173A (Actives) Staff PPO - Provider Benefits Fact Sheet

Calendar Year Medical Deductible: In-Network: $0; Out-of-Network: $200 per person; $400 per family

Network Out-of-Pocket Maximums

Once your cost sharing for network-covered expenses reaches these limits, the Plan pays 100% for most of your covered network expenses for the rest of the year (see your SPD for expenses that don't count).

Out-of-Pocket Limit per Calendar year for Medical Benefits:
In-Network: $6,350 per person, $12,700 per family (No out-of-pocket for out-of-network.)

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

Medical claims should be submitted to your local BCBS or mailed to:

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

W-9's should be submitted to: claims@uhh.org or Fax No. 630-236-4394

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 benefits.

	IN NETWORK (covered %)	OUT OF NETWORK
OFFICE VISITS BENEFIT		
Office visit for a primary care Healthcare Professional *(unless specified otherwise)* *Service: Non-preventive visit* Includes all services provided during the visit.	100% after $10 copayment per visit	80% after Calendar Year deductible
Office/Clinic Visits (PCP) *Service: Preventive Healthcare Services* Plan covers in-network preventive care, including screenings, and counseling, as required by the ACA. Certain age and frequency limits may apply.	100%	Not Covered
Office visit for treatment of Mental Health/Substance Abuse Disorders Includes all care provided during visit.	100% after $10 copayment per visit	80% after Calendar Year deductible
Specialist Care Office Visits Includes all care provided during visit. Without referral through HealthCheck360	100% after $20 copayment per visit	80% after Calendar Year deductible
Specialist Care Office Visits Includes all care provided during visit. With referral through HealthCheck360	100% after $10 copayment per visit	80% after Calendar Year deductible

	IN NETWORK (covered %)	OUT OF NETWORK
Allergy Shot		
	100%	80% after Calendar Year deductible
Maternity Care (PCP provided) *Service: Non-preventive* Cost sharing does not apply to certain preventive services. Depending on the type of services, a copayment or coinsurance may apply. Benefit covers employees and eligible dependents. 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% after $10 copayment per visit	80% after calendar year deductible
Mammogram Preventive *Service: Preventive Breast Cancer Mammography Screenings* One routine (preventive) mammogram screening each calendar year for all women age 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.		
	100%	Not Covered
Cervical Cancer Screening – Preventive *Service: Preventive Pap Smear/HPV* 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%	Not Covered

	IN NETWORK (covered %)	OUT OF NETWORK
Colonoscopies - Preventive *Service: Screening colonoscopy* Screening colonoscopy - 1 every 10 years beginning at age 50 to 75 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. No Prior Authorization required	100%	Not Covered
Acupuncture Limited to 25 visits per person each calendar year, of which no more than 20 can be out-of-network.	100% after $15 copayment per visit	80% after calendar year deductible 20 Visit Maximum
Chiropractic Services No visit max.	100% after $15 copayment per visit	80% after calendar year deductible
University of Pennsylvania Health System (Penn) Cancer Care (Eff 2.01.2024) $0 cost-sharing (deductible, coinsurance, and co-payments) on covered services for the diagnosis, treatment, and surveillance of non-pediatric cancer and benign hematology disorders (including related complications) provided by the University of Pennsylvania Health System (Penn) in addition to radiation treatment provided at Shore Medical Center for participants referred there by Penn for the treatment of cancer.	100%	Not Covered

	IN NETWORK (covered %)	OUT OF NETWORK
Routine Podiatric Services		
	100% after $15 copayment per visit	80% after Calendar Year deductible
Non-Routine Podiatric Services		
	100% after $15 copayment per visit	80% after Calendar Year deductible
Services provided at the UNITE HERE HEALTH Health Center (Atlantic City)		
	100%	Not Covered
URGENT AND EMERGENCY TREATMENT		
Urgent Care Center Visit		
	100% after $20 copayment per visit	80% after Calendar Year deductible
Hospital emergency room services *Service: Emergency Room*		
	100%	100% (no Calendar Year deductible)

	IN NETWORK (covered %)	OUT OF NETWORK
Hospital emergency room services for non-emergency care *Service: Emergency Room* Care and services that could be provided in a clinic, urgent care center or Healthcare Professional's office are not considered Emergency.	80%	60% after Calendar Year deductible

	IN NETWORK (covered %)	OUT OF NETWORK
Ambulance *Service: Professional Ambulance Transportation*	100%	100% after $100 Calendar Year deductible
INPATIENT TREATMENT		
Hospital inpatient department services, including inpatient professional services *Service: Hospitalization* Including inpatient professional services. Includes the treatment of Mental Health/Substance Abuse Disorders. Also applies to maternity/pregnancy delivery, and all inpatient services Prior authorization is required. Prior authorization is not required for maternity admissions less than 2 days for vaginal deliveries and 4 days for cesarean sections.	100%	80% after Calendar Year deductible
Skilled Nursing Facility confinement Limited to 70 days per person each calendar year for Network and Non-Network care combined. Prior authorization is required.	100%	80% after Calendar Year deductible
LABORATORY AND IMAGING SERVICES		
Laboratory Services	100%	80% after Calendar Year deductible

