GEASO BENEFITS
Frequently Asked Questions & Answers – April 2014

Benefit Year

When was the last increase in GEASO benefits and premium?
August 1, 2012

Is there any change to the Anniversary date of the GEASO health plan?
YES. The new Anniversary Date is August 1st. As such the plan year now runs from AUGUST 1st TO JULY 31st, each year. Your plan benefits will be refreshed on August 1st annually.

Understanding My Benefits

Who is eligible?
All government employees employed full-time in the central and local government ministries, departments and agencies.

Contractual and temporary employees may be allowed to enroll on the scheme upon approval from their HR departments and receipt of three (3) consecutive premium payments.

Three (3) months premiums must be paid before any claims can be made by the member.

How can I enroll?
You can enroll by completing an enrollment and a salary deduction authorization form. These forms can be obtained through your HR departments or at our Business Centre's island-wide.

Please note that all enrollment and salary deductions forms must be submitted through your HR department. No enrollment forms will be accepted directly from you at our Business Centres.

For **individual enrolment**, the employee is the only person covered while **family enrolment** covers;

- you the employee,
- your spouse (married or unmarried),
- your biological or legally adopted or spouse's child/children (step-children) under 19 years old

A birth certificate and/or marriage certificate is required for your spouse and only a birth certificate is required for your child/children. In event, your child was adopted, a copy of the Legal Adoption Certificate will be required for enrollment.

Your HR department will submitted a letter along with your enrollment forms and accompanying certificates. The letter must include:

- The name of the employee
- The type of employment (i.e. Permanent/Contractual)
- The effective date of employment
- The termination date for individuals who are employed by contract.

Can I change my spouse at any time?
NO. The Plan accommodates change of spouse between the periods July 1st to October 31st, of each year. Please note that this was changed in keeping with your current anniversary of August 1st. Please note, only (1) change of spouse will be allowed during a plan year, except in the case of marriage.

I just got married; can I add my spouse to my health plan?
YES. If you are already on the **Family plan**, then your spouse can be added immediately upon completion of the Subscriber Change Request form along with the submission of your Spouse's Birth Certificate and a copy of your Marriage Certificate.

If you are on an **individual plan** you will be required to upgrade from the individual to the family plan, by completing an enrolment form & the payroll deduction form authorizing transfer to the family plan and submitting it to your pay station, along with copies of your spouse's birth certificate and the marriage certificate.

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Can I put my mother and father on my health card?
NO. Parents, grandchildren and guardians are not considered eligible dependents by the plan.

I am solely responsible for my grandchild/godchild/niece/ nephew/little brother/little sister. Can I put them on my card?
They can be put on **only if you have legally adopted these children** i.e. you have adopted the child through the Court.

Lifetime Maximum/Major Medical

What is a Lifetime Maximum?
The Lifetime Maximum, otherwise known as "Major Medical" is a predetermined sum of money which establishes a limit to the amount to be utilized during the lifetime of a subscriber and/or dependent.

What is the new Lifetime Maximum?
As at August 1, 2012 it is $2,500,000. This was increased from $500,000.

I was told of a deductible to be satisfied before reimbursement is done from the major medical. What is a deductible? What is the GEASO deductible amount? What benefits goes into Major Medical?
A deductible is an out-of the-pocket expense borne by the insured before the major medical benefit is payable. GEASO deductible per contract year is $2000.00. Benefits such as Lab/X-Ray, ECG/EKG, Ultrasound goes into Major Medical once you have utilized the allowance issued on the swipe card. Surgical procedures are also covered under Major Medical.

If the lifetime maximum amount (Major Medical) is exhausted what happens to the plan?
The plan will still be effective as basic benefits will remain accessible. However, procedures and/or treatment which require Major Medical coverage will be denied.

Full-House Benefits

I have been told that I have "Full-house" benefits. What does this mean?
The term "Full-house" describes the benefit that features one limit that is shared by the combination of dental, optical and prescription drug benefits.

