New York Plan Unit 105 Class 1 & Class 2 Provider Benefits Fact Sheet

Effective 1/1/2018

The Plan Unit 105 provides two levels of benefits – Class 1 and Class 2. Each Plan is determined by the days/hours of work the member is credited with during a work period.

Medical network:

Inside of NJ: Horizon Direct Access

Outside of NJ: BlueCard PPO

Mental Health/Substance Abuse network: Optum

Annual deductible:

Class 1

In-network: Individual $0 Family $0

Out of network: Individual $400 Family $1,000

Class 2

In-network: Individual $0 Family $0

Out of network: NO OUT OF NETWORK BENEFITS

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.

Out of Pocket Limits: The maximum amount of coinsurance and copays for covered network medical and pharmacy services in one calendar year:

Class 1

Medical: $5,000/person and $10,000/family
Rx: $1,600/person and $3,200/family

Class 2

$6,600/person and $13,200/family
Rx: Preventative Healthcare Prescription Drugs and Supplies $0

THERE ARE NO OUT OF NETWORK BENEFITS FOR Class II.

	In-Network (Class 1)	Out of Network (Class 1)	In-Network (Class 2)	Out of Network (Class 2)
Office visits				
Preventive Care *(Including routine mammograms, osteoporosis screening, pap smears, colonoscopy, etc.)* Plan covers in-network routine care, including screenings, checkups, and counseling, as required by the ACA; Routine mammograms are covered on an annual basis; Osteoporosis screening is covered for women over 65 and over or younger women with increased risk of fractures; Routine pap smears are covered 1 every 3 years for women ages 21-65 and 1 every 5 years if performed in conjunction with HPV testing; Routine colonoscopy are covered 1 every 10 years for average risk, 1 every 2 years with diagnosis of high risk due to immediate family history.	$0 copay, 100%	Not covered (except breast pumps/supplies)	$0 copay, 100%	Not covered (except breast pumps/supplies)
Non-Preventive PCP Office Visit Including all care provided during the office visit.	$20 copay, 100% ($0 copay, 100% for PCP at Designated Medical Groups and Union Health Center)	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$20 copay, 100% ($0 copay, 100% for PCP at Designated Medical Groups and Union Health Center)	Not covered
Specialist Care Office Visit Covered services provided by the Union Health Center covered at 100%, $0 copay	$30 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$30 copay, 100%	Not covered

	In-Network (Class 1)	Out of Network (Class 1)	In-Network (Class 2)	Out of Network (Class 2)
Allergy shots without an office visit billed				
	$0 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$0 copay, 100%	Not covered
Mental Health/Substance Abuse Office Visit				
	$20 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$20 copay, 100%	Not covered
EAP Services				
	Telephonic EAP unlimited sessions and 5 face-to-face (including teleEAP) sessions per calendar year	Not covered	Telephonic EAP unlimited sessions and 5 face-to-face (including teleEAP) sessions per calendar year	Not covered
ABA Therapy *(Habilitative Therapy)* Precertification required; contact the Fund Office **(866) 261-5676** for more information.				
	$20 copay/day, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$20 copay/day, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family

	In-Network (Class 1)	Out of Network (Class 1)	In-Network (Class 2)	Out of Network (Class 2)
Chiropractic Services 24 visits per calendar year. Hot/Cold packs are not covered.	24 visits per year $20 copay, 100%	Not covered	24 visits per year $20 copay, 100%	Not covered
Acupuncture 24 visits per calendar year.	24 visits per year $20 copay, 100%	Not covered	24 visits per year $20 copay, 100%	Not covered
Routine Podiatry 4 visits per calendar year. Treatment of corns, calluses, nails conditions, & dermatological conditions.	4 visits per year $30 copay, 100%	Not covered	4 visits per year $30 copay, 100%	Not covered
Non-routine Podiatry Orthotics will be allowed only if foot strapping confirms the orthotic will be effective (not required for replacement orthotics).	$30 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$30 copay, 100%	Not covered

