178 Los Angeles PPO 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.

Network Out-of-Pocket Maximums *(Applicable for certain services as listed below)*
Individual: $300
Family: $600

Out-of-Pocket Limits
Basic: Applies to co-insurance for certain covered expenses $700 in Network only.
Safety: 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, including prescription drugs.

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% $0 copay	50%
FDA-approved Contraceptives *Service: Preventive Care* Covered for women under age 55 (may cover with cost sharing for older women when medically necessary). Quantity limits apply to both over-the-counter & prescription contraceptives. 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% $0 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% $0 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.	90% subject to deductible	50% subject to deductible

	Blue Cross of California	Out of Network
Osteoporosis Screening - Preventive *Service: Dexa Scan/Bone Density test* Women 65 and over or 60 and over if at increased risk of fractures.	100% $0 copay	50%
Cervical Cancer Screening *Service: Pap Smear* Cervical cancer screening and HPV screening will be covered once per calendar year.	100% $0 copay	50%
Routine Colonoscopies Adults ages 45 to 75 - Preventive *Service: Routine Colonoscopy including Cologuard.* 1 every 10 years for average risk. 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% $0 copay	50%
PCP and Specialty Care *Service: Office Visits* Including all care provided during the office visit. Excluding chiropractic or podiatric services.	90% subject to deductible	50% subject to deductible
Acupuncture Services must be within the scope of the provider's license. Coverage limited to $50 per visit. 40 visits per year (combined in and out of network)	80% subject to deductible	50% subject to deductible
Allergy Shots	90% subject to deductible	50% subject to deductible

	Blue Cross of California	Out of Network
Chiropractic 40 visits per year (combined in and out of network) Hot/cold packs, self-care/home management training and supplies/materials are not covered.	90% subject to deductible	50% 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	80% subject to deductible
Routine Podiatry Treatment of corns, calluses, nails conditions, & dermatological conditions.	Not Covered	Not Covered
Non-Routine Podiatry	90% subject to deductible	50% 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% $0 copay	Not Covered
Nutritional Counseling $200 maximum benefit/per calendar year.	100% $0 copay	Not Covered

	Blue Cross of California	Out of Network
Emergency & Urgent Care Benefit		
Urgent Care Clinic		
	90% subject to deductible	50% subject to deductible
Emergency Room Services *Service: True Emergency Care* Emergency care defined as care to prevent serious and permanent physical impairment or death. Copay waived if admitted.		
	100%, $100 copay	100%, $100 copay
Emergency Room Services *Service: Non Emergency Care*		
	50%, $100 copay, subject to deductible	50%, $100 copay, 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%, subject to deductible
Hospitalization *Service: Hospitalization through Emergency admission* Applies to all inpatient services, including physician/surgeon fees. Call HealthCheck360 (HC360) the first business day following admission: (844) 462-7812.		
	90%, subject to deductible	90%, subject to deductible

	Blue Cross of California	Out of Network
Inpatient Hospitalization		
Hospitalization *Service: Inpatient Hospitalization* Prior authorization required. HealthCheck360 (HC360) toll free (844) 462-7812. 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. 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. Maternal complications are covered for employees and spouses only.	90% subject to deductible	50% 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 per calendar year, combined network/non-network.	100% $0 copay	50% subject to deductible
Mental Health & Substance Abuse		
Office Visits *Service: Office Visit. Including medical management visits*	90% subject to deductible	50% 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).	90% subject to deductible	50% subject to deductible

	Blue Cross of California	Out of Network
Outpatient Partial Hospitalization, Intensive Outpatient & Ambulatory Detoxification *Service: Outpatient Treatment*	90% subject to deductible	50% subject to deductible
Lab & Imaging Services Benefit		
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.	90% subject to deductible	50% subject to deductible
Laboratory Services *Service: Laboratory Services*	90% subject to deductible	50% 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.	90% subject to deductible	50% subject to deductible
Sleep Study *Service: Sleep Study* Prior authorization required. HealthCheck360 (HC360) toll free (844) 462-7812.	90% subject to deductible	50% subject to deductible

