Monterey Provider Benefits Fact Sheet

The participant may be responsible for a share of cost: copay, coinsurance, deductible, charges the Plan doesn't pay, any amount over the maximum benefits and any expenses that are not covered by the Plan. Some care will only be paid up to a certain amount. Once a maximum benefit or visit limit has been met, no additional benefits are available from UNITE HERE HEALTH for the rest of the year for that type of care.

Annual deductible
Individual $400 Family $1,200
Applicable for certain services as listed below.

Out of Pocket Limits
Once the participant's share of certain covered in-network expenses reaches $6,350 per person ($12,700 per family) the Plan will pay 100% of most covered network services normally paid at 80% the rest of the year and copays.

Medical claims are submitted to the local Blue Cross. In California: Blue Cross, PO Box 60007, Los Angeles, CA 90060.

Disclaimer: Information provided does not guarantee payment.
All claims are subject to eligibility based on current information in our system and terms of the plan.

	BLUE CROSS OF CALIFORNIA	OUT OF NETWORK
OFFICE VISITS BENEFIT		
Preventative Care *Service: Routine Physical & Immunizations* Plan covers in-network routine care, including screenings, checkups, and counseling, immunizations, as required byt the ACA. Certain age and frequency limits may apply.	100%, no deductible, no copay	Not Covered
FDA-approved Contraceptives *Service: Preventive Care* Covered for women under age 55. Quantity limits apply to both over-the-counter and prescription contraceptives. Only generic prescription contraceptives will be covered at 100%. Brand name copay will apply to any brand name contraceptives unless no generic is available or unless the prescribing doctor works with Hospitality Rx to determine that the generic equivalent is not medically appropriate for the patient.	100%, no deductible, no copay	Not Covered

	BLUE CROSS OF CALIFORNIA	OUT OF NETWORK
Maternity Care Routine prenatal care including: office visits, tobacco cessation counseling, immunizations, lab services required by federal law. No coverage for pregnancy of a dependent child other than for preventive prenatal care. No benefits for maternal complications for dependent children.	100%, no deductible, no copay	Not Covered
Maternity Care This benefit level applies to visits for other Maternity care that is not routine prenatal, including but not limited to ultrasounds, and for employees and spouses only, maternal complications.	100%, $25 copay, no deductible	50% of allowed, subject to deductible
Routine Mammograms *Service: Breast Cancer Mammography* Screenings once at age 40, once every 2 years for women from age 41 to age 50, and annually beginning from age 51.	100%, no deductible, no copay	Not Covered
Osteoporosis Screening - Preventive *Service: Dexa Scan/Bone Density test* Women 65 and over or 60 and over if at increase risk of fractures.	100%, no deductible, no copay	Not Covered
Cervical Cancer Screening *Service: Pap Smear* For women ages 21-65 who still have a cervix: 1 every 3 years Or 1 every 5 years. if performed in conjunction with HPV testing.	100%, no deductible, no copay	Not Covered

	BLUE CROSS OF CALIFORNIA	OUT OF NETWORK
Routine Colonoscopies Adults ages 50 to 75 *Service: Routine Colonoscopy* 1 every 10 years for average risk of colon cancer. 1 every 2 years with diagnosis of high risk due to immediate family history.	100%, no deductible, no copay	Not Covered
PCP Office Visit *Service: Office Visits* Including all care provided during the office visit. Excluding chiropractic or podiatric services.	100%, $25 copay, no deductible	50% of allowed, subject to deductible
Specialist Care Office Visits Including all care provided during the office visit. Excluding chiropractic or podiatric services.	100%, $25 copay, no deductible	50% of allowed, subject to deductible
Acupuncture Services must be within the scope of the provider's license.	80%, subject to deductible	50% of allowed, subject to deductible
Chiropractic $500/year maximum benefit (combined in and out of network). Initial and Established office visits are allowed. X-rays are covered at the same benefit as listed for chiropractic, not subject to the $500/year maximum. Hot/cold packs, self-care/home management training and supplies/materials are not covered.	80%, subject to deductible	50% of allowed, subject to deductible

