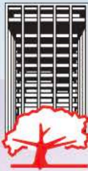

Tatil

... where people are people

Small Group Health Plan

The **Health Plan** tailored to your small business!

www.tatil.co.tt | 62TATIL (628-2845)
ghquotes@tatil.co.tt

COMPREHENSIVE MEDICAL BENEFIT

This leaflet gives a brief outline of the benefits to which you are entitled, but does not confer any contractual rights. All rights with respect to the benefits of a member will be governed by the Group Policy contract issued by TATIL.

It is very important that you know the scope of the benefits, since you are responsible for settlement of any amount charged for medical care in excess of the benefits payable under this plan. The benefits are designed to give financial assistance in meeting medical costs as a result of a covered accident or sickness.

GENERAL PROVISIONS

ELIGIBILITY

All permanent full-time employees who are less than 64 years of age and are employed for at least 30 hours each week are eligible to enroll in the plan. Active employees can transfer to the Retiree plan once they were covered under the plan on a continuous basis for at least (2) years prior to attainment of normal age of retirement. Coverage under the Retiree plan shall cease upon attainment of age 80.

Eligible dependants are the employee's spouse who is less than 64 years and unmarried, unemployed children from birth to 21 years or up to age 25 if attending full-time school.

Where the spouse of the insured employee is also an employee of the same company, only one shall be registered as the insured employee and the spouse shall be registered as a covered dependant.

EFFECTIVE DATE OF COVERAGE

Coverage is subject to evidence of insurability and will become effective on the beginning of the month after the application is approved by TATIL.

Additional medical reports or examinations, which may be required by TATIL, must be supplied at the expense of the applicant.

If an employee is not actively at work full-time, or a dependant is hospital-confined when coverage would normally become effective, coverage will be postponed until return to their work or following discharge from hospital.

PRE-EXISTING CONDITIONS

Pre-existing conditions are not covered. A pre-existing condition is any disease, illness or injury for which advice, medication and/or treatment was received or if symptoms were experienced, whether the condition was diagnosed or not, before coverage started.

CO-ORDINATION OF BENEFITS

Even if you are insured under another Health Plan, you are still

eligible to enroll in this plan. The primary insurer will make the initial payment and the other insurer will consider the balance up to its plan limits. The order of payment is agreed among insurers.

CONVERSION PRIVILEGE

Covered employees may apply for an individual Health Policy upon termination of coverage under this contract, provided that he/she has not attained the age of 55 years. Underwriting is waived once the application is submitted with 31 days of termination.

The conversion privilege shall also be available to a deceased employee's eligible dependants whose coverage terminated due to the employee's death. Such application must be submitted within 31 days of being eligible for this privilege.

MEDICAL BENEFIT

The plan provides coverage for charges which are reasonable and customary and which are in excess of the deductible amount. Co-insurance is applied to eligible expenses. The maximum amount payable in any calendar year is the Maximum Benefit Amount less any payments made during the preceding two (2) calendar years for Actives, and lifetime for Retirees.

The Deductible Amount is applied once each calendar year to the covered charges. The application of the Deductible Amount is limited to a maximum of three (3) family members for Active employees, and two (2) family members for Retirees.

Covered charges incurred in the last three (3) months of a calendar year, which were used to satisfy the Deductible, either in full or in part, and for which no Medical Benefit is paid may be carried over into the following year to assist in satisfying the Deductible.

All eligible expenses are subject to the Deductible and co-insurance stated in the Benefit Schedule. The following is a summary of the services covered under each benefit:

HOSPITAL EXPENSE

Room, board and general nursing services and all other hospital charges for medical treatment or supplies, rendered by the hospital. Also includes fees of an anaesthetist and hospital expenses for same-day surgery and emergency treatment within 48 hours of an accident.

SURGICAL EXPENSE

The amount payable for surgery is determined on the basis of reasonable and customary charges. The maximum allowed includes the fee for surgery and all visits after surgery.

DOCTOR'S VISIT

Doctor's fees for office, home or hospital visits, limited to one (1) visit per day up to the limits stated in the Benefit Schedule.

SPECIALIST CONSULTATION

Specialist visits are payable one (1) visit per day up to the limits stated in the Benefit Schedule. No referral required.

MISCELLANEOUS OUT-OF-HOSPITAL EXPENSE

Controlled drugs that can be bought only with a written prescription from a doctor. Over-the-counter drugs are not covered even if prescribed by a doctor.

DIAGNOSTIC EXPENSE BENEFIT

Benefits are payable for out-of-hospital diagnostic procedures (x-rays and laboratory tests) recommended by a physician. Does not cover routine tests or check-ups except as provided under the Preventative Care Benefit.

PHYSIOTHERAPY BENEFIT

Fees charged by a licensed physiotherapist for treatment rendered on the recommendation of a physician up to the limit stated in the Benefit Schedule.

