Sagicor

Know Your Benefits

There are a number of benefits that come with having Sagicor health insurance. Below are the answers to some frequently asked question.

Frequently Asked Questions Brochure

FAQs

When making a claim:

Your medical provider must indicate the diagnosis(es) , the name and address of the provider offering the service(s), name of the referring physician (if any), the charge for the service(s) and the amount paid. The provider must also stamp, sign and date the claim form. Remember you can submit your claim online via sagicorconnect.com or by email at slj_healthclaims@sagicor.com

Why is preauthorization required for special procedures??

Some benefits under your Sagicor health plan require you to get approval/pre-authorization* and in the case of large expenses, it allows you and your provider to know what will be covered. Approval should be granted by Sagicor before you proceed with the treatment.

**Pre-authorization is not required for emergencies, but only for planned procedures.*

Your health card limit is finished, what do you use?

For the remainder of the year you will not be able to swipe your card for prescription drugs. Purchases will have to be made upfront and be reimbursed by Sagicor. A detailed receipt from the pharmacy must accompany your claim form.

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

Is there a limit on my health card?

Yes, there is a limit. Your credit limit is the total dollar amount of prescription drugs that can be accessed using your health card.

What is a deductible?

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

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.

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.

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 are presented to client and accepted based on client's needs and affordability.

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. How premium rates are determined is also different.

Can an individual continue to have coverage after termination of employment?

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

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 the 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 pertained.