COVER THAT CARES.

CG | INSURANCE

PREMIER HEALTH SCHEDULE OF BENEFITS 2024-2025

On Island Benefits

EFFECTIVE 1ST JUNE, 2024

Lifetime maximum for On and Off Island benefits:

Full-time Active Employees $5,000,000

Retirees ..... $2,000,000 /Annual Limit $500,000

Please note: Benefits not described in this section "On island benefits" will be paid subject to the deductible and coinsurance listed in the "Off island benefits" section.

Standard Health Benefits (SHB): Claim reimbursement will be considered for services incurred at a Bermuda Hospital Board facility, which are not covered under the SHB, as regulated by The Act, the Bermuda Health Council, and/or the Bermuda Government fee schedule, whichever is applicable. For services outside of the Bermuda Hospital Board facilities, please visit www.healthcouncil.bm for a full listing of SHB eligible providers and services under the law.

The following are Fixed Plan Benefits

regardless of location where services are rendered unless otherwise stated.

Doctor's Visits

Office $136
Home $200
Specialist (based on medical necessity) Initial visit $325
Each subsequent Specialist visit paid as Office visit

CG Pharmacy Prescription Drug Plan (prescribed medication)
(For prescriptions filled at the CG Pharmacy)

Generic 100%
Brand name 80%
Prescribed Oral Contraceptives ..... as above
Diabetic Supplies - Easy Touch* Brand Only 100%
*ET Test Strips, ET Lancets, ET Glucose Meter Kit, ET Pen Needles
Diabetic Supplies - all other brands 80%
Vitamins** (prescribed prescription strength) 100%
**with prescription and pre-authorised as medically necessary

Note: Prior approval for singular prescriptions, $2,000 or more, is required. CG Insurance will have the local pharmacy who submits the lowest quote fulfill the prescription.

Non-CG Pharmacy Prescription Drug Plan (prescribed meds)

Generic drugs 100%
Brand name drugs 80%
Prescribed contraceptives (max $1,200/calendar year) 75%
Diabetic Supplies 80%

Note: Prior approval for singular prescriptions, $2,000 or more, is required. CG Insurance will have the local pharmacy who submits the lowest quote fulfill the prescription.

Obstetrics

New employees subject to 10 month waiting period. Prior insurance will be counted towards waiting period, See Policy for details.

Normal Delivery, Caesarean Section, Miscarriage ..... Paid in full according to Bermuda Government legislated fee schedule
Elective Abortion $750

Home Healthcare Services 80%
(max 60 days per calendar year) Requires a doctor's referral letter, must be medically necessary and subject to relevant Fee Schedule or Reasonable & Customary allowance.

Optometrist (1 visit/calendar year) $142

Hearing Aids ..... $4,000/5 calendar years

Artificial Limbs ..... lifetime max: $30,000

Speech Therapy (max 52 visits/calendar year) $70
Requires Doctor's referral letter

Health and Wellness Exam, Screening and Services

Annual Physical (1 exam/calendar year)

General Practitioner $350
Specialists/Gynecologist $350
Lab/Diagnostic Testing, Immunisations, Flu Shot, Vaccines $735

Contraceptive Management (2 visits/calendar year) $75

Preventative Care

Coverage for the following services is paid according to the relevant Fee Schedule: Annual mammogram, PSA, PAP smear, Occult bloods

Well Baby Visits (max 10 visits/calendar year) $115

Well Child Visits (age 3-16 annual physical) $205

Smoking Cessation ..... lifetime max: 100% up to $2,500

Weight Loss Program*/Holistic Health Care $70
*Physician Supervised (max 15 visits/year) related to a medically-approved nutrition program or for services by an approved, qualified holistic health care provider.

Nutritional Counseling (requires doctor's referral letter)

Initial Visit $165
Each subsequent visit (max 6/calendar year) $70

Mental Health (max combination of Psychiatrist, Psychologist, and Clinical Therapists visits allowed is 52 visits/calendar year)

Clinical Psychiatrist $190
Licensed Psychologist $160
Clinical Therapist $145

Employee Assistance Programme (EAP)

Connects you to local resources to help support your and your dependents' emotional, practical or physical needs through professional counselling. This service is free, confidential, and available 365 days per year.

Physiotherapy and Occupational Therapy $85
(max 25 visits/calendar year) A visit includes services for examination and therapies performed on the same day.

Chiropractor (max 20 visits/calendar year) $85
A visit includes services for examination and modalities performed on the same day. This benefit can be extended to an approved, qualified acupuncturist or massage therapist.

