ALASKA
ELECTRICAL TRUST FUNDS

ALASKA ELECTRICAL HEALTH AND WELFARE FUND

Summary Plan Description

January 2024

ALASKA IBEW LOCAL 1547

NECA ALASKA CHAPTER

Alaska Electrical Health and Welfare Plan

To All Covered Persons:

We are pleased to present this updated booklet describing the benefits provided by your Health and Welfare Plan as of January 1, 2024.

If you have any questions about the benefits available to you, please contact the Administrative Office where the staff will be happy to assist you.

Sincerely,

Board of Trustees
Alaska Electrical Health and Welfare Fund

QUICK TIP

You can find the most frequently asked questions about the Health and Welfare Plan and all forms & documents on our website at **www.aetf.com**.

Need Assistance?

The Administrative Office can help answer your Health and Welfare Plan eligibility, claims or other questions.

Phone: (800) 478-1246 | Email: aetfhw@aetf.com

IMPORTANT NOTICE

The Alaska Electrical Health and Welfare Fund (Fund) is committed to maintaining health care coverage for employees and their dependents at an affordable cost. However, the Board of Trustees (Trustees) reserves the right to amend or terminate coverage at any time and for any reason.

The Board of Trustees has the exclusive authority to interpret the provisions of the Plan, to determine eligibility for and entitlement to Plan benefits or to amend the Plan. Any interpretation or determination by the Trustees made in good faith, which is not contrary to law, is conclusive on all persons affected. The Board of Trustees has delegated to the Administrative Office the authority to administer the Plan and provide information relating to the amount of benefits, eligibility, and other Plan provisions. The Board of Trustees may also refer certain questions or plan administration issues to medical review organizations or other third-parties. In administering the Plan, the Administrative Office and any medical review organization used by the Fund may utilize internal guidelines and medical protocols in determining whether or not specific services or supplies are covered under the terms of the Plan. Neither the Administration Office nor any other third party has the authority to change the provisions of this Plan document. An interpretation or representation of the Plan or the Plan's terms by the Administrative Office is subject to review by the Board of Trustees. No individual Trustee, employer, employer association, labor organization, or any individual employed by an employer or labor organization, has any authority to interpret or change the Plan.

Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your dependents can find and refer to them.

Contents

Eligibility

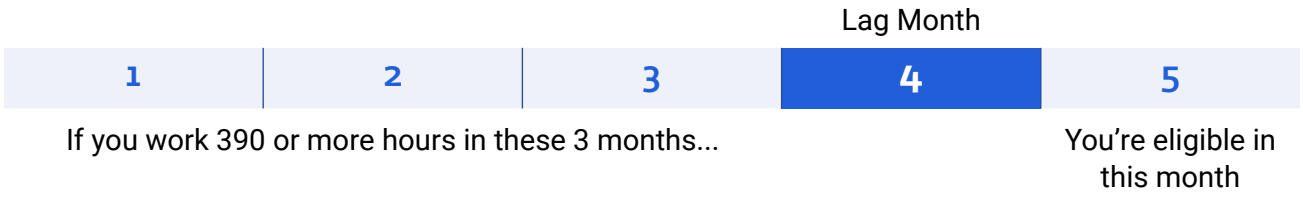
Eligibility

This section describes the eligibility requirements for active employees (both flat rate monthly eligibility and hour bank eligibility) and their dependents. There is no retiree eligibility under this Plan.

Hour Bank Eligibility

ESTABLISHING HOUR BANK ELIGIBILITY

Employees covered by an agreement calling for hourly contributions to the Fund will have all their hours worked reported and credited to an hour bank. These employees (hour bank employees) are initially eligible on the first day of the second calendar month following accumulation of 390 or more work hours reported and paid to the Fund within a consecutive 3-month period. These hours are accumulated into an hour bank. For example:



Note: in order to be initially eligible for coverage, *a minimum of 390 hours must be worked in three consecutive months*. Working 100 hours a month for four months does not meet this requirement.

The lag month is necessary for the processing of the prior month's reported hours by the Administrative Office.

CONTINUING HOUR BANK ELIGIBILITY

If you are an hour bank employee and you have satisfied the initial eligibility requirements above, you will continue to be eligible if you have at least 130 hours in your hour bank each month. All hours worked in excess of 130 in any one month will be credited to your hour bank (up to a maximum of 1,040 hours), which will provide coverage during subsequent months.

Example	
Hours worked in a calendar month	160
Subtract hours needed for coverage	130
Remaining hours applied to Hour Bank	30

The remaining 30 hours apply to your hour bank for future coverage.

The maximum that you can accumulate in your hour bank at any one time is 1,040 hours, after deduction for the current month's coverage; 520 hours for members working under the Electrical Industry Support Agreement.

You will be eligible and covered as long as you have 130 or more hours in your hour bank. Each month you are covered, 130 hours is deducted from your hour bank. The lag month continuously applies in computing your coverage. If your hour bank has less than 130 hours of credit on the first of a month, you will not be eligible for that month and your eligibility is terminated.

Please Note: The maximum number of hours that you can accumulate in your hour bank is 1,040 hours, which would currently fund 8 months of coverage. However, your hour bank is not a guarantee of coverage or a guarantee of specific number of months of eligibility. The Fund's Trustees reserve the right to change the number of hours required for coverage or eliminate hour bank eligibility.

It is your responsibility to check with your employer, the Administrative Office, or Local 1547 frequently to make certain that health and welfare contributions for which you are entitled are being made for you by your employer.

FORFEITURE AND REINSTATEMENT OF HOUR BANK ELIGIBILITY

If your coverage terminates because your hour bank has less than 130 hours, the balance of your hours, if any, will be carried for 4 months. If, during that 4 months, you work and add hours to your hour bank, your eligibility will be reinstated on the first day of the second month after the hour bank has a total of 130 hours. If you do not work sufficient hours during the 4-month period following termination to obtain reinstatement, the balance of your hours, if any, will be canceled and you will be required to satisfy the initial eligibility rules to again be covered.

However, if you have continued coverage pursuant to one of the Plan's continuation options, your hour bank will be kept frozen for the period that self-payments are received. Upon returning to work, the frozen hours will be used toward the 130-hour requirement and you will not need to re-satisfy the initial eligibility rules. If your continuation coverage ends and you don't acquire 130 hours within the 4 months, your frozen bank will be canceled, and you will be required to satisfy the initial eligibility rules.

If you transfer to a position providing monthly coverage, the balance in your hour bank will be frozen for up to 36 months and will be available should you lose coverage within that 36-month period. Thereafter, your frozen hour bank will be cancelled.

Reciprocal Eligibility

The Fund has entered into the Electrical Industry Health and Welfare Reciprocal Agreement. The Reciprocal Agreement permits you to retain your eligibility and benefits under the Alaska Electrical Health and Welfare Fund even though you are working in another area. **If you are contemplating employment outside of Local 1547's jurisdiction, please contact the Administrative Office for additional information in advance of leaving Alaska.**

To be eligible for coverage under the Reciprocal Agreement, you must meet the following requirements:

- You must be a member in good standing of Local 1547, and eligible for benefits under the Alaska Electrical Health and Welfare Fund during any time in the past six years, or

- If the Alaska Electrical Health and Welfare Fund is not your "Home Fund", you must meet certain criteria for declaring the Alaska Electrical Health and Welfare Fund as your Home Fund. Contact the Administrative Office for full details.

Under the Reciprocal Agreement, health and welfare contributions made on your behalf to the "Participating Fund" (the fund in the jurisdiction in which you are working) may be transferred to the Alaska Electrical Health and Welfare Fund. If the contribution rate for the Alaska Electrical Health and Welfare Fund is greater than that for the Participating Fund, the hours reported from the Participating Fund will be reduced on a pro rata basis.

For example, if you were to work in a jurisdiction with a contribution rate of $6.00 per hour, and the Alaska Electrical Health and Welfare Fund contribution rate is $10.00 per hour, the hours submitted to the Alaska Electrical Health and Welfare Fund by the Participating Fund would be multiplied by 0.6 and the resultant number of hours would be placed in your hour bank:

Away Trust $6.00 per hour = 0.6
Alaska Trust $10.00 per hour
If 200 hours were worked in the Participating Fund:
200 hours x 0.6 = 120 hours credited to Alaska Electrical Health and Welfare Fund hour bank.

Another example where the away Fund has an $8.00 per hour contribution rate would be:

Away Trust $8.00 per hour = 0.8
Alaska Trust $10.00 per hour
If 175 hours were worked in the Participating Fund:
175 hours x 0.8 = 140 hours credited to Alaska Electrical Health and Welfare Fund hour bank.

IMPORTANT — PLEASE NOTE: There may be plans that have an hourly rate so much lower than the Alaska Electrical Health and Welfare Fund that you may not be able to have enough hours credited to your hour bank to become or stay eligible. Should you need any assistance call the Administrative Office.

There are certain requirements which must be met in order for you to be covered under the Reciprocal Agreement. You must come into the Administrative Office or the union hall with photo identification and register electronically. The registration is a blanket authorization, so when you are working outside the jurisdiction of the Alaska Electrical Health and Welfare Fund, please inform the union hall or benefit office in the jurisdiction in which you are working that you have registered for reciprocal transfers through the **Electronic Reciprocal Transfer System** (ERTS).

Flat Rate Monthly Eligibility

Employees covered by an agreement calling for a flat rate monthly contribution will be eligible for coverage on the first day of the calendar month following the calendar month during which the employee worked the number of hours required for coverage (e.g., work during September provides coverage for October). The number of work hours required for coverage is set forth in the applicable collective bargaining agreement or special agreement. Flat rate monthly employees do not have an hour bank.

Your eligibility for coverage as a monthly employee will continue as long as the required contribution is received from your employer.

Termination of Employee Eligibility

Your eligibility as a flat rate monthly or hour bank employee will terminate on whichever the following dates occurs first:

- **For hour bank employees** — the last day of the calendar month prior to the month in which your hour bank has less than 130 hours of credit.
- **For flat rate monthly employees** — the last day of the calendar month that you did not work the number of hours required for a month of coverage.
- The date that any contribution required on your part (the employee's) is due and unpaid.
- The date you enter the armed forces on full-time active duty, subject to your right to continue coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) (page 11).
- The date the Plan is terminated.

If your coverage terminates, you may be eligible for continuation coverage. See page 8 for the various types of continuation coverage rights available from the Plan.

Dependent Eligibility

Your dependents are generally eligible when you are eligible. New dependents are covered on your date of marriage or their birth, or in the case of adoption, the date the child is placed in your home. The Administrative Office should be notified within 60 days of your acquiring a new dependent in order to ensure that claims are processed correctly. In no case will coverage of new dependents apply retroactively more than 365 days from the date the Administrative Office was notified.

Dependents are defined as:

- Your legal spouse.
- Children under age 26 including your natural children, legally adopted children or children placed for adoption, step-children, and foster children. In addition, foster children and similar children who are placed by an authorized placement agency, judgment, decree or court order, who reside with you or your spouse and for who you or your spouse is financially responsible for their care and support.
- Children age 26 and over, if as of the date they would otherwise lose coverage, the child is disabled, the disability arose before the child reached age 26 and as a result of that disability the child is primarily dependent on the employee for support. For this purpose, disability is defined as a mental or physical condition that is expected to be permanent and continuous for the remainder of the child's life and results in the inability to engage in self-sustaining employment,

including one or more of the following: the inability to perform activities of daily living, the inability to engage in normal social functions, the inability to independently complete tasks. Disability does not include conditions that are temporary or where recovery would be expected through treatment. A Social Security Disability Award will be considered presumptive evidence of disability. Absent a Social Security Disability Award, the Plan will make a disability determination based on the individual's facts and circumstances. The Plan may consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

In accordance with federal law, the Plan also provides medical/prescription drug/dental/vision coverage to certain dependent children (called alternate recipients) if directed to do so by a Qualified Medical Child Support Order (QMCSO) issued by a court or state agency of competent jurisdiction. Contact the Administrative Office for details. You and your dependents may obtain, without charge, a copy of the procedures governing medical child support orders and determinations from the Administrative Office.

Grandchildren and children of dependent children will only be covered if the child meets the eligibility criteria set forth above. Coverage is not automatic. You must make specific application to the Fund.

Enrollment

In order to avoid delay in processing your claims, an enrollment form must be on file at the Administrative Office.

QUICK TIP

You can find an electronic version of the Enrollment Form and other forms & documents on our website at **www.aetf.com**.

If you have not already done so, please obtain an enrollment form from the Administrative Office or the Fund's website. Complete it and return it to the Administrative Office as soon as possible. If you have not previously provided them, please attach true copies of the appropriate marriage certificate, dependent birth certificates, court approved adoption papers, child custody decrees and divorce decrees. This information will be used to determine eligibility and help coordinate benefits if you have coverage under more than one health plan.

The Plan does not limit enrollment to an annual open enrollment or require special enrollment. However, the Administrative Office should be notified within 60 days of adding a new dependent. In no case will coverage of new dependents apply retroactively more than 365 days from the date the Administrative Office was notified.

To ensure proper claim service, a new enrollment form should be filed for each additional dependent as soon as the dependent becomes eligible. The Plan will not process your claims until a completed enrollment form and all required documentation has been received.

It is also in your best interest to file a new enrollment form if you change your address or have need to make a change in your beneficiary designation.

Keep in mind that when a new enrollment form is filed, it must be complete because it replaces any form previously filed.

Note: *A separate Annual Medical/Dental Update form must be filed with the Administrative Office once every 12 months for each employee and covered dependent.*

QUICK TIP

Be sure to fill out a new enrollment form if you have a change of address or need to change your beneficiaries.

Termination of Dependent Eligibility

The coverage of any dependent shall terminate on the earliest of the following dates:

- The last day of the calendar month that the dependent no longer meets the definition of an eligible dependent.
- On the date the employee's coverage terminates.
- The date the Plan is terminated.

If your dependents' coverage terminates, your dependents may be eligible for continuation coverage. See **page 8** for the various types of continuation coverage rights available from the Plan.

Continuation Coverage

Continuation Coverage

If your eligibility for Plan coverage ends due to termination of employment, reduction in work hours, termination of your employer's contributions to the Fund or you become Totally Disabled, your death or entry into military service, you or your dependents may be able to continue coverage for a period of time.

Continuation Coverage During Lost Time Due to Illness or Injury

If you are unable to work as the result of an Illness or Injury, your and your dependents' coverage will continue during the period of disability up to a maximum of 6 months. In order to obtain this continuation coverage, you must have the period of Illness or Injury certified by your Physician.

An employee is allowed only one 6-month extension of eligibility for all disabilities commencing within the 6-month period. This 6-month extension begins on the first of the calendar month following the month in which the Illness or Injury arose. If your employer makes contributions for coverage after the Illness or Injury extension begins, any additional months of coverage will be added at the end of your Illness or Injury extension (when you recover from your Illness or Injury or the maximum 6-month continuation of coverage has been exhausted). Receipt of contributions will not affect the 6-month period for which you are eligible for the Illness or Injury extension.

If you are an hourly employee, the time lost during the 6-month Illness or Injury disability extension period will not be counted as unemployed time for the purposes of reinstatement of eligibility.

If you are a monthly employee, any months of coverage that are added due to employer contributions while disabled will be canceled if not used within 36 months after the month in which the coverage was gained.

Extension of Medical Benefits After Termination of Eligibility (Extended Benefits)

If you become Totally Disabled, medical and prescription drug benefits after termination of your eligibility may be continued for a non-occupational Illness or Injury following the 6-month extension described above. However, this extension is only for Covered Charges related to the condition(s) causing the Total Disability that are incurred during the calendar year in which such 6-month extension ends and the next following calendar year. However, if sooner, benefits shall end on the earlier of the date you:

- are no longer Totally Disabled; or
- have access to other group health coverage or governmental coverage (including, but not limited to, Medicare or Medicaid), whether in your own right or as a dependent of another individual.

To receive these benefits, the individual must contact the Administrative Office and submit proof of Total Disability within 60 days after eligibility ends.

A Covered Person who is eligible for both COBRA and an Extension of Medical Benefits After Termination of Eligibility (Extended Benefits) may choose either to self-pay through COBRA or to

receive Extended Benefits through the Plan. Extended Benefits cannot be elected following COBRA Continuation Coverage.

This Extended Benefits provision applies only to the employee or dependent who is Totally Disabled.

Widow's/Widower's Eligibility

FOR MONTHLY EMPLOYEES

If you should die while eligible under a monthly plan, coverage for your dependents will terminate on the last day of the calendar month for which you earned a month of coverage under the appropriate collective bargaining agreement or special agreement.

FOR HOURLY EMPLOYEES

If you should die while eligible under an hourly plan, coverage will continue to your dependents for as long as your hour bank has sufficient hours to continue coverage. Coverage will terminate on the last day of the calendar month in which you have fewer than 130 hours remaining in your hour bank.

FOR BOTH MONTHLY AND HOURLY EMPLOYEES

Your dependents may be eligible for additional continuation coverage in the Plan for up to 36 months on a self-pay basis (see COBRA Continuation Coverage section on page 14).

As an alternative to COBRA Continuation Coverage, if an employee dies before retiring, his/her surviving spouse may be eligible for coverage in the Alaska Electrical Retiree Health Reimbursement Arrangement Plan (contact the Administrative Office for more information).

Continuation Coverage During Family and Medical Leave of Absence

There are federal laws that provide paid or unpaid leave to care for yourself or family members in specific situations (generally referred to as FMLA). The application of these leave laws depend on where the employer is located and the size of the employer. Generally, to be eligible for FMLA coverage, you must be covered under the Plan when the leave began and your employer must continue to make the required contributions during the leave. FMLA coverage is limited to the permissible leave provided in the applicable statute. Coverage terminates the earlier of the expiration of FMLA leave or sooner as provided in the statute.

As a general matter, the Trust does not determine whether you are eligible for FMLA leave. If you believe you may be eligible for FMLA leave, you should contact your employer immediately. An employer must provide documentation to the Trust to confirm eligibility for FMLA leave, and make arrangements to pay the required contributions to continue coverage.

If you are eligible for FMLA leave, you may request that your dollar bank be frozen at the beginning of your leave period, which the Trust may grant at its discretion provided contributions are received from your employer and you do not lose coverage.

Following FMLA, the Plan's other Continuation of Coverage Options may be available.

Continuation Coverage During Military Service

The following procedures apply for administration of coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) after an employee enters military service. (In addition to active duty in the Armed Forces, this provision applies to service in the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, and the commissioned corps of the Public Health Service.)

PERIODS OF MILITARY SERVICE — USERRA CONTINUATION COVERAGE

If you leave employment with a contributing employer for military service, you have the following options:

- If you have an hour bank, you may elect to either run-out your hour bank; or freeze your hour bank until you return from military service. If you elect to run-out your hour bank, when your hour bank has less than one month of eligibility you may then elect to extend coverage by making self-payments for USERRA continuation coverage.
- If you do not have an hour bank, you still have the option of electing to self-pay for USERRA continuation coverage.

NOTICE OF MILITARY SERVICE

You are responsible for notifying the Administrative Office that you are entering military service. If you want to freeze your hour bank or if you do not have an hour bank, you must notify the Administrative Office within 60 days of beginning military service if you want to elect USERRA coverage.

If you want to run-out your hour bank, and elect USERRA continuation coverage when your hour bank runs out, you must notify the Administrative Office of your military service within 60 days of termination of your hour bank coverage. If you fail to notify the Administrative Office within the 60-day time period, you will not be entitled to elect USERRA continuation coverage.

ELECTION OF USERRA CONTINUATION COVERAGE

After timely notification to the Administrative Office of military service, you will be sent an election form to indicate whether you elect to freeze your hour bank and/or elect USERRA continuation coverage. Your completed election form must be sent to the Administrative Office, and postmarked or received within 60 days from the later of the date coverage would otherwise end, or 60 days from the date the notification is furnished. If you do not return your election form by the due date, your hour bank will run-out until it is depleted (or your return), and you will forfeit your right to elect USERRA continuation coverage.

LENGTH OF USERRA CONTINUATION COVERAGE

If you provide timely notice and properly elect to freeze your hour bank, it will be frozen the first of the month following the month in which you begin military service.

If you properly elect USERRA continuation coverage, the USERRA continuation coverage will begin on the first day of the month following the month in which you begin military service, provided the required self-payments are made.

If you decide to run-out your hour bank before commencing USERRA continuation coverage, USERRA continuation coverage will begin the first of the month following depletion of your hour bank, provided the required self-payments are made.