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Podiatric Orthotics Must be custom made and medically necessary. Orthotics costing $500 or more require prior authorization. Call NHS at **(855) 487-0343**.	80%, subject to deductible	50% of allowed, subject to deductible
Routine Podiatry Treatment of corns, calluses, nails conditions, & dermatological conditions.	Not Covered	Not Covered
Non-Routine Podiatry	80%, subject to deductible	50% of allowed, subject to deductible
Diabetes Education $200 maximum benefit. For the care, monitoring or treatment of diabetes and dietary needs. Not limited to a certified diabetes educator. The plan will cover diabetes education as long as the provider holds a valid state license & is within the scope of the license.	100%, no deductible, no copay	Not Covered
Nutritional Counseling $200 maximum benefit.	100%, no deductible, no copay	Not Covered

	BLUE CROSS OF CALIFORNIA	OUT OF NETWORK
Emergency & Urgent Care Benefit		
Urgent Care Clinic		
	100%, $25 copay, no deductible	50% of allowed, subject to deductible
Emergency Room Services *Service: True Emergency Care* Emergency Medical Treatment means covered medical services used to treat a medical condition displaying acute symptoms of sufficient severity (including severe pain) that an individual with average knowledge of health and medicine could expect that not receiving immediate medical attention could place the health of a patient in serious jeopardy or result in serious impairment of bodily functions or bodily organs or body parts.		
	80%, subject to deductible	80% of allowed, subject to deductible
Emergency Room Services *Service: Non-Emergency Care*		
	50%, subject to deductible	50% of allowed, subject to deductible
Ambulance Services *Service: Ambulance* Transportation by a professional ambulance service to an area medical facility equipped to provide the required treatment, including such transportation when a person has no control over the circumstances under which the ambulance is called i.e. - when an ambulance is called by a physician, nurse, or other medical professional; an employer; a law enforcement officer; or a school or other institution.		
	80%, subject to deductible	80% of allowed, subject to deductible

	BLUE CROSS OF CALIFORNIA	OUT OF NETWORK
Hospitalization *Service: Hospitalization through Emergency admission* Applies to all inpatient services, including physician/surgeon fees. Call NHS the first business day following admission: **(855) 487-0353**. $150 benefit reduction may apply if you do not certify. Retrospective review may result in total denial of benefits. Benefits for services by doctors specializing in emergency medicine, radiology, anesthesiology, or pathology, as well as in-hospital consultations furnished by non-network physicians, will be paid at the percent applicable to network providers. However, allowable charges will be determined according to the doctor's network or non-network status.	80%, subject to deductible	80% of allowed, subject to deductible
Inpatient Hospitalization		
Hospitalization *Service: Inpatient Hospitalization* Prior authorization is required. Call NHS at **(855)487-0353**. $150 benefit reduction may apply if you do not certify. Retrospective review may result in total denial of benefits. Prior authorization is not required for maternity admissions less than 48 hours for normal delivery or 96 hours for c-section.	80%, subject to deductible	50% of allowed, subject to deductible
Skilled Nursing Facility Care *Service: Skilled Nursing Facility Care* 60 days maximum per person per calendar year, combined network/non-network. The health care professional must certify that the skilled nursing facility confinement is necessary for the care & treatment of the same injury or sickness treated in the immediately preceding hospital confinement. Confinement must occur within 14 days of a hospitalization of at least 3 days, the person must be under the care of a health care professional during the confinement, the person must be confined as a regular bed patient. Prior authorization is required. Call NHS at **(855) 487-0353**.	80%, subject to deductible	50% of allowed, subject to deductible

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Mental Health & Substance Abuse		
Office Visits *Service: Office Visit, including medical management visits*	100%, $25 copay	50% of allowed, subject to deductible
Hospitalization *Service: Inpatient Hospitalization* Advance notification required. NHS **(855) 487-0353**. Inpatient treatment includes: residential care.	80%, subject to deductible	50% of allowed, subject to deductible
Outpatient Partial Hospitalization, Intensive Outpatient & Ambulatory Detoxification *Service: Outpatient Treatment*	80%, subject to deductible	50% of allowed, subject to deductible
Lab & Imaging Services Benefit		
Laboratory Services *Service: Laboratory Services*	80%, subject to deductible	50% of allowed, subject to deductible

