Sagicor

overview

COVERAGE FOR OVERAGE DEPENDENT STATUS

Overage Dependents

This applies only to children of subscribers under the following health scheme and plans:

- Government Employees' Administrative Services Only (GEASO)
- Public Sector Medical Officers (PSMO)
- Senior Government Executive

Dependent children retain eligibility until midnight of their nineteenth (19th) birthday.

Eligible dependent child/children over the age of 19 yrs up to age 20 yrs can be retained on the Scheme to complete CXC, GCE and CAPE subjects. The subscriber will be responsible for submitting a status letter from the high school (public/private) for approval.

However, coverage may continue beyond the nineteenth birthday until the twenty third (23rd) birthday if; a status letter is received from a recognized tertiary or vocational institution establishing that the dependent child is pursuing a full time Degree, Diploma or Certificate course at that institution within the same year of attaining age nineteen (19) with no break between high school and entry to the tertiary or vocational institution up to age 23 yrs.

In addition, each academic year, a status letter should be submitted to Sagicor from the tertiary or vocational institution establishing that the dependent child's enrolment is still-in force. This should also include the subscriber's name and policy identification number. Failure to comply with this requirement will result in the automatic cancellation of the child from the policy.

Challenged Child/Children

A special arrangement for dependent children of GEASO subscribers only, who are mentally and/or physically challenged and who are unable to care for themselves can be considered for over age dependent status beyond age 19 yrs: if they were covered under the Scheme prior to age 19 yrs. To establish eligibility, a medical letter/assessment must be submitted stating the extent of the disability. This report should be accompanied by a letter of request for over age dependent coverage for review and consideration by the Monitoring Committee. If status is granted the child/children will be re-enrolled and the subscriber will be duly informed.

benefits

benefits

Once you are enrolled and have been provided with your cards (Swipe & Benefit), you may access benefits except in

the case of those conditions for which waiting periods apply. (See Schedule of Benefits)

- Visit a Sagicor Participating Provider and present your cards;
- Ensure that the completed claim form is signed by both yourself and the provider
- If your Provider is not a Sagicor Participating Provider you are expected to pay in full for the service, obtain a signed & stamped original receipt and completed claim form for submission to Sagicor. Sagicor will then process your request for reimbursement of all eligible amounts.
- **Your claim must be submitted within 90 days of the service date.**
- Before undergoing elective surgery, you should ensure that the six-month waiting period has been satisfied. If it has, you should submit the following to Sagicor from your Doctor:
    - Details of the procedure/type of surgery to be done and;
    - A breakdown of the cost.

This will allow you to know, before hand, how much of the cost will be covered by your Health Scheme.

NB: Please note the following:

- Do not sign a blank Provider claim form
- Do not sign the Provider's claim form before the service is rendered
- Do not sign more than one line on the Provider's claim form

USE AND CARE OF HEALTH CARD

Your health card will continue to provide you with access to eligible services. Please note the following:

- The card must ONLY be used by the person whose name is stated on the card. To put it in perspective, if you allow others to use your health cards, you are in fact committing fraud.
- Do not use your card for anything other than medical/surgical purposes.
- Do not keep the card in close proximity to any magnetic device. Do not leave the card exposed to sunlight.
- Keep the encoded area unscratched. The card should not be bent at any time.
- Your Swipe Card should be signed in the appropriate place below the encoded area. If you have not yet signed your present card, please do so promptly.
- Report abuse or loss of your card promptly to any Sagicor office or our Contact Centre. Report misplaced or stolen cards immediately, replacement will take place upon your request at a minimal cost.
- Do not use your card just to exhaust an existing balance before the anniversary date of the plan. This will cause the utilization of the plan to be higher than necessary which may result in higher contributions being required of members.
- Remember that if you are a part of more than one health plan, you can coordinate your benefits by including the policy numbers for each plan on your claim form to reduce your out-of-pocket expense
- Check your claim information. When signing a claim form, ensure the provider completes the form with your correct information, including the diagnosis, the card number and the amount you were required to pay if applicable.

