106 Pittsburgh Class III Provider Benefits Fact Sheet

Calendar Year Medical Deductible: In-Network: $100 per person; $200 per family; Out-of-network: $500 per person

Network Out-of-Pocket Maximums

Once your cost sharing for network-covered expenses reaches these limits, the Plan pays 100% for most of your covered network expenses for the rest of the year (see your SPD for expenses that don't count).

In-Network: $1,000 per person (No out-of-pocket for out-of-network.)

Claims time filing limit: 18 months from date of service

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)* *Service: Non-preventive visit* Includes all services provided during the visit.	100% after $10 copayment per visit (no Calendar Year deductible)	50% after Calendar Year deductible
Office/Clinic Visits (PCP) *Service: Preventive Healthcare Services* Plan covers only the following in-network preventive care: well-baby care for children under age 6, routine pap smears, 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 Includes all care provided during visit.	100% after $10 copayment per visit (no Calendar Year deductible)	50% after Calendar Year deductible
Specialist Care Office Visits Includes all care provided during visit. Without referral through HealthCheck360.	100% after $20 copayment per visit (no Calendar Year deductible)	50% after Calendar Year deductible
Specialist Care Office Visits Includes all care provided during visit. With referral through HealthCheck360.	100% after $10 copayment per visit (no Calendar Year deductible)	50% after Calendar Year deductible

	IN NETWORK (covered %)	OUT OF NETWORK
Allergy Shot In Office (without an Office Visit).	90% after calendar year deductible	50% after Calendar Year deductible
Maternity Care (PCP provided) *Service: Non-preventive* Generally, no coverage provided for pregnancy of a dependent child other than preventive prenatal care. Cost sharing does not apply to certain preventive services. Depending on the type of services, a copayment or coinsurance may apply. 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 (no calendar year deductible)	50% after calendar year deductible
Mammogram Preventive *Service: Preventive Breast Cancer Mammography Screenings* 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% (no calendar year deductible)	Not Covered
Cervical Cancer Screening – Preventive *Service: Preventive Pap Smear/HPV* 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% (no calendar year deductible)	Not Covered

	IN NETWORK (covered %)	OUT OF NETWORK
Colonoscopies - Preventive *Service: Screening colonoscopy* Screening colonoscopy - For adults ages 45 to 75, covered every 10 years beginning at age 45; every two 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. No Prior Authorization required. Cologuard screening test is covered under preventive screening once every 3 years. No prior authorization required.	100%	Not Covered
Acupuncture Not covered unless provided by an M.D. or D.O. Prior Authorization may be required.	100% after $10 copayment per visit (no calendar year deductible)	50% after calendar year deductible
Chiropractic Services $400 annual maximum for chiropractic x-rays (Plan pays 90% after deductible)	100% Limited to $25 / Visit / $600 / Calendar year (no Calendar Year deductible)	Not Covered
Routine Podiatric Services	100% $25 visit max $500 calendar year (no calendar year deductible)	Not Covered

	IN NETWORK (covered %)	OUT OF NETWORK
URGENT AND EMERGENCY TREATMENT		
Urgent Care Center Visit	100% after $20 copayment per visit (no Calendar Year deductible)	50% after Calendar Year deductible
Hospital emergency room services *Service: Emergency Room*	90% after $50 copay (Copay waived if admitted)	50% after $50 copay (Copay waived if admitted)
Hospital emergency room services for non-emergency care *Service: Emergency Room* Care and services that could be provided in a clinic, urgent care center or Healthcare Professional's office are not considered Emergency.	50% $50 copay (no Calendar Year deductible)	50% after Calendar Year deductible
Ambulance *Service: Professional Ambulance Transportation*	90% after Calendar Year deductible	90% after Calendar Year deductible

	IN NETWORK (covered %)	OUT OF NETWORK
INPATIENT TREATMENT		
Hospital inpatient department services, including inpatient professional services *Service: Hospitalization* Including inpatient professional services. Includes the treatment of Mental Health/Substance Abuse Disorders. Also applies to maternity/pregnancy delivery for employees and spouses, 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.	90% after Calendar Year deductible	50% after Calendar Year deductible
Skilled Nursing Facility confinement Prior authorization is required. Up to 60 days total per person per year, no more than 30 days can be non-network	90% after Calendar Year deductible	50% after Calendar Year deductible
LABORATORY AND IMAGING SERVICES		
Laboratory Services	100%	50% after Calendar Year deductible
Radiology Including x-ray, ultrasound, fetal monitoring.	100% (no Calendar Year deductible)	50% (no Calendar Year deductible)

	IN NETWORK (covered %)	OUT OF NETWORK
Diagnostic Imaging Includes CT, MRI, PET, and Cardiac Testing. Prior authorization required for CT, discography, MRA, MRI and PET. Prior Authorization required.	90% after Calendar Year deductible	50% after Calendar Year deductible
OUTPATIENT SERVICES BENEFIT		
Outpatient Surgery *Service: Ambulatory surgical center* 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 required.	90% after Calendar Year deductible	50% after Calendar Year deductible
Outpatient Surgery *Service: Hospital outpatient department* 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.	90% after Calendar Year deductible	50% after Calendar Year deductible
Physical, speech, and occupational therapy Up to 30 visits per person per year for in/oon physical, speech, and occupational therapy combined. Prior Authorization required	90% after Calendar Year deductible	50% after Calendar Year deductible

