# 173 Staff Retiree - Provider Benefits Fact Sheet

**Calendar Year Medical Deductible**: INN: $200 per person; $400 per family; OON: $600 per person; $800 per family

**Lifetime Maximum (medical): $1,000,000**

**Medical claims time filing limit: 18** months from date of service; dental and vision filing limits may be different.

Medical claims should be submitted to your local BCBS or mailed to:

**Blue Cross and Blue Shield of Illinois**
P.O. Box 805107
Chicago, IL 60680-4112

W-9's and only medical records should be submitted to: claims@uhh.org; Fax No. 630-236-4394; or mail to UHH, PO Box 6020, Aurora, IL 60504.

**Disclaimers**:

Newborn dependents are not covered automatically; members must complete a special enrollment within the first 60 days of birth to be covered for any medical expenses from birth date. If there is no enrollment received, any/all charges will be denied as dependent not eligible.

Alternative medicine is considered an exclusion and not covered under the plan- this includes holistic /natural medicine.

Information provided does not guarantee payment. All claims are subject to eligibility based on current information in our system and terms of the plan.

See chart below for detailed benefits.

| | IN NETWORK (covered %) | OUT OF NETWORK |
|---|---|---|
| **OFFICE VISITS BENEFIT** | | |
| **Office visit for a primary care Healthcare Professional** *(unless specified otherwise)*<br>*Service: Non-preventive visit*<br>Includes all services provided during the visit. | 100% after $10 copayment per visit<br>(no Calendar Year deductible) | 60% after Calendar Year deductible |

| | IN NETWORK (covered %) | OUT OF NETWORK |
|---|---|---|
| **Office/Clinic Visits (PCP)**<br>*Service: Preventive Healthcare Services*<br>Plan covers only the following network preventive care: well-baby care up to 18 months, routine gynecological exams and cervical cancer screenings, routine mammograms, routine prostate exams, routine physical exam, routine colonoscopies, and routine immunizations. | 100% (no Calendar Year deductible) | Not Covered |
| **Office visit for treatment of Mental Health**<br>Includes all care provided during visit. | 100% after $20 copayment per visit<br>(no Calendar Year deductible) | 60% after Calendar Year deductible |
| **Specialist Care Office Visits**<br>Includes all care provided during visit. Without referral through HealthCheck360 | 100% after $20 copayment per visit<br>(no Calendar Year deductible) | 60% after Calendar Year deductible |
| **Specialist Care Office Visits**<br>Includes all care provided during visit. With referral through HealthCheck360 | 100% after $10 copayment per visit<br>(no Calendar Year deductible) | 60% after Calendar Year deductible |
| **Allergy** | 100%<br>(no Calendar Year deductible) | 60% after Calendar Year deductible |

| | IN NETWORK (covered %) | OUT OF NETWORK |
|---|---|---|
| **Maternity Care (PCP provided)**<br>*Service: Non-preventive*<br>Cost sharing does not apply to certain preventive services. Depending on the type of services, a copayment or coinsurance may apply. Benefit covers employees and eligible dependents.<br><br>Newborn dependents are not covered automatically; members must complete a special enrollment within the first 60 days of birth to be covered for any medical expenses from birth date. If there is no enrollment received, any/all charges will be denied as dependent not eligible. | 100% after $10 copayment per visit<br>(no calendar year deductible) | 60% after calendar year deductible |
| **Mammogram Preventive**<br>*Service: Preventive Breast Cancer Mammography Screenings*<br>One routine (preventive) mammogram screening each calendar year for all women age 35 and older. Routine mammogram screenings will also be covered once each calendar year for women under age 35 who are at high risk for breast cancer. 3D Mammograms are covered under the preventive benefit, no prior authorization is required. | 100%<br>(no calendar year deductible) | Not Covered |
| **Cervical Cancer Screening – Preventive**<br>*Service: Preventive Pap Smear/HPV*<br>Age related provisions have been removed, cervical cancer screening and HPV screening will be covered once per calendar year. Cervical cancer screenings (other than diagnostic) performed more frequently will not be a covered expense. | 100%<br>(no calendar year deductible) | Not Covered |