COORDINATION OF HEALTH BENEFITS

If you or any one of your dependents are covered under another health plan, your benefits can be coordinated by Sagicor so that you pay less out-of-pocket for prescription drugs, medical and surgical expenses.

The National Health Fund (NHF) provides prescription drugs benefits for Jamaicans with specific chronic conditions. It is important to advise us if you are enrolled on the National Health Fund or if have additional health care coverage, other than your health plan. This will help to ensure that you get the maximum benefits available under all your health insurance policies.

Coordination of Benefits with the National Health Fund (NHF) requires that you are first enrolled with the NHF and have submitted your Taxpayer Registration Number (TRN) to Sagicor for yourself and your eligible dependents. Once this is done, your prescription drug benefit can be automatically coordinated with the NHF at providers who automatically coordinate NHF & Sagicor.

Coordination of benefits also ensures that your insurers' combined payments do not add up to more than what we would have paid had we been your only insurance carrier. Coordination of benefits can also be applied if you have more than one health plan with the same insurance company.

OVERSEAS COVERAGE– Employees Only (NOT DEPENDENTS OR PENSIONERS

The back of your benefit card provides the contact information for the Canadian Medical Network (CMN). The numbers are:-

- USA and Canada 1-866-274-1755 (Toll Free)
- Elsewhere call collect 1-905-669-4308 - Fax: 1-905-669-2221.

This card can be used for the following services:

- Overseas Emergency Medical Service & Overseas Non-Emergency Medical Service, major medical services to the covered employee. This requires prior authorization from Sagicor. CMN allows covered employees to access health care services from Participating CMN entities which operate in, the USA and its provinces and in countries with which it trades up to a sum equivalent to your local entitlement
- Eligibility is limited to life threatening medical emergencies that occur within the first thirty (30) days of arrival in the country being visited. Subscribing employees should make every effort to contact CMN immediately as the need arises for service or within forty-eight (48) hours of the emergency. Contact must be made with CMN using the telephone contact information provided on the back of your Benefit Card.
- Please ensure that you provide information i.e.: Name, Group Policy Number, Policy Identification Number and Passport verification to obtain eligibility for the service and benefit amount. CMN will then verify your eligibility and category of service, they will then advise you and the provider how to proceed.
- Your Scheme allows you access to CMN in the USA and other parts of the world. The benefits payable for non-emergency services are listed in the schedule of benefits. Overseas non-emergency services require prior approval for service from Sagicor in response to a medical report and request from your local Medical Provider. Failure to procure prior authorization will result in non-payment of benefits.

SAGICOR PARTICIPATING HEALTH CARE PROVIDERS

Sagicor works with doctors, hospitals, pharmacies, dentists, optical providers and laboratories to provide service for our subscribers. We have contracts with participating providers that, in most instances; allow Sagicor to be billed directly for services rendered to our subscribers and their dependents.

This means that on presentation of your health card to a Sagicor participating provider, you are not required to pay the full amount for covered service. You will be charged only the co-payment which is a percentage of the cost according to your Benefit Schedule. Sagicor is obligated to pay the remainder to the participating provider up to your maximum benefit. You must pay in full for services and supplies that are not covered by your health plan.

If a Sagicor Provider refuses to accept your health card for services without a valid reason, you must report it to our Provider Relations Department immediately at 929-8920 Sagicor will investigate and take the appropriate action.

NON-PARTICIPATING PROVIDERS

If you visit a non-participating provider (a provider who has no contractual agreement with Sagicor) you will be required to make full payment for services received and submit a claim to Sagicor for reimbursement.

forms and faq

- GEASO FREQUENTLY ASKED QUESTIONS AND ANSWERS
- GPASO FREQUENTLY ASKED QUESTIONS AND ANSWERS
- SUBSCRIBER CHANGE REQUEST FORM
- KNOW YOUR CUSTOMER FORM
- ELECTRONIC FUND TRANSFER FORM

For further information, please do not hesitate to contact us at govtqueries@sagicor.com