HEAT & FROST INSULATORS & ALLIED WORKERS HEALTH CARE FUND
BENEFITS AND ELIGIBILITY AT A GLANCE
EFFECTIVE JANUARY 1, 2014

Active Participants and Pre-Medicare Retirees

Benefits		**In-Network**	**Out-of-Network**
Deductible		None	$250 for one member or $500 for the family each calendar year
Co-pays	Fixed dollar co-pays	• $20 for office visits, and • $100 for emergency room visits	$100 for emergency room visits
	Percent co-pays	50% of approved amount for private duty nursing and LASIK by Intralase Method 10% of approved amount for mental health care, substance abuse treatment, and private duty nursing 10% of approved amount for most other covered services	• 30% of approved amount for general services, and • 20% of approved amount for mental health care, substance abuse treatment, and private duty nursing • 50% of approved amount for private duty nursing and LASIK by Intralase Method
Annual co-pay dollar maximums - Applies to co-pays for all covered services – including mental health and substance abuse services – but **does not** apply to fixed dollar co-pays and private duty nursing percent co-pays		$500 for one member $1,000 for two or more members each calendar year	$1,500 for one member $3,000 for two or more members each calendar year **Note** :Out-of-network co-pays also apply toward the in-network maximum
Lifetime dollar maximum		None	

Preventive Care Services

***Payment for preventive care services is limited to a combined maximum of $750 per member per calendar year.**

Health maintenance exam – includes chest X-ray, EKG, and select lab procedures, one per calendar year	Covered – 100% approved amount*	Non covered
Gynecological exam – one per calendar year	Covered – 100% of approved amount*	Not covered
Pap smear screening – laboratory and pathology services, one per calendar year	Covered – 100% of approved amount*	Not covered
Well-baby and child care visits: • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 2 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • 1 visit per birth year, 48 months through age 15	Covered – 100% of approved amount*	Not covered
Adult & childhood immunizations as recommended by the Advisory Committee on Immunizations **Practices** and the American Academy of Pediatrics. **Note:** No age limit for the Hepatitis B immunization.	Covered – 100% of approved amount*	Not covered
Fecal occult blood screening – one per calendar year	Covered – 100% of approved amount*	Not covered
Flexible sigmoidoscopy exam – one per calendar year	Covered – 100% of approved amount*	Not covered
Prostate specific antigen (PSA) screening – one per calendar year	Covered – 100% of app.*	Not covered

Mammography	In-Network	Out-of-Network
Mammography screening – one per calendar year, no age restrictions	Covered – 100% of approved amount	Covered – 80% of approved amount after deductible

Physician Office Services

Office visits, Office consultations Urgent care visits	Covered - $20 co-pay per visit	Covered – 70% of app amt after deductible, must be medically necessary
Outpatient and home medical care visits	Covered – 90% of approved amount	Covered – 70% of app amount after deductible, must be medically necessary

Emergency Medical Care

Hospital emergency room	Covered - $100 co-pay for facility charges (waived if admitted or if injury is the result of an accidental injury)	Covered - $100 co-pay for facility charges (waived if admitted or if injury is the result of an accidental injury)
Ambulance services – must be medically necessary	Covered – 90% of approved amount	Covered – 90% of approved amount

Diagnostic Services

Laboratory and pathology services	Covered – 90% of approved amount	Covered – 70% of approved amount after deductible
Diagnostic tests and X-rays	Covered – 90% of approved amount	Covered – 70% of approved amount after deductible
Therapeutic radiology	Covered – 90% of approved amount	Covered – 70% of approved amount after deductible

Maternity Services Provided by a Physician or Certified Nurse Midwife

Prenatal and postnatal care	Covered – 90% of approved amount	Covered – 70% of approved amount after deductible
Delivery and nursery care	Covered – 90% of approved amount	Covered – 70% of approved amount after deductible

Hospital Care

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies – unlimited days. **Note:** Nonemergency services must be rendered in a **participating** hospital.	Covered - 90% of approved amount	Covered – 70% of approved amount after deductible
Inpatient consultations	Covered – 90% of approved amount	Covered – 70% of approved amount after deductible
Chemotherapy	Covered – 90% of approved amount	Covered – 70% of approved amount after deductible