USERRA continuation coverage will end on the first of the dates indicated below:

- 24 months following the month your coverage would normally end or your hour bank is frozen because of your entry into military service;
- The last day of the month in which you fail to return to employment or apply for a position of reemployment within the time required by USERRA; or
- The last day of the month for which a timely self-payment is not received or postmarked.

AVAILABLE COVERAGE

You may elect to self-pay for USERRA continuation coverage for yourself, yourself and your dependents, or only your dependents. You may elect the following coverage options:

- Medical, prescription drug, dental and vision.
- Medical and prescription drug only.

Once you elect a coverage option, that election cannot be changed for the duration of USERRA continuation coverage. Benefits are the same as those provided to similarly situated active employees. If Plan benefits change, USERRA continuation coverage will also change.

USERRA continuation coverage is not available for weekly disability income, life insurance, or AD&D benefits.

MONTHLY SELF-PAYMENTS REQUIRED

If your military leave is for 31 days or more, a monthly self-payment is required for USERRA continuation coverage. The Administrative Office will notify you of the self-payment amount when it sends you the election form. The rate for USERRA coverage is the same as the COBRA Continuation Coverage rate.

The initial payment for USERRA coverage is due within 45 days from the date the Administrative Office receives a completed election form. The first payment must cover all months for which coverage is sought through the month in which the first payment is made. Eligibility will not commence, nor will claims be processed until the initial payment has been made, at which time eligibility will be retroactive to the date your coverage ended (or hour bank was frozen).

After the initial payment, monthly payments are due on the first of each month for that month's coverage. USERRA continuation coverage terminates if a monthly payment is not postmarked or received by the Administrative Office within 30 days from the beginning of the month to be covered.

USERRA continuation coverage must be continuous and must immediately follow the date your coverage ended (or hour bank was frozen).

REINSTATEMENT OF ELIGIBILITY FOLLOWING MILITARY SERVICE

You are responsible for notifying the Administrative Office of your discharge from military service.

If you properly elected to freeze your hour bank when you entered military service, the balance in your hour bank will be carried over until you are discharged from military service. Your hour bank eligibility will be reinstated the first of the month in which you are discharged. Following reinstatement, hour bank eligibility will terminate the first day of any month your hour bank has less than 130 hours. You may make self-payments if you fail to work sufficient hours to reinstate hour bank eligibility before the previously frozen hour bank runs out.

If you return to employment with a contributing employer immediately following military service and within the time period required by USERRA, your eligibility will be reinstated on the first day of the second month after your hour bank has the minimum required for a month of coverage or, if you do not have hour bank coverage, the first day of the second month following a month you have worked the number of hours required for coverage. If you are on the out-of-work list at the local union, it is considered a return to employment with a contributing employer for purposes of making self-payments for coverage. Pending reinstatement of eligibility, you may make self-payments for coverage.

To request self-pay continuation coverage after leaving military service, you must notify the Administrative Office within 30 days following your return to employment. After timely notification, the Administrative Office will provide an election form. Your completed election form must be sent to the Administrative Office and postmarked or received within 60 days from the date it was mailed to you. The initial payment to continue coverage must be included with the completed election form, and cover all months through which the first payment is made. The self-payment rate is the same as the COBRA Continuation Coverage rate. The coverage provided will be that stated under USERRA continuation coverage.

The self-pay continuation coverage after leaving military service must be continuous, and must commence the later of the first of the month in which you return to employment within the time specified by USERRA or the first of the month following the termination of your previously frozen hour bank eligibility. The reinstated coverage terminates on the earliest of your receipt of six consecutive months of reinstated coverage, reinstatement of your eligibility based upon your hours worked, or the last day of the month for which a timely self-payment is not received or postmarked.

Regardless of whether you want to make self-payments for coverage, you should contact the Administrative Office if you return to employment within the time required by USERRA, so that you may be credited with your coverage when you left for military service, and eligibility can be reinstated without satisfying the rules for initial eligibility.

RELATIONSHIP OF USERRA CONTINUATION COVERAGE TO COBRA CONTINUATION COVERAGE

You may have the right to elect COBRA Continuation Coverage in lieu of USERRA continuation coverage. The length of USERRA continuation coverage may be different from that of COBRA Continuation Coverage. If you have questions regarding election or duration of COBRA Continuation Coverage, contact the Administrative Office.

COBRA Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), "qualified beneficiaries" may extend health benefits (medical, dental, vision) on a self-pay basis under certain circumstances called "qualifying events."

QUALIFIED BENEFICIARIES

A qualified beneficiary means:

- Any individual who, on the day before a qualifying event, is covered under the Plan, either as an employee or as a dependent of an employee.
- A child who is born to, adopted by, or placed for adoption with an employee (as opposed to another family member) during COBRA, provided the child is enrolled by submitting an enrollment form and a copy of the birth certificate or adoption papers to the Administrative Office within 30 days of birth, adoption, or placement for adoption, and the appropriate self-payments are made. The child will have the same COBRA rights as a dependent who was covered by the Plan before the qualifying event that resulted in the loss of coverage.

Dependents who are acquired by the employee during a period of COBRA may be enrolled in COBRA by submitting an enrollment form along with the appropriate certificates to the Administrative Office within 30 days of becoming a dependent. However, such dependents (other than newborns or newly adopted children) will not be considered qualified beneficiaries.

Only qualified beneficiaries may extend COBRA if there is a second qualifying event.

An individual ceases to be a qualified beneficiary if COBRA is not timely elected, or when the Plan's obligation to provide COBRA otherwise ends.

18-MONTH QUALIFYING EVENTS

You and your dependents may elect COBRA for a maximum of 18 months following the date coverage would otherwise end due to one of the following qualifying events:

- Your termination of employment; or
- Your layoff or reduction in hours of employment.

If Social Security determines that a qualified beneficiary is totally disabled either before the 18-month qualifying event or within the first 60 days of COBRA, the disabled individual and all

qualified beneficiaries may extend COBRA an additional 11 months beyond the original 18 months, to a maximum of 29 months. In order to qualify for this extension, the qualified beneficiary must notify the Administrative Office in writing no later than the date that the initial 18 months of COBRA expires. A copy of the Social Security determination must be included with the written notice. For an individual who has extended COBRA beyond the initial 18 months, COBRA will end on the earlier of 29 months from the qualifying event, or the month that begins more than 30 days after the final determination has been made that the disabled individual is no longer disabled.

36-MONTH QUALIFYING EVENTS

A dependent may elect COBRA for a maximum of 36 months following the date coverage would otherwise end due to one of the following qualifying events:

- Death of the employee;
- Divorce between the employee and spouse; or
- The dependent child ceases to meet the Plan's definition of "dependent."

SECOND QUALIFYING EVENT

An 18-month period of COBRA may be extended an additional 18 months, for a total of 36 months, for the affected qualified beneficiary (spouse or child), if one of the 36-month period qualifying events occurs during the first 18 months of COBRA. In no event will COBRA extend beyond 36 months from the date coverage was first lost due to the initial qualifying event. This extension applies only if the qualified beneficiary notifies the Administrative Office in writing within 60 days of the second qualifying event. The notice must identify the qualifying event that occurred. In the absence of such notice, COBRA will terminate.

MEDICARE ENTITLEMENT

If you have an 18-month qualifying event after becoming entitled to Medicare, your dependents may continue COBRA until the later of:

- 18 months from the date coverage would normally end due to the termination of employment or reduction in hours; or
- 36 months from the date you become entitled to Medicare.

NOTICE REQUIREMENTS

The Plan offers COBRA only after it has been notified of a qualifying event. A qualified beneficiary is responsible for notifying the Administrative Office of a qualifying event that is a divorce or child losing dependent status. **The qualified beneficiary must provide this notice to the Administrative Office in writing within 60 days of the later of the date of the qualifying event; or the date coverage would be terminated as a result of the qualifying event; or the date this booklet or other notice is provided describing the procedure for electing COBRA.** The notice must identify the individual who

has experienced a qualifying event, the employee's name, and the qualifying event which occurred. If the Administrative Office is not notified during the 60-day period, the qualified beneficiary will lose the right to elect COBRA.

The Administrative Office will notify qualified beneficiaries of loss of coverage due to termination of employment, reduction in work hours, or the employee's death. However, you are encouraged to inform the Administrative Office of any qualifying event to best ensure prompt handling of your COBRA rights.

ELECTION OF COBRA

When the Administrative Office is notified of a qualifying event, an election form is mailed to the qualified beneficiaries. The election form must be completed and returned to the Administrative Office within 60 days of the later of the termination of coverage, or the date the application was sent. If the election form is not sent to the Administrative Office by this date, the qualified beneficiaries will lose the right to elect COBRA.

Each qualified beneficiary has an independent right to elect COBRA. An employee or spouse may elect COBRA on behalf of other qualified beneficiaries in the family. A parent or legal guardian may elect COBRA on behalf of a child under age 18.

TYPE OF BENEFITS

The following benefit options are available under COBRA, provided the qualified beneficiary was eligible for such benefits immediately prior to the qualifying event:

- Medical and prescription drug; or
- Medical, prescription drug, dental, and vision.

Life insurance, accidental death and dismemberment benefits, and weekly disability income benefits are not available under COBRA.

COST AND PAYMENT

There is a cost for COBRA. Information regarding the cost will be sent with the election forms. The first payment is due 45 days from the date the election form is sent to the Administrative Office. The first payment must cover all months since the date coverage would have otherwise terminated. Thereafter, payments must be made monthly to continue COBRA. All payments must be sent to the Administrative Office.

COBRA eligibility will not commence, nor will claims be processed for expenses incurred following the date of the qualifying event, until the appropriate COBRA payments have been made. COBRA terminates if a monthly payment is made later than 30 days from the beginning of the month to be covered. If the initial payment, or any subsequent payment is not made in a timely fashion, COBRA terminates.

TERMINATION OF COBRA

COBRA ends on the first of the dates indicated below:

- The last day of the month the maximum coverage period for the qualifying event has ended (18, 29, or 36 months).
- The last day of the month for which the self-payment was paid, or when the qualified beneficiary does not make the next payment in full when due. Delinquent payments must be made up within 30 days after the due date.
- The date the qualified beneficiary first becomes, after the date of election of COBRA, covered under any other group health plan. A qualified beneficiary, who first becomes covered under any other group health plan after the date of the election of COBRA, must notify the Administrative Office in writing of the other coverage.
- The last day of the month that begins more than 30 days from the final determination that the qualified beneficiary is no longer disabled as determined by Social Security. This applies only to the 19th through 29th month of disability extended COBRA.
- The date the Fund no longer provides group health coverage.

COBRA is provided subject to eligibility. The Plan reserves the right to terminate COBRA retroactively in cases of fraud or misrepresentation.

RELATIONSHIP BETWEEN COBRA, MEDICARE AND OTHER COVERAGE

If you or your eligible dependent is Totally Disabled as the result of an accidental Injury or Illness, benefits related to the disability are available following the termination of coverage, in lieu of COBRA. However, COBRA may not be elected following the termination of the disability extension.

If you qualify for both COBRA and coverage by the Alaska Electrical Retiree Health Reimbursement Arrangement Plan ("Retiree HRA Plan"), you and your dependents may elect COBRA in lieu of the Retiree HRA Plan. Following termination of COBRA, you and your dependents may apply for enrollment in the Retiree HRA Plan. However, if COBRA is declined in favor of the Retiree HRA Plan, COBRA may not thereafter be elected.

EFFECT OF NOT ELECTING CONTINUATION COVERAGE

In considering whether to elect continuation coverage, please be aware that a failure to maintain health coverage can result in penalties under federal law as follows:

- You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your Plan coverage ends because of your qualifying event. You will also have the same special 30-day enrollment right at the end of the maximum continuation coverage period available to you, and
- You also have the right under the ACA to purchase healthcare coverage on your home state's Exchange within 30 days after your group health coverage from the Fund ends. If you do

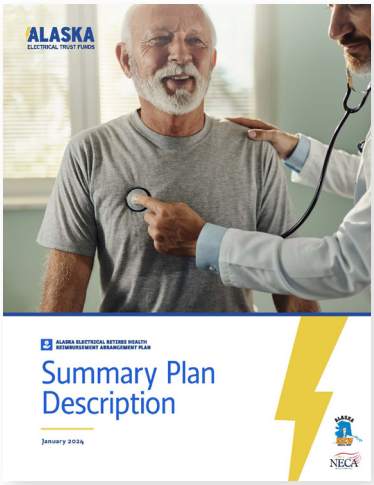
not obtain coverage in an Exchange plan during this period, you will have to wait until open enrollment to purchase coverage.

Note: *If you elect continuation coverage under the Plan, but decide to drop continuation coverage mid-year (for example, in May or August) you will not be able to enroll in a plan offered through the Exchange until the next annual open enrollment period*

Retired Employee Benefits

Retired Employee Benefits

No retiree coverage is provided under this Plan. The Fund provides eligible retirees with a benefit through the Alaska Electrical Retiree Health Reimbursement Arrangement Plan. A separate plan booklet describes that Plan. More information can be found on the Alaska Electrical Trust Funds website at aetf.com.



Medical Benefits

Medical Benefits

The Plan provides benefits for the Medically Necessary treatment of a non-occupational Injury or Illness for you and your eligible dependents. This section describes your deductibles, coinsurance, copayments and other out-of-pocket expenses for Plan benefits. The amount of your out-of-pocket expenses depends which medical Plan you participate in (Plan 500, 551, 552, 553 or 554). Your Plan identification card states which plan you are in. Additionally, you may contact the Trust Administration Office or review your Plan identification to determine which plan you participate in.

The amount of your out-of-pocket expenses also depends on the services you receive and whether your provider is a Preferred or non-Preferred Provider. Some services require preauthorization to receive full Plan benefits. Please review this section carefully to fully understand your Plans.

Deductibles

The Deductible is the amount you pay for covered medical expenses before the Plan starts to pay its benefits.

If your coverage is reinstated during a calendar year, any Deductible amounts you have satisfied under this Plan prior to your termination of coverage will be applied to Covered Charges incurred after the date of reinstatement for the remainder of the calendar year.

ANNUAL DEDUCTIBLE

Each year you must pay an annual Deductible before the Plan begins paying most benefits. This Deductible applies separately to each employee or dependent (up to the family maximum) during each calendar year. The Plans' annual Deductibles are as follows:

Plan 500	Plan 551/552	Plan 553	Plan 554
$500/Individual	$500/Individual	$600/Individual	$600/Individual
$1,500/Family	$1,000/Family	$1,200/Family	$1,800/Family

HOSPITAL INPATIENT DEDUCTIBLE

There is also a separate Hospital inpatient Deductible per admission per eligible Covered Person. The Deductible at a Preferred Provider Hospital is $300; at a non-Preferred Provider Hospital it is $600, subject to the Out-of-Pocket Maximum. If the Out-of-Pocket Maximum has been reached, no separate Hospital Deductible will be charged. This is in addition to the annual Deductible (described above). This Deductible only applies if you or a dependent is admitted to a Hospital.

In determining when one Hospital admission ends and a new one begins, all Hospital admissions are considered as having occurred during one Hospital admission unless:

- The latest Hospital admission is due to causes entirely unrelated to the cause of all previous admissions, or

- The individual concerned has been free of Hospital admissions for at least three months.

Reimbursement Percentage

After you satisfy your Deductible, benefits for the calendar year are paid according to the reimbursement percentages for Covered Charges. The reimbursement percentages are as follows:

Plan 500	Plan 551/552	Plan 553	Plan 554
80% of Covered Charges for Preferred Providers	85% of Covered Charges for Preferred Providers	85% of Covered Charges for Preferred Providers	80% of Covered Charges for Preferred Providers
60% of Covered Charges for Non-Preferred Providers	65% of Covered Charges for Non-Preferred Providers	65% of Covered Charges for Non-Preferred Providers	60% of Covered Charges for Non-Preferred Providers

See the Preferred Provider Provisions section on page 24 for a complete description as to when the reduced reimbursement percentage is applied for non-Preferred Provider services.

Medical Out-of-Pocket Maximums

The amount of the Plan's coinsurance increases once your Out-of-Pocket expenses reach the limits set forth in the charts below. The Out-of-Pocket expenses that count toward these limits include your Deductibles, any Emergency room Copayments, and your Coinsurance amounts for Preferred Providers.

The Plan's coinsurance increases to 90% once you reach the following limits:

Plan 500	Plan 551/552	Plan 553	Plan 554
$2,500 per person or $5,000 per family	$2,600 per family	$2,700 per family	$2,600 per person or $5,200 per family

The Plan's coinsurance increases to 100% once you reach the following limits:

Plan 500	Plan 551/552	Plan 553	Plan 554
$5,000 per person or $10,000 per family	$5,200 per family	$5,400 per family	$5,200 per person or $10,400 per family

However, **the following do not apply toward the annual Out-of-Pocket Maximum:**

- The 20% coinsurance reduction for services received from non-Preferred Hospitals within Anchorage or any non-preferred facilities outside of Alaska.

- The difference between the billed charges and the Covered Charges (balanced billed amount) for non-Preferred Providers, subject to the balanced billing protections under the No Surprises Act.
- The 50% reduction in the charges billed by the non-Preferred Provider outpatient facility for x-rays, imaging and surgery within the Municipality of Anchorage.
- $1,000 penalty for using a non-Preferred Provider Hospital within the Municipality of Anchorage for non-emergency inpatient services.
- Any expenses that are not Covered Charges.
- Expenses under the Fund's Prescription Drug, Dental and Vision benefits.

If your coverage is reinstated during a calendar year, any out-of-pocket amounts you have paid for medical benefits under this Plan prior to your termination of coverage will be applied to your Out-of-Pocket Maximum for the remainder of the calendar year.

Preferred Provider Provisions

When services are provided by a Preferred Provider, the Plan generally pays a higher percentage of services than it does when services are provided by a non-Preferred Provider. In addition, a non-Preferred Provider may balance bill a Covered Person for the difference between the billed charges and the Covered Charge. Therefore, in most cases, a Covered Person's out-of-pocket costs are higher when services are provided by a non-Preferred Provider than when services are provided by a Preferred Provider.

QUICK TIP

The list of Preferred Providers is available at www.aetf.com.

Please note, within the Anchorage metropolitan area, the Plan's Preferred Provider hospitals, surgical centers and outpatient therapy providers are:

- Alaska Regional Hospital,
- Matsu Medical Center,
- Alaska Surgery Center,
- Alpine Surgery Center,
- Surgery Center of Anchorage,
- Alaska Hand Rehabilitation,
- Ascension Physical Therapy, and
- Chugach Physical Therapy

For all other types of facilities and geographical regions (including Alaska, outside of the Anchorage metropolitan area, and outside the state of Alaska), the Trust has contracted with Aetna to provide a PPO Network.

You can contact the Administrative Office for help finding a Preferred Provider as follows:

Phone: (907) 276-1246 or toll free at (800) 478-1246, Monday – Friday from 8 am – 5 pm

Email: aetfhw@aetf.com

It is important to confirm whether a Provider is a non-Preferred Provider before services are rendered. If more than one Provider will be involved in treatment, the status of all Providers should be confirmed. For example, if surgery is being scheduled, higher benefits are provided if all Providers (Physician, assistance surgeon, and anesthesiologist) are Preferred Providers. A Covered Person should also inquire whether any freestanding lab or x-ray services used by a Physician or facility are Preferred Providers.

For non-Preferred Provider charges, the Plan has contracted with Zenith American Solutions (which in turn has contracted with Zelis) to negotiate a payment amount that, if accepted by the non-Preferred Provider professional or facility, will result in no balance billing for you or your dependent.

Note: *Zelis does not negotiate with Preferred Providers or Providers that are part of Aetna's PPO network (PPO Providers).*

If the provider does not reach a negotiated payment amount, Covered Charges are subject to the Plan's U&C and to the penalties discussed below in the section titled "Penalties for Using Non-PPO Providers." The non-Preferred Provider or Non-PPO professional or facility may also balance bill you or your dependent.

Other Direct Contracted Providers

Please note, the Plan also has direct contracts with the Coalition Health Center in Fairbanks and New Frontier Anesthesia.

Dialysis

DIALYSIS TREATMENT — IN-PATIENT

The Plan pays for medically necessary in-patient dialysis on the same basis as any other in-patient treatment. Non-emergency in-patient dialysis requires preauthorization.

