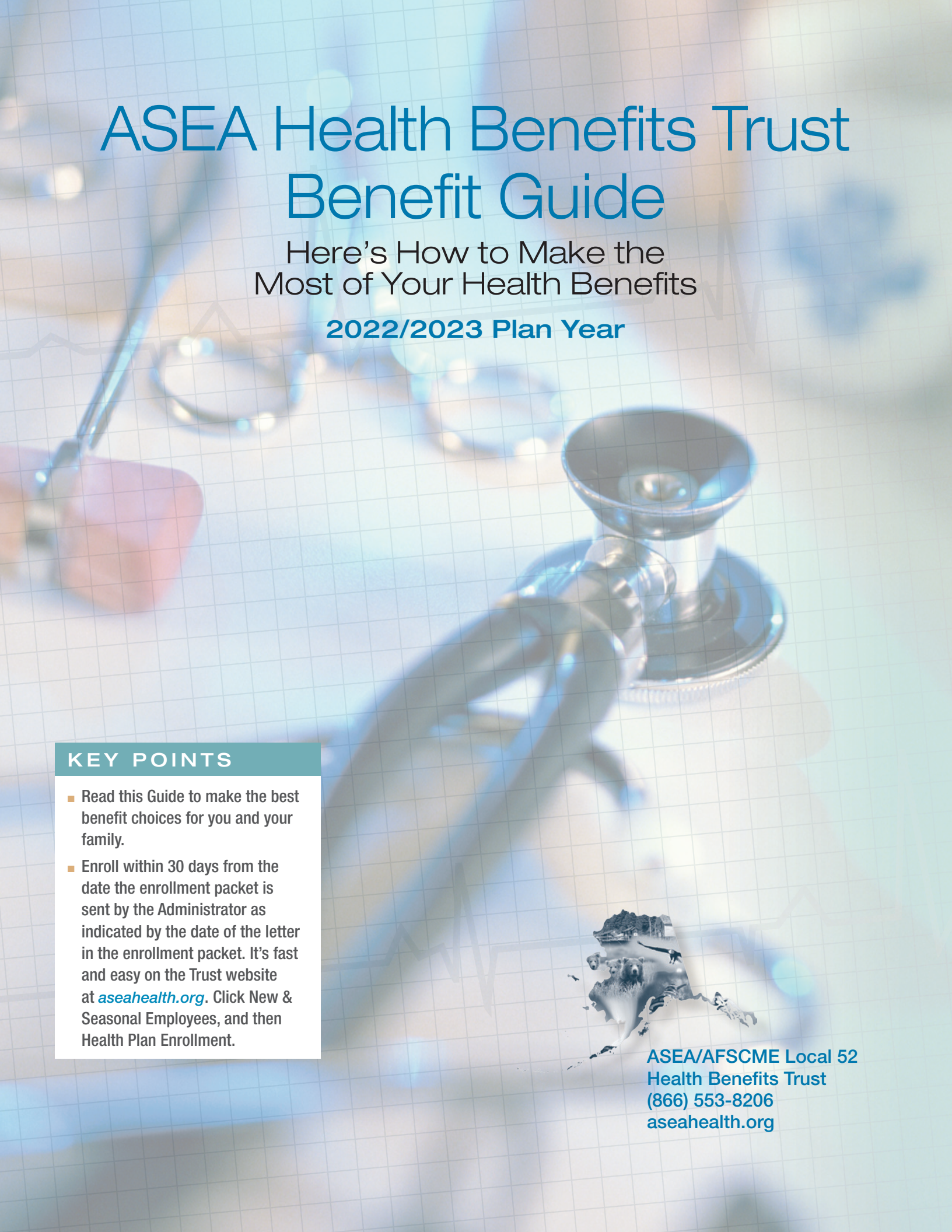
# ASEA Health Benefits Trust Benefit Guide

## Here's How to Make the Most of Your Health Benefits

### 2022/2023 Plan Year



**KEY POINTS**

- Read this Guide to make the best benefit choices for you and your family.
- Enroll within 30 days from the date the enrollment packet is sent by the Administrator as indicated by the date of the letter in the enrollment packet. It's fast and easy on the Trust website at *aseahealth.org*. Click New & Seasonal Employees, and then Health Plan Enrollment.



ASEA/AFSCME Local 52
Health Benefits Trust
(866) 553-8206
aseahealth.org

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## KEY POINTS

- This guide provides an overview only. If there is a difference between this guide and the Plan provisions, the Plan provisions will apply.
- For details about the Plan, including who's eligible, what the Plan covers, and exclusions and limitations, please refer to the Benefits Plan Booklet on the Trust website at *aseahealth.org* (or call the Health Trust Administrator to request a paper copy).
- The coverage provided through the Trust may not be regulated under Alaska insurance law and may not be covered by the Alaska Life and Health Insurance Guaranty Association under AS 21.79.

## Welcome to the ASEA/AFSCME Local 52 Health Benefits Trust!

We provide health benefits to over 8,000 employees and 10,000 of their eligible family members from the ASEA/AFSCME Local 52 General Government Bargaining Unit, the PSEA Local 803 members from the State of Alaska, the City of Fairbanks, and the City of Ketchikan, and the employees of ASEA/AFSCME Local 52 and PSEA Local 803. And now, we are glad to extend benefit coverage to you and your family as well.

Your Trust benefits include medical, hospital, surgical, prescription drug, dental, vision and audio coverage. And, to help you maintain your good health, all of the Health Plan options cover preventive care as recommended by the Affordable Care Act (ACA) with no deductible required.

We encourage you to invest a few minutes in reading this guide to learn about your Plan options and benefit coverage. Then, visit our user-friendly website at *aseahealth.org* to get more information, if you need it. You can enroll for benefit coverage online, and log in anytime to check your claims, eligibility and coverage information.

Here's to your good health!

**KEY POINT**

We encourage you to invest a few minutes in your own good health by reading this guide to learn about your Plan options and benefit coverage.

# ASEA Health Trust Website

We recommend you visit the Health Benefits Trust website at *aseahealth.org* and register right away. Once you register, it's fast and easy to enroll for benefits online.

## Here's How to Register

1 Click *Website Registration* under *Quick Links* on the home page to register for the first time.

2 Enter your personal information in the secure site.

3 Create your own username and password.

4 Once registered, you can log in at the top of the home page to the secure area of the website.

## Log in to the Secure Area of the Website

When you sign in with your own password, your personal information is always secure and confidential—and right at your fingertips!

- **Submit forms online:** Complete and submit most forms online (instead of printing them, filling them out and mailing/faxing them). Click on *Forms*, then select the forms you wish to complete.
- **View your own benefit information:** Click *Your Account*, then log in to see your health claims, HCRA claims, eligibility and enrollment information and more.
- **Manage your mail-order prescriptions:** Link directly to CVS/caremark to refill a prescription or check on the status of your mail order prescription. Log in and click *Your Account*, choose *Your Claims*, then click *Prescription Drug Claims* to view your prescription transactions.

## Find What You Need to Know, Fast

The website has many user-friendly features that help you find all the information you need to get the most from your Health Plan, for example:

- Use the *New and Seasonal Employees* to learn more about what you need to do to get the most from your benefits.


### KEY POINT

Go to the Trust website at *aseahealth.org* and get registered right away. Once you register, it's fast and easy to enroll for benefits online.

