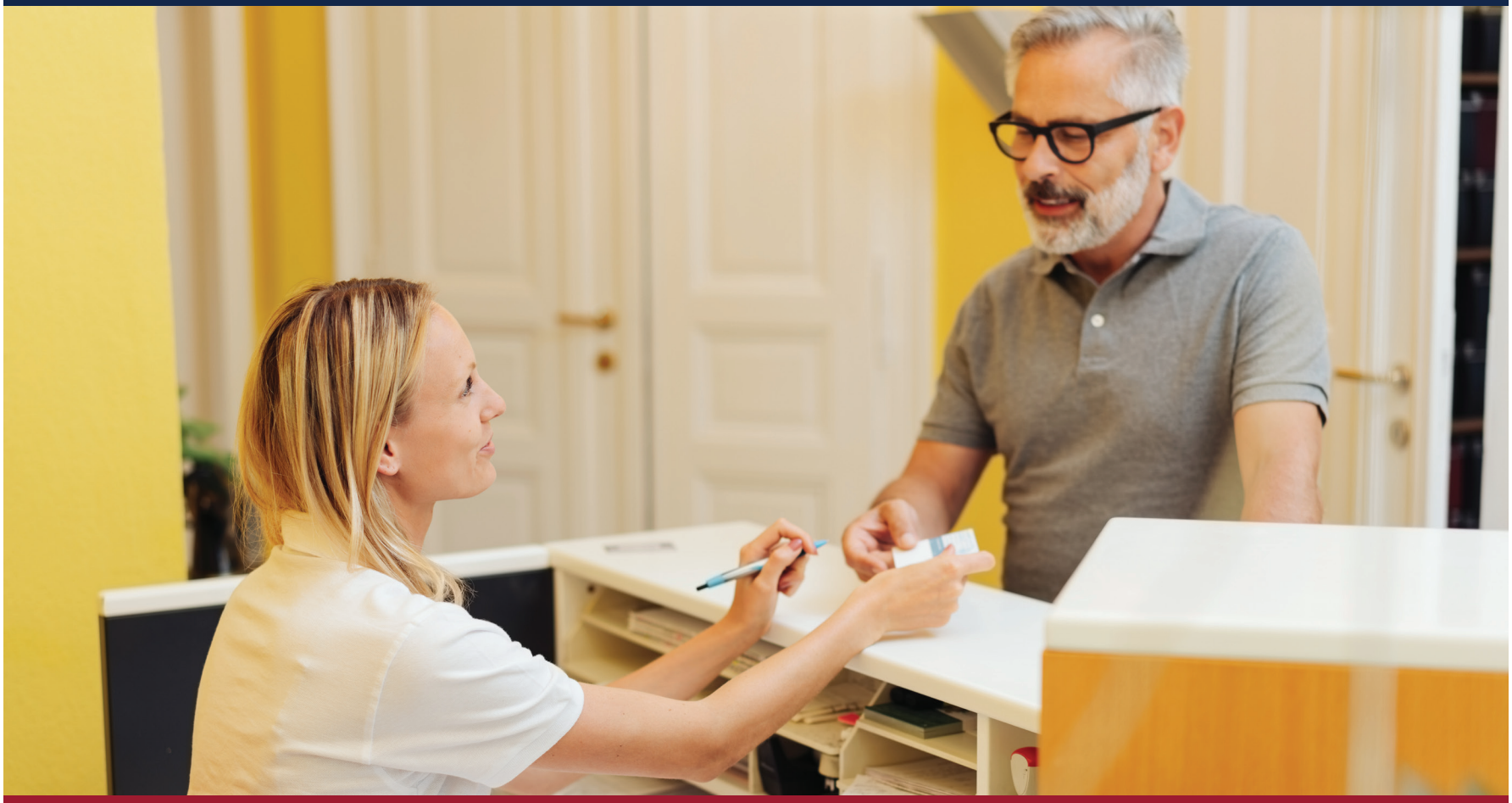
HOSPITALITY PLAN
UNITE HERE HEALTH

Copayment Book



SILVER PLAN

Beginning on and after January 1, 2024

This booklet shows the copayments for **In-Network benefits**.

For more information on **Out-of-Network benefits, please review your Summary Plan Description (SPD) or call 855-405-3863**.

The information in this Copay Book is based on the Plan Document. However, in the event of a conflict between the Copay Book and the Plan Document, **the Plan Document will govern**.

For the latest information, please visit **www.hospitalityplan.org** or call the Customer Service Office at **855-405-3863**.