Alternatives to Hospital Care

Skilled nursing care – up to 120 days per member per calendar year	Covered – 90% of approved amount	Covered – 90% of approved amount
Hospice care – limited to dollar maximum that is reviewed and adjusted periodically	Covered – 100% of app amount	Covered – 100% of app amount
Home health care – must be medically necessary and provided and billed by a **participating** home health care agency	Covered – 90% of approved amount	Covered – 90% of approved amount
Home infusion therapy – must be medically necessary and given by **participating** home infusion therapy providers	Covered – 90% of approved amount	Covered – 90% of approved amount

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Surgical Services	**In-Network**	**Out-of-Network**
Surgery – includes related surgical services and medically necessary facility services provided by a BCBSM **participating** ambulatory surgery facility	Covered – 90% of approved amount	Covered – 70% of approved amount after deductible
Presurgical consultations – with a doctor of medicine, osteopathy, podiatry or an oral surgeon	Covered – 100% of approved amount	Covered – 70% of approved amount after deductible
LASIK surgery by the Intralase Method – up to a lifetime maximum of $1,000 per eye	Covered – 50% of approved amount	Covered – 50% of approved amount
Colonoscopy	Covered – 90% of approved amount	Covered at 70% of approved amount
Voluntary sterilization	Covered – 90% of approved amount	Covered – 70% of approved amount after deductible
Voluntary abortions	Not covered	Not covered

Human Organ Transplants

Specified human organ transplants – **in designated facilities only**, when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504)	Covered – 100% of approved amount, limited to a $1 million **lifetime** maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504); specific criteria apply	Covered – 90% of approved amount	Covered – 70% of approved amount after deductible
Kidney, cornea, and skin transplants	Covered – 90% of app. Amt	Covered – 70% of app amt after deductible

Mental Health Care and Substance Abuse Treatment

Inpatient mental health care – unlimited days	Covered – 90% of approved amount	Covered – 70% of approved amount after deductible
Inpatient substance abuse treatment – unlimited days	Covered – 90% of approved amount	Covered – 70% of approved amount after deductible
Outpatient mental health care – In a facility or clinic	Covered – 90% of approved amount	Covered – 90% of approved amount
Physician’s office	Covered – 90% of approved amount	Covered – 70% of approved amount after deductible
Outpatient substance abuse treatment – up to the state-dollar amount that is adjusted annually, in approved facilities only	Covered – 90% of approved amount	Covered – 90% of approved amount

Other Covered Services

Outpatient diabetes management program	Covered – 90% of approved amount	Covered -70% of approved amount after deductible
Allergy testing and therapy	Covered – 100% of approved amount	Covered – 70% of approved amount after deductible
Chiropractic spinal manipulation – a maximum of 24 visits (network and non-network providers **combined**) per member per calendar year	Covered – 100% of approved amount	Covered – 70% of approved amount after deductible

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Other Covered Services		In-Network	Out-of-Network
Outpatient physical, speech, and occupational therapy – a **combined** 60 -visit maximum per calendar year for physical therapy in the outpatient department of a hospital as well as in the physician's office	In a facility or clinic	Covered – 100% of approved amount	Covered – 70% of approved amount
	In the physician's office- **excludes speech**	Covered – 100% of approved amount	Covered – 70% of approved amount after deductible
Durable medical equipment, Prosthetic and orthotic appliances		Covered– 90% of approved amount	Covered – 90% of approved amount
Private duty nursing		Covered – 50% of approved amount	Covered – 50% of app. Amount

Blue Vision Coverage	VSP network doctor	Non-VSP provider
Eye Exam	$5 co-pay	$5 co-pay applies to charge
Prescription glasses (lenses and/or frames	A combined $10 co-pay	Member responsible for difference between approved amount and provider's charge, less $10 co-pay
Medically necessary contact lenses	$10 co-pay	Member responsible for difference between approved amount and provider's charge, less $10 co-pay
Eye Exam – one exam per year		
Complete eye exam by an ophthalmologist or optometrist	$5 co-pay	Reimbursement up to $35, less $5 co-pay
Lenses and Frames – one pair of lenses and frame per year		
Standard lenses prescribed and dispensed by an ophthalmologist or optometrist	$10 co-pay (one co-pay applies to both lenses and frames)	Reimbursement up to predetermined amount based on lenses type after co-pay
Standard frames	$10 co-pay (one co-pay applies to both lenses and frames)	Reimbursement up to $45, less $10 co-pay
Contact Lenses – one pair of contact lenses per year		
Medically necessary contact lenses	$10 co-pay	Reimbursement up to $210 after $10 co-pay
Elective contact lenses that improve vision	$130 allowance that is applied toward contact lens exam and the contact lenses	$105 allowance that is applied toward contact lens exam and the contact lenses