- Choose from the *Quick Links* menu on the home page for the most frequently used information.
- Use the Life Changes checklists. The Health Trust's website makes it easy for you to update your benefits when a significant life event occurs, like a marriage, a new baby or a change in work status. From the Home Page, click *Your Life Changes* navigation button on the top of the home page.
- Check out *More*. You will find FAQs, information about the Trust, Key Provider contact information and more!
- **View the Benefit Booklet 24/7.** Click *Benefits Plan Booklet* under *Quick Links* to see the entire booklet anytime.
- **Send secure messages.** The Contact Us feature protects the personal information often required to identify your account. It also keeps your questions about your benefits and claims confidential. Log in on *aseahealth.org* with your secure password and then click *Contact Us*, to use this feature. You'll get a reply within two business days (except weekends or holidays). Watch for an email telling you to log into your account on *aseahealth.org* to view the response. As an added plus, a history of your messages and the Administrator's responses are permanently stored with your account.

# Eligibility

You are eligible for Trust benefits if you are: 1) a permanent or long-term nonpermanent employee of the State of Alaska who is a member of the ASEA/AFSCME Local 52 General Government Bargaining Unit 2) a member of PSEA Local 803 who works for the State of Alaska, the City of Fairbanks, or the City of Ketchikan, or 3) an employee of ASEA/AFSCME Local 52 or PSEA Local 803.

- Full-time employees scheduled to work 30 or more hours a week on a regular basis
- Full-time seasonal employees
- Part-time employees scheduled to work at least 15 but less than 30 hours a week on a regular basis who elect to participate in the Plan (special rules apply for part-time employees who want to participate in the Health Plan)

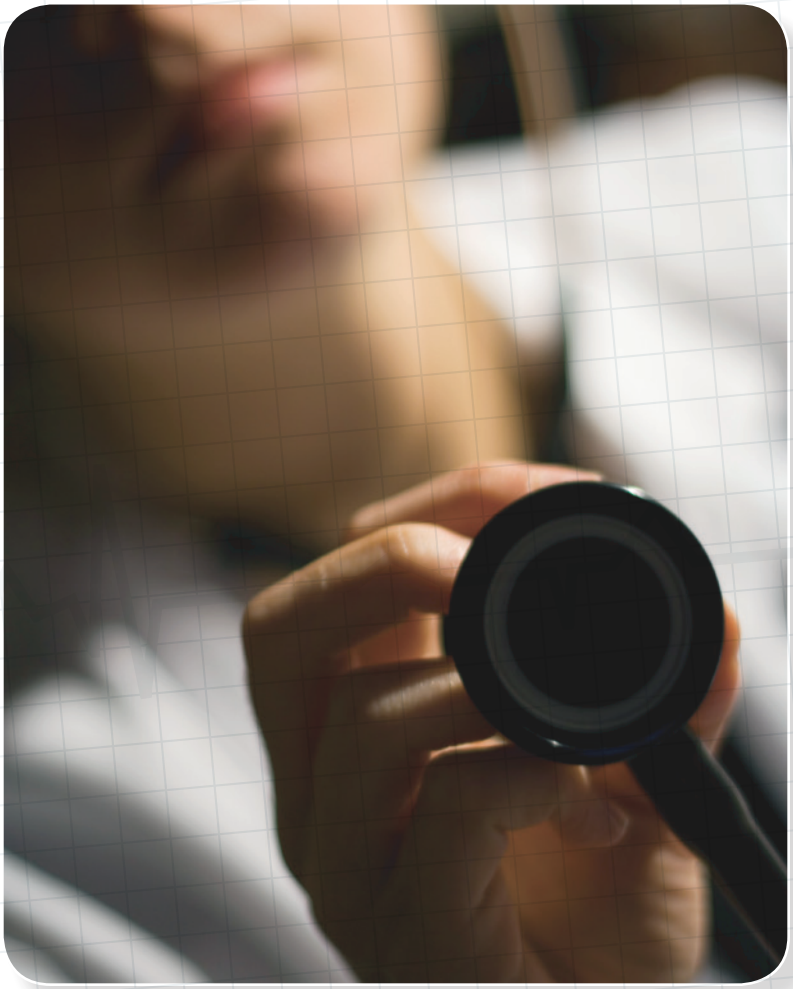
See the Eligibility section of the Benefits Plan Booklet for more details.

## Eligible Dependents

As an eligible employee, you may also enroll the following dependents for Trust benefit coverage:

- Your spouse (you may be legally separated but not divorced)
- Your children from birth to age 26

See the Benefits Plan Booklet for details.



**KEY POINT**

If you are eligible for Trust benefits, you may also enroll your eligible dependents for benefit coverage.

**KEY POINT**

State statute requires permanent full-time or permanent full-time seasonal employees and their spouses and eligible dependent children to have health coverage. In addition, for those groups who are in a union, contracts with the unions require health insurance. A large portion of the cost of your health premium, called the Employer Contribution, is paid on your behalf monthly by your employer. The Employer Contribution as well as the health plan coverage itself is a significant part of your monthly benefit package. Permanent part-time or permanent part-time seasonal employees are not required to select a health plan—if they do select one, your employer contributes one-half the benefit credit it provides to full-time employees. (Part-time employees can get contribution rates and the part-time employee enrollment form on *aseahealth.org* under Forms, Enrollment and Eligibility Forms.) Even if you don't use your health plan today or haven't used it very much in the past, one of the reasons to have the coverage is in case you experience an unexpected health need that could otherwise be financially devastating.

# Enrollment

## New Hires, Status Changes and Transfers

If you are new to the ASEA Health Trust, you must enroll within 30 days from the date the enrollment packet is sent by the Administrator. The 30-day period will begin on the date of the letter in the enrollment packet.

### KEY POINT

If you do not enroll within 30 days, you will default to Plan A—Full Plan for Employees & Families, the most expensive plan—and you will lose the ability to enroll in a Health Care Reimbursement Account (HCRA) for the Plan Year. If you are a part-time employee, you will not be enrolled in health benefits. You will not have another opportunity to enroll until the next annual open enrollment period unless your employment status changes or you have a qualifying event in your family.

### How to Enroll

It's fast and easy to enroll online.

- Simply go to the Health Benefits Trust website at *aseahealth.org* and log in. Not registered yet? See page 2 for registration information.
- Click *Enroll in Your Health Plan* under *Quick Links*. This option is simple, quick and only requires you to fill out one online form. Avoid filling out multiple forms, making copies, mailing or faxing and enroll online today.
- Once you complete the online enrollment process a confirmation email will be sent to you.

Another option is to download and print the forms, fill them out and send them to the ASEA Health Benefits Trust Administrator by fax, mail or attached to a secure message through *Contact Us*.

1 Complete the **Employee Information Form.** This form is used to report your personal information (name, address, etc.) and your work status.

2 Complete the **Family Information Form**. This form includes information about yourself, your spouse and your dependents. It allows you to report other health plan coverage for you and your dependents, for coordination of benefits.

3 Complete the **Flexible Benefits Enrollment Form for Full-Time Employees** or **Flexible Benefits Enrollment Form for Part-Time Employees**.

## Annual Open Enrollment Period

Every year, usually from mid-May to mid-June, the Health Benefits Trust has an Open Enrollment period for the next Plan Year, which runs from July 1 through June 30.This is your opportunity each year to:

- change your Health plan choice,
- verify your spouse's enrollment in other employer-sponsored health plan coverage (if you're enrolled in Plan A),
- enroll in a Health Care Reimbursement Account (HCRA), and
- update your Family Information Form.

### Enrollment Election Appeals Policy

If you believe you have been enrolled in your benefits incorrectly, you have the right to appeal to the Health Benefits Trust and request a change. Submit your appeal request in writing to the Board of Trustees within 45 days after your first payroll deduction. The form can be downloaded from the Trust website.

Please note that the Trustees must abide by IRS regulations, which limit the circumstances in which participants can make election changes, when deciding Enrollment appeals.

