



# Medical Benefits

## At a Glance



You may not have all these benefits. Your benefits are determined by your collective bargaining agreement and your enrollment choices. If you have questions about your coverage or your specific benefits, contact your health fund at **(855) 405-FUND**.

Blue Cross Blue Shield	Silver Plus	
WHAT'S COVERED <small>(effective 1/1/2018)</small>	WHAT YOU PAY— <b>Network</b>	WHAT YOU PAY— <b>Non-network</b>
<b>Office Visits</b>		
Preventive Care	\$0 copay	Not covered
Primary Care Provider (PCP) <i>(includes all care received during visit)</i>	\$25	50% after deductible
Doctor on Demand <i>(telemedicine)</i>	\$15	Not covered
Specialist <i>(all care received during visit)</i>	\$50	50% after deductible
Mental Health/Substance Abuse	\$25	50% after deductible
Chiropractic Services <i>(12 visits per year)</i>	\$25	Not covered
Diabetes Education	\$0	Not covered
<b>Emergency, Urgent Care, and Inpatient Services</b>		
Urgent Care Center	\$50	50% after deductible
ER for Emergency	\$200 <i>(waived if admitted)</i>	\$200 <i>(waived if admitted)</i>
ER for Routine Care	50% of charges after deductible	Not covered
Ground Ambulance <i>(2 trips per year)</i>	30% after deductible	30% after deductible
Inpatient Hospitalization	30% after deductible	50% after deductible
Skilled Nursing Facility <i>(30 days per year)</i>	30% after deductible	50% after deductible
<b>Outpatient Services</b>		
Outpatient Surgery	20% after deductible; ambulatory surgical center	50% after deductible
	30% after deductible; hospital	
Physical and Occupational Therapy <i>60 visits per year, combined</i>	\$30 office or non-hospital facility	
	\$60 hospital outpatient	
Speech Therapy <i>30 visits per year</i>	\$30 office or non-hospital facility	
	\$60 hospital outpatient	
Infusion Medication and Chemotherapy	\$0 home	
	\$25 office or infusion center	
	30% after deductible; hospital outpatient <i>(max of \$250 per visit)</i>	
Kidney Dialysis	\$0 home or dialysis center	
	30% after deductible; hospital outpatient <i>(max of \$250 per visit)</i>	
Radiation Therapy	30% after deductible	

More benefits on back

<b>Medical</b> <i>(continued)</i>	<b>Silver Plus</b>	
WHAT'S COVERED	WHAT YOU PAY— <b>Network</b>	WHAT YOU PAY— <b>Non-network</b>
<b>Lab and Imaging Services</b>		
<b>Laboratory Services and Radiology</b> <i>No extra copays when part of an office visit</i>	\$25 office or non-hospital lab	50% after deductible
	\$100 hospital outpatient	
<b>Diagnostic Imaging (CT, MRI, PET)</b>	\$175 office or non-hospital facility	
	\$300 hospital outpatient	
<b>Other Care and Expenses</b>		
Home Health Care Visit <i>(30 visits per year)</i>	\$15	50% after deductible
Hospice Care	\$0	50% after deductible
<b>Podiatric Orthotics</b> <i>\$500 max every 24 months</i>	\$0	Not covered
Durable Medical Equipment	25% after deductible	Not covered
<b>Prescription Drug</b> True Choice network excludes CVS and certain other chains and independents <i>(non-preferred brand name drugs are not covered)</i>		
Generic	\$10 copay per prescription	Not covered
<b>Preferred Brand Name Drugs</b> <i>On the formulary</i>	\$30 copay per prescription	
Specialty or Biosimilar Drugs	25% coinsurance <i>(\$50 max per prescription)</i>	
<b>Other</b>		
Medical Deductible	\$1,500 individual; \$3,000 family	
<b>Network Out-of-Pocket Spending Limit</b> 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 <i>(see your SPD for expenses that don't count).</i>	<b>Medical</b>	\$5,000 individual; \$10,000 family
	<b>Pharmacy</b>	\$1,600 individual; \$3,200 family

**(855) 405-FUND**  
**www.uhh.org**

*This document is an easy-to-read summary and does not include all benefits. If you want more details about your benefits or want to find out which treatments/services require prior authorization, please refer to your Summary Plan Description (SPD) or call UNITE HERE HEALTH.*



# Non-Medical Benefits



## At a Glance

### PPO Dental, Vision, Short-Term Disability, Life and AD&D

Effective 1/1/2018

#### Dental and vision offered as a bundled package

Dental   Cigna DPPO		
Effective January 1, 2018	WHAT YOU PAY—Network	WHAT YOU PAY—Non-network
<b>Diagnostic and Preventive Care</b> <i>Includes routine exams, cleanings and x-rays</i>	\$0	30% of charges
<b>Basic Restorative Care</b> <i>Includes fillings, root canals, periodontics, bridge/crown repair</i>	20% of charges, after deductible	40% of charges, after deductible
<b>Major Restorative Care</b> <i>Includes crowns, bridges, jackets, implants, dentures</i>	50% of charges, after deductible	60% of charges, after deductible
<b>Orthodontic Care</b>	Plan pays 50% of charges up to a \$2,500 lifetime maximum	
<b>Calendar Year Deductible</b>	\$50 per person; \$150 per family <i>(does not apply to diagnostic, preventive and orthodontic care)</i>	
<b>Maximum Benefit Per Person</b> <i>Calendar year</i>	Plan pays up to \$1,500 <i>(does not apply to exams for persons under age 19)</i>	