The total amount can be used for dental services or optical services or prescription drugs. You can use all the benefits in any combination that you may need or find most useful.

Please note that under the Family plan, this benefit is a shared benefit. As such, one amount is allotted for the use of all members of the family on the scheme.

The total amount on the Full-house benefits can be used by one member of the family; or you can manage the benefits in any combination that you or your family may need or find most useful.

When is the Full house benefit refreshed?
This amount will be refreshed on August 1st annually.

If I don't use all the money on my card, can the balance be carried forward to the following year?
NO. There is no provision for carry forward of benefits.

Can my Major Medical be used for drugs when the money on the swipe card is exhausted?
NO. Your full house benefit is replenished on an annual basis (i.e. August 1 every year). Once the amount for the full-house benefit is exhausted, no top-ups will be given until the benefits are refreshed on August 1st. **Please note that your Major Medical does not cover prescription drugs.**

How often can my card be used for Lens/Frames or Dental Services?

- Lens – every 12 months from the last service date.
- Frames – every 24 months from the last service date.
- Dental Cleaning – every six months from the last service date.

If there is a balance on my dependent card can I use it?
There are no balances on dependent Full- house. The amount on the Full-house benefit is allocated for the use of the entire family for the plan year.

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Surgical Benefits

As a new member, I am schedule to do a surgical procedure, am I automatically eligible for coverage?

NO. You are required to serve the mandated six (6) months waiting period for surgery, major Diagnostics (MRI, CAT scan) and Hospitalization.

I am a GEASO cardholder scheduled to do a surgery that costs $800,000. How much of this expense will be covered by my health plan?

Your surgeon will be required to submit an invoice which should include an estimate of the charges, the type of procedure and the diagnosis to Sagicor's Pre-authorization Unit. We will inform your surgeon of the coverage amount within three (3) to five (5) working days.

The Pre-authorization Unit can be contacted at pre_auth@sagicor.com.

The maximum payable for surgical expenses is $500,000 per disability. Please note that this amount covers:

- Room & Board
- Hospital Miscellaneous
- (i.e. lab/prescription drugs/disposables etc.)
- Surgeon/Assistant Surgeon/Anesthetist
- Pre and Post testing, as well as follow-up visits relating to the condition.

My doctor asked me to do an MRI and CT scan. Do I have to pay the full cost?

NO. Your health plan will cover a part of the cost. Please ask your Provider to submit an estimate of the charges and also the doctor's referral to the Pre-Authorization Unit. Please note that the referral should state the reason why this test is necessary.

Maternity Benefits

Who is eligible for the maternity benefit?

Members and spouses enrolled under the Family plan and have served a waiting period of nine (9) months. All maternity related expenses, including doctor's visits, prescription drugs, diagnostic tests (i.e. labs, x-rays and ultrasounds) are paid from the maternity benefit. **Please note that you cannot receive the maternity benefit while on an individual plan.**

What is my Ante-natal benefit?

Please note that the plan pays approximately 50% of your normal delivery maximum for your antenatal care. This is done to ensure that monies are available for the payment of expenses associated with the delivery.

Is my baby covered under my health plan immediately after birth?

YES. The enrolment information (i.e. birth registration slip and completed Subscriber Change Request Form) should be submitted within 90 days after the birth of your baby. In this case, the effective date of enrolment on the plan will be the child's birth date.

If your baby is not enrolled on the plan within 90 days after its birth, then the child's enrolment will take effect on the actual date of enrolment and not from the child's birth date.

Electronic Fund Transfer (EFT)

What is Electronic Fund Transfer (EFT)?

Electronic Funds Transfer (EFT) is a system of transferring money from one financial institution account directly to another without any paper money or cheques changing hands.

What are the advantages of EFT?

The advantages to you are:-

- *It reduces the waiting period to receive payment.*
- *It eliminates the need to visit your bank to encash or lodge claim cheques*
- *It reduces incidents of lost/stale dated cheques which also eliminates the current* ***$600.00*** *replacement charge for stale dated cheques.*
- *It eliminates time and transportation cost in collecting cheques.*
- *Provides immediate access to funds as there is no waiting time for cheque clearing.*

Will Sagicor charge me to have money sent directly to my account?

