UNITE HERE HEALTH ALASKA

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**.

Silver Plan

WHAT'S COVERED *(effective 1/1/2023)*	WHAT YOU PAY – **Coalition/PPO Provider or Any Provider Outside of Anchorage***	WHAT YOU PAY – **Non-PPO (Non-Coalition) in Anchorage***
Office Visits		
Preventive Care	**No charge**	**No charge**
Primary Care Provider *(includes all care received during visit)*	**30% coinsurance after deductible**	**30% coinsurance after deductible**
Teladoc *(telehealth)*	**No charge**	**Not covered**
Specialist *(all care received during visit)*	**30% coinsurance after deductible**	**30% coinsurance after deductible**
Mental Health/Substance Abuse	**30% coinsurance after deductible**	**30% coinsurance after deductible**
Chiropractic Services *(1 visit per day)*	**30% coinsurance after deductible**	**30% coinsurance after deductible**
Diabetes Education	**No charge**	**No charge**
Emergency, Urgent Care, and Inpatient Services		
Urgent Care Center	**30% coinsurance after deductible**	**30% coinsurance after deductible**
ER for Emergency *(waived if admitted)*	**$100 copay + 30% coinsurance after deductible**	**$100 copay + 30% coinsurance after deductible**
ER for Routine Care	**$100 copay + 30% coinsurance after deductible**	**$100 copay + 30% coinsurance after deductible**
Ground Ambulance *(100 days per confinement)*	**30% coinsurance after deductible**	**30% coinsurance after deductible**
Inpatient Hospitalization *(copay is waived after 4 or more stays/person/calendar year)*	**$350 copay + 30% coinsurance after deductible**	**$350 copay + 40% coinsurance after deductible**
Skilled Nursing Facility *(Up to 100 days per confinement)*	**No charge**	**No charge**
Outpatient Services		
Outpatient Surgery	**30% coinsurance after deductible**	**Ambulatory Surgery Center: 30% coinsurance after deductible** **Outpatient Hospital: 40% coinsurance after deductible**
Physical and Occupational Therapy	**30% coinsurance after deductible**	**30% coinsurance after deductible**
Speech Therapy	**30% coinsurance after deductible**	**30% coinsurance after deductible**
Infusion Medication and Chemotherapy	**30% coinsurance after deductible**	**30% coinsurance after deductible**
Kidney Dialysis	**30% coinsurance after deductible**	**30% coinsurance after deductible**
Radiation Therapy	**30% coinsurance after deductible**	**30% 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.

Medical *(continued)*	**Silver Plan**	
WHAT'S COVERED	WHAT YOU PAY – **Coalition/PPO Provider or Any Provider Outside of Anchorage***	WHAT YOU PAY – **Non-PPO (Non-Coalition) in Anchorage***
Lab and Imaging Services		
Laboratory Services and Radiology	**30% coinsurance after deductible**	**Non-hospital - 30% coinsurance after deductible** **Hospital - 40% coinsurance after deductible**
Diagnostic Imaging *(CT, MRI, PET)*	**30% coinsurance after deductible**	
Other Care and Expenses		
Home Health Care Visit *(100 visits per calendar year)*	**No charge**	**No charge**
Hospice Care *(must be terminally ill with a life expectancy of 12 months or less)*	**30% coinsurance after deductible**	**30% coinsurance after deductible**
Podiatric Orthotics	**Not covered**	**Not covered**
Durable Medical Equipment	**30% coinsurance after deductible**	**30% coinsurance after deductible**
Prescription Drug		
Generic	**40% coinsurance ($5 minimum at retail; $10 minimum at mail)**	
Brand Drugs	**40% coinsurance ($5 minimum at retail; $10 minimum at mail)**	
Diabetes Oral Medications, Insulin and Supplies	**$5 copay retail / $10 copay mail**	
Specialty Drugs	**40% coinsurance ($5 minimum at retail; $10 minimum at mail)**	
Other		
Medical Deductible	**$500 individual/$1,000 family for Coalition/PPO Provider or Any Provider Outside of Anchorage,** **$1,000 individual/$2,000 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 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).	***Medical***	**$3,500 individual** **$7,000 family**
Non-PPO (Non-Coalition) in the Municipality of Anchorage Out-of-Pocket Spending Limit	***Medical***	**$10,000 individual** **$20,000 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

UNITE HERE HEALTH ALASKA

Dental, Life and AD&D, and Vision

Dental – Employee Only

Effective January 1, 2023	
Maximum Benefit Per Person *Calendar year*	Plan pays up to $2,000
Preventive and Diagnostic Services	Plan pays 100% of Usual and Customary Charge
Coinsurance	50%*
Calendar Year Deductible	$0

Life and AD&D – Employee Only

EMPLOYEE	WHAT THE PLAN PAYS
Life Insurance	$20,000
Accidental Death & Dismemberment Insurance	

Vision | VSP – Employee Only

Effective January 1, 2023 *(services covered once every calendar year)*	WHAT YOU PAY	
	VSP Network	**Non - Network**
Vision Exam	$0 copay	$0 copay; up to $45
Prescription Glasses	$25 copay	$25 copay
Frames	$175 frame allowance	Up to $70
Lenses	$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
Lens Enhancements	$0 copay Standard progressive lenses and scratch resistant coating covered in full. Average savings of 30% on other lens enhancements.	Not covered
Elective Contact Lenses *(instead of glasses)*	$25 copay; up to $175 allowance Contact lens fitting and exam: 15% (up to $50 max copay)	$25 copay; up to $120
Medically Necessary Contact Lenses	$0 copay	$0 copay; up to $120
Retinal Screening	Up to $39 copay At a VSP Premier Provider and Visionworks locations	Not covered

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UNITE HERE HEALTH ALASKA

Prior authorization rules

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.

Prior Authorization List - Subject to Change	
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**.