105 Greater New York Regional Hotel, Class I & II Provider Benefits Fact Sheet

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

Medical network:

If the employee lives inside New Jersey:

If the employee lives inside New Jersey: Network for care inside New Jersey is Horizon Direct Access; Network for care outside New Jersey is BlueCard PPO

If the employee lives outside New Jersey: Network for care inside New Jersey is Horizon PPO; Network for care outside New Jersey is BlueCard PPO

Mental Health/Substance Abuse network: Horizon Behavioral Health. Marriage Counseling is not covered on the basis that it is not medically necessary.

Annual Deductible:

Class I

In-network: Individual $0 Family $0 / Out of network: Individual $400 Family $1,000

Class II

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 I

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

Class II

$6,600/person and $13,200/family / **Out of network:** NO OUT OF NETWORK BENEFITS in Class II.

Rx: Preventive Healthcare Prescription Drugs and Supplies $0 (Very Limited Prescription Drug Benefits (ACA Requirement Only)

Claims time filing limit: 18 months from date of service

Medical claims should be submitted to your local Horizon BCBS of New Jersey or mailed to:

Horizon Blue Cross and Blue Shield of New Jersey
P. O. Box 1219
Newark, NJ 07101-1219

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 (Class I)	Out of Network (Class I)	In-Network (Class II)	Out of Network (Class II)
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, one per calendar year for all women age 35 and older and one per calendar year for women under 35 who are at high risk for breast cancer; Osteoporosis screening is covered for women over 65 and over or younger women with increased risk of fractures; Routine pap smears are covered one every calendar year for all women regardless if 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. Effective 9/1/21 the minimum age for colorectal cancer screening is lowered to 45. Cologuard screening test is covered under preventive screening once every 3 years. No prior authorization required.	$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				

	In-Network (Class I)	Out of Network (Class I)	In-Network (Class II)	Out of Network (Class II)
	$30 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$30 copay, 100%	Not covered
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
ABA Therapy *(Habilitative Therapy)* Prior authorization required; contact **HealthCheck360** for prior authorization at **(844) 462-7812.**				
	$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
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

	In-Network (Class I)	Out of Network (Class I)	In-Network (Class II)	Out of Network (Class II)
Acupuncture 24 visits per calendar year.	24 visits per year $20 copay, 100%	Not covered	24 visits per year $20 copay, 100%	Not covered
Maternity Care ▪ No coverage provided for pregnancy of a dependent child other than preventive prenatal care. Coverage for dependent child maternity care is covered for individuals living in Massachusetts. ▪ $0, $20 or $30 copay is determined based on the services billed on whether it is considered a preventive or an office visit. ▪ 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.	$0, $20 or $30 / Visit, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$0, $20 or $30 / Visit, 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 I)	Out of Network (Class I)	In-Network (Class II)	Out of Network (Class II)
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

	In-Network (Class I)	Out of Network (Class I)	In-Network (Class II)	Out of Network (Class II)
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)
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 prior authorization.	$100 copay/trip, 100%	$100 copay/trip, 100%	$150 copay/trip, 100%	$150 copay/trip, 100%
Inpatient Hospital Prior authorization required through Utilization Management at Horizon: **(866) 899-0626**. For mental health/substance abuse inpatient hospital, prior authorization required through Horizon Behavioral Health: **(800) 626-2212**.				

	In-Network (Class I)	Out of Network (Class I)	In-Network (Class II)	Out of Network (Class II)
	$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
Inpatient Surgery UNITE HERE HEALTH Center of Excellence (CoE) Program for Hip and Knee Joint Replacement and Bariatric Surgeries in partnership with Mt. Sinai Health System. **Mt. Sinai Union Services: (914) 677-1601.**				
	$0, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	Not covered	Not covered
OUTPATIENT SERVICE				
Outpatient Surgery in Ambulatory Surgical Center (ASC) Prior authorization required through Utilization Management at Horizon: **(866) 899-0626**. Refer to Prior authorization List.				
	$30 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 Hospital UNITE HERE HEALTH Center of Excellence (CoE) Program for Hip and Knee Joint Replacement and Bariatric Surgeries in partnership with Mt. Sinai Health System. **Mt. Sinai Union Services: (914) 677-1601.**				
	$0, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	Not covered	Not covered
Outpatient Surgery in PCP Office *(with or without office visit charge)*				

