

Use “Ctrl + F” to search for keywords.

115 Midwest Plan 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 5348, Oak Brook, IL 60522-5348.

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.

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	GREEN NETWORK *See Notes Below	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
OFFICE VISITS BENEFIT			
Preventative Care			
<p><i>Service: Routine Physical & Immunizations</i> Plan covers in-network routine care, including screenings, checkups, and counseling, as required by the ACA.</p> <p><i>Service: Birth Control:</i> All FDA approved contraceptives including IUD and female sterilization. HealthLinc locations will provide primary care services for participants (including dependents) with a \$0 copay.</p>			
	100% \$0 copay	100% \$0 copay	Not Covered
Routine Mammograms			
<p><i>Service: Breast Cancer Mammography Screenings</i> Covered on an annual basis.</p>			
	100% \$0 copay	100% \$0 copay	Not Covered
Osteoporosis Screening			
<p>Women 65 and over or younger women at increased risk of fractures.</p>			
	100% \$0 copay	100% \$0 copay	Not Covered
Cervical Cancer Screening			
<p><i>Service: Pap Smear</i> 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.</p>			
	100% \$0 copay	100% \$0 copay	Not Covered
Routine Colonoscopies Adults ages 45 to 75			
<p><i>Service: Routine Colonoscopy</i> 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.</p>			
	100% \$0 copay	100% \$0 copay	Not Covered

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	GREEN NETWORK *See Notes Below	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
<p>PCP Office Visit</p> <p><i>Service: Office Visits</i></p> <p>Including all care provided during the office visit. HealthLinc locations will provide primary care services for participants (including dependents) with a \$0 copay.</p>	100% \$0 copay	100% \$10 copay	Not Covered
<p>Specialist Care Office Visits</p> <p><i>*Effective 1/1/2025, participants are required to use the Fund-designated transplant & CAR-T networks through Optum & Cigna LifeSOURCE for all transplant-related and CAR-T related services. Prior authorization is required for transplant (including evaluation) & CAR-T services through HealthCheck360.</i></p>	100% \$10 copay	100% \$20 copay	Not Covered
<p>Acupuncture</p> <p>12 visits per calendar year.</p>	100% \$10 copay	100% \$10 copay	Not Covered
<p>Chiropractic</p> <p>24 visits per calendar year. No Prior authorization required. Hot/Cold packs are not covered.</p>	100% \$10 copay	100% \$10 copay	Not Covered
<p>Routine Podiatry</p> <p>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.</p>	100% \$10 copay	100% \$10 copay	Not Covered
<p>Podiatric Orthotics</p> <p>Orthotics will be allowed only if foot strapping confirms the orthotic will be effective (not required for replacement orthotics).</p>			

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	GREEN NETWORK *See Notes Below	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
	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. <i>*Effective 06/01/2025, The 4-visit per person per calendar year limit for Nutritional Counseling no longer applies/ visit limit is removed.</i>	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 UCC.	100% \$30 copay	100% \$30 copay	Not Covered
Emergency Room Services <i>Service: Emergency room</i> Copay waived if admitted.	100% \$100 copay	100% \$200 copay	100% of allowable charges after \$200 copay
Ambulance Transportation to Hospital <i>Service: Ambulance</i> Copay waived if admitted. Plan does not cover non-ambulance transportation services like MediCar or MediCoach or similar services.			

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GREEN NETWORK *See Notes Below	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
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
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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.

***Effective 1/1/2025, participants are required to use the Fund-designated transplant & CAR-T networks through Optum & Cigna LifeSOURCE for all transplant-related and CAR-T related services. Prior authorization is required for transplant (including evaluation) & CAR-T services through HealthCheck360.**

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.
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LAB & IMAGING SERVICES BENEFIT

Laboratory Services

Service: Laboratory Services

HealthLinc locations will provide laboratory services for participants (including dependents) with a \$0 copay.

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GREEN NETWORK *See Notes Below	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
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 – <u>No other benefits are payable</u>

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
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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.

100% \$0 copay	Non-Hospital: 100% \$100 copay Hospital: 100% \$150 copay	Not Covered
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Sleep Study

Service: Sleep study.

Prior authorization may be required. Refer to authorization list below or call HealthCheck360 (HC360) toll free (844) 462-7812 to verify.

100% \$50 copay	100% \$50 copay	Not Covered
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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.

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GREEN NETWORK *See Notes Below	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
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.

Non-Hospital: 100% \$0 copay Hospital: 100% \$30 copay	Non-Hospital: 100% \$10 copay Hospital: 100% \$30 copay	Not Covered
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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
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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.

HealthLinc locations will provide mental health care services for participants (including dependents) with a \$0 copay.

