

# Your Summary of Benefits



## PPO Commercial Active and PPO Retirees Effective 9/1/15 Health & Benefit Trust Fund of the I.U.O.E. Local 94

| Benefit   | In-Network (1)   | Out-of-Network (2, 3)                           |
|---|--|---|
| Deductible  | \$100/\$400  | \$100/\$400 combined with in-network deductible |
| Coinsurance   | 20%  | 20%   |
| Coinsurance Stop Loss / Total Out-of-Pocket Max   | \$0 / \$0 out-of-pocket max  | \$0 / \$0 out-of-pocket max                     |
| Lifetime Maximum  | Unlimited  | Unlimited                                       |
| Dependent Children - covered to end of month  | Age 26   | Age 26  |
| <b>Home/Office/Outpatient Care</b>  | <b>Member Pays In-Network (1)</b>  | <b>Member Pays Out-of-Network (2,3)</b>         |
| Home/Office Visits  | \$30 Copay   | Deductible, Coinsurance and Balance Bill        |
| Emergency Room (Facility Only)<br>Initial visit per occurrence  | \$50 Copay - waived if admitted within 24 hours  | \$50 Copay - waived if admitted within 24 hours |
| Well-Child Care<br>Up to age 19; including necessary immunizations  | \$0  | Deductible, Coinsurance and Balance Bill        |
| Maternity Care  | Initial Routine Visit \$30 Copay;<br>Non-Routine Visits \$30 Copay;<br>Deductible and Coinsurance will apply for other services. | Deductible, Coinsurance and Balance Bill        |
| Allergy Care  |  |   |
| -Office Visit   | \$30 Copay   | Deductible, Coinsurance and Balance Bill        |
| -Testing  | Deductible and Coinsurance   | Deductible, Coinsurance and Balance Bill        |
| -Treatment  | \$0  | Deductible, Coinsurance and Balance Bill        |
| Home Health Care<br>Up to 200 visits per calendar year. Combined in-network and out-of-network  | \$0  | Deductible, Coinsurance and Balance Bill        |
| Home Infusion Therapy (Professional)  | Deductible and Coinsurance   | Deductible, Coinsurance and Balance Bill        |
| Hospice Care Up to 210 days per lifetime  | \$0  | Deductible, Coinsurance and Balance Bill        |
| Annual Physical Exam  | \$30 Copay   | Covered In Network Only                         |
| Well-Woman Care   | \$30 Copay   | Deductible, Coinsurance and Balance Bill        |
| Surgery (4), Anesthesia   | Deductible and Coinsurance   | Deductible, Coinsurance and Balance Bill        |
| Pre-Surgical Testing<br>Testing must be done within 7 days of surgery and testing must be done in facility surgery is performed   | \$0  | Deductible, Coinsurance and Balance Bill        |
| Chemotherapy, Radiation Therapy   | Deductible and Coinsurance   | Deductible, Coinsurance and Balance Bill        |
| Mammograms  | Deductible and Coinsurance   | Deductible, Coinsurance and Balance Bill        |
| Laboratory Tests  | \$10 Copay   | Deductible, Coinsurance and Balance Bill        |
| MRI (4) MRA (4)<br><b>Effective 9/1/15 precertification is also required for CAT Scan (4) PET Scan (4), Nuclear Stress tests (4) Echocardiogram (4)</b>   | Deductible and Coinsurance   | Deductible, Coinsurance and Balance Bill        |
| Chiropractic Care- Covered for contract holder and spouse only. Up to 20 visits per calendar year. Combined in-network and out-of- network.   | \$30 Copay   | Deductible, Coinsurance and Balance Bill        |
| Cardiac Rehabilitation  | Deductible and Coinsurance   | Deductible, Coinsurance and Balance Bill        |
| Second Surgical Opinion (6)   | \$30 Copay   | Deductible, Coinsurance and Balance Bill        |
| Kidney Dialysis   | \$0  | Deductible, Coinsurance and Balance Bill        |
| Physical Therapy (4)<br>Up to 30 visits per calendar year in home, office or outpatient facility. Combined in-network and out-of network.   | \$30 Copay   | Deductible, Coinsurance and Balance Bill        |
| Other Short-Term Rehabilitative Therapies (4)<br>-Speech/Language, Occupational<br>Up to 30 visits per calendar year combined in home, office or outpatient facility. Combined in-network and out- of- network. | \$30 Copay   | Deductible, Coinsurance and Balance Bill        |
| Vision Therapy Up to 30 visits per calendar year.   | \$30 Copay   | Deductible, Coinsurance and Balance Bill        |

