FSP Silver+ 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: $1,500 per person; $3,000 per family

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 $25 copayment per visit (no Calendar Year deductible)	50% after Calendar Year deductible
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% (no Calendar Year deductible)	Not Covered

	IN NETWORK (covered %)	OUT OF NETWORK
Office visit for treatment of Mental Health/Substance Abuse Disorders Includes all care provided during visit.	100% after $25 copayment per visit (no Calendar Year deductible)	50% after Calendar Year deductible
Specialist Care Office Visits Includes all care provided during visit.	100% after $50 copayment per visit (no Calendar Year deductible)	50% after Calendar Year deductible
Telehealth Healthcare Professional *Service: Telemedicine* Must be with the Fund-designated Contracted Provider, Doctor on Demand	100% after $25 copayment per visit (no Calendar Year deductible)	Not Covered
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% (no Calendar Year deductible)	Not Covered
Allergy Shot	100% after $25 copayment per visit (no Calendar Year deductible)	50% after Calendar Year deductible

	IN NETWORK (covered %)	OUT OF NETWORK
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 $25 copayment per visit	50%
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

	IN NETWORK (covered %)	OUT OF NETWORK
Colonoscopies - Preventive *Service: Screening colonoscopy* 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
Acupuncture Plan Exclusion	Not Covered	Not Covered
Chiropractic Services Limited to 12 visits per person each calendar year.	100% after $25 copayment per visit (no Calendar Year deductible)	Not Covered
Routine Podiatric Services Plan Exclusion	Not Covered	Not Covered
Non-Routine Podiatric Services	100% after $50 copayment per visit (no Calendar Year deductible)	50% after Calendar Year deductible

	IN NETWORK (covered %)	OUT OF NETWORK
Services provided at the UNITE HERE HEALTH health center		
	100% (no Calendar Year deductible)	Not Covered
URGENT AND EMERGENCY TREATMENT		
Urgent Care Center Visit		
	100% after $50 copayment per visit (no Calendar Year deductible)	50% after Calendar Year deductible
Hospital emergency room services *Service: Emergency Room*		
	100% after $200 copayment (no Calendar Year deductible) *Copayment waived if admitted to the Hospital due to emergency room care*	100% after $200 copayment (no Calendar Year deductible) *Copayment waived if admitted to the Hospital due to emergency room care*
Hospital emergency room services for routine care *Service: 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% after Calendar Year deductible	Not Covered

	IN NETWORK (covered %)	OUT OF NETWORK
Ambulance *Service: Professional Ambulance Transportation* Prior authorization is required for air ambulance transports: **(855) 487-0353**.	70% after Calendar Year deductible	70% after Calendar Year deductible
INPATIENT TREATMENT		
Hospital inpatient department services, including inpatient professional services *Service: 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.	70% after Calendar Year deductible	50% after Calendar Year deductible
Skilled Nursing Facility confinement Limited to 60 days per person each calendar year for Network and Non-Network care combined. Prior authorization is required **(855) 487-0353**.	70% after Calendar Year deductible	50% after Calendar Year deductible
LABORATORY AND IMAGING SERVICES		
Laboratory Services *Service: Office or non-Hospital facility* Genetic testing requires prior authorization: **(855) 487-0353**.	100% after $25 copayment per visit (no Calendar Year deductible)	50% after Calendar Year deductible

	IN NETWORK (covered %)	OUT OF NETWORK
Laboratory Services *Service: Hospital outpatient department* Genetic testing requires prior authorization **(855) 487-0353**.	100% after $100 copayment per visit (no Calendar Year deductible)	50% after Calendar Year deductible
Radiology *Service: Office or non-Hospital facility* Including x-ray, ultrasound, fetal monitoring.	100% after $25 copayment per visit (no Calendar Year deductible)	50% after Calendar Year deductible
Radiology *Service: Hospital outpatient department* Including x-ray, ultrasound, fetal monitoring.	100% after $100 copayment per visit (no Calendar Year deductible)	50% after Calendar Year deductible
Diagnostic Imaging *Service: 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% after $175 copayment per visit (no Calendar Year deductible)	50% after Calendar Year deductible

	IN NETWORK (covered %)	OUT OF NETWORK
Diagnostic Imaging *Service: 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 $300 copayment per visit (no Calendar Year deductible)	50% after Calendar Year deductible
OUTPATIENT SERVICES BENEFIT		
Outpatient Surgery *Service: 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 colonoscopy/sigmoidoscopy) call: **(855) 487-0353**.	80% after Calendar Year deductible	50% after Calendar Year deductible
Outpatient Surgery *Service: 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 colonoscopy/sigmoidoscopy) call: **(855) 487-0353**.	70% after Calendar Year deductible	50% after Calendar Year deductible
Physical, speech, and occupational therapy *Service: 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 $30 copayment per visit (no Calendar Year deductible)	50% after Calendar Year deductible

