Benefits at a Glance

Midwest Casino Plan 116

This document is an easy-to-read summary and does not include all benefits. If you want more detail about your benefits or want to find out which treatments/services require prior authorization, please refer to your Summary Plan Description (SPD) or call UNITE HERE HEALTH.

About Your Benefits

In general, your out-of-pocket costs will be lowest when you get treatment from network providers.

Some care will only be paid up to a certain amount. Once a **maximum benefit** or visit limit has been met, no additional benefits are available from UNITE HERE HEALTH for the rest of the year for that type of care.

Calendar Year Deductible — None

Out of Pocket Limits — Once your out-of-pocket copays and coinsurance for covered network expenses reach the limits below, the Plan will pay 100% of most covered network services for the rest of the year.

- ***Medical:***
  $5,000 per person; $10,000 per family
- ***Pharmacy:***
  $1,600 per person; $3,200 per family

Have benefit or healthcare questions?

Your Care Coordinators are ready to help you

Sometimes we call you – please call us back so we can help you!

Call us BEFORE you see a specialist or get a service listed on the back of your ID card!

- Save money on specialist copays by getting a referral from your primary care provider (PCP). When your PCP calls us BEFORE your specialist visit, your copay gets lowered by half.
- Have your doctor call us BEFORE you get a service listed on the back of your ID card. If you don't, in certain cases, your healthcare claim may not be paid at all.

Call toll-free: (866) 686-0003 • www.uhh.org

Medical — Blue Cross Blue Shield of Illinois

WHAT YOU PAY (per visit)	**Network**	**Non-Network**
Office Visits		
Preventive Care — *Certain limits may apply*	No charge	Not Covered
Primary Care Provider (PCP)	$20 copay	40%
Specialist — *When your PCP calls the Care Coordinators first*	$20 copay	40%
Specialist — *When your PCP DOESN'T call the Care Coordinators first*	$40 copay	40%
Mental Health/Substance Abuse Office Visit	$20 copay	40%
Emergency & Urgent Care Services		
Urgent Care Center	$30 copay	40%
Emergency Room (ER) — *Waived if admitted*	No charge after $350 copay	
Ambulance — *Waived if admitted*	$50 copay	
Inpatient Services		
Hospital Treatment	$300 copay per day; up to $900 per admission	40%
Mental Health/Substance Abuse Treatment	$300 copay per day; up to $900 per admission	40%
Skilled Nursing Facility — *60-day maximum per year; no more than 30 of these days can be for non-network care*	$150 copay per day; up to $750 per admission	40%
Outpatient/Select Covered Services		
Surgery	$150 copay, surgery center	40%
	$500 copay, hospital outpatient	
X-rays and Laboratory Tests	$30 copay, office or non-hospital	40%
	$100 copay, hospital	
Physical and Occupational Therapy — *60 visits per year*	$20 copay, office or non-hospital	40%
Speech Therapy — *30 visits per year*	$40 copay, hospital	
Chiropractic Care — *24 visits per year, unless more are approved*	$20 copay	Not covered
Routine Podiatric Care — *4 visits per year*	$20 copay	Not covered
Podiatric Orthotics — *$500 every 24 months*	No charge	Not covered
Acupuncture — *12 visits per year*	$20 copay	Not covered
Durable Medical Equipment — *includes prosthetics*	20%	Not covered
Home Healthcare — *60 days per year*	$20 copay per day	40%

Prescription Drugs — TrueChoice *(Benefits available at most pharmacies except CVS, Wal-Mart and certain independents)*

Certain Preventive Drugs/Supplies	No charge	Not covered
Generic Drugs	$10 copay per prescription	Not covered
Preferred Brand Name Drugs	$20 copay per prescription	Not covered
Non-Preferred Brand Name Drugs	$50 copay per prescription	Not covered
Specialty or Biosimilar Drugs	25% of charges; $50 max	Not covered

Dental — Cigna *($50 deductible applies to certain services; $1,000 year maximum does not apply to exams for persons under age 19)*

	Cigna DPPO Network	**Cigna Non-Network**
Diagnostic and Preventive Services	No charge	20%
Restorative Services	Basic — 20% after deductible	Basic — 30% after deductible
	Major —50% after deductible	Major — 60% after deductible
Orthodontic Services — *Lifetime orthodontia maximum of $1,000*	50% *(benefit limited to children under age 19)*	

Vision — Davis *(Non-network exam maximum does not apply to children under 5)*

Covered services available every 12 months, measured from the first day of the month during which the covered expense is incurred; you pay any amounts in excess of what the Plan pays. Maximum allowances may apply.	No charge *(Covered services including exam, lenses, Davis Vision Fashion or Designer collection frames)*	No charge. Benefits limited to $30 for exams, $25-60 for lenses, $30 for frames, $75 for elective contacts

Short-Term Disability	**WHAT THE PLAN PAYS**	***Life and AD& D***	**WHAT THE PLAN PAYS**
Weekly benefit: $225 — *Benefits begin 1st day due to injury; 8th day to sickness; 15-week maximum for any one period of disability*		Life insurance: $10,000 Accidental Death & Dismemberment Insurance: $5,000	