117 Chicago Sporting Events

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** (Combined Medical and Pharmacy)

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.	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.	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

	AMITA/PRESENCE HEALTH NETWORK	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
Chiropractic 24 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
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

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

	AMITA/PRESENCE HEALTH NETWORK	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
Laboratory Services *Service: Laboratory Services*	**Non-Hospital:** 100% $20 copay **Hospital:** 100% $100 copay	**Non-Hospital:** 100% $20 copay **Hospital:** 100% $100 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% $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. HealthCheck360 (HC360) toll free (844) 462-7812.	**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. HealthCheck360 (HC360) toll free (844) 462-7812.	100% $100 copay	100% $150 copay	Not Covered
OUTPATIENT SERVICES BENEFIT			

	AMITA/PRESENCE HEALTH NETWORK	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
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 *(After 12th 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. 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
MENTAL HEALTH & SUBSTANCE ABUSE			
Office Visits *Service: Office Visit. Including medical management visits.* Chemotherapy Treatment and Chemotherapy Medication requires Prior Authorization. HealthCheck360 (HC360) toll free (844) 462-7812.	100% $0 copay	100% $10 copay	Not Covered

	AMITA/PRESENCE HEALTH NETWORK	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
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.
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

	AMITA/PRESENCE HEALTH NETWORK	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
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
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
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.	
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**			

	AMITA/PRESENCE HEALTH NETWORK	BLUE CHOICE PPO NETWORK/BLUE CARD	OUT OF NETWORK
	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
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 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.

(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)
Bariatric surgery (including but not limited to gastric bypass and banding procedures
Blepharoplasty
Chemotherapy
Cholecystectomy (laparoscopic)
Clinical trials
Dialysis — *notification only*
Durable medical equipment over $500 (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
Mammoplasty (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)

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