PLAN UNIT 173—RETIREE PPO

Benefits at a Glance

UNITE HERE! *Staff*

Contact the Fund:
Monday – Friday, 9 AM – 6 PM EST

(866) 686-0003
www.uhh.org

HealthCheck360 is ready to help you!

Call HealthCheck360 BEFORE you get certain types of care: (844) 462-7812

- Save money on specialist copays by getting a referral from your primary care provider (PCP). When your PCP calls us **BEFORE** your specialist visit, your copay gets lowered by half.
- Have your doctor call HealthCheck360 **BEFORE** you get certain types of outpatient care or have an inpatient stay. If you don't, your claim may not be paid.
- Transplant (including evaluation) and CAR-T Therapy Services—You MUST use the Optum or Cigna LifeSOURCE network; prior authorization is required. www.uhh.org/transplant

Medical — Blue Cross Blue Shield PPO	You pay	
Calendar Year Deductible	$200 per person $600 per family	$400 per person $800 per family
Basic Inpatient and Outpatient Benefits	**Network**	**Non-Network***
Inpatient Hospitalization	$0 after deductible	40% after deductible
Hospital Outpatient and Diagnostic Services	$0 after deductible	40% after deductible
Ambulatory Surgical Services	$0 after deductible	40% after deductible
Skilled Nursing Facility — *Up to 70 total days per person each year*	$0 after deductible	40% after deductible
Home Healthcare Services — *Up to 200 total visits per person each year*	$0 after deductible	40% after deductible
Hospice Care — *Up to 210 total lifetime visits per person*	$0 after deductible	40% after deductible
Hospital Emergency Room	$0 after deductible	$0 after deductible
Medical and Surgical Benefits	**Network**	**Non-Network***
Lifetime Maximum Benefit per Person	$1,000,000	
Preventive Care		
Well Baby Care — *For children up to 18 months of age*	$0	Not Covered
Immunizations	$20 copay	Not Covered
Routine Colonoscopy or Routine PSA Tests — *Frequency limits and age restrictions apply*	$0	Not Covered
Preventive Exam — *1 per person each year*	$0	Not Covered
Office Visits		
Primary Care Provider (PCP)	$10 copay	40% after deductible

*Non-network rates are paid at the allowable amount rate.

Effective 1/1/2025

UNITE HERE HEALTH

This is an easy-to-read summary and does not include all benefits. If there is a conflict between this summary and your plan documents, then your plan documents are correct. For more details about your benefits or to find out which treatments/services require prior authorization, please refer to your Summary Plan Description (SPD) or call us at (866) 686-0003.

Specialist — *When your PCP calls HealthCheck360 first*	$10 copay	40% after deductible
Specialist — *When your PCP DOESN'T call HealthCheck360 first*	$20 copay	40% after deductible
Mental Health/Substance Abuse Office Visit	$20 copay	40% after deductible
Chiropractic	$20 copay	40% after deductible
Podiatric Services	$20 copay	40% after deductible
Urgent Care		
Urgent Care Center	$20 copay	40% after deductible
Ambulance	First $50 in charges — $0 After first $50 in charges — 40% after deductible	
Other Services and Supplies		
Certified Diabetes Educator — *Up to $200 per person each year*	$0	Not Covered
Registered Dietitian — *Up to $200 per person each year*	$0	Not Covered
Speech and Physical Therapy — *Speech therapy for children limited to $2,500 per person each year*	$0 after deductible	40% after deductible
Durable Medical Equipment	$0 after deductible	40% after deductible
Formulary Prescription Drug Benefits — Hospitality Rx ***Available at network pharmacies (not covered at non-network pharmacies like CVS, Longs and Wal-Mart)***	**Network Retail** ***Up to a 34-day supply***	**Network Mail Order** ***Up to a 60-day supply***
Covered Immunizations & Smoking Cessation Drugs and Supplies *(including prescription generic over-the-counter products,generic products, and certain brand products)*	$0	
Generic and Some Brand Drugs	$15 copay	
Preferred and Non-Preferred Drugs	$30 copay	
Select Specialty and Biosimilar Drugs* *Current pharmacy benefit provider will actively manage and determine drugs in tier.*	Not Covered	**Generic:** $15 copay **Brand:** 25% coinsurance
Non-Formulary Prescription Drugs and Supplies	Not covered unless an exception is approved	

Vision Benefits — What You Pay

Benefits covered once every calendar year	Davis Vision Network Provider	Non-Network Provider
Eye Exam	$0 copay	$0 copay; $75 maximum
Retinal Imaging	$20 copay	Not covered
Lenses	$0 copay	$0 copay; $175 maximum for all materials, evaluations, and fittings combined
Frames	$0 copay for Davis collection Fashion, Designer, or Premier frames; $150 benefit maximum for all other frames	
Elective Contact Lenses, in lieu of Glasses	$0 copay for Davis collection contacts; $150 benefit maximum, plus $60 benefit maximum for the evaluation and fitting, for all other contacts	
Medically Necessary Contact Lenses	$0 copay	

Dental — Delta Dental PPO

Only available to certain grandfathered retirees and their dependents

Covered services	You Pay
Calendar Year Deductible	$25 per person $100 per family
Dental Services (Non-Orthdontic) Calendar Year Maximum Benefit	$2,000 per person
Diagnostic and Preventive Services	$0
Emergency Palliative Services	$0
Minor & Major Restorative Services	20% after deductible
Prosthodontic Services	20% after deductible
Orthodontic Services *Children under age 19 only*	40%
Orthodontic Lifetime Maximum Benefit	$500 per child

Life Insurance

Only available to certain grandfathered retirees

Life Insurance	The Plan pays $5,000

Hearing Aid Benefit	What the Plan pays
Maximum benefit every 3 calendar years	Plan pays 100% up to $3,000

*Specialty drugs are only available through the specialty mail order pharmacy or the Atlantic City Health Center. However, if you take specialty medications as part of your HIV treatment plan, you may be able to receive an exception to use your network retail pharmacy instead.