# Your Summary of Benefits

**PPO Commercial Active and PPO Retirees Effective 7/1/19**

**Health & Benefit Trust Fund of the I.U.O.E. Local 94**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network (1)</th>
<th>Out-of-Network (2, 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$100/$400</td>
<td>$100/$400 combined with in-network deductible</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Coinsurance Stop Loss / Total Out-of Pocket Max</td>
<td>$0 / $0 out-of-pocket max</td>
<td>$0 / $0 out-of-pocket max</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Dependent Children - covered to end of month</td>
<td>Age 26</td>
<td>Age 26</td>
</tr>
</tbody>
</table>

**Home/Office/Outpatient Care**

<table>
<thead>
<tr>
<th>Member Pays In-Network (1)</th>
<th>Member Pays Out-of-Network (2,3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home/Office Visits</td>
<td>$20 Copay</td>
</tr>
<tr>
<td>LiveHealth Online Medical / Allergy</td>
<td>$15 Copay</td>
</tr>
<tr>
<td>Emergency Room (Facility Only) Initial visit per occurrence</td>
<td>$70 Copay - waived if admitted within 24 hours</td>
</tr>
<tr>
<td>Well-Child Care Up to age 19; including necessary immunizations</td>
<td>$0</td>
</tr>
<tr>
<td>Maternity Care Initial Routine Visit $20 Copay; Non-Routine Visits $20 Copay; Deductible and Coinsurance will apply for other services.</td>
<td>Deductible, Coinsurance and Balance Bill</td>
</tr>
</tbody>
</table>

**Allergy Care**

<p>| -Office Visit | -Testing | -Treatment | Home Health Care Up to 200 visits per calendar year. Combined in-network and out-of-network | Home Infusion Therapy (Professional) | Hospice Care Up to 210 days per lifetime | Annual Physical Exam | Well-Woman Care | Surgery (4), Anesthesia | Pre-Surgical Testing Testing must be done within 7 days of surgery and testing must be done in facility surgery is performed | Chemotherapy, Radiation Therapy | Mammograms | Laboratory Tests | MRI (4), MRA (4) | Effective 9/1/15 precertification is also required for CAT Scan (4), PET Scan (4), Nuclear Stress tests (4), Echocardiogram (4) | Chiropractic Care- Covered for contract holder and spouse only. Up to 20 visits per calendar year. Combined in-network and out-of-network. | Cardiac Rehabilitation | Second Surgical Opinion (6) | Kidney Dialysis | Physical Therapy (4) Up to 30 visits per calendar year in home, office or outpatient facility. Combined in-network and out-of-network. | Other Short-Term Rehaebilative Therapies (4) -Speech/Language, Occupational Up to 30 visits per calendar year combined in home, office or outpatient facility. Combined in-network and out-of-network. |
|----------------|----------|------------|--------------------------------|---------------------------------|------------------------|---------------------|---------------------|------------------------|--------------------------------|--------------------------|----------------|----------------|----------------|-------------------------------------------------|---------------------------------|----------------|------------------------|---------------------|------------------------------|---------------------------------|---------------------------------|------------------------|------------------------|---------------------|-------------------------|</p>
<table>
<thead>
<tr>
<th>Service</th>
<th>Inpatient Hospital</th>
<th>Physical Therapy, Physical Medicine or Rehabilitation</th>
<th>Skilled Nursing Facility</th>
<th>Mental Health Care</th>
<th>Alcohol / Substance Abuse Care</th>
<th>Other Services</th>
<th>Inpatient Care (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined in-network and out-of-network.</td>
<td>As many days as medically necessary; semi-private room and board.</td>
<td>Up to 30 inpatient days per calendar year</td>
<td>Up to 60 inpatient days per calendar year</td>
<td>Outpatient Visits in Office or Facility</td>
<td>$40 Copay</td>
<td>Member Pays In-Network (1)</td>
<td>$40 Copay</td>
</tr>
</tbody>
</table>

**Vision Therapy**
- Up to 30 visits per calendar year.
- Combined in-network and out-of-network.

**Inpatient Care (4)**
- Member Pays In-Network (1)
- Member Pays Out-of-Network (2,3)

**Inpatient Hospital**
- As many days as medically necessary; semi-private room and board.

**Physical Therapy, Physical Medicine or Rehabilitation**
- Up to 30 inpatient days per calendar year

**Skilled Nursing Facility**
- Up to 60 inpatient days per calendar year

**Mental Health Care**
- Member Pays In-Network (1)
- Member Pays Out-of-Network (2,3)

**Outpatient Visits in Office or Facility**
- $40 Copay
- Deductible, Coinsurance and Balance Bill

**Inpatient Care (5)**
- $0
- Deductible, Coinsurance and Balance Bill

**LiveHealth Online**
- $15 Copay
- Deductible, Coinsurance and Balance Bill

**Alcohol / Substance Abuse Care**
- Member Pays In-Network (1)
- Member Pays Out-of-Network (2,3)

**Inpatient Detoxification (5)**
- $0
- Deductible, Coinsurance and Balance Bill

**Inpatient Rehabilitation (5)**
- $0
- Deductible, Coinsurance and Balance Bill

**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)**
- 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.

**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.

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