Provider Benefits Fact Sheet

HOSPITALITY PLAN
UNITE HERE HEALTH

Silver Plus Plan (Plan Unit 185)

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.*

When to call for 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.

A list of items subject to prior authorization is on pages 9-10.

For Prior Authorization, please contact:

Nevada Health Solutions

Phone: **(855) 487- 0353 toll free**

Fax: **(866) 201-5601**

www.nevadahealthsolutions.org

Once a participant's cost sharing for network covered expenses reaches the out-of-pocket maximums listed below, the Plan pays 100% for most covered network expenses for the rest of the calendar year.

Deductible and Network Out-of-Pocket Maximums	
Calendar Year Deductible	$750 per person/$1,500 per family per calendar year
Medical Benefits Out-of-Pocket Maximum (Network)	$2,000 per person/$6,000 per family per calendar year
Prescription Drug Benefit Out-of-Pocket Maximum	$1,600 per person/$3,200 per family per calendar year
Medical Benefits Out-of-Pocket Maximum (Non-Network)	None

Preventive Services

Type of Care	Service or Location	What the Patient Pays (Network)	What the Patient Pays (Non-Network)	Other Information
Office/Clinic Visits (PCP)	Preventive healthcare services	No copay (no calendar year deductible)	Not covered	Plan covers in-network preventive care, including screenings, and counseling, as required by the ACA. Certain age and frequency limits may apply.
Cervical Cancer Screening	Preventive pap smear/HPV	No copay	Not covered	Preventive cervical cancer screening (pap smears) and HPV screenings will be covered annually at all ages.
Colonoscopies	Screening colonoscopy	No copay	Not covered	Screening colonoscopy - 1 every 10 years beginning at age 50 for persons of average risk
Contraceptives	Birth control	No copay	Not covered	Covered under woman's preventive care. FDA approved contraceptive methods are covered.
Mammogram	Preventive breast cancer mammography screenings	No copay	Not covered	One per calendar year for all women age 35 and older. One per calendar year for women under age 35 who are at high risk for breast cancer. Preventive screenings (other than diagnostic mammography) performed more frequently or for women under age 35 or over age 75 who are not at high risk will not be a covered expense. *Routine mammogram screenings are covered as preventive healthcare at 100%.
Prostate Specific Antigen	PSA	No copay	Not covered	Covered once every 12 months for men between the ages of 40-69.

Office Visits

Type of Care	Service or Location	What the Patient Pays (Network)	What the Patient Pays (Non-Network)	Other Information
Office Visit for a Primary Care Healthcare Professional	Non-preventive visit	$25 copay per visit (no calendar year deductible)	50% after calendar year deductible	Includes all services provided during the visit.
Office Visit for treatment of Mental Health/ Substance Abuse Disorders		$25 copay per visit (no calendar year deductible)	50% after calendar year deductible	Includes all services provided during the visit.
Specialist Care Office Visits		$50 copay per visit (no calendar year deductible)	50% after calendar year deductible	Includes all care provided during visit.

Telehealth Healthcare Professional	Telemedicine	$15 copay per visit (no calendar year deductible)	Not covered	Must be with the Fund-designated contracted provider, Teladoc.
Acupuncture		Not covered	Not covered	Plan exclusion.
Allergy Shot		No copay (no calendar year deductible)	50% after calendar year deductible	
Maternity Care		$25 copay per visit	50%	No coverage provided for pregnancy of a dependent child other than preventive prenatal care. Cost sharing does not apply to certain preventive services. Depending on the type of services, a copay or coinsurance may apply.
Chiropractic Services		$25 copay per visit (no calendar year deductible)	Not covered	Limited to 12 visits per person each calendar year.
Routine Podiatric Services		Not covered	Not covered	Plan exclusion.
Non-Routine Podiatric Services		$50 copay per visit (no calendar year deductible)	50% after calendar year deductible	
Sleep Study Performed in a Doctor's Office		30% after calendar year deductible	50% after calendar year deductible	**Prior authorization required. Call 855-487-0353.**

Urgent and Emergency Treatment

Type of Care	Service or Location	What the Patient Pays (Network)	What the Patient Pays (Non-Network)	Other Information
Urgent Care Center Visit		$50 copay per visit (no calendar year deductible)	50% after calendar year deductible	
Hospital Emergency Room (ER) Services	Emergency room	$200 copay (no calendar year deductible). Copay waived if admitted to the Hospital due to ER care.	$200 copay (no calendar year deductible) Copay waived if admitted to the Hospital due to ER care	Care and services that could be provided in a clinic, urgent care center or healthcare professional's office are not considered emergency.
Hospital Emergency Room Services for Routine Care	Emergency room	50% after calendar year deductible	Not covered	Routine care.