| | IN NETWORK (covered %) | OUT OF NETWORK |
|---|---|---|
| **Colonoscopies - Preventive**<br>*Service: Screening colonoscopy*<br>Screening colonoscopy - 1 every 10 years beginning at age 45 to 75 for persons of average risk, or once every 2 years if diagnosed as high risk, such as diagnosed with a high risk of colon cancer due to own medical history or medical history of immediate family members. Cologuard screening test is covered under preventive screening. No Prior Authorization required | 100% | Not Covered |
| **Acupuncture**<br>Excluded | | |
| **Chiropractic Services**<br>No visit max. | 100% after $20 copayment per visit<br>(no Calendar Year deductible) | 60% after calendar year deductible |
| **University of Pennsylvania Health System (Penn) Cancer Care (Eff 2.01.2024)**<br>$0 cost-sharing (deductible, coinsurance, and co-payments) on covered services for the diagnosis, treatment, and surveillance of non-pediatric cancer and benign hematology disorders (including related complications) provided by the University of Pennsylvania Health System (Penn) in addition to radiation treatment provided at Shore Medical Center for participants referred there by Penn for the treatment of cancer. | 100% | Not Covered |

| | IN NETWORK (covered %) | OUT OF NETWORK |
|---|---|---|
| **Routine Podiatric Services**<br>No visit max. | | |
| | 100% after $20 copayment per visit<br>(no calendar year deductible) | 60% after Calendar Year deductible |

| | IN NETWORK (covered %) | OUT OF NETWORK |
|---|---|---|
| **Non-Routine Podiatric** | | |
| | 100% after $20 copayment per visit<br>(no Calendar Year deductible) | 60% after Calendar Year deductible |
| **Services provided at the Unite Here Health Center (Atlantic City)** | | |
| | 100%<br>(no Calendar Year deductible) | Not Covered |
| **URGENT AND EMERGENCY TREATMENT** | | |
| **Urgent Care Center Visit** | | |
| | 100% after $20 copayment per visit<br>(no Calendar Year deductible) | 60% after Calendar Year deductible |
| **Hospital emergency room services**<br>*Service: Emergency Room* | | |
| | 100% after Calendar Year deductible | 100% after Calendar Year deductible |

| | IN NETWORK (covered %) | OUT OF NETWORK |
|---|---|---|
| **Hospital emergency room services for non-emergency care**<br>*Service: Emergency Room*<br>Care and services that could be provided in a clinic, urgent care center or Healthcare Professional's office are not considered Emergency. Non-network physician services paid at 80% after CYD. | 80% after Calendar Year deductible | 40% after Calendar Year deductible |
| **Ambulance**<br>*Service: Professional Ambulance Transportation* | 100% first $50, then 60% after Calendar Year deductible | 100% first $50, then 60% after Calendar Year deductible |
| **INPATIENT TREATMENT** | | |
| **Hospital inpatient department services, including inpatient professional services**<br>*Service: Hospitalization*<br>Including inpatient professional services. Includes the treatment of Mental Health/Substance Abuse Disorders. Also applies to maternity/pregnancy delivery, and all inpatient services Prior authorization is required. Prior authorization is not required for maternity admissions less than 2 days for vaginal deliveries and 4 days for cesarean sections. OON physician services paid at 80% after CYD. | 100% after Calendar Year deductible | 60% after Calendar Year deductible |
| **Skilled Nursing Facility confinement**<br>Limited to 70 days per person each calendar year for Network and Non-Network care combined. Prior authorization is required. | 100% after Calendar Year deductible | 60% after Calendar Year deductible |

| | IN NETWORK (covered %) | OUT OF NETWORK |
|---|---|---|
| **LABORATORY AND IMAGING SERVICES** | | |
| **Laboratory Services** | 100% after Calendar Year deductible | 60% after Calendar Year deductible |
| **Radiology**<br>Including x-ray, ultrasound, fetal monitoring. | 100% after Calendar Year deductible) | 60% after Calendar Year deductible |
| **Diagnostic Imaging**<br>Includes CT, MRI, PET, and Cardiac Testing. Prior authorization required for CT, MRA, MRI and PET. | 100% after Calendar Year deductible | 60% after Calendar Year deductible |
| **OUTPATIENT SERVICES BENEFIT** | | |
| **Outpatient Surgery**<br>*Service: Ambulatory surgical center*<br>Physician/surgeon fees are included in the copay and coverage level for both in-network and out-of-network for surgery in an Ambulatory Surgical Center. Prior Authorization may be required. | 100% after Calendar Year deductible | 60% after Calendar Year deductible |

