?

For Health – You can elect to apply for an individual health plan (Executive Health, Executive Health Plus, Supreme Health).

For Life – You have the right within 30 days following cancellation to apply for an individual life insurance policy except term insurance, without disability benefits, term riders or other supplementary benefits for an amount not exceeding the amount of insurance cancelled under the policy.

Q WHO DETERMINES THE COVERAGE AND NEGOTIATES YOUR HEALTH BENEFITS?

- Your employer selects/determines the plan(s)/benefit(s) for the group which is dependent on your employer's budget and objectives.
- Plans are designed based on client's request.
- Benefit options presented to client and benefit accepted based on client's needs and affordability.

Q WHO IS ELIGIBLE FOR COVERAGE?

- Employees where the Employer is the policyholder
- Members of an Association

Q WHO IS AN ELIGIBLE DEPENDENT?

Employee's legal/common law spouse.
Unmarried natural, legally adopted and step child(ren) of husband or wife under 26 yrs. of age.

Q WHEN CAN I ADD A NEWBORN?

Newborn children are covered 14 days after birth. You should notify your employer in order to convert your membership to family coverage and to add new members to your existing family.

If you are already covered by a family plan, under HMO health care services, your newborn can be added to the plan at least 1 month prior to delivery.

Q WITH MY SAGICOR HEALTH CARD, DO I HAVE ACCESS TO ANY SAGICOR PROVIDER?

Yes.

Q WHAT IS PRE-EXISTING CONDITION?

Disease or injury for which the insured member received treatment or services or took prescribed medicine during the six (6) months immediately preceding the effective date of coverage.

Q WHAT DOES THE TERM WAITING PERIOD MEAN?

The specified time after the effective date of the coverage within which certain benefits are not payable. These include:

- Surgery
- Hospitalization
- Major tests, such as MRI's and CT Scans Specific waiting periods for various policies:

All Group policies	- 6 months (for pre-existing conditions)
Executive Health Policies	-12 months (or pre-existing conditions)

Q WHAT IS CONSIDERED AN EMERGENCY?

Emergencies are sudden onset of a life threatening condition.

Q WHAT IS R&C (REASONABLE & CUSTOMARY CHARGES):

Charges at the general level of fees usually charged for similar services or materials by other professionals or institutions within the community where the fee is charged.

Q WHAT HAPPENS IF I HAVE USED UP THE CREDIT LIMIT ON MY CARD? DOES IT MEAN THAT I HAVE NO MORE ACCESS TO PRESCRIPTION DRUGS?

No. What it means is that, for the remainder of the year you will not be able to swipe your card for drugs. You may purchase the drugs and be reimbursed by Sagicor. A detailed receipt from the Pharmacy must accompany your claim form.

However, some plans may have continuous swipe benefit' where you must satisfy a deductible before you continue to swipe.

Q WHY ARE ORIGINAL RECEIPTS IMPORTANT WHEN SUBMITTING A CLAIM?

- Prevents duplication of payments
- Maximum payable on any one claim is 100% of cost

Q CONSULTATION WITH A SPECIALIST, WHAT DOES THIS MEAN?

When your condition requires the care of a specialist, your physician will refer you to a specialist who is qualified to handle your particular problem. Unless a referral has been made by a General Practitioner, services rendered by specialists will only be covered at the primary care level.

Q MAY I GO TO ANY CONSULTANT I CHOOSE?

YES. However, consultants (except for gynaecologists and paediatricians) may be seen only on referral - (letter from your doctor). Since the majority of consultants do not allow credit, you will be required to pay upfront and claim back.

Q WHAT IS LIFETIME MAXIMUM?

The maximum amount which Sagicor will pay in benefits to an insured individual during the individual's lifetime for the health care of a covered member.

Or

Q ANNUAL LIMIT?

The maximum amount which Sagicor will pay in benefits to an insured individual during the year for the health care of a covered member. The benefit amount refreshes every year.

Q CO-ORDINATION OF BENEFITS AND DETERMINING THE PRIMARY CARRIER

If you have other insurance which also covers hospital, medical or other health care expenses, Sagicor will coordinate the refund of these benefits with your other carrier.

First, Sagicor will determine which health insurance plan of the member would be considered the primary plan and which would be considered the secondary plan. Once the covered member's primary plan is determined, the benefits that the member is eligible for under the primary plan will pay out first, then the second one will kick in to pay towards the remaining cost that the first plan didn't cover completely.

Q WHAT IS COORDINATION OF BENEFITS?

Where a client has two or more policies, then coordination of benefits is required policies may all be with Sagicor or another health insurance carrier.

Plan where insured is a covered employee of an organization would be primary, when compared to one where that employee is a dependent of a spouse.

The plan taken out first would be primary to one taken out second, where this is pertinent.

Q DETERMINING PRIMARY CARRIER

The Plan where the insured is a covered employee of an organization would be primary, when compared to one that the employee is a dependent of a spouse.

The plan taken out first would be primary to one taken out second.

Secondary carrier will pick up unpaid balance, based on statement from primary carrier -This is the only instance where an original receipt will not be required.