Chiropodist (max 20 visits/calendar year) $80

Diabetic Counseling ..... as per the BHB fee schedule

Asthma Counseling

Initial Visit $168
Each subsequent visit (max 6 visits/calendar year) $70

Allergy Shots and Testing (when prescribed by a physician)

Initial Test (SET, RAST or PRIST) (max 1/lifetime) $650
Allergy Shots - per shot (max 25/calendar year) $25

Neuropsychological Testing 100%
(max $5,000, one test every 2 years). Must be pre-authorised.

Behavioural Therapies for Autism Spectrum and Attention Deficit Disorders 100%
(max $12,000/member/year). Must be pre-authorised. Includes:

- Treatment for any Pervasive Development Disorder, ADD, ADHD;
- Family or individual applied behavioral analysis therapies;
- Family psycho-educational therapy, occupational, speech, physical, and behavioral therapies.

Off Island Benefits

EFFECTIVE 1ST JUNE, 2024

Overseas Prescription Drugs Pharmacy Benefit

USA - In Network.....No deductible applies
Generic Drugs 80%
Brand Drugs 70%
Brand Name Drugs (if no Generic equivalent is available).....80%

USA - Out of Network.....Deductible applies
Generic Drugs 70%
Brand Drugs 60%
Brand Name Drugs (if no Generic equivalent is available).....70%

Worldwide (excl. USA).....No deductible applies
Drugs 80%

Cancer Center of Excellence (COE)	when Cancer COE is used	when non-Cancer COE is used
Deductible:	$0	$300
Co-insurance: (Insured's portion)	0%	25%
Stop-loss:	$0	Not Applicable

Chemotherapy & Radiation Therapy must be pre-certified regardless of the location where services are performed. If a Member is referred for Chemotherapy & Radiation Therapy and services are performed at a Cancer COE and prior approval obtained, the commercial air transportation overseas allowance can be used.

For all medical services and supplies Deductible/calendar year	when In Network Provider is used	Out of Network/ All other providers
Each Individual	$0	$300
Family maximum	$0	$600
Co-insurance (Insured's portion)	0%	20%
Stop-Loss (in addition to deductible)		
Each Individual	$0	$2,500
Family maximum	$0	$5,000

Hospital Room & board Unlimited number of days	100%	$1,000/day
Intensive care supplement Unlimited number of days	100%	$2,000/day

(includes Overseas Hospital Room & Board amount above)

Please note: **Care rendered In Network is reimbursed at 100% of the contracted rate. Care rendered Out of Network is reimbursed at 80% of Reasonable & Customary rates and is subject to the Deductible and Co-insurance.**

Substance Abuse & Mental Nervous Conditions
Mental nervous benefit inclusive of treatment for substance abuse. Pre-authorisation required. Reimbursed at $800/night for facility and doctors up to 28 days per admission up to lifetime max $50,000.

Transplant related charges *Institute of Excellence (IoE)	When IoE* provider is used	Out of Network/ All other providers
Deductible:	$0	$300
Co-insurance: (Insured's portion)	0%	25%
Stop-loss:	$0	Unlimited

The deductible and coinsurance will NOT apply to the following benefits:

Air Ambulance* .....$75,000/calendar year
Based on Medical Necessity

Commercial air transportation* ..... $6,500/calendar year
Specialist referral letter is required

Repatriation* ..... $10,000 lifetime max
Airfare for repatriation to home country of mortal remains

Overseas allowance*
Patient only $325/day
Patient and approved companion $375/day
(max 120 days/calendar year) May be used for accommodation, car rental, taxi hire, food or a combination of these, not to exceed the limits stated above. Advanced funding of emergency care: Airfare and 5 days per diem, current limits and specific documentation apply. The accompanying adult companion must be pre-approved as medically necessary to be eligible under this benefit.

*Please note: **If you elect for treatment overseas and this treatment is available in Bermuda, you will not qualify for these benefits.**

Optional Extra Benefits

These benefits are available only upon the request of the employer and for an additional premium.

Vision Plan..... $450
Can be applied towards Lasik Eye Surgery after a 12 month waiting period

Lasik Eye Surgery .....$2,500 lifetime max
12 month waiting period

Dental Benefits.....$3,000, $4,000 or $5,000

Corporate Wellness Programme

Executive Physicals

IMPORTANT

In order to receive the Off island benefits, notification must be given for all proposed inpatient admissions. For services in the US, please call 1-800-423-9130. For services outside the US or Bermuda, please call 1-317-927-6820 (collect call).

When you choose to receive treatment from an Out of Network provider, Coralisle Medical will reimburse at the percentage shown of Reasonable & Customary rates. These rates are subject to the Deductible and Co-insurance. When an In Network provider is used, eligible benefits are reimbursed at 100% based on contracted rates.

