116 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 employee works in Illinois: employee and dependents must use a BlueChoice network provider to stay in-network when they get care in Illinois.
- If employee works in Indiana (or any state other than Illinois): the Blue network is the BCBSIL PPO if employee and dependents get care in Illinois.
- If employee or dependents need care outside of Illinois: employee and dependents must use a BCBS BlueCard PPO provider to stay in-network.

Generally, no Plan benefits are payable for medical care provided in Illinois if member does not use BlueChoice providers. (See the chart below for exceptions.)

Member will usually pay less if member uses the Green Network. The following providers are also in the "Green Network": Ascension Illinois, AdventHealth, Saint Anthony Hospital in Chicago, and Little Company of Mary Hospital in Evergreen Park. Member is responsible for cost sharing (usually copay), member's 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.

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.

Network Out-of-Pocket Maximums

Once the cost sharing for network covered expenses reaches the limits below, the Plan pays 100% for most of the covered in-network expenses for the rest of the year.

Calendar Year Medical Deductible: Individual $0 / Family $0 (In-Network & Out-of-Network)

Out-of-Pocket Limit per Calendar year for Medical Benefits:

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.

Claims time filing limit: 18 months from date of service.

Network Provider:

Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, IL 60680-4112

Claims should be submitted to your local Blue Cross Blue Shield office.

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 medical benefits.
Also see prior authorization list at the end of this document to confirm if prior authorization is required.

OFFICE VISITS	Member Pays in Green Network (coverage %)	Member Pays in BlueChoice/PPO/BlueCard Network (coverage %)	Member Pays Out-of-Network (coverage %)
Preventive Care	$0 copay / 100%	$0 copay / 100%	Not Covered
▪Plan covers in-network routine care, including screenings, checkups and counseling as required by the ACA. ▪LIPID PANEL screenings are only covered once every 12 months, not every calendar year. Members must wait full 12 months before another lipid panel screening (cholesterol screening) or it will be denied.			
Colonoscopy	$0 copay / 100%	$0 copay / 100%	Not Covered
▪ For adults ages 45 to 75, covered every 10 years beginning at age 45; every two years if diagnosed as high risk. ▪ Cologuard screening test is covered under preventive screening once every 3 years. No prior authorization required. ▪ Screening colonoscopy or sigmoidoscopy - 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 medical history of immediate family members.			
Mammogram	$0 copay / 100%	$0 copay / 100%	Not Covered
▪ One routine (preventive) mammogram screening each calendar year for all women aged 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.			
Pap Smear (Cervical Cancer)	$0 copay / 100%	$0 copay / 100%	Not Covered
Cervical cancer screenings (pap smear and human papillomavirus (HPV) screening) are covered once per calendar year for women regardless of age.			
Prostate Specific Antigen (PSA)	$0 copay / 100%	$0 copay / 100%	Not Covered
▪ 1 / Every 12 months from the last date rendered			
PCP Office Visit	$0 copay / 100%	$40 copay / 100%	Not Covered
Employer-required exams and employment drug screening tests (including tuberculosis / TB tests) are not covered benefits.			
Specialist Office Visit	$20 copay / 100%	$60 copay / 100%	Not Covered

Maternity Care	$0 copay / 100%	$0 or $40 copay / 100%	Not Covered
▪ No charge for preventive prenatal care. The copay applies to all other care. ▪ No coverage provided for pregnancy of a dependent child other than preventive prenatal care. -- Coverage for dependent child maternity care is covered for individuals living in Massachusetts. ▪ 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.			
Mental Health/Substance Abuse Office Visit	$0 copay / 100%	$40 copay / 100%	Not Covered
Chiropractic Services	$10 copay / 100%, 24 visits/year	$40 copay / 100%, 24 visits/year	Not Covered
Hot/Cold packs are not covered.			
Acupuncture	$10 copay / 100%, 12 visits/year	$40 copay / 100%, 12 visits/year	Not Covered
Routine Podiatry	$20 copay, 4 visits/year	$40 copay, 4 visits/year	Not Covered
Treatment of corns & calluses (cutting & removing), trimming, cutting, clipping or debriding of nails, Keratoderma, Athlete's foot (Tinea Pedis), and dermatophytosis.			
Non-Routine Podiatry	$20 copay / 100%	$40 copay / 100%	Not Covered
Allergy Injections in an Office (without an office visit)	$0 copay / 100%	$0 copay / 100%	Not Covered
EMERGENCY AND URGENT CARE	**Member Pays in Green Network (coverage %)**	**Member Pays in BlueChoice/PPO/BlueCard Network (coverage %)**	**Member Pays Out-of-Network (coverage %)**
Urgent Care Center (UCC)	$30 copay / 100%	$40 copay / 100%	Not Covered
Emergency Room Services	$350 copay / 100% (copay waived if admitted)	$400 copay / 100% (copay waived if admitted)	$400 copay / 100% (copay waived if admitted)
Ambulance	$100 copay / 100% (copay waived if admitted)	$100 copay / 100% (copay waived if admitted)	$100 copay / 100% (copay waived if admitted)
Plan does not cover non-ambulance transportation services like MediCar or MediCoach or similar services. Prior authorization required for non-emergent air ambulance transportation.			

