Benefits At A Glance
Plan C

HIGHLIGHTS OF WELFARE FUND BENEFITS

WELFARE FUND BENEFITS IN BRIEF					
Medical and Hospital Benefits	Empire BlueCross BlueShield Plan C-1		Empire BlueCross BlueShield Plan C-2		Empire BlueCross BlueShield Plan C-3
	All reimbursements of eligible out-of-network expenses are paid as a percentage of Empire BlueCross BlueShield's "allowed amount," which is the maximum Empire will pay for any service or supply. If an out-of-network provider charges more than the allowed amount, you will be responsible for the excess, in addition to your normal coinsurance. In addition, applicable limits on services or service frequencies are applied to both in-network and out-of-network care combined.				Plan C-3 requires you to use an in-network provider. The doctor's office copayments apply to exams and evaluations only. Other services you receive may be subject to the deductible and coinsurance. If you go to an out-of-network provider, no benefits will be paid.
	See your Empire BlueCross BlueShield description of benefits for complete details on these and other provisions, including the precertification requirement that applies to some services.				
Features	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
Calendar Year Deductible	$0	$200/Individual $500/Family	$0	$500/Individual $1,250/Family	$1,000/Individual $2,500/Family
Coinsurance	N/A	You pay 25% of allowed amount and Plan pays 75% of allowed amount (50% for behavioral health care services)	For certain services indicated below, you pay 20% of allowed amount and Plan pays 80%	You pay 40% of allowed amount and Plan pays 60% of allowed amount (50% for behavioral health care services)	For certain services indicated below, you pay 20% of allowed amount and Plan pays 80%
Doctor visits and certain other covered services	$20 per visit	Deductible & 25% coinsurance	$25 per visit	Deductible & 40% coinsurance	$30 per visit (not subject to deductible)
Hospital inpatient admissions	$0	Deductible & 25% coinsurance	20% coinsurance	Deductible & 40% coinsurance	Deductible & 20% coinsurance
Emergency Room	$35 per visit (waived if admitted to hospital within 24 hours)	$35 per visit (waived if admitted to hospital within 24 hours)	$50 per visit (waived if admitted to hospital within 24 hours)	$50 per visit (waived if admitted to hospital within 24 hours)	$50 per visit (waived if admitted to hospital within 24 hours)
Annual Out-of-Pocket Coinsurance Limit	N/A	$1,500/Individual $3,750/Family	$1,000/Individual $2,500/Family	$5,000/Individual $12,500/Family	$3,000/Individual $7,500/Family
Lifetime Maximum	Unlimited	$1 million per individual	Unlimited	$1 million per individual	Unlimited
Claim Forms to File	None	Yes	None	Yes	None
Necessary Approvals/ Precertification/ Referrals	Check your BlueCross SPD	Check your BlueCross SPD	Check your BlueCross SPD	Check your BlueCross SPD	Check your BlueCross SPD

HIGHLIGHTS OF PLAN BENEFITS (CHECK YOUR SPD FOR DETAILS.)					
	Plan C-1		Plan C-2		Plan C-3
Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
Doctor's office visits (including specialists)	$20 per visit	Deductible & 25% coinsurance	$25 per visit	Deductible & 40% coinsurance	$30 per visit (not subject to deductible)
Chiropractic visits	$20 per visit	Deductible & 25% coinsurance	$25 per visit	Deductible & 40% coinsurance	$30 per visit (not subject to deductible)
Annual Physical Exam	$20 per visit	Not Covered	$25 per visit	Not Covered	$30 per visit (not subject to deductible)
Certain Diagnostic Screening Tests (see your SPD for details)	$0	Deductible & 25% coinsurance	20% coinsurance	Deductible & 40% coinsurance	Deductible & 20% coinsurance
Allergy Testing	$20 per visit	Deductible & 25% coinsurance	$25 per visit	Deductible & 40% coinsurance	Deductible & 20% coinsurance
Allergy Treatment	$0	Deductible & 25% coinsurance	$0	Deductible & 40% coinsurance	$0
Well Woman Care					
• Office visits	$20 per visit	Deductible & 25% coinsurance	$25 per visit	Deductible & 40% coinsurance	$30 per visit (not subject to deductible)
• Pap Smears	$0	Deductible & 25% coinsurance	20% coinsurance	Deductible & 40% coinsurance	$30 per visit
• Mammogram (based on age & medical history)	$0	Deductible & 25% coinsurance	20% coinsurance	Deductible & 40% coinsurance	$30 per visit

