HOSPITALITY PLAN
UNITE HERE HEALTH

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 *(effective 1/1/2022)*	WHAT YOU PAY—**Network**	WHAT YOU PAY—**Non-network**
Office Visits		
Preventive Care	**$0 copay**	**Not covered**
Primary Care Provider (PCP) *(includes all care received during visit)*	**$25**	**50% after deductible**
Teladoc *(telehealth)*	**$0**	**Not covered**
Specialist *(all care received during visit)*	**$50**	**50% after deductible**
Mental Health/Substance Abuse	**$25**	**50% after deductible**
Chiropractic Services *(12 visits per year)*	**$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** *(waived if admitted)*	**$200** *(waived if admitted)*
ER for Routine Care	**50% after deductible**	**Not covered**
Ground Ambulance *(2 trips per year)*	**30% after deductible**	**30% after deductible**
Inpatient Hospitalization	**30% after deductible**	**50% after deductible**
Skilled Nursing Facility *(30 days per year)*	**30% after deductible; less any copay for hospital stay**	**50% after deductible**
Outpatient Services		
Outpatient Surgery	**20% after deductible; ambulatory surgical center**	**50% after deductible**
	30% after deductible; hospital	
Physical and Occupational Therapy *60 visits per year, combined*	**$30 office or non-hospital facility**	
	$60 hospital outpatient	
Speech Therapy *30 visits per year*	**$30 office or non-hospital facility**	
	$60 hospital outpatient	
Infusion Medication and Chemotherapy	**$0 home**	
	$25 office or infusion center	
	30% no deductible; hospital outpatient *(max of $250 per visit)*	
Kidney Dialysis	**$0 home or dialysis center**	
	30% no deductible; hospital outpatient *(max of $250 per visit)*	
Radiation Therapy	**30% after deductible**	

More benefits on back

Medical *(continued)*	**Silver Plus**	
WHAT'S COVERED	WHAT YOU PAY—**Network**	WHAT YOU PAY—**Non-network**
Lab and Imaging Services		
Laboratory Services and Radiology *No extra copays when part of an office visit*	**$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 *(30 visits per year)*	**$0**	**50% after deductible**
Hospice Care	**$0**	**50% after deductible**
Podiatric Orthotics *$500 max every 24 months*	**$0**	**Not covered**
Durable Medical Equipment	**25% after deductible**	**Not covered**
Prescription Drug **True Choice network excludes CVS and certain other chains and independents** *(non-preferred brand name drugs are not covered)*		
Generic	**$5 copay per prescription**	**Not covered**
Preferred Brand Name Drugs *On the formulary*	**$30 copay per prescription**	
Brand Name Diabetes Oral Medications, Insulin, and Supplies *On the formulary*	**$15 copay per prescription**	
Generic Specialty or Biosimilar Drugs *on the formulary*	**$5 copay**	
Brand Name Specialty or Biosimilar Drugs *on the formulary*	**25% coinsurance**	
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 *(see your SPD for expenses that don't count).*	***Medical***	**$2,000 individual; $6,000 family**
	Pharmacy	**$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

HOSPITALITY PLAN
UNITE HERE HEALTH

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

Effective 1/1/2022

Dental and vision offered as a bundled package

Dental | Delta Dental PPO		
Effective January 1, 2022	WHAT YOU PAY—**Network**	WHAT YOU PAY—**Non-network**
Diagnostic and Preventive Care *Includes routine exams, cleanings and x-rays*	$0	30% of charges
Basic Restorative Care *Includes fillings, root canals, periodontics, bridge/crown repair*	20% of charges, after deductible	40% of charges, after deductible
Major Restorative Care *Includes crowns, bridges, jackets, implants, dentures*	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 *(does not apply to diagnostic, preventive and orthodontic care)*	
Maximum Benefit Per Person *Calendar year*	**Plan pays** up to $2,000 *(does not apply to exams for persons under age 19)*	

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Vision | VSP		
Benefits available every 12 months	WHAT YOU PAY	
	VSP Network	**Non-network**
Eye Exam	$0 copay	$0 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-$65, depending on lens type
Elective Contact Lenses *Instead of glasses*	Contacts—$0 copay; Plan pays up to $175; fitting and evaluation copay up to $50	Plan pays up to $120 for contacts, fitting and evaluation

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

Life and AD&D	
Employees only	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

HOSPITALITY PLAN
UNITE HERE HEALTH

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

Effective 1/1/2022

Offered as a bundled package

Dental | DeltaCare (DHMO)

Choose a network dentist! *Call Delta Dental:* ***(800) 422-4234***	WHAT YOU PAY
Routine Oral Exams/Cleanings	$0 copay
Most X-Rays	$0 copay
Fillings *Amalgam*	$0 copay
Crowns *One replacement per person every 5 years*	$35–$195 copay, depending on type
Root Canal	$45–$220 copay, depending on type
Orthodontics *24-month max*	$1,700 copay for children under age 19 $1,900 copay for adults age 19 and older
Coverage for network benefits only; no deductible; no non-orthodontic maximum	

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Vision | VSP

Benefits available every 12 months	WHAT YOU PAY	
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Short-Term Disability

Employees only	WHAT THE PLAN PAYS
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Life and AD&D

Employees only	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, Union contract) and your enrollment choices.

All of the information in this Benefits at a Glance is based on the Plan Document. However, in the event of a conflict between this document and the Plan Document, the Plan Document will govern. If you have questions about your coverage or your specific benefits, contact your health fund.

855-405-3863
www.uhh.org

UNITE HERE HEALTH

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 inpatient and residential behavioral health services, 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