INPATIENT TREATMENT	Member Pays in Green Network (coverage %)	Member Pays in BlueChoice/PPO/BlueCard Network (coverage %)	Member Pays Out-of-Network (coverage %)
Inpatient Hospital	$150 copay / 100% /day $450 max/admission	$300 copay / 100% /day $1,200 max/admission (No coverage once patient may safely be moved to a participating provider.)	$300 copay / 100% /day $1,200 max/admission (No coverage once patient may safely be moved to a participating provider.)
▪ Physician/surgeon fees are included in the copay and coverage level for both in-network and out-of-network inpatient hospital. ▪ Prior authorization is not required for 2-day vaginal deliveries and 4-day Cesarean sections.			
Skilled Nursing Facility (SNF) Care	$50 copay / 100% /day	$100 copay / 100% /day	Not Covered
OUTPATIENT SERVICES	**Member Pays in Green Network (coverage %)**	**Member Pays in BlueChoice/PPO/BlueCard Network (coverage %)**	**Member Pays Out-of-Network (coverage %)**
Outpatient Surgery in Ambulatory Surgical Center (ASC)	$150 copay / 100%	$300 copay / 100%	Not Covered
▪ Physician/surgeon fees are included in the co-pay and coverage level for both in-network and out-of-network for outpatient surgery in an Ambulatory Surgical Center. Includes in office surgeries when billed as a surgery and not an office visit. ▪ Not limited to but including: Upper GI, endoscopy (EDG), diagnostic colonoscopy, varicose veins, elective abortion, and vasectomy. Refer to prior authorization list. Diagnostic Colonoscopies do not require prior authorization.			
Outpatient Surgery in Hospital	$300 copay / 100%	$600 copay / 100%	Not Covered
▪ Physician/surgeon fees are included in the co-pay and coverage level for both in-network and out-of-network for outpatient surgery in a Hospital Outpatient Department. ▪ Not limited to but including: Upper GI, endoscopy (EDG), diagnostic colonoscopy, varicose veins, elective abortion, and vasectomy. Refer to prior authorization list. Diagnostic Colonoscopies do not require prior authorization.			
Physical/Occupational Therapy	Non-Hospital: $20 copay / 100% 60 visits/year Hospital: Not covered	Non-Hospital: $30 copay / 100% 60 visits/year Hospital: Not covered	Not Covered
Hot & cold pack not covered. Office visits are not covered when performed with Physical Therapy/Occupational Therapy services.			

Speech Therapy	Non-Hospital: $20 copay / 100% 30 visits/year Hospital: Not covered	Non-Hospital: $30 copay / 100% 30 visits/year Hospital: Not covered	Not Covered
Infusion Medication	Non-Hospital: $20 copay / 100% Hospital: $40 copay / 100%	Non-Hospital: $30 copay / 100% Hospital: $60 copay / 100%	Not Covered
Chemotherapy	Non-Hospital: $20 copay / 100% Hospital: $40 copay / 100%	Non-Hospital: $30 copay / 100% Hospital: $60 copay / 100%	Not Covered
Kidney Dialysis	Non-Hospital: $20 copay / 100% Hospital: $40 copay / 100%	Non-Hospital: $30 copay / 100% Hospital: $60 copay / 100%	Not Covered
Radiation Therapy	Non-Hospital: $20 copay / 100% Hospital: $40 copay / 100%	Non-Hospital: $30 copay / 100% Hospital: $60 copay / 100%	Not Covered
Mental Health / Substance Abuse / Intensive Outpatient / Partial Hospitalization / Ambulatory Detoxification Treatment	$20 copay / 100%	$20 copay / 100%	$20 copay / 100%
LAB AND IMAGING SERVICES	**Member Pays in Green Network (coverage %)**	**Member Pays in BlueChoice/PPO/BlueCard Network (coverage %)**	**Member Pays Out-of-Network (coverage %)**
Laboratory Services	Non-Hospital: $20 copay / 100% Hospital: $100 copay / 100%	Non-Hospital: $20 copay / 100% Hospital: $100 copay / 100%	Non-Hospital: $20 copay / 100% (**for independent lab services only**)
Drug screening tests (including tuberculosis / TB tests) required for employment are not a covered benefit.			
Radiology (X-ray, Ultrasound, Fetal Monitoring)	Non-Hospital: $30 copay / 100% Hospital: $100 copay / 100%	Non-Hospital: $50 copay / 100% Hospital: $100 copay / 100%	Not Covered
Diagnostic Imaging (CT, MRI, PET, etc.)	Non-Hospital: $200 copay / 100% Hospital: $400 copay / 100%	Non-Hospital: $300 copay / 100% Hospital: $500 copay / 100%	Not Covered