Benefits	Plan C-1		Plan C-2		Plan C-3
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
Well Child Care Office visits & associated lab services provided within 5 days of visit, at frequencies specified in SPD; Immunizations	$0	Deductible & 25% coinsurance	$0	Deductible & 40% coinsurance	$0
Diagnostic Procedures X-rays & other imaging; MRIs/MRAs; All lab tests	$0	Deductible & 25% coinsurance	20% coinsurance	Deductible & 40% coinsurance	Deductible & 20% coinsurance
Emergency Room	$35 per visit (waived if admitted within 24 hours)		$50 per visit (waived if admitted within 24 hours)		$50 per visit (waived if admitted to hospital within 24 hours)
Ambulance Local professional ground ambulance to nearest hospital	$0 as long as the ambulance charge doesn't exceed the allowed amount (you pay any difference between allowed amount and actual charge)		20% coinsurance	$0 as long as the ambulance charge doesn't exceed the allowed amount (you pay any difference between allowed amount and actual charge)	Deductible & 20% coinsurance
Air Ambulance Transportation to nearest acute care hospital for emergency or inpatient admissions	$0	You pay the difference between the allowed amount and the total charge	20% coinsurance	You pay the difference between the allowed amount and the total charge	Deductible & 20% coinsurance
Maternity Care • Prenatal & postnatal care in doctor's office • Lab tests, sonograms & other diagnostic procedures • Obstetrical care in hospital • Routine newborn nursery care (in hospital) • Obstetrical care (in birthing center)	$0 $0 $0 $0 $0	Deductible & 25% coinsurance Deductible & 25% coinsurance Deductible & 25% coinsurance Deductible & 25% coinsurance Not covered	20% coinsurance 20% coinsurance 20% coinsurance 20% coinsurance 20% coinsurance	Deductible & 40% coinsurance Deductible & 40% coinsurance Deductible & 40% coinsurance Deductible & 40% coinsurance Not covered	$30 copay for initial visit Deductible & 20% coinsurance Deductible & 20% coinsurance Deductible & 20% coinsurance Deductible & 20% coinsurance
Hospital Services Semi-private room & board; general, special & critical nursing care; intensive care; services of physicians & surgeons; anesthesia, oxygen, blood work, diagnostic x-rays & lab tests; chemotherapy & radiation therapy; drugs & dressings; presurgical testing; surgery (inpatient & outpatient) The hospital services benefit does not include inpatient or outpatient behavioral health care or physical therapy/ rehabilitation. Outpatient hospital surgery and inpatient admissions need to be precertified. Special rules apply where more than one procedure is performed during an authorized surgery.	$0	Deductible & 25% coinsurance	20% coinsurance	Deductible & 40% coinsurance	Deductible & 20% coinsurance
Chemotherapy, X-Ray, Radium & Radionuclide Therapy	$0	Deductible & 25% coinsurance	20% coinsurance	Deductible & 40% coinsurance	[Deductible & 20% coinsurance]
Durable Medical Equipment (for example, hospital-type bed, wheelchair, sleep apnea monitor, orthotics and prosthetics)	$0	Not covered	20% coinsurance	Not covered	Deductible & 20% coinsurance

Benefits	Plan C-1		Plan C-2		Plan C-3
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
Medical Supplies (for example, catheters, oxygen, syringes)	$0	Difference between the allowed amount and the total charge (deductible & coinsurance don't apply)	20% coinsurance	Difference between the allowed amount and the total charge (deductible & coinsurance don't apply)	Deductible & 20% coinsurance
Nutritional Supplements (enteral formulas and modified solid food products)	$0	Deductible & 25% coinsurance	20% coinsurance	Deductible & 40% coinsurance	Deductible & 20% coinsurance
Skilled Nursing Facility Up to 60 days per calendar year	$0	Not covered	20% coinsurance	Not covered	Deductible & 20% coinsurance
Hospice Care Up to 210 days per lifetime	$0	Not covered	20% coinsurance	Not covered	Deductible & 20% coinsurance
Home Health Care *Up to 200 visits per calendar year (a visit equals 4 hours of care) (treatment maximums are combined for in-network and out-of-network services)*	$0	25% coinsurance, no deductible	20% coinsurance	40% coinsurance, no deductible	20% coinsurance, no deductible
Home Infusion Therapy	$0	Not covered	20% coinsurance	Not covered	Deductible & 20% coinsurance
Physical Therapy & Rehabilitation • Up to 30 days of in patient service per calendar year (treatment maximums are combined for in-network and out-of-network care) • Up to 30 visits combined in home, office or outpatient facility per calendar year	$0 $20 per visit	Deductible & 25% coinsurance Not covered	20% coinsurance $25 per visit	Deductible & 40% coinsurance Not covered	Deductible & 20% coinsurance $30 per visit
Occupational, Speech or Vision Therapy Up to 30 visits combined in home, office or outpatient facility per calendar year	$20 per visit	Not covered	$25 per visit	Not covered	$30 per visit
Cardiac Rehabilitation	$20 per outpatient visit	Deductible & 25% coinsurance	$25 per outpatient visit	Deductible & 40% coinsurance	$30 per outpatient visit
Mental Health Care Outpatient Up to 40 visits per calendar year (treatment maximums are combined for in-network and out-of-network care)	$25 per visit	Deductible & 50% coinsurance	$25 per visit	Deductible & 50% coinsurance	$25 per visit
Inpatient • Up to 30 days per calendar year • Up to 30 visits from mental health care professionals per calendar year	$0 $0	Not covered Not covered	20% coinsurance 20% coinsurance	Not covered Not covered	Deductible & 20% coinsurance [Deductible & 20% coinsurance]