	IN NETWORK (covered %)	OUT OF NETWORK
Radiology Including x-ray, ultrasound, fetal monitoring.	100%	80% after Calendar Year deductible
Diagnostic Imaging Includes CT, MRI, PET, and Cardiac Testing. Prior authorization required for CT, MRA, MRI and PET.	100%	80% after Calendar Year deductible
OUTPATIENT SERVICES BENEFIT		
Outpatient Surgery *Service: Ambulatory surgical center* Physician/surgeon fees are included in the copay and coverage level for both in-network and out-of-network for surgery in an Ambulatory Surgical Center. Prior Authorization may be required.	100%	80% after Calendar Year deductible
Outpatient Surgery *Service: Hospital outpatient department* Physician/surgeon fees are included in the copay and coverage level for both in-network and out-of-network for surgery in an outpatient hospital. Prior Authorization may be required.	100%	80% after Calendar Year deductible

	IN NETWORK (covered %)	OUT OF NETWORK
Physical, speech, and occupational therapy Prior Authorization required.	100%	80% after Calendar Year deductible
OTHER CARE		
Podiatric Orthotics Prior authorization required if over $500.	100%	80% after Calendar Year deductible
Diabetes Education For the care, monitoring, or treatment of diabetes & dietary needs.	100%	Not Covered
Nutritional Counseling Maximum $200/year.	100%	Not Covered
Partial Hospitalization, Intensive outpatient and Ambulatory Detoxification Treatment Prior Authorization required.	100%	80% after Calendar Year deductible

	IN NETWORK (covered %)	OUT OF NETWORK
Home Healthcare 200 Days / Year (combined in/non-network) Prior Authorization required.	100%	80% after Calendar Year deductible
Hospice Care 210 Days / lifetime (combined in/non-network) Prior Authorization required.	100%	80% after Calendar Year deductible
Durable Medical Equipment - DME Prior authorization is required for durable medical equipment (DME), orthotics and prosthetics exceeding $500. If durable medical equipment can either be rented or purchased, and if rental fees for prescribed course of treatment expects to exceed purchase price, the Fund may limit covered expense to durable medical equipment purchase price.	100%	80% after Calendar Year deductible
Non-hospital-grade breast pumps Limited to purchase of one 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. Breast pumps and supplies over $500 require prior authorization.	100%	100% (no Calendar Year deductible)
Habilitative therapy for children with Autism Spectrum Disorder Limited to 30 hours per week, at least 2 years old but not older than 8 years old. Child must have a diagnosis of autism spectrum disorder, and have a prorated mental age of at least 11 months. Prior Authorization required.	100% after $10 copayment per day of treatment	80% after Calendar Year deductible

	IN NETWORK (covered %)	OUT OF NETWORK
Medical foods for inborn metabolic errors Medical foods for covered persons with inborn errors of metabolism (IEM). The medical food must be: (1) ordered by and used under the supervision of a healthcare provider; (2) the primary source of nutrition; and (3) labeled and used for dietary management of IEM. Prior Authorization required.	100%	
Travel and lodging for certain serious medical conditions Reimbursement of 100% up to $10,000 per episode of care, including a per diem of up to $250 for lodging and meals. Prior Authorization required.	100% (no Calendar Year deductible)	
All Other Covered Expenses	100%	5080% after Calendar Year deductible
Hearing Aids Plan Exclusion - Through 12/31/2022	Not Covered	Not Covered
Hearing Aids Effective 1/1/2023	Plan pays $3,000 / 3 calendar years	Plan pays $3,000 / 3 calendar years
Infertility 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.		
Contraceptives *Service: Birth control* Covered under woman's preventative care. FDA approved contraceptive methods are covered.	100%	Not Covered

	IN NETWORK (covered %)	OUT OF NETWORK
Dental *Service: Delta Dental of Illinois (PPO)* 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
Vision *Service: Davis Vision* Vision Plan is administered by Davis Vision, additional information can be found at www.davisvision.com/member or by calling (800) 999-5431.		
PRESCRIPTION DRUG BENEFITS		
Preventive Healthcare Services and supplies on the formulary Mail order prescription drug service is only available through WellDyneRx: (844) 813-3860; specialty drugs must be obtained through WellDyne Specialty Pharmacy: (800) 373-1879, https://welldynespecialty.com. Visit Hospitality Rx for more detailed information.	100%	Not Covered
Formulary generic drugs	100% after $15 copayment per prescription fill or refill for up to 34-day supply	Not Covered
Formulary brand name drugs	Preferred: 100% after $25 copayment Non-preferred: 100% after $35 copayment per prescription fill or refill for up to 34-day supply	Not Covered
Formulary Select Specialty & Select Biosimilar Drugs – Brand	25% up to 60-day supply	Not Covered
Formulary Select Specialty & Select Biosimilar Drugs – Generic		

	IN NETWORK (covered %)	OUT OF NETWORK
	$10 copay up to 60-day supply	Not Covered
Prescription drugs and supplies at the UNITE HERE HEALTH Health Center (Atlantic City)		
	100%	N/A

Prior Authorization List for Plan Unit 173

Provider should get prior authorization with HealthCheck360 at **(844) 462-7812** before any of the following:

• 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, residential treatment, maternity admissions following 48 hours for a vaginal delivery and 96 hours following a Cesarean delivery, and 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 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)

*The prior authorization list may change from time, contact HealthCheck360 at **(844) 462-7812** for the most up-to-date information.*

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