OUT-PATIENT DIALYSIS

All out-patient dialysis providers are considered out-of-network (non-PPO) and will be subject to a specific pricing methodology as described in this document. Outpatient Dialysis Treatment Claims are subject to specific conditions which do not apply to other types of claims. Please refer to this Dialysis Treatment Outpatient description. The definition of Usual Customary & Reasonable charges in the Plan booklet will not apply to out-patient dialysis providers.

For medically necessary out-patient dialysis treatment, the Fund will determine the Plan benefit amount based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable

market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Fund may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated. Covered Charges is not the same as the Usual and Reasonable Charge as defined in the outpatient dialysis provision.

This Plan provision shall apply to all out-patient dialysis claims filed by, or on behalf of, Plan participants for reimbursement of products and services provided for purposes of out-patient dialysis, regardless of the condition causing the need for dialysis.

The Plan will review all out-patient dialysis charges to determine whether there is a reasonable probability that market concentration and/or discrimination in charges have resulted in an increase of the charges for out-patient dialysis products and/or services for the dialysis-related charges under review. If the Plan determines that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services, the Plan may subject the claims, and all future claims for out-patient dialysis goods and services from the same provider with respect to the member, to a cost-containment review to determine the appropriate Plan benefit amount.

Where appropriate, the Fund may enter into an agreement with a provider establishing the rates payable for out-patient dialysis goods and/or services, provided that such agreement must identify this section of the Plan and clearly state that such agreement is intended to supersede this Plan section.

This change does not apply to in-patient dialysis claims.

END-STAGE RENAL DISEASE

If you are diagnosed with End-stage Renal Disease (ESRD), you may be eligible for Medicare coverage by nature of your diagnosis. If you apply for Medicare, you are required to provide the Trust Administration Office with the effective date of your Medicare coverage so that the Plan can ensure the correct coordination of claims payments between the Plan and Medicare.

DIALYSIS PREAUTHORIZATION

Both non-emergency in-patient dialysis and non-emergency out-patient dialysis require preauthorization.

Protection From Balanced Billing

The No Surprises Act, protects Plan participants from balance billing for the following services:

- Emergency treatment of an emergency medical condition (“Emergency Medical Condition” means a medical condition or injury with acute symptoms of sufficient severity (including severe pain) that, lacking immediate medical attention, could reasonably be expected to result in the health of the person (including an unborn child) being placed in serious jeopardy or result in serious impairment or dysfunction of any bodily organ or part.)
- Air ambulance services, and

- Services performed by a non-Preferred Provider at a Preferred Provider facility by an (a common example is an anesthesiologist working at a Preferred Provider hospital).

If you go to non- Preferred Provider providers in other situations, they can still balance bill you.

The law provides that your costs for these services shall be limited to no more than what you would have paid, had you gone to Preferred Provider. Your cost sharing under the health plan (such as your deductible or coinsurance) must count towards your annual deductible and out-of-pocket maximums.

The law's protections do not apply if you sign a consent to be balance billed by the non- Preferred Provider. Certain non-emergency providers, however, cannot request you to waive your balance billing protection in any situation. Providers and facilities which cannot ask you to waive your balance billing protections include assistant surgeons and hospitalists, anesthesiologists, pathologists, radiologist, laboratories, and other specialists that you typically do not select. Always remember: You are never required to give up your protections from balance billing and you should review any document you are asked to sign regarding billing.

If a health care provider requests your consent to balance billing:

- The written consent must be clear and understandable;
- Generally, the written consent form must be provided at least 72 hours prior to the date of the item or service;
- The written consent form must state that payment of the out-of-network bill may not accrue towards the individual's deductible or annual out-of-pocket maximum;
- The written consent form must state that by signing the consent, the individual agrees to be treated by the non-PPO provider and understand the individual may be balance billed and subject to cost-sharing requirements that apply to services furnished by the non-PPO provider; and
- The written consent form must document the time and date on which the individual received the written notice and the time and date on which the individual signed the written consent form.

You must also be provided with an estimate of the cost for the service or treatment and additional information. If you believe a provider has violated these requirements, please request a copy of your consent form and go to https://www.cms.gov/nosurprises.

Reduced Reimbursement of Charges by Non-PPO Providers The Plan limits the reimbursement of claims if you choose to go to a non-Preferred Provider in the Anchorage metropolitan area, or to a non-PPO Provider (a Provider not contracted with Aetna) regardless of location, unless an exception applies. The limitations on reimbursement differ depending on where you receive the services.

PENALTIES THAT APPLY WITHIN THE ANCHORAGE METROPOLITAN AREA

If you choose to go to a non-Preferred Provider within the Anchorage metropolitan area for inpatient or outpatient Hospital or facility services, imaging, physical therapy or occupational therapy services, your Covered Charges will be limited as follows:

- For non-emergency inpatient services at a non-Preferred Provider Hospital, Covered Charges will be equal to the contracted rate at the Preferred Provider Hospital.
- For outpatient Hospital or facility services in connection with x-rays and/or imaging, as well as physical therapy and occupational therapy services at a non-Preferred Provider, Covered Charges will be limited to 50% of the billed charges.
- A $1,000 penalty will be imposed for non-emergency inpatient care at a non-Preferred Provider Hospital.
- For all non-Preferred Provider services, the Plan's reimbursement percentage will be reduced by 20% for the first $50,000 of Covered Charges, prior to application of the Plan's standard Out-of-Pocket Maximum.

The above penalties will be waived for services that are not available at the Preferred Provider Hospital or facility in the Anchorage metropolitan area. If you receive services from a non-Preferred Provider in the Anchorage metropolitan area that you believe to be unavailable at the Preferred Provider Hospital or facility, it is your responsibility to contact the Administrative Office so the Plan can verify whether the penalty can be waived.

The $1,000 penalty and 20% reduction in the reimbursement percentage as well as any difference between the billed charges and the Covered Charges will not apply to your medical Out-of-Pocket Maximum.

Following is an example of how a claim is processed if you chose to use a non-Preferred Provider Hospital in Anchorage for inpatient services:

- First the billed charges would be reduced to the Covered Charges at the Preferred Provider Hospital.
- Then the $1,000 penalty would be applied.
- If you have not met your Deductible, your Deductible would be applied.
- If the Plan's reimbursement percentage is 80%, the Plan would pay the remaining Covered Charges at a 60% reimbursement percentage until you met the first medical Out-of-Pocket Maximum. The reimbursement percentage would increase to 70% until the second Out-of-Pocket Maximum has been met.
- Thereafter, the reimbursement percentage would be 80% until $50,000 in Covered Charges (not including the $1,000 penalty) are adjudicated.
- Any remaining Covered Charges would be paid at 100%.

If you receive services other than inpatient or outpatient hospital, physical or occupational therapy, or imagery services from a non-PPO Provider (a Provider not contracted with Aetna) in the Anchorage metropolitan area, no penalty applies.

The Plan has contracted with Zenith American Solutions (which in turn has contracted with Zelis) to negotiate a payment amount that, if accepted by the non-PPO Provider, will result in no balance

billing for you or your dependent. If the non-Preferred Provider does not agree to a negotiated price this may result in balanced billing by the non-Preferred Provider professional or facility. Reimbursement will be limited to U&C charges, as described in the section titled "Usual, Customary and Reasonable Charge."

NON-PPO PROVIDER CHARGES IN ALASKA, BUT OUTSIDE OF MUNICIPALITY OF ANCHORAGE

If you choose to go to a non-PPO Provider (a Provider not contracted with Aetna) in Alaska but outside of the Municipality of Anchorage, no penalty applies. Reimbursement will be limited to U&C charges, as described in the section titled "Usual, Customary and Reasonable Charge."

The Plan has contracted with Zenith American Solutions (which in turn has contracted with Zelis) to negotiate a payment amount that, if accepted by the non-PPO Provider professional or facility, will result in no balance billing for you or your dependent. If the non-Preferred Provider does not agree to a negotiated price this may result in balanced billing by the non-PPO Provider professional or facility.

REDUCED REIMBURSEMENT OF NON-PPO PROVIDER CHARGES OUTSIDE ALASKA

If you choose to go to a non-PPO Provider for services outside of Alaska (a Provider not contracted with Aetna), the Plan reimburses according to the U&C charges, as described in the section titled "Usual, Customary and Reasonable Charge." In this case, for all non-PPO services, the Plan's reimbursement percentage will be reduced by 20% for the first $50,000 of Covered Charges, prior to application of the Plan's standard Out-of-Pocket Maximum.

The 20% reduction in reimbursement percentage will be waived if there are no PPO Providers within 25 miles of where medical care is provided that provide the medical care you receive. The 20% reduction in the reimbursement percentage as well as any difference between the billed charges and the Covered Charges will not apply to your medical Out-of-Pocket Maximum.

The Plan has contracted with Zenith American Solutions (which in turn has contracted with Zelis) to negotiate a payment amount that, if accepted by the non-PPO Provider professional or facility, will result in no balance billing for you or your dependent. If the non-Preferred Provider does not agree to a negotiated price this may result in balanced billing by the non-Preferred Provider professional or facility.

QUESTIONS ABOUT NON-PREFERRED PROVIDERS OR NON-PPO PROVIDERS

If you have any questions about what happens when you use a non-Preferred Provider in the Anchorage metropolitan area, or a non-PPO Provider (a Provider not contracted with Aetna) for medical/surgical or mental health/substance use disorder benefits, or about the penalty exception for services that are not available at the PPO Hospital or facilities, please contact the Administrative Office. You can contact the Administrative Office as follows:

Phone: (907) 276-1246 or toll free at (800) 478-1246, Monday – Friday from 8 am – 5 pm

Email: aetfhw@aetf.com

Medical Management Provisions

To help ensure the effective use of medical services, the Fund has contracted with Aetna to provide medical case management and utilization review services. Aetna will work with you and your Provider to determine the treatment options that will provide the most beneficial and cost-effective care in your specific case. This may help to avoid unnecessary or more expensive medical procedures while promoting patient safety.

SERVICES REQUIRING PREAUTHORIZATION

The Plan only provides benefits for services that are determined to be Medically Necessary. Medically Necessary services must be prescribed by a Provider and considered by the Plan to be necessary and appropriate and within generally accepted health care practice, non-experimental, non-investigational and not in conflict with accepted medical standards. To assist in this process, the Plan requires preauthorization for all inpatient confinements in a Hospital, Skilled Nursing Facility, Alcoholism or Drug Abuse Treatment Facility or other treatment facility, as well as for some outpatient services. This program is intended to ensure you receive services only when Medically Necessary, and for the appropriate length of stay when admitted.

- **If you use an Aetna Preferred Provider,** your provider is responsible for obtaining the necessary preauthorization for you. If your provider fails to preauthorize required services, and the services are later determined to not be Medically Necessary, the provider will not be reimbursed and they cannot bill you for the services.
- **If you use a non-Preferred Provider,** your provider may preauthorize for certain services on your behalf. If you or your provider fail to preauthorize required services, Aetna will review the Medical Necessity of these services when the claim is filed and they will be subject to financial penalty as outlined below.

IF YOU USE A NON-PREFERRED PROVIDER, IT IS YOUR RESPONSIBILITY TO ENSURE THAT YOUR PROVIDER OR FACILITY COMPLIES WITH THE PREAUTHORIZATION REQUIREMENTS OF THE PLAN. FAILURE TO OBTAIN A PREAUTHORIZATION MAY RESULT IN SIGIFICANT FINANCIAL CONSEQUENCES TO YOU AND YOUR DEPENDENTS.

INPATIENT PREAUTHORIZATION

When confinement in a Hospital, Skilled Nursing Facility, Alcoholism or Drug Abuse Treatment Facility or other treatment facility is necessary, you will need to follow the procedures below in order to qualify for payment of these charges at the Plan's standard reimbursement rates. Benefits payable for each period of confinement will be limited unless an inpatient preauthorization is requested by you, your Provider or the facility and approved by Aetna. The procedures differ depending on the type of admission:

- **For Non-Emergency Medical Admissions**
  All non-emergency inpatient admissions must be preauthorized. Ask your Provider to contact Aetna with the requested information.

- **For Emergency Medical Admissions**
  Emergency admissions must be authorized within 48 hours of admission (within 72 hours if you were admitted on a weekend or legal holiday), or as soon as reasonably possible. Ask your Provider to contact Aetna with the requested information.
- **To Extend Hospitalization**
  Aetna will contact the facility on the anticipated date of discharge. If a longer confinement is anticipated, the attending Provider will be contacted to determine whether an extended stay is covered under the terms of the Plan.

Pursuant to Federal law, the Plan does not require preauthorization for a Hospital stay in connection with childbirth for either the mother or newborn child, provided that the Hospital stay is limited to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean section. Preauthorization is required for any Hospital stay in connection with childbirth that is longer than the periods described above.

Notification of the number of inpatient days authorized will be provided to the facility by Aetna. You or your Provider may at any time request them to reevaluate or extend the length of an inpatient preauthorization. If you or your Provider has any questions, please contact Aetna.

If a non-Preferred Provider preauthorization is not obtained according to the timeframes shown above, Aetna will review the services for Medical Necessity after the services are provided. If benefits are payable, the benefits will be subject to a penalty of the lesser of 50% of the Covered Charges or $1,000.

OUTPATIENT SERVICES PREAUTHORIZATION

Preauthorization is also required for some outpatient services. Aetna maintains a list for which services require preauthorization. The complete list can be found online at **https://www.aetna.com/health-care-professionals/precertification/precertification-lists.html** or you can contact Aetna for the complete list. The following lists includes some, but not all of the services that require pre-authorization.

- Observation stay more than 48 hours
- Ambulance transportation by fixed-wing aircraft (plane)
- Autologous chondrocyte implantation, Carticel
- Cochlear device and/or implantation
- Dental implants (to the extent covered by the medical plan)
- Dialysis visits
- Dorsal column (lumbar) neurostimulators: trial or implantation
- Electric or motorized wheelchairs and scooters
- Gastrointestinal tract imaging through capsule endoscopy

- Hip surgery to repair impingement syndrome
- Private duty nursing
- Hyperbaric oxygen therapy
- Lower limb prosthetics
- Drugs and medical injectables to the extent these services are provided in a doctor's office or medical facility. Please ask your provider to refer to Aetna's National Preauthorization List for a full listing of medications that should be precertified.
- Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint
- Osseointegrated implant
- Osteochondral allograft/knee
- Power morcellation with uterine myomectomy, with hysterectomy or for removal of uterine fibroids
- Proton beam radiotherapy
- Reconstructive or other procedures that may be considered cosmetic, including, but not limited to:
  - Blepharoplasty/canthoplasty
  - Breast reconstruction/breast enlargement
  - Breast reduction/mammoplasty
  - Cervicoplasty
  - Chemical peels
  - Excision of excess skin due to weight loss
  - Gastroplasty/gastric bypass
  - Injection of filling material
  - Lipectomy or excess fat removal
  - Sclerotherapy or surgery for varicose veins
- Spinal procedures, including, but not limited to:
  - Artificial intervertebral disc surgery
  - Cervical, lumbar and thoracic laminectomy/ laminotomy procedures
  - Spinal fusion surgery
- Uvulopalatopharyngoplasty, including laser-assisted procedures

- Ventricular assist devices
- BRCA genetic testing
- Infertility services
- Organ transplants
- Pre-implantation genetic testing
- Pediatric congenital heart surgery
- Transthoracic echocardiogram
- Chiari Malformation Decompression Surgery

If an outpatient preauthorization is obtained, benefits payable for the Covered Charges for the test, procedure, or surgery-related charges will be paid as any other medical expense.

Planned Surgery Benefit — Transcarent

The Fund has contracted with Transcarent to provide employees and their dependents with access to high quality providers across the United States. This includes access to centers of excellence as well as surgeons who are highly rated in the United States for their specialty.

You should contact Transcarent for information about this program if you or your dependents have planned major surgeries such as:

- Cardiac surgery
- Vascular surgery
- Spine surgery
- Joint replacement
- Specific cancer treatments

Upon acceptance of your case, the following enhanced Plan provisions will apply when you utilize Transcarent network providers:

- Your Deductible and Coinsurance will be waived;
- Air and hotel are covered for the patient and companion, if medically required;
- A meals and incidentals allowance will be provided; and
- A Transcarent Care Coordinator will help coordinate all aspects of your treatment by helping collect the required medical records, assisting with provider selection and making travel arrangements.

This benefit is not available for Covered Persons for whom Medicare is primary.

To obtain more information about this benefit, contact Transcarent at (877) 478-1246 and identify yourself as an Alaska Electrical Health and Welfare Fund participant or go online at www.TranscarentMedical.com and register using the Fund's code, WSQXO.

Transcarent is an independent third-party contractor to the Fund. Neither the Fund nor Transcarent provide medical services and neither are engaged in the practice of medicine. The Transcarent Surgery Benefit program is entirely voluntary. It is up to you and your Provider to determine whether to use a Transcarent contracted provider, act on any performance ratings Transcarent provides or upon guidance about potential or recommended surgical procedures and alternative approaches or conservative treatment alternatives to surgery.

Covered Medical Expenses

The Plan provides benefits for the following services and supplies provided they are Medically Necessary for the treatment of non-occupational Illness or Injury:

Acupuncture for the treatment of pain, if performed by an appropriately licensed Provider.

Ambulance services as described in detail under Transportation Services on page 41.

Anesthesia and its administration.

Behavioral Health services for inpatient or outpatient treatment of behavioral health disorders, such as substance abuse treatment and mental health treatment, are paid on the following basis:

- Outpatient mental health treatment benefits are paid in the same manner as the majority of other outpatient Provider services provided under the Plan, subject to the Out-of-Pocket Maximum.
- Inpatient mental health treatment benefits are paid in the same manner as other inpatient Hospital treatment under the Plan and are subject to the inpatient Deductible and preauthorization requirements.

Note: *Failure to use a Preferred Provider Hospital within the Municipality of Anchorage and outside of Alaska, or failure to comply with the Medical Management provisions of the Plan for inpatient services, will result in financial penalties. Please see* pages 24 to 30 *for more details.*

Biofeedback Training, if performed by a Provider or billed by a Hospital during an inpatient stay, for anxiety disorders, migraine and tension headaches, intractable pain, neuromuscular disorders such as whiplash or back strain, stroke rehabilitation, and muscle spasms.

Chiropractic treatment by or under the supervision of a licensed chiropractor, up to a maximum of 24 visits per calendar year. Diagnostic x-rays related to chiropractic treatment are limited to one set per calendar year.

Cosmetic Surgery required for the repair of an Injury, treatment of a congenital abnormality, or initial reconstruction following or coinciding with surgery that would otherwise be covered by the Plan and was required for treatment of Illness.

Dental treatment by a Dentist or dental surgeon for repair of damage to the jaw and natural teeth as a direct result and within six months of an Injury (excluding charges payable under the dental benefit). The dental benefit calendar year maximum must have been paid out before any expenses are reimbursed under this medical benefit.

Diagnostic X-ray and Laboratory services performed in a Provider's office, Hospital outpatient department, or other independent facility.

Note: *For outpatient diagnostic x-rays and/or imaging not performed in a Provider's office, failure to use a Preferred Provider Hospital within the Municipality of Anchorage will result in financial penalty. Please see* **page 24** *for more details.*

Durable Medical Equipment and Supplies for rental or purchase, including surgical dressings, casts, splints, braces, crutches, artificial limbs, artificial eyes or for rental of a wheelchair, Hospital-type bed or an artificial respirator, oxygen (including rental of equipment for its administration). In certain instances, the Plan will seek to rent the equipment with the rental fees applied to the purchase price.

Covered expenses are limited to the standard model of medical appropriate level of performance and quality for the diagnosed condition; deluxe or luxury equipment or items for convenience or comfort are not covered by the Plan.

Emergency Room services are covered, subject to a $100 Copayment per visit and after the annual Deductible is met. This Copayment is waived if admitted directly to the Hospital or other facility.

Hearing Aid Devices, including the fitting of the device, are covered at 100% with no deductible, copayment or coinsurance, up to $2,500 per ear every 36 months.

In order to receive this hearing aid benefit, you must be examined by a Provider before obtaining a hearing aid and obtain a written certification from the examining Provider that you are suffering from a hearing loss that may be lessened by the use of a hearing aid. Benefits will not be provided without this certification.

Benefits for an otologic examination by a Provider or an audiologic examination and hearing evaluation by a certified or licensed audiologist are covered under the Provider's services section as described on **page 39**.