## Family Changes

In keeping with IRS regulations, you may make midyear changes to your benefit choices only if you have a qualifying event in your family like these:

- Marriage
- Birth or adoption of a child
- Divorce or legal separation
- Death of a covered dependent
- Covered dependent ceasing to be eligible or uncovered dependent gaining eligibility
- Loss, gain or significant change in spouse's coverage. Exception: HCRA elections may not be changed following a loss, gain or significant change in your spouse's benefits.
- Change from full-time to part-time status or vice versa

To request a midyear change in an enrollment, submit proof of the qualifying event and a new Flexible Benefits Enrollment form to the Health Benefits Trust Administrator within 60 days of the event.

# When Coverage Begins and Ends

Changes become effective the first day of the month after the Administrator receives your submission.

You may be required to provide supporting documentation. Claims incurred will not be paid until proper documentation has been submitted.

If you are adding a new dependent, see "New Dependents" for more information.

**KEY POINT**

**If you have a qualifying event in your family, you have 60 days after the event to request a midyear enrollment change.**

## New Employees

If you are a permanent full-time, long-term nonpermanent full-time, or full-time seasonal employee, you and your eligible dependents are covered on the first day of the month following 30 consecutive days in paid status, provided that health benefit contributions have been reported to the ASEA Health Benefits Trust on your behalf.

For example, if you begin work on October 10, you are covered on December 1, assuming you have no periods of leave without pay and you do not terminate your employment during that time.

For employees who are rehired, returning from leave without pay or layoff, moving from a nonparticipating unit, transferring from full-time to part-time or vice versa, the date your coverage becomes effective depends on your change in employment status. See the Eligibility section of the Benefits Plan Booklet for details.

## New Dependents

If you add a new dependent to your Plan, the dependent is eligible for benefits immediately if you are currently enrolled in a Family Plan option (Plan A / Full Plan for Employees and Families, Plan C / Supplemental Plan for Employees and Families or Plan D / Low Option Plan for Employees and Families).

If you are covered under an Employee Only Plan option (Plan B / Full Plan for Employees Only), you must notify the Health Benefits Trust Administrator that you acquired a new dependent and then you must switch to a Family Plan option (Plan A, Plan C or Plan D). You must do this within 60 days of acquiring that dependent, unless your newly acquired dependent has other health coverage.

If you do not have supporting documentation such as a birth certificate, state-certified marriage license or Social Security number you may enroll your dependent and submit the document to the ASEA Health Benefits Trust at a later date. However, any claims incurred will not be paid until proper documentation has been submitted.

Your newborn or newly adopted child will automatically be covered, regardless of your plan election, for 31 days. If you change your plan election, the change will be effective retroactive to the date of the birth or adoption.

## When Coverage Ends

If you terminate employment or move to a nonparticipating unit, your coverage ends on the last day of the month in which you worked or were moved out of this bargaining unit. For example, if you last worked on May 15, your coverage ends on May 31.

If you take leave without pay or are laid off, your coverage ends on the last day of the month in which you were last in paid status, except in the case of Family Medical Leave.

Coverage for dependents ends on the same day that your coverage ends, with a few exceptions.

Your coverage will end if you or your employer fails to pay the contribution; the change will be effective at the end of the month in which the last required contribution was made.

See the Eligibility section of the Benefits Plan Booklet for details.

## Continuation Coverage

You and/or your covered dependents may be able to temporarily extend your Health Plan coverage (called "continuation coverage" or "COBRA

*Continued on page 8*

# Flexible Benefits Plan Choices

## WHEN COVERAGE BEGINS AND ENDS

*Continued from page 7*

coverage") if you experience a qualifying event such as:

- Your employment is terminated (for reasons other than your gross misconduct)
- Your hours are reduced
- You become divorced or legally separated from your covered spouse
- Your child is no longer eligible as a covered dependent under the Plan
- You die

The Health Trust Administrator must be notified within 60 days of a qualifying event to be eligible for continuation coverage. See the Continuation Coverage section of the Benefits Plan Booklet for details.

There are other options for health care coverage that may be less expensive than the Trust continuation coverage such as a Health Insurance Marketplace health plan, Medicaid or coverage through a spouse's plan.

To learn more about Health Insurance Marketplace coverage including plan comparisons and costs, go to ***HealthCare.gov*** or call (800) 318-2596.

Be sure to compare all your options carefully and choose the coverage that is best for you.

The Health Benefits Trust's flexible benefit options give you several plan choices. Please take the time to carefully select the plan that is best for you and your family.

## Plan A—Full Plan for Employees and Families

Plan A provides medical, dental, prescription and vision benefits for employees and eligible family members. Of all the options, this Plan costs the most per month. That's because:

- It generally pays the highest level of medical benefits
- It includes prescription, dental and vision coverage

### Before You Choose Plan A: Spousal Surcharge

If you enroll in Plan A and enroll a working spouse who has opted out of coverage through his or her employer, a $125 monthly surcharge will be added to your payroll deduction. (See page 10 for monthly contribution amounts.)

## Plan B—Full Plan for Employees Only

Plan B is identical to Plan A, but costs less per month because it covers only you, not your family.

If you have dependents, you may choose this option only if all of your eligible family members are covered by another health plan—for example, through your spouse's employer.

## Plan C—Supplemental Plan for Employees and Families

Plan C pays a 20% medical plan benefit, as well as prescription, dental and vision benefits. This cost-effective plan is designed to work with most other coverage you and your family have in order to pay up to 100% of covered services.

- Plan C pays 20% of covered medical costs (with no deductible)—whether or not you use a PPO provider.
- You may choose this option **only if you and all of your eligible family members are covered by another health plan**—for example, through your spouse's employer.

### Before You Choose Plans B or C: Check with your other health plan.

When you or your dependents are covered by another health plan, and enroll in Plans B or C, the other health plan may reduce its benefits.

Therefore, if you want to enroll in Plan C or Plan B (if you have dependents), before you enroll, call the other health plan's administrator to find out how the plans will coordinate benefits.

For example, if your other coverage is through the State of Alaska's AlaskaCare Plan, they may reduce your benefits if you waive dependent coverage under the Health Benefits Trust plan by selecting Plan B; or you select a plan that pays less than 70%, Plan C, or you select a high deductible plan, Plan D.

### Before You Choose Plan B or C: Other coverage information is required.

If you decide to enroll in Plan C or Plan B (if you have dependents), you will need to provide information about the other health plan when you enroll.

NOTE: Indian Health Services benefits qualify as other health coverage for anyone electing Plan B or Plan C.

**If the information about the other coverage is missing on your enrollment form, or if it is incorrect, the Health Benefits Trust will automatically enroll you in Plan A.**

**If a retroactive change is required because you provided incorrect information, you will be responsible for any retroactive contribution amount due.**

Plan B and Plan C participants must notify the Health Benefits Trust Administrator within 60 days if they gain eligible new family members or if their family members lose their other coverage.

## Plan D—Low Option Plan With HRA for Employees and Families

With Plan D, the Health Benefits Trust provides a $1,000 (per employee) Health Reimbursement Arrangement (HRA). You can be reimbursed from your HRA for eligible expenses, such as prescription medications or a portion of your deductible. Plan D does not provide dental or vision coverage—but you can use the HRA to pay for dental and vision expenses.

You may use your HRA to pay for any of the eligible expenses allowed with a Health Care Reimbursement Account (HCRA). However, if you have both a HCRA and an HRA, you must use your annual HCRA amount before the HRA reimburses your eligible expenses.

Plan D pays for preventive care that meets standard recommendations, with no deductible required. However, the Plan provides non-preventive medical coverage only after you satisfy a high annual deductible ($5,000 per person and $10,000 per family). After you meet the deductible, Plan D pays 100% of most covered costs or 80% of the contracted price for non-PPO services. Plan D is appropriate if:

- Your estimated annual eligible medical expenses are up to $1,000 (which may be reimbursed by your HRA)
- You are willing to pay for health care costs over $1,000 (and up to the deductible amount) out of your own pocket
- You want protection against the high cost of a serious medical condition

You might also want to consider Plan D if you and your family have other group health care coverage.

