



Standard Schedule of Benefits

Effective 1 April 2011 – 31 March 2012

Basic (Act) Benefits for Care and Services at KEMH*	
Public Ward Hospitalization	As per The Health Insurance Act
Newborn Infants Unit Hospitalization	As per The Health Insurance Act
Mid Atlantic Wellness Institute Hospitalization	As per The Health Insurance Act
Hospice Inpatient Care	As per The Health Insurance Act
Emergency & Outpatient Services, Laboratory & Diagnostic Imaging	100% of the BHB Schedule
Government Approved Private Testing Facility	100% of the Bermuda Fee Schedule
Artificial Limbs and Appliances	\$15,000.00 per lifetime

Supplementary Benefits for Care & Services at KEMH	
Semi Private Ward Hospitalization*	As per The Health Insurance Act
Private Ward Hospitalization*	As per The Health Insurance Act
Charges for Surgery, Anesthesia, Diagnostic Labs & Imaging at KEMH	100% of the BHB Schedule
Ground Ambulance	100% of the BHB Schedule
Prosthetic Supplies	100% of the BHB Schedule

* Number of inpatient days per year is unlimited

Vision Care (VC on your insurance card)	
Annual Eye exam (performed by an Optometrist)	\$80.00 (1 visit every 12 months)
Glasses or Contact Lenses	\$600.00 maximum every 24 months

Prescribed Medications (PD on your insurance card)
80% for prescribed brand name drugs 100% for prescribed generic drugs 75% for prescribed oral contraceptives

Note: Items in red denote change from 2010

Preventative & Diagnostic Services (H/O on your insurance card)	
Asthma or Allergy or Audiology Initial Consult	\$127.00
Asthma or Allergy or Audiology Subsequent Visits	\$43.00 (2 visits per calendar year)
Nutritional Initial Consult	\$127.00
Nutritional Subsequent Visits	\$32.00 (6 visits per calendar year)
Diabetic Counseling Initial Consult	\$127.00
Diabetic Counseling Subsequent Visits	\$32.00 (6 visits per calendar year)
Annual General Health Exam General Practitioner**	\$126.00
Annual General Health Exam Specialist**	\$194.00
Routine Diagnostic Testing performed w/ annual exam	\$261.00 maximum per calendar year
Annual GYN exam ∞	\$122.00 (1 visit every 12 months)
Well Baby Care	\$56.00 (Maximum 8 visits in first 2 years of life)
Pediatric Annual Exam	\$106.00 (Valid for children age 2 to 16 years old)
Diagnostic Testing & Imaging at a Private Facility	100% of the Bermuda Fee Schedule
Cardiac Care	\$123.00 per session (23 visits per calendar year)

** One exam every 12 months if over age 40 or every 24 months if under age 40

∞ Females: one annual physical or GYN exam is separately reimbursed only if 6 months apart or performed by two different physicians

Home and Office Medical Benefits (H/O on your insurance card)	
General Practitioner Office Visit	\$56.00
General Practitioner or Specialist Home Visit	\$127.00
Specialist Initial Consult	\$194.00 per Consult
Specialist Follow-up visit	\$56.00
In Office Surgery	100% of the Bermuda Fee Schedule
Physical/Occupational/Speech Therapy, TENS, Chiropractor, Therapeutic Massage or Acupuncture	\$58.00 per visit (\$1,000.00 maximum per year)
Chiropodist/Podiatrist	\$49.00 (12 visits per calendar year)
Outpatient or In Office Psychiatry	\$144.00 (25 visits per calendar year)
Outpatient or In Office Clinical Psychology (Individual)	\$80.00 (12 visits per calendar year)
Outpatient or In Office Clinical Psychology (Group Therapy)	\$37.00 (24 visits per calendar year)

Note: Items in red denote change from 2010

Major Medical Benefits	
(MM on your insurance card)	
Lifetime maximum per Insured	Under age 65 - \$5,000,000.00 Over age 65 - \$500,000.00
Inpatient Care Overseas Room & Board	Reasonable and Customary charges up to a maximum of 120 days per year if under age 65 or 45 days per calendar year if over age 65
Intensive Care Unit Overseas Room & Board	Reasonable and Customary charges up to a maximum of 120 days per year if under age 65 or 45 days per calendar year if over age 65
Overseas Outpatient & Emergency Services	Reasonable and Customary charges
Surgical, Anesthesia, Diagnostic & Medical Care	Reasonable and Customary charges
Inpatient treatment for Substance Abuse	Mid Atlantic Wellness Institute per day- Maximum of two 28 day admissions per lifetime
Inpatient Physical Rehabilitation Room & Board	\$45,000.00 per calendar year
Skilled Nursing Facility Room & Board	\$25,000.00 per calendar year
Home Health Nursing Care	Maximum of 4 hours per day (up to \$25,000.00 per calendar year)
Ground Ambulance	Reasonable & Customary charges payable at 100%
Commercial Air Fare≈	Maximum \$4,000.00 per calendar year
Overseas Hotel Accommodation≈	Maximum \$150.00 per day (up to 120 days per calendar year) Inclusive of ground transport, food and/or room rate
Sclerotherapy	Up to \$5,000.00 in any 6 year period (maximum of 6 treatments)
Air Ambulance	Reasonable and Customary charges payable at 100%
Hearing Aids	\$1,500 per aid and per ear every 5 years
Durable Medical Equipment	80% up to \$15,000.00 per calendar year
Orthotics and Surgical Hose	Reasonable & Customary charges, maximum 2 pair per year
Allergy Testing	80% to a maximum of \$500.00 per lifetime
Allergy Injections	80% to a maximum of \$500.00 per calendar year
Repatriation of remains	Maximum of \$5,000.00

≈ Airfare/Accommodation expenses are not reimbursed for elective care

Note: Items in red denote change from 2010

Overseas Care	
TREATMENT TYPE	COVERAGE
Emergency Treatment	100% of Reasonable & Customary charges for services
Referred Treatment	100% of Reasonable & Customary charges if services rendered within BF&M's Preferred Provider Network & pre-approved. 50% of Reasonable & Customary charges if services rendered outside of BF&M's Preferred Provider Network.
Elective Treatment♣	Reasonable & Customary charges are considered & paid in accordance with the Bermuda Fee Schedule for services.
♣ Airfare and accommodation costs are not covered for elective care	

Dental Benefits	
BF&M requests submission of a cost estimate for services exceeding \$500	COVERAGE
Basic Dental (BD on your insurance card)	Medically Necessary services paid in accordance with ODA Fee Guide*
Periodontal Treatment (BD on your insurance card)	Maximum of \$1,500.00 per calendar year paid at 50%
Restorative (R or R80 on your insurance card)	Maximum of \$3,000.00 per calendar year paid at 50% or 80% dependent on plan type♣
Orthodontic (O on your insurance card. ■)	Maximum of \$3,000.00 per lifetime and \$1,500.00 per calendar year paid at 50%

**ODA = 2011 Ontario Dental Association Fee Guide

- ♣ Dental implant coverage is excluded
- Applicable to insured dependant child only