The hearing aid (monaural or binaural) prescribed as a result of such examination, will include:

- ear molds,
- the hearing aid instrument,
- initial batteries, cords and other necessary ancillary equipment,
- a warranty, and
- follow up consultation within thirty days following delivery of the hearing aids.

Benefit payments will not be made for:

- the replacement of a hearing aid for any reason more than once in a period of 36 months; or
- batteries or other ancillary equipment other than that obtained upon purchase of the hearing aid; or
- repairs, servicing or alteration of hearing aid equipment; or
- a hearing aid which exceeds the specifications prescribed for correction of hearing loss; or

- expenses incurred after termination of coverage under this program except expenses for a hearing aid which was ordered prior to termination and was delivered within 30 days after the date of termination.

Home Health Care services provided by a Home Health Care Agency, up to a maximum of 130 visits per calendar year for the following:

- Part-time or intermittent home nursing care by or under the supervision of a registered nurse.
- Part-time or intermittent Home Health Aide Services which consist primarily of caring for the individual.
- Physical, occupational or speech therapy, subject to certain limitations.
- Medical supplies, drugs and medicines prescribed by the attending Provider but only to the extent that such supplies, drugs and medicines would have been provided had the individual remained Hospitalized.
- Laboratory services by or on behalf of the Hospital but only to the extent that such services would have been provided had the individual remained Hospitalized.

Each visit by a member of the Home Health Care team shall be considered as one Home Health Care visit and four hours of home health services shall be considered as one Home Health Care visit.

Home Health Care services are available provided the treatment or service is in accordance with a Home Health Care Plan. A Home Health Care Plan means a program for continued care and treatment of an individual established and approved in writing by the individual's attending Physician within seven days after termination of a Hospital confinement for the same injury or sickness for which the individual was hospitalized, together with such Physician's certification that the proper treatment of the injury or sickness would require continued confinement in a Hospital in the absence of the services and supplies provided as a part of the Home Health Care Plan.

A Home Health Care Plan cannot include reimbursement for:

- Any services of an individual who ordinarily resides in your home or is a member of your family.
- Any custodial care (services which are provided primarily to assist an individual in the activities of daily living — e.g., meals and personal grooming).
- Any transportation services.

Hospice Care provided by a hospice, Hospital, Home Health Care Agency, or Skilled Nursing Facility, up to a maximum Coverage Charge of $150 per day and a lifetime maximum benefit of $10,000 for:

- any sick or injured individual (you or your dependent) who, in the opinion of the attending Physician, has no reasonable prospect of cure and is expected to live no longer than six months; and
- the family (you and your dependents) of any such individual;

but only to the extent that such hospice care Services are provided under the terms of a hospice care and are billed through the Hospice that manages that program.

Hospice care consist of:

- Inpatient and outpatient care, home care, nursing care, counseling, and other supportive services and supplies provided to meet the physical, psychological, spiritual, and social needs of the dying individual.
- Drugs and medicines (requiring a Provider's prescription) and other supplies prescribed for the dying individual by any Provider who is a part of the hospice care Team.
- Instructions for care of the patient, counseling, and other supportive services for the family of the dying individual.

Hospice care does not include:

- Services or supplies not approved by the attending Provider and the Plan's medical management service organization.
- Transportation services.
- Custodial care (services or supplies provided to assist a person in daily living — e.g., meals and personal grooming).
- Care provided at a time other than during an episode of hospice care.

An episode of hospice care means the period of time:

- beginning on the date a hospice care is established for a dying individual; and
- ending on the earlier of the date six months after the date the hospice care is established, the date the attending Physician withdraws approval of the hospice care Program, the date the individual recovers, or the date the individual dies.

Two or more episodes of hospice care for the same individual will be considered one episode of hospice care, unless separated by a period of at least three months during which no hospice care is in effect for the individual.

Hospital room, board, services and supplies in excess of the Hospital inpatient Deductible. Room and board benefits are limited to the Hospital's semi-private room rate.

Note: *Failure to use a Preferred Provider Hospital within the Municipality of Anchorage and outside of Alaska, or failure to comply with the Medical Management provisions of the Plan, will result in financial penalties. Please see* **pages 24 to 30** *for more details.*

Infertility treatment is covered the same as any other condition, up to a lifetime maximum benefit of $12,000 per person. Infertility treatment shall include:

- diagnostic testing used to determine the medical cause of infertility,
- confinement, treatment or service related to the restoration of fertility or the promotion of conception, including artificial insemination, in-vitro fertilization, embryo transplantation, reversal tubal ligation, and reversal vasectomy procedures, and

- prescription medications used to treat infertility as well as to promote pregnancy with some limitations.

Infertility expenses are available to you and your spouse, dependent children are not eligible.

The Plan does not provide benefits for embryo storage or donor charges.

Mastectomy is covered the same as any other treatment and benefits include:

- reconstruction of the breast on which a mastectomy was performed,
- surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

Services will be considered in a manner determined in consultation with the attending Physician and the patient.

Maternity related expenses, including pregnancy, childbirth, miscarriage, or abortion, are covered like any other medical condition. In accordance with federal law, the Plan does not restrict lengths of Hospital stays for a mother or newborn to less than 48 hours following normal vaginal delivery or 96 hours following cesarean delivery. In consultation with your Provider, you may choose not to stay the full 48/96 hours. The length of inpatient care may, however, be extended upon application of the mother's or newborn's attending Provider to the Plan, provided that the Plan determines that the extended stay is Medically Necessary.

Maternity expenses are available for you and your spouse, dependent children are not eligible.

Any services or supplies received in connection with a participant or dependent acting as a surrogate mother, regardless of whether a participant or covered dependent is a biological parent are not eligible. (See page 44, #28)

Note: *Failure to use a Preferred Provider Hospital within the Municipality of Anchorage and outside of Alaska, or failure to comply with the Medical Management provisions of the Plan for inpatient services, will result in financial penalties. Please see* pages 24 to 30 *for more details.*

Mechanized Spinal Distraction Therapy is covered up to a maximum Covered Charge of $175 per session and 20 lifetime sessions.

Naturopathic services by a licensed naturopath for treatment of an Illness or Injury.

Nutritional Counseling is covered for the care of diabetes or for treat of a diagnosed behavioral health condition.

Obesity Related Treatment for Provider office visits and lab testing are covered. The initial consultation with a registered dietitian is also covered. Participation in weight loss programs such as Medifast, Weight Watchers, and Jenny Craig are not covered by the Plan.

In order for the Plan to consider coverage for a gastric bypass operation, you must receive preauthorization from Aetna. The maximum Hospital Covered Charge for a gastric bypass procedure

is the facility rate at the Preferred Provider Hospital in Anchorage. The lifetime maximum Plan benefit for gastric bypass treatment is $50,000, which includes the gastric bypass procedure and all related costs, as well as complications and future procedures, including but not limited to panniculectomies.

Orthotics provided they are custom made to treat a covered condition.

Physical Therapy, Occupational Therapy and Speech Therapy for habilitative and rehabilitative services are covered as follows:

- If part of a prescribed treatment program, medically necessary habilitative therapy services, including occupational therapy, speech therapy, physical therapy and related therapies, to treat a health condition or congenital birth defect.
- If part of a prescribed treatment program, medically necessary rehabilitative therapy services on an outpatient basis, including occupational therapy, speech therapy and physical therapy to the extent that the therapy will significantly restore and improve a lost function(s) following a severe illness, injury or surgery.

Habilitative and rehabilitative services are subject to the following conditions:

- The service must be necessary to improve function or to maintain function where significant deterioration in function would result without the therapy;
- The services must be prescribed by the attending Physician and administered by a licensed Provider. The Plan may periodically request a review of the services by a Physician and the patient must continue under the care of the attending Physician during the time the therapy is being provided; and
- The services must not be custodial in nature.

Benefits for habilitative and rehabilitative therapy services will end when the Plan determines that no additional clinical improvement is expected as a result of the therapy.

Note: *Failure to use a Preferred Provider Physical Therapist or Occupational Therapist within the Municipality of Anchorage will result in financial penalty. Please see* **page 24** *for more details.*

Physician's or other Provider's services for medical treatment when received in the Physician or Provider's office, at home, in the hospital or elsewhere, provided such charges are not made by a Hospital or Skilled Nursing Facility.

Podiatry services by a licensed podiatrist for treatment of an Illness or Injury. The Plan does not cover routine or cosmetic foot care including, but not limited to, callus or corn paring and trimming of toenails.

Pre-admission Testing relating to a Hospital admission, if done on an outpatient basis within 7 days prior to a Hospital admission, is payable at 100% of Covered Charges, and is not subject to the annual medical Deductible. Test performed on an inpatient basis is subject to the Plan provisions regarding inpatient treatment.

Preventive Care services will be covered at 100%, with no Coinsurance or Deductible. The following services are covered:

- Preventive care services and screenings per the US Preventive Services Task Force (USPSTF) A and B recommendations. Covered procedures include such services as blood pressure and cholesterol screening, various cancer and sexually transmitted infection screenings.
- For employees and spouses, routine physical exams are covered subject to the following frequency limits:

Age	Frequency
Under age 40	Once every 5 years
Age 40-49	Once every 2 years
Age 50 and older	Once every year

  For children, routine physical exams are covered subject to Plan guidelines.

  Note: *"Fit-to-work" physical exams will be covered to maintain certifications necessary/required to complete covered employment. These non-preventive exams are covered at 100% of Usual and Customary Charges and are not subject to the annual Deductible and Coinsurance. Routine immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) and published in the Centers for Disease Control (CDC) annual immunization schedules for children and adults.*

- Preventive care services and screenings for infants, children and adolescents as recommended by the Health Resources and Services Administration (HRSA).
- Preventive care services and screenings for women recommended by the Health Resources and Services Administration (HRSA).

If you have any questions about what is covered under the Plan's preventive care benefit, please contact the Administrative Office.

Private Duty Nursing services by a graduate registered nurse. Payment is not made for services which are custodial or for services which do not require the skill level of a registered nurse. If extended nursing care is anticipated, we recommend that you contact the Administrative Office to determine the amount of nursing care that will be covered.

Radial Keratotomy or Laser Eye Surgery, only if eyesight is 20/70 or worse and cannot be corrected with eyeglasses or contact lenses.

Seasonal Affective Disorder (SAD) Lighting, up to a lifetime maximum benefit of $200 per family.

Skilled Nursing Facility charges, up to 120 days per calendar year, for confinement due to the same or related Injury or Illness. In order to be covered, the attending Physician must certify that 24-hour nursing care is essential for recuperation from an Injury or Illness, and:

- The confinement is preceded by at least three consecutive days of Hospital confinement which qualifies for benefits under the Plan; and

- The confinement is due to the Injury or Illness requiring Hospital confinement and commences within the 14 days after termination of such Hospital confinement or within 14 days after termination of a Skilled Nursing Facility confinement which qualifies for benefits under the Plan.

The attending Physician must continue treatment and certify that continuation of such confinement is necessary for treatment of the Injury or Illness requiring such confinement. Confinement for custodial care (services and supplies which are provided primarily to assist an individual in the activities of daily living — e.g., meals and personal grooming) are excluded.

Note: *Failure to use a Preferred Provider facility outside of Alaska, or failure to comply with the Medical Management provisions of the Plan, will result in financial penalties. Please see* **pages 24 to 30** *for more details.*

Sterilization procedures such as vasectomy or tubal ligation for you or your spouse.

Surgical Services for Medically Necessary surgeries resulting from an Illness or Injury. Included are surgical procedures performed in a Hospital, at a Physician's office or elsewhere. If you are hospitalized, surgical benefits are in addition to the Plan's Hospital benefits.

Assistant surgeon services are covered, up to 25% of the primary surgeon's covered charge, for a surgical procedure performed by an assistant surgeon or assistant Physician (other than a hospital intern or resident) when medically necessary.

Second surgical opinions help you understand surgery risks and alternatives. The Plan covers a second surgical opinion for non-emergency procedures; a third surgical opinion is also covered if the first two opinions do not agree.

Multiple surgical procedures performed at the same time, whether related or not, are limited as follows:

- Up to 100% of the Covered Charge is allowed for the primary procedure.
- For subsequent procedures, up to 50% of the Covered Charge is allowed for each additional procedure.

If you or your dependents have planned major surgery, the Transcarent surgery benefit, as described on **page 33**, is available for certain surgeries.

Transplant services in connection with a human organ or tissue, provided the services are preauthorized in advance by the Plan's medical management service organization.

Transportation Services for you or your eligible dependents will be considered as a Covered Charge if the expenses meet the following definition:

- Emergency transportation:
  - by a professional ambulance, to and from a Hospital; or
  - air or surface transportation from any location where a covered individual is injured or become ill to the nearest legally operated Hospital equipped to provide the treatment necessary to treat the condition.

- Non-Emergency transportation of you or your eligible dependents will be covered only if the condition cannot be treated locally (within 100 miles from your home). Covered Charges for Non-Emergency Transportation will include:
  - air or surface transportation by a regularly scheduled commercial carrier to the nearest facility able to treat the condition. The Plan will pay the actual cost of documented travel expenses, not exceeding the cost of coach class commercial air transportation, from the site of the Illness or Injury to the nearest professional treatment. No travel benefits will be payable for travel to any location other than the closest location in which treatment is available.
  - benefits for an accompanying adult if the patient is a child under age 18 or an incapacitated adult.

No benefits will be paid for food or lodging.

Participants must contact the Administrative Office to pre-certify Non-Emergency Air Transportation benefits.

TMJ surgery.

Note: *Failure to use a Preferred Provider Hospital within the Municipality of Anchorage and outside of Alaska, or failure to comply with the Medical Management provisions of the Plan for inpatient services, will result in financial penalties. Please see* **pages 24 to 30** *for more details.*

X-ray, radium, and radioactive isotope therapy.

Note: *Failure to use a Preferred Provider Hospital within the Municipality of Anchorage and outside of Alaska, or failure to comply with the Medical Management provisions of the Plan for inpatient services, will result in financial penalties. Please see* **pages 24 to 30** *for more details.*

Limitations and Exclusions

No medical benefits are payable for the following:

1. Any treatment, service or confinement not prescribed or provided by an appropriately licensed Provider.
2. Any treatment or service not Medically Necessary.
3. Any treatment or service due to sickness which is covered by a Worker's Compensation Act or other similar legislation, or due to injury arising out of or in the course of any employment for wage or profit.
4. Any treatment or service which is compensated for or furnished by the United States Government or any Agency thereof (except as required under Medicaid provisions or Federal law).
5. Any charges for hearing aids, except as specifically provided.
6. Any charges for glasses, or eye examinations for the correction of vision or fitting of glasses, except for the first pair of glasses or first pair of lenses for use after cataract surgery. Routine eye care is covered under the Vision Benefits section beginning on **page 63**.

7. Any treatment or service received primarily for cosmetic purposes unless:
   - due directly to an accidental injury and furnished within 12 months after the accident; or
   - the medically necessary treatment of a congenital birth defect; or
   - for reconstructive breast surgery necessary because of a mastectomy; or
   - as a result of breast cancer, for all stages of one reconstructive breast reduction on the nondiseased breast to make it equal in size with the diseased breast following reconstructive surgery on the diseased breast.
8. Any treatment or service due to pregnancy, or complications there from, of dependent children, except to the extent covered under the preventive benefits.
9. Any procedure or treatment that is Experimental or Investigational.
10. Charges you are not obligated to pay or for which you would not have been billed if you were not covered by the Plan.
11. Charges for cancelled or broken appointments or completion of forms or reports, except as required by the Plan.
12. Nutritional or dietary supplements or substitutes, and non¬prescription medications or supplements, except as necessary treat a mental health condition or to the extent covered under the preventive benefits.
13. Any service rendered by a person who ordinarily lives in your home or by an immediate family member.
14. Services and associated expenses for:
   - nutritional counseling except for diabetic nutrition training and services covered under preventive care.
   - baldness or hair removal.
   - physical exercise or physical conditioning programs.
   - educational services or treatment for a learning disability.
   - educational material, even if it is prescribed by a Physician or Provider.
   - treatment for developmental delays except as specifically provided for in the Physical, Occupational and Speech Therapy section (page 39).
15. Services and associated expenses for or which are incidental to sexual reassignment, inter-sex (trans-sexual) operations, procedures designed to alter physical characteristics to those of the opposite sex, or any resulting medical complications, except to the extent necessary to treat a behavioral health condition.
16. Appliances or equipment primarily for convenience or environmental control, such as air conditioners, humidifiers and dehumidifiers, air filters, whirlpools, Jacuzzi or hot tub devices, exercise equipment, or expenses incurred for modifications of your home, property or vehicles.

17. Fitness facilities and fitness program memberships.
18. Biofeedback equipment.
19. Treatment for any of the following:
    - relationship, marriage, custody, adoption, academic or other counseling when not attributable to a mental disorder.
    - involuntary commitments, police detentions, court ordered therapy, and other similar arrangements unless also Medically Necessary.
20. Custodial care, regardless of who prescribes or provides it.
21. Massage therapy whether or not prescribed by a Physician or Provider.
22. Therabands, pillows, wedges, heel lifts, foot inserts, orthopedic shoes or boots, incontinence supplies, blood pressure monitors or any personal care items.
23. Lost or stolen medical equipment.
24. Chelation therapy, except for the treatment of heavy metal toxicity.
25. Travel expenses, except as provided under Transportation Service Expenses. Examples of non-covered travel expenses include lodging, meals, and car rentals.
26. For any treatment while on active duty in the U.S. Armed Forces, subject to the participant's right to self-pay for continuation coverage under USERRA.
27. Treatment or services for an Illness or Injury caused by the act or omission of another person (known as the "third party") for which recovery may be available from the third party or the third party's insurer, under an automobile policy, commercial premises policy, homeowners' policy, medical malpractice policy, renter's policy, or any other liability policy, including first-party uninsured or under insured motorist policy. The Plan may agree to advance benefits if the Covered Person agrees to reimburse the Plan as set forth in the Plan's reimbursement provision.
28. Any services or supplies received in connection with an Employee or dependent acting as a surrogate mother, regardless of whether the Employee or covered dependent is a biological parent. This exclusion applies to services or supplies related to the surrogate mother becoming pregnant, pregnancy and delivery charges. Additionally, a child of a surrogate mother shall not be considered a covered dependent if the child is not the biological child of an Employee or adult covered dependent or if the surrogate mother has entered into a contract or has an understanding prior to becoming pregnant that she will relinquish the child following its birth. The Plan also does not cover services or supplies provided to an individual not covered by the Plan who acts as a surrogate mother for a participant or covered dependent. "Surrogate mother" is defined as a woman who becomes pregnant through artificial or assisted methods for the purpose of carrying the fetus to term for a third party.
29. Charges for services or supplies which are not provided or billed in accordance with generally accepted professional standards and/or medical practice, including up-coding, unbundling, duplication, excessive or improperly coded billing charges.

30. Any services or supplies that are contrary to guidelines adopted by the Trust, the Trust's Preferred Provider Organization or the Trust's Prescription Benefit Manager, including guidelines concerning industry standards for diagnosis, treatment, prescription or billing practices.

31. Claims received or completed after the 12-month filing limit. A claim is completed when all requested documentation needed to process the claim has been received.

If any services or supplies are not specifically addressed in this booklet, whether as an exclusion or as a covered expense, you should not assume that such services or supplies are covered under the Plan. Please contact the Administrative Office if you have a question regarding covered services or supplies.

Payments for medical expenses as described in this section are made only for those charges incurred while covered except for benefits continued after termination of coverage as specifically indicated in the Extended Benefits section (page 9).

Coalition Health Center

Coalition Health Center

All Covered Persons including covered dependents age 5 or older have access to primary and preventive care through the Coalition Health Centers in Anchorage, Fairbanks and Wasilla.

Charges for services provided at the Center do not apply towards your annual Medical Deductible, or Medical Out-of-Pocket maximum. Also, the medical reimbursement percentages do not apply. Instead, you will be charged a flat dollar Copayment for each visit.

Coalition Health Center Services

The Coalition Health Center is staffed by experienced master's level trained Advanced Nurse Practitioners (ANP) providing the following services:

- Acute episodic care and symptom relief (strains, sprains and pains) and minor injuries.
- Cholesterol, hypertension, and diabetes screenings, treatment, and management.
- Treatment of sore throats, earaches, headaches, cough and sinus.
- Treatment of rashes and allergies.
- Treatment of acute urinary symptoms.
- Well-woman, well-man, well-child exams and physicals (annual, school and sports).
- Health education.
- Standard immunizations and flu shots.

