



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, call **855-405-3863**.

Blue Cross Blue Shield	Silver Plan	
WHAT'S COVERED <i>(effective 1/1/2023)</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>	\$25	50% after deductible
Teladoc <i>(telehealth)</i>	\$0	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>(Up to 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>
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>(Up to 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>(Up to 60 visits per year, combined)</i>	\$30 office or non-hospital facility	
	\$60 hospital outpatient	
Speech Therapy <i>(Up to 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	

Medical (continued)	Silver Plan	
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>Up to 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
Formulary Prescription Drug Benefits True Choice network excludes CVS and certain other chains and independents <i>(non-formulary prescription drugs and supplies are not covered)</i>		
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	\$750 individual; \$1,500 family	
Network Out-of-Pocket Spending Limit <i>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).</i>	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

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

Effective 1/1/2023

Dental and vision offered as a bundled package

Dental Delta Dental PPO		
Effective January 1, 2023	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		
Benefits available every 12 months	WHAT YOU PAY	
	VSP Network	Non-network
Eye Exam	\$0 copay	\$0 copay; Plan pays up to \$45
Frames and Lenses	\$25 copay; Plan pays up to \$175 for frames and lenses	\$25 copay; Plan pays up to \$70 for frames; Plan pays \$30-\$65 for lenses (depending on lens type). You pay the rest.
Elective Contact Lenses <i>Instead of glasses</i>	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

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.

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Short-Term Disability	
Employees only	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	
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

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

Effective 1/1/2023

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 <i>Amalgam</i>	\$0 copay
Crowns <i>One replacement per person every 5 years</i>	\$35-\$195 copay, depending on type
Root Canal	\$45-\$220 copay, depending on type
Orthodontics <i>24-month max</i>	\$1,700 copay for children under age 19 \$1,900 copay for adults age 19 and older
<i>Coverage for network benefits only; no deductible; no non-orthodontic maximum</i>	

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Vision VSP		
<i>Benefits available every 12 months</i>	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
Contact Lenses <i>Instead of glasses</i>	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

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, 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.hospitalityplan.org



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. 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