



# Medical Benefits

## At a Glance



You may not have all these benefits. Your benefits are determined by your collective bargaining agreement and your enrollment choices. If you have questions about your coverage or your specific benefits, contact your health fund at **844-427-8501**.

### Gold Plan

WHAT'S COVERED <i>(effective 1/1/2023)</i>	WHAT YOU PAY – Coalition/PPO Provider or Any Provider Outside of Anchorage*	WHAT YOU PAY – Non-PPO (Non-Coalition) in Anchorage*
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#### Office Visits

<b>Preventive Care</b>	No charge	No charge
<b>Primary Care Provider</b> <i>(includes all care received during visit)</i>	20% coinsurance after deductible	20% coinsurance after deductible
<b>Teladoc</b> <i>(telehealth)</i>	No charge	Not covered
<b>Specialist</b> <i>(all care received during visit)</i>	20% coinsurance after deductible	20% coinsurance after deductible
<b>Mental Health/Substance Abuse</b>	20% coinsurance after deductible	20% coinsurance after deductible
<b>Chiropractic Services</b> <i>(1 visit per day)</i>	20% coinsurance after deductible	20% coinsurance after deductible
<b>Diabetes Education</b>	No charge	No charge

#### Emergency, Urgent Care, and Inpatient Services

<b>Urgent Care Center</b>	20% coinsurance after deductible	20% coinsurance after deductible
<b>ER for Emergency</b> <i>(waived if admitted)</i>	\$100 copay + 20% coinsurance after deductible	\$100 copay + 20% coinsurance after deductible
<b>ER for Routine Care</b>	\$100 copay + 20% coinsurance after deductible	\$100 copay + 20% coinsurance after deductible
<b>Ground Ambulance</b>	20% coinsurance after deductible	20% coinsurance after deductible
<b>Inpatient Hospitalization</b> <i>(copay is waived after 4 or more stays/person/calendar year)</i>	\$350 copay + 20% coinsurance after deductible	\$350 copay + 30% coinsurance after deductible
<b>Skilled Nursing Facility</b> <i>(Up to 100 days per confinement)</i>	No charge	No charge

#### Outpatient Services

<b>Outpatient Surgery</b>	20% coinsurance after deductible	Ambulatory Surgery Center: 20% coinsurance after deductible Outpatient Hospital: 30% coinsurance after deductible
<b>Physical and Occupational Therapy</b>	20% coinsurance after deductible	20% coinsurance after deductible
<b>Speech Therapy</b>	20% coinsurance after deductible	20% coinsurance after deductible
<b>Infusion Medication and Chemotherapy</b>	20% coinsurance after deductible	20% coinsurance after deductible
<b>Kidney Dialysis</b>	20% coinsurance after deductible	20% coinsurance after deductible
<b>Radiation Therapy</b>	20% coinsurance after deductible	20% coinsurance after deductible

\*Services received from a Non-PPO provider will be covered up to the Usual & Customary Charge (UCC). Any amounts above the UCC will not be covered and you may receive a balance bill from the provider. The Allowed amount for service at a Non-PPO facility in Anchorage will be the rate of the PPO Provider.

<b>Medical</b> <i>(continued)</i>	<b>Gold Plan</b>	
WHAT'S COVERED	WHAT YOU PAY – Coalition/PPO Provider or Any Provider Outside of Anchorage*	WHAT YOU PAY – Non-PPO (Non-Coalition) in Anchorage*
<b>Lab and Imaging Services</b>		
Laboratory Services and Radiology	20% coinsurance after deductible	Non-hospital - 20% coinsurance after deductible Hospital - 30% coinsurance after deductible
Diagnostic Imaging (CT, MRI, PET)	20% coinsurance after deductible	
<b>Other Care and Expenses</b>		
Home Health Care Visit <i>(100 visits per calendar year)</i>	No charge	No charge
Hospice Care <i>(must be terminally ill with a life expectancy of 12 months or less)</i>	20% coinsurance after deductible	20% coinsurance after deductible
Podiatric Orthotics	Not covered	Not covered
Durable Medical Equipment	20% coinsurance after deductible	20% coinsurance after deductible
<b>Prescription Drug</b>		
Generic	30% coinsurance (\$5 minimum at retail; \$10 minimum at mail)	
Brand Drugs	30% coinsurance (\$5 minimum at retail; \$10 minimum at mail)	
Diabetes Oral Medications, Insulin and Supplies	\$5 copay retail / \$10 copay mail	
Specialty Drugs	30% coinsurance (\$5 minimum at retail; \$10 minimum at mail)	
<b>Other</b>		
Medical Deductible	\$250 individual/\$500 family for Coalition/PPO Provider or Any Provider Outside of Anchorage, \$500 individual/\$1,000 family for Non-PPO (Non-Coalition) in the Municipality of Anchorage	
Coalition/PPO Provider or Any Provider Outside of Anchorage Out-of-Pocket Spending Limit <i>Once your cost sharing for PPO covered expenses reaches these limits, the Plan pays 100% for most of your covered PPO expenses for the rest of the year (see your SPD for expenses that don't count).</i>	<b>Medical</b>	\$3,000 individual \$6,000 family
Non-PPO (Non-Coalition) in the Municipality of Anchorage Out-of-Pocket Spending Limit	<b>Medical</b>	\$8,750 individual \$16,500 family
Prescription Drug Out-of-Pocket Spending Limit		\$2,350 individual \$4,700 family