In addition, labs are performed on site and some generic prescriptions are dispensed at no cost to you.

Cost of Service

- $20 Copayment per visit per person.
- $50 Copayment if three or more family members visit the clinic at the same time for services.
- $0 Copayment per visit for preventive care services required under the Affordable Care Act.

The Copayment includes the visit and any lab work needed as well as any prescription medications dispensed at the Health Center.

Payment is due at the time of services and you will not have to fill out a claim form.

Location of the Coalition Health Centers

The Coalition Health Centers are located in Anchorage at 701 East Tudor Road, Suite 120, in Fairbanks at 570 Riverstone Way #3, and in Wasilla at North Fork Professional Building, 1700 East Bogard Road, Building A.

The Coalition Health Centers can be reached by phone at (907) 264-1370 or online at coalitionhealthcenter.com if you have any questions or want to schedule an appointment.

Walk-in visits may be available if their schedule permits.

Wellness and Minor Care Program

Wellness and Minor Care Program

The Fund contracts with several medical clinics in Alaska to provide preventive and minor care for Covered Persons. By contracting with these clinics, the Fund is able to take advantage of negotiated discounts in order to help control health care costs.

The Wellness and Minor Care Program is provided in addition to the Plan's medical benefits. Charges for services provided under this program will not apply towards your annual Deductibles, reimbursement percentages, or Out-of-Pocket limits under your medical benefit.

You are not required to use this program. Preventive and minor care services may be covered under your medical benefits, but by using the Wellness and Minor Care Program, you may pay less in Out-of-Pocket expenses and reduce your waiting time.

A list of the participating clinics is found in the Plan Service Providers insert.

Summary of Clinic Services

A Physician, Physician's assistant, or nurse practitioner operating within the scope of their license will provide all services. Coverage includes treatment for conditions noted in the contract between the Fund and the clinic, such as:

- Colds
- Flu
- Minor illness or accident
- General medical care (minor)
- Needed x-rays or lab tests in conjunction with a covered service
- Preventive care

Services Not Covered

- Occupational accidents or illnesses.
- Treatment for infants under the age of one or preventive exams for children under the age of two.
- Treatment for substance abuse
- Treatment for chronic conditions
- Medicare-covered expenses
- Sutures to the face

Costs for Service

- $20 Copayment per visit, per person
- $50 Copayment if three or more family members visit the clinic at the same time for services

Payment is due at the time of service.

You do not have to fill out a claim form.

The Copayment will be waived for preventive care services required under the Affordable Care Act. The Copayment will remain applicable for all other eligible services.

Other Important Information

If the clinic provides you with services that are not specifically covered under the Wellness and Minor Care Program, the associated charges should be submitted to the Administrative Office for consideration under your medical Plan and those provisions would apply. If you have questions about what is covered under the Wellness and Minor Care Program, please contact the Administrative Office. Medical records, including x-rays and lab test results, will be forwarded to your regular Physician.

Prescription Drug Benefits

Prescription Drug Benefits

Prescription drug coverage is available in two convenient ways: either through the Retail Pharmacy program (up to a 30-day supply) or the Mail Service Pharmacy program (up to a 90 day supply). Both programs are administered by CVS/caremark.

Retail Pharmacy

The retail pharmacy program is designed for short term or single use medications.

CVS/caremark has contracted with pharmacies nationwide as well as many independent local pharmacies. These pharmacies have agreed to fill prescriptions at negotiated price levels that should save money both for you and for the Fund. You may use any pharmacy; the choice is yours each time you fill a prescription.

The CVS/caremark retail pharmacy network works as follows:

1. Take your prescription to a network pharmacy and present it and your health plan ID card to the pharmacist.
2. The pharmacy will have access to the Fund's on-line eligibility and your Plan's provisions and will confirm your eligibility. Once your eligibility for benefits is confirmed, the pharmacy will ask you to pay according to the following schedule for each prescription:
   - **Generic Drugs** – $15 Copayment, for up to a 30 day supply
   - **Brand-Name Drugs (generic not available)** – $35 Copayment, for up to a 30 day supply
   - **Brand-Name Drugs (generic available)** – 100% of the cost; these drugs are not covered by the Plan unless approved through medical necessity
3. The pharmacist will then fill your prescription and bill the Plan directly for the remaining costs. You will not have to fill out any claim forms.

A list of CVS/caremark participating pharmacies can be obtained by accessing the CVS/caremark website at www.caremark.com, through CVS/caremark's smart phone app, by calling CVS/caremark's customer care at (877) 478-1246, or contacting the Administrative Office.

If you choose a pharmacy that is not in the CVS/caremark network, you will need to pay the full amount billed by the pharmacy and submit a Prescription Reimbursement Claim Form to CVS/caremark. You must submit a claim form along with your receipt for reimbursement. Claim forms can be obtained from CVS/caremark, the Administrative Office or the Fund's website.

Claims are reimbursed at the participating pharmacy's negotiated rate, less the appropriate Copayment. The difference between the amount you paid and the CVS/caremark negotiated rate is your responsibility and will not count toward the prescription drug Out-of-Pocket Maximum.

Note: *If you live in or are traveling in an area which has no CVS/caremark network pharmacy within 25 miles, your paper claim will be reimbursed for the price of the prescription less your Copayment.*

Mail Service Pharmacy

The mail service program is designed for long term maintenance medications needed for ongoing or chronic conditions.

Using the mail service pharmacy will lower your Out-of-Pocket costs, and medications will be delivered directly to your home, or other address that you choose. You should contact the mail service pharmacy at least two weeks before you need your next fill to allow for processing and mailing of the prescription.

For prescriptions ordered through the mail service pharmacy, the following Copayments apply for each prescription:

- **Generic Drugs** – $30 Copayment, for up to a 90-day supply
- **Brand-Name Drugs (generic not available)** – $70 Copayment, for up to a 90-day supply
- **Brand-Name Drugs (generic available)** – 100% of the cost; these drugs are not covered by the Plan unless approved through medical necessity.

You can get started with mail service by a variety of ways:

- Calling CVS/caremark — Be sure to have your ID card, doctor's contact information, prescription information and payment method ready for the representative and CVS/caremark will reach out to your doctor on your behalf.
- Asking your doctor to send a prescription to CVS/caremark mail service for maintenance medications once your doctor has determined the dose best for you. Your doctor may phone, fax or electronically prescribe to mail service.
- Mailing a 90 day prescription and Mail Service Order form to CVS/caremark. Allow at least two weeks from the day you submit your order for delivery of your medicine. Ask your doctor for a 30 day supply you can fill at retail while you wait for your mail service order if you choose this option. A Mail Service Order Form can be found online at www.caremark.com. A form can also be obtained at the Administrative Office or the Fund's website. A new order form and envelope will be sent to you with each delivery.

Preventive Care Prescription Drugs

In accordance with the Affordable Care Act (ACA), the Plan covers preventive care drugs at 100% with no Copayment. Preventive care drugs may include aspirin, tobacco cessation drugs, contraceptive drugs and devices, vitamin and mineral supplements as well as other products. Gender, age and/or other limits may apply. Please note that over the counter (OTC) drugs require a prescription to be covered and quantity limits may apply to some drugs.

Routine Immunizations

Routine immunizations are available from many retail pharmacies with no Copayment.

The Plan provides benefits for routine immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) and published in the Centers for Disease Control (CDC) annual immunization schedules for children and adults.

Specialty Drugs

The Plan employs various management programs for specialty drugs to ensure the safe and cost-effective use of these medications. This may include, but not be limited to, prior authorization, days supply limits and formulary management. Specialty drugs share some of the following characteristics:

- High cost
- Unique storage or shipping requirements
- May require patient compliance and safety monitoring
- Potential for significant waste due to the high costs
- Prescribed for complex conditions like multiple sclerosis, rheumatoid arthritis, cancer as well as others

CVS/specialty is the Plan's preferred pharmacy provider for specialty drugs. Some specialty drugs may have limited distribution and may only be available from select pharmacies. An up-to-date list of specialty drugs may be obtained from the prescription benefit manager's website www.cvsspecialty.com.

Prescription Drug Out-of-Pocket Maximum

Once you and/or your dependents have reached the following Out-of-Pocket Maximums for prescription drugs, all Copayments are waived for that person or family for the rest of the calendar year:

	Out-of-Pocket Maximum
Person	$750 per calendar year
Family	$1,500 per calendar year

Prescription drugs filled at retail or mail service apply to the Out-of-Pocket Maximum. However, the following charges will not apply to the prescription drug Out-of-Pocket Maximum, and the Plan will not pay these charges, even if the prescription drug Out-of-Pocket Maximum has been satisfied:

- Your Copayment if you purchase your medication from a non-network pharmacy, unless there is no CVS/caremark network pharmacy within 25 miles, or

- The difference between the billed charge and the contracted rate for prescriptions purchased without using your health plan ID card, or
- Brand-name drugs when a generic is available.

Prescription Drug Exclusions

The following are excluded from this prescription drug benefit and *not covered* by the Plan:

1. Any drugs for illness, disease or injury provided in whole or in part by state or federal Workers' Compensation laws or other legislation.
2. Cosmetic drugs or health and beauty aids.
3. Nontherapeutic vitamins, dietary supplements, or herbal remedies unless specifically stated as covered for preventive care, as stated in the section above.
4. Over-the-counter drugs, unless prescribed and specifically provided for preventive care as stated in the section above.
5. Medications (such as Viagra), or devices to treat erectile dysfunction.
6. Claims received after the 12-month filing limit.
7. Drugs administered or taken while confined in the Hospital, Skilled Nursing Facility, rest home, nursing home or similar institution, or a health care provider's office.
8. Drugs prescribed for the treatment of conditions, which are not within the medical uses approved by the FDA or the manufacturer (i.e. off label uses).
9. Drugs which are considered Experimental or Investigational or which are not Medically Necessary.
10. Drugs reimbursable by any government program – national, state, county, or municipal.
11. Medicines dispensed without a prescription.
12. Drugs lost, stolen, or damaged.
13. Drugs in excess of those with quantity limits.

Dental Benefits

Dental Benefits

The Fund sponsors multiple Dental Plans. The Dental Plans differ in their deductibles, annual benefit maximums and reimbursement percentages. Additionally, not all of the dental plans cover orthodontic benefits. Your benefits depend on which Dental Plan you participate in pursuant to your collective bargaining agreement or special agreement with the Fund. Contact the Trust Administration Office or review your Plan identification to determine which plan you participate in.

Annual Deductible

The annual deductible is the amount you pay for covered dental expenses before the Dental Plan starts to pay for certain Part I, II and III services. Not all Dental Plans have an annual deductible. If a deductible applies, it is $25 per person $75 per family. If you Dental Plan has an annual deductible, the deductible applies separately to each employee or dependent (up to the family maximum) during each calendar year.

Reimbursement Percentage

After you satisfy the annual deductible, if any, benefits for the remainder of the calendar year are paid as a percentage of Covered Charges.

Maximum Dental Benefit

PART I, II AND III SERVICES

Dental benefits are subject to the following maximum benefits for each Covered Person per calendar year. The maximum benefit will be waived for covered dependent children under age 19.

Plans 500/601/602	Plans 603/606
$2,000/Individual	$1,500/Individual

DENTAL INJURY

Dental expenses incurred for repair of damage to the jaw or natural teeth as a direct result and within six months of an Injury may be covered under your medical benefit if you have reached the calendar year maximum benefit under your dental benefit.

Predetermination of Benefits

Predetermination of benefits allows for review of a proposed dental treatment plan in advance and provides a chance to resolve any questions before the services have been provided to you. As a result, you will know in advance which services are covered and the estimated amount of benefits the Plan will pay. Contact the Administrative Office if you have any questions about a proposed dental treatment plan.

Covered Dental Expenses

The Dental Plans reimburse dental expenses based on a percentage of the dentist's actual charge (or the usual and customary charge for that service as determined by the Plan, whichever is lower).

The following shows the majority of services that are considered Part I, Part II and Part III covered dental services:

Part I – Exams and Prevention			
Reimbursement Percentage			
Plans 500/602	Plan 601	Plan 603	Plan 606
100%	90%	70%	40%
Common Covered Services and Limitation			
Prophylaxis (cleaning)		Two times per calendar year	
Routine oral examination		Two times per calendar year	
2 Bitewings		Two times per calendar year	
Fluoride Treatment		Once per calendar year	
Panoramic or full mouth X-ray		Once every 24 months	
Sealants (unrestored teeth only no age limit)		Once every 24 months	
Biopsy of oral tissue and microscopic examination			
Space Maintainer		No age limit	

Part II - Restorative Dentistry/Oral Surgery			
Reimbursement Percentage			
Plans 500/602	Plan 601	Plan 603	Plan 606
80%	90%	70%	40%
Common Covered Services and Limitation			
Non-routine dental exams			
Fillings (amalgam, resin, gold and silicate, acrylic, and plastic)		Once per calendar year (reduced to amalgam rate on posterior teeth)	

Uncomplicated extractions and removal of impacted teeth	
Alveolar or gingival reconstruction	
Periodontal scaling and root planing	Once every 24 months per quadrant
Periodontal maintenance	Four times per year
Other Periodontics – emergency, full mouth debribement, gingivectomy	
Endontics – root canals, pulp capping, pulpotomy, remineralization, apioectomy	
Treatment of cysts and neoplasms	
General anesthesia	Not a covered expense
Nitrous Oxide	Only dependents age 12 or under
Intravenous Sedation	Only when treatment warrants
Pill Sedation	Not a covered expense
Behavior management	Not a covered expense
Repair and maintenance of prosthesis	
Miscellaneous other items such as occlusal adjustment, peripheral nerve block, antibiotic injections, injections of sclerosing agent into temporomandibular joint	

Part III - Major Dentistry/Prosthesis**

Reimbursement Percentage

Plans 500/602/603	Plan 601	Plan 606	Plan 606
50%	90%	40%	40%

Covered Services and Limitation

Night Guard (for bruxism and/or TMJ)	Replacement once every 5 years
Bridges	Replacement once every 5 years
Crowns	Replacement once every 5 years

Prosthetics/Partial or full denture (fees include adjustments for a six-month period following installation)	Replacement once every 5 years
Implants	Replacement once every 5 years
Inlays/onlays	Replacement once every 5 years
All radiology not listed under Part I	

***Please note that all major dentistry is paid on the prep date and the patient must be eligible on the preparation date. All major work reduced to the gold or metallic rate on posterior teeth.*

ORTHODONTIA BENEFITS (NOT COVERED FOR PLAN 602)

The Dental Plans covers orthodontic services subject to a $2,000 lifetime maximum benefit for each covered dependent child. The orthodontia benefit is provided only for dependent children and is not available for you or your spouse.

Payment will be made at 50% of Covered Charges for services and supplies furnished by a Dentist in connection with orthodontic treatment rendered to your dependent child while covered.

Orthodontic claims are paid as follows:

- Initial orthodontic appliances, evaluation, x-rays and treatment plan, exclusive of extractions, will be paid provided they do not exceed 35% of the total orthodontic fee for the treatment.
- Payments for the monthly or quarterly charges are then made.

Payment for orthodontic treatment is not automatic. The service must be provided (the dependent child must be seen by the Dentist) and the provider must submit an invoice. You will only be reimbursed when the service is provided and the payment is made to the provider.

Dental Limitations

Benefits are not payable for:

1. Treatment or service which is not prescribed by a Dentist and performed by a Dentist or Dental Hygienist.
2. Treatment or service primarily for cosmetic purposes.
3. Athletic mouth guard or appliance.
4. Charges for drugs and medicines (prescription medications should be obtained through the Prescription Drug benefits, see page 52)
5. Replacement of full or partial dentures, bridge, inlay/onlay, crown, or implant prior to five years following the date of the initial placement or the date of the most recent replacement. However,

payments will be made for any replacement if the dentures or other restorations were broken by an accidental injury. The breakage must result from such injury, directly and independently of all other causes and you must show proof of having incurred medical expenses as a result of the injury. Any replacement of dentures under this provision will not constitute a new five-year period for denture replacement due to any other cause.

6. Replacement of a night guard for bruxism or TMJ prior to five years following the date the appliance was obtained.
7. Replacement due to loss or theft of retainer, night-guard, full or partial dentures, or any other dental appliance.
8. Replacement of a filling prior to one year following the date of the filling.
9. Any portion of charges for treatment in excess of the Covered Charges.
10. A crown, dentures, or appliance where the tooth was prepared, or the impressions were made before the individual was covered.
11. Any treatment or service not Medically Necessary.
12. Any treatment or service due to sickness which is covered by a Worker's Compensation Act or other similar legislation, or due to injury arising out of or in the course of any employment for wage or profit.
13. Any procedure or treatment that is Experimental or Investigational.
14. Charges for telephone or online consultations, cancelled or broken appointments or completion of forms or reports, except as required by the Plan.

Vision Benefits

Vision Benefits

The Fund sponsors multiple Vision Plans. The Vision Plans differ in their copay amounts and may include other minor differences. Your copay amount depends on which Vision Plan you participate in pursuant to your collective bargaining agreement or special agreement with the Fund. Contact the Trust Administration Office or review your Plan identification to determine which plan you participate in.

The Fund has an agreement with VSP to provide vision benefits to you and your eligible dependents. Under this agreement, you can use any provider you wish. However, if you use a VSP network provider, you may receive higher benefits and the provider will automatically file claims for you.

Copayment

The following copayment amounts apply toward your exam and eyewear.

Plans 500/702	Plan 701	Plans 703/704
Exam $20 copay	Exam $10 copay	Exam $20 copay
Lenses & Frames	Lenses & Frames	Lenses & Frames
$30 copay	$20 copay	$40 copay

Summary of Benefits and Frequency Limits

The Plan provides the following vision benefits, both in and out of network, after you pay your exam copayment and the copayment toward your eyewear.

Covered Expense		
	If you see a VSP Network Provider	*If you see a non-VSP Provider*
Lenses & Frames	Lenses & Frames	Lenses & Frames
$30 copay	$20 copay	$40 copay
Lenses		
• Single Vision	Paid in full*	Paid up to $45
• Lined Bifocal	Paid in full*	Paid up to $65
• Lined Trifocal	Paid in full*	Paid up to $85
• Lenticular	Paid in full*	Paid up to $125
Frames	Paid up to $120**	Paid up to $47
Contacts — instead of lenses and frames		
• Necessary***	Paid in full	Paid up to $250
• Cosmetic	Paid up to $120	Paid up to $105

Frequency Limits	
Exam	Every 12 months, except Plan 704 which is every 24 months.
Lenses	Every 12 months, except Plan 704 which is every 24 months.
Frames	Every 12 months, except Plans 500 and 704 which is every 24 months.
Contacts (instead of glasses)	Every 12 month, except Plan 704 which is every 24 months.

**Lenses are paid in full, excluding cosmetic extras, such as oversized 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.*

If you need assistance locating a VSP network provider, call VSP at (877) 478-1246, visit www.vsp.com, or contact the Administrative Office. Then make an appointment and tell the provider you are a VSP member. Your provider and VSP will handle the rest.

Additional Discounts

In addition to the benefits shown on the Schedule of Benefits insert, VSP network providers have also agreed to provide the following:

- 30% discount for unlimited additional pairs of prescription glasses and/or non-prescription sunglasses purchased on the same day with the same provider who performed the exam.
- 20% discount on additional glasses and sunglasses, including lens options. This is available from any VSP provider within 12 months of your last eye exam.
- 15% discount off the cost of contact lens exam (fitting and evaluation). Contacts are provided at the usual and customary fees. This discount can be used with the VSP contact lens allowance or can be used to purchase contacts if glasses have already been received.
- Average 15% discount off the regular price, or 5% off the promotional price, of laser vision correction from contracted facilities.

Low Vision Benefit

A low vision benefit is available for severe visual problems that are not correctable with regular lenses. This benefit requires prior approval from VSP. Please discuss your options with your provider. Coverage includes:

- Two low vision supplemental evaluations every two years. VSP pays up to $125 for each exam.
- Supplemental testing — Covered in full
- Supplemental aids — 75% of cost (25% Copayment)
- Benefit maximum — $1,000 every two years

Low vision benefits secured from a non-VSP provider are subject to the same time limits as described above for a VSP network provider. You should pay the non-VSP provider's full fee. You will then be reimbursed up to the amount that would have been paid to a VSP network provider in similar circumstances.