| | IN NETWORK (covered %) | OUT OF NETWORK |
|---|---|---|
| **Outpatient Surgery**<br>*Service: Hospital outpatient department*<br>Physician/surgeon fees are included in the copay and coverage level for both in-network and out-of-network for surgery in an outpatient hospital. Prior Authorization may be required. | 100% after Calendar Year deductible | 60% after Calendar Year deductible |
| **Physical, speech, and occupational therapy**<br>Services must be within the scope of the provider's license. Prior Authorization required. Speech therapy for children limited to $2,500/year. | 100% after Calendar Year deductible | 60% after Calendar Year deductible |
| **OTHER CARE** | | |
| **Podiatric Orthotics**<br>Prior authorization required if over $500. | 100% after Calendar Year deductible | 60% after Calendar Year deductible |
| **Diabetes Education**<br>For the care, monitoring, or treatment of diabetes & dietary needs. Maximum $200/year. Covered only if certified diabetes educator. | 100%<br>(no Calendar Year deductible) | Not Covered |

| | IN NETWORK (covered %) | OUT OF NETWORK |
|---|---|---|
| **Nutritional Counseling**<br>Maximum $200/year. Covered only if registered dietician. | 100%<br>(no Calendar Year deductible) | Not Covered |
| **Partial Hospitalization, Intensive outpatient and Ambulatory Detoxification Treatment**<br>Prior Authorization required. | $20 copay 100%<br>(no Calendar Year deductible) | 60% after Calendar Year deductible` |
| **Home Healthcare**<br>200 Days / Year (combined in/non-network) Prior Authorization required. | 100% after calendar year deductible | 60% after Calendar Year deductible |
| **Hospice Care**<br>210 Days / lifetime (combined in/non-network) Prior Authorization required. | 100% after Calendar Year deductible | 60% after Calendar Year deductible |
| **Durable Medical Equipment - DME**<br>Prior authorization is required for durable medical equipment (DME), orthotics and prosthetics exceeding $500. If durable medical equipment can either be rented or purchased, and if rental fees for prescribed course of treatment expects to exceed purchase price, the Fund may limit covered expense to durable medical equipment purchase price. | 100% after Calendar Year deductible | 60% after Calendar Year deductible |

| | IN NETWORK (covered %) | OUT OF NETWORK |
|---|---|---|
| **Non-hospital-grade breast pumps**<br>NOT COVERED | | |
| | 100% (no Calendar Year deductible) | 100% (no Calendar Year deductible) |
| **Habilitative therapy for children with Autism Spectrum Disorder**<br>Limited to 30 hours per week, at least 2 years old but not older than 8 years old. Child must have a diagnosis of autism spectrum disorder, and have a prorated mental age of at least 11 months. Prior Authorization required. | | |
| | 100% after $10 copayment per day of treatment (no calendar year deductible) | 60% after Calendar Year deductible |
| **Medical foods for inborn metabolic errors**<br>Medical foods for covered persons with inborn errors of metabolism (IEM). The medical food must be: (1) ordered by and used under the supervision of a healthcare provider; (2) the primary source of nutrition; and (3) labeled and used for dietary management of IEM. Prior Authorization required. | | |
| | 100%<br>(no Calendar Year deductible) | |
| **Travel and lodging for certain serious medical conditions**<br>Excluded. | | |
| | | |
| **All other Covered Expenses** | | |
| | 100% after Calendar Year deductible | 60% after Calendar Year deductible |

| | IN NETWORK (covered %) | OUT OF NETWORK |
|---|---|---|
| **Hearing Aids**<br>Plan Exclusion - Through 12/31/2022 | Not Covered | Not Covered |
| **Hearing Aids**<br>Effective 1/1/2023 | Plan pays $3,000 / 3 calendar years | Plan pays $3,000 / 3 calendar years |
| **Prostate Specific Antigen**<br>*Service: PSA*<br>Covered annually for men between the ages of 40-69. | 100% | Not Covered |
| **Dental**<br>*Service: Delta Dental of Illinois (PPO)*<br>Dental plan is administered by Delta Dental, additional information can be found at www.deltadentalil.com or by calling **(800) 323-1743**. | Contact Delta Dental for additional info | Contact Delta Dental for additional info |
| **Vision**<br>*Service: Davis Vision*<br>Vision Plan is administered by Davis Vision, additional information can be found at www.davisvision.com/member or by calling (800) 999-5431. | | |