Ambulance	Professional ambulance transportation	30% after calendar year deductible	30% after calendar year deductible	Limited to 2 trips per year; Limitation applies to network and non-network services combined. **Prior authorization is required for air ambulance transports. Call 855-487-0353.**

Inpatient Treatment

Type of Care	Service or Location	What the Patient Pays (Network)	What the Patient Pays (Non-Network)	Other Information
Hospital Inpatient Department Services, Including Inpatient Professional Services	Hospitalization	30% after calendar year deductible	50% after calendar year deductible	Including inpatient professional services. Includes the treatment of Mental Health/Substance Abuse Disorders. Also applies to maternity/pregnancy delivery for employees and spouses, and all inpatient services. **Prior authorization required. Call 855-487-0353.** Prior authorization is not required for maternity admissions less than 2 days for vaginal deliveries and 4 days for cesarean sections, or for mental health/substance abuse services.
Skilled Nursing Facility Confinement		30% after calendar year deductible	50% after calendar year deductible	Limited to 30 days per person each calendar year for network and non-network care combined. **Prior authorization required. Call 855-487-0353.**

Laboratory and Imaging Services

Type of Care	Service or Location	What the Patient Pays (Network)	What the Patient Pays (Non-Network)	Other Information
Laboratory Services	Office or non-Hospital facility	$25 copay per visit (no calendar year deductible)	50% after calendar year deductible	No extra copay applies when part of an office visit. **Prior authorization required for genetic testing. Call 855-487-0353.**
	Hospital outpatient department	$100 copay per visit (no calendar year deductible		
Radiology	Office or non-Hospital facility	$25 copay per visit (no calendar year deductible)	50% after calendar year deductible	No extra copay applies when part of an office visit. Including x-ray, ultrasound, and fetal monitoring.
	Hospital outpatient department	$100 copay per visit (no calendar year deductible)		

Diagnostic Imaging	Office or non-hospital facility	$175 copay per visit (no calendar year deductible)	50% after calendar year deductible	Includes CT, MRI, PET, and Cardiac Testing. **Prior authorization required for CT, discography, MRA, MRI and PET. Call 855-487-0353.**
	Hospital outpatient department	$300 copay per visit (no calendar year deductible)		

Outpatient Services

Type of Care	Service or Location	What the Patient Pays (Network)	What the Patient Pays (Non-Network)	Other Information
Outpatient Surgery	Ambulatory surgical center	20% after calendar year deductible	50% after calendar year deductible	Physician/surgeon fees are included in the copay and coverage level for both in-network and out-of-network for surgery in an Ambulatory Surgical Center. **Prior authorization required for all outpatient surgery or procedures (except colonscopy/sigmoidscopy). Call 855-487-0353.**
	Hospital outpatient department	30% after calendar year deductible		
Physical, Speech, and Occupational Therapy	Office or non-hospital facility	$30 copay per visit (no calendar year deductible)	50% after calendar year deductible	Limited to 60 visits per Person for physical and occupational therapy combined each Calendar Year, and 30 visits per Person for speech therapy each Calendar Year. Maximum visit limits apply to Network and Non-Network care combined. **Prior authorization required. Call 855-487-0353.**
	Hospital outpatient department	$60 copay per visit (no calendar year deductible)		
Infusion Medication and Chemotherapy	Home	No copay (no calendar year deductible)	50% after calendar year deductible	**Prior authorization required. Call 855-487-0353.**
	Office or non-hospital infusion center	$25 copay per visit		
	Hospital outpatient department	30%, coinsurance per person limited to $250 per visit		
Kidney Dialysis	Home, office, or non-hospital dialysis center	No copay (no calendar year deductible)	50% after deductible	**Prior authorization required. Call 855-487-0353.**
	Hospital outpatient department	30% after calendar year deductible, maximum cost-sharing of $250 per visit		

