

COVERAGE COMPARISON - SCHEDULE OF BENEFITS				
GENMED			SAGICOR	
	ACTIVES	RETIREEES	ACTIVES	RETIREEES
	Benefit	Benefit	Benefit	Benefit
	<u>Maximums</u>	<u>Maximums</u>	<u>Maximums</u>	<u>Maximums</u>
Maximum Benefit	1,500,000.00	\$500,000.00	\$500,000.00	\$500,000.00
Benefit Period	3 Year Renewable	6 Year Renewable	3 Year Renewable	3 Year Renewable
Deductible per Calendar Year	\$750.00	\$1,000.00	\$1,000.00	\$1,250.00
Deductibles per Family	3	3	3	3
Co-Insurance Percentage	75%	70%	75%	70%
Carry Over Provision	NIL	NIL	Last 3 months of Cal Yr	Last 3 months of Cal Yr
Pre-existing Condition Maximum	\$2,500.00	N/A	\$2,500.00	N/A
Daily Room & Board: (quoted in TT dollars)				
Overseas (Non-Caricom)	\$2,500.00	\$2,500.00	\$2,500.00	\$2,500.00
Locally (Caricom)	\$700.00	\$700.00	\$700.00	\$700.00
Intensive Care Benefit (Non-Caricom)	\$1,000.00	\$1,000.00	\$1,000.00	\$1,000.00
Intensive Care Benefit (Caricom)	\$3,000.00	\$3,000.00	\$3,000.00	\$3,000.00
Private Duty Nursing				
Maximum Per 8-hour shift - Private Residence (Day)	\$250.00	\$250.00	\$250.00	\$250.00
Maximum Per 8-hour shift - Private Residence (Night)	\$250.00	\$250.00	\$250.00	\$250.00
Maximum Per 8-hour shift - Hospital (Night)	\$250.00	\$250.00	\$250.00	\$250.00
Maximum per calendar year		\$20,000.00	\$20,000.00	\$20,000.00
Doctor Visits (Office, Home, Hospital)	\$200.00 / \$250.00 / \$250.00	\$200.00 / \$250.00 / \$250.00	\$200.00 / \$250.00 / \$250.00	\$200.00 / \$250.00 / \$250.00
Specialist Visits (Office, Home, Hospital)	\$300.00	\$300.00	\$300.00	\$300.00
Psychiatrist Visits (Office, Home, Hospital)	\$200.00	\$200.00	\$200.00	\$200.00

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Psychologist Benefit:				
Maximum per treatment	\$200.00	\$200.00	\$200.00	\$200.00
Maximum number of treatments per calendar year	10	10	10	10
Co-Insurance Percentage		70%	75%	70%
Physiotherapy / Occupational / Speech Therapy Benefit:				
Maximum per treatment	\$150.00	\$150.00	\$150.00	\$150.00
Maximum number of treatments per calendar year	10	10	10	10
Co-Insurance Percentage	75%	70%	75%	70%
Chiropractic Benefit (Upon Referral)				
Maximum per treatment	\$200.00	\$200.00	\$200.00	\$200.00
Maximum number of treatments per calendar year	10	10	10	10
Co-Insurance Percentage	75%	70%	75%	70%
Acupuncture Benefit (Upon Referral)				
Maximum per treatment	\$200.00	\$200.00	\$200.00	\$200.00
Maximum number of treatments per calendar year	10	10	10	10
Co-Insurance Percentage	75%	70%	75%	70%
Maternity Benefit:				
(10-Month Waiting Period)				
Normal Delivery	\$5,000.00	Not Covered	\$5,000.00	Not Covered
Caesarean Section/Extra Uterine Pregnancy	\$8,000.00	Not Covered	\$8,000.00	Not Covered
Miscarriage/ Dilation & Curettage/ Pre- natal (incl in Maternity Max)	\$2,000.00	Not Covered	\$2,000.00	Not Covered

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Airfare Benefit:				
Maximum per calendar year	\$10,000.00	\$5,000.00	\$10,000.00	\$5,000.00
Maximum Number of Trips per Calendar Year	2	2	2	2
Co-Insurance Percentage	75%	70%	75%	70%
Emergency Air Ambulance Benefit				
Maximum per calendar year	US\$25,000.00	US\$18,000.00	US\$25,000.00	US\$18,000.00
Maximum Number of Trips per Calendar Year	2	2	2	2
Benefit Payment	100%	100%	100%	100%
Emergency Local Ground Ambulance Benefit				
Benefit Payment	100%	100%	100%	100%
Repatriation of Mortal Remains	\$20,000.00	\$20,000.00	\$20,000.00	\$20,000.00