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NO. Sagicor will not charge you to send funds to your account and most banks will not charge you for receiving payments by EFT. You can confirm with your particular bank to determine if there are any charges.

How do I authorize that my claim payments are sent directly to my account instead via cheque?
You can visit any of our branch offices islandwide and complete the EFT request form. Upon receipt, your account information will be added to your policy immediately. Due to the confidentiality of your information, your account information is only accessible by authorized personnel internally.

If you can deposit money into my account, what is to stop you from taking money out?
We do not have access to remove cash from your account. The arrangement that we have with the financial institutions is for deposits only. We send the institution an electronic file with your account number, name and payment amount. The institution will in turn deposit the funds to your account.

How will I know when my claim reimbursements are deposited to my account?
You will receive an alert via email or SMS text message. This message will include the amount and date of the deposit.

How long does it takes for my reimbursement to be deposited in my account?
Deposits are usually made within 1-3 business days after the claim has been processed.

Claims

My Benefit Card states that I am covered for $1,500.00 of each office visit but my doctor charges $3,000.00 for each visit. Can I submit a claim for the $1,500.00 I paid?
NO. The difference you pay is called your "co-payment". The benefit of $1,500 and your co-payment cannot be covered under the same plan. However, if you are part of a second health plan, you can coordinate your benefits by also using your second plan to reduce your co-payment.

I wish to submit a claim form I received 6 months ago, will it be processed?
NO. All claims must be submitted within ninety (90) days of the service except in the case of Maternity where you have the option to submit claims 90 days from your delivery date. The Benefits are subject to exclusions.

How long does it take for my claim to be processed?
We currently process claim payments within three to five working days from receipt.

If I am unconscious and not able to make the call within 48 hours of the emergency overseas, what happens?
You should be sure to carry your travel card with you so that the Providers will know that you have emergency overseas coverage. It is also very important to let your family/friend etc. with whom you are staying know that you have this coverage.

In this situation, your host, companion or Health Care Provider should make the call on your behalf within the specified time (i.e. within 48 hours of the occurrence).

Over-aged Dependents

My daughter is now nineteen and is presently in sixth form; can she remain on my health plan?
YES. A dependent child is terminated from the plan on his/her 19th birthday; if the child is in sixth form, coverage can be extended up to age 20, once a status letter from an approved secondary institution is submitted. Thereafter, coverage can continue until their twenty-third (23rd) birthday if:

- There is no academic break between high school and tertiary/vocational studies, up to age 23.
- A status letter from an approved tertiary/vocational institution is submitted annually.

My son is now 20 years old and attending University; but he took a year off to rest and gain some work experience, can he be reinstated on my health plan?
NO. The plan can only accommodate dependents who are full-time students with no academic break

between high school and their entry into a tertiary institution.

What should the school status letter include?
The school status letter should include:

- Full name of the student
- Year of study (i.e. 2013/2014)
- Course of study (i.e. CAPE or CSEC/ Degree/Diploma/Certificate course(s))
- Field of study (i.e. English, Business, Medicine)

The member's policy number should be affixed to the letter. It should be noted that only full-time students may remain on their parent's health plan.

How often must the school status letter be submitted to Sagicor?
The school status letter must be submitted on an annual basis at the beginning of each new academic year.

If I have a child that is challenged, can the child remain on my health plan over the age of nineteen (19) years?
YES. Medical proof is required with a written request from the member requesting that the child remain on his/her plan. This request will be reviewed by our GEASO Monitoring Committee. Upon approval, coverage will be extended.