	In-Network (Class I)	Out of Network (Class I)	In-Network (Class II)	Out of Network (Class II)
	$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				
	$30 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$30 copay, 100%	Not covered
Speech Therapy				
	$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 Prior authorization required through Magellan Rx: **(800) 424-4508**.				

	In-Network (Class I)	Out of Network (Class I)	In-Network (Class II)	Out of Network (Class II)
	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
Radiation Therapy Prior authorization 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 Prior authorization required through Horizon Behavioral Health: **(800) 626-2212**.				
	$0 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$0 copay, 100%	Not covered

	In-Network (Class I)	Out of Network (Class I)	In-Network (Class II)	Out of Network (Class II)
LABORATORY 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
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

	In-Network (Class I)	Out of Network (Class I)	In-Network (Class II)	Out of Network (Class II)
Diagnostic Imaging *(CT, MRI, PET)* Prior authorization 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 Prior authorization 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
Hospice Care Prior authorization 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

	In-Network (Class I)	Out of Network (Class I)	In-Network (Class II)	Out of Network (Class II)
Skilled Nursing Facility (SNF) Care Prior authorization 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. Prior authorization required for over $500; prior authorization required through Care Centrix: **(855) 243-3324**.	Plan pays up to $500 every calendar year	Not covered	Not covered	Not covered
Prosthetics and Orthotics Prior authorization required for over $500; prior authorization 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
Durable Medical Equipment (DME) Prior authorization 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

	In-Network (Class I)	Out of Network (Class I)	In-Network (Class II)	Out of Network (Class II)
Sleep Studies				
	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				
Infertility				
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.				
Telehealth				
Telehealth services provided by Amwell, (**844) 733-3627**; uhh.amwell.com; for primary and urgent care services. (Any time, day or night. Behavioral Health appts. available 7 a.m. - 11 p.m.)				
	$20 copay	Not covered	$20 copay	Not covered
Professional Fees				
Physician/surgeon fees are included in the copay and coverage level for both in-network and out-of-network inpatient hospital.				
	$0 copay, 100%	50% (of 100% of Medicare) after deductible $400 individual/$1,000 family	$0 copay, 100%	Not covered

	In-Network (Class I)	Out of Network (Class I)	In-Network (Class II)	Out of Network (Class II)
Prior Authorization 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				
Through 12/31/2022	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
Effective 1/1/2023	Plan pays $3,000/3 calendar years	Plan pays $3,000/3 calendar years	Not covered	Not covered
PRESCRIPTION DRUG BENEFITS				
Generic				
	$10 copay	Not covered	Limited to preventive healthcare drugs	Not covered

	In-Network (Class I)	Out of Network (Class I)	In-Network (Class II)	Out of Network (Class II)
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
Select specialty and select biosimilar drugs				
	25% coinsurance	Not covered	Limited to preventive healthcare drugs	Not covered

	In-Network (Class I)	Out of Network (Class I)	In-Network (Class II)	Out of Network (Class II)
Pharmacies 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.				
	CVS CVS/Longs United Drug Albertsons Vons/Pavilion Winn Dixie Costco Kmart Ralph's Randalls Martins/Giant/Stop & Shop Safeway Kroger/Fred Meyer/Fry's/King Soopers Shoprite Supervalu Tom Thumb	Walgreens Duane Reade RiteAid/Brooks/Eckerd USA Drugs Wal-Mart Certain independent local pharmacies	CVS CVS/Longs United Drug Albertsons Vons/Pavilion Winn Dixie Costco Kmart Ralph's Randalls Martins/Giant/Stop & Shop Safeway Kroger/Fred Meyer/Fry's/King Soopers Shoprite Supervalu Tom Thumb	Walgreens Duane Reade RiteAid/Brooks/Eckerd USA Drugs Wal-Mart Certain independent local pharmacies