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Laboratory Services *Service: Quest Diagnostics - Laboratory Services*	Quest Diagnostics: 100%, no deductible, no copay	n/a
Radiology *Service: Including but not limited to: Diagnostic Mammogram, X-rays, Ultrasound Echocardiogram & Fetal monitoring* Refer to prior authorization list for radiology services that require prior authorization.	80%, subject to deductible	50% of allowed, subject to deductible
Diagnostic Imaging and Cardiac Testing *Service: CT/CTA/CTA, MRI/MRA, PET Scan, Cardiac Testing* Refer to prior authorization list for services that require prior authorization.	80%, subject to deductible	50% of allowed, subject to deductible
Sleep Study *Service: Sleep Study* Prior authorization required. Nevada Health Solutions: **(855) 487-0353.**	80%, subject to deductible	50% of allowed, subject to deductible

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Outpatient Services Benefit		
Outpatient Surgery *Service: Not limited to but including: Upper GI Endoscopy (EDG), Diagnostic Colonoscopy, Varicose Veins, Elective abortion, Vasectomy.* Refer to prior authorization list. Elective abortion not covered for dependent children. Benefits for services by doctors specializing in emergency medicine, radiology, anesthesiology, or pathology, as well as in-hospital consultations furnished by non-network physicians, will be paid at the percent applicable to network providers. However, allowable charges will be determined according to the doctor's network or non-network status.	80%, subject to deductible	50% of allowed, subject to deductible
Sterilization For women, FDA-approved sterilization is covered as preventive care at 100%, no deductible, no copay. For women getting sterilization that is not considered preventive care, and for male employees and spouses, the applicable benefit applies in and out of network (see Office, Surgery, Outpatient Surgery etc.)	100%, no deductible, no copay	Not covered
Other Hospital Outpatient Services Refer to prior authorization list.	80%, subject to deductible	50% of allowed, subject to deductible
Therapies *Service: Physical, Speech, Occupational Therapy, Massage Therapy* Prior authorization required. NHS **(855) 487-0353**. Limited to 60 visits/pern/year, no more than 30 of these visits can be non-network. Office visits are not covered when performed with PT services. Hot and Cold Packets are not covered. Allowed: one initial PT evaluation.	80%, subject to deductible	50% of allowed, subject to deductible

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Hematology and Oncology Services *Service: Infusion Medication, Chemotherapy, Kidney Dialysis* Prior authorization required. NHS **(855) 487-0353**.	80%, subject to deductible	50% of allowed, subject to deductible
ABA Therapy *Service: Habilitative therapy for children with Autism Spectrum Disorder (ASD)* Prior authorization required: NHS **(855) 487-0353**. Treatment plan reviewed semi- annually. Visit Maximum: 36 months/life, 30 hours/week. Child must be at least 2 years of age and up to age 8 with valid diagnosis of autism spectrum disorders (ASD) & a prorated mental age (PMA) of at least 11 months. Therapy must be ordered by a pediatrician, child psychiatrist/psychologist, or any provider operating w/in the scope of their license. Supervising provider must be certified & Licensed by the Behavioral Analyst Certification Board (BACB) as a Board Certified Behavior Analyst (BCBA) or Board Certified Behavior Analyst Doctorate (BCBA-D), be certified and licensed by an equivalent certifying body, or be a Health Care Professional; the individual providing the therapy must be trained & certified by the BACB, including but not limited to a Board Certified Assistant Behavioral Analyst (BCaBA) or Registered Behavioral Technician (RBT), be trained and certified by an equivalent certifying body, or be a Health Care Professional.	100%, $10 copay per day of treatment, no deductible	50% of allowed, subject to deductible
Other Care & Medical Expenses		
Home Health Care Prior authorization required. NHS **(855) 487-0353.** Maximum 60 days per calendar year – combined In and Out of Network. Including infusion therapy, but excluding general housekeeping services or custodial care.	80%, subject to deductible	50% of allowed, subject to deductible

	BLUE CROSS OF CALIFORNIA	OUT OF NETWORK
Hospice Care *Service: Hospice Care* Prior authorization required for inpatient hospice care. NHS **(855) 487-0353**. Services & supplies authorized by a doctor for a person whose life expectancy is 6 months or less.	80%, subject to deductible	50% of allowed, subject to deductible
Breast Pump & Supplies Benefit is per pregnancy. Limit of one breast pump per pregnancy. Breast pump supplies are limited to $200 per pregnancy. Breast pumps can be purchased from a network provider or out-of-network provider, or retailers such as Target. Breast pumps costing $500 or more require prior authorization. NHS **(855) 487-0353**. Hospital grade breast pumps are considered DME and are covered under the applicable benefits for DME. If costing $500 or more require prior authorization through NHS.	100%, no deductible, no copay	100%, no deductible, no copay
Durable Medical Equipment – DME *Service: DME* $500 & over prior authorization required. Nevada Health Solutions **(855) 487-0353**. Covers rental to purchase price. Costs for repair or maintenance are also considered covered expenses. Orthotics must be custom made. Diabetic shoes may be eligible for benefit.	80%, subject to deductible.	80% of allowed, subject to deductible

