114A Chicago Hotels Provider Benefits Fact Sheet

Generally, no Plan benefits are payable for medical care provided in Illinois if you don't use Blue Choice providers. (See the chart on this page and the next for exceptions.) You will usually pay less if you use a Presence Health System provider. You are responsible for your cost sharing (usually copay), your share of allowable charges the Plan doesn't pay, any amount over the maximum benefits, and any expenses that are not covered by the Plan.

Annual deductible: Individual $0 Family $0

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 is **$6,350/person** and **$12,700/family**. In addition the maximum amount of coinsurance a person will pay for covered network medical services in one calendar year is $2,500 (Plan 114-A Only).

Claims time filing limit: 18 months from date of service

Claims Address: Blue Cross and Blue Shield of Illinois P.O Box 805107 Chicago, IL 60680

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

	AMITA/PRESENCE HEALTH NETWORK	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
OFFICE VISITS BENEFIT			
Preventative Care *Service: Routine Physical & Immunizations* Plan covers in-network routine care, including screenings, checkups, and counseling, as required by the ACA.	100% $0 copay	100% $0 copay	Not Covered
Routine Mammograms *Service: Breast Cancer Mammography Screenings* Covered on an annual basis.	100% $0 copay	100% $0 copay	Not Covered

	AMITA/PRESENCE HEALTH NETWORK	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
Osteoporosis Screening Women 65 and over or younger women at increased risk of fractures. Prior authorization required through Medical Cost Management **(800) 367-9938**.	100% $0 copay	100% $0 copay	Not Covered
Cervical Cancer Screening *Service: Pap Smear* 1 every 3 years for women ages 21-65. 1 every 5 years if performed in conjunction with HPV testing.	100% $0 copay	100% $0 copay	Not Covered
Routine Colonoscopies Adults ages 50 to 75 *Service: Routine Colonoscopy* 1 every 10 years for average risk. 1 every 2 years with diagnosis of high risk due to immediate family history.	100% $0 copay	100% $0 copay	Not Covered
PCP Office Visit *Service: Office Visits* Including all care provided during the office visit.	100% $0 copay	100% $10 copay	Not Covered
Specialist Care Office Visits	100% $10 copay	100% $20 copay	Not Covered
Acupuncture 12 visits per calendar year.	100% $10 copay	100% $10 copay	Not Covered
Chiropractic 40 visits per calendar year. No Prior authorization required. Hot/Cold packs are not covered.	100% $10 copay	100% $10 copay	Not Covered

	AMITA/PRESENCE HEALTH NETWORK	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
Routine Podiatry 4 visits per calendar year. Treatment of corns & calluses (cutting & removing), trimming, cutting, clipping or debriding of nails, Keratoderma, Athlete's foot (Tinea Pedis), & dermatophytosis.	100% $10 copay	100% $10 copay	Not Covered
Podiatric Orthotics Orthotics will be allowed only if foot strapping confirms the orthotic will be effective (not required for replacement orthotics).	100% up to $500 max every 24 months	100% up to $500 max every 24 months	Not Covered
Diabetes Education For the care, monitoring, or treatment of diabetes and dietary needs.	100% $0 copay	100% $0 copay	Not Covered
Nutritional Counseling 4 visits per calendar year.	100% $0 copay	100% $0 copay	Not Covered
EMERGENCY & URGENT CARE BENEFIT			
Urgent Care Clinic	100% $30 copay	100% $30 copay	Not Covered
Emergency Room Services *Service: Emergency room* Copay waived if admitted.	100% $100 copay	100% $200 copay	100% of allowable charges after $200 copay

	AMITA/PRESENCE HEALTH NETWORK	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
Ambulance Transportation to Hospital *Service: Ambulance* Copay waived if admitted. Plan does not cover non-ambulance transportation services like MediCar or MediCoach or similar services.	100% $50 copay	100% $50 copay	100% $50 copay
Ambulance Transportation between Hospitals *Service: Ambulance* Plan does not cover non-ambulance transportation services like MediCar or MediCoach or similar services.	100% $0 copay	100% $0 copay	100% $0 copay
Hospitalization *Service: Hospitalization* Including inpatient professional services. Prior authorization required. Medical Cost Management **(800) 367-9938**.	100% $150 copay per day/ $300 copay max per admission	100% $250 copay per day/ $500 copay max per admission	100% $250 copay per day/ $500 copay max per admission. Only emergency treatment is covered.
LAB & IMAGING SERVICES BENEFIT			
Laboratory Services *Service: Laboratory Services*	**Non-Hospital:** 100% $0 copay **Hospital:** 100% $30 copay	**Non-Hospital:** 100% $0 copay **Hospital:** 100% $30 copay	100% $0 Copay for services billed by an independent lab ONLY – No other benefits are payable

