FSP Platinum+ PPO Provider Benefits Fact Sheet

Network Out-of-Pocket Maximums

Once your cost sharing for network covered expenses reaches these limits, the Plan pays 100% for most of your covered network expenses for the rest of the year (see your SPD for expenses that don't count).

Calendar Year Medical Deductible: None

Out-of-Pocket Limit per Calendar year for Medical Benefits: In-Network $5,000 per person, $10,000 per family. (No out-of-pocket for out-of-network.)

Prescription Drug Benefits; Out-of-Pocket Limit per Calendar year: In-Network $1,600 per person, $3,200 per family. (No out-of-pocket for out-of-network.)

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.

	In-Network (covered %)	Out of Network
Office visits benefit		
Office visit for a primary care Healthcare Professional *(unless specified otherwise)* *Service: Non-preventive visit* Includes all services provided during the visit	100% after $10 copayment per visit	50%
Office/Clinic Visits (PCP) *Service: Preventive healthcare services* Plan covers in-network preventive care, including screenings, and counseling, as required by the ACA. Certain age and frequency limits may apply.	100%	Not Covered
Office visit for treatment of Mental Health/Substance Abuse Disorders Includes all services provided during the visit.	100% after $10 copayment per visit	50%

	In-Network (covered %)	Out of Network
Specialist Care Office Visits Includes all care provided during visit.	100% $20 copayment per visit	50%
Telehealth Healthcare Professional *Service: Telemedicine* Must be with the Fund-designated Contracted Provider, Doctor on Demand.	100% $10 copayment per visit	Not Applicable
Medical advice calls with the Fund-designated Contracted Provider *Service: Teleadvice (no medical care provided)* Must be with the Fund-designated Contracted Provider, Consejo Sano.	100%	Not Applicable
Allergy Shot	100% after $10 copayment per visit	50%
Maternity Care (PCP provided) *Service: Non-preventive* Generally 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 copayment or coinsurance may apply.	100% after $10 copayment per visit	50%

	In-Network (covered %)	Out of Network
Mammogram Preventive *Service: Preventive Breast Cancer Mammography Screenings* One every 12 months for women age 40-74. Screenings before age 40 and after age 74 will be covered only if the patient is diagnosed as high risk. Preventive screenings (other than diagnostic mammography) performed more frequently or for women under age 40 or over age 75 who are not at high risk will not be a covered expense. 3D Mammograms are covered under the preventive benefit, no prior authorization is required.	100%	Not Covered
Cervical Cancer Screening – Preventive *Service: Preventive Pap Smear/HPV* Covered for women between age 21 and age 65 who still have a cervix once every 36 months for pap smear testing alone and one every 60 months for screenings with a combination of pap smear and human papillomavirus (HPV) testing. Preventive cervical cancer screenings (other than diagnostic) performed more frequently or for women under 21 or over age 65 will not be a covered expense.	100%	Not Covered
Colonoscopies – Preventive *Service: Screening colonoscopy or sigmoidoscopy* Screening colonoscopy - 1 every 10 years beginning at age 50 for persons of average risk, or once every 2 years if diagnosed as high risk, such as diagnosed with a high risk of colon cancer due to own medical history or medical history of immediate family members. Cologuard screening test is covered under preventive screening, Prior Authorization is required.	100%	Not Covered

	In-Network (covered %)	Out of Network
Acupuncture Limited to 12 visits per person each calendar year.	100% after $10 copayment per visit	Not Covered
Chiropractic Services Limited to 24 visits per person each calendar year.	100% after $10 copayment per visit	Not Covered
Routine Podiatric Services Limited to 4 visits per year.	100% after $10 copayment per visit	Not Covered
Non-Routine Podiatric Office Visits Non-Routine podiatric office visit are considered a specialist visit.	100% after $20 copayment per visit	50%
Services provided at the UNITE HERE HEALTH health center	100% *(no Calendar Year deductible)*	Not Covered