Prior Authorization List for Plan Unit 105A&B, Class I & II

Visit Horizon website for up-to-date list or review below:

- Air Ambulance Transportation – NON-EMERGENT
- Bariatric or Gastric Bypass Procedures – Surgery for Morbid Obesity, including but not limited to, Bariatric Procedures, Gastroplasty, Gastric Bypass - outpatient
- Cardiac Radiology Services – non-emergent only Please note that only the following Cardiology Imaging Services require PA by eviCore healthcare for these members. (Visit the Cardiology Imaging Program webpage or call eviCore healthcare at **1-866-496-6200**)
    - Stress testing (Myocardial perfusion imaging [SPECT and PET], Stress echocardiography)
    - Cardiac CT and MRI
    - Echocardiography: transthoracic and transesophageal
    - Diagnostic heart catheterization
- Clinical Trials
- Cosmetic Procedures and Potentially Cosmetic Procedures, including, but not limited to, cosmetic dermatology services, varicose vein procedures
- Durable Medical Equipment (DME) - certain DME items costing over $500 (Visit the Horizon Care@Home webpage or call CareCentrix at **1-855-243-3321**)
- Gender reassignment surgical services and certain hormone therapy
- Habilitative therapy for children with autism spectrum disorder (ABA therapy) (Call HealthCheck360 at **1-844-462-7812**)
- Home Health Care Services – all skilled services in the home
- Home Hospice Services
- Home Infusion Services (Visit the Horizon Care@Home webpage or call CareCentrix at **1-855-243-3321**)
- Hyberbaric Oxygen Therapy
- Inpatient Admissions
    - Medical admissions
    - Surgical admissions
    - Hospice admissions (exclusive of maternity delivery)
    - Rehabilitation facility admissions (acute rehab, skilled nursing and sub-acute)
    - Mental health and substance abuse admissions (call Horizon Behavioral Health at **1-800-626-2212**)
- Medical Foods
- Mental Health and Substance Abuse Services (call Horizon Behavioral Health at **1-800-626-2212**)
    - Inpatient (IP)
    - Inpatient Detox
    - Residential (RTC)
    - 23hr Bed
    - 72hr Bed
    - Partial Hospitalization (PHP)
    - Intensive Outpatient (IOP)
    - Psychological Testing
    - In-Home Services

    - Electroconvulsive Therapy (ECT)
    - Transcranial Magnetic Stimulation (TMS)
- Molecular and Genomic Testing services (Visit the Molecular and Genomic Testing Program webpage or call eviCore healthcare at **1-866-496-6200**)
- Prosthetics/Orthotics - over $500 (Visit the Horizon Care@Home webpage or call CareCentrix at **1-855-243-3321**)
- Radiation Therapy services (Visit the Radiation Therapy Program webpage or call eviCore healthcare at **1-866-242-5749**)
- Radiology/Imaging Services, including but not limited to the following. (Visit the Radiology/Imaging Services webpage or call eviCore healthcare at **1-866-496-6200)**
    - Magnetic Resonance Imaging (MRI)
    - Magnetic Resonance Angiograms (MRAs)
    - Positron Emission Tomography (PET) scans
    - Positron Emission Tomography – Computed Tomography (PET-CT)
    - Computerized Tomography (CT) scans
    - Computed Tomography Angiography (CTA) scans
    - Nuclear Medicine
    - Nuclear Cardiac Imaging
- Specialty Pharmaceuticals/Medical Injectable Drugs (e.g., Botox, IVIG, Flolan and derivatives, Xolair) (Visit the Medical Injectables Program webpage or call Magellan Rx Management at **1-800-424-4508**)
- Transplant Services, except Corneal Transplants (Case Management)
- Travel and Lodging benefits (call UHH at **1-833-637-3519**)