	AMITA/PRESENCE HEALTH NETWORK	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
Radiology *Service: Including but not limited to: diagnostic mammogram, x-rays, ultrasound, echocardiogram, and fetal monitoring.*	**Non-Hospital:** 100% $0 copay **Hospital:** 100% $0 copay	**Non-Hospital:** 100% $10 copay **Hospital:** 100% $50 copay	Not Covered
Diagnostic Imaging and Cardiac Testing *Service: CT/CTA/CTA, MRI/MRA, PET Scan, Bone Density Scans (DEXA), Cardiac Testing, Nuclear Medicine, Myelography, Radiation Therapy.* Prior authorization required. Medical Cost Management **(800) 367-9938**. (Radiation therapy does not require prior authorization.)	100% $0 copay	**Non-Hospital:** $100 copay **Hospital:** $150 copay	Not Covered
Sleep Study *Service: Sleep study.* Prior authorization required. Medical Cost Management **(800) 367-9938**.	100% $50 copay	100% $50 copay	Not Covered
OUTPATIENT SERVICES BENEFIT			
Outpatient Surgery *Service: Not limited to but including: Upper GI, endoscopy (EDG), diagnostic colonoscopy, varicose veins, elective abortion, vasectomy.* Refer to prior authorization list.	**Non-Hospital:** $0 copay **Hospital:** $0 copay	**Non-Hospital:** $100 copay **Hospital:** $200 copay	Not Covered

	AMITA/PRESENCE HEALTH NETWORK	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
Therapies *(After 10th visit prior authorization required.)* *Service: Physical, Speech & Occupational Therapy.* Physical Therapy: Hot & cold pack not covered. Office visits are not covered when performed with Physical Therapy/Occupational Therapy services.	**Non-Hospital:** 100% $0 copay **Hospital:** 100% $30 copay	**Non-Hospital:** 100% $10 copay **Hospital:** 100% $30 copay	Not Covered
Infusion Chemotherapy Kidney Dialysis *Service: Infusion Medication Chemotherapy Kidney Dialysis.* Chemotherapy Treatment and Chemotherapy Medication requires Prior Authorization. Medical Cost Management **(800) 367-9938**.	**Non-Hospital:** 100% $0 copay **Hospital:** 100% $100 copay	**Non-Hospital:** 100% $0 copay **Hospital:** 100% $100 copay	Not Covered
MENTAL HEALTH & SUBSTANCE ABUSE			
Office Visits *Service: Office Visit. Including medical management visits.* Chemotherapy Treatment and Chemotherapy Medication requires Prior Authorization. Medical Cost Management **(800) 367-9938**.	100% $0 copay	100% $10 copay	Not Covered
Hospitalization *Service: Hospitalization.* Prior authorization required. Medical Cost Management **(800) 367-9938**. Including but not limited to residential treatment.	100% $150 copay per day/ $300 copay max per admission	100% $250 copay per day/ $500 copay max per admission	100% $250 copay per day/ $500 copay max per admission. Only emergency treatment is covered.

	AMITA/PRESENCE HEALTH NETWORK	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
Outpatient Partial Hospitalization, Intensive Outpatient & Ambulatory Detoxification *Service: Outpatient non-routine treatment.*	100% $0 copay	100% $0 copay	100% $0 copay
OTHER CARE & MEDICAL EXPENSES			
Skilled Nursing Facility Up to 60 days per calendar year. Prior authorization required. Medical Cost Management **(800) 367-9938**.	100% $50 copay per day/ $250 max per admission	100% $100 copay per day/ $500 max per admission	Not Covered
Home Health Care Up to 60 days per calendar year. Prior authorization is required beginning with the first visit. Medical Cost Management **(800) 367-9938**.	100% $10 copay	100% $20 copay	Not Covered
Hospice Care *Service: Hospice care.* Services & supplies authorized by a doctor for a person whose life expectancy is 6 months or less. Prior authorization required. Medical Cost Management **(800) 367-9938**.	100% $0 copay	100% $0 copay	Not Covered
Durable Medical Equipment -DME *Service: DME.* $500 & over prior authorization required. Medical Cost Management **(800) 367-9938**. Rental fees are covered up to the purchase price. Costs for repair or maintenance are also considered covered expenses if DME is purchased.	80% No Deductible	80% No Deductible	Not Covered