Prescription Drug Coverage – ALL ELIGIBLE PARTICIPANTS

Benefits	Network Pharmacy	Non-Network Pharmacy
1 to 30-day period	20% of approved amount for each prescription, but not less than $5 or more than $100	20% of approved amount for each prescription, but no less than $5 or more than $100 ***plus*** 25% of the BCBSM approved amount for the drug
31 to 83-day period **Note: Network mail order provider –** 20% of approved amount for each prescription, but no less than $5 or more than $100	No coverage	No coverage

Prescription Drug Coverage – ALL ELIGIBLE PARTICIPANTS

84 to 90-day period **Note: Network mail order provider –** 20% of approved amount for each prescription, but not less than $10 or more than $200	No coverage	No coverage

Other Covered Drug Services

FDA-approved drugs	Covered – 100% of approved amount less plan co-pay	Covered – 75% of approved amount less plan co-pay
Prescribed over-the-counter drugs – when covered by BCBSM	Covered – 100% of approved amount less plan co-pay	Covered – 75% of approved amount less plan co-pay
State-controlled drugs	Covered – 100% of approved amount less plan co-pay	Covered – 75% of approved amount less plan co-pay
Disposable needles and syringes – dispensed w/ insulin or other covered injectable legend drugs	Covered – 100% of approved amount less plan co-pay	Covered – 75% of approved amount less plan co-pay
Prescription contraceptive medications	Covered – 100% of approved amount less plan co-pay	Covered – 75% of approved amount less plan co-pay
Specialty drugs – limited to a 30-day supply	Not covered	Not covered

Hearing Care	**Participating provider**	**Nonparticipating provider**
Deductible	None	Not applicable
Co-pay	None	Not applicable
Audiometric exam – one every 36 months	Covered – 100% of approved amount	Not covered
Hearing aid evaluation – one every 36 months	Covered – 100% of approved amount	Not covered
Ordering and fitting the hearing aid – one every 36 months	Covered – 100% of approved amount	Not covered
Hearing aid conformity test – one every 36 months	Covered – 100% of approved amount	Not covered
Audiometric exam – one every 36 months	Covered – 100% of approved amount	Not covered
Hearing aid evaluation – one every 36 months	Covered – 100% of approved amount	Not covered
Ordering and fitting the hearing aid – one every 36 months	Covered – 100% of approved amount	Not covered
Hearing aid conformity test – one every 36 months	Covered – 100% of approved amount	Not covered

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Dental Coverage ACTIVE PARTICIPANTS ONLY

Benefits	**Out-of-Pocket Costs**
Co-pays Class I Services Class II & III Services Class IV Services	 No co-pay (covered at 100% of approved amount); **Not included in the annual dollar maximum** Covered – 25% of approved amount Not Covered
Annual maximum **Lifetime** maximum	$1,000 per member per calendar year Not applicable

Class I Services

Benefits	**Out-of-Pocket Cost**
Oral exam – once every six consecutive months	Covered – 100% of approved amount
Teeth cleaning – once every six consecutive months	Covered – 100% of approved amount
Bitewing X-rays – once every twelve months	Covered – 100%of approved amount
Full-mouth X-rays – once every 36 months	Covered – 100% of approved amount
Fluoride treatment	Covered – 100% of approved amount
Space maintainers – up to age 19	Covered – 100% of approved amount
Palliative emergency treatment	Covered – 100% of approved amount

Class II Services

Benefits	**Out-of-Pocket Cost**
Fillings (amalgam, acrylic, or silicate)	Covered – 75% of approved amount
Inlays, onlays, and crowns	Covered – 75% of approved amount
Root canal therapy	Covered – 75%of approved amount
Periodontic treatments	Covered – 75% of approved amount
General anesthesia	Covered – 75% of approved amount
Oral surgery including extractions	Covered – 75% of approved amount
Repairs to existing dentures	Covered – 75% of approved amount

