



Standard Schedule of Benefits

Effective 1 April 2009 – 31 March 2010

| Basic (Act) Benefits for Care and Services at KEMH* | |
|------------------------------------------------------------------|------------------------------------------------------|
| Public Ward Hospitalization | \$1056.00 per day |
| Newborn Infants Unit Hospitalization | \$451.00 per day |
| Mid Atlantic Wellness Institute Hospitalization | \$683.00 per day (maximum 40 days per calendar year) |
| Hospice Inpatient Care | \$549.00 per day (maximum 40 days per calendar year) |
| Emergency & Outpatient Services, Laboratory & Diagnostic Imaging | 100% of the Bermuda Fee 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* | \$1,262.00 per day |
| Private Ward Hospitalization* | \$1,514.00 per day |
| Charges for Surgery, Anesthesia, Diagnostic Labs & Imaging at KEMH | 100% of the Bermuda Fee Schedule |
| Ground Ambulance | 100% of the Bermuda Fee Schedule |
| Prosthetic Supplies | 100% of the Bermuda Fee Schedule |

* Number of inpatient days per year is unlimited

| Vision Care (VC on your insurance card) | |
|------------------------------------------------|----------------------------------|
| 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 2008

| Preventative & Diagnostic Services (H/O on your insurance card) | |
|----------------------------------------------------------------------------|-----------------------------------------------------|
| Asthma or Allergy or Audiology Initial Consult | \$120.00 |
| Asthma or Allergy or Audiology Subsequent Visits | \$41.00 (2 visits per calendar year) |
| Nutritional Initial Consult | \$120.00 |
| Nutritional Subsequent Visits | \$30.00 (6 visits per calendar year) |
| Diabetic Counseling Initial Consult | \$120.00 |
| Diabetic Counseling Subsequent Visits | \$30.00 (6 visits per calendar year) |
| Annual General Health Exam General Practitioner** | \$119.00 |
| Annual General Health Exam Specialist** | \$184.00 |
| Routine Diagnostic Testing performed w/ annual exam | \$246.00 maximum per calendar year |
| Annual GYN exam ∞ | \$115.00 (1 visit every 12 months) |
| Annual Eye exam (performed by an Optometrist) | \$75.00 (1 visit every 12 months) |
| Well Baby Care | \$53.00 (Maximum 8 visits in first 2 years of life) |
| Pediatric Annual Exam | \$100.00 (Valid for children age 2 to 16 years old) |
| Diagnostic Testing & Imaging at a Private Facility | 100% of the Bermuda Fee Schedule |

** 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 | \$53.00 |
| General Practitioner or Specialist Home Visit | \$120.00 |
| Specialist Initial Consult | \$184.00 per Consult |
| Specialist Follow-up visit | \$53.00 |
| In Office Surgery | 100% of the Bermuda Fee Schedule |
| Physical/Occupational/Speech Therapy, TENS, Chiropractor, Therapeutic Massage or Acupuncture | \$55.00 per visit (\$1000.00 maximum per year) |
| Chiropodist/Podiatrist | \$47.00 (12 visits per calendar year) |
| Outpatient or In Office Psychiatry | \$136.00 (25 visits per calendar year) |
| Outpatient or In Office Clinical Psychology (Individual) | \$75.00 (12 visits per calendar year) |
| Outpatient or In Office Clinical Psychology (Group Therapy) | \$35.00 (24 visits per calendar year) |

Note: Items in red denote change from 2008

| 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 | \$683.00 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 2008

| Overseas Care | |
|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| TREATMENT TYPE | COVERAGE |
| Emergency Treatment | 100% of Reasonable & Customary charges for services |
| Referred Treatment (Services deemed to be medically necessary/cannot be performed in Bermuda) | 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 ♣ <i>Airfare and accommodation costs are not covered for elective care</i> | Reasonable & Customary charges are considered & paid in accordance with the Bermuda Fee Schedule for services. |

| Dental Benefits | |
|--------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| <i>BF&M requests submission of a cost estimate for services exceeding \$500</i> | 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 = 2009 Ontario Dental Association Fee Guide

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