# Benefits at a Glance

Plan 100A
***Class I and Class II***

## UNITE HERE HEALTH

Your health fund!
**www.uhh.org • (866) 261-5676**

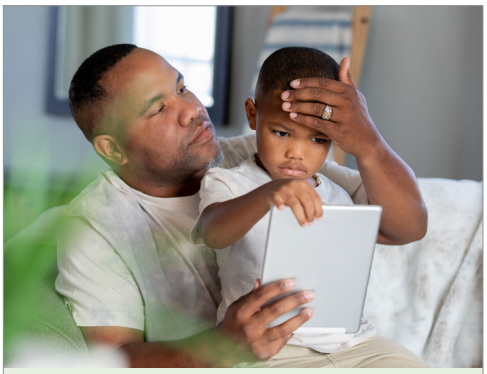
*Call Member Services if you have benefit questions or need help finding a doctor!*

*Get 24/7 access to your benefits and more!*

- **Member Portal:** www.uhh.org/member
- **Mobile app:** scan the QR code

iPhone

Android



### Need to see a doctor NOW?

***Your telemedicine benefit offers 24/7 care with $0 copay!***

Scan the QR code to download the Amwell mobile app.

- You'll need a "service key" (enter: **UHH**)
- Select your insurance: Horizon Blue Cross Blue Shield of New Jersey
- Enter your Subscriber ID (the member ID from your Horizon BCBS ID card)

You can also call Amwell: (844) 733-3627.

### *Your BCBS network depends on where you live...*

| | |
|---|---|
| ***Find a doctor near you!*** | NJ residents only: *your network is Horizon Direct Access* (visit **doctorfinder.horizonblue.com)**<br>Everyone else: *your network is BlueCard PPO* (visit **provider.bcbs.com)** |

### Other important contact info

| | |
|---|---|
| ***Prior authorization***<br>For diagnostic imaging, cardiology, radiation therapy, and genetic testing | eviCore<br>(866) 496-6200 |
| For all other medical services | Horizon<br>(866) 899-0626 |
| ***Prescription Drugs*** *(Hospitality Rx)*<br>Find a network pharmacy or get pharmacy prior authorization | (844) 813-3860<br>hospitalityrx.org |
| Mail order (WellDyneRx) | (844) 813-3860 |
| Specialty drugs (Welldyne Specialty Pharmacy) | (800) 373-1879 |
| ***Delta Dental of Illinois*** | (800) 323-1743<br>deltadentalil.com |
| ***Davis Vision*** | (800) 999-5431<br>davisvision.com |

**About your coverage:**

The plan provides two levels of benefits — Class I and Class II — each determined by the days/hours of work you are credited with during a work period. Coverage for your dependents is available at no cost to you.

UNITE HERE HEALTH

*This is an easy-to-read summary and does not include all benefits. If there is a conflict between this summary and your plan documents, then your plan documents are correct. For more details about your benefits or to find out which treatments/services require prior authorization, please refer to your Summary Plan Description (SPD) or call us at (866) 261-5676.*