# Your Summary of Benefits



| Combined in-network and out- of- network.  |                                   |  |
|--|-----------------------------------|--|
| <b>Inpatient Care (4)</b>  | <b>Member Pays In-Network (1)</b> | <b>Member Pays Out-of-Network (2,3)</b>  |
| Inpatient Hospital<br>As many days as medically necessary; semi-private room and board.  | \$0                               | Deductible, Coinsurance and Balance Bill |
| Physical Therapy, Physical Medicine or Rehabilitation<br>Up to 30 inpatient days per calendar year   | \$0                               | Deductible, Coinsurance and Balance Bill |
| Skilled Nursing Facility<br>Up to 60 inpatient days per calendar year  | \$0                               | Covered In-Network Only                  |
| <b>Mental Health Care</b>  | <b>Member Pays In-Network (1)</b> | <b>Member Pays Out-of-Network (2,3)</b>  |
| Outpatient Visits in Office or Facility  | \$30 Copay                        | Deductible, Coinsurance and Balance Bill |
| Inpatient Care (5)   | \$0                               | Deductible, Coinsurance and Balance Bill |
| <b>Alcohol / Substance Abuse Care</b>  | <b>Member Pays In-Network (1)</b> | <b>Member Pays Out-of-Network (2,3)</b>  |
| Outpatient Visits  | \$0                               | Deductible, Coinsurance and Balance Bill |
| Inpatient Detoxification (5)   | \$0                               | Deductible, Coinsurance and Balance Bill |
| Inpatient Rehabilitation (5)   | \$0                               | Deductible, Coinsurance and Balance Bill |
| <b>Other Services</b>  | <b>Member Pays In-Network (1)</b> | <b>Member Pays Out-of-Network (2,3)</b>  |
| Medical Supplies   | Deductible and Coinsurance        | Deductible, Coinsurance and Balance Bill |
| Durable Medical Equipment (4)  | Deductible and Coinsurance        | Deductible, Coinsurance and Balance Bill |
| Prosthetics (4)  | Deductible and Coinsurance        | Deductible, Coinsurance and Balance Bill |
| Orthotics (4)  | Deductible and Coinsurance        | Deductible, Coinsurance and Balance Bill |
| Ambulance  | Deductible and Coinsurance        | Deductible, Coinsurance and Balance Bill |
| Air Ambulance(4) required for scheduled air ambulance  | Deductible and Coinsurance        | Deductible, Coinsurance and Balance Bill |
| Genetic Testing (4)  | Deductible and Coinsurance        | Deductible, Coinsurance and Balance Bill |
| Infertility – (Medical and Prescription)<br>The combined lifetime maximum is for the contract holder and spouse. The lifetime maximum is \$12,500.00, subject to 80% coinsurance, \$10,000.00 total. Infertility prescriptions are part of this lifetime maximum, but Empire does not process the prescription claims. You must submit prescription claims to Fund office. | Deductible and Coinsurance        | Deductible, Coinsurance and Balance Bill |

- 1) Network provider delivers care. The in-network office co-payment applies to examinations and evaluations only. Other services performed at the office setting may be subject to the in-network deductible and coinsurance.
- 2) Out-of-network services (except Mental Health Care and Alcohol/Substance Abuse Care – see footnote 5) are those from a provider that does not participate in Empire’s PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. (This does not apply to emergency benefits.)
- 3) Out-of-network (O-O-N) providers – those who do not participate in Empire’s PPO network or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. Out-of-network providers, who do not participate with Empire or with another Blue Cross and Blue Shield Plan, will be reimbursed at the in-network rate and the provider may balance bill you over Empire’s allowed amount.
- 4) You are responsible for obtaining precertification from Empire Blue Cross Blue Shield Medical Management for these services provided in-area and out-of-area, in-network and out-of-network. Your provider may call for you. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary.
- 5) You are responsible for obtaining precertification from Empire’s Behavioral Healthcare Management for these services. Your provider may call for you.
- 6) In-network office copay applies to Second Surgical Opinion visit unless waived by Empire Blue Cross Blue Shield Medical Management. In-network deductible and coinsurance may apply to other services performed at the office setting.

Services provided by Empire HealthChoice HMO Inc. and/or Empire HealthCare Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of Independent Blue Cross and Blue Shield plans.

NOTE: This is a benefits summary only and is subject to the terms, conditions, limitations and exclusions set forth in the contract. Failure to comply with Empire Blue Cross Blue Shield Medical Management or Behavioral Healthcare Management Program requirements could result in benefit reductions.