175 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.

Claims time filing limit: 18 months from date of service

Medical claims should be submitted to your local BCBS or mailed to:

Blue Cross Blue Shield of California
PO Box 60007
Los Angeles, CA 90060

W-9's and only **medical records** should be submitted to: claims@uhh.org; Fax No. 630-236-4394; or mail to UHH, PO Box 6020, Aurora, IL 60504.

Disclaimers:

Newborn dependents are not covered automatically; members must complete a special enrollment within the first 60 days of birth to be covered for any medical expenses from birth date. If there is no enrollment received, any/all charges will be denied as dependent not eligible.

Alternative medicine is considered an exclusion and not covered under the plan- this includes holistic /natural medicine.

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

See chart below for detailed benefits.

	BLUE CROSS OF CALIFORNIA	OUT OF NETWORK
OFFICE VISITS BENEFIT		
Preventive Care *Service: Routine Physical & Immunizations* Plan covers in-network routine care, including screenings, checkups, and counseling, immunizations, as required by 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
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. Newborn dependents are not covered automatically; members must complete a special enrollment within the first 60 days of birth to be covered for any medical expenses from birth date. If there is no enrollment received, any/all charges will be denied as dependent not eligible.	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 including 3D Mammograms; no prior authorization is required.* One routine screening each calendar year for all women age 35 and older. One screening each calendar year for women under age 35 who are at high risk of breast cancer.		

	BLUE CROSS OF CALIFORNIA	OUT OF NETWORK
	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 increased risk of fractures.		
	100%, no deductible, no copay	Not Covered
Cervical Cancer Screening *Service: Pap Smear* Cervical cancer screening and HPV screening will be covered once per calendar year.		
	100%, no deductible, no copay	Not Covered
Routine Colonoscopies Adults ages 45 to 75 *Service: Routine Colonoscopy including Cologuard.* 1 every 10 years for average risk of colon cancer. 1 every 2 years with diagnosis of high risk due to immediate family history. Cologuard screening test is covered under preventive screening once every 3 years. No prior authorization required.		
	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 Effective April 1, 2025- 100%, $10 copay, no deductible	50% of allowed, subject to deductible
Santa Lucia Medical Group (PCP Office Visit) Santa Lucia Medical Group (Primary care and labs), located at 1336 Natividad Rd., Slainas, CA 93906.		
	Effective April 1, 2025- 100%, no deductible, no copay	Not Covered

	BLUE CROSS OF CALIFORNIA	OUT OF NETWORK
Specialist Care Office Visits Including all care provided during the office visit. Excluding chiropractic or podiatric services.	100%, $25 copay, no deductible Effective April 1, 2025- 100%, $40 copay, no deductible	50% of allowed, subject to deductible
Pacific Cancer Center For the diagnosis, treatment, and surveillance of cancer. Pacific Cancer Center is located at 5 Harris Ct. Building T, Suite 201, Monterey, CA 93940.	Effective April 1, 2025- 100%, no copay, no deductible.	Not Covered
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
Podiatric Orthotics Must be custom made and medically necessary. Orthotics costing $500 or more require prior authorization. Prior Authorization required through HealthCheck360 (HC360) toll free **(844) 462-7812**.	80%, subject to deductible	50% of allowed, subject to deductible
Routine Podiatry Treatment of corns & calluses (cutting and removing) , Trimming, cutting, clipping, or debriding of nails, Athlete's foot (Tinea Pedis) & Dermatophytosis.		

	BLUE CROSS OF CALIFORNIA	OUT OF NETWORK
	Not Covered	Not Covered
Non-Routine Podiatry		
	80%, subject to deductible	50% of allowed, subject to deductible
Diabetes Education 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
EMERGENCY & URGENT CARE BENEFIT		
Urgent Care Clinic		
	100%, $25 copay, no deductible Effective April 1, 2025- 100%, $35 copay, no deductible	50% of allowed, subject to deductible

	BLUE CROSS OF CALIFORNIA	OUT OF NETWORK
Emergency Room Services *Service: True Emergency Care* True emergency is defined as care to prevent serious and permanent physical impairment or death.	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
Hospitalization *Service: Hospitalization through Emergency admission* Prior authorization required. HealthCheck360 (HC360) toll free **(844) 462-7812**. Applies to all inpatient services, including physician/surgeon fees. Call HealthCheck360 the first business day following admission 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		