# Medical Benefits

**Effective 7/1/2023**

| MEDICAL | *At network providers, you pay...* | | | | | |
|---|---|---|---|---|---|---|
| **Deductible** | ***Class I*** | | | ***Class II*** | | |
| | $0 | | | $0 | | |
| **Office Visits & Labs** | ***Class I*** | | | ***Class II*** | | |
| Preventive Care<br>*Certain routine tests and screenings like colonoscopies and mammograms; limits may apply* | $0 | | | $0 | | |
| Primary Care at Designated Medical Groups and Union Health Center | $0 | | | $0 | | |
| Primary Care at other providers | $10 | | | $10 | | |
| Covered Services provided by the Union Health Center | $0 | | | $0 | | |
| Amwell *(telehealth)* | $0 | | | $0 | | |
| Mental Health/Substance Abuse Visits | $10 | | | $10 | | |
| Specialist Visits | $20 | | | $20 | | |
| Laboratory Services | ***Non-hospital***<br>$10 | ***Hospital***<br>$20 | | ***Non-hospital***<br>$10 | ***Hospital***<br>$20 | |
| Radiology *(x-ray, ultrasound)* | ***Non-hospital***<br>$20 | ***Hospital***<br>$50 | | ***Non-hospital***<br>$20 | ***Hospital***<br>$50 | |
| **Emergency Care Services** | ***Class I*** | | | ***Class II*** | | |
| Urgent Care Center | $10/visit | | | $10/visit | | |
| Emergency Room Services | $150/visit | | | $150/visit *(Plan pays up to $900/visit)* | | |
| Ambulance | $100/trip | | | $150/trip | | |
| **Inpatient Services** *(facility fees)* | ***Class I*** | | | ***Class II*** | | |
| Hospitalization *(including residential treatment)* | $50/day | | | Plan pays up to $2,500/admission | | |
| Skilled Nursing Facility | $0 | | | | | |
| **Outpatient Services** | ***Class I*** | | | ***Class II*** | | |
| Cardiac Testing and Diagnostic Imaging *(CAT/CT, MRI, PET scans, etc.)* | ***Non-hospital***<br>$30 | ***Hospital***<br>$100 | | ***Non-hospital***<br>$30 | ***Hospital***<br>$100 | |
| Surgery | ***Non-hospital***<br>$20 | ***Hospital***<br>$50 | | ***Non-hospital/Hospital***<br>$100 *(Plan pays up to $900/visit)* | | |
| Knee & Hip Replacement, Weight Loss (Bariatric) Surgery<br>***Call (914) 677-1601 or visit uhh.org/mtsinai*** | ***Fund Center of Excellence (COE)****<br>$0 | ***Non-COE***<br>50%<br>(exceptions apply) | | Not applicable | | |
| Physical, Speech, and Occupational Therapy | $20 | | | $20 | | |
| Chemotherapy/ Infusion Therapy | ***Home***<br>$0 | ***Office or Infusion Center***<br>$20 | ***Hospital***<br>$50 | ***Home***<br>$0 | ***Office or Infusion Center***<br>$20 | ***Hospital***<br>$50 |
| Radiation Therapy | $20 | | | $20 | | |
| Kidney Dialysis | $0 | | | $0 | | |
| **Other Care and Expenses** | ***Class I*** | | | ***Class II*** | | |
| Routine Podiatry *(4-visit maximum/person/calendar year)* | $20 | | | $20 | | |
| Podiatric Orthotics *(per person/calendar year)* | $500 maximum | | | Not covered | | |
| Acupuncture; Chiropractic Care<br>*(24-visit maximum/person/calendar year for each)* | $10 | | | $10 | | |
| Diabetes Education | $0 | | | $0 | | |

# Medical & Rx Benefits

| Other Care and Expenses | *Class I* | *Class II* |
|---|---|---|
| Nutrition Counseling *(4-visit max/person/calendar year)* | $0 | $0 |
| Medical Equipment for Home Use (DME) | 20% | Not covered |
| Hearing Aids *(device only)* | $3,000 max reimbursement for prescription hearing aids every 3 calendar years | Not covered |
| Home Healthcare | $0 | $0 |
| Hospice Care | $0 | $0 |
| All Other Covered Expenses | 20% | Not covered |
| Out-of-pocket Spending Limits | $5,000 individual/$10,000 family | $6,600 individual/$13,200 family |
| **Non-Network Coverage** | ***Class I*** | ***Class II*** |
| Deductible | $400/individual; $1,000/family *(no deductible when you stay in network)* | NOT covered *(except ambulance transportation and emergency services)* |
| Non-Network Services | 50% after deductible | |
| Non-Network Services that are NOT covered | Preventive healthcare, chiropractic care, acupuncture, routine podiatry, skilled nursing facility, diabetes education, nutrition counseling, durable medical equipment, podiatric orthotics, and sleep studies | |