	In-Network (Class 1)	Out of Network (Class 1)	In-Network (Class 2)	Out of Network (Class 2)
Diabetes Education For the care, monitoring or treatment of diabetes and dietary needs.	$0 copay, 100%	Not covered	$0 copay, 100%	Not covered
Nutritional Counseling 4 visits per calendar year.	$0 copay, 100% 4 visits per year	Not covered	$0 copay, 100% 4 visits per year	Not covered
Emergency and Urgent Care				
Urgent Care Center (UCC)	$50 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$50 copay, 100%	Not covered
Emergency Room Services	$200 copay, 100%	$200 copay, 100%	$200 copay, 100% benefit max of $900 per visit (max applies to facility only)	$200 copay, 100% benefit max of $900 per visit (max applies to facility only)

	In-Network (Class 1)	Out of Network (Class 1)	In-Network (Class 2)	Out of Network (Class 2)
Emergency Room for Non-Emergency				
	$200 copay, then 50%	$200 copay, then 50%	$200 copay, then 50% benefit max of $900 per visit (max applies to facility only)	Not covered
Ambulance Non-emergency transportation requires precertification.				
	$100 copay/trip, 100%	$100 copay/trip, 100%	$150 copay/trip, 100%	$150 copay/trip, 100%
Inpatient Hospital Precertification required through Utilization Management at Horizon: **(866) 899-0626**. For mental health/substance abuse inpatient hospital, precertification is required through Optum: **(866) 248-4094**.				
	$50 copay/day, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	Plan pays max of $2,500/admission (facility fees)	Not covered
Outpatient Service				
Outpatient Surgery in Ambulatory Surgical Center (ASC) Precertification required through Utilization Management at Horizon: **(866) 899-0626**. Refer to Precertification List.				
	$30 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$100 copay, benefit max of $900	Not covered

	In-Network (Class 1)	Out of Network (Class 1)	In-Network (Class 2)	Out of Network (Class 2)
Outpatient Surgery in Hospital Precertification required through Utilization Management at Horizon: **(866) 899-0626**.	$75 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$100 copay, benefit max of $900	Not covered
Outpatient Surgery in PCP Office *(with or without office visit charge)*	$20 copay, 100% ($0 copay for PCP at Designated Medical Groups and Union Health Center)	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$20 copay ($0 copay for PCP at Designated Medical Groups and Union Health Center)	Not covered
Outpatient Surgery in Specialist Office *(with or without office visit charge)*	$30 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$30 copay, 100%	Not covered
Physical/Occupational Therapy Precertification required through Utilization Management at Horizon: **(866) 899-0626**.	$30 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$30 copay, 100%	Not covered

	In-Network (Class 1)	Out of Network (Class 1)	In-Network (Class 2)	Out of Network (Class 2)
Speech Therapy Precertification required through Utilization Management at Horizon: **(866) 899-0626**. Refer to precertification list.				
	$30 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$30 copay, 100%	Not covered
Infusion Medication, Chemotherapy in Home, Office or Non-Hospital Infusion Center, or Hospital Outpatient Precertification required through Magellan Rx: **(800) 424-4508**.				
	Home: $0 copay, 100% Office or Infusion Center: $30 copay, 100% Hospital Outpatient: $75 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	Home: $0 copay, 100% Office or Infusion Center: $30 copay, 100% Hospital Outpatient: $75 copay, 100%	Not covered
Kidney Dialysis				
	$0 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$0 copay, 100%	Not covered

	In-Network (Class 1)	Out of Network (Class 1)	In-Network (Class 2)	Out of Network (Class 2)
Radiation Therapy Precertification required through eviCore: **(866) 496-6200**.	$30 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$30 copay, 100%	Not covered
MH/SA IOP, PHP, ambulatory detox Precertification required through Optum: **(866) 248-4094**.	$0 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$0 copay, 100%	Not covered
Lab and imaging services				
Laboratory Services	Office/Free-standing: $20 copay, 100% Hospital Outpatient: $40 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	Office/Free-standing: $20 copay, 100% Hospital Outpatient: $40 copay, 100%	Not covered