	BLUE CROSS OF CALIFORNIA	OUT OF NETWORK
Hospitalization *Service: Inpatient Hospitalization* Prior authorization required. HealthCheck360 (HC360) toll free **(844) 462-7812**. 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* Prior authorization required. HealthCheck360 (HC360) toll free **(844) 462-7812**. 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.	80%, subject to deductible	50% of allowed, subject to deductible
MENTAL HEALTH & SUBSTANCE ABUSE		
Office Visits *Service: Office Visit, including medical management visits* Prior authorization required. HealthCheck360 (HC360) toll free **(844) 462-7812**. Prior authorization is required for Electroconvulsive Therapy (ECT) and Transcranial Magnetic Stimulation (TMS).	100%, $25 copay Effective April 1, 2025- 100%, $10 copay	50% of allowed, subject to deductible
Hospitalization *Service: Inpatient Hospitalization* Prior authorization required. HealthCheck360 (HC360) toll free **(844) 462-7812**. Inpatient treatment includes residential care (i.e. confinement less restrictive than hospitalization, but which provides 24-hour supervision & monitoring by the nursing staff & intensive psychiatric interventions more frequently than once each day).		

	BLUE CROSS OF CALIFORNIA	OUT OF NETWORK
	80%, subject to deductible	50% of allowed, subject to deductible
Outpatient Partial Hospitalization, Intensive Outpatient & Ambulatory Detoxification *Service: Outpatient Treatment* Prior authorization required. HealthCheck360 (HC360) toll free **(844) 462-7812**.		
	80%, subject to deductible	50% of allowed, subject to deductible
LABORATORY & IMAGING SERVICES BENEFIT		
Laboratory Services *Service: Laboratory Services* Drug screening tests (including tuberculosis / TB tests) required for employment are not a covered benefit.		
	80%, subject to deductible	50% of allowed, subject to deductible
Laboratory Services *Service: Quest Diagnostics - Laboratory Services* Drug screening tests (including tuberculosis / TB tests) required for employment are not a covered benefit.		
	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

	BLUE CROSS OF CALIFORNIA	OUT OF NETWORK
Radiation Therapy 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* Prior authorization required. HealthCheck360 (HC360) toll free **(844) 462-7812**.	80%, subject to deductible	50% of allowed, subject to deductible
Sleep Study *Service: Sleep Study* Prior authorization required. HealthCheck360 (HC360) toll free **(844) 462-7812.**	80%, subject to deductible	50% of allowed, subject to deductible
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. Bariatric Surgery (Surgical treatment of morbid obesity including but not limited to Bariatric Procedures, Gastroplasty, Gastric Bypass, Banding Procedures.) 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

	BLUE CROSS OF CALIFORNIA	OUT OF NETWORK
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.) Reversal of voluntary sterilization is not covered.	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 (After 12th visit prior authorization required.) *Service: Physical, Speech, Occupational Therapy, Massage Therapy* Prior authorization required. HealthCheck360 (HC360) toll free **(844) 462-7812.** Limited to 60 visits/per/year, no more than 30 of these visits can be non-network. Physical Therapy: Hot & cold pack not covered. Office visits are not covered when performed with Physical Therapy/Occupational Therapy services.	80%, subject to deductible	50% of allowed, subject to deductible
Hematology and Oncology Services *Service: Infusion Medication, Chemotherapy, Kidney Dialysis* Chemotherapy Treatment and Chemotherapy Medication requires Prior Authorization. HealthCheck360 (HC360) toll free **(844) 462-7812**.	80%, subject to deductible	50% of allowed, subject to deductible

	BLUE CROSS OF CALIFORNIA	OUT OF NETWORK
ABA Therapy *Service: Habilitative therapy for children with Autism Spectrum Disorder (ASD)* Prior authorization required: HC360 **(844)462-7812**. 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