OTHER CARE AND EXPENSES	Member Pays in Green Network (coverage %)	Member Pays in BlueChoice/PPO/BlueCard Network (coverage %)	Member Pays Out-of-Network (coverage %)
Diabetes Education	$0 copay / 100%	$0 copay / 100%	Not Covered
Nutritional Counseling	$0 copay / 100%, 4 visits/year	$0 copay / 100%, 4 visits/year	Not Covered
Home Health Care	$20 copay / 100%, 60 visits/year	$20 copay / 100%, 60 visits/year	Not Covered
Includes all skilled visits in the home including home infusion.			
Hospice Care	$0 copay / 100%	$0 copay / 100%	Not Covered
Podiatric Orthotics	$0 copay / 100% coverage limited to $500/24 months	$20 copay / 100% coverage limited to $500/24 months	Not Covered
Orthotics will be allowed only if foot strapping confirms the orthotic will be effective (not required for replacement orthotics).			
Prosthetics & Orthotics (other than podiatric orthotics)	80%	80%	Not Covered
Durable Medical Equipment (DME)	70%	70%	Not Covered
▪ For all durable medical equipment including artificial limbs and organs. Covers rental up to the purchase price. If DME is bought, costs for repair or maintenance are also covered. ▪ Compression stockings prescribed by a healthcare professional are covered under the DME benefit up to $500. Prior authorization is required if the purchase price exceeds $500 per item. DME may not be purchased at OON pharmacies. ▪ Prior authorization is required if medical equipment is over $500 per item.			
Sleep Studies	$100 copay / 100%	$150 copay / 100%	Not Covered

Habilitative Therapy for children with autism spectrum disorders (ABA therapy)	$20 copay / 100% /day 30 hours max/week	$20 copay / 100% /day 30 hours max/week	Not Covered
▪ 30 Hours / Week / 36 Months / Person ▪ At least 2 years old and benefit ends on the child's 8th birthday. ▪ 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. ▪ "Habilitative therapy" includes applied behavioral analysis (ABA) therapy and similar types of treatment. It does not include physical, speech, or occupational therapy.			
Medical Foods	Plan reimburses 100%	Plan reimburses 100%	Plan reimburses 100%
Telehealth			
Plan covers telehealth visits as long as the Fund would have covered the same service through an in-person visit by an in-network or out-of-network provider. The telehealth visit will be covered at the same in-person cost-sharing benefit (copays, deductibles, or coinsurance), including any rules about out-of-network coverage.			
Hearing Aids	Not covered	Not covered	Not Covered
All other covered expenses	80%	80%	Not Covered
Birth Control (Contraceptives)			
Covered under woman's preventive care. FDA approved contraceptive methods are covered.			
Breast Pump & Supplies	100%	100%	100%
▪ Limit of one (1) breast pump per pregnancy. Non-hospital grade breast pumps and supplies are payable at 100% under preventive 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. ▪ Hospital grade breast pumps and supplies are payable at the DME coverage level. ▪ Breast pumps and supplies over $500 require prior authorization.			
Infertility	Plan Exclusion	Plan Exclusion	Plan Exclusion
The initial exam and any procedures used to arrive at the diagnosis of infertility is an allowable expense. Once a determination of infertility is established, any services for or in connection with treatment for infertility is excluded.			

Marriage Counseling	Plan Exclusion	Plan Exclusion	Plan Exclusion

Benefits at a Glance

Dental Services: Delta Dental of Illinois (PPO) The Dental PPO option only applies if member is enrolled in the dental PPO option. Dental plan is administered by Delta Dental, additional information can be found at http://www.deltadentalil.com or by calling (800) 323-1743.
Pharmacy: Hospitality Rx - Get prior authorization for certain medications and find a network pharmacy (844) 813-3860 or go to website at Hospitality Rx
Vision: Davis Vision, Inc. - (800) 999-5431 or https://davisvision.com/

Prior Authorization List for Plan 116

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**.

Provider must call HC360 to prior authorize benefits before providing 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)

This list changes from time to time. Call HealthCheck360 (HC360) toll free at **(844) 462-7812.**

Last update 03/23/2023

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.