	In-Network (Class 1)	Out of Network (Class 1)	In-Network (Class 2)	Out of Network (Class 2)
Radiology *(Xray, Ultrasound, Fetal Monitoring)*				
	Office/Non-Hospital: $30 copay, 100% Hospital Outpatient: $75 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	Office/Non-Hospital: $30 copay, 100% Hospital Outpatient: $75 copay, 100%	Not covered
Diagnostic Imaging *(CT, MRI, PET)* Precertification required through eviCore: **(866) 496-6200**.				
	Office/Non-Hospital: $50 copay, 100% Hospital Outpatient: $100 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	Office/Non-Hospital: $50 copay, 100% Hospital Outpatient: $100 copay, 100%	Not covered
Other care and expenses				
Home Health Care Precertification required through Care Centrix: **(855) 243-3324**.				
	$0 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$0 copay, 100%	Not covered

	In-Network (Class 1)	Out of Network (Class 1)	In-Network (Class 2)	Out of Network (Class 2)
Hospice Care Precertification required through Utilization Management at Horizon: **(866) 899-0626**.	$0 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$0 copay, 100%	Not covered
Skilled Nursing Facility (SNF) Care Precertification required through Utilization Management at Horizon: **(866) 899-0626**.	$0 copay, 100%	Not covered	No copay/deductible, Plan pays max of $2,500/admission (facility fees)	Not covered
Podiatric Orthotics Participant pays amounts over $500 per person per calendar year.	Plan pays up to $500 every calendar year	Not covered	Not covered	Not covered
Prosthetics and Orthotics Precertification required for over $500; Precertification required through Care Centrix: **(855) 243-3324**.	20% coinsurance	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	Not covered (except breast protheses)	Not covered

	In-Network (Class 1)	Out of Network (Class 1)	In-Network (Class 2)	Out of Network (Class 2)
Durable Medical Equipment (DME) Precertification required for DME over $500 through Care Centrix: **(855) 243-3324**. Rental fees are covered up to the purchase price. Costs for repair or maintenance are also considered covered expenses if DME is purchased.	20% coinsurance	Not covered	Not covered	Not covered
Sleep Studies Precertification required through Utilization Management at Horizon: **(866) 899-0626**.	20% coinsurance	Not covered	Not covered	Not covered
All other	20% coinsurance	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	Not covered	Not covered
Other topics				
Telehealth	$20 copay	Not covered	$20 copay	Not covered

	In-Network (Class 1)	Out of Network (Class 1)	In-Network (Class 2)	Out of Network (Class 2)
Professional fees				
	$0 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$0 copay, 100%	Not covered
Pre-cert penalty Claim will be denied in its entirety.				
	No Penalty	No Penalty	No Penalty	Not covered
Private Duty Nursing				
	Not covered	Not covered	Not covered	Not covered
Hearing Aids				
	Class I only: Plan pays up to $500 per 24 months (24 month period begins from date hearing aid is delivered).	Class I only: Plan pays up to $500 per 24 months (24 month period begins from date hearing aid is delivered).	Not covered	Not covered

	In-Network (Class 1)	Out of Network (Class 1)	In-Network (Class 2)	Out of Network (Class 2)
Prescription Drug Benefits				
Generic	$10 copay	Not covered	Limited to preventive healthcare drugs	Not covered
Formulary Brand	$20 copay	Not covered	Limited to preventive healthcare drugs	Not covered
Non-Formulary Brand	$50 copay	Not covered	Limited to preventive healthcare drugs	Not covered
Specialty	25% coinsurance, max $50	Not covered	Limited to preventive healthcare drugs	Not covered
Pharmacies Mail order prescription drug service is only available through WellDyneRx: **(844) 813-3860**; specialty drugs must be obtained through Walgreens Specialty Mail Order Pharmacy: (**877) 647-5807.**	CVS, Eckerd, Kmart, Certain independent local pharmacies	Walgreens, Duane Reade, Certain independent local pharmacies	CVS, Eckerd, Kmart, Certain independent local pharmacies	Walgreens, Duane Reade, Certain independent local pharmacies

