Local 95 Head Start Employees Welfare Fund

Summary of Benefits

Eligibility: Eligible dependents are your lawful spouse, domestic partner, and your dependent children up to age 26 (without employer sponsored coverage). Coverage is provided through the Empire BlueCross BlueShield EPO BlueConnect Network.

	Coverage when an In-Network Provider is used	**When an Out Of Network Provider is Used**
Lifetime Benefit Maximum	None	Out of network Claims are not covered
Annual Benefit Maximum	None	Out of network Claims are not covered
Annual Deductible	$500 Individual / $1,000 Family	Out of network Claims are not covered
Out-of Pocket Maximum-Medical	$5,000 Individual / $10,000 Family	Out of network Claims are not covered
Out of Pocket Maximum- Prescription	$2,500 Individual / $5,000 Family	Out of network Claims are not covered
Member Co-Insurance	12% of the Empire In-Network Rate	Out of network Claims are not covered

In-Network Benefits

Hospital Charges	**Co-Pay**	**Benefit**
Semi-Private Room & Board,Intensive Care Unit, Coronary Care Unit, and Ancillary Charges.	12% Co-insurance of the Empire In-Network RatePre-Certification is required for all days including Maternity admissions longer than 48 hours for normal delivery or 96 hours for Caesarean Section.	Out of network Claims are not covered
Ambulatory Surgery	$ 25 Copay	Out of network Claims are not covered
Emergency Room	$ 150 waived upon admission	$ 150 Copay
In-patient Mental Health	12% Co-insurance of the Empire In-Network RatePre-Certification is required for all days including Maternity admissions longer than 48 hours for normal delivery or 96 hours for Caesarean Section.	88% of the Empire In-Network rate after $200 Co-Pay per admission. Pre-Certification is required for all days.
In-patient Substance Abuse/ Detoxification	12% Co-insurance of the Empire In-Network RatePre-Certification is required for all days including Maternity admissions longer than 48 hours for normal delivery or 96 hours for Caesarean Section.	88% of the Empire In-Network rate after $200 Co-Pay per admission. Pre-Certification is required for all days.

Hospice Care (Includes hospice,respite care and bereavement)	12% Co-insurance of the Empire In-Network Rate	Out of network Claims are not covered
Pre-admission testing	$200 Co-Pay plus Co-insurance	Out of network Claims are not covered
In-patient Physical Rehabilitation	12% Co-insurance of the Empire In-Network Rate	88% of the Empire In-Network rate after $200 Co-Pay upto 30 visits per calendar year. Pre-Certification is required for all days.
Skilled Nursing Facility no maximum	12% Co-insurance of the Empire In-Network Rate	Out of network Claims are not covered
Home Health Care & Skilled Nursing Home Visits	20% Co-insurance of the Empire In-Network Rate	80% of the network rate for up to 200 visits maximum per calendar year.Pre-Certification is require & Re-Precertification > 60 visits Penalty if no prior authorization.
Hospice Care (Includes hospice,respite care and bereavement)	12% Co-insurance of the Empire In-Network Rate	Out of network Claims are not covered
OUTPATIENT CARE: The following benefits are available through the Empire BCBS Network*		
	Empire BCBS Network	**Benefit**
Deductible	$500 Individual / $1,000 Family	Out of network Claims are not covered
Coinsurance	12% of the Empire In Network Rate	Out of network Claims are not covered
Physician Services		
Office Visit	$ 25 co-pay Physician Office visit.	Out of network Claims are not covered
Specialist Care	$ 25 co-pay Physician Office visit.	Out of network Claims are not covered
Surgery	Covered in full	Out of network Claims are not covered
Emergency Room Physician Professional Charges	Coinsurance 12% of the Empire In- Network Rate	Coinsurance 12% of the Empire In- Network Rate
Urgent Care Center (Freestanding facility)	$ 50 co-pay	Out of network Claims are not covered
Diagnostic Tests & X-Ray	$ 25 co-pay if performed in a non hospital setting.	Out of network Claims are not covered
Outpatient Diagnostic Tests	$ 25 co-pay if performed in a non hospital setting.	Out of network Claims are not covered
Outpatient Hospital Diagnostic Tests (i.e. MRI's, CT Scans, Lab & X-ray Services)	$ 200 co-pay in hospital outpatient setting.	Out of network Claims are not covered
Acupuncture		

Licensed M.D. or D.O. only	$ 25 co-pay Limited to 18 visits per calendar year.	Out of network Claims are not covered
Out-patient Physical Therapy	$ 25 co-pay if performed in a non hospital setting. Limited to 15 visits per calendar year.	Out of network Claims are not covered
Mental Health		
Out-patient non hospital facility setting	$ 25 co-pay if performed in a non hospital setting.	Out of network Claims are not covered

Prescription Drug Card	**Coverage thru Navitus Rx**
Retail Pharmacy Generic	$10 Generic Copay
Retail Pharmacy Brand Preferred Formulary Drug list	The greater of $ 25 or 25% of cost of Drug
Retail Pharmacy Non-Preferred Formulary Drug	The greater of $ 50 or 25% of cost of Drug
Mail Order Generic (3 month supply)	The greater of $ 25 or 25% of cost of Drug
Mail Order Preferred Formulary (3 month supply)	The greater of $ 50 or 25% of cost of Drug
Mail Order Non-Preferred Formulary (3 month supply)	The greater of $ 75 or 25% of cost of Drug
Copay Max Plus Program	$0 Copay if medication is qualified.
Pharmacy Out of Pocket Maximum	$2,500 individual / $5,000 family

Dental (In-Network Only)	**Important Phone Numbers**	**Important Website**
HealthPlex Dental	Managed Dental Care (800)-468-0600	www.HealthPLEX.com
Local 95 HSEWF Fund Office for Eligibility Questions	(212) 343-1660	www.dc1707l95wf.net
Empire BlueCross BlueShield	Member Services (800)-633-5568	www.EmprieBlue.com
Navitus Health Solutions Rx Provider	(866) 333-2757	www.navitus.com
HealthPlex Dental	(800) 468-0600	www.HealthPLEX.com

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