Expenses Not Covered

There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (less than a +.50 diopter power)

- Two pair of glasses in lieu of bifocals
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available
- Medical or surgical treatment of the eyes; this may be covered under your medical benefits
- Corrective vision treatment of an experimental nature
- Costs for services and/or materials above Plan allowances
- Services and/or materials not indicated on this schedule as covered Plan benefits

Weekly Disability Income Benefits (Employee Only)

Weekly Disability Income Benefits (Employee Only)

The Fund sponsors multiple Weekly Disability Income Benefit Plans. Your Weekly Disability Income benefit depends on which Plan you participate in pursuant to your collective bargaining agreement or special agreement with the Fund. Contact the Trust Administration Office or review your Plan identification to determine which plan you participate in.

To qualify for benefits, you must have active eligibility in the month you become Totally Disabled as a result of an injury or illness. In addition, you must be unable to perform the duties of your occupation and not engaged in any other occupation for wage or profit. You must also be under the care of a Physician. Verification of Total Disability by your attending Physician will be required every 30 days. Additional documentation may be requested to determine if the disability is non-occupational or occupational. Weekly disability income benefits are not available to your dependents.

Benefit

The Plan provides the following Weekly Disability Income Benefits for non-occupational injury or illness resulting in Total Disability occurring on or after January 1, 2024:

Plan 500	Plan 801	Plan 802	Plan 803	Plan 804
$400 for weeks 1 through 13	$600 for weeks 1 through 13	$440 for weeks 1 through 13	$400 for weeks 1 through 13	$120 for weeks 1 through 13
$350 for weeks 14 through 26	$481 for weeks 14 through 104	$350 for weeks 14 through 91	$350 for weeks 14 through 26	

Except as provided below for Plan 500, no coverage is provided for occupational disabilities. Occupational disabilities are Total Disabilities resulting from injuries or illness sustained while engaged in any occupation for remuneration or profit, and for which worker's compensation or similar benefits are payable.

Two or more periods of Total Disability due to the same cause are considered one period of Total Disability unless they are separated by your return to full-time work for a continuous period of at least one week.

Two or more periods of Total Disability due to an unrelated injury or illness will be considered one period of Total Disability unless they are separated by your return to full-time work for at least one day.

Non-Occupational Disability Benefits

For a non-occupational Total Disability, the benefit will begin on the 1st day of Total Disability due to Injury, hospitalization or same day surgery, and on the 8th day of continuous Total Disability due to illness.

Occupational Disability Benefits (Plan 500 Only)

Note: *Only Plan 500 provides coverage for occupational disabilities. For Plan 500, the benefit for an occupational disability is the same as the benefit for non-occupational disability but begins on the 8th day of Total Disability due to injury or illness. In order to be eligible for this benefit, you must have incurred a Total Disability while working for a contributing employer to this Fund. In addition, you must have been continuously eligible for the Fund's benefits for at least 24 months of the 60 months immediately preceding the month in which the Total Disability began. This means that during the 5 years prior to your Total Disability, you must have had a 24-month period where you were eligible every month.*

Life and Accidental Death and Dismemberment (AD&D) Benefits (Employee Only)

Life and Accidental Death and Dismemberment (AD&D) Benefits (Employee Only)

The Fund sponsors multiple Life and Accidental Death and Dismemberment Plans. Your Life and Accidental Death and Dismemberment benefit depends on which Plan you participate in pursuant to your collective bargaining agreement or special agreement with the Fund. Contact the Trust Administration Office or review your Plan identification to determine which plan you participate in. Life and Accidental Death and Dismemberment benefits are available only to the employee. The Plan does not provide Life and Accidental Death and Dismemberment benefits for dependents.

Life Insurance

Life insurance benefits are underwritten by an insurance company. In the event of your death while insured, a life insurance benefit will be paid to your beneficiary. Payment will be made in the event of your death at any time or place or from any cause. The following is the amount of benefit payable under each Plan.

Plans 500/903	Plan 901	Plan 902
$5,000	$50,000	$20,000

DESIGNATION OF BENEFICIARY

You should file with the Administrative Office a written designation of the person or persons to whom the benefits shall be paid in the event of your death. Your beneficiary designation should be kept up to date to assure that benefits will be paid in accordance with your wishes. Beneficiary designation forms may be obtained from the Administrative Office or on the Fund's website. No beneficiary change is effective until written notice is received by the Administrative Office.

If you die without designating a beneficiary, or if your named beneficiary does not survive you, your survivors in the following priority order are deemed your beneficiaries:

- Your surviving spouse
- Your children, equally
- Your parents, equally
- Your estate

Your beneficiary may elect payment of your Life Insurance in monthly installments in lieu of a lump sum payment. To arrange for such optional payments, contact the Administrative Office.

If the beneficiary is a minor, a court-appointed financial guardian is required.

TOTAL DISABILITY

If you become Totally Disabled while covered Plan participant and prior to age 60, and you remain so disabled from the date your Plan coverage terminates to the date of your death, your beneficiary will be paid the amount of your life insurance. Initial proof of total disability must be submitted within one year of the date of the disability and must be approved by the insurance company. Proof of the continuation of such disability must be submitted periodically thereafter. This benefit terminates on the date you attain age 65, even if you are still totally disabled. The requirements for submission of proof can be obtained from the Administrative Office.

CONVERSION PRIVILEGE

If your eligibility for life insurance would terminate, you may convert your insurance to an individual policy. The amount of insurance which may be converted cannot exceed the amount in force on your life as of the date of termination of your insurance.

In the event the group policy terminates or is amended to terminate your insurance and you have been continuously insured under the group policy for at least 5 years, you may convert the smaller of:

- the amount of insurance which is terminated less any amount for which you become eligible under any other group life policy within 31 days of such termination of insurance, or
- $5,000.

The individual policy may be issued on any one of the forms, except term insurance, then customarily being offered by the insurance company. The policy will not include disability or other supplementary benefits. The premium is based on the current insurance company rate according to the form and amount of the policy and your attained age on its date of issue. The effective date is the 32nd day following the date your group insurance terminates.

The individual policy will be issued only if written application and payment of the first premium is made within 31 days after the date of termination of your insurance. Evidence of insurability is not required. Conversion forms may be obtained from the Administrative Office.

If you die during the period of time conversion is available, your beneficiary will be paid the amount of insurance you were entitled to convert, whether or not you have applied for conversion.

Accidental Death And Dismemberment (AD&D) Insurance

The following Principal Sum benefit applies to a loss due to an accidental injury.

Plan 500/903	Plan 901	Plan 902
$5,000	$50,000	$20,000

For	Benefit
Loss of life	Principal Sum
Loss of both hands, both feet or sight of both eyes	Principal Sum
Loss of one hand and one foot	Principal Sum
Loss of speech and hearing in both ears	Principal Sum
Loss of one hand or one foot and sight of one eye	Principal Sum
Loss of one hand or one foot or sight of one eye	1/2 Principal Sum
Loss of speech	1/4 Principal Sum
Loss of hearing in both ears	1/4 Principal Sum
Loss of thumb and index finger of same hand	1/4 Principal Sum

Loss of hands or feet means loss by being permanently, physically severed at or above the wrist or ankle. Loss of sight means total and permanent loss of sight. Loss of speech and hearing means total and permanent loss of speech and hearing. Loss of thumb and index finger means loss by being permanently, physically, entirely severed.

No benefits are payable for loss of the use of the hand, foot or thumb and index finger.

Payment will not exceed the Principal Sum for all losses due to the same accident.

Death Benefits are paid to the same designated beneficiary under the Life Insurance benefit. All other benefits are paid to you.

Accidental Injury, as used in this section, means an injury caused by accidental means. The injury must occur while insured. The loss must result from such injury, directly and independently of sickness and all other causes, and must occur within 180 days after the injury.

ACCIDENTAL DEATH AND DISMEMBERMENT EXCLUSIONS

No benefits are paid for loss directly or indirectly caused by any of the following:

- Suicide or intentionally self-inflicted injury, while sane or insane.
- Physical or mental illness.
- Bacterial infection or bacterial poisoning, except for infection from a cut or wound caused by an accident.
- Riding in or descending from an aircraft as a pilot or crew member.
- Any armed conflict, whether declared as war or not, involving any country or government.

- Injury suffered while in the military service for any country or government.
- Injury which occurs when you commit or attempt to commit a felony.
- Use of any drug, narcotic or hallucinogenic agent –
  - Unless prescribed by a doctor.
  - Which is illegal.
  - Not taken as directed by a doctor or the manufacturer.
- Your intoxication. Intoxication means your blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred.

Note: *The above is a summary of the Life and Accidental Death and Dismemberment benefits provided by the Plan through an insurance contract. If there is a conflict between the insurance contract and this summary, the insurance contract will govern.*

General Provisions

General Provisions

Coordination of Benefits (COB) With Other Plans

If a Covered Person is covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, then the other plan(s) pays.

The primary plan (which is the plan that pays benefits first) pays the benefits that are payable under its terms as if there were no other coverage.

The secondary plan (which is the plan that pays benefits after the primary plan has paid) will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the primary plan will not exceed 100% of total Covered Charges. The amount of benefits the secondary plan pays will not exceed the amount it would have paid had it been the primary plan.

ORDER OF BENEFIT DETERMINATION

Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform set of order of benefit determination rules that are applied in the specific sequence outlined below. This Fund uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) which are commonly used by insured and self-funded plans. Any group plan that does not use these same rules always pays its benefits first.

When two group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:

Rule 1: Non-Dependent or Dependent

A. The plan that covers a person other than a dependent, for example, as an employee, member or subscriber is the primary plan that pays first; and the plan that covers the same person as a dependent is the secondary plan that pays second.

B. There is one exception to this rule. If the person is also a Medicare beneficiary, and Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person as a retired employee, then the order of benefits is reversed, so that the plan covering the person as a dependent pays first, and the plan covering the person as a retired employee pays second.

Rule 2: Dependent Child Covered Under More than One Plan

A. The plan that covers the parent whose Birthday falls earlier in the calendar year pays first, and the plan that covers the parent whose Birthday falls later in the calendar year pays second, if:

   1. the parents are married;

   2. the parents are not separated (whether or not they ever have been married);

3. the parents have joint custody either through a court order or otherwise and there is no court order specifying that one parent has the responsibility for the child's health care expenses or to provide health care coverage for the child; or

4. the child is over age 18 and neither parent has custody.

B. If both parents have the same Birthday, the plan that has covered one of the parents for a longer period of time pays first, and the plan that has covered the other parent for the shorter period of time pays second.

C. The word "Birthday" refers only to the month and day in a calendar year, not the year in which the person was born.

D. If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any Plan Year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

   If the specific terms of a court decree state that both parents are responsible for the dependent child's health care expenses or health care coverage, the plan that covers the parent whose Birthday falls earlier in the calendar year pays first, and the plan that covers the parent whose Birthday falls later in the calendar year pays second.

E. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their Spouses (if any) is:

1. The plan of the custodial parent pays first; and

2. The plan of the spouse of the custodial parent pays second; and

3. The plan of the non-custodial parent pays third; and

4. The plan of the spouse of the non-custodial parent pays last.

Rule 3: Active/Laid-Off or Retired Employee

A. The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first, and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second.

B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

C. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

A. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.

B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

C. If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than this rule.

Rule 5: Longer/Shorter Length of Coverage

A. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first, and the plan that covered the person for the shorter period of time pays second.

B. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.

C. The start of a new plan does not include a change:

1. in the amount of scope of a plan's benefits;
2. in the entity that pays, provides or administers the plan, or
3. from one type of the plan to another (such as from a single employer plan to a multiple employer plan).

D. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

In order to receive benefits, the Covered Person must give the Administrative Office any information which is needed to coordinate benefits. Failure to provide information about other coverage may be considered fraud.

Effect of Medicare on Active Employees

When you reach the age of eligibility for Medicare, you will have the opportunity to elect either to be covered by the Fund's Plan or Medicare. In order that you may make a meaningful choice, you will be given the following information:

- The specific terms and conditions of the Fund's Plan.
- The consequences of choosing the Fund's Plan and the extent to which Medicare may supplement these benefits.
- The consequences of electing Medicare instead of the Fund's Plan.

We suggest you contact the Administrative Office approximately three to six months prior to becoming Medicare-eligible to make this election.

If the claimant has coverage through an "active" employee plan, benefits will be determined under the active plan first. Medicare will be secondary and then this Fund will calculate its payment under the "Coordination of Benefits" provisions. If the claimant does not have active coverage, Medicare will be primary, and this Fund will pay secondary to Medicare.

Benefits payable by Medicare will be considered when determining how much is payable by this Plan. The maximum benefit payable under the Plan for Medicare eligible services will be the difference between the Medicare allowable cost and the Medicare payable amount. If you use a provider who is not participating in Medicare, you are responsible for the difference between the Medicare allowable cost and the amount charged by the provider, as well as the amount Medicare would have paid.

Coordination with Medicare for Participants with End Stage Renal Disease (ESRD)

Medicare becomes the primary payor for ESRD on the 31st month of coverage for the duration of ESRD coverage.

Third Party Reimbursement

The Plan excludes benefits for a Covered Person if the Covered Person incurs an Illness or Injury caused by the act or omission of another party (known as the "third party").

- If a Covered Person is pursuing or investigating a claim or lawsuit against a third party or insurer for an Illness or Injury caused by the act or omission of the third party, the Fund may initially advance payment for benefits related to the third-party Illness or Injury. By accepting advance payment for benefits, the Covered Person agrees that the Plan's payment related to the Illness or Injury is conditioned on repayment from any recovery from the third party or first part coverage available under an automobile policy (including uninsured or underinsured motorist coverage), commercial premises policy, homeowners' policy, medical malpractice policy, renter's policy, or any other liability policy.

- If the Fund advances benefits, the Fund shall be entitled to first dollar priority to 100% reimbursement from the Covered Person, with respect to any full or partial recovery by the Covered Person, whether by judgment, settlement, award or otherwise, from any third party, insurer or persons making payments on behalf of a third party. If the Covered Person and the Covered Person's attorney or personal representative recognize the Fund's right to reimbursement, comply with the terms of the Plan and cooperate fully with the Fund, the Fund will deduct reasonable attorney fees and a pro rata share of the costs from the reimbursement amount.
- The Fund's right to reimbursement applies without regard to the characterization of the recovery by the Covered Person and/or any third party or the source of the recovery. The Fund does not recognize the make whole doctrine, which is expressly rejected. The Fund does not otherwise agree to limit its right to reimbursement based on the amount of the Covered Person's recovery; however, the Fund's right to reimbursement will not exceed the amount of the Covered Person's recovery, after payment of attorney fees and expenses.
- Before advancing benefits, the Fund may require that the Covered Person and/or the Covered Person's attorney or personal representative execute, in writing, an agreement acknowledging this reimbursement right, the name and address of the party at fault, the name of any insurance company through which coverage may be available, the name of any other lien holders involved and a factual description of the accident and/or Injury.
- The Covered Person and/or the Covered Person's attorney or personal representative also agree that in the event of a dispute as to the amount of the Fund's claimed reimbursement, the Fund's reimbursement amount will be paid into a trust account and held there until the Fund's claim is resolved by mutual agreement or court order. The obligation to place the reimbursement amount in trust is independent of the obligation to reimburse the Fund. If the funds necessary to satisfy the Fund's reimbursement amount are not placed in trust, the Covered Person or the individual named to hold the funds in trust shall be liable for any loss the Fund suffers as a result.
- If the Fund is forced to bring a legal action against the Covered Person to enforce the terms of the Plan, it shall be entitled to its reasonable attorney fees, costs of collection and court costs.
- If there is a reasonable basis to believe that this provision or any agreement to reimburse the Fund is not enforceable or that the Covered Person will not honor the terms of this provision or any agreement to reimburse, the Fund will deny coverage and may seek refunds of overpaid benefits from providers. The Fund may also cease advancing benefits and exclude future expenses incurred after a judgment, settlement, or proposed settlement of the claim, irrespective of the amount of the recovery, if such expenses are related to the third-party recovery.
- If the Covered Person fails to honor the terms of this provision or any agreement to reimburse, any advanced benefits will be considered overpaid benefits and the Fund may take appropriate action to collect the overpaid benefits, including, but not limited to, seeking refunds from providers, offsetting future benefits, including those of family members, denying future payments, bringing a breach of contract action in state court to enforce the Fund's right to reimbursement under this Plan provision or seeking a construction trust in federal court under ERISA § 502(a)(3). In addition to the overpaid benefits, the Covered Person will be liable for interest, and all costs of collection, including reasonable attorney fees and court costs. Interest

will be calculated at the prime interest rate then prevailing at any national bank located in Anchorage, Alaska, on the date of the breach, plus five (5) percentage points, but not to exceed the amount permitted by law.

- The Fund shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any overpaid or advanced benefits received by the Covered Person, or a representative of a Covered Person (including an attorney) that is due to the Fund, and any such amount shall be deemed to be held in trust by the Covered Person for the benefit of the Fund until paid to the Fund. By accepting Plan benefits from the Fund, the Covered Person consents and agrees that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any overpayment or advancement of benefits, and in accordance with that constructive trust, lien, and/or equitable lien by agreement, the Covered Person agrees to cooperate with the Fund in reimbursing it for all of its costs and expenses related to the collection of those benefits.
- Venue for any enforcement action of the Plan provision will be in the U.S. District Court for the District of Alaska in Anchorage. The Fund may bring an action in an appropriate court to enforce the agreement to reimburse, enforce the requirement that funds be placed in trust or seek other appropriate relief.

Motor Vehicle Accidents

Your motor vehicle liability policy may provide primary liability insurance, such as personal injury protection ("PIP") and primary medical payment insurance.

The Fund will not pay benefits for health care costs to the extent that the eligible individual is able to, or is entitled to, recover from primary motor vehicle insurance, including payments under a PIP policy. Benefits will not be provided to the extent an eligible individual has failed to acquire PIP coverage where required to do so by law or PIP coverage has been terminated before being exhausted for failure to cooperate or otherwise for cause. The Fund will pay benefits toward expenses over the amount covered by primary motor vehicle insurance subject to the Plan's Third-Party Reimbursement Provision.

If the Fund pays benefits before primary motor vehicle insurance payments are made, the Fund is entitled to reimbursement out of any subsequent motor vehicle insurance payments made to the eligible individual and, when applicable, the Fund may recover benefits the Fund has paid directly from the motor vehicle insurer or out of any settlement or judgment which the eligible individual obtains in accordance with the Plan's Third-Party Reimbursement Provisions.

Right of Recovery

In the event that through mistake, misrepresentation, fraud, inadvertence or any other circumstance, the Plan has paid an individual or has paid a provider on an individual's behalf, more than the individual or provider is entitled to under the Plan or under the law, the payment will not constitute a waiver of applicable Plan provisions, including any limitation or exclusion. The Fund may set off, recoup or recover the amount of overpayment or excess credit accrued or thereafter accruing from

the individual, or it may offset future benefit payments due to the individual or the individual's family members by the amount paid in error.

The Fund may also request refunds from a provider or reduce future payments to the provider by the amount of the overpayment. The reduction or offset of future payments may involve this Plan or other health plans that are administered by the Plan's joint claim administrator/network provider. Under this process, the Plan's joint claim administrator/network provider reduces future payments to providers by the amount of the overpayment they received, and then credit the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when the Plan's joint claim administrator/network provider recovers overpayments for other plans administered by the joint claim administrator/network Provider. The Plan may also take such further action as the Board of Trustees shall determine.

Definitions

Definitions

The following terms when used in this document, have the following meanings unless a different meaning is clearly required by context.

Alcoholism or Drug Abuse Treatment Facility means a facility which specializes in the treatment of alcoholism and/or drug abuse and which is licensed, accredited or approved by the appropriate state authority established to regulate such facilities.

Coronary Care Unit is a hospital ward specialized in the care of patients with various cardiac conditions that require continuous monitoring and treatment by highly trained hospital personnel.

Cosmetic Surgery means surgery performed to alter:

- the texture or configuration of the skin, or
- the configuration or relationship with continuous structures of any feature of the human body,

which is performed primarily for psychological purposes or which does not correct or materially improve a bodily function. Cosmetic Surgery is performed to improve appearance and is not Medically Necessary.

Covered Charges are the billed costs charged for covered services to the extent that such charges are Usual, Customary, and Reasonable for the area and the type of service. For non-Preferred Provider services in Anchorage, the Covered Charges for inpatient Hospital services will be limited to the contracted rate at the Preferred Provider Hospital and a $1,000 penalty will be imposed. The Covered Charges for outpatient Hospital or facility charges at a non-Preferred Provider in Anchorage will be 50% of the billed charges.

