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GROUP HEALTH & LIFE PLAN FOR MEMBERS

Health Insurance FAQ (Frequently Asked Questions)

1. **Do I Have to do a medical to join the plan?**

   The plan begins effective April 01, 2020. If an application form is not submitted by June 30, 2020, members under age 65 will be required by the Underwriters to complete a Medical Report. Members over 65 cannot join the plan after June 30, 2020.

2. **What Major Medical Options can I choose**

   Members have three options from which they can choose. Major Medical Options of $300,000/$500,00 and $1,000,000

3. **Can Members change their Major Medical Coverage during the year?**

   Members must wait on the policy year renewal of April to change their Major Medical Coverage. If increasing Major Medical coverage from $300,000 to $500,000, a Medical would be required for this increase in coverage. Decreasing your Major Medical Coverage from $1,000,000 to $500,000, written notice of the change must be given at the renewal date of April

4. **Is the Life plan mandatory?**

   Yes, the Life plan is mandatory. There are two options to choose from.

5. **What does Eligible Expenses mean?**

Eligible expenses refer to costs incurred for medical care resulting from accident or illness. These must be administered/prescribed by a licensed medical practitioner and the services rendered must be related to the diagnosis.

6. **What is a Deductible?**

This is the dollar amount of covered expenses for which the Insured is responsible before benefits can be payable under the Policy.

7. **What is Co-Insurance?**

This is the percentage split of the covered expenses, between the Insurer and the Insured

8. **Is there a timeframe in which to submit a claim?**

All claims must be submitted to Guardian Life within 90 days from the date the service was rendered

9. **What is a Pre-Existing Condition?**

A pre-existing condition is a condition resulting from illness or injury for which a Covered insured has received a diagnosis, consultation, medical treatment or drug prescription prior to the effective date of the policy or the date cover was effective; OR

For which symptom and/or sign of illness, if presented to a physician prior to the effective date of the policy would have resulted in the diagnosis of an illness or medical condition whether or not the patient was aware of the condition.

10. **Does the plan have a Pre-existing clause?**

Yes, the plan will not cover any expenses incurred within the first 12 months of being effective on the medical plan due to a pre-existing condition.

11. **What does Guardian Life define as an Emergency**

Emergency means the sudden and unexpected onset of a medical condition accompanied by acute signs or symptoms, which could reasonably result in placing the Insured's life or physical integrity in immediate danger if medical attention is not provided immediately.

12. **What happens if I have an Emergency while on vacation or business abroad**

Guardian Life's Managed Care is handled by Aragon Agency located in Miami Florida. Members should call the number that is provided at the back of the Lifecare Provisor Card (1-305-443-2700 or 1-305-443-2800).

Aragon Agency will make arrangements for you to receive medical attention from a Provider within our Overseas Network. They will also handle any queries or concerns whilst you are abroad.

13. **<u>How do I access Emergency medical attention at the Local Private Hospitals?</u>**

<u>AS AN OUTPATIENT</u>: In the event of an emergency arising from an illness or injury and an insured requires emergency medical attention, they can access outpatient treatment at any of the Providers on the Network. Upon presentation of the Lifecare Provisory Card and one form of identification, the Insured will receive medical attention up to a maximum of $1,000.00 (In Hospital) and $500.00 (Doctor Office) in accordance with the Emergency Accident Benefit of the group health plan. Charges in excess of $1000.00 for emergency medical attention will be for the insured's account.

<u>AS AN INPATIENT</u>: In the event of an emergency arising from illness or injury and an insured requires emergency medical attention that requires inpatient treatment the following will apply:

- Based on the patient's assessment at the time of admission, the insured will be required to make a deposit on the estimated charges made by the hospital

- A request for pre-certification (statement of estimated charges) will be sent from the Provider to Guardian Life's Employee Benefit Customer Care Department

- A response will be given within 24-48 hours advising the Provider of Guardian Life's and the Insured's liability.

14. **<u>What is Pre-Certification?</u>**

Pre-Certification is a notification of anticipated or schedule medical services that is required in advance of the actual medical treatment. Before you actually receive treatment or incur the medical expenses, Guardian Life upon request by the Provider, issues a pre-approval letter stating whether the anticipated service is eligible for coverage and the level of charges that would be reimbursed from the health plan.

Note: Any difference between the actual charges and the estimated cost as stated on the pre-certification will be for the insured's account.

15. **<u>What is required to attain Pre-Certification</u>**

A letter from the treating Physician or Medical facility with an itemization of the charges and the type of treatment/procedure recommended or scheduled must be sent to Guardian Life's Employee Benefits Customer Care Department.

16. **<u>What are Exclusions and Limitations?</u>**

Exclusions and Limitations refer to services, equipment, procedures and types of treatment that are not covered under the plan.

17. **<u>What is Usual, Customary & Reasonable (UCR)</u>**

UCR means the charge or fee determined by the Company to be the general rate charged by others who render or furnish such treatments services or supplies to persons whose injuries or illnesses are comparable in nature and severity.

The Company will consider such factors as; complexity; degree of skill needed, type of specialist required, and the range of services or supplies provided by the facility. For example, if a doctor charges $3000.00 for a surgical procedure and the usual fee for the procedure is $2000, then the plan will reimburse you based on the charge of $2000 and applicable co-insurance will apply.

18. Who pays the difference after Guardian Life settles percentage of eligible expenses?

Guardian Life settles a percentage of the eligible expenses. Any difference that is not covered by the plan will be for the insured's account.

19. What is Co-ordination of Benefits (COB)

When an individual is covered under more than one health plan and is able to claim for the expenses incurred from both plans, the benefits under this policy will be reduced to an amount which when added to the benefit of the other plan will be equal 100% of medical expenses incurred.

The following will determine which plan will pay first:

- The plan covering the insured as an employee;
- The plan covering the insured as a Dependant of a Male employee; and
- If the above do not establish an order of priority, the plan which has covered the insured for the longer period of time pays the benefits first.

20. Should I use the Network plan if I have two or more Medical Plans

No. Pay first and submit your claim and Include your COB information, so that the claim would be sent to the secondary Insurer for payment.

21. If I want to make a claim for a visit to a specialist, would I have needed a referral from a General Practitioner (GP) or could I have gone on my own

You need to have a referral from a GP in order to make a claim for a visit to a specialist. Ensure that you keep a copy of this referral to attach to the claim form. Should you visit a specialist without a referral, you would be reimbursed as if you visited a GP.

22. Who is Dalian Medical Concierge Services

Dalian Medical Concierge Services Limited is an affiliate of Guardian Life of the Caribbean Limited whose role is to facilitate access to medical services (inclusive of emergency treatment) from the top private hospitals in Trinidad & Tobago to the members of the Credit Union. They arrange for members not to have to pay a significant amount upfront as is usually required and they monitor all procedures and billings to ensure accuracy. They also eliminate the red tape normally experienced at hospitals allowing you and your approved dependents to be treated as quickly as possible. You simply call the hotline at 338-2070 to access this service at no additional cost to you.

23. Is there a waiting period before I can make a claim?

There is no waiting period to make a Medical claim. Dental and Vision claims carry 3 months waiting period.

24. **<u>How often can I claim for Frames and Lenses?</u>**

You can claim for lenses once per calendar year, and frames once every two calendar years.

25. **<u>How often can I clean my teeth?</u>**

You can claim for a dental cleaning once ever 6 months. Please this is subjected to the overall dental maximum.