Medical Benefits

An Overview of Your Medical Benefits

The Painters & Allied Trades District Council No. 35 Health Plan covers most medically necessary expenses. For provider discounts, we contract with CareLink, a Preferred Provider Organization (PPO) alliance between Tufts Health Plan and CIGNA HealthCare. Your medical claims are paid directly by the Painters & Allied Trades District Council No. 35 Health Plan at the Fund Office. Claim payments will be considered and paid in accordance with the CareLink generally accepted procedures and practices.

When you visit a PPO provider (an "in-network" provider) you receive services at a discounted rate. All in-network services are paid at a percentage of a discounted network rate. Most covered medical expenses in the PPO are paid at 90%. You are responsible for paying the other 10% and any applicable copayments.

The Plan will pay up to $1 million per person in medical expenses. This is called the "Lifetime Maximum." For more information, see page 13.

What's Covered?

Most medically necessary services are covered by the Plan. However, different levels of coverage and/or limits apply to some services. Check the Summary of Benefits on the following pages for more information or call the Fund Office at (617) 524-1240 to see if a specific service is covered.

Coverage Out-of-Network

Most providers participate within the PPO network; however, you can still choose to visit an out-of-network provider. The Plan will pay less—60% instead of 90%—and you'll have to meet a deductible first.

The chart below summarizes the differences between in- and out-of-network coverage.

	In-Network	Out-of-Network
Annual Deductible	$0	$250 per individual, $500 per family
Coverage	90% of PPO rate	60% of "reasonable and customary" rate
Out-of-Pocket Maximum (the most you can pay out of your own pocket for covered medical expenses each year)	$1,500 individual $3,000 family	$3,000 individual $7,000 family
Lifetime Maximum (the most the Plan will pay on each participant's behalf)	$1,000,000	

Summary of Medical Benefits

The following schedule shows the amount the Health Benefits Fund pays for medically necessary covered services and treatment when rendered by a **PPO in-network** provider.

Service	Plan Pays	Notes
Acupuncture and/or Chiropractic Benefit	100% up to $800 (combined) calendar year maximum	Claims for dependents 18 or younger must have prior approval.
Ambulance **Air Ambulance**	70% 70% of first $2,000 in charges for air ambulance	Ambulance services for any other transport must be pre-approved. Physician charges or wheel chair transport not covered. Air ambulance for a life-threatening medical emergency only. See page 73 for more information.
Diagnostic Testing	90% network hospital or 100% network non-hospital	• Laboratory • Radiology • MRIs or Pet Scans • Stress/EKG/EEG • Allergy • Sleep study (dependents 18 and under must have prior approval).
Home Health Services/Hospice	100%	Pre-approval by CareAllies is required. See page 74 for more information.
Hospital Services	90%	Pre-approval by CareAllies is required. • Anesthesia • Room and board (semi-private room rate) • Maternity • Physician • Surgeon • Surgical Day Care • Outpatient • Dental (see page 19 for details).

Summary of Medical Benefits *continued*

Service	Plan Pays	Notes
Hospital Emergency Room	90% after $100 deductible	
Injections **Immunizations**	90% 100%	• Allergy, Spinal, Cortisone • Immunizations must be AMA/FDA approved and provided according to age requirements. No coverage for adult meningitis vaccine.
Learning Disability Benefits	100% after $20 copayment	No coverage available for ADD, ADHD, Hyperkinetic Syndrome, Conduct Disorders or Developmental Delays except as indicated. Covered services are limited to a neurological evaluation by a neurologist to rule out brain pathology and services of a physician to monitor medication in office setting only.
Medical Equipment or Supplies Purchase or Rental	100%	Rental or purchase of medical equipment must be reviewed and approved through the Fund Office prior to purchase or rental for the following covered expenses: • Catheter Supplies • Colostomy/Ostomy • Diabetic Supplies • Insulin Pumps (once every five years) • Nebulizer (up to $250, once per lifetime) • Prosthetic Appliances - Initial purchase of prosthetic appliance including artificial limbs and eyes. Subsequent purchase or replacement of these items is not a covered expense • Hair Prosthesis (85% maximum, $5,000 per year) • Wigs (for hair loss due to alopecia or chemotherapy) Limit $600 every five years. See page 74 for more information.
Occupational/ Physical Therapy	100% Maximum of 60 visits per calendar year	Referring physician must recommend a specific number of treatments prior to service being rendered. See page 75 for more information.
Office Visit	100% after $20 copayment	

Summary of Medical Benefits *continued*

Service	Plan Pays		Notes	
Organ Transplants	90% All-inclusive fixed dollar limit of $50,000 for all services and drugs		• Coverage is limited to a member or dependent who has been covered by the Plan for 12 consecutive months prior to the transplant procedure • Transplantation must be performed in a federal or state approved center • The transplantation cannot be considered experimental by the American Medical Association • Pre-approval by CareAllies required.	
Physical Exam	100% after $20 copayment		Covered for the whole family	
Psychiatric Benefit	**Inpatient Coverage** 90%, 60 days lifetime maximum	**Outpatient Coverage** 100% after $20 copay, 25 visits per year (combined with Substance Abuse Benefit)	**Inpatient Notes** Admissions must be approved in advance by MAP through the Employee Assistance Program.	**Outpatient Notes** Psychiatric treatment for non-substance abuse. Covers only services of a psychiatrist, psychologist or licensed social worker.
Psychiatric Testing Benefit	90% $500 per year maximum			
Rehabilitation Hospital Benefit **Cardiac/Pulmonary Rehabilitation Outpatient Benefit**	90%, 25 days per admission 90%, 36 visits per calendar year		Maximum 25 days per admission; facility must be a licensed rehabilitation hospital. No coverage for vocational rehabilitation facility or skilled nursing facility.	

Summary of Medical Benefits *continued*

Service	Plan Pays		Notes	
Substance Abuse Benefit	**Inpatient Coverage** 90%, annual maximum $10,000; lifetime maximum $15,000	**Outpatient Coverage** 100%, $20 copayment; Calendar Year maximum: 25 visits combined with Psychiatric Benefit	**Inpatient Notes** All admissions must be approved in advance by MAP through the Employee Assistance Program. See page 27 for more information	**Outpatient Notes** Covers only services of a psychiatrist, psychologist or licensed social worker. Must be approved in advance by MAP through the Employee Assistance Program. See page 27 for more information

Are You Being Overcharged?

Overcharges on hospital bills may range from 10% to 13% of billed charges. Carefully review your Explanation of Benefits. Question charges that look unfamiliar!