Class III Services

Benefits	**Out-of-Pocket Cost**
Removable dentures	Covered – 75% of approved amount
Fixed bridges	Covered – 75% of approved amount
Endosteal Implants	Covered – 75% of approved amount
Class IV services	**Out-of-Pocket Cost**
Minor treatment for tooth guidance appliances	Not covered
Minor treatment to control harmful habits	Not covered
Interceptive and comprehensive orthodontic treatment	Not covered

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BCBS Supplemental Coverage	Medicare	Blue Traditional Supplemental
Deductible amounts	**Medicare Part A** $1,132 (days 1-60) each benefit period **Medicare Part B** $162 each benefit period	Master Medical 65 coverage requires a $100 deductible for each member in each calendar year
Fixed dollar co-pays	**Hospitalization** $283 (days 61-90) and $566 (days 91-150) each benefit period **Skilled nursing facility care** $141.50 (days 21-100) each benefit period	None
Coinsurance/percent co-pay amounts	20% of Medicare approved amount for most general services 45% of Medicare approved amount for outpatient mental health care 50% of Medicare approved amount for outpatient substance abuse	After the deductible is met, member pays a 20% co-pay. Master Medical 65 benefits are payable up to $2,500 for each member in each calendar year, with a lifetime maximum of $5,000
Preventive care services		
Health Maintenance Exam	Covered – 100% of Medicare approved amount, once every 12 months	Covered in full by Medicare
Gynecological exam	Covered – 100% of Medicare approved amount, once every 24 months	Covered in full by Medicare
Pap Smear Screening – laboratory services only	Covered – 100% at Medicare approved amount, once every 24 months	Covered in full by Medicare
Fecal occult blood test	Covered – 100% of Medicare approved amount, once every 12 months over age 50	Covered in full by Medicare
Flexible sigmoidoscopy exam	Covered – 100% of Medicare approved amount, once every 48 months at age 50 and older	Covered in full by Medicare
Prostate Specific Antigen (PSA) Test	Covered – 100% of Medicare approved amount, once every 12 months over age 50	Covered in full by Medicare
Mammography Screening	Covered – 100% of Medicare approved amount, once every 12 months at age 40 and older	Covered in full by Medicare
Flu shots	Covered – 100% of Medicare approved amount, one per flu season in the fall or winter	Covered in full by Medicare
Hepatitis B shots – for those at high or medium risk of contracting the disease	Covered – 100% of Medicare approved amount	Covered in full by Medicare
Pneumococcal shot	Covered – 100% of Medicare approved amount	Covered in full by Medicare
Colonoscopy	Covered at 100% of Medicare approved amount, once every 10 years	Covered in full by Medicare
Well-baby and child care visits	One health maintenance exam covered at 100% of Medicare approved amount, every 12 month	Covered in full by Medicare

Physician Office Services

Office Visits, Outpatient & Home visits, office consultations, ambulance services, surgery	Covered at 80% of Medicare approved amount less Part B coins	Not covered

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Emergency Medical Care	Medicare	Blue Traditional Supplemental
Hospital Emergency Room (professional services) – must be medically necessary	Covered at Medicare approved amount less Part B deductible and coinsurance or set co-payment	Covers Medicare deductible and coinsurance or set co-payment
Ambulance services – must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance

Clinical Laboratory Services

Laboratory and Pathology Tests – used in the diagnosis and treatment of an illness or injury	Covered at 100% of Medicare approved amount for most diagnostic laboratory and pathology services	Covered in full by Medicare

Hospital Care

Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies		
• Days 1-60	Covered at 100% Medicare approved amount less Part A deductible	Covers Medicare deductible
• Days 61-90	Covered at 100% Medicare approved amt less Part A daily coinsurance.	Covers Medicare daily coinsurance.
• Lifetime Reserve Days (60 days)	Covered at 100% Medicare app. amt less Part A daily coinsurance	Covers Medicare daily coinsurance
• Additional days	Not covered	Covered at BCBSM approved amount, up to 275 days; additional days under MM65 at BCBSM approved amount
Chemotherapy	Covered at 80% of Medicare approved amount for administration and drugs, must meet Medicare criteria	Covers Medicare deductible and coinsurance

Alternatives to Hospital Care

Skilled Nursing Facility Care – specific criteria applies		
• Days 1-20 • Days 21-100	Covered at 100% Medicare approved amount	Covered in full by Medicare
• Days 101 and after	Not covered	Not covered
Hospice Care	Covered at Medicare app. amt less small co-pay for outpatient drugs less small coinsurance for inpatient respite care	Covers limited costs not covered by Medicare
Home Health Care – medically necessary	Covered at 100% Medicare approved amount	Covered in full by Medicare

Human Organ Transplants

Heart and Liver, Lung and Liver Cornea, Bone Marrow & Kidney	Covered at 80% Medicare approved amount less deductible and coinsurance	Covers Medicare deductible and coinsurance
Pancreas	Not covered **Note**: Pancreas transplants are covered under certain conditions. Please call Medicare for more information.	Not covered **Note**: Covers Medicare deductible and coinsurance when covered by Medicare.

