Alaska Electrical Health and Welfare Fund
SCHEDULE OF BENEFITS
Plan 500

MEDICAL	
Annual Deductible	
Per Person	$500
Per Family	$1,500
Hospital Inpatient Deductible	
Alaska Regional Hospital Mat-Su Regional Hospital Alaska Hospitals (outside of Anchorage) Aetna Preferred Hospitals (outside of Alaska)	$300
Non-Preferred Hospitals (in Anchorage and outside of Alaska)	$600
Reimbursement Percentage	
Preferred Provider and Out-of-Area	80%
Non-Preferred Provider*	60%
Reimbursement Percentage After Out-of-Pocket Maximum is Reached	
90%	$2,500 per person or $5,000 per family Out-of-Pocket maximum
100%	$5,000 per person or $10,000 per family Out-of-Pocket maximum

*Applies to first $50,000 of Covered Charges; thereafter reimbursed at the Preferred Provider percentage.

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DENTAL	
Annual Deductible	None
Reimbursement Percentage	
Part I – Routine and Preventive	100%
Part II – Basic Dental	80%
Part III – Major Dental	50%
Orthodontia	50%
Annual Benefit Maximum (Part I, II, III)	
Per Person	$2,000
Orthodontia Benefit	
Dependent Children Only	$2,000 lifetime maximum benefit

WEEKLY DISABILITY INCOME	
Benefit (weeks 1-13)	$250 per week
Benefit (weeks 14-26)	$200 per week
Both non-occupational and occupational disabilities are covered.	

LIFE INSURANCE	
Employee	$5,000
ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT	
Employee Principal Sum	$5,000

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VISION	If You See a VSP Network Provider	If You See a Non-VSP Provider
Copayment		
Exam Lenses & Frame	$20 $30	$20 $30
Covered Expenses		
Eye Exam	Paid in full	Up to $45
Lenses Single Vision Lined Bifocal Lined Trifocal Lenticular	 Paid in full* Paid in full* Paid in full* Paid in full*	 Up to $45 Up to $65 Up to $85 Up to $125
Frames	Paid up to $120**	Up to $47
Contacts – instead of lenses and frames Necessary*** Cosmetic	 Paid in full* Up to $120	 Up to $250 Up to $105
Frequency Limits		
Exam Lenses Frames Contacts (instead of glasses)	Every 12 months Every 12 months Every 24 months Every 12 months	Every 12 months Every 12 months Every 24 months Every 12 months

* Lenses are paid in full, excluding cosmetic extras. Cosmetic extras include (but are not limited to) oversize lenses, coated lenses, tinted or photochromic lenses, progressive addition or blended lenses.

** A variety of frames are covered in full. If your frame exceeds the allowable cost, you will receive a 20% discount on your out-of-pocket costs for the frame.

*** Medically necessary contact lenses may be prescribed by a provider for certain conditions. Your VSP provider will determine if you qualify for coverage for these types of contacts at the time of service.