



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	Gold Plus	
WHAT'S COVERED <i>(effective 1/1/2021)</i>	WHAT YOU PAY— Network	WHAT YOU PAY— Non-network
Office Visits		
Preventive Care	\$0 copay	Not covered
Primary Care Provider <i>(includes all care received during visit)</i>	\$20	50%
Teladoc <i>(telehealth)</i>	\$15	Not covered
Specialist <i>(all care received during visit)</i>	\$40	50%
Mental Health/Substance Abuse	\$20	50%
Chiropractic Services <i>(12 visits per year)</i>	\$20	Not covered
Diabetes Education	\$0	Not covered
Emergency, Urgent Care, and Inpatient Services		
Urgent Care Center	\$40	50%
ER for Emergency <i>(waived if admitted)</i>	\$150	\$150
ER for Routine Care	50%	Not covered
Ground Ambulance <i>(2 trips per year)</i>	\$150/trip	\$150/trip
Inpatient Hospitalization	\$250 per day <i>(\$750 max per admission)</i>	50%
Skilled Nursing Facility <i>(30 days per year)</i>	\$250 per day <i>(\$750 max per admission; no copay following a hospital stay)</i>	50%
Outpatient Services		
Outpatient Surgery	\$150 ambulatory surgical center	50%
	\$250 hospital	
Physical and Occupational Therapy <i>60 visits per year, combined</i>	\$20 office or non-hospital facility	
	\$40 hospital outpatient	
Speech Therapy <i>30 visits per year</i>	\$20 office or non-hospital facility	
	\$40 hospital outpatient	
Infusion Medication and Chemotherapy	\$0 home	
	\$20 office or infusion center	
	20% hospital outpatient <i>(max of \$200 per visit)</i>	
Kidney Dialysis	\$0 home or dialysis center	
	20% hospital outpatient <i>(max of \$200 per visit)</i>	
Radiation Therapy	20%	

More benefits on back

Medical <i>(continued)</i>	Gold 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>	\$20 office or non-hospital lab	50%
	\$80 hospital outpatient	
Diagnostic Imaging (CT, MRI, PET)	\$150 office or non-hospital facility	
	\$250 hospital outpatient	
Other Care and Expenses		
Home Health Care Visit <i>(30 visits per year)</i>	\$0	50%
Hospice Care	\$0	50%
Podiatric Orthotics <i>\$500 max every 24 months</i>	\$0	Not covered
Durable Medical Equipment	25%	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	
Generic Specialty or Biosimilar Drugs <i>on the formulary</i>	\$5 copay	
Brand Name Specialty or Biosimilar Drugs <i>on the formulary</i>	25% coinsurance	
Other		
Medical Deductible	\$0	
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 1/1/2021

Dental and vision offered as a bundled package

Dental Delta Dental PPO		
<i>Effective January 1, 2021</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 \$2,000 <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	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-\$65, 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

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.

855-405-3863
www.uhh.org

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 1/1/2021

Offered as a bundled package

Dental DeltaCare (DHMO)	
<i>Choose a network dentist!</i> Call Delta Dental: (800) 422-4234	WHAT YOU PAY
Routine Oral Exams/Cleanings	\$0 copay
Most X-Rays	\$0 copay
Fillings <i>Amalgam</i>	\$0 copay
Crowns <i>One replacement per person every 5 years</i>	\$35-\$195 copay, depending on type
Root Canal	\$45-\$205 copay, depending on type
Orthodontics—Child under 19 24-month max	\$1,700 copay total
<i>Coverage for network benefits only; no deductible; no non-orthodontic maximum</i>	

+

Vision VSP		
<i>Benefits available every 12 months</i>	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-\$65, 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

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.

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

855-405-3863
www.uhh.org



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 **855-405-3863** 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

Sleep Studies

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 continued

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 (including consults)

All genetic testing

All air ambulance transports

Medical foods for inborn errors of metabolism

Durable Medical Equipment items over \$500 (whether rented or purchased)

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 **855-405-3863**.

NOTIFICATION ONLY:

Inpatient and Residential Behavioral Health services