If there are unused funds in your HRA at the end of the Plan Year, these funds will be rolled over to the following Plan Year. If you select a different Plan or are no longer eligible for Health Trust benefits, you must forfeit any remaining funds in your HRA.

# Health Plan Benefit Overview

The chart below helps you compare the features and benefits of the different Plans—and choose which one is best for you.

| BENEFIT | PLAN A<br>FULL PLAN FOR EMPLOYEES AND FAMILIES | PLAN B<br>FULL PLAN FOR EMPLOYEES ONLY | PLAN C<br>SUPPLEMENTAL PLAN FOR EMPLOYEES AND FAMILIES WITH OTHER COVERAGE | PLAN D WITH $1,000 HRA<br>LOW OPTION PLAN FOR EMPLOYEES AND FAMILIES |
|---|---|---|---|---|
| **2022/2023 Monthly Full-time Employee Contribution** | **$295.00**<br>May be subject to an additional $125/mo. Spousal Surcharge payroll deduction. (See page 8.) | **$140.00** | **$35.00** | **$40.00** |
| **MEDICAL** | | | | |
| Annual Deductible | $300 / Individual<br>$600 / Family | $300 / Individual | None | $5,000 / Individual<br>$10,000 / Family |
| Plan Pays<br>Based on Plan's Allowable Expenses. | 80% (60% of contracted price for non-PPO services*) | 80% (60% of contracted price for non-PPO services*) | 20% | 100% (80% of contracted price for non-PPO services*) |
| Out-of-Pocket Limit*<br>(not including deductible) | $1,200 / Individual<br>($2,400 / Individual for non-PPO services*) | $1,200 ($2,400 for non-PPO services*) | None | None |
| Preventive Care<br>Based on Plan's Allowable Expenses. | 100% for services recommended under ACA–not subject to deductible; 80% for all others | 100% for services recommended under ACA–not subject to deductible; 80% for all others | 100% for services recommend-ed under ACA–not subject to deductible; 20% for all others | 100% for services recommended under ACA–not subject to deductible; 80% for all others |
| Prescription Drugs | Member copays:<br>20% brand name, 10% generic up to $60 per Rx**<br>$600 copay max per person per Plan Year | Member copays:<br>20% brand name, 10% generic up to $60 per Rx**<br>$600 copay max per person per Plan Year | Plan pays 20%,<br>Member pays 80%** | Under the Medical Plan:<br>Plan pays 100% after deductible |
| Major Medical Maximum | Unlimited | Unlimited | Unlimited | Unlimited |
| **DENTAL** | | | | |
| Annual Deductible | $25 / Individual<br>$75 / Family | $25 | $25 / Individual<br>$75 / Family | Not Covered |
| Plan Pays<br>Based on Plan's Allowable Expenses. | Preventive: 100%  General: 85%  Major: 50%<br>(Benefits paid for preventive services do not apply to the $2,000 annual maximum.) | | | Not Covered |
| Individual Maximum | $2,000 / Plan Year | $2,000 / Plan Year | $2,000 / Plan Year | Not Covered |
| **VISION** | | | | |
| Plan Pays<br>Based on Plan's Allowable Expenses. | **VSP In-Network**<br>Exam: Covered in full every Plan Year<br>Basic Single Vision or Lined Lenses: Covered in full every Plan Year<br>Polycarbonate lenses and UV coating: Covered in full every Plan Year<br>One of the following covered in full every Plan Year: Progressive or photochromic lenses or anti-reflective coating<br>Frames: $150 retail allowance every other Plan Year and 20% discount on the amount over the allowance.<br>Contacts: $200 allowance in lieu of lenses and frames and contact lens exam covered in full after $60 copay | | **Out-of-Network**<br>Exam: up to $150, every Plan Year<br>Single Vision or Lined Lenses: up to $175, every Plan Year<br>Frames: up to $150, every other Plan Year<br>Contacts: up to $200, every Plan Year, in lieu of lenses and frames | Not Covered |

*Non-PPO out-of-pocket limit provisions apply to inpatient and outpatient services obtained at a non-preferred hospital in Anchorage or performed at a non-preferred physical therapist provider in Anchorage.

** Benefits subject to formulary exclusions. Plan pays 80% of generic equivalent for brand name, if generic equivalent is available. For non-network pharmacies, you are responsible for the difference between the retail price at the pharmacy and the network reimbursement rate. The Plan covers pediatric oral and vision services to the extent required by the Affordable Care Act (ACA).

## Preferred Provider Organizations (PPOs)

The ASEA Health Benefits Trust has negotiated discounts with Preferred Provider Organizations (PPOs), which means these providers charge less for the services they provide to Health Trust participants. This helps to keep your health care costs down, while also helping the Trust maintain outstanding benefits and minimize your monthly employee contribution rates.

In some cases, the Plan benefits are the same, regardless of whether you use a PPO provider. In other cases, you will pay more if you use a non-PPO provider for services that could have been obtained from a PPO provider. **Please note that the Health Benefits Trust has several types of PPOs.**

### PPO Facilities Within the Municipality of Anchorage

To receive the discounted rate and avoid paying the out-of-network penalty, use one of these PPO facilities within the Municipality of Anchorage:

- Alaska Regional Hospital
- Surgery Center of Anchorage
- Geneva Woods Birth Center
- Chugach Physical Therapy
- Ascension Physical Therapy
- Alaska Hand Rehabilitation

The Trust has negotiated discounted rates with these additional providers:

- Mat-Su Regional Hospital
- Alaska Center for Ear, Nose and Throat (ACENT)
- Anchorage Fracture and Orthopedic Clinic

*Important:* You may receive care from any licensed provider, but you will save money for yourself and the Trust by receiving care from a PPO provider within the Municipality of Anchorage/Mat-Su Borough.

### Quick Tips

If you live in the Mat-Su Borough, consider using Alaska Regional Hospital in Anchorage for inpatient care and outpatient surgery services:

- You may be able to obtain less expensive services at Alaska Regional Hospital.
- The Plan will pay you an incentive of 10% of the amount the plan pays to Alaska Regional Hospital (up to $500 for outpatient procedures/surgeries and up to $1,000 for inpatient hospital services). See the Preferred Provider Provisions section of the Benefits Plan Booklet for details.
- If you use a non-preferred facility in Anchorage (such as Providence Hospital, Providence Imaging Center or a non-preferred physical therapy provider) for inpatient or outpatient services that could have been done at one of the PPOs within the Municipality of Anchorage/Mat-Su Borough, Plan payment will be based on either the PPO facility contracted price or 50% of the billed charges. The Plan pays a lower percentage (60% versus 80%), and you will have higher annual out-of-pocket maximums for care received from non-preferred facilities.
- No penalty applies if you receive medical services from a non-PPO facility if those services are not available at the PPO facility.
  - Emergency services will not be penalized. However, the patient must be transferred to a PPO as soon as medically possible. Services incurred in a non-PPO facility after the patient can be transferred will be subject to non-PPO reimbursement.
  - No penalty applies to physician services. This includes X-rays, lab work or other outpatient services obtained in the doctor's office, by the doctor's staff with the doctor's equipment. Some doctors maintain separate practices but share resources with other doctors in the same building. A penalty may apply to the services if the doctor or clinic does not own the equipment.

