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376 Food Service Gold+ Provider Benefits Fact Sheet

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

Out-of-Pocket Limit per Calendar year for Medical Benefits:
In-Network - Medical: $5,000 / Person; $10,000 / Family - (No out-of-pocket for out-of-network.)

Prescription Drug Benefits; Out-of-Pocket Limit per Calendar year:
In-Network - Prescription: $1,600 / Person; $3,200 / Family - (No out-of-pocket for out-of-network.)

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

Network Provider:

Horizon Blue Cross and Blue Shield of New Jersey
P.O. Box 1219
Newark, NJ 07101-1219

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-Network (coverage %)	Member Pays Out-of-Network (coverage %)
Preventive Care	$0 copay / 100%	Not Covered
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%	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%	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%	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%	Not Covered
▪ 1 / Every 12 months from the last date rendered ▪ Ages 40-69		

PCP Office Visit	$20 copay / 100%	50%
Employer-required exams and employment drug screening tests (including tuberculosis / TB tests) are not covered benefits.		
Specialist Office Visit	$40 copay / 100%	50%
Maternity Care	$0 or $20 copay / 100%	0% or 50%
▪ 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	$20 copay / 100%	50%
Chiropractic Services	$20 copay / 100%, 12 visits/year	Not Covered
Acupuncture	$20 copay / 100%, 12 visits/year	Not Covered
Routine Podiatry	$20 copay / 100%, 4 visits/year	Not Covered
Non-Routine Podiatry	$40 copay / 100%	50%
Allergy Injections in an Office (without an office visit)	$0 copay / 100%	50%
University of Pennsylvania Health System (Penn) Cancer Care (Eff 2.01.2024)	$0 copay/ 100%	Not Covered
▪$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.		
EMERGENCY AND URGENT CARE	**Member Pays In-Network (coverage %)**	**Member Pays Out-of-Network (coverage %)**
Urgent Care Center (UCC)	$40 copay / 100%	50%
Emergency Room Services	$150 copay / 100% (copay waived if admitted)	$150 copay / 100% (copay waived if admitted)
Ambulance	$150 copay / 100%	$150 copay / 100%
INPATIENT TREATMENT	**Member Pays In-Network (coverage %)**	**Member Pays Out-of-Network (coverage %)**

Inpatient Hospital	$250 copay/day / 100% $750 max/admission	50%
▪ 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. ▪ 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.		
Skilled Nursing Facility (SNF) Care	$250 copay/admission / 100% 60 days/year (Combined in/out-of-network)	50%

OUTPATIENT SERVICES	60 days/year (Combined in/out-of-network)	Member Pays Out-of-Network (coverage %)
Outpatient Surgery in Ambulatory Surgical Center (ASC)	$150 copay / 100%	50%
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.		
Outpatient Surgery in Hospital	$250 copay / 100%	50%
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.		
Physical/Occupational Therapy	Non-Hospital: $20 copay / 100% Hospital: $40 copay / 100% combined 60 visits/year (Combined in/out-of-network)	50%
Speech Therapy	Non-Hospital: $20 copay / 100% Hospital: $40 copay / 100% combined 30 visits/year (Combined in/out-of-network)	50%
▪ For dependent children, speech therapy is only covered to: - Screen, detect, and treat pervasive developmental disorders, such as autism and Asperger's. - Restore or improve speech for speech-language and developmental delay disorders caused by a non-chronic sickness, intra-uterine trauma, hearing loss, difficulty swallowing or acute sickness or injury. - Treat a speech delay associated with a specific disease, injury, or congenital defect, such as cleft lip and palate. ▪ For adults, only speech therapy to restore speech lost as the result of injury or sickness is covered.		
Infusion Medication	Home: $0 copay / 100% Office or Infusion Center: $20 copay / 100% Hospital: 80%, $200 max/visit	50%
Chemotherapy	Home: $0 copay / 100% Office or Infusion Center: $20 copay / 100% Hospital: 80%, $200 max/visit	50%
Kidney Dialysis	Home, Office, or Dialysis Center: $0 copay / 100% Hospital: 80%, $200 max/visit	Not Covered
Radiation Therapy	80%	50%

Mental Health / Substance Abuse / Intensive Outpatient / Partial Hospitalization / Ambulatory Detoxification Treatment	$40 copay/day / 100% $750 max/episode of care	50%
LAB AND IMAGING SERVICES	**Member Pays In-Network (coverage %)**	**Member Pays Out-of-Network (coverage %)**
Laboratory Services	Non-Hospital: $20 copay / 100% Hospital: $80 copay / 100%	50%
Drug screening tests (including tuberculosis / TB tests) required for employment are not a covered benefit.		
Radiology (X-ray, Ultrasound, Fetal Monitoring)	Non-Hospital: $20 copay / 100% Hospital: $80 copay / 100%	50%
Diagnostic Imaging (CT, MRI, PET, etc.)	Non-Hospital: $150 copay / 100% Hospital: $250 copay / 100%	50%
OTHER CARE AND EXPENSES	**Member Pays In-Network (coverage %)**	**Member Pays Out-of-Network (coverage %)**
Diabetes Education	$0 copay / 100%	Not Covered
Nutritional Counseling	$0 copay / 100%, 4 visits/year	Not Covered
Home Health Care	$0 copay / 100%, 60 visits/year	50%
Includes all skilled visits in the home including home infusion.		
Hospice Care	$0 copay / 100%	50%
Podiatric Orthotics	$0 copay / 100% coverage limited to $500/24 months	Not Covered
Prosthetics & Orthotics (other than podiatric orthotics)	80%	50%

Durable Medical Equipment (DME)	75%	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	80%	50%
Habilitative Therapy for children with autism spectrum disorders (ABA therapy)	$20 copay/day / 100% 30 hours max/week	50%
▪ 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%
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 Aid Reimbursement	Plan pays $3,000/3 calendar years	Plan pays $3,000/3 calendar years
Hearing aids are covered as a reimbursement and not through Blue Cross Blue Shield. Member must submit a medical reimbursement form directly to UNITE HERE HEALTH.		
All other covered expenses	80%	50%

Birth Control (Contraceptives)		
Covered under woman's preventive care. FDA approved contraceptive methods are covered.		
Breast Pump & Supplies	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
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

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.