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Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
The Maximum yearly amount you have to pay out of your pocket for your deductible, copays and coinsurance is **$2,000** per person or **$6,000** per family for medical services and **$1,600** per person or **$3,200** for family for prescription drug services. (Excludes dental copays). Annual deductible of **$750** per person and **$1,500** per family is the amount you must pay before your health plan pays for certain services. The deductible does not apply to services with Copays, such as doctor visits or to the pharmacy.						
Preventive Services	Immunizations for adults (age appropriate) and children (birth to age 18)	$0	No coinsurance	100% of allowable charges	No maximum benefit	For a complete list of preventive services covered by the Affordable Care Act please visit **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/** You can also contact the Customer Service Office at **855-405-3863** if you have any questions. (No out of network benefits)
	Well baby/child exams (birth to age 21)					
	Annual physical exams					
	Nutritional counseling					
	Osteoporosis screening (women age 65 and older)					
	Mammography (women age 35 and older); 1 per calendar year (women under age 35 who are at high risk for breast cancer); 1 per calendar year					
	Women's well check					
	Colonoscopy and Sigmoidoscopy (Ages 45 to 75)					

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Doctor Office Services	Primary doctor	$25	No coinsurance	100% of allowable charges after copay	No maximum benefit	No other information.
	Teladoc	$0				
	Specialist	$50				
	In-patient services	$0	No coinsurance	100% of allowable charges		
	Injection					
	IV treatment					
	Pulmonary treatment					
	Pulmonary test					
	Chiropractor	$25	No coinsurance	100% of allowable charges after copay	Up to 12 visits per year	No out of Network benefits.
	Urgent care	$50	No coinsurance	100% of allowable charges after copay	No maximum benefit	If enrolled in a PPO medical benefit option: Free podiatry services at the UHH-Health Center in Atlantic City. For additional information, please call the Customer Service Office at **855-405-3863**.
	X-ray/ultrasound	$25				
	Radiology- CT, MRI, PET	$175 per visit				
	Lab	$25				

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Doctor Office Services (continued)	Ophthalmologist/ Optometrist (eye exam)	$0	No coinsurance	100% of allowable charges	No maximum benefit	Covered under the vision plan. Coverage for lenses and frames are listed in the "Other Services" section of this book.
	Chemotherapy	$25	No coinsurance	100% of allowable charges after copay	No maximum benefit	Hearing aid benefit: Maximum benefit every 3 calendar years: $3,000
	Radiation therapy	$0	30% after deductible	70% of allowable charges after deductible		
	Hearing and speech exam	$0	No coinsurance	100% of allowable charges		
	Allergy testing					
	Allergy immunotherapy					
	Surgery in the physician's office					
	Nerve conduction studies					
	Dialysis management					
	All other physician office procedures					
	Sleep study performed in a doctor's office	$0	30% after deductible	70% of allowable charges after deductible		

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Prescriptions	Generic and Some Brand Drugs	$5	No coinsurance	100% after copay	No maximum benefit	For a complete list of retail pharmacies included in the Network, contact **Hospitality Rx at 844-813-3860**.
	Preferred Drugs	$15	No coinsurance	100% after copay	No maximum benefit	For a complete list of retail pharmacies included in the Network, contact **Hospitality Rx at 844-813-3860**. Quantity limits, prior authorization requirements and other cost containment programs may apply.
	Non-Preferred Drugs	$30				
	Select Specialty and Select Biosimilar Drugs	Generic: $5	No coinsurance	100% after copay	No maximum benefit	Contact **Hospitality Rx at 844-813-3860**. Prior Authorization (approval) is required.
		Brand name: $0	25% of allowable charges	75% of allowable charges		
Ambulatory Surgery Center	Surgery	$0	20% after deductible	80% of allowable charges after deductible	No maximum benefit	No other information.

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Therapy at an Outpatient Free Standing Facility (Not at a hospital)	Physical therapy and occupational therapy	$30	No coinsurance	100% of allowable charges after copay	Up to 60 visits per year, combined	Maximum visit limits apply to Network and Non-Network care combined.
	Speech therapy	$30	No coinsurance	100% of allowable charges after copay	Up to 30 visits per year	
Free-Standing Facility Services (Not at a hospital)	Lab	$25	No coinsurance	100% of allowable charges after copay	No maximum benefit	No other information.
	X-ray/ultrasound					
	CT Scan, MRI, MRA, PET	$175				
	Dialysis	$0	No coinsurance	100% of allowable charges	No maximum benefit	Some services require prior authorization (approval).
	Sleep study	$0	30% after deductible	70% of allowable charges after deductible	No maximum benefit	
	Cardiac/pulmonary rehabilitation	$0	30% after deductible	70% of allowable charges after deductible	30 visits annual limit	

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Outpatient Services in a Hospital	Lab for hospital based preoperative or diagnostic services only	$100	No coinsurance	100% of allowable charges after copay	No maximum benefit	Some services require prior authorization (approval).
	X-ray/ultrasound	$100				
	MRI, MRA, CT Scan PET and combined PET/CT	$300				
	Chemotherapy	$0	30% after deductible ($250 max per visit)	70% of allowable charges, and 100% of allowable charges after max of $250 per visit	No maximum benefit	No other information.
	Dialysis	$0	30% after deductible ($250 max per visit)		No maximum benefit	Some services require prior authorization (approval).
	Physical and occupational therapy	$60	No coinsurance	100% of allowable charges after copay	Up to 60 visits per year, combined	Maximum visit limits apply to Network and Non-Network Care combined. Some services require prior authorization (approval).
	Speech therapy (after discharge from inpatient Hospital admission)	$60	No coinsurance	100% of allowable charges after copay	Up to 30 visits per year	
	Cardio/pulmonary rehab (after discharge from inpatient hospital admission)	$0	30% after deductible	70% of allowable charges after deductible	Up to 60 visits per year, combined	Some services require prior authorization (approval).

