



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 **855-405-3863**.

Blue Cross Blue Shield	Silver Plus	
WHAT'S COVERED <i>(effective 1/1/2019)</i>	WHAT YOU PAY— Network	WHAT YOU PAY— Non-network
Office Visits		
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
Emergency, Urgent Care, and Inpatient Services		
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
Outpatient Services		
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

Medical <i>(continued)</i>	Silver Plus	
WHAT'S COVERED	WHAT YOU PAY— Network	WHAT YOU PAY— Non-network
Lab and Imaging Services		
Laboratory Services and Radiology <i>No extra copays when part of an office visit</i>	\$25 office or non-hospital lab	50% after deductible
	\$100 hospital outpatient	
Diagnostic Imaging (CT, MRI, PET)	\$175 office or non-hospital facility	
	\$300 hospital outpatient	
Other Care and Expenses		
Home Health Care Visit <i>(30 visits per year)</i>	\$0	50% after deductible
Hospice Care	\$0	50% after deductible
Podiatric Orthotics <i>\$500 max every 24 months</i>	\$0	Not covered
Durable Medical Equipment	25% after deductible	Not covered
Prescription Drug True Choice network excludes CVS and certain other chains and independents <i>(non-preferred brand name drugs are not covered)</i>		
Generic	\$5 copay per prescription	Not covered
Preferred Brand Name Drugs <i>On the formulary</i>	\$30 copay per prescription	
Brand Name Diabetes Oral Medications, Insulin, and Supplies <i>On the formulary</i>	\$15 copay per prescription	
Specialty or Biosimilar Drugs	25% coinsurance <i>(\$50 max per prescription)</i>	
Other		
Medical Deductible	\$750 individual; \$1,500 family	
Network Out-of-Pocket Spending Limit 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> .	<i>Medical</i>	\$2,000 individual; \$6,000 family
	<i>Pharmacy</i>	\$1,600 individual; \$3,200 family

855-405-3863
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 1/1/2019

Dental and vision offered as a bundled package

Dental Cigna DPPO		
<i>Effective January 1, 2019</i>	WHAT YOU PAY— Network	WHAT YOU PAY— Non-network
Diagnostic and Preventive Care <i>Includes routine exams, cleanings and x-rays</i>	\$0	30% of charges
Basic Restorative Care <i>Includes fillings, root canals, periodontics, bridge/crown repair</i>	20% of charges, after deductible	40% of charges, after deductible
Major Restorative Care <i>Includes crowns, bridges, jackets, implants, dentures</i>	50% of charges, after deductible	60% of charges, after deductible
Orthodontic Care	Plan pays 50% of charges up to a \$2,500 lifetime maximum	
Calendar Year Deductible	\$50 per person; \$150 per family <i>(does not apply to diagnostic, preventive and orthodontic care)</i>	
Maximum Benefit Per Person <i>Calendar year</i>	Plan pays up to \$1,500 <i>(does not apply to exams for persons under age 19)</i>	

Vision VSP		
<i>Benefits available every 12 months</i>	WHAT YOU PAY	
	VSP Network	Non-network
Eye Exam	\$0 copay	\$10 copay; plan pays up to \$45
Frames	\$25 copay; plan pays up to \$175 for frames	\$25 copay; plan pays up to \$70
Lenses		\$25 copay; plan pays up to \$30-\$100, depending on lens type
Elective Contact Lenses <i>Instead of glasses</i>	Contacts—\$0 copay; up to \$50 for exam; plan pays up to \$175	Plan pays up to \$120

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

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

**Benefit amount depends on your CBA.*



Non-Medical Benefits



At a Glance

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

Effective 1/1/2019

Offered as a bundled package

Dental Cigna DHMO	
Choose a network dentist! <i>Your benefits aren't effective until you do! Call Cigna: (800) 244-6224</i>	WHAT YOU PAY
Routine Oral Exams/Cleanings	\$0 copay
Most X-Rays	\$0 copay
Fillings <i>Amalgam</i>	\$6 – \$18 copay, depending on number of surfaces
Crowns <i>One replacement per person every 5 years</i>	\$370 – \$460 copay, depending on type
Root Canal	\$275 – \$440 copay, depending on type
Orthodontics— Child under 19 <i>24-month max</i>	\$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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Vision VSP		
Benefits available every 12 months	WHAT YOU PAY	
	VSP Network	Non-network
Eye Exam	\$0 copay	Plan pays up to \$45
Frames	\$25 copay; plan pays up to \$175 for frames	Plan pays up to \$70
Lenses	20% discount on other frames over the allowance; extra \$20 off some name brand frames	Plan pays up to \$30-\$100, depending on lens type
Contact Lenses <i>Instead of glasses</i>	Contacts—\$0 copay; up to \$50 for exam; plan pays up to \$175	Plan pays up to \$120 for contacts, fitting and evaluation

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Life Insurance	\$10,000 - \$30,000
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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:

In Office
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
End stage renal disease treatment facility
Dialysis
Home health and home infusion services
All skilled services in a home setting
Inpatient
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
Outpatient hospital
Hyperbaric treatment
Radiology services: CT/CTA, Discography, MRI/MRA, PET Scans
Hematology/oncology services
Dialysis

Outpatient hospital <i>continued</i>
Physical, speech, and occupational therapies
Sleep studies
All surgery & invasive diagnostic procedures performed in surgery area (except colonoscopy/sigmoidoscopy)
Ambulatory surgery center
All outpatient surgery or procedures (except colonoscopy/sigmoidoscopy)
Additional services
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