Midwest Casino Provider Benefits Fact Sheet

The providers in the Blue Network depend on whether the employee works in Illinois or outside of Illinois.

- **If the employee works in Illinois**, the Blue Network is the BlueCross BlueShield (BCBS) BlueChoice network. A special exception may apply if the employee or his or her dependents lice outside the BlueChoice network.
- **If the employee works outside Illinois**, the Blue Network is the BCBS BlueCard network (the BCBSIL PPO network for care received inside Illinois).

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.

Medical Out of Pocket Limits: The maximum amount of coinsurance and copays for covered network medical services in one calendar year is **$5,000/person** and **$10,000/family**.

Pharmacy Out of Pocket limits: $1,600/person and $3,200/family.

Medical claims time filing limit: 18 months from date of service, dental and vision filing limits may be different.

Medical 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.

	Green (Presence/AMITA) Network	BLUE Network	Non-network
OFFICE VISITS BENEFIT			
Preventive Care *Service: Routine Care & 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

	Green (Presence/AMITA) Network	BLUE Network	Non-network
Routine Mammograms *Service: Breast Cancer Mammography Screenings including 3D Mammograms; no prior auth is required* Covered on an annual basis.	100% $0 copay	100% $0 copay	Not Covered
Cervical Cancer Screening *Service: Pap Smear* 1 every 36 months for women ages 21-65. 1 every 60 months 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, additional colorectal cancer screening may be covered.* Screening colonoscopy - 1 every 10 years beginning at age 50 for persons of average risk, or once every 2 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. Cologuard screening test is covered under preventive screening, Prior Authorization is required.	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% $40 copay	Not Covered
Specialist Care Office Visits	100% $20 copay	100% $60 copay	Not Covered
Acupuncture 12 visits per calendar year.	100% $10 copay	100% $40 copay	Not Covered

	Green (Presence/AMITA) Network	BLUE Network	Non-network
Chiropractic 24 visits per calendar year. Hot/Cold packs are not covered.	100% $10 copay	100% $40 copay	Not Covered
Routine Podiatry Visit Maximum 4 visits per calendar year. Following diagnoses and services are considered routine podiatry. Treatment of corns & calluses (cutting & removing), trimming, cutting, clipping or debriding of nails, Keratoderma, Athlete's foot (Tinea Pedis), & dermatophytosis.	100% $20 copay	100% $40 copay	Not Covered
Non –Routine Podiatric Office Visits No Visit Maximum	100% $20 copay	100% $40 copay	Not Covered
Podiatric Orthotics Orthotics will be allowed only if foot strapping confirms the orthotic will be effective.	100% up to $500 max every 24 months	100% up to $500 max every 24 months/ $20 copay	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% $40 copay	Not Covered

	Green (Presence/AMITA) Network	BLUE Network	Non-network
Emergency Room Services *Service: Emergency room*	100% $350 copay (Waived if admitted)	100% $400 copay (Waived if admitted)	100%$400 copay (Waived if admitted)
Ambulance Transportation to Hospital *Service: Ambulance* Copay waived if admitted.	100% $100 copay/trip	100% $100 copay/trip	100% $100 copay/trip
Hospitalization *Service: Hospitalization* Including inpatient professional services. Prior authorization required. Medical Cost Management **(800) 367-9938**. Including but not limited to residential treatment.	100% $150 copay per day/ $450 copay max per admission	100% $300 copay per day/ $1,200 copay max per admission	100% $300 copay per day/ $1,200 copay max per admission. For emergency admissions only. Not covered after patient stabilized
LAB & IMAGING SERVICES BENEFIT			
Laboratory Services *Service: Laboratory Services,* Genetic testing requires prior authorization:	**Non-Hospital:** 100% $20 copay **Hospital:** 100% $100 copay	**Non-Hospital:** 100% $20 copay **Hospital:** 100% $100 copay	**Non-Hospital :** 100% $20 Copay for independent labs ONLY otherwise Not Covered

