

# Los Angeles Provider PPO 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.

**Medical Claims time filing limit:** 18 months from date of service

**Medical claims Mailing Address:** Blue Cross of California: 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
<b>Office Visits Benefit</b>		
<b>Preventive Care</b>		
<p><i>Service: Routine Physical &amp; Immunizations</i></p> <p>Plan covers routine care, including screenings, checkups, and counseling, as required by the ACA. Certain age and frequency limits may apply.</p>		
	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 charge for in-network preventive prenatal care. No coverage for pregnancy of a dependent child other than for preventive prenatal care. No benefits for maternal complications for dependent children.

100% \$0 copay

50% (preventive)

**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

**Osteoporosis Screening - Preventive***Service: DEXA Scan/Bone Density test*

Women 65 and over or 60 and over if at increase risk of fractures.

100% \$0 copay

50%

**Cervical Cancer Screening - Preventive***Service: Pap Smear*

1 every 3 years for women ages 21-65. 1 every 5 years if performed in conjunction with HPV testing.

100% \$0 copay

50%

	Blue Cross of California	Out of Network
<p><b>Routine Colonoscopies Adults ages 50 to 75 - Preventive</b></p> <p><i>Service: Routine Colonoscopy</i>  1 every 10 years for average risk. 1 every 2 years with diagnosis of high risk due to immediate family history.</p>	100% \$0 copay	50%
<p><b>PCP and Specialty Care</b></p> <p><i>Service: Office Visits</i>  Including all care provided during the office visit. Excluding chiropractic or podiatric services.</p>	90% subject to deductible	50% subject to deductible
<p><b>Acupuncture</b></p> <p>Coverage limited to \$50 per visit. 40 visits per year (combined in and out of network)</p>	80% subject to deductible	50% subject to deductible
<p><b>Allergy Shots</b></p>	90% subject to deductible	50% subject to deductible
<p><b>Chiropractic</b></p> <p>40 visits per year (combined in and out of network)</p>	90% subject to deductible	50% subject to deductible
<p><b>Podiatric Orthotics</b></p> <p>Orthotics over \$500 require prior authorization through NHS at <b>(855) 487-0353</b>.</p>	80% subject to deductible	80% subject to deductible

	Blue Cross of California	Out of Network
<b>Routine Podiatry</b> Treatment of corns, calluses, nails conditions, & dermatological conditions.	Not Covered	Not Covered
<b>Non-Routine Podiatry</b>	90% subject to deductible	50% subject to deductible
<b>Diabetes Education</b> 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
<b>Nutritional Counseling</b> \$200 maximum benefit/per calendar year.	100% \$0 copay	Not Covered
<b>Emergency &amp; Urgent Care Benefit</b>		
<b>Urgent Care Clinic</b>	90% subject to deductible	50% subject to deductible
<b>Emergency Room Services</b> <i>Service: True Emergency Care</i> Copay waived if admitted.	100%, \$100 copay	100%, \$100 copay

	Blue Cross of California	Out of Network
<p><b>Emergency Room Services</b></p> <p><i>Service: Non Emergency Care</i></p>	50%, \$100 copay, subject to deductible	50%, \$100 copay, subject to deductible
<p><b>Ambulance Services</b></p> <p><i>Service: Ambulance</i></p> <p>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.</p>	80%, subject to deductible	80%, subject to deductible
<p><b>Hospitalization</b></p> <p><i>Service: Hospitalization through Emergency admission</i></p> <p>Applies to all inpatient services, including physician/surgeon fees. Call NHS the first business day following admission: <b>(855)487-0353</b>.</p>	90%, subject to deductible	90%, subject to deductible
<b>Inpatient Hospitalization</b>		
<p><b>Hospitalization</b></p> <p><i>Service: Inpatient Hospitalization</i></p> <p>Prior authorization required through NHS at <b>(855) 487-0353</b>. 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.</p>	90% subject to deductible	50% subject to deductible