Radiation Therapy		30% after calendar year deductible	50% after calendar year deductible	

Other Care

Type of Care	Service or Location	What the Patient Pays (Network)	What the Patient Pays (Non-Network)	Other Information
Podiatric Orthotics		No copay (no calendar year deductible)	Not covered	Limited to $500 per person every 24 months.
Diabetes Education		No copay (no calendar year deductible)	Not covered	For the care, monitoring, or treatment of diabetes & dietary needs.
Nutritional Counseling		No copay (no calendar year deductible)	Not covered	Limited to 4 visits per person each calendar year.
Partial Hospitalization, Intensive Outpatient, Ambulatory Detoxification, and Outpatient (non-office) Treatment for Mental Health/ Substance Abuse Disorder		No copay (no calendar year deductible)	50% after calendar year deductible	
Home Healthcare		No copay (no calendar year deductible)	50% after calendar year deductible	Limited to 30 visits per person each calendar year for network and non-Network care combined.
Hospice Care		No copay (no calendar year deductible)	50% after calendar year deductible	

Other Care (continued)

Type of Care	Service or Location	What the Patient Pays (Network)	What the Patient Pays (Non-Network)	Other Information
Durable Medical Equipment -DME		25% after calendar year deductible	Not covered	For all durable medical equipment including artificial limbs and organs. Covers rental up to the purchase price. If DME is bought, costs for repair or maintenance are also covered. **Prior authorization is required for rental or purchase of DME, orthotics and prosthetics exceeding $500. Call 855-487-0353.**

Non-Hospital-Grade Breast Pumps		No copay (no calendar year deductible)	No copay (no calendar year deductible	Limited to purchase of one per pregnancy. **Prior authorization required if cost exceeds $500.** **Call 855-484-0353.**
Habilitative Therapy for Children with Autism Spectrum Disorder		Not Covered	Not covered	Plan exclusion.
Medical Foods for Inborn Metabolic Errors		Reimbursement of 100% (no calendar year deductible)		**Prior authorization required.** **Call 855-487-0353.**
Travel and Lodging for Certain Serious Medical Conditions		Reimbursement of 100% up to $10,000 per Person per episode of care, including a per diem of up to $250 for lodging and meals (no calendar year deductible)		**Prior authorization required.** **Call 855-487-0353.**
Hearing Aids		Not covered	Not covered	Plan exclusion.
Sleep Study	Office, hospital outpatient department or non-hospital facility	30% after calendar year deductibe	50% after calendar year deductible	**Prior authorization required.** **Call 855-487-0353.**
All Other Covered Expenses		30% after calendar year deductible	50% after calendar year deductible	

Prescription Drug Benefits

Type of Care	What the Patient Pays (Network)	What the Patient Pays (Non-Network)
Preventive Healthcare Services and Supplies on the Formulary	No copay	Not covered
Formulary Generic Drugs	$5 copay per prescription fill or refill	Not covered
Formulary Brand Name Drugs	$30 copay per prescription fill or refill	Not covered
Diabetes Brand Oral Medication, Insulin and Supplies	$15 copay per prescription fill or refill	Not covered
Brand Name Drugs Not on the Formulary	Not covered, unless approved under the prior authorization program, then subject to applicable cost sharing based on tier	Not covered
Formulary Generic Specialty and Biosimilar Drugs	$5 copay per prescription fill or refill	Not covered

Formulary Brand Specialty and Biosimilar Drugs	25% coinsurance per prescription fill or refill	Not covered
Prescription Drugs and Supplies at a Participating Health Center	No copay	N/A

Dental DHMO

Type of Care	Service or Location	What the Patient Pays (Network)	What the Patient Pays (Non-Network)	Other Information
Dental	DeltaCare DHMO	Contact DeltaCare for additional info	Contact DeltaCare for additional info	Dental plan is administered by Delta Dental of Illinois, additional information can be found at www.deltadentalins.com/deltacare or by calling **800-422-4234**. Participants must choose a dentist with DeltaCare DHMO before receiving any dental care.