	BLUE CROSS OF CALIFORNIA	OUT OF NETWORK
OTHER CARE & MEDICAL EXPENSES		
Home Health Care Maximum 60 days per calendar year – combined In and Out of Network. Including infusion therapy but excluding general housekeeping services or custodial care. Prior authorization is required beginning with the first visit. HealthCheck360 (HC360) toll free **(844) 462-7812**.	80%, subject to deductible	50% of allowed, subject to deductible
Hospice Care *Service: Hospice Care* Services and supplies authorized by a doctor for a person whose life expectancy is 6 months or less. Prior authorization required. HealthCheck360 (HC360) toll free **(844) 462-7812**.	100%, no deductible, no copay	50% of allowed, subject to deductible
Breast Pump & Supplies Limit of one breast pump per pregnancy. Non-hospital breast pumps & supplies are payable at 100%. Breast pumps can be purchased from a network provider or out-of-network provider, or retailers such as Target. Hospital grade breast pumps & supplies are considered DME and are covered under the applicable benefits for DME. If costing $500 or more require prior authorization through (HC360) toll free **(844) 462-7812**.	100%, no deductible, no copay	100%, no deductible, no copay

	BLUE CROSS OF CALIFORNIA	OUT OF NETWORK
Durable Medical Equipment – DME *Service: DME* $500 & over prior authorization required. HealthCheck360 (HC360) toll free **(844) 462-7812**. 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
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 HealthCheck360 (HC360) toll free **(844) 462-7812.** 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.	80%, subject to deductible.	50% of allowed, subject to deductible
Vision *Service: Davis Vision* (800) 999-5431 • davisvision.com		
Hearing Aids Effective 1/1/2023	Plan pays $3,000/3 calendar years	Plan pays $3,000/3 calendar years

	BLUE CROSS OF CALIFORNIA	OUT OF NETWORK
Infertility *Service: Treatment of Infertility* Plan Exclusion The initial exam and any procedures used to arrive at the diagnosis of infertility is an allowable expense. Once a determination of infertility is established, any services for or in connection with treatment for infertility is excluded.	Not covered	Not covered

Pharmacy

Mail order prescription drug service is only available through WellDyneRx: (844) 813-3860; specialty drugs must be obtained through WellDyne Specialty Pharmacy: (800) 373-1879, https://welldynespecialty.com. Visit Hospitality Rx for more detailed information.

Prior Authorization List for Plan 175

Medical Management Review is a mandatory program requiring prior authorization and review of certain treatments and procedures. UNITE HERE HEALTH has contracted with HealthCheck360 (HC360) to provide 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.

To certify medical and surgical treatment, call HealthCheck360 (HC360) toll free at **(844) 462-7812**.

Provider must call HC360 to prior authorize benefits before receiving any of the services listed below. 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 All non-maternity inpatient admissions require prior authorization.
- 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.

Observation

Authorization required only if patient is admitted following observation.

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

Visit Prior Authorization Rules for up-to-date list or review below:

- Air Ambulance
- Bariatric Surgery (Including but not limited to gastric bypass and banding procedures)
- Blepharoplasty
- Chemotherapy
- Clinical trials
- Diagnostic imaging services as follows: CT, CTA, CAT, MRA, MRI, PET scan
- Dialysis- notification only
- Durable medical equipment if the cost is more than $500 (whether rented or purchased, including breast pumps costing over $500)
- Electroconvulsive therapy (ECT)
- Gender reassignment surgical services & certain hormone therapy
- Genetic testing
- Gynecomastia surgery
- Habilitative therapy for children with Autism Spectrum Disorder (ASD)
- Hospice services
- Hysterectomy
- Select injectable, infused, ingested, or inhaled medications administered by your provider in an outpatient setting.
- Joint replacements, including but not limited to hip and knee replacements
- Laminectomy
- Le Fort osteotomy
- Lipectomy and panniculectomy
- Mammoplasty (breast reduction)
- Home Health and Home Infusion services - Skilled services provided in a home setting, (the plan excludes general housekeeping services or custodial care)
- Hyperbaric oxygen therapy treatment

- Medical foods for inborn errors of metabolism
- Orthognathic surgery
- Orthotics and prosthetics (including podiatric orthotics) over $500
- Partial hospitalization & intensive outpatient programs
- Physical, occupational, and speech therapy after the first 12 visits
- Radiation therapy
- Reconstructive surgery
- Sinus surgery (including but not limited to rhinoplasty, and/or septoplasty, and submucous resection)
- Skilled services provided in a home setting, including home healthcare, home therapy (PT, OT, ST) and home infusion
- Sleep studies
- Temporomandibular joint (TMJ) procedures -
- Transcranial magnetic stimulation (TMS)
- Transplant services
- Travel and lodging
- Varicose vein procedures (including vein sclerotherapy)

This list changes from time to time. Call HealthCheck360 (HC360) toll free at **(844) 462-7812** for up-to-date information.

Last update 03/18/2025