	Blue Cross of California	Out of Network
<b>Skilled Nursing Facility Care</b> <i>Service: Skilled Nursing Facility Care</i> Prior authorization required though NHS at <b>(855) 487-0353</b> . 60 days maximum per person per calendar year, combined network/non-network. Benefits may be reduced by \$150 or denied if prior authorization program is not followed.		
	100% \$0 copay	50% subject to deductible
<b>Mental Health &amp; Substance Abuse</b>		
<b>Office Visits</b> <i>Service: Office Visit. Including medical management visits</i>		
	90% subject to deductible	50% subject to deductible
<b>Hospitalization</b> <i>Service: Inpatient Hospitalization</i> Notification Required though NHS <b>(855) 487-0353</b> .		
	90% subject to deductible	50% subject to deductible
<b>Outpatient Partial Hospitalization, Intensive Outpatient &amp; Ambulatory Detoxification</b> <i>Service: Outpatient Treatment</i>		
	90% subject to deductible	50% subject to deductible
<b>Lab &amp; Imaging Services Benefit</b>		
<b>Radiology</b> <i>Service: Including but not limited to: Diagnostic Mammogram, X-rays, Ultrasound Echocardiogram &amp; Fetal monitoring</i> Refer to prior authorization list for radiology services that require prior authorization.		
	90% subject to deductible	50% subject to deductible

	Blue Cross of California	Out of Network
<p><b>Laboratory Services</b>  <i>Service: Laboratory Services</i></p>	90% subject to deductible	50% subject to deductible
<p><b>Diagnostic Imaging and Cardiac Testing</b>  <i>Service: CT/CTA/CTA, MRI/MRA, PET Scan, Cardiac Testing</i>  Refer to prior authorization list for services that require prior authorization.</p>	90% subject to deductible	50% subject to deductible
<p><b>Sleep Study</b>  <i>Service: Sleep Study</i>  Prior authorization required. Nevada Health Solutions: <b>(855) 487-0353</b>.</p>	90% subject to deductible	50% subject to deductible
<b>Outpatient Service Benefit</b>		
<p><b>Outpatient Surgery</b>  <i>Service: Not limited to but including: Upper GI Endoscopy (EDG), Diagnostic Colonoscopy, Varicose Veins, Elective abortion, Vasectomy.</i>  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.</p>	90% subject to deductible	50% subject to deductible
<p><b>Sterilization</b>  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.</p>	90% subject to deductible	50% subject to deductible

**Blue Cross of California**

**Out of Network**

**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 co insurance.

90% subject to deductible

50% subject to deductible

**Therapies**

*Service: Physical, Speech, Occupational Therapy.*

Prior authorization required. NHS (855) 487-0353. Limited to 60 visits/person/year.

90% subject to deductible

50% subject to deductible

**Infusion, Chemotherapy, Kidney Dialysis**

*Service: Infusion Medication, Chemotherapy, Kidney Dialysis*

Prior authorization required. NHS (855) 487-0353.

90% subject to deductible

50% 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

50% subject to deductible



## Other Care &amp; Medical Expenses

**Home Health Care**

Prior authorization required. NHS (855) 487-0353 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. NHS (855) 487-0353. 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

**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: NHS (855) 487-0353. Hospital grade breast pumps are considered DME & are covered under the applicable benefits for DME. If costing \$500 or more require prior authorization through NHS: (855) 487-0353.

100% \$0 copay

100% \$0 copay

**Durable Medical Equipment - DME**

*Service: DME*

\$500 & over prior authorization required. Nevada Health Solutions (855) 487-0353.

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.*

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. Prosthetics more than \$500 require prior authorization. Must be pre-approved in writing by the Fund.

90% subject to deductible

50% subject to deductible

	Blue Cross of California	Out of Network
<b>Vision</b> <i>Service: Eye exam &amp; Eye Wear</i> Plan Exclusion.	Not covered	Not covered
<b>Hearing Aids</b> Plan Exclusion.	Not covered	Not covered
<b>Infertility</b> <i>Service: Treatment of Infertility</i> Plan Exclusion.	Not covered	Not covered
<b>Clinical Trials</b> 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.

## 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](http://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

### 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.

*(See next page for more info)*

**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, 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 orthognathic surgery
- Transplant services (including consultations)
- Travel and lodging expenses
- Varicose vein procedures