	In-Network (covered %)	Out of Network
Urgent and emergency treatment		
Urgent Care Center Visit		
	100% $25 copayment per visit	50%
Hospital emergency room services *Services: Emergency Room*		
	100% after $100 copayment *(waived if admitted)*	100% after $100 copayment *(waived if admitted)*. In-network copays apply.
Hospital emergency room services for routine care *Services: Emergency Room* Care and services that could be provided in a clinic, urgent care center or Healthcare Professional's office are not considered Emergency.		
	50%	Not Covered
Ambulance *Services: Professional Ambulance Transportation* Prior authorization is required for air ambulance transports: **(855) 487-0353**.		
	100% after $50 copayment per trip *(waived if admitted)*	100% after $50 copayment per trip *(waived if admitted)*

	In-Network (covered %)	Out of Network
Inpatient treatment		
Hospital inpatient department services, including inpatient professional services *Services: Hospitalization* 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 is required **(855) 487-0353**. Prior authorization is not required for maternity admissions less than 2 days for vaginal deliveries and 4 days for cesarean sections. Prior notification is required for mental health/substance abuse services.	100% after $100 copayment per day; total copayment per Person limited to $200 per admission	50%
Skilled Nursing Facility Care Limited to 60 days per person each calendar year for Network and Non-Network care combined. Prior authorization is required: **(855) 487-0353**.	100% after $200 copayment per admission	50%
Laboratory and Imaging Services		
Laboratory Services *Services: Office or non-Hospital facility* Genetic testing requires prior authorization: **(855) 487-0353**.	100%	50%
Laboratory Services *Services: Hospital outpatient department* Genetic testing requires prior authorization: **(855) 487-0353**.	100% after $30 copayment per visit	50%

	In-Network (covered %)	Out of Network
Radiology *Services: Office or non-Hospital facility* Including x-ray, ultrasound, fetal monitoring.	100%	50%
Radiology *Services: Hospital outpatient department* Including x-ray, ultrasound, fetal monitoring.	100% after $30 copayment per visit	50%
Diagnostic Imaging *Services: Office or non-Hospital facility* Includes CT, MRI, PET, and Cardiac Testing. Prior authorization required for CT, discography, MRA, MRI and PET: **(855) 487-0353**.	100%	50%
Diagnostic Imaging *Services: Hospital outpatient department* Includes CT, MRI, PET, and Cardiac Testing. Prior authorization required for CT, discography, MRA, MRI and PET: **(855) 487-0353**.	100% after $50 copayment per visit	50%
OUTPATIENT SERVICES BENEFIT		
Outpatient Surgery *Services: Ambulatory surgical center* 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**.	100% after $25 copayment per visit	50%

	In-Network (covered %)	Out of Network
Outpatient Surgery *Services: Hospital outpatient department* 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**.	100% after $75 copayment per visit	50%
Physical, speech, and occupational therapy *Services: Office or non-Hospital facility* 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 notification should be obtained: (**855) 487-0353**.	100% after $10 copayment per visit	50%
Physical, speech, and occupational therapy *Services: Hospital outpatient department* 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 notification should be obtained: (**855) 487-0353**.	100% after $30 copayment per visit	50%
Infusion medication and chemotherapy *Services: Home* Prior authorization required: **(855) 487-0353**.	100%	50%
Infusion medication and chemotherapy *Services: Office or Non-Hospital Infusion Center* Prior authorization required: **(855) 487-0353**.	100% after $10 copayment per visit	50%

	In-Network (covered %)	Out of Network
Infusion medication and chemotherapy *Services: Hospital outpatient department* Prior authorization required: **(855) 487-0353**.	100% after $25 copayment per visit	50%
Kidney dialysis *Services: Home, Office, or Non-Hospital dialysis center* Prior authorization should be obtained: **(855) 487-0353**.	100%	Not Covered
Kidney dialysis *Services: Hospital outpatient department* Prior authorization should be obtained: **(855) 487-0353**.	100% after $25 copayment per visit	50%
Radiation Therapy Prior authorization is required: **(855) 487-0353**.	100%	50%
Other care		
Podiatric Orthotics Limited to $500 per Person every 24 months.	100%	Not Covered