Dental PPO

(Administered by Delta Dental of Illinois, additional information can be found at deltadentalil.com or by calling 800-323-1743.)

Type of Care	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-network Dentist*
Calendar year Deductible	$50 single/ $150 family		
Dental Benefits Out-of-Pocket Maximum	$2,000 per person each calendar year (does not apply to exams for patients under age 19)		
Diagnostic & Preventive	100%	70%	70%
General Services	100%	70%	70%
Minor Restorative	80%	60%	60%
Endodontic Services	80%	60%	60%
Periodontic Services	80%	60%	60%
Oral Surgery	80%	60%	60%
Major Restorative	50%	40%	40%
Prosthodontic Services	50%	40%	40%
Prosthodontic Maintenance	80%	60%	60%
Orthodontic Care ($2,500 lifetime maximum for each person)	50%	50%	50%
Implants and Harmful Habit Appliances	50%	40%	40%

*For participants living in Louisiana, Mississippi and Texas, the Non-network benefit will be the same as the Network benefit.

VISION				
Type of Care	**Service or Location**	**What the Patient Pays (Network)**	**What the Patient Pays (Non-Network)**	**Other Information**
Vision	Vision Service Plan (VSP)	Contact VSP for Additional info.	Contact VSP for Additional info.	Participant may be enrolled in a Vision benefit. Participant should call the number on the back of their ID card to verify eligibility and benefit.

When to call for prior authorization

The patient or healthcare professional must contact
Nevada Health Solutions before any of the following:

- Air ambulance transportation
- Clinical trials
- Durable medical equipment rentals or purchases over $500 (whether rented or purchased). (This includes breast pumps costing over $500.)
- Genetic testing
- Hyperbaric treatment
- Inpatient admissions (except 2 day vaginal deliveries and 4 day cesarean sections), other than for treatment of mental health/substance abuse, admissions following observation or an emergency room visit, and admissions for skilled nursing facility care, acute rehabilitation care, and long-term acute facility care
- Medical foods for inborn errors of metabolism
- Oncology and hematology services
- Orthotic and prosthetic appliance rentals or purchases of over $500
- Orthognathic surgery
- Outpatient surgery or procedures performed in an ambulatory surgical center, and surgery or invasive diagnostic procedures performed in the outpatient hospital surgery area. However, colonoscopies or sigmoidoscopies do not require prior authorization
- Radiology services below:
  - CT or CTA scans (computed tomography or computed tomography angiography)
  - Discography
  - MRA or MRI (magnetic resonance imaging or magnetic resonance angiography
  - PET-Scan (positron emission tomography scintiscan)
- Skilled services provided in a home setting, including home healthcare and home infusion

Additional information on next page

When to call for prior authorization *(continued)*

- Sleep studies
- TMJ procedures
- Transplant services, including consultations
- Travel and lodging
- Varicose vein procedures

Additionally, prior authorization is required for the types of care listed below.

Nevada Health Solutions may reach out to the patient or the healthcare professional to make sure that this care is received at the most cost-effective location and is medically appropriate.

- Dialysis
- Physical, speech, or occupational therapy

Finally, the patient or healthcare professional is required to notify Nevada Health Solutions for the following types of care listed below. Again, Nevada Health Solutions may reach out to the patient or the healthcare professional to make sure that this care is received at the most cost-effective location and is medically appropriate.

- All inpatient and residential mental health/substance abuse treatment

The patient or healthcare professional should contact Nevada Health Solutions before any of the above types of services and supplies are given.

If a patient needs emergency care, the patient or healthcare professional should contact Nevada Health Solutions as soon as possible, but no later than the next business day, after the service or supply is received.

If a patient is hospitalized because they are having a baby, the patient or healthcare professional must call Nevada Health Solutions if the stay will be longer than 48 hours for normal childbirth, or 96 hours for a Cesarean section.

- › Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or a newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section.
- › However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).
- › In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).