	Green (Presence/AMITA) Network	BLUE Network	Non-network
Radiology *Service: Including but not limited to: diagnostic mammogram, x-rays, ultrasound, and fetal monitoring.*	**Non-Hospital:** 100% $30 copay **Hospital:** 100% $100 copay	**Non-Hospital:** 100% $50 copay **Hospital:** 100% $100 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**. (Cardiac Testing and radiation therapy do not require prior authorization.)	**Non-Hospital:** 100% $200 copay **Hospital**: 100% $400 copay	**Non-Hospital:** 100% $300 copay **Hospital:** 100% $500 copay	Not Covered
Sleep Study *Service: Sleep study.* Prior authorization required. Medical Cost Management **(800) 367-9938**.	100% $100 copay	100% $150 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**%** $150 copay **Hospital:** 100**%** $300 copay	**Non-Hospital:** 100**%** $300 copay **Hospital:** 100% $600 copay	Not Covered

	Green (Presence/AMITA) Network	BLUE Network	Non-network
Therapies *(After 10th visit prior authorization required.)* *Service: Physical & Occupational Therapy. 60 / Year (Combined with Occupational Therapy)* *Service: Speech Therapy. Visit maximum: 30/Year* Physical Therapy: Hot & cold pack not covered. Office visits are not covered when performed with Physical Therapy/Occupational Therapy services.	**Non-Hospital:** 100% $20 copay **Hospital:** Not covered	**Non-Hospital:** 100% $30 copay **Hospital:** Not covered	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% $20 copay **Hospital:** 100% $40 copay	**Non-Hospital:** 100% $30 copay **Hospital:** 100% $60 copay	Not Covered
MENTAL HEALTH & SUBSTANCE ABUSE			
Office Visits	100% $0 copay	100% $40 copay	Not Covered
Hospitalization *Service: Hospitalization.* Prior authorization required. Medical Cost Management **(800) 367-9938**. Including residential treatment.	100% $150 copay per day/ $450 copay max per admission	100% $300 copay per day/ $1,200 copay max per admission	100% $300 copay per day/ $1,200 copay max per admission. For emergency admissions only. Out-of-network services not covered once patient can be safely transported to a network hospital.

	Green (Presence/AMITA) Network	BLUE Network	Non-network
Outpatient Partial Hospitalization, Intensive Outpatient & Ambulatory Detoxification *Service: Outpatient non-routine treatment.*	100% $20 copay	100% $20 copay	100% $20 copay
OTHER CARE & MEDICAL EXPENSES			
Skilled Nursing Facility Prior authorization required. Medical Cost Management **(800) 367-9938**.	100% $50 copay per day	100% $100 copay per day	Not Covered
Home Health Care Up to 60 visits per calendar year. Prior authorization is required beginning with the first visit. Medical Cost Management **(800) 367-9938**.	100% $20 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.	70%	70%	Not Covered

	Green (Presence/AMITA) Network	BLUE Network	Non-network
Dental *Services: Cigna Dental* Dental plan is administered by Cigna, additional information can be found at www.cigna.com or by calling **(800) 244-6224.**			
Routine Vision – contact Davis Vision at (800) 999-5431 *Payable every 12 months*			
Hearing Aids Plan exclusion.	Not Covered	Not Covered	Not Covered
Maternity Care – office visits *Refer to hospital benefit for additional benefit info.* With respect to pregnancy, the copay ($0 Presence/AMITA; $40 Blue Network) 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:** Non-preventive healthcare for a dependent child's pregnancy, including but not limited to ultrasounds, charges associated with a high-risk pregnancy, abortions, and maternity and delivery charges will not be covered.	100% $0 copay after first visit	100% $40 copay	Not Covered
Infertility Plan exclusion.	Not Covered	Not Covered	Not Covered

	Green (Presence/AMITA) Network	BLUE Network	Non-network
Breast Pump & Supplies Visit Maximum: One/Pregnancy. 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 (70%). There is no dollar maximum, however breast pumps 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)*
Gender reassignment surgical services and certain hormone therapy
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 Organ transplants
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
Treatment of TMJ, craniofacial disorders or orthognathic disorders
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