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Outpatient Services in a Hospital (continued)	Outpatient surgery	$0	30% after deductible	70% of allowable charges after deductible	No maximum benefit	Some services require prior authorization (approval).
	Diabetes education	$0	No coinsurance	100% of allowable charges		
	Sleep study	$0	30% after deductible	70% of allowable charges after deductible		
	All other outpatient hospital services					
Ambulance	Ground	$0	30% after deductible	70% of allowable charges after deductible	Limited to 2 trips per year	No other information.
	Air	$0	20% after deductible	80% of allowable charges after deductible	No maximum benefit	
Emergency Room vs. Urgent Care	Emergency room	$200 per visit	No coinsurance	100% of allowable charges after copay, including all other covered ER services, as well as lab and X-ray	No maximum benefit	**Tip:** please go to the **Urgent Care** for non-life threatening issues. **Copay waived if admitted.**
	Urgent care	$50 per visit	No coinsurance	100% of allowable charges after copay	No maximum benefit	No other information.
In-Network Hospital (in-patient)	Inpatient stay	$0	30% after deductible	70% of allowable charges after deductible	No maximum benefit	Some services require prior authorization (approval). **Tip:** Call the Customer Service Office at **855-405-3863 to make sure your hospital is in the BCBS Network.**
	Obstetrics					
	Skilled nursing facility	$0	30% after deductible	70% of allowable charges after deductible	30 days per year	
	Inpatient rehabilitation					
	Surgery/anesthesia	$0	30% after deductible	70% of allowable charges after deductible	No maximum benefit	

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Mental Health and Addictions	Outpatient therapy	$25	No coinsurance	100% of allowable charges after copay	No maximum benefit	Some services require prior authorization (approval). Call the Customer Service Office at **855-405-3863**.
	Inpatient	$0	30% after deductible	70% of allowable charges after deductible		
	Residential treatment					
	Partial hospital admission	$0	No coinsurance	100% of allowable charges		
	Intensive outpatient program					
Breast Care at a Free-Standing Facility*	Preventive (annual mammogram)	$0	No coinsurance	100% of allowable charges	No maximum benefit	No other information.
	Mammogram-Additional Views					
	Diagnostic mammogram	$25	No coinsurance	100% of allowable charges after copay	No maximum benefit	
	Breast ultrasound	$25				
	Breast MRI	$175				
	Needle-guided breast biopsy under ultrasound	$0	20% after deductible	80% of allowable charges after deductible		
	*Needle-guided breast biopsy under ultrasound when performed in a physician's office	$0				
	Needle-guided breast biopsy under CT Scan	$0				

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Other Services	Home Healthcare	$0	No coinsurance	100% of allowable charges	Maximum benefit of up to 30 visits per calendar year	Maximum visit limits apply to Network and Non-Network care, combined.
	Home Infusion Therapy	$0	No coinsurance	100% of allowable charges	No maximum benefit	No other information.
	Hospice					
	Diabetic shoes	$0	25% after deductible	75% of allowable charges after deductible	No maximum benefit	
	Mastectomy bras	$0	25% after deductible	75% of allowable charges after deductible	Up to 6 per year	
	Compression stockings	$0	25% after deductible	75% of allowable charges after deductible	Up to 12 pairs per year	Requires prior authorization if over $500.
	Orthotic shoe inserts	$0	No coinsurance	100% of allowable charges after copay	$500 every 24 months	No out-of-network benefit.
	Durable medical equipment and medical supplies	$0	25% after deductible	75% of allowable charges after deductible	No maximum benefit	Prior Authorization (approval) is required for items over $500.

Type of Care	Services	Copay per Visit	Coinsurance	Plan Pays	Maximum Benefit	Other Information
Other Services (continued)	Medical foods	$0	No coinsurance	100% reimbursement	No maximum benefit	Same benefit for out-of-network services. Requires medical review.
	Prosthetic and orthotic appliances	$0	30% of allowable charges	70% of allowable charges	No maximum benefit	Prior Authorization (approval) is required.
	Lenses and frames	• Glasses - $25 copay • Lenses - $0 copay (included in prescription glasses: single vision, line bifocal, and lined trifocal lenses)	No coinsurance	100% of allowable charges after copay $175 maximum allowance will apply to frames and lenses	Once every calendar year	Covered under the vision plan. Retinal Screening: Up to $39 copay at a VSP Premier Provider and Visionworks locations.
	Elective contact lenses (instead of glasses)	$25 copay; 15% (Up to $50 max copay for contact lens fitting and exam); Medically necessary contact lenses: $0 copay	No coinsurance	$175 maximum allowance	Once every calendar year	

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