100% \$0 copay	100% \$10 copay	Not Covered
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	GREEN NETWORK *See Notes Below	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
Hospitalization <i>Service: Hospitalization.</i> 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.
Outpatient Partial Hospitalization, Intensive Outpatient & Ambulatory Detoxification <i>Service: Outpatient non-routine treatment.</i>			
	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 <i>Service: Hospice care.</i> 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

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	GREEN NETWORK *See Notes Below	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
Durable Medical Equipment -DME <i>Service: DME.</i> \$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
ABA Therapy (Habilitative Therapy for Children with Autism Spectrum Disorders) <i>Service: "Habilitative therapy" includes applied behavioral analysis (ABA) therapy and similar types of treatment. It does not include physical, speech, or occupational therapy.</i> 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 <i>*Effective 06/01/2025, the weekly max and lifetime max have been removed.</i> Age related Provision: At least 2 years old and benefit ends on the child's 8th birthday. <i>*Effective 06/01/2025, the age limitations have been removed.</i>			
	100% / \$10 copay per day	100% / \$10 copay per day	Not Covered
Artificial Limbs & Organ Transplants <i>Service: Transplants for stem cell, cornea, heart, lung, kidney, intestine liver, or pancreas.</i> 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

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	GREEN NETWORK *See Notes Below	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
Dental <i>Service: Delta Dental of Illinois (PPO)</i> 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. HealthLinc locations will provide maternity care services for participants with a \$0 copay.			
	100% \$0 copay	100% \$10 copay	Not Covered
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 visits 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.			

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	GREEN NETWORK *See Notes Below	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
	100% \$0 copay	100% \$0 copay	100% \$0 copay
ALL OTHER COVERED EXPENSES			
	80%	80%	Not Covered

*Green Network: Effective during 2022: The following providers which are in the “Green Network” will replace AMITA: Ascension Illinois, AdventHealth, Saint Anthony Hospital in Chicago, and Little Company of Mary Hospital in Evergreen Park.

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 (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.

- All **inpatient** admissions, including but not limited to:
 - Observation longer than 48 hours
 - Long-term acute care (LTACH) admissions
 - Skilled nursing facility admissions
 - Residential treatment (mental health and substance abuse)
 - Long-term rehabilitation care
 - Maternity admissions following 48 hours for a vaginal delivery and 96 hours following a Cesarean delivery, and elective Cesarean section (C-section) admissions before 38 weeks of gestation
- All **outpatient surgeries** that are not performed in a provider’s office. *However*, prior authorization is *not* required for colonoscopies, sigmoidoscopies, or esophagogastroduodenoscopy (EGD)

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<ul style="list-style-type: none"> • Air ambulance (non-emergency)
<ul style="list-style-type: none"> • Advanced imaging, including but not limited to: <ul style="list-style-type: none"> ○ CT, CTA, MRI, MRA, PET ○ Nuclear imaging ○ Non-emergency cardiac radiology services, such as stress testing (myocardial perfusion imaging such as SPECT and PET), and cardiac CT/MRI scans
<ul style="list-style-type: none"> • Clinical trials
<ul style="list-style-type: none"> • Cosmetic (or potentially cosmetic) procedures, including but not limited to: <ul style="list-style-type: none"> ○ Abdominoplasty, lipectomy, or panniculectomy ○ Cosmetic dermatology services (including treatment of keloids) ○ Facial procedures, including blepharoplasty, rhinoplasty or septoplasty ○ Mammoplasty and mastopexy (except in connection with breast cancer treatment) ○ Orthognathic surgery ○ Varicose vein procedures and sclerotherapy
<ul style="list-style-type: none"> • Dialysis—notification only
<ul style="list-style-type: none"> • Durable medical equipment rentals or purchases over \$500 (including breast pumps)
<ul style="list-style-type: none"> • Gender reassignment surgical services and certain hormone therapy
<ul style="list-style-type: none"> • Genetic testing
<ul style="list-style-type: none"> • Home health care services, including all skilled services provided in a home setting (such as but not limited to home nursing, home therapy (physical, speech, and occupational therapy), and home infusion)
<ul style="list-style-type: none"> • Hospice services, including both outpatient and inpatient services
<ul style="list-style-type: none"> • Medical foods for inborn errors of metabolism
<ul style="list-style-type: none"> • Non-routine outpatient mental health and substance abuse treatment, including: <ul style="list-style-type: none"> ○ Intensive outpatient programs (IOP) ○ Partial hospital programs (PHP) ○ Electro-convulsive treatment (ECT) ○ Transcranial magnetic stimulation (TMS) ○ ABA therapy
<ul style="list-style-type: none"> • Physical therapy after 12 visits per calendar year
<ul style="list-style-type: none"> • Occupational therapy after 12 visits per calendar year
<ul style="list-style-type: none"> • Orthotics or prosthetics rentals or purchases over \$500 (including podiatric orthotics)
<ul style="list-style-type: none"> • Speech therapy after 12 visits per calendar year

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| • Radiation therapy |
| • Select injectable , infused, ingested, or inhaled medications administered by a healthcare professional in an office or other outpatient setting |
| • Travel and lodging expenses |
| • Transplant and CAR-T services (except for corneal transplants), including the transplant evaluation |

Last updated 03/19/2026