| **PRESCRIPTION DRUG** | **Your health fund manages your pharmacy and drug benefits directly under the name "Hospitality Rx."** | | |
|---|---|---|---|
| ***Class I*** | | | |
| **Formulary Prescription Drug Benefits** | ***What you pay per prescription at network providers...*** | | |
| | **Retail Pharmacy** *up to a 34-day supply* | **Mail Order Pharmacy** *up to a 60-day supply* | |
| Certain Preventive Drugs | $0 | | |
| Generic and Some Brand Drugs | $1 | | |
| Preferred Drugs | $15 | | |
| Non-Preferred Drugs | $30 | | |
| Select Specialty and Select Biosimilar Drugs* | Not covered | ***Generic*** $1 | ***Brand*** 25% |
| Non-formulary Prescription Drugs and Supplies | Not covered, unless an exception is approved | | |
| Out-of-pocket Spending Limits | $1,600 individual/$3,200 family | | |

** Specialty drugs are only available through the specialty mail order pharmacy. However, if you take specialty medications as part of your HIV treatment plan, you may be able to receive an exception to use your network retail pharmacy instead of the specialty pharmacy.*

| **Network Pharmacies** | **Non-Network Pharmacies** *(not covered)* |
|---|---|
| CVS, Costco, Stop & Shop, Shoprite | Duane Reade, Rite Aid, Walgreens, certain independent pharmacies |

# Rx & Additional Benefits

| **PRESCRIPTION DRUG** | ***What you pay per prescription at network providers...*** | |
|---|---|---|
| ***Class II*** ***Remember, this benefit is limited to preventive healthcare drugs and supplies.*** | **Retail Pharmacy** ***up to a 34-day supply*** | **Mail Order Pharmacy** ***up to a 60-day supply*** |
| Certain Preventive Drugs | $0 | |
| All Other Drugs | Not covered | |
| Non-Formulary Prescription Drugs and Supplies | Not covered | |

| **DENTAL** ***Delta Dental PPO network*** | **At network providers, you pay...** | **At Delta Dental Premier network & non-network providers, you pay...** |
|---|---|---|
| Diagnostic, Preventive, and Minor Restorative Services *(examples: x-rays, routine cleaning, fillings)* | $0 | 30% |
| Endodontic and Periodontic Services, Oral Surgery, and Prosthodontic Maintenance *(examples: root canals, periodontal (gum) maintenance, extractions)* | 20% | 40% |
| Prosthodontic and Major Restorative Services and Implants *(examples: complete or partial dentures, bridges, crowns)* | 40% | 60% |
| Orthodontic Treatment — limited to children under 19 | $0 | $0 |
| Calendar Year Maximum Benefit For Dental *(non-ortho)* Treatment | $3,000 per person | |
| Lifetime Maximum Benefit For Orthodontia Treatment | $5,000 per child | |

| **VISION** ***Davis Vision network—Covered once every calendar year*** | **At network providers, you pay...** | **At non-network providers, you pay...** |
|---|---|---|
| Retinal Imaging | $20 per exam | Not covered |
| Eye Exams | $0 | **1)** Pay provider at time of service<br>**2)** Submit a claim to Davis<br>**3)** Get reimbursed: $75 maximum for an exam and $175 maximum for all materials, evaluations, and fittings combined |
| Frames | $0 for Fashion, Designer & Premier levels in Davis Vision Collection<br>$150 allowance for other frames plus 20% off balance; no copay | |
| Lenses | $0 | |
| Cosmetic Contacts *(instead of glasses)* | $0 for Davis Vision Collection<br>$150 allowance for other contacts plus 15% off balance; $60 allowance for evaluation & fitting; no copay | |

| **LIFE INSURANCE** | The Plan pays $20,000 for each |
|---|---|
| **ACCIDENTAL DEATH & DISMEMBERMENT** | |

*Updated: 4/21/2023*