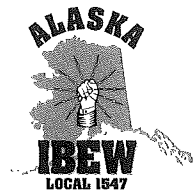

Alaska Electrical Trust Funds

PENSION FUND – HEALTH AND WELFARE FUND – LEGAL FUND
701 E Tudor Suite 200 • Anchorage, AK 99503
(907) 276-1246 • (800) 478-1246 • Fax: (907) 278-7576
www.aetf.com

Dear plan participant,

As a participant in the Alaska Electrical Health and Welfare Fund, you have the right to appeal a full or partial denial of benefits.

Before invoking the hearing procedures listed below, you should contact the office that denied your claim. That office may be able to solve the problem without a review or hearing before the Claims Appeal Committee. Contact the Administrative Office for eligibility, disability, dental and medical claims, including pre-admission certification or medical necessity review; Caremark for prescriptions; Vision Service Plan for vision claims; ReliaStar Life Insurance Company for life and accidental death and dismemberment benefits.

Review and Appeal Hearing

If your claim is denied, you have the right to appeal the denial to the Committee. The appeal must be made within 180 days from the date of the denial notification. The 180 days includes mailing time. *If the Administrative Office does not receive your request for appeal within the 180-day period, you waive your right to appeal.*

To be considered, *all appeals must be in writing* with the following information included in your letter:

- Your name
- Social Security number
- Address
- Telephone number
- Date of document in which benefits were denied
- The decision or action you are appealing
- An explanation of why you believe benefits were denied incorrectly
- Any additional information you feel is pertinent
- If you desire to appear in person before the Committee
- If legal counsel will represent you, provide legal counsel's name and address.

Except for urgent and pre-service health claims, an appeal will be presented to the Committee at its next quarterly meeting. If an appeal is received less than 30 days before the next quarterly meeting, consideration of the appeal may be postponed (if necessary) until the second quarterly meeting following receipt of the appeal. In the event of an urgent or pre-service health claim, the appeal will be presented to designated members of the Board of Trustees as expeditiously as possible. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of you claim. If you believe that your situation is urgent, you may request an expedited appeal by calling the Administration Office directly at (907) 276-1246 or (800) 478-1246.

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If you request an oral hearing, both you and your representative may attend the hearing. Before the hearing, you are entitled to inspect the Fund's claim file and any relevant documents. You should provide a list of witnesses you intend to call to testify on your behalf as well as copies of all documents you'll offer as evidence. This information should be sent to the Administrative Office before your hearing.

At the hearing, you and/or your representative can present information in opposition to the decision previously made. The Trustees, Administrator, and legal counsel for the Fund have the right to question you and your witnesses. When you finish your presentation, the Administrator may introduce information in opposition to the appeal. You have the right to question all evidence and testimony. Evidence is not required to conform to common law or statutory rules of evidence.

A written record is made of the hearing testimony. Documents and records reviewed by the Committee or introduced by you are part of the record. (If an oral hearing is not requested, the Committee's action is recorded in the meeting minutes.)

After the Committee considers the appeal, a written decision is prepared explaining the reasons for their decisions and referencing the plan provisions and procedures that apply to the claim. A copy of the decision is mailed (by certified mail with a return receipt requested) to you within five days. When appropriate, the Committee may issue a more detailed explanation of the reasons for its decision within 30 days of the hearing.

If a decision cannot be reached at the initial meeting at which the appeal is heard, the Committee may defer a decision on an appeal until the next quarterly scheduled appeals meeting provided that written notice is provided to you.

Pre-Service Claims (applies only to properly filed claims that must be preauthorized to receive full benefits from the Fund.)

Pre-Service health claims will be conducted in accordance with the above procedures with the following modifications:

i. A decision or an appeal of a denial of a pre-service health claim will be issued in 30 days of receipt of the appeal.

ii. Unless the appeal hearing coincides with a quarterly Committee meeting, the Committee meeting will be conducted by a telephone conference call. You or your authorized representative may participate to the extent necessary for the Committee to develop an adequate record. If you wish to appear in person, you may elect to postpone the hearing until the next quarterly Committee meeting.

More Questions?

If you have additional questions, please contact the Administrative Office at the address and phone number above.