**PPO vs. Non-PPO in Anchorage—How the Out-of-Network Penalty Adds Up**

| | PPO HOSPITAL | NON-PPO HOSPITAL |
|---|---|---|
| Billed Amount | $30,000 | $30,000 |
| Discount Amount | $15,000 | $0<br>(no PPO discount) |
| Allowed Amount | $15,000 | $15,000<br>(Non-PPO penalty reduces the allowed amount to the PPO allowed amount) |
| Plan Payment | $13,800<br>(80%of the allowed amount until the $1,200 out-of-pocket limit is reached;<br>100% thereafter) | $12,600<br>(60% of the allowed amount until the $2,400 non-PPO out-of-pocket limit is reached; 100% thereafter) |
| Amount You Pay | $1,200<br>(Allowed amount minus Plan payment) | $17,400<br>(Billed amount minus Plan payment) |

This example for Plans A or B assumes you have met the annual deductible. Please refer to the Plan Booklet on *aseahealth.org* for your Plan's specific reimbursement rates and other provisions.

### Coalition Health Centers

There is no cost to you at the Coalition Health Centers in Anchorage and Fairbanks for primary and preventive care services (including wellness visits, physicals, immunizations and lab tests), urgent care, work-related exams, imaging and minor procedures. The Centers can also fill many prescriptions for conditions that are being treated there. Your Health Plan pays 100% for services at the Coalition Health Centers. You do not have to pay a copay or meet the annual deductible.

You must schedule an appointment. If you are unable to keep your scheduled appointment, you must cancel or reschedule at least 24 hours in advance or you will be charged a $75 "no-show" fee that you must pay before your next appointment.

### Nationwide PPO: Aetna

For health care services that can't be performed by a PPO provider within the Municipality of Anchorage/Mat-Su Borough or at a Coalition Health Center, consider choosing an Aetna network doctor for your regular health care or for specialty care right here at home. Or, search for providers throughout the U.S. when you need health care services outside of Alaska.

The Health Plan pays the same benefit percentage (and there's no penalty) whether you choose an Aetna PPO provider or a non-PPO provider. However, you'll save money because Aetna providers charge discounted rates on health care services and you will not incur charges over usual customary and reasonable (UCR).

- Find an Aetna provider or health care facility in a particular city by visiting *aetna.com*. Register and log in to your secure account, or continue as a guest and choose "Aetna Choice POS II (Open Access)" when prompted to select a Plan.
- Show your ASEA Health Benefits Trust ID card to the provider. Instructions on how to file a claim are included on the ID card.

### Additional PPOs

**Specialized Networks for Transplants or Other Services:** The Trust has access to specialty networks for services such as transplants. Please contact the Health Benefits Trust Administrator for more information prior to seeking services.

**Prescription Drug Pharmacy Network:** If you obtain your prescriptions at CVS/caremark participating network pharmacies or the mail order program, you pay only your prescription drug copay. (See page 13 for more information on the Prescription Drug Plan.)

**VSP Vision Program:** To receive vision benefits, you may choose any vision provider. However, if you choose a provider from the VSP network, you will receive exams, basic lenses, polycarbonate lenses and UV coating all covered in full. You'll also receive discounted rates for other services such as contact lenses. (See page 14 for more information on the Vision Plan.)

**KEY POINT**

You'll save money when you take advantage of the discounts the Health Benefits Trust offers to you through its PPO networks.

## Medical Plan

### Precertification Requirements for Medical Benefits

Your provider must obtain precertification for all inpatient hospital stays, confinement in a treatment facility or skilled nursing facility, inpatient mental health and inpatient substance use, and many outpatient procedures.

To obtain precertification, your physician or the medical care facility must call the Utilization Review Provider, Aetna, at the number for providers on your ID card, at least:

- 14 days prior to a prescheduled admission or as soon as the admission is scheduled (your physician must call before the confinement or services begin)
- 60 days before the expected delivery date
- Within two days following an emergency admission or as soon as reasonably possible

Aetna will review the information to establish medical necessity of the treatment or procedure. Precertification ONLY determines medical necessity. Medical expenses must be for a covered benefit under the Plan in order to be paid. If Aetna denies precertification, the Plan will not pay benefits.

However, if you do not obtain precertification and the care is determined to be medically necessary, a penalty may apply.

See the Precertification Requirements section of the Benefits Plan Booklet for details.

### Preauthorization of Travel Benefits

If you must travel to receive treatment, and that treatment is not available locally, the Health Plan covers travel expenses under certain conditions. Non-

emergency travel must be preauthorized to receive treatment under the Medical Plan. In order for the travel expenses to be considered for reimbursement, you and your physician must complete the **Travel Preauthorization Form** and submit the form to the Health Benefits Trust Administrator before you travel. The form can be downloaded from the Trust website.

Travel is covered and the requirement for preauthorization is waived if you have an emergency condition requiring immediate transfer to a hospital with special facilities for treating your condition.

See the Preauthorization Requirements section of the Benefits Plan Booklet for details.

**KEY POINT**

Be sure to obtain precertification when required by the Plan to make sure you avoid penalties.

## Prescription Drug Plan

CVS/caremark is the Prescription Benefit Manager for the Health Benefits Trust's prescription plan. CVS/caremark has a website specifically for Trust members that lets you manage your prescriptions, view your prescription plan summary, locate a pharmacy, and more. When you log into the secure portion of the Trust's web site, you can link directly to the secure section of CVS/caremark's website without signing in again.

The amount the Plan pays for prescription drugs is based on the Plan's Allowable Expenses of the medical plan option in which you are enrolled (shown in the Health Plan Summary Chart on page 8). Please note that the Allowable Expense at an out-of-network pharmacy will be the negotiated network rate. Any amount above the Allowable Expense will be your responsibility and will not apply to the maximum copay per prescription or per person per benefit year. Also, prescription drug copayments do not apply to the Medical Annual Out-of-Pocket Limit.

Unless otherwise indicated by the physician, pharmacies may automatically substitute the generic equivalent when available and permissible by law.

**Formulary Exclusions:** The CVS/caremark drug formulary is a list of generic and brand name prescription drugs that are evaluated by a committee of experts and chosen for their safety and effectiveness. Drugs that are not in the formulary will be excluded from coverage.

**Brand-Name Coverage When Generic Available:** If you purchase a brand-name prescription when a generic equivalent is available (even if your doctor's prescription does not allow a substitution), the Plan will pay 80% of the generic equivalent. The difference in cost between the brand-name and generic will not apply to your out-of-pocket total.

**$1,500 Claim Threshold:** Prescriptions for non-specialty drugs that cost more than $1,500 will be reviewed by a CVS/caremark pharmacist prior to allowing benefits for the medication. This may include dosage, quantity, days' supply and/or billable amounts.

**Diabetic Test Strip Quantities are Limited:** You will initially be allowed up to 200 strips per month or up to 300 strips per month following prior authorization.

### Retail Prescription Drugs

You can get your prescription drugs either from a pharmacy participating in the CVS/caremark network or any other pharmacy. If you obtain your prescriptions at a participating network pharmacy, you will only need to pay your prescription drug copay. The pharmacy will file the claim for you. Simply present your Health Benefits Trust Identification Card to the pharmacist for verification.

If you obtain your prescriptions at a non-participating pharmacy, you must pay for the prescription yourself and then file a claim with CVS/caremark. In addition, you must pay any amount charged above the Allowable Expense.

### Mail-Order Prescription Drugs

If you take a medication on an ongoing basis; for example, to lower your cholesterol or manage your blood pressure, it is usually more cost effective to obtain your prescription from a CVS/caremark mail-order pharmacy. Complete the **Prescription Mail Order Form** and send it to the pharmacy along with your physician's prescription. Or, provide the form to your physician; in most cases, they can electronically submit your prescription to CVS/caremark.

### Specialty Prescription Medication Guidelines

Specialty medications are used by about 1% of participants for less common conditions such as multiple sclerosis, rheumatoid arthritis, and hepatitis, among others.