| | IN NETWORK (covered %) | OUT OF NETWORK |
|---|---|---|
| **Contraceptives**<br>*Service: Birth control*<br>Covered under prescription drug benefit. | 100% | Not Covered |
| **Infertility**<br>Plan exclusion. The initial exam and any procedures used to arrive at the diagnosis of infertility is an allowable expense. Once a determination of infertility is established, any services for or in connection with treatment for infertility is excluded. | | |

| | IN NETWORK (covered %) | OUT OF NETWORK |
|---|---|---|
| **PRESCRIPTION DRUG BENEFITS**<br>**Effective 4/1/22 Maximum benefit: $21,000/year/family** | | |
| Mail order prescription drug service is only available through WellDyneRx: (844) 813-3860; specialty drugs must be obtained through WellDyne Specialty Pharmacy: (800) 373-1879, https://welldynespecialty.com. Visit Hospitality Rx for more detailed information. | | |
| **Preventive Healthcare Services and supplies on the formulary** | | |
| | | Not Covered |
| **Formulary generic drugs** | | |
| FORMULARY BRAND - $30 (34-day retail/60-day mail) | 100% after $15 copayment per prescription fill or refill (34-day retail/ 60-day mail) | Not Covered |
| **Formulary Select Specialty & Select Biosimilar Drugs – Brand** | | |
| | 25% up to 60-day supply | Not Covered |
| **Formulary Select Specialty & Select Biosimilar Drugs – Generic** | | |
| | $15 copay up to 60-day supply | Not Covered |
| **Non-Formulary Prescription Drugs and Supplies** | | |
| | Not Covered | Not Covered |
| **Prescription drugs and supplies at the UNITE HERE HEALTH Health Center (Atlantic City)** | | |
| | 100% | N/A |

# Prior Authorization List for Plan Unit 173 Staff Retiree

Provider should get prior authorization with HealthCheck360 at **(844) 462-7812** before any of the following:

• Any inpatient admission, regardless of the type of facility or care, including but not limited to admissions following observation or an emergency visit, skilled nursing facility care, hospice care, acute rehabilitation care, long-term acute facility care, residential treatment, maternity admissions following 48 hours for a vaginal delivery and 96 hours following a Cesarean delivery, and elective Cesarean section (C-section) admissions under 38 weeks

• Bariatric surgery (including but not limited to gastric bypass and banding procedures)

• Blepharoplasty

• Chemotherapy

• Clinical trials

• Diagnostic imaging services as follows:

- CT, CTA, and CAT scans (computed tomography scintiscan or computerized axial tomography scintiscan)
- MRA and MRI (magnetic resonance angiography or magnetic resonance imaging)
- PET scan (positron emission tomography scintiscan)

• Dialysis – notification only

• Durable medical equipment over $500 (including breast pumps costing over $500)

• Electroconvulsive therapy (ECT)

• Gender reassignment surgical services and certain hormone therapy

• Genetic testing

• Gynecomastia surgery

• Habilitative therapy for children with autism spectrum disorder

• Hospice services

• Hyperbaric oxygen therapy treatment

• Hysterectomy

- Select injectable, infused, ingested, or inhaled medications administered by your provider in an outpatient setting
- Joint replacements, including but not limited to hip and knee replacements
- Laminectomy
- Le Fort osteotomy
- Lipectomy and panniculectomy
- Mammoplasty (breast reduction)
- Medical foods for inborn errors of metabolism
- Orthognathic surgery
- Orthotics or prosthetics (including podiatric orthotics) over $500
- Partial hospitalization and intensive outpatient programs
- Physical, occupational, and speech therapy after the first 12 visits
- Radiation therapy
- Reconstructive surgery
- Sinus surgery (including but not limited to rhinoplasty, and/or septoplasty, and submucous resection)
- Skilled services provided in a home setting, including home healthcare, home therapy (PT, OT, ST) and home infusion
- Sleep studies
- Temporomandibular joint surgery
- Transcranial magnetic stimulation (TMS)
- Transplant services
- Travel and lodging
- Varicose vein procedures (including vein sclerotherapy)

*The prior authorization list may change from time to time, contact HealthCheck360 at **(844) 462-7812** for the most up-to-date information.*

Last Update 07/19/2024