MATERNITY EXPENSE BENEFIT

Pregnancy is covered only if it begins after 30 days of continuous coverage. All expenses related to pregnancy are covered under this benefit only.

PSYCHIATRIC EXPENSE BENEFIT

Psychiatric fees are payable and limited to one (1) visit per day up to the limits stated in the Benefit Schedule. No referral required.

PREVENTATIVE CARE BENEFIT

Covers expenses for the early detection and prevention of diseases subject to the limits stated in the Benefit Schedule.

OVERSEAS TREATMENT

Medical expenses incurred for treatment abroad will be payable at the reasonable and customary levels prevailing in Trinidad and Tobago, unless it is proved to the satisfaction of the Company that such medical treatment is not available locally. This must be certified by two (2) physicians, one of whom must be a specialist in the field of medicine to which the illness applies. TATIL's Medical Advisor must give approval of treatment prior to departure abroad. Referral letters should indicate the diagnosis, treatment received or recommended, patient's response to treatment and reasons why overseas treatment is necessary.

GROUND AMBULANCE BENEFIT

Provides reimbursement of necessary ambulance service to and from a hospital as a result of a covered accident or sickness up to the limit stated in the Benefit Schedule.

AIRFARE BENEFIT

Covers the airfare of the patient only, in cases where local

treatment is not available and overseas treatment is approved by TATIL.

AIR AMBULANCE

Covers the cost of Air Ambulance Services for emergency transportation of the patient outside of Trinidad and Tobago, necessitated as a result of a covered injury or sickness, provided that such treatment has been approved by the Company's Medical Advisor in accordance with the provision entitled in Overseas Treatment.

VISION CARE BENEFIT

Covers expenses for eye test, lenses and frames. Eye test and lenses are payable once in every 12 consecutive months. Contact lenses and frames are payable once in every 24 consecutive months.

There is a 90-day qualification period for this benefit.

DENTAL EXPENSE BENEFIT

Covers expenses for care and treatment in excess of the deductible amount and subject to the maximum benefit stated in the Benefit Schedule. Examination and cleaning are payable twice per calendar year and not subject to the deductible.

Orthodontic treatment is covered for children only and if treatment commences after six (6) months of continuous coverage.

There is a 90-day qualification period for this benefit.

FUNERAL EXPENSE BENEFIT

This is an employee only benefit. It provides reimbursement of the actual charges incurred for services rendered by a licensed Funeral Home for the burial or cremation of the deceased employee up to the limit stated in the Benefit schedule.

There is a 180-day qualification period for this benefit.

GROUP LIFE BENEFIT

This is an employee only benefit and is payable in the event of the insured's death.

Only one (1) option can be selected and must apply to all employees within the company.

Accidental Death - Double indemnity coverage that provides for the unintentional death or dismemberment of the insured ONLY. Dismemberment includes the loss, or the loss of use, of body parts or functions (such as limbs, speech, eyesight, and hearing).

Critical Illness insurance provides additional coverage for medical emergencies like heart attacks, strokes, or cancer. Critical illness insurance can pay for costs not covered by traditional insurance. The money can also be used for nonmedical costs related to the illness, including transportation, child care, and so on. Coverage for up to 18 illnesses are provided for up to the maximum stated on the schedule.

HOW TO CLAIM

You are initially responsible for payment of your medical bills. The claim form must be fully completed and signed by your doctor and yourself. A copy of the original claim form/receipts must be submitted via TATIL's health portal. The originals can be kept for your records. Claims must be submitted within 90 days from the date of the first covered expense. Claims for Maternity Benefits will be settled at the end of the pregnancy. On submission of a properly documented claim, you will be reimbursed according to the limits payable under the plan.

Arrangements may be made for provider payment of Hospital and Surgical Benefits only. In such a case, the amount recoverable will be paid directly to the provider.

A written claim estimate with details of your proposed medical treatment should be submitted to your Plan Administrator.

GROUP HEALTH PORTAL

Mytatilhealth.com

Members can access our 24/7 health portal to:

- Submit and track your claims online.
- View your claims history.
- View and download your explanation of benefits.
- View eligibility and plan details.

Please contact your Broker, Agent or Plan Administrator for instructions on signing up.

Note: Claim forms do not require a signature from the Plan Administrator.

SOME IMPORTANT EXCLUSIONS

1. Expenses incurred for any medical condition that existed before the effective date of your coverage.
2. Suicide, self-inflicted injury, war or aviation, except as a passenger in a regular commercial airline.
3. Alcoholism or drug addiction.
4. Infertility, in vitro fertilisation or any other treatment or procedure to induce pregnancy, birth control, tubal-ligation, vasectomy.
5. Acquired Immune Deficiency Syndrome (AIDS) or related conditions.
6. Any procedure that is experimental or not generally accepted by the medical profession; any treatment that has not been recommended and approved by a physician.
7. Routine medical examinations, x-rays, lab tests, immunisation except as provided for under the Preventative Care Benefit.
8. Any benefits provided by law or payable under a Workmen's Compensation Policy.