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	<u>Maximums</u>	<u>Maximums</u>	<u>Maximums</u>	<u>Maximums</u>
Radiotherapy/ Chemotherapy Benefit/ Dialysis	Subject to Deductible and Co-Insurance up to a maximum of \$150,000	Subject to Deductible and Co-Insurance up to a maximum of \$100,000.00	\$150,000.00	\$100,000.00
Congenital Birth Defects	\$250,000	Not Covered	75% after Deductible	Not Covered
Surgical Benefit (Reasonable & Customary fees apply)	75% after Deductible	70% after Deductible	75% after Deductible	70% after Deductible
Anaesthetic Benefit	25% of Surgical R&C	25% of Surgical R&C	25% of Surgical R&C	25% of Surgical R&C
Prescribed Drugs, Generic or Brand Name	75% after Deductible	70% after Deductible	75% after Deductible	70% after Deductible
Maximum Calendar Year		\$50,000.00	\$10,000.00	\$10,000.00
Durable Medical Equipment	\$20,000.00	\$20,000.00	\$20,000.00	\$20,000.00
Miscellaneous Benefit	75% after Deductible	70% after Deductible	75% after Deductible	70% after Deductible
Maximum Calendar Year			\$10,000.00	\$10,000.00
Diagnostic Benefit (X-rays,Blood work, CT/PET scans,MRIs)	75% after Deductible	\$50,000.00	75% after Deductible	\$50,000.00
Maximum Calendar Year				
Internal Plan Limits	<u>Lifetime Maximums</u>	<u>Lifetime Maximums</u>	<u>Lifetime Maximums</u>	<u>Lifetime Maximums</u>
Mental & Nervous	\$25,000.00	\$25,000.00	\$25,000.00	\$25,000.00
Acquired Immune Deficiency Syndrome	\$50,000.00	\$50,000.00	\$50,000.00	\$50,000.00
Transplants	\$250,000.00	\$250,000.00	\$250,000.00	\$250,000.00
Covid 19 & Hospitalization	\$250,000.00			
AGE LIMIT FOR COVERAGE:	65TH BIRTHDAY	99TH BIRTHDAY	65TH BIRTHDAY	99TH BIRTHDAY

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	<u>Maximums</u>	<u>Maximums</u>	<u>Maximums</u>	<u>Maximums</u>
<u>Preventative Care Benefits</u>				
Male Wellness*	\$1,000.00	\$1,000.00	\$1,000.00	\$1,000.00
Female Wellness*	\$1,000.00	\$1,000.00	\$1,000.00	\$1,000.00
* Available to all full time employees and their covered spouses				
Listed below are the eligible benefits:				
1. Annual physical examination				
2. Chest X-ray				
3. Complete urinalysis				
4. Blood profiles				
a. HBAIC				
b. CBC				
c. Lipid profile				
d. Kidney function				
e. Liver function				
f. PSA				
g. FBS				
h. Cholesterol				
i. Creatinine				
j. Thyroid profile				
5. Annual gynecological exam				
6. Annual pap smear test				
7. Annual screening mammogram and/or ultrasound				
8. Annual prostate exam				
9. Annual CA 125 test - women age 35 and over			\$350.00	\$350.00
10. Annual fecal immunochemical blood test (FiT)			\$1,000.00	\$1,000.00

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11. Colonoscopy - over age 50, and every 10 years			\$1,000.00	\$1,000.00
12. Adult immunizations:			\$500.00	\$500.00
a. yellow fever				
b. chicken pox				
c. tetanus				
d. HPV (Adults and Children up to age 26)				
13. Dependant child (up to age 7) immunizations: ALL			\$500.00	Not Covered
14. Doctor's visit - One doctor's visit is payable on ONE preventative care benefit per annum for adults and children				
All services are subject to overall Annual Wellness Benefit of	TT\$1000.00	TT\$1000.00	TT\$1000.00	TT\$1,000.00

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DENTAL:	<u>Maximums</u>	<u>Maximums</u>	<u>Maximums</u>	<u>Maximums</u>
(3-Month Waiting Period)				
Maximum Benefit per Calendar Year:	\$2,000.00	\$1,500.00	\$2,000.00	\$1,500.00
Deductible per Calendar Year:	\$250.00	\$250.00	\$250.00	\$250.00
Benefit:				
Level 1 - Preventative	75%	70%	75%	70%
Level 2 - Restorative	75%	70%	75%	70%
Level 3 - Major Restorative	75%	70%	75%	70%
Orthodontic Treatment (for children only up to age 19)				
Maximum Lifetime Benefit	\$2,000.00	Not Covered	\$2,000.00	Not Covered
Annual Maximum	\$1,000.00	Not Covered	\$1,000.00	Not Covered
Co-Insurance Percentage	75%	Not Covered	75%	Not Covered
VISION:				
(3-Month Waiting Period)				
Maximum Benefit per Calendar Year:	\$1,750.00	\$1,250.00	\$1,750.00	\$1,250.00
Deductible per Calendar Year:	\$250.00	\$250.00	\$250.00	\$250.00
Co-Insurance Percentage	75%	70%	75%	70%

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Contacts	Paid under Vision Max	Paid under Vision Max	Paid under Vision Max	Paid under Vision Max
Lenses & Contacts - Every 12 months				
Frames - Every 24 months				
AGE LIMIT FOR COVERAGE:	65TH BIRTHDAY	99TH BIRTHDAY	65TH BIRTHDAY	99TH BIRTHDAY