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	*Gold 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 *(includes all care received during visit)*	**$20**	**50%**
Teladoc *(telehealth)*	**$0**	**Not covered**
Specialist *(all care received during visit)*	**$40**	**50%**
Mental Health/Substance Abuse	**$20**	**50%**
Chiropractic Services *(12 visits per year)*	**$20**	**Not covered**
Diabetes Education	**$0**	**Not covered**
Emergency, Urgent Care, and Inpatient Services		
Urgent Care Center	**$40**	**50%**
ER for Emergency *(waived if admitted)*	**$150**	**$150**
ER for Routine Care	**50%**	**Not covered**
Ground Ambulance *(2 trips per year)*	**$150/trip**	**$150/trip**
Inpatient Hospitalization	**$250 per day** *($750 max per admission)*	**50%**
Skilled Nursing Facility *(30 days per year)*	**$250 per day** *($750 max per admission; less any copays paid for hospital inpatient stays immediately preceding the SNF confinement)*	**50%**
Outpatient Services		
Outpatient Surgery	**$150 ambulatory surgical center**	**50%**
	$250 hospital	
Physical and Occupational Therapy *60 visits per year, combined*	**$20 office or non-hospital facility**	
	$40 hospital outpatient	
Speech Therapy *30 visits per year*	**$20 office or non-hospital facility**	
	$40 hospital outpatient	
Infusion Medication and Chemotherapy	**$0 home**	
	$20 office or infusion center	
	20% hospital outpatient *(max of $200 per visit)*	
Kidney Dialysis	**$0 home or dialysis center**	
	20% hospital outpatient *(max of $200 per visit)*	
Radiation Therapy	**20%**	

Medical *(continued)*	**Gold 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*	**$20 office or non-hospital lab** **$80 hospital outpatient**	**50%**
Diagnostic Imaging *(CT, MRI, PET)*	**$150 office or non-hospital facility** **$250 hospital outpatient**	
Other Care and Expenses		
Home Health Care Visit *(30 visits per year)*	**$0**	**50%**
Hospice Care	**$0**	**50%**
Podiatric Orthotics *$500 max every 24 months*	**$0**	**Not covered**
Durable Medical Equipment	**25%**	**Not covered**
Formulary Prescription Drug Benefits **True Choice network excludes CVS and certain other chains and independents** *(non-formulary prescription drugs and supplies are not covered)*		
Generic and some Brand drugs	**$5 copay per prescription**	**Not covered**
Preferred Drugs	**$15 copay per prescription**	
Non-Preferred Drugs	**$30 copay per prescription**	
Select Specialty and select biosimilar drugs	**Generic: $5 copay per prescription** **Brand: 25% coinsurance per prescription**	
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 *(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.hospitalityplan.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–$222 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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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
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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 hospice 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