9. Any disability for which you are not under the continuing care of a physician.

COMPREHENSIVE MAJOR MEDICAL PLAN

(Active Employees and Retirees)

BENEFIT SCHEDULE (Revised July 1, 2024)	Limits
MAJOR MEDICAL MAXIMUM (Active Employees)	$500,000
Benefit Period	3 years
Deductible per calendar year	$500
Deductible per family	$1,500
Co-Insurance	80%/ 20%
MAJOR MEDICAL MAXIMUM (Retirees)	$300,000
Benefit Period	Lifetime
Deductible per calendar year	$500
Deductible per family	$1,000
Co-Insurance	80%/ 20%
DAILY HOSPITAL ROOM AND BOARD LIMIT	80% up to
Local (Caricom)	$600
Overseas (Non-Caricom)	$2,000
Intensive Care Benefit	$1,800
MISCELLANEOUS HOSPITAL BENEFIT	80%
SURGICAL BENEFIT	80% of R&C Charges
Anaesthesia	25% of Surgical R&C
DOCTOR'S VISIT BENEFIT	80% up to
Office	$200
Home/Hospital	$300
SPECIALIST CONSULTATION EXPENSE BENEFIT	
(No referral required)	80% up to
Office/Home/Hospital	$350
MISCELLANEOUS OUT-OF-HOSPITAL EXPENSE/ PRESCRIBED DRUGS	80%
DIAGNOSTIC BENEFIT	80%
PHYSIOTHERAPY BENEFIT	80% up to
Maximum per visit	$150
PSYCHIATRIC EXPENSE BENEFIT	
(No referral required)	80% up to
Maximum per visit	$200
Maximum per calendar year	$3,000
EMERGENCY ACCIDENT EXPENSE BENEFIT	80% up to
Maximum per accident	$2,000
MATERNITY EXPENSE BENEFIT* (Active Employees Only)	
(30 days qualificaton period)	100% up to
Normal Delivery	$5,000
Caesarean section/ Extra-uterine pregnancy	$15,000
Miscarriage/ Dilation & Curettage/ Pre-natal (included in Maternity Maximum)	$2,500

**Conception date must be at least 30 days from inception of coverage.*

PREVENTATIVE CARE EXPENSE **(no waiting period)** 100% up to

Vaccinations for children up to 12 years $300
Annual Pap Smear $75
Annual Mammogram $250
Annual Prostatic Specific Antigen (PSA) Test $200
Annual Glaucoma Test $100
Annual Lipid Profile $150
Annual Fasting Blood Sugar $50

HOME NURSING CARE **(Medically prescribed home nursing by a registered nurse following hospitalisation due to serious accident/ illness)**

..... 80% up to
Maximum per shift $150

EMERGENCY LOCAL GROUND AMBULANCE BENEFIT ..... 80% up to

Maximum per trip $500

AIRFARE BENEFIT ..... 80% up to

Maximum per trip $4,000
Number of trips per calendar year ..... Two (2)

EMERGENCY AIR AMBULANCE BENEFIT ..... 80% up to

Maximum per calendar year $100,000

INTERNAL PLAN LIMITS:
CALENDAR YEAR MAXIMUM:

Durable Medical Equipment/ Prosthesis $10,000
Chemotherapy/ Radiotherapy (combined) $100,000
Dialysis $100,000

LIFETIME MAXIMUM:

Organ transplants ..... 50% of Major Medical Maximum

VISION CARE BENEFIT **(90 day qualification period)**

Calendar year deductible $100
Benefit Payable 80%
Maximum per calendar year **(Active Employees)** $2,000
Maximum per calendar year **(Retirees)** $1,500

* *Examination & Lenses will be limited to one (1) per person any twelve (12) consecutive months*
* *Frames & Contact Lenses will be limited to one set (1) per person any twenty-four (24) consecutive months*

DENTAL CARE BENEFIT **(90 day qualification period)**

Calendar year deductible $100
Benefit Payable 80%
Maximum per calendar year $2,000
Orthodontic treatment *(for children only up to age 19)*
(Active Employees Only)
Waiting period - 6 months
Orthodontic Annual Maximum $2,000
Orthodontic Lifetime Maximum $4,000

FUNERAL EXPENSE BENEFIT **(Active Employees Only)** $3,000

GROUP LIFE & AD&D COVERAGE **(Active Employees Only*)**

Only one option can be selected and must apply to all employees within the company
Option 1 ..... $50,000
Option 2 ..... $100,000

OPTIONAL CRITICAL ILLNESS (CI) COVERAGE **(Active Employees Only)**

Coverage applies to all employees within the company
Existing $50,000 Life coverage $25,000
Existing $100,000 Life coverage $50,000

Not applicable to Dependents

Note: This health plan is renewable annually. Premiums and benefits are subject to change at the time of renewal. TATIL reserves the right to modify, revoke, suspend, terminate or change this program in whole or in part at any point of time.