	IN NETWORK (covered %)	OUT OF NETWORK
OTHER CARE		
Podiatric Orthotics Prior authorization is required if the purchase price exceeds $500 per item.	90% after Calendar Year deductible	50% after Calendar Year deductible
Diabetes Education For the care, monitoring, or treatment of diabetes & dietary needs.	100% (no Calendar Year deductible)	Not Covered
Nutritional Counseling Maximum $200/year.	100% (no Calendar Year deductible)	Not Covered
Partial Hospitalization, Intensive outpatient and Ambulatory Detoxification Treatment Prior Authorization required.	90% after Calendar Year deductible	50% after Calendar Year deductible
Home Healthcare Includes all skilled visits in the home including home infusion. Prior Authorization required.	90% after Calendar Year deductible 60 / Year / Person (Combined in/non-network)	50% after Calendar Year deductible 30 / Year / Person (Combined in/non-network)

	IN NETWORK (covered %)	OUT OF NETWORK
Hospice Care Prior Authorization required.	90% after Calendar Year deductible	50% after Calendar Year deductible
Durable Medical Equipment - DME 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.	90% after Calendar Year deductible	50% after Calendar Year deductible
Habilitative therapy for children with Autism Spectrum Disorder 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)	50% after Calendar Year deductible
Medical foods for inborn metabolic errors 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% (no Calendar Year deductible)	
Travel and lodging for certain serious medical conditions Reimbursement of 100% up to $10,000 per episode of care, including a per diem of $250 for lodging and meals. Prior Authorization required.	100% (no Calendar Year deductible)	

	IN NETWORK (covered %)	OUT OF NETWORK
All other Covered Expenses		
	90% after Calendar Year deductible	50% after Calendar Year deductible
Hearing Aids Plan Exclusion.		
	Not Covered	Not Covered
Prostate Specific Antigen *Service: PSA* Covered annually for men between the ages of 40-69.		
	100%	Not Covered
Dental Excluded.		
Vision Excluded.		
Contraceptives *Service: Birth control* Covered under woman's preventative care. FDA approved contraceptive methods are covered.		
	100%	Not Covered

	IN NETWORK (covered %)	OUT OF NETWORK
PRESCRIPTION DRUG BENEFITS		
Preventive Healthcare Services and supplies on the formulary		
	100%	Not Covered
Formulary generic drugs- Mail		
	$3 copay up to 34-day supply	Not Covered
Formulary Preferred Brand Name Drugs - Mail		
	$27 copay up to 34-day supply	Not Covered
Non-Formulary Prescription Drugs and Supplies - Retail		
	Not Covered	Not Covered
No Health Center access		

Prior Authorization Lists for Plan 106

Medical Management Review is a mandatory program requiring prior authorization and review of certain treatments and procedures. UNITE HERE HEALTH has contracted with HealthCheck360 (HC360) to provide the following medical and surgical utilization review services: inpatient pre-admission prior authorizations, emergency admission review, prior authorization of certain outpatient medical procedures and treatments, as well as retrospective review when prior authorization or authorization is not obtained as required.

To certify medical and surgical treatment, call HealthCheck360 (HC360) toll free at **(844) 462-7812**. Prior Authorization Injectables List below.
Provider must call HC360 to prior authorize benefits before receiving any of the services listed below. Services may be denied if they are not considered medically necessary.

- 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, and residential treatment
  - maternity admissions following 48 hours for a vaginal delivery and 96 hours following a Cesarean delivery
  - 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, 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

- Mammaplasty (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)

Prior Authorization Injectables List – HealthCheck360

Final PA List	Generic Name	J Code
Actemra	Tocilizumab	J3262
Aranesp	Darbepoetin alfa	J0881, J0882
Avastin (no PA required for Ophthalmic indication)	Bevacizumab	J9035, C9257, Q5118
Botox	OnabotulinumtoxinA	J0585. J0588
Entyvio	Vedolizumab	J3380
Eylea	Aflibercept	J0178, J9400
Gammunex/Gammaked/Gammgard	Immune globulin injection	J1575
Durolane, Eufflexxa, Gel-One, GelSyn-3, GenVisc 850, Hyalgan, Hyalgan LL, Hymovis, Monovisc, Orthovisc, Sodium Hyaluronate, Supartz, Supartz FX, Synojoynt, Synvisc, Synvisc-One, Triluron, TRiVisc, Visco-3	Hyaluronic acid (all derivatives)	J7327 ,J7328, J7323, J7324, J7325, J7326, J7321, J7318, J7329, K7320, J7322, J7331, J7332
Humira	Adalimumab	J0135
Lupron	Leuprolide acetate	J1950, J9218, J9219, J9217
MaKena	17-hydroxyprogesterone caproate	J1726
Ocrevus	Ocrelizumab	J2350
Orencia	Abatacept	J0129, C9399, J3590
Prolia/Xgeva	Denosumab	J0897
Reclast	Zoledronic acid	J3489
Remicade	Infliximab	J1745, Q5103, Q5104, Q5109, Q5121
Simponi	Golimumab	J1602
Solaris	Eculizumab	J1300, J1303
Tecentriq	Atezolzumab	J9022
Tysabri	Natalizumab	J2323
Xolair	Omalizumab	J2357

Cancer medications with J Codes in the J9xxx range (chemotherapy and immunotherapy) require prior authorization.

If the medication is not on the list above and it is not a cancer treatment medication, then prior authorization is not required.

The Prior Authorization lists above may change from time to time. Call HealthCheck360 (HC360) toll free at **(844) 462-7812** for up-to-date information.

Last update 1/1/23