Your Summary of Benefits

Empire BlueCross BlueShield

PPO School Active and PPO Retirees Effective 7/1/2020
Health & Benefit Trust Fund of the I.U.O.E. Local 94

Benefit	In-Network (1)	Out-of-Network (2, 3)
Deductible	$0/$0	$200/$800
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	$50 Copay - waived if admitted within 24 hours	$50 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 Office Visit $20 Copay; Non-Routine Visits $20 Copay; Coinsurance will apply for other services	Deductible, Coinsurance and Balance Bill
Allergy Care		
-Office Visit	$20 Copay	Deductible, Coinsurance and Balance Bill
-Testing	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 and Out of Network.	$0	Deductible, Coinsurance and Balance Bill
Home Infusion Therapy (Professional)	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	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	Coinsurance	Deductible, Coinsurance and Balance Bill
Mammograms	Coinsurance	Deductible, Coinsurance and Balance Bill
Laboratory Tests	$0	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 test (4) Echocardiogram (4)**	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	$20 Copay	Deductible, Coinsurance and Balance Bill
Cardiac Rehabilitation	Coinsurance	Deductible, Coinsurance and Balance Bill
Second Surgical Opinion (6)	$20 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.	$20 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.	$20 Copay	Deductible, Coinsurance and Balance Bill
Vision Therapy - Up to 30 visits per calendar year. Combined in-network and out- of- network.	$20 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	$20 Copay	Deductible, Coinsurance and Balance Bill
LiveHealth Online Psychology/Psychiatry	$15 Copay	Deductible, Coinsurance and Balance Bill
Inpatient Care (5)	$0	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	Coinsurance	Deductible, Coinsurance and Balance Bill
Durable Medical Equipment (4)	Coinsurance	Deductible, Coinsurance and Balance Bill
Prosthetics (4)	Coinsurance	Deductible, Coinsurance and Balance Bill
Orthotics (4)	Coinsurance	Deductible, Coinsurance and Balance Bill
Ambulance	Coinsurance	Deductible, Coinsurance and Balance Bill
Air Ambulance (4) required for scheduled air ambulance	Coinsurance	Deductible, Coinsurance and Balance Bill
Genetic Testing (4)	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 the Fund office.	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 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. 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 Empire's Behavioral Healthcare Management Program requirements could result in benefit reductions.