	Blue Cross of California	Out of Network
Outpatient Service 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. Allowable charges will be determined according to the doctor's network or non-network status.	90% subject to deductible	50% 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 spouse (not for dependent male children) the applicable benefit applies in and out of network (see Office, Surgery, Outpatient Surgery etc.) Reversal of voluntary sterilization is not covered.	100% $0 copay	50% subject to deductible
Other Hospital Outpatient Services Refer to prior authorization list. 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. Allowable charges will be determined according to the doctor's network or non-network status. Sterilization procedures for females - only the procedure is covered at 100% with a network provider - facility charges are subject to any applicable deductibles and coinsurance.	90% subject to deductible	50% subject to deductible
Therapies *Service: Physical, Speech, Occupational Therapy.* Prior authorization required. HealthCheck360 (HC360) toll free (844) 462-7812. Limited to 60 visits/person/year. The 60 visits are combined with in-network / non-network. Physical Therapy: Hot & cold pack not covered. Office visits are not covered when performed with Physical Therapy/Occupational Therapy services. Benefits are the same for non-hospital (office setting), and hospital setting.	90% subject to deductible	50% subject to deductible

	Blue Cross of California	Out of Network
Infusion, Chemotherapy, Kidney Dialysis *Service: Infusion Medication, Chemotherapy, Kidney Dialysis* Prior authorization required. HealthCheck360 (HC360) toll free (844) 462-7812.	90% subject to deductible	50% subject to deductible
ABA Therapy *Service: Habilitative therapy for children with Autism Spectrum Disorder (ASD)* Prior authorization required. HealthCheck360 (HC360) toll free (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	50% subject to deductible
Other Care & Medical Expenses		
Home Health Care Prior authorization required. HealthCheck360 (HC360) toll free (844) 462-7812. Maximum 60 days per calendar including infusion therapy, combined In and Out of Network.	100% $0 copay	50% subject to deductible
Hospice Care *Service: Hospice Care* Prior authorization required. HealthCheck360 (HC360) toll free (844) 462-7812. Services & supplies authorized by a doctor for a person whose life expectancy is 6 months or less. 60 days/year combined in and out of network.	100% $0 copay	100% $0 copay

	Blue Cross of California	Out of Network
Breast Pump & Supplies – Preventive Benefit is per pregnancy. Limit of one breast pump 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: HealthCheck360 (HC360) (844) 462-7812. Hospital grade breast pumps are considered DME & are covered under the applicable benefits for DME. If costing $500 or more require prior authorization .	100% $0 copay	100% $0 copay
Durable Medical Equipment - DME *Service: DME* $500 & over prior authorization required. HealthCheck360 (HC360) toll free (844) 462-7812	80% subject to deductible	80% subject to deductible
Artificial Limbs & Organ Transplants *Service: Transplants covered by Medicare including but not limited to intestine, stem cell, cornea, heart, lung, kidney, intestine liver, or pancreas.* 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. Prosthetics more than $500 require prior authorization. Must be pre-approved in writing by the Fund.	90% subject to deductible	50% subject to deductible
Vision *Service: Eye exam & Eye Wear* Plan Exclusion.	Not covered	Not covered
Hearing Aids Plan Exclusion.	Not covered	Not covered

	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
Clinical Trials Covered if: ancillary to trial involvement & a covered expense if the patients weren't involved in the trial; aren't for any device, item, service, or drug studied as part of the trial, or done solely for data collection & analysis purposes instead of for clinical management of patient; Aren't directly supplied, provided, or dispensed by the provider of the clinical trial; satisfy protocols prescribed by the clinical provider, not inconsistent w widely accepted & established standards of care for a patient's diagnosis; Aren't provided by a non-par provider if par provider is willing to accept the patient to the trial; & the patient provides the plan with medical & scientific information establishing medical necessity. Requires prior authorization.	Varies	Covered if no network clinical trial. Cover routine costs associated with the non-network clinical trial.

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 178

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.

For Prior Authorization, please contact HealthCheck360 (HC360)

Phone: **(844) 462-7812** toll free

You 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.

<u>Notification only:</u>
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 HealthCheck360 (HC360) is not notified in advanced.

(See next page for more info)

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 transportation
- Clinical trials
- Dialysis
- Durable medical equipment items over $500 (whether rented or purchased)
- All 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 over $500
- Physical therapy, speech therapy, and occupational therapies
- Radiology services: CT/CTA, MRI/MRA, PET scans, and discography
- Sleep studies
- All Surgery or invasive diagnostic procedures performed in surgery area (except colonoscopies and sigmoidoscopies)
- Temporomandibular joint (TMJ) procedures or orthognathic surgery
- All Transplant services (including consultations)
- Travel and lodging expenses
- Varicose vein procedures

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

Last update 07/19/2024