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**844-427-8501**  
**www.alaskaplan.org**

*This document is an easy-to-read summary and does not include all benefits. If you want more details about your benefits or want to find out which treatments/services require prior authorization, please refer to your Summary Plan Description (SPD) or call UNITE HERE HEALTH.*



# Non-Medical Benefits

## At a Glance



### Dental, Life and AD&D, and Vision

#### Dental – Employee Only

Effective January 1, 2023

<b>Maximum Benefit Per Person</b> <i>Calendar year</i>	Plan pays up to \$2,000
<b>Preventive and Diagnostic Services</b>	Plan pays 100% of Usual and Customary Charge
<b>Coinsurance</b>	50%*
<b>Calendar Year Deductible</b>	\$0

#### Life and AD&D – Employee Only

EMPLOYEE	WHAT THE PLAN PAYS
<b>Life Insurance</b>	\$20,000
<b>Accidental Death &amp; Dismemberment Insurance</b>	

#### Vision | VSP – Employee Only

Effective January 1, 2023  
*(services covered once every calendar year)*

#### WHAT YOU PAY

	VSP Network	Non - Network
<b>Vision Exam</b>	\$0 copay	\$0 copay; up to \$45
<b>Prescription Glasses</b>	\$25 copay	\$25 copay
<b>Frames</b>	\$175 frame allowance	Up to \$70
<b>Lenses</b>	\$0 copay (Included in Prescription Glasses: single vision, lined bifocal, and lined trifocal lenses)	Up to \$30 for single vision lenses Up to \$50 for lined bifocal lenses Up to \$65 for trifocal lenses Up to \$50 for progressive lenses
<b>Lens Enhancements</b>	\$0 copay Standard progressive lenses and scratch resistant coating covered in full. Average savings of 30% on other lens enhancements.	Not covered
<b>Elective Contact Lenses</b> <i>(instead of glasses)</i>	\$25 copay; up to \$175 allowance Contact lens fitting and exam: 15% (up to \$50 max copay)	\$25 copay; up to \$120
<b>Medically Necessary Contact Lenses</b>	\$0 copay	\$0 copay; up to \$120
<b>Retinal Screening</b>	Up to \$39 copay At a VSP Premier Provider and Visionworks locations	Not covered

\*Services received will be covered up to the Usual & Customary Charge (UCC). Any amounts above the UCC will not be covered and you may receive a balance bill from the provider.

For Prior Authorization, please have your provider call Aetna. Your Aetna providers may submit most prior authorization requests electronically to Aetna through the secure website or using your Electronic Medical Record (EMR) system portal.

Call UNITE HERE HEALTH at **844-427-8501** to verify benefits and eligibility.

The following are the services that will require prior authorization. The prior authorization list may change from time to time. Contact member services at **844-427-8501** for the most up-to-date information.

<b>Prior Authorization List - Subject to Change</b>	
Inpatient admissions (except hospice)	Osseointegrated implant
Ambulance by plane	Osteochondral allograft/knee
Autologous chondrocyte implantation	Proton beam radiotherapy
Chiari malformation decompression surgery	Reconstructive or other procedures that maybe considered cosmetic
Coverage at an in-network benefit level for out-of-network provider/facility (excludes emergent services)	Shoulder Arthroplasty including revision procedures
Dialysis	Spinal procedures
Dorsal column (lumbar) neurostimulators; trial or implantation	Uvulopalatopharyngoplasty, including laser-assisted procedures
Endoscopic nasal balloon dilation procedures	Ventricular assist devices
Functional endoscopic sinus surgery (FESS)	Whole exome sequencing
Gender reassignment surgery	Applied behavioral analysis (ABA)
Hip surgery to repair impingement syndrome	Inpatient admissions
Hyperbaric oxygen therapy	Partial hospitalization programs (PHPs)
Lower limb prosthetics, such as microprocessor-controlled lower limb prosthetics	Residential treatment center (RTC) admissions
Non-participating freestanding ambulatory surgical facility services, when referred by a participating provider	Transcranial magnetic stimulation (TMS)
Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint	Cochlear device and/or implantation
Drugs and medical injectables (medications administered by or supervised by a provider) paid by the medical plan	Infertility services and pre-implantation genetic testing
Electric or motorized wheelchairs and scooters	Dental implants
Private duty nursing	

**This table is only a general guideline to UHH Plans prior authorization requirements.**

This list may be updated from time to time. It is the provider's responsibility to check for updates. If the procedure billed is not the procedure approved, there may be no payment and the patient is not liable. The presence or absence of a procedure code and/or service on this list does not determine benefits or coverage for your patient. Verification of benefits and eligibility should be obtained by calling **UNITE HERE HEALTH** at **844-427-8501**.