Vision   VSP		
Benefits available every 12 months	WHAT YOU PAY	
	VSP Network	Non-network
<b>Eye Exam</b>	\$10 copay	\$10 copay; plan pays up to \$45
<b>Frames</b>	\$25 copay; plan pays up to \$160 for frames	\$25 copay; plan pays up to \$70
<b>Lenses</b>		\$25 copay; plan pays up to \$30-\$100, depending on lens type
<b>Elective Contact Lenses</b> <i>Instead of glasses</i>	Contacts—\$0 copay; up to \$60 for exam; plan pays up to \$160	Plan pays up to \$120

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Short-Term Disability	
Employees only	WHAT THE PLAN PAYS
<b>*Short-Term Disability</b> <i>1st day accident/8th day illness</i>	\$200-400/week; 26-week max

Life and AD&D	
Employees only	WHAT THE PLAN PAYS
<b>*Life Insurance</b>	\$10,000 - \$30,000
<b>*Accidental Death &amp; Dismemberment Insurance</b>	

\*Benefit amount depends on your CBA.



# Non-Medical Benefits



## At a Glance

### HMO Dental, Vision, Short-Term Disability, Life and AD&D

Effective 1/1/2018

Offered as a bundled package

<b>Dental   Cigna DHMO</b>	
<b>Choose a network dentist!</b> <i>Your benefits aren't effective until you do! Call Cigna: (800) 244-6224</i>	WHAT YOU PAY
<b>Routine Oral Exams/Cleanings</b>	\$0 copay
<b>Most X-Rays</b>	\$0 copay
<b>Fillings Amalgam</b>	\$6 – \$18 copay, depending on number of surfaces
<b>Crowns One replacement per person every 5 years</b>	\$370 – \$460 copay, depending on type
<b>Root Canal</b>	\$275 – \$440 copay, depending on type
<b>Orthodontics—Child under 19 24-month max</b>	\$2,280 copay total (\$95 copay per month)
<i>Coverage for network benefits only; no deductible; no non-orthodontic maximum</i>	

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<b>Vision   VSP</b>		
<i>Benefits available every 12 months</i>	WHAT YOU PAY	
	VSP Network	Non-network
<b>Eye Exam</b>	\$10 copay	\$10 copay; plan pays up to \$45
<b>Frames</b>	\$25 copay; plan pays up to \$160 for frames	\$25 copay; plan pays up to \$70
<b>Lenses</b>	20% discount on other frames over the allowance; extra \$20 off some name brand frames	\$25 copay; plan pays up to \$30-\$100, depending on lens type
<b>Elective Contact Lenses Instead of glasses</b>	Contacts—\$0 copay; up to \$60 for exam; plan pays up to \$160	Plan pays up to \$120

<b>Short-Term Disability</b>	
<i>Employees only</i>	WHAT THE PLAN PAYS
<b>Short-Term Disability</b> <i>1st day accident/8th day illness</i>	\$200-\$400/week*; 26-week max

<b>Life and AD&amp;D</b>	
<i>Employees only</i>	WHAT THE PLAN PAYS
<b>Life Insurance</b>	\$10,000 - \$30,000*
<b>Accidental Death &amp; Dismemberment Insurance</b>	

\*Benefit amount depends on you CBA.

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Hospitality Plan 185  
Monterey Plan 175  
Los Angeles Plan 178

# Prior authorization rules *by place of service*

For Prior Authorization, please contact NEVADA HEALTH SOLUTIONS:

Phone: **(855) 487-0353** toll free

Fax: **(866) 201-5601**

<https://www.nevadahealthsolutions.org>

Call UNITE HERE HEALTH at **(855) 405-FUND (3863)** to verify benefits and eligibility.

Prior authorization is required for:

<b>In Office</b>
All hematology/oncology services
Hyperbaric treatment
Orthotic & prosthetic appliances over \$500
Radiology services: CT/CTA, Discography, MRI/MRA, PET Scans
Varicose veins
TMJ procedures orthognathic surgery
Physical, speech and occupational therapy
<b>End stage renal disease treatment facility</b>
Dialysis
<b>Home health and home infusion services</b>
All skilled services in a home setting
<b>Inpatient</b>
All inpatient admissions (except 2 day Vaginal Deliveries and 4 day Cesarean Sections)
All admissions to skilled nursing, acute rehabilitation, and long term acute care facilities
<b>Outpatient hospital</b>
Hyperbaric treatment
Radiology services: CT/CTA, Discography, MRI/MRA, PET Scans
Hematology/oncology services
Dialysis

<b>Outpatient hospital</b> <i>continued</i>
Physical, speech, and occupational therapies
Sleep studies
All surgery & invasive diagnostic procedures performed in surgery area <b>(except colonoscopy/sigmoidoscopy)</b>
<b>Ambulatory surgery center</b>
All outpatient surgery or procedures <b>(except colonoscopy/sigmoidoscopy)</b>
<b>Additional services</b>
All transplant services <i>(including consults)</i>
All genetic testing
All air ambulance transports
Medical foods for inborn errors of metabolism
Sleep Studies
Durable Medical Equipment items over \$500 <i>(whether rented or purchased)</i>
All clinical trials

***This table is only a general guideline to UHH Plans prior authorization requirements.***

This list may be updated from time to time. It is the provider's responsibility to check for updates. If the procedure billed is not the procedure approved, there may be no payment and the patient is not liable. The presence or absence of a procedure code and/or service on this list does not determine benefits or coverage for your patient. Verification of benefits and eligibility should be obtained by calling UNITE HERE HEALTH at **(855) 405-FUND (3863)**.

**NOTIFICATION ONLY:**

Inpatient and Residential Behavioral Health services