	In-Network (covered %)	Out of Network
Diabetes Education For the care, monitoring, or treatment of diabetes & dietary needs.	100%	Not Covered
Nutritional Counseling Limited to 4 visits per Person each Calendar Year.	100%	Not Covered
Partial hospitalization, intensive outpatient, ambulatory detoxification, and outpatient (non-office) treatment for Mental Health/Substance Abuse Disorder	100% after $25 copayment per day; total copayment per Person limited to $200 per episode of care	50%
Home Health Care Limited to 60 visits per Person each Calendar Year for Network and Non-Network care combined. Prior authorization required **(855) 487-0353**.	100%	50%
Hospice Care Prior authorization is required for inpatient hospice care: **(855) 487-0353.**	100%	50%

	In-Network (covered %)	Out of Network
Durable Medical Equipment - DME 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: (855) 487-0353.**	100%	Not Covered
Non-hospital-grade breast pumps Limited to purchase of one per pregnancy. PA is required if cost exceeds $500: **(855) 484-0353.**	100%	100%
Habilitative therapy for children with Autism Spectrum Disorder Limited to 30 hours per week Prior authorization is required: **(855) 487-0353**.	100% after $10 copayment per day of treatment	50%
Medical foods for inborn metabolic errors Prior authorization is required: **(855) 487-0353**.	Reimbursement of 100%	
Travel and lodging for certain serious medical conditions Prior authorization is required: **(855) 487-0353**.	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	
All other Covered Expenses	100%	50%

	In-Network (covered %)	Out of Network
Hearing Aids Plan exclusion	Not Covered	Not Covered
Prostate Specific Antigen *Services: PSA* Covered once every 12 months for men between the ages of 40-69.	100%	Not Covered
Dental *Services: Cigna Dental DHMO* Dental plan is administered by Cigna, additional information can be found at www.cigna.com or by calling **(800) 244-6224**. Members must choose a dentist with Cigna before receiving any dental care.	Contact Cigna for additional info	Contact Cigna for additional info
Dental *Services: Cigna Dental PPO* The Dental PPO option only applies if you are enrolled in the dental PPO option. Dental plan is administered by Cigna, additional information can be found at www.cigna.com or by calling **(800) 244-6224**.	Contact Cigna for additional info	Contact Cigna for additional info
Vision Member may be enrolled in a Vision benefit. Member should call the number on the back of their ID card to verify eligibility and benefit.		
Contraceptives *Services: Birth Control* Covered under woman's preventative care. FDA approved contraceptive methods are covered.	100%	Not covered

	In-Network (covered %)	Out of Network
Prescription Drug Benefits		
Preventive Healthcare Services and supplies on the formulary		
	100%	Not covered
Formulary generic drugs		
	100% after $3 copayment per prescription fill or refill	Not covered
Formulary brand name drugs		
	100% after $20 copayment per prescription fill or refill	Not covered
Brand name drugs not on the formulary		
	Not covered, unless approved by the Fund or its designee, then subject to applicable cost sharing based on tier	Not covered
Formulary specialty brand and biosimilar drugs		
	75% until Person has paid $35 total coinsurance per prescription fill or refill, then 100%	Not covered
Prescription drugs and supplies at the UNITE HERE HEALTH Health Center		
	100%	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.

To certify medical and surgical treatment, call Medical Cost Management (MCM) toll free **(800) 367-9938**.

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

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

When to call for prior authorization

You or your healthcare provider should contact Nevada Health Solutions before any of the following:

- Air ambulance transportation.
- Clinical trials.
- The following radiology services:
    - 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).
- Durable medical equipment rentals or purchases over $500. (This includes breast pumps costing over $500.)
- Genetic testing.
- Skilled services provided in a home setting, including home healthcare and home infusion.
- Habilitative therapy for children with autism spectrum disorder.
- Hyperbaric treatment.
- Inpatient admissions, 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.
- Sleep studies.
- TMJ procedures.
- Transplant services, including consultations.
- Travel and lodging.
- Varicose vein procedures.

Additionally, you should also get prior authorization for the types of care listed in the next section. Nevada Health Solutions may reach out to you or your 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, you are required to notify Nevada Health Solutions for the following types of care listed below. Again, Nevada Health Solutions may reach out to you or your 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

You should contact Nevada Health Solutions before receiving any of the above types of services and supplies. If you need emergency care, you should contact Nevada Health Solutions as soon as possible, but no later than the next business day, after you get the service or supply. If you are hospitalized because you are having a baby, you must call Nevada Health Solutions if your 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).