For certain specialty drugs, the Health Plan may require you to try a preferred medication before using non-preferred medications. If you don't follow these steps, you may have to pay the full cost of the non-preferred medication.

- specialty medications are limited to 30 day supply
- prior authorization is required
- for a current list of covered specialty medications, visit ***cvsspecialty.com*** or call Specialty Customer Care at (800) 237-2767 (toll-free).

Please refer to the Prescription Drugs section of the Benefits Plan Booklet for details.

**KEY POINT**

You can save money on prescription drugs by choosing a participating CVS/caremark pharmacy, using the mail-order pharmacy for ongoing medications and asking your doctor to authorize generics on all of your prescriptions.

## Dental Plan

The Health Benefits Trust's Dental Plan covers diagnostic and preventive services, basic and major restorative services, as well as prosthetics such as inlays, crowns, implants, bridges and dentures. Dental benefits paid for preventive dental care (up to 2 visits per year each for you and your dependents) do not apply to your $2,000 annual dental benefit maximum. Only benefits paid for restorative care or prosthetic services apply to your annual maximum. You may receive care from any licensed dental practitioner.

The Medical Plan Option in which you are enrolled may include benefits for dental care. Dental benefits are allowed for services that are medically necessary and payment is based on the Usual, Customary and Reasonable charge for the covered service (see details on page 8).

Please see the Benefits Plan Booklet for more information.

**KEY POINT**

You may choose any licensed dentist or dental practitioner to provide dental services.

## Vision Plan

The Health Benefits Trust's Vision benefits are administered through VSP. VSP's network of providers offers discounts off their retail charges.

You may use the provider of your choice, but if you use a VSP network provider you'll receive exams, basic lenses, polycarbonate lenses and UV coating all paid at 100% once each Plan Year, and you don't have to submit a claim form. Discounts and benefit limitations will apply on other services. Use the VSP Out-of-Network Reimbursement Form to submit your claims for care received from an out-of-network provider.

To find a VSP provider, check on a claim or ask a question, call VSP at (800) 877-7195 (toll-free) or visit their website at ***vsp.com***.

The Vision Plan does not cover services for the treatment of an eye condition. If you have a medical condition of the eye, you will reduce your out-of-pocket costs if you select a provider in the Aetna PPO network.

The Vision Plan covers:

- Complete vision examination including required refraction, by a legally qualified ophthalmologist or optometrist
- Single vision, bifocal, trifocal, or lenticular lenses
- Frames
- Contact lenses

The Medical Plan Option in which you are enrolled may include benefits for Vision Care. Vision benefits are allowed for services that are medically necessary and payment is based on the allowable expense for the covered service (see details on page 8).

Please see the Benefits Plan Booklet for more information.

**KEY POINT**

Save money by choosing a VSP provider when you need vision services or when you buy glasses or contact lenses.

## Audio Plan

The Health Benefits Trust's Audio Plan provides benefits (hearing exams, hearing devices, assistive devices, etc.) with coverage of up to $5,000 per person every three Plan years.

You may choose any qualified health care provider for your hearing care.

The Medical Plan Option in which you are enrolled includes benefits for Audio Care. Audio benefits are allowed for services that are medically necessary and payment is based on the Usual, Customary and Reasonable charge for the covered service.

Please see the Benefits Plan Booklet for more information.

# Health Care Reimbursement Account (HCRA)

The key feature of a Health Care Reimbursement Account (HCRA) is that you can pay for out-of-pocket health care expenses with pretax money. You set aside part of your pay (you determine how much) before income tax withholding or supplemental benefits and Medicare costs are withheld from your paycheck.

As a result, your taxes are calculated on a smaller amount. In this way, you can easily reduce your taxes and increase your net pay—by hundreds of dollars each year.

The example below assumes your income is $40,000 a year and you have $2,850 in eligible health care expenses during the year. By participating in a HCRA, your net pay for the year after health care expenses increases by $342 in tax savings!

## How To Use A HCRA Wisely

### 1 Take the time to estimate your expected health care expenses carefully.

- Use the HCRA worksheet (on the Health Trust website, under *Your Benefits*, then select *HCRA* and follow step one) to help you determine your annual health care expenses.

### 2 Decide how much you want to contribute to your HCRA each month.

- The minimum is $20 per month, and the maximum is $2,850 per year.
- The amount you choose is deducted directly from your paycheck before taxes are withheld and "deposited" into your HCRA.

### 3 Enroll in a HCRA.

- You may enroll in a HCRA when you enroll for benefits as a new employee.
- **You must enroll during Open Enrollment every year to have a HCRA in the next Plan Year, even if you have a HCRA for the current Plan Year.**
- If you are a new hire, you must make an election within the first 30 days of employment. Failure to elect coverage timely will result in no enrollment in the HCRA.
- When you enroll in a HCRA, your medical claims will be coordinated if you check "Coordination of Medical Claims" on your enrollment form. (You must submit prescription drug and other claims.)

### 4 Manage your HCRA Account on the Health Trust website or on the mobile app.

- You have powerful self-service capabilities on the Health Trust website HCRA portal or mobile app. Check your account balance and year-to-date spending, set up notifications and alerts by email or text, submit claims and get reimbursed through direct deposit.
  - Website: Log in to your account on *aseahealth.org*, then go to *Your Account*, *Your Claims*, *HCRA Account* and *Claim Summary*
  - Mobile app: Search for Zenith Flex in the app store for Apple and Android
  - Registration ID: Select employer name from the dropdown menu
  - Employer Name: Enter "ASEA"
  - Your ID: Your social security number

To receive your reimbursements more quickly, be sure to take advantage of the HCRA Direct Deposit feature. Your reimbursements will be deposited directly into your bank account. You can sign up for HCRA Direct Deposit from your Personal Dashboard on the HCRA portal or mobile app. From your profile, change your "Reimbursement Method" to "Direct Deposit" and follow the prompts to complete your application.

## Tax Savings Example

| | WITH A HCRA | WITHOUT A HCRA |
|---|---|---|
| Annual Income | $40,000 | $40,000 |
| Contribution to Account | $2,850 | $0 |
| Taxable Income | $37,150 | $40,000 |
| Estimated Taxes* | $4,165 | $4,507 |
| After-tax Expenses | $0 | $2,850 |
| Net Pay (After Health Care Expenses) | $32,985 | $32,653 |
| Savings | $342 | $0 |

*Using the 2022 federal tax table—Married, Filing Jointly

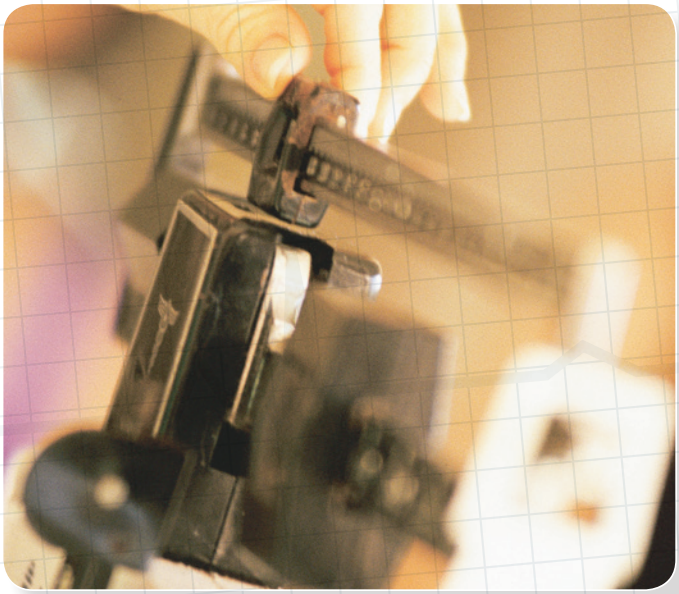
# Health Care Reimbursement Account (HCRA)

## 5 Make sure you use the money in your HCRA and submit claims by the deadline.

- You may carry over up to a maximum of $570 of unused funds left in your account each Plan Year to be used for expenses in the following Plan Year.