	IN NETWORK (covered %)	OUT OF NETWORK
Physical, speech, and occupational therapy *Service: 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 $60 copayment per visit (no Calendar Year deductible)	50% after Calendar Year deductible
Infusion medication and chemotherapy *Service: Home* Prior authorization required **(855) 487-0353**.	100% (no Calendar Year deductible)	50% after Calendar Year deductible
Infusion medication and chemotherapy *Service: Office or Non-Hospital Infusion Center* Prior authorization required **(855) 487-0353**.	100% after $25 copayment per visit (no Calendar Year deductible)	50% after Calendar Year deductible
Infusion medication and chemotherapy *Service: Hospital outpatient department* Prior authorization required **(855) 487-0353**.	70% after Calendar Year deductible, maximum cost-sharing of $250 per visit	50% after Calendar Year deductible

	IN NETWORK (covered %)	OUT OF NETWORK
Kidney dialysis *Service: Home, office, or non-Hospital dialysis center* Prior authorization required **(855) 487-0353**.	100% (no Calendar Year deductible)	Not Covered
Kidney dialysis *Service: Hospital outpatient department* Prior authorization required **(855) 487-0353**.	70% after Calendar Year deductible, maximum cost-sharing of $250 per visit	Not Covered
Radiation therapy Prior authorization required **(855) 487-0353**.	70% after Calendar Year deductible	50% after Calendar Year deductible
OTHER CARE		
Podiatric Orthotics Limited to $500 per Person every 24 months.	100% (no Calendar Year deductible)	Not Covered

	IN NETWORK (covered %)	OUT OF NETWORK
Diabetes Education For the care, monitoring, or treatment of diabetes & dietary needs.	100% (no Calendar Year deductible)	Not Covered
Nutritional Counseling Limited to 4 visits per person each calendar year.	100% (no Calendar Year deductible)	Not Covered
Partial hospitalization, intensive outpatient, ambulatory detoxification, and outpatient (non-office) treatment for Mental Health/Substance Abuse Disorder	100% (no Calendar Year deductible)	50% after Calendar Year deductible`
Home Healthcare Limited to 30 visits per person each calendar year for Network and Non-Network care combined. Prior authorization required **(855) 487-0353**.	100% after $15 copayment per visit (no Calendar Year deductible)	50% after Calendar Year deductible
Hospice Care Prior authorization is required for inpatient hospice care: **(855) 487-0353**.	100% (no Calendar Year deductible)	50% after Calendar Year deductible

	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**.	75% after Calendar Year deductible	Not Covered
Non-hospital-grade breast pumps Limited to purchase of one per pregnancy. Prior Authorization is required if cost exceeds $500: **(855) 484-0353**.	100% (no Calendar Year deductible)	100% (no Calendar Year deductible)
Habilitative therapy for children with Autism Spectrum Disorder Plan Exclusion	Not Covered	Not Covered
Medical foods for inborn metabolic errors Prior authorization required: **(855) 487-0353**.	Reimbursement of 100% (no Calendar Year deductible)	
Travel and lodging for certain serious medical conditions Prior authorization 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 (no Calendar Year deductible)	

	IN NETWORK (covered %)	OUT OF NETWORK
All other Covered Expenses		
	70% after Calendar Year deductible	50% after Calendar Year deductible
Hearing Aids Plan Exclusion		
	Not Covered	Not Covered
Prostate Specific Antigen *Service: PSA* Covered once every 12 months for men between the ages of 40-69.		
	100%	Not Covered
Dental *Service: 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 *Service: 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.		

	IN NETWORK (covered %)	OUT OF NETWORK
Contraceptives *Service: Birth control* Covered under woman's preventative care. FDA approved contraceptive methods are covered.	100%	Not Covered
PRESCRIPTION DRUG BENEFITS		
Preventive Healthcare Services and supplies on the formulary	100%	Not Covered
Formulary generic drugs	100% after $10 copayment per prescription fill or refill	Not Covered
Formulary brand name drugs	100% after $30 copayment 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 specialty brand and biosimilar drugs	75% until Person has paid $50 total coinsurance per prescription fill or refill, then 100%	Not Covered
Prescription drugs and supplies at the UNITE HERE HEALTH Health Center	100%	N/A

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

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).