	AMITA/PRESENCE HEALTH NETWORK	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
Artificial Limbs & Organ Transplants *Service: Transplants for stem cell, cornea, heart, lung, kidney, intestine liver, or pancreas.* Prior Authorization required through Medical Cost Management **(800) 367-9938**. Benefits for donor expenses are only available to the extent that the donor has no other coverage & no benefits are provided if you or a covered dependent are a donor. Prosthetics more than $500 require prior authorization.	80% No Deductible	80% No Deductible	Not Covered
Routine Vision Reimbursement Plan through UNITE HERE HEALTH *(Note: This is separate from the medical benefits and not included as part of the OOP limit).* *Service: Eye exam & eye wear.* Dollar limit doesn't apply to exams & lenses for persons under age 19. Plan allows 1 vision exam each calendar year. 1 eyeglass lenses- one set each calendar year. **Covered services:** Vision exams, contact lenses, single vision, bi-focal, or tri-focal lenses, frames. **Not covered services:** Non-glare coating, warranty & any other convenience items.	$250 max per person every 24 months beginning Jan 1 of every odd numbered year.	$250 max per person every 24 months beginning Jan 1 of every odd numbered year.	
Hearing Aids Plan exclusion.	Not Covered	Not Covered	Not Covered
Maternity Care With respect to pregnancy, the $10 copay will be taken only for the first prenatal visit for non-Preventive Health Care Services; follow-up prenatal visits will be considered part of the total charge for the delivery and no further office visit copay will be due. **Not Covered:** Any treatment, services or supplies for or in connection with the pregnancy of a dependent child, including abortions except for ACA-required preventive care services.	100% $0 copay	100% $10 copay	Not Covered

	AMITA/PRESENCE HEALTH NETWORK	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
Infertility Plan exclusion.	Not Covered	Not Covered	Not Covered
Breast Pump & Supplies Visit Maximum: One/Pregnancy. No dollar maximum. No age related provision. No life visit maximum. Breast pump supplies consist of replacement tubing, adapters, caps, breast shields & splash protectors, bottles, and rings. Hospital grade breast pumps & supplies are payable at the DME coverage level (80%). Breast pump and supplies over $500 require prior authorization. Non-hospital grade breast pumps & supplies are payable at 100% under preventative care, whether in network or out-of-network, or purchased at such retailers as Target, Walmart, etc. and be reimbursed when providing a purchase receipt.	100% $0 copay	100% $0 copay	100% $0 copay
ALL OTHER COVERED EXPENSES			
	80%	80%	Not Covered

Prior Authorization

Medical Management Review is a mandatory program requiring prior authorization and review of certain treatments and procedures. UNITE HERE HEALTH has contracted with Medical Cost Management (MCM) 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 Medical Cost Management (MCM) toll free (800) 367-9938

You must call MCM to prior authorize benefits before receiving any of the services listed below. Services may be denied if they are not considered medically necessary.

(More info on next page)

Inpatient Admissions

For all non-maternity inpatient admissions require prior authorization - including in a skilled nursing facility:

- For all non-emergency confinements, any time prior to admission.
- For all emergency or urgent care confinements, the first business day following admission.

For maternity hospitalizations, benefits must be prior authorized for any lengths of stay exceeding:

- 48 hours for the normal delivery of a newborn child; or
- 96 hours for the delivery of a newborn child by caesarean section.

Outpatient Services and Supplies

Arthroscopy (Knee)
Blepharoplasty
Cardiac Catheterization
Carpal Tunnel Release
Chemotherapy
Cholecystectomy (laparoscopic)
Clinical trials
Coronary Angioplasty (percutaneous)
Diagnostic Laparoscopy
Durable Medical Equipment *(over $500)*
Genetic Testing
Habilitative Therapy for children with autism spectrum disorder
Home Healthcare
Hospice Services
Hyperbaric Oxygen Therapy
Hysterectomy Vaginal & Laparoscopic
Le Fort Osteotomy
Mammoplasty (Reduction)
Medical Foods
Myelogram
Nuclear Medicine Procedures, inc. Imaging
Occupational Therapy *(after 10 visits)*
Percutaneous Diskectomy
Physical Therapy *(after 10 visits)*
Prosthetics/Orthotics *(over $500)*
Rhinoplasty
Septoplasty
Sleep Studies
Speech Therapy (*after 10 visits*)
Stem Cell Transplant
Submucous Resection
Surgical Treatment for Obesity
Travel and Lodging
Uvulopalatopharyngoplasty
Varicose Veins Procedures

Diagnostic Imaging Procedures, such as:

CT Scan (Computer Tomography Scintiscan, also known as CAT Scan-Computerized Axial Tomographic Scintiscan)
CTA Scan (Computerized Tomographic Angiography)
DEXA Scan: Densitometry, AKA Bone mineral density test. MRA (Magnetic Resonance Angiography)
MRI: Magnetic Resonance Imaging
PET-Scan: Position Emission Tomography Scintiscan & PET-CT