Prior Authorization List for Plan Unit 105

- All inpatient admissions (through Horizon or Optum), regardless of the type of facility or care, including but not limited to skilled nursing facility care, hospice, residential treatment (through Optum), and, elective cesarean section admissions under 38 weeks.
- Ambulance transportation that is non-emergent (ground or air)
- Arthroscopy (regardless of setting)
- Bariatric surgery, including gastric bypass and banding procedures
- Blepharoplasty
- Carpal tunnel release
- Clinical trials
- Cochlear implants
- Diagnostic imaging services (through eviCore) as follows:
  - CT, CTA, and CAT scans (computed tomography scintiscan or computerized axial tomography scintiscan)
  - MRA and MRI (magnetic resonance imaging or magnetic resonance angiography)
  - PET scan (positron emission tomography scintiscan)
  - Cardiac catheterization
  - Echocardiogram
  - Nuclear medicine
- Durable medical equipment (DME) over $500, including breast pumps over $500
- Electromyogram (EMG)
- Excision of excessive skin
- Genetic testing
- Gynecomastia (surgical treatment)
- Habilitative therapy for children with autism spectrum disorder
- Hip replacement
- Home healthcare services, including home infusion
- Hospice services
- All hospital-based outpatient surgical procedures
- Hyperbaric oxygen therapy
- Certain injectable medications
- Knee replacement
- Laminectomy
- Lipectomy (removal of excessive fat/tissue)
- Mammoplasty (breast reduction)
- Medical foods for inborn errors of metabolism
- Meniscectomy
- Myelogram
- Non-routine outpatient mental health and substance abuse services (through Optum), including:
  - Electro-convulsive treatment
  - Extended outpatient visits lasting longer than 53 minutes
  - Intensive outpatient programs
  - Methadone maintenance
  - Partial hospitalization programs
  - Psychological testing
  - Transcranial magnetic stimulation
- Nuclear cardiac imaging
- Orthognathic jaw surgery including treatment for temporomandibular joint disorder (TMJ) and other craniofacial disorders
- Orthotics over $500
- Percutaneous discectomy reduction
- Physical therapy
- Prosthetics over $500
- Radiation therapy (through eviCore)
- Requests for the network level of benefits for non-network treatment or supplies when a network deficiency exists
- Rhinoplasty/septoplasty
- Sclerotherapy (surgery for varicose veins)
- Sleep studies
- Speech therapy
- Submucous resection
- Transplant services
- Travel and lodging benefits
- Uvulopalatopharyngoplasty (UPPP)

Important Contacts

Fund Office
Find a PCP/ask about benefits
(866) 261-5676 • uhh.org

Hospitality Rx
Find a network pharmacy
(844) 813-3860 • hospitalityrx.org

Horizon BCBS
Find a network doctor
(800) 810-2583

Get prior authorization for certain services
(866) 899-0626 • horizonblue.com

EmblemHealth
Find a network dentist
(800) 624-2414 • emblemhealth.com

eviCore
Get prior authorization for diagnostic imaging
(CAT/CT, CTA, Cardiac CT, MRI, MRA, PET scans, Nuclear Medicine, Nuclear Cardiac Imaging, Cardiac Catheterization, & Echocardiograms)
(866) 496-6200

Davis Vision
Find a network vision provider
(800) 999-5431 • davisvision.com

Optum
Find a mental health/substance abuse provider, get prior authorization for certain services, and use EAP services
(866) 248-4094