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 below for exceptions.) Members will usually pay less if you use the Green Network. The following providers are in the "Green Network": Ascension Illinois, AdventHealth, Saint Anthony Hospital in Chicago, and Little Company of Mary Hospital in Evergreen Park. Providers contracted with their local BCBS as part of the BlueChoice PPO/BlueCard Network are in the "Blue Network." Members are responsible for cost sharing (usually copay), cost 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

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.

Disclaimer:

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.

	GREEN 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. *Service: Birth Control:* All FDA approved contraceptives including IUD and female sterilization.	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
Osteoporosis Screening Women 65 and over or younger women at increased risk of fractures.	100% $0 copay	100% $0 copay	Not Covered
Cervical Cancer Screening *Service: Pap Smear* 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% $0 copay	100% $0 copay	Not Covered
Routine Colonoscopies Adults ages 45 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. Cologuard screening test is covered under preventive screening once every 3 years. No prior authorization required.	100% $0 copay	100% $0 copay	Not Covered

	GREEN NETWORK	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
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
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

	GREEN NETWORK	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
Nutritional Counseling 4 visits per calendar year.	100% $0 copay	100% $0 copay	Not Covered
EMERGENCY & URGENT CARE BENEFIT			
Urgent Care Clinic $0 copay at Illinois Physicians Immediate Care (PIC) locations; although now merged with WellNow Urgent Care Team, WellNow Urgent Care locations follow regular cost-sharing benefit for Urgent Care Clinic (UCC).	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
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

	GREEN NETWORK	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
Hospitalization *Service: Hospitalization* Including inpatient professional services. Prior authorization required. HealthCheck360 (HC360) toll free (844) 462-7812. 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% $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
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. HealthCheck360 (HC360) toll free (844) 462-7812.			

	GREEN NETWORK	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
	100% $0 copay	**Non-Hospital:** 100**%** $100 copay **Hospital:** 100**%** $150 copay	Not Covered
Sleep Study *Service: Sleep study.* Prior authorization required. HealthCheck360 (HC360) toll free (844) 462-7812.	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, and vasectomy.* Refer to prior authorization list.	**Non-Hospital:** 100**%** $0 copay **Hospital:** 100**%** $0 copay	**Non-Hospital:** 100**%** $100 copay **Hospital:** 100% $200 copay	Not Covered
Therapies *(Prior authorization is not required for the first 12 visits. Thereafter, prior authorization is required even for a different diagnosis or body part.)* *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. HealthCheck360 (HC360) toll free (844) 462-7812	**Non-Hospital:** 100% $0 copay **Hospital:** 100% $30 copay	**Non-Hospital:** 100% $10 copay **Hospital:** 100% $30 copay	Not Covered

	GREEN NETWORK	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
Infusion, Chemotherapy, Kidney Dialysis *Service: Infusion Medication Chemotherapy Kidney Dialysis.* Chemotherapy Treatment and Chemotherapy Medication requires Prior Authorization. HealthCheck360 (HC360) toll free (844) 462-7812.	**Non-Hospital:** 100% $0 copay **Hospital:** 100% $100 copay	**Non-Hospital:** 100% $0 copay **Hospital:** 100% $100 copay	Not Covered
Cardiac Rehabilitation Therapy 36 Visit Max /Episode *Coverage level varies, if services are billed with an office visit, the member is subject to specialist office visit copayment and coverage level. If services billed are just for the Cardiac rehab services, then is covered at 80% for in-network, not covered out-of-network.*	80% No Deductible	80% No Deductible	Not Covered
MENTAL HEALTH & SUBSTANCE ABUSE			
Office Visits *Service: Office Visit. Including medical management visits.* Electroconvulsive Therapy (ECT) and Transcranial Magnetic Stimulation (TMS) requires Prior authorization. HealthCheck360 (HC360) toll free (844) 462-7812. *Marriage Counseling is not covered on the basis that it is not medically necessary.*	100% $0 copay	100% $10 copay	Not Covered
Hospitalization *Service: Hospitalization.* Prior authorization required. HealthCheck360 (HC360) toll free (844) 462-7812. 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.

	GREEN 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. HealthCheck360 (HC360) toll free (844) 462-7812.	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. HealthCheck360 (HC360) toll free (844) 462-7812.	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. HealthCheck360 (HC360) toll free (844) 462-7812.	100% $0 copay	100% $0 copay	Not Covered
Durable Medical Equipment -DME *Service: DME.* $500 & over prior authorization required. HealthCheck360 (HC360) toll free (844) 462-7812. 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

	GREEN 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 HealthCheck360 (HC360) toll free (844) 462-7812. 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
Dental *Service: Delta Dental of Illinois (PPO)* The Dental PPO option only applies if you are enrolled in the dental PPO option. 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	Contact Delta Dental for additional info
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
Infertility Plan exclusion.	Not Covered	Not Covered	Not Covered

	GREEN NETWORK	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
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
Habilitative Therapy for Children with Autism Spectrum Disorders (ABA Therapy) *Service: "Habilitative therapy" includes applied behavioral analysis (ABA) therapy and similar types of treatment. It does not include physical, speech, or occupational therapy.* Prior Authorization required through HealthCheck360 (HC360) toll free (844) 462-7812. Child must have a diagnosis of autism spectrum disorder and have a prorated mental age of at least 11 months. Benefits will only be paid for services supplemental to any therapy for which the child is eligible through his or her school or school district. No benefits will be paid for therapy provided through the school or school district. ***Visit Maximum:*** 30 Hours / Week / 36 Months / Person ***Age related Provision:*** At least 2 years old and benefit ends on the child's 8th birthday.	100% / $10 copay per day	100% / $10 copay per day	Not Covered

	GREEN NETWORK	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK	
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 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**

You 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 initial 12 visits in a single calendar year
- 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)

This list changes from time to time.