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

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
Home/Office/Outpatient Care	**Member Pays In-Network (1)**	**Member Pays Out-of-Network (2,3)**
Home/Office Visits	$20 Copay	Deductible, Coinsurance and Balance Bill
LiveHealth Online Medical / Allergy	$15 Copay	Deductible, Coinsurance and Balance Bill
Emergency Room (Facility Only) Initial visit per occurrence	$70 Copay - waived if admitted within 24 hours	$70 Copay - waived if admitted within 24 hours
Well-Child Care Up to age 19; including necessary immunizations	$0	Deductible, Coinsurance and Balance Bill
Maternity Care	Initial Routine Visit $20 Copay; Non-Routine Visits $20 Copay; Deductible and Coinsurance will apply for other services.	Deductible, Coinsurance and Balance Bill
Allergy Care		
-Office Visit	$40 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 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	$20 Copay	Covered In Network Only
Well-Woman Care	$20 Copay	Deductible, Coinsurance and Balance Bill
Surgery (4), Anesthesia	Deductible and Coinsurance	Deductible, Coinsurance and Balance Bill
Pre-Surgical Testing 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	$15 Copay	Deductible, Coinsurance and Balance Bill
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)**	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.	$40 Copay	Deductible, Coinsurance and Balance Bill
Cardiac Rehabilitation	Deductible and Coinsurance	Deductible, Coinsurance and Balance Bill
Second Surgical Opinion (6)	$40 Copay	Deductible, Coinsurance and Balance Bill
Kidney Dialysis	$0	Deductible, Coinsurance and Balance Bill
Physical Therapy (4) Up to 30 visits per calendar year in home, office or outpatient facility. Combined in-network and out- of network.	$40 Copay	Deductible, Coinsurance and Balance Bill
Other Short-Term Rehabilitative 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.	$40 Copay	Deductible, Coinsurance and Balance Bill

Vision Therapy - Up to 30 visits per calendar year. Combined in-network and out- of- network.	$40 Copay	Deductible, Coinsurance and Balance Bill
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.	$0	Deductible, Coinsurance and Balance Bill
Physical Therapy, Physical Medicine or Rehabilitation Up to 30 inpatient days per calendar year	$0	Deductible, Coinsurance and Balance Bill
Skilled Nursing Facility Up to 60 inpatient days per calendar year	$0	Covered In-Network Only
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 Psychology/Psychiatry	$15 Copay	Deductible, Coinsurance and Balance Bill
Alcohol / Substance Abuse Care	**Member Pays In-Network (1)**	**Member Pays Out-of-Network (2,3)**
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
Other Services	**Member Pays In-Network (1)**	**Member Pays Out-of-Network (2,3)**
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.	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.