New hires are eligible for reimbursements on the first day of coverage.

The amount available for reimbursement is based on your annual contribution amount (minus any previous reimbursements), not on your contributions to date.



## Eligible Expenses

You can use your HCRA for most medically necessary expenses that are not covered by any health plan.

**Following are some typical eligible expenses:**

- Annual deductibles
- Copays (the dollar amount you pay when you receive services)
- Coinsurance (the percentage you pay for covered services)
- Menstrual supplies
- Non-PPO penalties
- Personal protective equipment and supplies—including masks, hand sanitizer and sanitizing wipes
- Prescription copays and coinsurance
- Travel and lodging costs related to medically necessary care and treatment.
- Over-the-counter drugs or medications without a doctor's prescription, such as, pain relievers, cold and allergy medication, smoking cessation products, etc.
- Over-the-counter items in these eligible categories: bandages and wraps, birth control, braces and supports, catheters, contact lens supplies, denture adhesive, diagnostic tests and monitors, first-aid supplies, insulin and diabetes supplies, ostomy products, reading glasses, wheelchairs, walkers and canes
- Dental services not covered by the health plan
- Orthodontia
- Vision exams, eyeglasses and contacts

**Examples of expenses that are NOT eligible for reimbursement:**

- Monthly employee contributions toward your Health Plan
- Expenses reimbursed under any health plan
- Medical services that are not medically necessary
- Insurance premiums for Long-Term Care
- Daily supplements (such as vitamins) unless prescribed by a physician to treat a specific condition.

For a complete list of what's eligible for reimbursement, refer to Internal Revenue Service Publication 502, "Medical and Dental Expenses," available at *irs.gov*.

To protect the Plan's qualified tax-exempt status, the Trust will make the final determination on eligibility of an expense and/or provider requirements. If you have a question about whether or not a particular expense is eligible, be sure to contact the Health Benefits Trust Administrator.

Instead of the HCRA, you may be able to take a tax deduction for eligible medical expenses on your federal income tax return. The deduction, however, is available only for expenses that total more than 7.5% of your adjusted gross income. The deduction is not available for expenses reimbursed through the HCRA. For help determining which approach may be better for you, you may want to consult a professional tax advisor.

### KEY POINT

A HCRA can easily reduce your taxes and increase your net pay after health care expenses—by hundreds of dollars each year.

# Know About Benefits Available to You

These free, confidential, voluntary programs can help you and your family stay on the road to good health.

## Optum Disease Management Program

The Disease Management Program (also known as Condition Management), helps people with chronic pain as well as those with certain chronic health conditions. It is a free, voluntary, confidential program available to all participants with any of these conditions:

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Coronary artery disease
- Diabetes
- Heart failure
- Musculoskeletal pain, including:
  - Back pain (neck, upper and lower back)
  - Fibromyalgia
  - Headaches: migraine or tension
  - Osteoarthritis
  - Regional musculoskeletal disorders (RMD)
  - Rheumatoid arthritis

The program connects you with experts who can teach you how to improve your health, professionals you can call with your questions or concerns, and health information online and by mail.

Best of all, with knowledgeable, caring support you can improve your health. Disease Management is proven to help people with chronic conditions stay healthier, feel better and enjoy the best quality of life possible. To learn more, go to *asea.optum.com*.

**KEY POINT**

If you have chronic pain or one of the listed chronic conditions, participation in the Disease Management Program can help you better manage your condition. The program is voluntary and free to participants in the Health Trust.

## Chronic Kidney Disease (CKD) Management

The ASEA Health Benefits Trust has partnered with Renalogic to help you learn about kidney health and how to manage your lifestyle to prevent Chronic Kidney Disease (CKD). If left untreated, CKD can worsen and lead to end-stage renal disease (ESRD) which is fatal without artificial filtering (dialysis) or a kidney transplant. If you or your covered dependents have a higher risk for developing CKD, or if you already have CKD or ESRD, you are eligible for this free program. A Renalogic Nurse Patient Advocate will partner with you to help you get the health care you need and make the most of your benefits. Your participation is completely voluntary and confidential.

To learn more, go to *aseahealth.org* and click *Chronic Kidney Disease Management (CKD)*, found under *Your Benefits*. Or, go to *renalogic.com/afscmelocal52*.

## Teladoc for Your Non-Urgent Medical Care

Who wants to go out, even to a doctor's appointment, when you're not feeling well? Now you can seek treatment with a board-certified physician by phone, online video or mobile app anytime—at no cost to you—through Teladoc. When you have a minor illness (such as sinus problems, bronchitis, allergies, cold and flu symptoms, or respiratory or ear infection), you may request a doctor's visit by web, phone or mobile app. Then a board-certified doctor will contact you to diagnose your condition,

recommend treatment and prescribe medication, if appropriate. It's that easy! To learn more, go to *aseahealth.org* and click *Teladoc*, found under *Your Benefits*.

## Teladoc for Your Behavioral Health

Your behavioral health is important, too! You can seek treatment with a Teladoc behavioral health provider—online, through the mobile app or by phone—for behavioral health issues (such as depression, stress and anxiety, emotional difficulties, grieving issues and trauma resolution). There is no cost to you; no copay or deductible. When you make an appointment with Teladoc, a licensed behavioral health provider will contact you to diagnose your condition, recommend treatment and prescribe medication, if needed. Behavioral health services through Teladoc are available to participants ages 13 and over. Services may be limited for dependents ages 13–17 and require your supervision. To learn more, go to *aseahealth.org* and click *Teladoc*, found under *Your Benefits*.

## SWORD Virtual Physical Therapy

You can receive physical therapy services virtually from the comfort of your home through the SWORD Virtual Physical Therapy benefit. There is no cost to you.

SWORD provides virtual physical therapy for all the major musculoskeletal issues, at any point in the journey: prevention, acute conditions, chronic pain and post-surgical recovery.

You will be matched with a therapist who will create your personalized program and work with you every step of the way. Your therapist tracks your progress and corrects your form in real time, so you get better, faster.

This is a new benefit beginning July 1, 2022. To learn more, go to *aseahealth.org* and click on *SWORD Virtual Physical Therapy* under *Your Benefits*.

## Transcarent Surgery Care—Planned, Non-Urgent Surgery Outside of Alaska

Transcarent Surgery Care (formerly known as BridgeHealth) is an option to consider when you need planned, non-urgent surgery (such as a total hip or knee replacement, coronary artery bypass graft or spinal fusion). Through Transcarent Surgery Care, you may be able to have your surgery performed by top rated surgeons in premier facilities across the United States, at no cost to you! If you choose Transcarent Surgery Care, the Health Trust:

- Covers ALL medical costs; there is no deductible or coinsurance
- Pays for your travel expenses, including first-class airfare, lodging and food, up to plan limitations
- Pays the travel expenses for a companion (whom you choose) to go with you as your caregiver

Upon your return home, the Health Trust covers follow-up care as a regular medical expense. You will pay your normal copay or coinsurance after you meet the annual deductible. This includes follow-up doctor visits, medications, tests, physical therapy, etc. To keep your out-of-pocket costs down, be sure to use PPOs within the Municipality of Anchorage.

When you have surgery arranged by Transcarent Surgery Care, you'll work with a Care Coordinator, who will help you understand your treatment options, choose a surgeon and facility, make your travel arrangements, and much more. To learn more, go to *aseahealth.org* and click *Transcarent Surgery Care* found under *Your Benefits*.