	BLUE CROSS OF CALIFORNIA	OUT OF NETWORK
Artificial Limbs & Organ Transplants *Service: Medical services for organ transplants are covered to the extent that such transplant is covered by Medicare, including meeting Medicare's clinical, facility and provider requirements for coverage* Prior Authorization required through NHS (855) 487-0353. Benefits for donor expenses are only available to the extent that the donor has no other coverage & no benefits are provided if you or a covered dependent are a donor. Please refer to appropriate benefit type for coverage information, i.e. Office Visit, DME, Outpatient Surgery, Inpatient Hospitalization etc.		Not Covered
Routine Vision Reimbursement Plan through UNITE HERE HEALTH *Service: Eye exam & Eye Wear* Dollar limit doesn't apply to exams for persons under age 19. Covered Services: Vision exams, contact lenses, Single vision, bi-focal, or tri-focal lenses, Frames. Not covered Services: Non-glare coating, warranty & any other convenience items.	$200 max benefit every 24 months, per eligible person	$200 max benefit every 24 months, per eligible person
Hearing Aids *Service: Eye exam & Eye Wear* Plan Exclusion	Not covered	Not covered
Infertility *Service: Treatment of Infertility* Plan Exclusion	Not covered	Not covered

Prior Authorization

Medical Management Review is a mandatory program requiring prior authorization and review of certain treatments and procedures. Call Nevada Health Solutions toll free at **(855) 487-0353** for the following medical and surgical utilization review services: inpatient pre-admission prior authorizations, emergency admission review, prior authorization of certain outpatient medical procedures and treatments, as well as retrospective review when prior authorization or authorization is not obtained as required.

For Prior Authorization, please contact NEVADA HEALTH SOLUTIONS (NHS)

Phone: **(855) 487- 0353** toll free
Fax: **(866) 201-5601**
www.nevadahealthsolutions.org

You must call NHS to prior authorize benefits before receiving any of the services listed below. **If you do not call as required, a $150 penalty may apply**, or services may be denied if they are not considered medically necessary.

This table is only a general guideline to prior authorization requirements. This list may be updated from time to time. The presence or absence of a procedure code and/or service on this list does not determine benefits or coverage for your patient.

- All inpatient admissions (other than for treatment of mental health/substance abuse).
- All non-maternity inpatient admissions require prior authorization - including admission to a skilled nursing facility.
- For all non-emergency confinements, any time prior to admission.
- For all emergency or urgent care confinements, the first business day following admission.
- For maternity hospitalizations, benefits must be prior authorized for any lengths of stay exceeding:
    - 48 hours for the normal delivery of a newborn child; or
    - 96 hours for the delivery of a newborn child by caesarean section
- All admissions to skilled nursing, acute rehabilitation, and long-term acute care facilities.

Notification only:

Inpatient Mental Health/Substance Abuse requires advance notification instead of prior authorization. Services/supplies will not be denied and no penalty will be applied if Nevada Health Solutions is not notified in advanced.

Observation

Authorization required only if patient is admitted following observation.

Prior authorization is required for the following, regardless of place of service:

- Air ambulance transportation
- Clinical trials
- Dialysis
- Durable medical equipment if the cost is more than $500 (whether rented or purchased)
- Genetic testing
- Habilitative therapy for children with Autism Spectrum Disorder (ASD)
- Hematology and oncology services
- Home Health and Home Infusion services - Skilled services provided in a home setting, (the plan excludes general housekeeping services or custodial care)
- Hyperbaric treatment
- Medical foods for inborn errors of metabolism
- Orthotics and prosthetic appliances that cost more than $500
- Physical therapy, speech therapy, massage therapy and occupational therapy
- Radiology services: CT/CTA, MRI/MRA, PET, and discography
- Sleep studies
- Surgery or invasive diagnostic procedures performed in surgery area (except colonoscopies and sigmoidoscopies)
- Temporomandibular joint (TMJ) procedures or orthographic surgery
- Transplant services (including consultations)
- Varicose vein procedures