Mental Health Care

Inpatient Mental Health Care in psychiatric facility • Days 1-190 **lifetime**	Covered at Medicare approved amount less deductible and coinsurance. N**ote**: In most cases, psychiatric care in general (as opposed to psychiatric) hospitals is not subject to the 190-day limit.	Covers Medicare deductible and coinsurance
• Additional days after 190 lifetime days are used	Not covered	Covered under MM65 less MM65 deductible and co-pay*
Outpatient Mental Health Care – Diagnostic services are covered at the Medicare approved amount less Part B deductible and coinsurance	Covered at 55% Medicare approved amount less Part B deductible and coinsurance or set co-payment for therapeutic services.	Covers Medicare deductible and coinsurance or set co-payment

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Other Services	**Medicare**	**Blue Traditional Supplemental**
Allergy Testing and Therapy – with approved diagnosis	Covered at 80% of Medicare approved amount less Part B deductible and coinsurance	Covers Medicare deductible and coinsurance for testing. Injections are not covered.
Chiropractic Spinal Manipulation – must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible and coinsurance	Not covered
Outpatient Physical, Speech and Occupational Therapy	Covered at Medicare approved amount less Part B deductible and coinsurance or set co-payment. **Note**: Services of independent physical or occupational therapist subject to annual dollar limit.	Covers Medicare deductible and coinsurance or set co-payment
Durable Medical Equipment & Prosthetic Appliances	Covered at 80% Medicare approved amount less Part B deductible and coinsurance	Covers Medicare deductible and coinsurance
Private Duty Nursing	Not covered	Covered under MM65 less MM65 deductible and co-pay*
Prescription Drugs	Not covered	Not covered
Oral Cancer Drugs	Approved drugs are covered	Covered in full by Medicare

Foreign Travel

Hospital & Physician Services	Not covered, except for inpatient hospital services in Canada or Mexico in rare situations	Covered at BCBSM approved amount, up to 30 days for covered services

*Master Medical 65 coverage requires a $100 deductible per member each calendar year. After the deductible is met, member pays a 20 percent co-pay (50 percent co-pay for private duty nursing). Master Medical 65 benefits are payable up to $2,500 per member per calendar year, with a lifetime maximum of $5,000. Once member reaches the $5,000 maximum, an additional $1,000 allowance is restored each calendar year of continuous coverage.

Deductible, Co-pays and Dollar Maximums

Deductible	None	$250 for one member $500 for the family
Co-pays • Fixed Dollar Co-pay	$20 co-pay for office visits $100 co-pay for emergency room visits	$100 for emergency room visits
• Percent Co-pay	50% of approved amount for private duty nursing and LASIK by Intralase Method 10% of approved amount for mental health care and substance abuse treatment 10% of approved amount for most other covered services	50% of approved amount for private duty nursing and LASIK by Intralase Method 20% of approved amount for mental health care and substance abuse treatment 30% of approved amount for most other covered services
Annual Co-pay Dollar Maximums- applies to co-pays for all covered services – including mental health and substance abuse services- but **does not** apply to fixed dollar co-pays and private duty nursing percent co-pays	$500 for one member $1,000 for two or more members each calendar year	$1,500 for one member $3,000 for two or more members each calendar year
Lifetime Dollar Maximums	None	

Additional Information

Death Benefits	Active Participants (Member only) $ 25,000 Accidental Death & Dismemberment $25,000 Spouse $10,000 Dependent Child $5,000 Dependent Infant $2,000
Disability Benefits	Active participants only. Receive $200 per week for 1st six-weeks,$250 per week for the 7th week through the maximum payable of 39 weeks
Eligibility	Initial: 520 hours within six consecutive months, skip the 7th month for book keeping, eligible the 8th month If ineligible for more than 12 months, must reinstate with 520 hours