Covered Person is an employee or dependent who is eligible and enrolled in this Plan.

Custodial Care is care that does not require the continuing services of skilled medical or allied health professionals and is primarily to assist the patient in activities of daily living. This may include institutional care to support self-care and provide room and board or home care. Types of custodial care include help in walking, getting into and out of bed, bathing, dressing, feeding and preparing of special diets, and supervising medications that are ordinarily self- administered.

Dentist means an individual who is legally licensed to practice dentistry and shall include a Physician furnishing dental services which he or she is licensed to perform.

Dental Hygienist means an individual who is under the supervision of a Dentist and is currently licensed to practice dental hygiene by a governmental authority which has jurisdiction over the licensure and practice of dental hygiene.

Durable Medical Equipment means equipment that: (1) is designed for repeated use; (2) is mainly and customarily used for medical purposes; and (3) is not generally of use to a person in the absence of a disease or injury. Durable Medical Equipment includes, but is not limited to, such items as: Hospital bed; wheelchair; respirator; traction apparatus; intermittent positive pressure breathing machine; brace; crutches.

The items in the list that follows are examples of some, but not all, of the types of equipment that is not considered to be Durable Medical Equipment: air conditioner; air purifier; heat lamp; heating pad; bed board; orthopedic shoes; corrective device for use in shoes; gravity traction device; exercise bicycle; weight lifting equipment; blood pressure monitor; exam gloves; food or formula; incontinence supplies; specially equipped van.

Experimental or Investigational (Dental Care) means a service or supply is considered experimental or investigational if any of these conditions is present:

- The service or supply is described as an alternative to more conventional therapies in written documents by the provider that performs the services;
- The service or supply may be given only with approval of an Institutional Review Board as defined by federal law;
- There is an absence of authoritative dental, medical, or scientific literature on the subject, or that literature indicates the service or supply is experimental or investigational or that more research is needed;
- The Food and Drug Administration (FDA) has not approved marketing of the service or supply or has it under consideration; or
- The service or supply is available only through clinical trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

The Board of Trustees has the discretion and authority to determine if a service or supply is or should be considered experimental or investigational. That determination is based on the information and resources available when the service is performed or the supply is provided.

Experimental or Investigational (Medical Care) means a service or supply if any of these applies:

- The drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given for regular nonexperimental or noninvestigational purposes at the time the drug or device is furnished;
- The drug, device, medical treatment, or procedure has been determined experimental or investigational by the treating facility's institutional review board or other board or other body serving a similar function, and the patient has signed an informed consent document acknowledging such experimental status;
- Federal law classifies the drug, device or medical treatment under an investigational program;
- Reliable evidence shows the drug, device, medical treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy compared with standard means of treatment or diagnosis; or
- Reliable evidence shows the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies of clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy compared with standard means of treatment or diagnosis (except as provided below),

For this section, "reliable evidence" means only published reports and articles in peer reviewed authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure (except as provided below).

Exceptions: A service or supply will not be considered experimental or investigational if it is part of an approved clinical trial. An approved clinical trial is one that meets the criteria in either Category 1 or 2 below:

Category 1

- The trial is a Phase III or Phase IV trial approved by the National Institutes of Health, the FDA, the Department of Veteran Affairs or an approved research center;
- The trial has been reviewed and approved by a qualified institutional review board; and
- The facility and personnel have sufficient experience or training to provide the treatment or use the supplies.

Category 2

- The trial is to treat a condition too rare to qualify for approval under Category 1;
- The trial has been reviewed and approved by a qualified institutional review board;
- The facility and personnel have sufficient experience or training to provide the treatment or use the supplies;
- The available clinical or preclinical data provide a reasonable expectation that the trial treatment will be at least as effective as noninvestigational therapy; and
- There is no therapy that is clearly superior to the trial treatment.

The Administrative Office shall investigate each claim for benefits that might include experimental or investigational treatment. The Administrative Office may consult with medical professionals, including its own staff, to determine whether the treatment is excluded as experimental or investigational, or whether it is covered as one of the exceptions stated above.

Home Health Aide Services means those services which may be provided by an individual, other than a registered nurse, which are Medically Necessary for the proper care and treatment of any individual and are not considered Custodial Care.

Home Health Care Agency means any institution which is licensed pursuant to any state or local law and is operated primarily for the purpose of providing skilled nursing care and therapeutic services in an individual's home and

- maintains clinical records on each patient and the services are under the supervision of a Physician or appropriately licensed Provider; and

- has operational policies established by a professional group including at least one Physician and one registered nurse;

excluding any institution which is primarily involved in providing Custodial Care.

Hospice means a facility, agency, or service that:

- is licensed, accredited, or approved by the proper regulatory authority to establish and manage hospice care; and
- arranges, coordinates, and/or provides hospice care services for dying individuals and their families; and
- maintains records of hospice care services provided and bills for such services on a consolidated basis.

Hospital means an institution operated pursuant to law for the care and treatment of sick or injured individuals, with organized facilities for diagnosis and major surgery, and 24 hour nursing service. Any institution, or part thereof (other than an Alcoholism or Drug Abuse Treatment Facility), which is used primarily as an extended care facility or for training, custodial or convalescent purposes is excluded.

Hospital Confinement Charges mean Covered Charges by a Hospital for room, board, and other usual services and by a Physician for pathology, radiology, or the administration of anesthesia while a person is confined in a Hospital. The charges must be incurred while the person is confined for a period of at least 23 consecutive hours (for any cause).

Illness means a bodily disorder, infection, or disease and all related symptoms and recurrent conditions resulting from the same cause. An Illness identified in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is considered to be a mental health disorder for the purposes of this Plan. If there are multiple diagnoses, only the treatment for the Illness identified under the DSM code is considered mental health treatment. Illness does not include a condition incurred or aggravated while performing a job-related task, engaging in any activity for wage or profit, or for which compensation could be available if application were made under a workers' compensation or occupational injury law or similar legislation.

Injury means physical harm sustained as the direct result of a non-occupational accident, effected solely through external means, and all related symptoms and recurrent conditions resulting from the same accident.

Intensive Care Unit is a Hospital ward specialized in the care of critically ill patients that require continuous monitoring and treatment by highly trained hospital personnel.

Medically Necessary means a procedure, service or supply that meets the following criteria and limitations:

- It is appropriate to the diagnosis and/or treatment of the patient's Illness or Injury.
- It is known to be effective in improving health outcomes for the patient's medical condition in accordance with sufficient scientific evidence and professional recognized standards.

- It represents the most economically efficient use of medical services and supplies that may be provided safely and effectively to the patient.
- It is not primarily for the convenience of the patient or provider.
- When applied to an inpatient, it cannot safely be provided to the patient as an outpatient.

A service or supply may be medically necessary in part only. The fact a procedure, service, or supply may be furnished, prescribed, recommended or approved by a provider or other provider does not, of itself, make it medically necessary under the terms of the Plan.

Physician means a provider who is legally licensed to practice medicine and is acting within the scope of his/her license. Physician includes:

- medical doctor, MD
- osteopathic doctor, DO

Provider means a Physician and other health care professionals who are legally licensed to practice medicine and is acting within the scope of his/her license, including:

- podiatrist, DPM
- chiropractor; DC
- psychologist Phd, or PsyD
- a licensed social worker whether or not under the direct supervision of a medical doctor or psychologist
- naturopath, ND
- licensed or certified practitioner rendering counseling services when regulated by the appropriate state agency
- a state certified midwife
- physician's assistant, PA
- a nurse practitioner
- audiologist

Preadmission Testing Charges mean Covered Charges by a Hospital or other health care provider for tests that are performed:

- on an outpatient basis; and
- within seven days prior to admission to a Hospital for surgery or other inpatient treatment; and
- according to a formal preadmission testing arrangement with the Hospital where the surgery or other inpatient treatment will occur.

Skilled Nursing Facility means an institution, or a distinct part thereof, which is licensed pursuant to state or local law and is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from injury or sickness, and

- has organized facilities for medical treatment and provides twenty-four-hour nursing service under the full-time supervision of a Physician or graduate registered nurse; and
- maintains daily clinical records on each patient and has available the services of a Physician under an established agreement; and
- provides appropriate methods for dispensing and administering drugs and medicines; and
- has transfer arrangements with one or more Hospitals, a utilization review plan in effect and operational policies developed with the advice of, and reviewed by, a professional group including at least one Physician;

excluding any institution which is other than incidentally a rest home, a home for the aged, or a place for the treatment of mental diseases, drug addiction or alcoholism.

Totally Disabled or Total Disability means you are completely and continuously disabled because of an Injury or Illness, unable to perform the duties of your occupation and not engaged in any other occupation for wage or profit.

Usual, Customary and Reasonable Charge

Usual and Customary Charges (U&C) charge for Preferred Providers in the Anchorage metropolitan area and PPO Providers (providers contracted with Aetna), means their contracted fee amount. U&C charges for non-Preferred Providers means the amount payable (for services other than outpatient dialysis) as determined by the Board of Trustees or its designee for a particular service, and subject to the following:

1. The U&C Charges for a claim governed by the No Surprises Act, or similar federal balance billing protections, will be determined in accordance with the applicable law;
2. Charges for services or supplies which are not provided or billed in accordance with generally accepted professional standards and/or medical practice are not considered U&C Charges regardless of the amount billed;
3. In no event will the U&C charge exceed the amount billed or the amount for which the covered person is financially responsible;
4. U&C may not reflect the actual billed charges and does not take into account the professional service provider's training, experience or category of licensure;
5. The Plan's U&C methodology may vary between claims based on the facts and circumstance of the claim, the services provided and the expected savings;
6. The Trust may hire a third-party reviewer to determine the U&C amount consistent with this provision;

7. Irrespective of the Plan's U&C methodology or U&C determination, the Trustees reserve the right to negotiate an acceptable U&C amount directly with a provider; and
8. For outpatient dialysis services, see the Dialysis benefit section for the determination of the Plan benefit amount.

For properly billed non-PPO professional service provider charges, the Plan has contracted with Zenith American Solutions (which in turn has contracted with Zelis) to negotiate a payment amount that, if accepted, will result in no balance billing for you or your dependent. If the non-PPO professional service provider does not accept Zelis' proposed payment, the U&C amount shall be no higher than the 90th percentile identified by a commercially available database selected by the Trust. When there is, in the Board of Trustees' determination, minimal data available from the database for a covered service, the Board of Trustees will determine the U&C amount by calculating the unit cost for the applicable service category using the database, and multiplying that by the relative value of the covered service assigned by the Medicare resource based relative value scale (supplemented with a commercially available relative value scale selected by the Plan where one is not available from Medicare). In the event of an unusually complex procedure, a new procedure, or a procedure that otherwise does not have a relative value that is in the Board of Trustees' determination applicable, the Trust may assign one.

For properly billed non-PPO facility services, the Plan has contracted with Zenith American Solutions (which in turn has contracted with Zelis) to negotiate a payment amount that, if accepted, will result in no balance billing for you or your dependent. If the non-PPO facility does not accept Zelis' proposed payment, U&C means 200% of the Medicare reimbursement amount.

Note: *This provision does not apply to facility charges that are subject to the penalties discussed above in the section titled "Reduced Reimbursement of Charges by Non-Preferred Providers."*

Non-PPO Providers (including both professionals and facilities) seeking claim payment under the Plan shall be obligated to submit to a prompt audit of their claims by the Trust, notwithstanding any internal rules they may have to the contrary. In the event a non-PPO Provider refuses or delays a reasonable audit request by the Trust, the Trust shall have the right to withhold payment to the said non-PPO Provider on the claim in question and on other pending or future claims by said non-PPO Provider

If you have any questions about U&C for medical/surgical or mental health/substance use disorder benefits, please contact the Administrative Office. You can contact the Administrative Office as follows:

Phone: (907) 276-1246 or toll free at (800) 478-1246, Monday – Friday from 8 am – 5 pm

Email: **aetfhw@aetf.com**

How to File a Claim

How to File a Claim

In order to receive payment for your claims, you must maintain a current Annual Medical/Dental Update form on file at the Administrative Office for you and each of your eligible dependents. To avoid a delay in payment of your claims, you must send an updated form to the Administrative Office at least annually and any time there is a change, such as a change in other insurance coverage.

Note: *Even though many healthcare providers will bill the Fund directly for services you receive, it is your responsibility to ensure your claims are complete and filed in a timely manner. The Administration Office will only process claims incurred while you are eligible for Plan benefits.*

All claims, supporting documentation and additional information that is requested to process the claims must be submitted within one year of the date services are rendered unless you are not legally capable. Incomplete claims will be denied. Claims submitted or completed more than one year from the date of service will not be considered.

All payments for services by Preferred Providers will be made directly to such providers. In the case of non-Preferred Providers, payments will be made, at the Fund's option, to the participant, to his or her estate, to the provider or as required under federal law, including qualified medical child support orders. No assignment whether made before or after services are provided, of any amount payable according to this Plan shall be recognized or accepted as binding upon the Trust, unless otherwise required by federal law.

Medical Benefits

1. In most situations, providers will submit bills directly to Aetna. If your provider does not directly bill Aetna you should obtain the bills that set forth the services and treatments received. Be sure the itemized bills show the following:
   - Patient's name
   - Employee's name and ID number
   - Providers name, address and TIN number
   - Dates of service
   - Diagnosis codes
   - Medical claims: current procedural code (CPT)
   - Hospital claims: itemized bill
2. Forward your itemized bills and all necessary information to the Administration Office or:

   Aetna
   P.O. Box 981106
   El Paso, TX 79998-1106

3. If you want payment sent directly to the provider (hospital, doctor, etc.) you must assign benefits to the provider and indicate you want payment to the provider.
4. If your dependent has other group coverage, list the dependent's other insurance provider and attach the other insurance's Explanation of Benefits (EOB).

Prescription Drug Benefits

See pages 52 to 56 for a detailed description on filing claims under the prescription drug program administered by CVS/caremark.

Dental Benefits

In most situations, providers will submit bills to the Fund directly. If your provider does not bill directly, you should request an itemized statement of the services, including the ADA codes, and forward it to the Administrative Office.

Vision Benefits

USING VSP PROVIDERS

When making an appointment with a VSP provider, inform them that your coverage is with VSP and provide them with the employee's social security number. The provider will verify your eligibility and available benefits. At the time of your appointment, your provider will collect your Copayment and bill VSP directly. No claim form is needed.

USING NON-VSP PROVIDERS

If you use an eyecare provider that is not a member of the VSP network, you are responsible for paying the provider in full at the time of service. Services obtained through out-of-network providers are subject to the same allowable frequency and Copayments as services obtained through VSP providers. You will need to file a claim for reimbursement with VSP; a VSP claim form is available on the Fund's website.

To submit your claim, you may do one of the following:

1. Fill out a VSP claim form and mail it with itemized bills and receipts to:

   VSP

   Out-of-Network Provider Claims

   P.O. Box 997105

   Sacramento, CA 95899-7105
2. You may submit the itemized bills and receipts without a claim form to the Administrative Office and they will be forwarded to VSP for you.
3. Keep a copy of the claim information for your records.

Weekly Disability Income Benefits

1. Obtain a weekly disability income claim form from the Administrative Office or the Fund's website.
2. Complete, sign and date part 1 of the form.
3. Have your Physician complete, sign and date part 2 of the form. Mail the fully completed form to the Administrative Office.
4. If your application is approved, you will need to complete the employee section of the Supplementary Disability Claim Form each week that your disability continues and submit this form to the Administrative Office. Once every 30 days your Physician will need to complete the Statement of attending Physician section of the Supplementary Disability Claim Form.

Life Insurance and Accidental Death or Dismemberment Benefits

1. Notify the Administrative Office, and in the event of death, submit a certified copy of the death certificate.
2. The Administrative Office will forward all information to the life insurance company for processing.

Procedures for Processing Claims

Properly filed claims are generally processed according to the guidelines below. The Fund makes every reasonable effort to process the claims within these timeframes. However, large and/or complex claims may require additional time to review beyond the general timelines below. If this is the case, the Fund will attempt to work directly with the provider to ensure timely process of claims.

POST-SERVICE CLAIMS

Any properly filed claim for health benefits that is not a pre-service, urgent care or concurrent care claim (as defined on the following pages) is processed as a post-service claim.

A post-service claim ordinarily is processed within 30 days of receipt. This may be extended for an additional 15 days if the Administrative Office determines that the extension is necessary due to matters beyond the Fund's control and the Fund provides the reason for the extension within the initial 30 days – including a statement of unresolved issues and the information required to resolve them. If more information is needed, you (or your dependent) will be notified and given at least 45 days to provide the information. If the additional information is not provided, the claim may be denied. If the additional information is provided, the period for processing the claim will not include the period from the date the information is requested until the requested information is received.

PRE-SERVICE CLAIMS

Pre-service claim procedures apply to processing treatment plans submitted for preauthorization. As explained in more detail on pages 30 to 33, inpatient admissions at Hospitals, Skilled Nursing Facilities, and other treatment facilities as well as certain outpatient services must be preauthorized in order to qualify for payment of these charges at your Plan's standard rate.

A decision on a pre-service claim ordinarily is made within 15 days. This time may be extended for an additional 15 days if the Administrative Office determines that the extension is necessary due to matters beyond the Fund's control and the Fund provides the reason for the extension within the initial 15 days – including a statement of unresolved issues and the information required to resolve them. If more information is needed, you (or your dependent) will be notified and given at least 45 days to provide the information. If the additional information is not provided, the claim may be denied. If the additional information is provided, the period for processing the claim will not include the period from the date the information is requested until the requested information is received.

If services requiring preauthorization have been provided, and the issue is payment, the claim is processed as a post-service claim.

URGENT CARE CLAIMS

Urgent care claims are for services where following the normal claims processing timing rules could seriously jeopardize the Covered Person's health or ability to regain maximum function, or in the opinion of a Provider familiar with the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims may be filed, orally, or in writing, by the Covered Person, or Physician or covered Provider with knowledge of the condition. Determinations about whether a claim is urgent are made using the judgment of a prudent layperson with average knowledge of health and dentistry.

The claim is resolved as soon as possible, but no more than 48 hours after the Fund receives the claim. The Fund will inform you as soon as possible (and not more than 24 hours after the claim is received) of any additional information that is required to process the claim. If the additional information is not provided, the claim may be denied. If the additional information is provided, the period for processing the claim will not include the period from when the information is requested until the requested information is received.

If urgent care services have been provided, and the issue is payment, the claim is processed as a post-service claim.

CONCURRENT CARE CLAIMS

Concurrent care claims are claims involving an ongoing course of treatment that has received medical necessity approval from the Plan's medical management service organization. While the approved treatment is continuing, the provider or Covered Person may request additional or extended treatment plan. In addition, the medical management service organization may issue notice that approval will be withdrawn before the full course of treatment is completed. The

Covered Person is notified of any denial or reduction at least 30 days in advance to allow time to appeal and obtain a determination on the appeal before the decision takes effect.

Any request to extend treatment that involves urgent care is decided as soon as reasonably practical. The Covered Person is notified of the determination within 24 hours of when the Plan receives the claim, if it's received at least 24 hours before the previously approved treatment ends.

Any appeal of a concurrent care claim is treated as a post-service, pre-service or urgent care claim appeal, as appropriate.

NOTICE OF DENIAL

A benefit denial contains the following information:

1. The reason for the denial.
2. Reference to the Plan provision(s) relied on.
3. Description of any additional material needed for the claim, with an explanation of why it is necessary.
4. Reference to any internal rule, guideline or protocol used in denying the claim, with a statement that a copy is available without charge upon request.
5. An explanation of the medical judgment – applying Plan terms to the Covered Person's circumstances – if the denial is based on the service or supply being Medically Necessary or Experimental or Investigational, or an equivalent exclusion.
6. An explanation of the Plan's appeal procedures, including applicable time limits

The denial will be mailed to the Covered Person at the last known address.

Appeal to the Board of Trustees

The Board of Trustees has adopted the following procedures to review benefit claim denials.

APPEAL PROCEDURES

The procedures specified below are the exclusive procedures available to a Covered Person who is dissatisfied with an eligibility determination, benefit award or is otherwise adversely affected by an action of the Fund or its authorized claims payers. These procedures must be exhausted before a Covered Person may file suit under ERISA § 502(a). A Covered Person who is seeking benefits from an insurance company with which the Fund contracts shall utilize the procedures established by that entity.