Benefits	Plan C-1		Plan C-2		Plan C-3
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
Alcohol or Substance Abuse Treatment					
Outpatient Up to 60 visits per calendar year, including up to 20 visits for family counseling (treatment maximums are combined for in-network and out-of-network care)	$0	Deductible & 25% coinsurance	20% coinsurance	Deductible & 40% coinsurance	Deductible & 20% coinsurance
Inpatient Up to 7 days of detoxification per calendar year	$0	Not covered	20% coinsurance	Not covered	Deductible & 20% coinsurance

Other Welfare Fund Benefits	Plan C-1 and Plan C-2	Plan C-3
Prescription Drugs	**At a participating pharmacy:** You can receive a 30-day supply or refill of a medication through a Caremark participating pharmacy. The copays are: • **Plan C-1:** $10 for a generic drug, $20 for a brand-name drug with no generic equivalent and $30 for a brand-name drug with a generic equivalent • **Plan C-2:** $15 for a generic drug, $30 for a brand-name drug with no generic equivalent and $40 for a brand-name drug with a generic equivalent **Mail-order pharmacy:** You pay twice the retail copay for up to a 90-day supply. **At a non-participating pharmacy:** You must pay the full charge and then file a claim for reimbursement with Caremark for the difference between what you paid and the copay that would have applied at a participating pharmacy. See your SPD for limitations and exclusions that may apply to some medications.	**At a participating pharmacy:** You can receive a 30-day supply or refill of a medication through a Caremark participating pharmacy. The copays are $15 for a generic drug, $30 for a brand-name drug with no generic equivalent and $40 for a brand-name drug with a generic equivalent. **Mail-order pharmacy:** You pay twice the retail copay for up to a 90-day supply. There is an **annual maximum** prescription drug benefit of $2,000 per individual. Prescription drugs are not covered when received from a **non-participating pharmacy.**
Vision Care	**Plans C-1 and C-2 offer the following services through three vision care providers:** One eye exam and one pair of glasses or contact lenses from an approved group of products every 24 months. For covered children, an exam and lenses are provided every 12 months, while frames are available only every 24 months. There may be an additional charge for contact lenses or frames that are not in the approved group. For out-of-network vision services, reimbursement of up to $100 is available every 24 months (every 12 months for exams and lenses for children).	No coverage
Physical Exam & Hearing Aid Benefit	**Physical Exam:** If you don't go to a BlueCross provider for a physical exam, the plan pays up to $300 per calendar year for a physical examination. **Hearing Aid:** The Plan pays up to $1,500 in a 36-month period for a hearing aid, batteries and/or repairs.	No coverage
HMOS and PPO	The HMO option is available only in some areas of the country and the PPO option is available only in Puerto Rico. If you elect HMO or PPO coverage, you will not be eligible for the hospital, medical, and prescription drug benefits described above, but you will be entitled to the Vision Care, Dental and Life Insurance benefits.	N/A
Dental Care	• Up to $2,000 per year per covered person paid according to a set fee schedule. • In-network dentists have agreed to accept amount on fee schedule as payment in full. • Out-of-network dentists are paid the same amount under the fee schedule as in-network dentists, but an out-of-network dentist may charge you an additional amount. • Orthodontia not covered.	Covers only basic preventive care in accordance with schedule of dental benefits • Oral exams and cleanings, up to two of each per calendar year • X-rays, once per calendar year
Medical Reimbursement Program	You may withdraw certain excess funds in your CAPP account as reimbursement for: • Expenses that aren't paid in full under your Fund medical coverage • Premiums you pay for medical coverage other than that provided by the Fund (if you don't have the Fund's medical coverage). Check your SPD for more details on how much of your CAPP account is available for reimbursement and which types of expenses are eligible for reimbursement.	
Life Insurance	Pays a benefit of $20,000 if you die. (Life insurance is not available for covered dependents.)	No coverage

These highlights of Welfare Fund benefits are designed to serve as a quick reference to the principal benefits provided by the Welfare Fund. The SPD has complete details on all the benefits provided by the Fund, how participants and dependents qualify for coverage, and exclusions and limitations on benefits. If there is any inconsistency between the information contained in these highlights and the SPD, the terms of the SPD will control.