The amounts listed are the maximums paid by Coralisle Medical for the applicable services.

On and Off Island Benefits

EFFECTIVE 1ST JUNE, 2024

Premier Health at Home:

1. Always carry your Medical ID Card with you.
2. Toll-free 24/7 Nurse on Call line 1-800-423 9130
3. All pharmacies in Bermuda accept the Coralisle Medical ID Card.
4. To verify your benefits or receive advice, call Coralisle Medical (8:30 am - 5:00 pm Mon - Fri) 441-296-3200

Premier Health Overseas:

1. Always carry your Medical ID and RX cards with you when you travel.
2. Over 50,000 US Pharmacies participate in the RX Card programme. To find a pharmacy call 1-800-927-8802
3. Call to advise of proposed inpatient services:
   In the USA: 1-800-423-9130
   Worldwide excluding US: 1-317-927-6820 (collect)
4. To locate an In Network Facility or Provider:

   USA: ASA PPO Network by Aetna - www.aetna.com/asa

   Worldwide (excluding US): IMG Assistance - 1-317-927-6820 (collect) or ipa.imglobal.com

Off-Island Benefits:

Your ID card is a passport to overseas network care that will be billed directly to Coralisle Medical. By choosing an In Network hospital or physician, you will not be required to pay up-front or at the time services are rendered. Network facilities and providers accept assignment of benefits and they agree to accept negotiated contract rates. Charges will be paid in full at agreed rates.

In Network Services:

Facility and hospital charges will be reimbursed at 100% of the negotiated contract rate. Remember, however, the attending physician charges are billed separately and you should make sure that his/her services are also provided In Network.

Out of Network Services:

If you receive services from a facility or provider that is not within the Network, the cost of those services will be reimbursed at Reasonable & Customary rates (R&C). You will be responsible for paying the Deductible and 20% Co-insurance. However, your max liability will be $2,800 for charges that are Reasonable and Customary.

IMPORTANT: Should the physician charge at a rate higher than the R&C rates, then you are responsible for the balance.

How using In Network care makes financial sense:

Example (illustration only - for typical charges of $22,000)

Hospital and Physician Charges	$22,000
R&C (allowed by your plan)	$20,000
Network Contracted Rate	$15,000

Your Plan pays as follows:	In Network	Out of Network
Amount Billed	$22,000	$22,000
Allowed by your Plan R&C	not applicable	$20,000
Network Rate	$15,000	not applicable
Coralisle Pays	$15,000	$17,200
You Pay	Nil	$4,800*

*$300 Deductible + 20% Co-insurance capped at $2,500 + $2,000 physician fees above R&C not covered by your plan.

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Dental & Vision Benefits

EFFECTIVE 1ST JUNE, 2024

Coralisle's Dental and Vision Plans are optional extra benefits. Please check with your Employer to confirm coverage and at which level.

THE DENTAL PLAN

Dental Benefits are paid in accordance with the Ontario Dental Association Fee Schedule. Any amounts charged above and beyond these rates are the responsibility of the Insured. There are two levels of coverage available - Basic and Comprehensive.

Calendar Year Maximum (CYM): $3,000 or $4,000 or $5,000 (whichever is applicable to your plan)

Dental Benefits	% Payable
Basic Dental (Includes Preventative Treatment) Routine Examinations, Cleaning & Scaling, Bitewings, Fluoride Treatment (under 16 years) - 2 per calendar year; Periodontal Treatment of Gums - 4 per calendar year; Full mouth X-ray - 1 per 2 calendar years; Fillings; Extractions; Oral Surgery; Sealants (under 14 years); Space Maintainers (under 14 years); Retainers; Rebasing & Relining of Dentures; Root Canals	100%
Comprehensive Dental (Includes Preventative, Restorative and Orthodontic Treatment) Preventative: see above Restorative: Inlays, Onlays, Crowns, Bridges, Bridge Repair, Dentures, Denture Repair, Implants Orthodontic: Braces for Teeth Alignment (**Lifetime Maximum:** $3,000 in addition to above CYM)	as above 80% 50%

Limitations & Exclusions: TMJ Treatment, Cosmetic Dentistry (other than repairs of accidental injury within 90 days of accident)

THE VISION PLAN

Calendar Year Maximum (CYM): $450

Vision Benefits	% Payable
Prescription Eyeglasses and Prescription Sunglass (frames and lenses) Prescription Contact lenses (soft, hard, disposable)	100%

Limitations & Exclusions: Medical eye examination not included (covered under the Medical Plan. Please refer to the relevant Schedule of Benefits.).

The Vision Plan CYM can be applied towards Lasik Eye Surgery after a 12 month waiting period.

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