APPEAL OF BENEFIT DENIAL

Covered Persons will have 180 days from the date of denial to appeal an adverse benefit determination except denials of life insurance and AD&D claims must be filed within 60 days. An

appeal shall be submitted by the Covered Person or an authorized representative in writing. It shall be submitted to the proper address for either the Administrative Office or the claims administrative agent that made the denial. An appeal shall identify the benefit determination involved, set forth the reasons for the appeal and provide any information the Covered Person believes is pertinent. Except for urgent care claims, appeals will be accepted from an authorized representative only if accompanied by a written statement signed by the Covered Person (or parent or legal guardian where appropriate), which identifies the representative and authorizes him or her to seek benefits for the Covered Person. The Fund does not recognize an assignment of benefits and an assignment of benefits, by itself, is not sufficient to make a provider an authorized representative.

The failure to file a claim appeal within 180 days of the denial (or 60 days for life and AD&D claims) will bar any claim for benefits or for other relief from the Fund.

Information To Be Provided Upon Request

You, and/or your authorized representative, may upon request have reasonable access free of charge to all documents relevant to the claim for benefits. Relevant documents include information relied upon, submitted, considered or generated in making the benefit determination. It will also include internal guidelines, procedures or protocols concerning the denied treatment option without regard to whether such document or advice was relied on in making the benefit determination. Absent a specific determination by the Board of Trustees that disclosure is appropriate, relevant documents do not include any other Covered Person's medical or claim records or information specific to the resolution of other Covered Persons' claims.

If a denial is based upon a medical determination, an explanation of that determination and its application to your medical circumstances is also available upon request.

Conduct of Hearings By the Appeals Committee

Except for urgent care and pre-service health claims, an appeal will be presented to the Fund's Appeals 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.

The Appeals Committee shall consist of at least one employer Trustee and one labor organization Trustee. The Appeals Committee will review the administrative file, which will consist of all documents relevant to the claim. A copy of the administrative file will be mailed to you and you will be provided with an opportunity to submit additional documentation for consideration by the Appeals Committee. The Appeals Committee will review all additional information submitted by or on your behalf. The review will be de novo and without deference to the initial denial.

If the denial is based on medical judgment, the Appeals Committee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Fund may have an individual with a different licensure review a matter if they are trained to deal with the condition involved. The health care professional consulted will not be the individual who made the initial benefit determination nor the subordinate of that individual. The Appeals Committee will identify by name any individuals consulted for medical or vocational advice.

You or your representative will be allowed to appear before the Appeals Committee and present any evidence or witnesses. If you do not elect to appear, the hearing will be determined based on the administrative file and the comments of any witnesses consulted.

If you appear at the hearing (or if the Appeals Committee otherwise determines that such a record is appropriate) a stenographic record shall be made of any testimony provided. The Appeals Committee may in its discretion set conditions upon the conduct of the hearing, the testimony or attendance of any individual or address other procedural matters which may occur during a specific hearing.

Issuance of a Decision

The Appeals Committee will provide you written notification of its decision within five days. Where appropriate, the Appeals Committee may issue a more detailed explanation of the reasons for its decision within 30 days of the hearing. The decision will set out the specific reasons for an adverse decision, reference the plan procedure involved, inform you that all information relevant to the individual's claim is available upon request and free of charge, notify you of your rights under ERISA § 502(a), identify any internal rule or guideline relied on (or reference that it is available free of charge), and if a denial is based on a medical judgment, an explanation of the medical judgment applying it to your case or a statement that such information is available.

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

MODIFICATIONS TO THE APPEAL PROCEDURES FOR PRE-SERVICE AND URGENT CARE CLAIMS

The following modifications will be made in the appeal procedures set forth above for claims involving pre-service claims or urgent care claims:

Pre-Service Claims

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

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

Urgent Care Claims

Appeals involving denial of urgent care will be subject to the rules set forth above with the following modifications:

- An initial decision will be made within 72 hours if the initial claim was complete when submitted or an additional 48 hours after receiving additional information if it was necessary to process the claim.
- An appeal may be made orally or in writing.
- A health care professional with knowledge of your medical condition may act as your representative without a prior written authorization.
- Information will be provided to you or your authorized representative via telephone, facsimile or other expedited method.
- A decision will be issued within 72 hours of an appeal of an initial denial.

EXTERNAL REVIEW

If you remain dissatisfied after the Board of Trustees issues its decision on appeal, you may request an external review with an Independent Review Organization or bring a civil action under ERISA § 502(a). If you request an external review, such request is subject to the following:

- The Plan's claim appeal process must be exhausted before external or judicial review can be sought.
- External reviews are only available for appeals involving medical judgment or the retroactive rescission of health coverage. There is no external review for weekly disability income, accidental death and dismemberment or life insurance benefits.
- You have four months from the date of the final adverse benefit determination to file a request for external review. Failure to request an external review within the four-month period will end your ability to seek external review.

Requests for external review should be sent to the Administrative Office.

Preliminary Review of External Review Request

Within five business days of receipt of a request for external review, the Fund will complete a preliminary review of the external review request. The preliminary review will be expedited if the request satisfies the requirements for an expedited external review. Within one business day after completion of this review, the Fund will notify you of its decision. If the request is not eligible for external review, the Fund will notify you. If the request for external review is incomplete, the Fund will identify what is needed and you will have the longer of 48 hours or the remaining portion of the four-month external review request period to provide the information. If the external review request is complete and eligible for external review, the Fund will refer the matter to an Independent Review Organization.

Expedited External Review

You may request an expedited external review if you received:

- an adverse denial of benefits which involves a medical condition for which the timeframe for completing an expedited appeal to the Board of Trustees would seriously jeopardize your life or health or your ability to regain maximum function and you have filed a request for an expedited appeal to the Board of Trustees; or
- an adverse decision on appeal to the Trustees which involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or your ability to regain maximum function, or the decision concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Review by Independent Review Organization

If a properly filed request for external review is received, the Plan will provide the Independent Review Organization with the required documentation in the time required by applicable federal regulations. The Independent Review Organization will provide a response to you within 45 days after it has received the request to review.

If a claim satisfies the requirements for an expedited external review, the Independent Review Organization will provide a response to you within 72 hours after it has received the request to review, provided that written confirmation may be provided within 48 hours after the date the response is provided.

Judicial Review of Denied Claims

The Fund provides for no voluntary alternative dispute resolution procedures. If a Covered Person remains dissatisfied after the issuance of the Trustees' decision on appeal, or issuance of the Independent Review Organization's decision, you may bring a civil action under ERISA § 502(a). Any civil action must be brought no later than 180 days after the date of issuance of the Trustees' decision on an appeal. The question on review will be whether, in the particular instance, the Trustees:

- were in error upon an issue of law;
- acted arbitrarily or capriciously in the exercise of their discretion; or
- whether their findings of fact were supported by substantial evidence.

Right to Sue

A lawsuit to obtain benefits will be deemed untimely if it is filed before:

- You have appealed the denial of your claim to the Board of Trustees, or
- The Board of Trustees has issued a decision on appeal; or
- You have exhausted the Plan's appeals processes for every issue you deem relevant.

The ERISA Statement of Rights provides additional information on legal action you can take if you feel your right to a benefit has been improperly denied.

Special Disclosure Information

Special Disclosure Information

Name of Plan

This Plan is known as the Alaska Electrical Health and Welfare Plan.

Board of Trustees-Plan Administrator

This Plan is maintained and administered by a joint labor- management Board of Trustees, the name, address and telephone number of which is:

Board of Trustees
Alaska Electrical Health and Welfare Fund
701 E Tudor, Suite 200
Anchorage, Alaska 99503

Telephone: (907) 276-1246
Toll Free: (800) 478-1246
Fax: (907) 278-7576
www.aetf.com

A list of participating employers and labor organizations can be examined at this office.

Members of the Board of Trustees

The current members of the Board of Trustees are:

MANAGEMENT TRUSTEES

Larry Bell (Co-Chair)
Alaska Chapter, NECA
712 West 36th Avenue
Anchorage, AK 99503

Alan Growden
Sturgeon Electric Company
1301 E 64th Avenue
Anchorage, AK 99518

Paul Lantz
Alcan Electric
P.O. Box 91499
Anchorage, AK 99509

Nathan Maki
Lineworks LLC
P.O. Box 201146
Anchorage, AK 99520

Elliott Marlow
Endeavor Electric
3560 W 74th Avenue
Anchorage, AK 99520

LABOR TRUSTEES

Vince Beltrami
P.O. Box 569
Cooper Landing, AK 99572

Pamela Cline
IBEW LU No. 1547
3333 Denali Street, Suite 200
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Diana Ruhl
IBEW LU No. 1547
3333 Denali Street, Suite 200
Anchorage, AK 99503

Matthew Rumery
IBEW LU No. 1547
813 W 12th Street
Juneau, AK 99801

Doug Tansy (Co-Chair)
IBEW LU No. 1547
3333 Denali Street, Suite 200
Anchorage, AK 99503

Agent for Service of Legal Process

Each member of the Board of Trustees and the Plan Administrator is an agent for the purpose of accepting service of legal process on behalf of this Plan.

Identification Number and Plan Number

The Employer Identification Number assigned to the Plan by the Internal Revenue Service is EIN 92-6001972; the Plan number is: 501.

Type of Plan

This Plan can be described as a welfare plan providing the following kinds of benefits to active employees: medical and prescription drug benefits; for active employees only: dental, vision care, weekly disability, accident and death benefits.

Type of Administration

This Plan is administered by a joint labor-management Board of Trustees.

Description of Collective Bargaining Agreements

This Plan is maintained under several Collective Bargaining Agreements between contributing Employers and the International Brotherhood of Electrical Workers of Local 1547. A copy of such agreements may be obtained by participants and beneficiaries at the Administrative Office, and at the Local Union offices, upon 10 days advance written request. The Trustees may impose a reasonable charge to cover the cost of furnishing the agreement. You may wish to inquire as to the amount of the charges before requesting copies.

Participation, Eligibility and Benefits

Employees are entitled to participate in this Plan, if they work under one of the collective bargaining agreements described above and if their employer makes contributions to the Fund on their behalf. Also, certain non-bargaining unit employees are entitled to participate pursuant to special agreements between their employers and the Board of Trustees.

The eligibility rules which determine which employees and beneficiaries are entitled to benefits are set forth in the Eligibility section of this booklet.

The benefits to which eligible employees and beneficiaries are entitled are set forth in this booklet.

Circumstances Which May Result in Ineligibility or Denial of Benefits

The circumstances which may result in disqualification, ineligibility, denial, or loss of benefits appear throughout this booklet.

Termination of Plan

The Board of Trustees has the authority to terminate the Plan. The Plan will also terminate upon the expiration of all collective bargaining agreements and special agreements requiring the payment of contributions to the Fund.

In the event of the termination of the Plan, any and all monies and assets remaining in the Fund, after payment of expenses, shall be used for the continuance of the benefits provided by the then existing benefit plans, until such monies and assets have been exhausted.

Entities Used for Accumulation of Assets and Payment of Benefits

The employer contributions and employee self-payments are received and held in trust by the Board of Trustees pending the payment of benefits, insurance premiums and reasonable administrative expenses. Medical, prescription drug, dental, vision and weekly disability benefits are self-funded and benefits are paid directly from the Fund.

The life insurance and accidental death and dismemberment benefits provided by the Fund are fully insured by an insurance company.

An insurance company provides a policy of stop loss insurance to the Fund, under which they have assumed the financial responsibility for medical claims exceeding a deductible amount per covered individual per policy year.

Source of Contributions

The Plan is funded through employer contributions, the amount of which is determined through collective bargaining between participating employers and labor organizations, and which is specified in the underlying collective bargaining agreement. Self-payments are also permitted, as outlined in this booklet to continue employee and dependent coverage.

Plan Year

The Plan Year on which financial records are based ends December 31.

Statement of ERISA Rights

As a participant in the Alaska Electrical Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

- Examine, without charge, at the Administrative Office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and

collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Security Benefits Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Fund's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request materials from the Fund and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the

materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

- If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.
- If it should happen that Plan fiduciaries misuse the Fund's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Administrative Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Claims Review and Appeal

Claims review and appeal procedures are summarized in the section entitled "How to File A Claim."

Availability of Information

Plan documents and all other pertinent documents required to be made available under ERISA are available for inspection at the Administrative Office during regular business hours. Upon written request, copies of these documents will be provided. However, the Trustees may make a reasonable charge for the copies; the Plan Administrator will state the charge for specific documents on request so that you can find out the cost before ordering.

Plan Amendment

The Board of Trustees of the Alaska Electrical Health and Welfare Fund reserves the right to amend all or any part of this Plan at any time; to amend any contract providing insured benefits or other services; and to remove or change any insurance company or service company at any time.

Any amendment must be in writing and shall be effective upon adoption by the Board of Trustees, or at any such time as may be otherwise specified in the amendment, unless prohibited by applicable law.

Termination

The Board of Trustees of the Alaska Electrical Health and Welfare Fund reserves the right to terminate all or any part of this Plan at any time, and any contract providing insured benefits or other services. If any part of this Plan is terminated and replaced with similar benefits, any wage reduction amounts that were designated to pay premiums and/or monthly coverage costs for the terminated part of this Plan will be applied instead to pay premiums and/or monthly coverage costs for the new part of the Plan.

Notice of Privacy Practices

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Pursuant to regulations issued by the federal government, the Fund is providing you this Notice about the possible uses and disclosures of your health information. Your health information is information that constitutes protected health information as defined in the Privacy Rules of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). As required by law, the Fund has established a policy to guard against unnecessary disclosure of your health information. This Notice describes the circumstances under which and the purposes for which your health information may be used and disclosed and your rights in regard to such information.

Protected Health Information

Protected health information generally means information that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and (3) identifies the individual, or there is a reasonable basis to believe the information can be used to identify the individual.

Use and Disclosure of Health Information

Your health information may be used and disclosed without an authorization for the purposes listed below. The health information used or disclosed will be limited to the "minimum necessary," as defined under the Privacy Rules.

To Make or Obtain Payment. The Fund may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Fund may use your health information to pay claims, or share information regarding your coverage or health care treatment with other health plans to coordinate payment of benefits.

To Facilitate Treatment. The Fund may disclose information to facilitate treatment which involves the provision, coordination or management of health care or related services. For example, the Plan may disclose the name of your treating Provider to another Provider for the purpose of obtaining medical records.

To Conduct Health Care Operations. The Fund may use or disclose health information for its own operations to facilitate the administration of the Fund and as necessary to provide coverage and services to all of the Fund's participants. Health care operations include such activities as: contacting health care providers; providing participants with information about health-related issues or treatment alternatives; developing clinical guidelines and protocols; conducting case management, medical review and care coordination; handling claim appeals; reviewing health

information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits; and performing the general administrative activities of the Fund (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, including cost management and planning related analyses and formulary development, and accreditation, certification, licensing or credentialing activities).

In Connection With Judicial and Administrative Proceedings. If required or permitted by law, the Fund may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process. The Fund will make reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

When Legally Required For Law Enforcement Purposes. The Fund will disclose your health information when it is required to do so by any federal, state or local law. Additionally, as permitted or required by law, the Fund may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Fund has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

To Conduct Health Oversight Activities. The Fund may disclose your health information to a health oversight agency for authorized activities including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary action. The Fund, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In the Event of a Serious Threat to Health or Safety. The Fund may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Fund, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions. In certain circumstances, federal regulations require the Fund to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

To Your Personal Representative. The Fund may disclose your health information to an individual who is considered to be your personal representative under applicable law.

To Individuals Involved in Your Care or Payment for Your Care. The Fund may disclose your health information to immediate family members, or to other individuals who are directly involved in your care or payment for your care.

To Business Associates. The Fund may disclose your health information to its Business Associates, which are entities or individuals not employed by the Fund, but which perform functions for the Fund involving protected health information, such as claims processing, utilization review, or legal,

consulting, accounting or administrative services. The Fund's Business Associates are required to safeguard the confidentiality of your health information.

For Workers' Compensation. The Fund may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

For Disclosure to the Plan Trustees. The Fund may disclose your health information to the Board of Trustees (which is the plan sponsor) and to necessary advisors for plan administration functions, such as those listed in this summary, or to handle claim appeals, solicit bids for services, or modify, amend or terminate the plan. The Fund may also disclose information to the Trustees regarding whether you are participating or enrolled in the plan.

Authorization to Use or Disclose Health Information

Other than as stated above, the Fund will not disclose your health information without your written authorization. Authorization forms are available from the Privacy Contact Person, listed below. If you have authorized the Fund to use or disclose your health information, you may revoke that authorization in writing at any time. The revocation should be in writing, include a copy of or reference your authorization and be sent to the Privacy Contact Person, listed below.

Special rules apply to disclosure of psychotherapy notes. Your written authorization will generally be required before the Plan will use or disclose psychotherapy notes. Psychotherapy notes are separately filed notes about your observations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed to defend against litigation filed by you.

Your written authorization will be required for any disclosure of your health information that involves marketing, the sale of your health information, or any disclosure involving direct or indirect remuneration to the Fund.

Your Rights with Respect to Your Health Information

You have the following rights regarding your health information that the Fund maintains:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Fund's disclosure of your health information to someone involved in the payment of your care. However, the Fund is not required to agree to your request unless the disclosure is to another health plan for the purpose of carrying out payment or health care operations and your health care provider has been paid out of pocket in full. If you wish to request restrictions, please make the request in writing to the Fund's Privacy Contact Person listed below.

Right to Confidential Communications. You have the right to request that the Fund communicate with you in a certain way if you feel the disclosure of your health information through regular procedures could endanger you. For example, you may ask that the Fund only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications,

please make your request in writing to the Fund's Privacy Contact Person, listed below. The Fund will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. This right, however, does not extend to psychotherapy notes or information compiled for civil, criminal or administrative proceedings. The Fund may deny your request in certain situations subject to your right to request review of the denial. A request to inspect and copy records containing your health information must be made in writing to the Privacy Contact Person, listed below. If you request a copy of your health information, the Fund may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Fund amend the records. That request may be made as long as the information is maintained by the Fund. A request for an amendment of records must be made in writing to the Fund's Privacy Contact Person, listed below. The Fund may deny the request if it does not include a reasonable reason to support the amendment. The request also may be denied if your health information records were not created by the Fund, if the health information you are requesting be amended is not part of the Fund's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Fund determines the records containing your health information are accurate and complete.

If the Fund denies a request for amendment, you may write a statement of disagreement. The Fund may write a rebuttal statement and provide you with a copy. If you write a statement of disagreement, then your request for amendment, your statement of disagreement, and the Fund's rebuttal will be included with any future release of the disputed health information.

Right to an Accounting. You have the right to request a list of disclosures of your health information made by the Fund. The request must be made in writing to the Privacy Contact Person listed below. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003 when the Privacy Rules became effective. Accounting requests may not be made for periods of time going back more than six (6) years. An accounting will not include disclosure made to carry out treatment, payment, and health care operations; disclosures that were made to you; disclosures that were incident to a use or disclosure that is otherwise permitted by the Privacy Rules; disclosures made pursuant to an authorization; or in other limited situations. The Fund will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Fund will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Contact Person, listed below.

Right to Opt Out of Fundraising Communications. If the Fund participates in fund raising, you have the right to opt-out of all fundraising communications.

Privacy Contact Person. To exercise any of these rights related to your health information you should contact the Privacy Contact Person listed below. The Fund has also designated a Privacy Official, listed below.

Alaska Electrical Health & Welfare Fund

Attn: Health & Welfare Supervisor

The Administrative Office

701 E. Tudor Suite 200

Anchorage, Alaska 99503

aetfhw@aetf.com

Duties of the Fund

The Fund is required by law to maintain the privacy of your health information as set forth in this Notice, to provide to you this Notice of its duties and privacy practices, and to notify you following a breach of unsecured protected health information. The Fund is required to abide by the terms of this Notice, which may be amended from time to time. The Fund reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Fund changes its policies and procedures, the Fund will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Fund and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Fund should be made in writing to the Privacy Contact Person identified above. The Fund encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for filing a complaint.

The Fund is prohibited by law from using or disclosing genetic health information for underwriting purposes.

ALASKA
ELECTRICAL TRUST FUNDS

Alaska Electrical Trust Funds
701 E. Tudor Suite 200
Anchorage, Alaska 99503

www.aetf.com