Note: Plan limitations and exclusions will apply with respect to surgical procedures covered by the Plan. If the ASEA Health Benefits Trust Plan is your secondary health plan, Transcarent Surgery Care may not be available to you. Contact Transcarent for more information by email at *surgerycare@transcarent.com* or by phone at (844) 249-8108, or go to *transcarent.com/surgery-care*.

## Lifeworks Employee Assistance Program (EAP)

Could you use some help finding solutions to challenges you face, such as parenting issues, relationships, financial strain or work stress? Contact your Employee Assistance Program (EAP).

Your EAP benefits provide you and your covered dependents with up to six free counseling sessions per condition per year, plus referrals to community resources, information and much more. **The EAP is 100% confidential**, even if you call to discuss work-related problems.

Here's how to connect to the EAP: call (877) 234-5151 (toll-free), 24 hours a day, 7 days a week, or go to *lifeworks.com* (User ID = asea; Password = eap) for information resources.

Use the LifeWorks mobile app to quickly access valuable information. To install the app, search for and choose "LifeWorks" in the app store for your device. The first time you use it, enter Username: asea and password: eap (case sensitive).

### KEY POINT

The Employee Assistance Program helps you and your covered dependents find solutions to life's challenges with free counseling and valuable information resources.

## Submitting Claims for Payment

The Trust has a relationship with Aetna that requires all medical providers to submit their claims through Aetna. Whether you use a PPO provider or a Non-PPO provider, all medical claims must be submitted directly to Aetna either electronically or to the address listed on the back of your ID card.

Claims that you expect to be reimbursed for should be submitted directly to the Health Benefits Trust Administrator. Examples are expenses for authorized travel benefits or a covered expense that was not billed by the provider, which you paid for at the time of service. You must turn in a Request for Reimbursement Medical/Dental Benefits claim form and attach an itemized bill. The form can be found on the Trust website. The itemized bill must include:

- Your provider's name
- Your provider's IRS number
- The date of service
- An itemized description of the service and charges

### Claim Filing Deadline

To receive benefits, claims must be submitted as soon as possible, but not later than 12 months after the date you incurred the expenses, even if the delay in filing is a result of a third party's failure to provide timely information to you, the Plan, or another medical plan which coordinates coverage with this Plan.

## Claim Appeals Process

If the Health Benefits Trust Administrator denies payment for your claim, or any portion of it, your Explanation of Benefits (EOB) explains the reasons why. If you do not understand these reasons, call the Health Benefits Trust Administrator for clarification.

To ensure claims are paid properly, and to give everyone a fair hearing, participants have access to three levels of claim appeals. The original benefit decision may be reversed at any level, but each level must be pursued in order. Failure to timely appeal the denial of benefits under these procedures will preclude further review of your claim.

**LEVEL 1—Appeal to the Health Benefits Trust Administrator**: You must appeal the denial within 180 days following the date of the claim denial.

**LEVEL 2—Appeal to the Board of Trustees**: You file a written appeal to the Board of Trustees within 60 days following the date of the determination in Step 1. The appeal form can be found on the Trust website (select Forms, then choose Appeals). The Board of Trustees reviews the appeal at the next regularly scheduled appeals meeting. You or your attorney may choose to present the appeal in person or telephonically. The Board of Trustees may seek an independent medical evaluation, if necessary, prior to making a determination on the appeal.

**LEVEL 3—Appeal to an IRO**: You can request an external review of an appeal involving medical judgment or the rescission of a benefit. An external review, conducted by a qualified Independent Review Organization (IRO), can be requested if your appeal qualifies for an external review, was filed timely and the completion of Levels 1 and 2 of the internal process have been completed. The decision of the IRO is binding upon you and the Plan, except to the extent other remedies may be available under applicable law.

See "If a Claim is Denied" in the Benefits Plan Booklet for a full explanation of the Claim Appeals process.

### KEY POINT

It is your responsibility to make sure your providers submit claims on time. Log in to the secure portion of the site to view medical and dental claims that have been submitted for you and check their status.

# Key Contacts

## BENEFITS ADMINISTRATION
- Filing benefit claims
- Checking the status of a claim
- Filing appeals
- Eligibility and enrollment
- Travel preauthorization
- Making a self- payment
- Health Care Reimbursement Account (HCRA) information
- Changing your mail or email address

**Zenith American Solutions**
**(the ASEA Health Benefits Trust Administrator)**
- (866) 553-8206 (toll-free) Fax: (509) 323-7614
- Mail: PO Box 5434, Spokane, WA 99205

## CHRONIC KIDNEY DISEASE MANAGEMENT
*Get program information*

**Renalogic**
- (844) 841-5065 Website: renalogic.com/afscmelocal52

## COALITION HEALTH CENTERS
- Preventive Care
- Work-related physicals
- Routine Care
- Treatment for illness or injury

**Coalition Health Centers**
Website: coalitionhealthcenter.org
- Anchorage: (907) 264-1370, 701 East Tudor Road
- Fairbanks: (907) 450-3300, 575 Riverstone Way, Unit 1

## DISEASE MANAGEMENT PROGRAM

**Optum**
- (855) 738-1768 (toll-free) Website: asea.optum.com

## EMPLOYEE ASSISTANCE PROGRAM
*Confidential, free counseling and referral services*

**LifeWorks**
- (877) 234-5151 (toll-free)
- Website: lifeworks.com Login: asea / Password: eap

## NATIONWIDE PPO PROVIDER
*Outside the Municipality of Anchorage / Alaska*

**Aetna**
- Website: aetna.com
  Select the "Aetna Choice POS II (Open Access)" network.

## PPO PROVIDERS
*Within the Municipality of Anchorage/Mat-Su Borough*

**Alaska Regional Hospital**
- (907) 276-1131 Website: alaskaregional.com

**Mat-Su Regional Medical Center**
- (907) 861-6000 Website: matsuregional.com

**Geneva Woods Birth Center**
- (907) 561-5152 Website: midwivesatgenevawoods.net

## PPO PROVIDERS, continued

**Chugach Physical Therapy**
- (907) 272-8615

**Ascension Physical Therapy**
- (907) 770-6693

**Alaska Hand Rehabilitation**
- (907) 563-8318

**Surgery Center of Anchorage**
- (907) 563-1800 Website: surgerycenterofanchorage.com

**Alaska Center for Ear, Nose and Throat (ACENT)**
- (907) 279-8800 Website: acentalaska.com

**Anchorage Fracture and Orthopedic Clinic**
- (907) 563-3145 Website: afoc.com

## PRESCRIPTION DRUG BENEFITS
- Locating a network pharmacy
- Using the mail order service
- Checking the status of claim you submitted
- Getting answers to your prescription benefit questions

**CVS/caremark**
- Participants: (866) 818-6911 (toll-free)
- Pharmacies: (800) 364-6331 (toll-free)
- Website: caremark.com

## SURGICAL CARE
*Talk to a Care Coordinator about surgery options*

**Transcarent Surgery Care (formerly known as BridgeHealth)**
- (844) 249-8108 Website: transcarent.com/surgery-care
- Email: surgerycare@transcarent.com

## TELADOC FOR VIRTUAL NON-URGENT MEDICAL CARE AND BEHAVIORAL HEALTH CARE
*Free access to a healthcare provider by phone, online video or mobile app*

**Teladoc**
- (800) TELADOC (toll free) Website: teladoc.com

## VISION BENEFITS
- Filing benefit claims
- Locating a VSP vision provider

**VSP**
- (800) 877-7195 (toll-free) Website: vsp.com

## YOUR HEALTH TRUST BENEFITS
- Health Plan benefits information
- Online enrollment
- Forms to download
- Contacting ASEA Health Benefits Trust representatives

**ASEA/AFSCME Local 52 Health Benefits Trust**
- Website: aseahealth.org
- Email: After logging in to the Trust website, send a secure message through Contact Us.