UNITE HERE HEALTH Center of Excellence (CoE) Program for Hip and Knee Joint Replacement and Bariatric Surgeries in partnership with Mt. Sinai Health System

(Effective 6/1/2022)

$0 copay for inpatient and outpatient hip and knee total joint replacement and bariatric weight loss surgeries and related follow-up care (see procedure chart below; including inpatient admissions, if applicable) performed by certain providers at certain facilities in the following states: New York, New Jersey, Connecticut, Pennsylvania, Massachusetts, Florida.

To find participating providers, use below links:

Joint Replacement Surgery

Bariatric Surgery

Members residing in above states and in Rhode Island who are considering hip or knee replacement or bariatric surgery should be referred to Mt. Sinai Union Services at 914-677-1601.

Post-surgical covered expenses (related to the surgery)	Length of time $0 copay applies (post-surgery)
Outpatient surgery (including ambulatory surgical center); skilled nursing Including anesthesia	30 days
Radiology, diagnostic imaging, testing, and pathology	30 days
Procedural visits	30 days
Evaluation and management visits	30 days
Emergency room services	30 days
Readmissions	30 days
Durable medical equipment	30 days
Physical therapy (with any freestanding non-hospital network provider)	50 days

Members will still be responsible for any applicable cost-sharing for pre-surgical diagnostic testing, imaging, and other pre-surgical care and office visits. If the participant does not to use the CoE program, standard Plan benefits and cost-sharing will apply to all covered expenses in connection with the surgery.

Procedures:

Index Procedure	Place of Service Code	Code on Facility Claim	Code on Professional Claim
Gastric Bypass	21 (Inpatient Hospital)	MSDRG 619, MSDRG 620, MSDRG 621	CPT 43644, CPT 43645
Gastric Sleeve	21 (Inpatient Hospital)	MSDRG 619, MSDRG 620, MSDRG 622	CPT 43775
Total Hip Replacement Inpatient	21 (Inpatient Hospital)	MSDRG 469, MSDRG 470	CPT 27130
Total Hip Replacement Outpatient	22 (On Campus-Outpatient Hospital), 24 (Ambulatory Surgical Center)	CPT 27130	CPT 27130
Total Knee Replacement-Inpatient	21 (Inpatient Hospital)	MSDRG 469, MSDRG 470	CPT 27447
Total Knee Replacement - Outpatient	22 (On Campus-Outpatient Hospital), 24 (Ambulatory Surgical Center)	CPT 27447	CPT 27447

Note: This program does not apply to employees or dependents for whom the Fund is secondary for coordination of benefits purposes.

Important Phone Numbers

UNITE HERE HEALTH Fund Office
Ask benefit questions or find a network pharmacy
(888) 437-3480 • uhh.org

Horizon BCBS
Find a network provider
(866) 261-5676
Get prior authorization for hospitalizations and certain medical services
(866) 899-0626 • horizonblue.com

eviCore
Get prior authorization for outpatient diagnostic imaging services, molecular and genomic testing services, and radiation therapy services
(866) 496-6200

CareCentrix
Get prior authorization for prosthetics/orthotics - over $500
(855) 243-3321

Magellan Rx Management
Get prior authorization for specialty Pharmaceuticals/Medical Injectable Drugs (e.g., Botox, IVIG, Flolan and derivatives, Xolair)
(800) 424-4508

HealthCheck360
Get prior authorization for ABA (Habilitative) Therapy
(844) 462-7812

Horizon Behavioral Health
Get prior authorization for mental health and substance abuse admissions
(800) 626-2212

Hospitality Rx
Get prior authorization for certain medications and find a network pharmacy
(844) 813-3860 • hospitalityrx.org

Delta Dental of Illinois
Find a network dentist
(800) 323-1743

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

Amwell
Telehealth
(**844) 733-3627** • **Amwell**

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