Approved Leave of Absence

I am presently on no-pay leave completing my Master's degree; can I remain on the health plan while studying?
YES. Sagicor must receive written notification from your employer advising the reason for non-payment and the period of the leave of absence. Once this information is received by our Customer Care Department, you may pay the outstanding premium via cash or cheque, at the cashier located at Sagicor's office. **Please note that you will be required to pay 100% of premiums (i.e. the Government -80% and Subscriber-20%)**

Based on the response above, I am now returning to work after seven months no-pay leave, can I be reinstated without paying the outstanding amount?
NO. Reinstatements are only allowed within three (3) months of your effective leave of absence date. You must now re-enrol to access the GEASO benefits. You will be required to serve the waiting periods prior to access to the following benefits:

- Maternity (family plan only) – 9 months
- Surgical – 6 months

Non-Payments of Premiums

The Accounts department in error did not deduct my health premiums for a particular month, will my plan be terminated? Can I make the payments over the counter? How do I correct this error?
YES. Your health plan is automatically terminated once payments of premiums cease.

NO. We cannot accept payments over the counter, as this is only allowed if you are on an approved no-pay leave.

This can be corrected by submission of a Commitment Letter.
The HR Director or Accountant can commit to deducting the outstanding premium payment(s) from your next salary or make a payment on behalf of the employee. This commitment must be sent to the Group Insurance Administrator at Sagicor prior to the next premium payment. Once the information sent is considered satisfactory, the policy will be reinstated immediately.

My salary was received late for June and no deductions were made for my health plan. I resumed duties in July and only July deductions were made. Will there be any disruption in my services?
YES. Your policy will be automatically terminated for non-payment of premiums. A commitment letter from your pay site will be required stating the reason for non-payment and the stipulated period the outstanding funds will be recovered. Once the information received is considered satisfactory, the policy will reinstated immediately.

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Change of Pay Site

I recently changed pay sites from the Ministry of Tourism to the Ministry of National Security, how can I ensure that health plan is not terminated?

Changing from one pay station or from one Ministry/Department/Agency to another without notifying Sagicor, will likely disrupt your payment record. Sagicor must receive written notifications from the old and new pay-sites along with the effective date of transfer.

Sagicor will accept a faxed copy of the notification letter to fax number 929-4730 to the attention of your Group Insurance Administrator or an email from the pay station to geaso-enquiries@sagicor.com.

General Information

What is the difference between a Consultation and a Specialist visit?

A Consultant visit is initiated by a letter of referral from a General Practitioner. A Consultant visit has a limitation of two (2) visits per disability per annum. During any one contract year, a plan member may access six (6) Consultation visits thus limiting the member to three (3) paid areas per plan year e.g. Cardiology, Pediatrics and Gynecology.

When Specialist visits succeed Consultation visits, they are limited to six (6) visits in the particular area of specialization. A member who goes directly to a Specialist without first going to a Consultant, may access eight (8) visits for which the service is paid. Thereafter, the benefit payment will revert to Office Visit payment for the same illness or disability.

Explain what is meant by "per disability"?

This means that the associated benefit recognizes more than one illness being covered on your health plan.

Explain what is meant by "Executive Profile"?

This refers to a set of chosen diagnostic, laboratory tests ordered by the medical doctor to affirm wellness or confirm a disease process as well as for the provision of treatment (i.e. medical or surgical).

Can I coordinate my GEASO health card with another insurance plan?

YES. If you or your dependents are covered under another health insurance policy, benefits may be coordinated to further reduce your co-payments. Benefits are coordinated in the following order:

1. The benefits will be first processed under the **Employee's** health plan.
2. The benefits will then be processed under the **Dependent's** health plan.

In the event, your child or children are on both your spouse's health plan and your own. The coordination of the benefits for your child or children will take the following order:

1. The benefits will be first processed under the **father's** health plan.
2. The benefits will then be processed under the **mother's** health plan.

It is important that you indicate in the space provided on the claim form whether or not you have coverage under another health plan administered by Sagicor in order to facilitate automatic coordination of your benefits. If you have health insurance with another insurance company, kindly attach a copy of the explanation of benefits from the other insurance company upon submitting your claims.

Contact Us:

If you have any other questions, please feel free to contact your Health Plan Administrator, Sagicor Life Jamaica Limited, at:

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