Dental Services: DeltaCare (DHMO) The Dental HMO option only applies if member is enrolled in the dental HMO option. Dental plan is administered by Delta Dental, additional information can be found at http://www.deltadentalins.com/deltacare or by calling (800) 422-4234.

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 Unit 376

Visit Horizon website for up-to-date list or review below:

- Air Ambulance Transportation – NON-EMERGENT
- Bariatric or Gastric Bypass Procedures – Surgery for Morbid Obesity, including but not limited to, Bariatric Procedures, Gastroplasty, Gastric Bypass - outpatient
- Cardiac Radiology Services – non-emergent only Please note that only the following Cardiology Imaging Services require PA by eviCore healthcare for these members. (Visit the Cardiology Imaging Program webpage or call eviCore healthcare at **1-866-496-6200**)
    - Stress testing (Myocardial perfusion imaging [SPECT and PET], Stress echocardiography)
    - Cardiac CT and MRI
    - Echocardiography: transthoracic and transesophageal
    - Diagnostic heart catheterization
- Clinical Trials
- Cosmetic Procedures and Potentially Cosmetic Procedures, including, but not limited to, cosmetic dermatology services, varicose vein procedures
- Durable Medical Equipment (DME) - certain DME items costing over $500 (Visit the Horizon Care@Home webpage or call CareCentrix at **1-855-243-3321**)
- Gender reassignment surgical services and certain hormone therapy
- Habilitative therapy for children with autism spectrum disorder (ABA therapy) (Call HealthCheck360 at **1-844-462-7812**)
- Home Health Care Services – all skilled services in the home
- Home Hospice Services
- Home Infusion Services (Visit the Horizon Care@Home webpage or call CareCentrix at **1-855-243-3321**)
- Hyberbaric Oxygen Therapy
- Inpatient Admissions
    - Medical admissions
    - Surgical admissions
    - Hospice admissions (exclusive of maternity delivery)
    - Rehabilitation facility admissions (acute rehab, skilled nursing and sub-acute)
    - Mental health and substance abuse admissions (call Horizon Behavioral Health at **1-800-626-2212**)
- Medical Foods
- Mental Health and Substance Abuse Services (call Horizon Behavioral Health at **1-800-626-2212**) Marriage Counseling is not covered on the basis that it is not medically necessary.
    - Inpatient (IP)
    - Inpatient Detox
    - Residential (RTC)
    - 23hr Bed
    - 72hr Bed
    - Partial Hospitalization (PHP)

    - Intensive Outpatient (IOP)
    - Psychological Testing
    - In-Home Services
    - Electroconvulsive Therapy (ECT)
    - Transcranial Magnetic Stimulation (TMS)
- Molecular and Genomic Testing services (Visit the Molecular and Genomic Testing Program webpage or call eviCore healthcare at **1-866-496-6200**)
- Prosthetics/Orthotics - over $500 (Visit the Horizon Care@Home webpage or call CareCentrix at **1-855-243-3321**)
- Radiation Therapy services (Visit the Radiation Therapy Program webpage or call eviCore healthcare at **1-866-242-5749**)
- Radiology/Imaging Services, including but not limited to the following. (Visit the Radiology/Imaging Services webpage or call eviCore healthcare at **1-866-496-6200)**
    - Magnetic Resonance Imaging (MRI)
    - Magnetic Resonance Angiograms (MRAs)
    - Positron Emission Tomography (PET) scans
    - Positron Emission Tomography – Computed Tomography (PET-CT)
    - Computerized Tomography (CT) scans
    - Computed Tomography Angiography (CTA) scans
    - Nuclear Medicine
    - Nuclear Cardiac Imaging
- Specialty Pharmaceuticals/Medical Injectable Drugs (e.g., Botox, IVIG, Flolan and derivatives, Xolair) (Visit the Medical Injectables Program webpage or call Magellan Rx Management at **1-800-424-4508**)
- Transplant Services, except Corneal Transplants (Case Management)
- Travel and Lodging benefits (call UHH at **1-833-637-3519**)

The Prior Authorization List changes from time to time. Visit the Horizon website for up-to-date list.

Last update 03/08/2023

Important Phone Numbers

UNITE HERE HEALTH Fund Office
For information not found on the provider portal.
(833) 637-3519 • uhh.org

Horizon BCBS
Get prior authorization for
hospitalizations and certain medical services.
(866) 899-0626 • horizonblue.com

eviCore
Get prior authorization for outpatient diagnostic imaging services, molecular and genomic testing services, and radiation therapy services
(866) 496-6200

CareCentrix
Get prior authorization for prosthetics/orthotics - over $500
(855) 243-3321

Magellan Rx Management
Get prior authorization for specialty Pharmaceuticals/Medical Injectable Drugs (e.g., Botox, IVIG, Flolan and derivatives, Xolair)
(800) 424-4508

HealthCheck360
Get prior authorization for ABA (Habilitative) Therapy
(844) 462-7812

Horizon Behavioral Health
Get prior authorization for
mental health and substance abuse admissions
(800) 626-2212

Hospitality Rx
Get prior authorization for
certain medications and find a network pharmacy
(844) 813-3860 • hospitalityrx.org