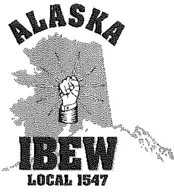



# Alaska Electrical Trust Funds

PENSION FUND – HEALTH AND WELFARE FUND – LEGAL FUND
2600 Denali Suite 200 • Anchorage, AK 99503-2782
(907) 276-1246 • (800) 478-1246 • Fax: (907) 278-7576
www.aetf.com

December 2010

Re: Alaska Electrical Health & Welfare Fund

Dear Plan Participants:

This mailing contains important information concerning the following:

- a special enrollment opportunity for your dependent children age 19 to age 26
- an enrollment/change form to be filled out if you add new dependents
- changes to your Plan as a result of the Patient Protection and Affordable Care Act (health care reform law).
- other notices required by law

Please read this information carefully and keep it with your benefit booklet for future reference.

## New Eligibility Rules for Overage Dependent Children

Effective January 1, 2011, as a result of requirements under the health care reform law, Plan benefits will be available to all eligible dependent children to age 26 including those eligible dependents whose coverage ended, or who were denied coverage, or who were not eligible for coverage under the previous Plan provisions. This coverage is tax free and available to all eligible dependent children to age 26 regardless of student status, marital status, or financial dependency. This coverage will not be extended to the spouse or children of an eligible dependent child.

You must complete the enclosed ***Enrollment/Change Form*** and include all dependent children age 19 to age 26 that you want to enroll or re-enroll. Claims for eligible dependents not currently covered will be pended until an updated Enrollment/Change Form has been received by the Fund. In order to keep your information up to date, we ask that you include all of your current dependents as well as any new dependents to be covered on this Enrollment/Change Form.

This notice is being given to you for distribution to your children. Please make sure you provide a copy of this notice to any children entitled to coverage based on these new eligibility rules.

GCIU 722C

## Elimination of Annual and Lifetime Limits on Certain Benefits

The following chart shows other benefit changes effective January 1, 2011:

| Current Limit | Effective January 1, 2011 |
|---|---|
| Substance abuse treatment - $8,300 per year and $16,600 per lifetime | No annual or lifetime dollar limits |
| Physical exam – $500 maximum per year | No annual dollar limit |
| Dental – $1,000 to $2,000 per year | No annual dollar limit for children under the age of 19. Lifetime dollar limit for orthodontia treatment still applies |
| Spinal Therapy – up to 24 visits per year, $125 maximum per visit, $100 annual maximum for x-rays | Up to 24 visits per year, no per visit or annual dollar limits if care is part of a rehabilitation plan prescribed by your physician |
| Mechanized spinal distraction therapy – up to 20 sessions per lifetime, $175 maximum per session | Up to 20 sessions per lifetime, no per session dollar limit if part of a rehabilitation plan prescribed by a physician |

In addition, effective January 1, 2011, the preexisting condition limitation for dependents under age 19 is eliminated.

## Expanded Coverage of Preventive Care Services

Effective January 1, 2011, the Fund will cover recommended preventive services as required by the health care reform law. Recommended preventive services are defined by the recommendations of various health task forces. These services fall into the following basic categories:

- Evidence-based tests or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force. Covered procedures include blood pressure and cholesterol screening, diabetes screening for individuals with hypertension, various cancer and sexually transmitted infection screenings, and counseling in defined medically appropriate areas;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved:
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to women, such additional preventive care and screenings not described above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. Covered procedures would include items such as mammograms and cervical cancer screenings given in accordance with the guidelines.

If you or your provider has questions about specific services, and if they are recommended preventive services, please contact the Administrative Office or review the list of recommended preventive services at http://www.healthcare.gov/center/regulations/prevention.html

Covered recommended preventive services will be reimbursed at 100% of contracted or usual customary and reasonable charges unless applicable preferred provider (PPO) provisions have not been met, in which case, existing benefit reductions will apply.

## Wellness and Minor Care Clinics

If you use one of the Wellness and Minor Care Clinics that contract with the Fund, and receive recommended preventive services as outlined in the prior section, you will have your $10 copay waived for those services.

## New Claim and Appeal Procedures

The Fund's claim appeal procedures are modified for any initial benefit denial or other initial adverse action that affects a participant made on or after January 1, 2011. These changes modify the Fund's existing claim appeal procedures and create a new right to request an external review if a participant remains dissatisfied with the Fund's decision after exhausting the Fund's internal claim appeal procedures.

The Fund has an internal claim appeal process that must be exhausted before external or judicial review can be sought. Once the internal claim appeal process is exhausted, a participant has four months from the date of the Fund's final adverse benefit determination to file a request for an external review. Failure to request an external review within four months from the date of the Fund's final adverse benefit determination will end the individual's ability to seek external review.

A participant may request external review for any denied claim except for denials based on finding that the individual has failed to meet the eligibility requirements for a benefit under the terms of the applicable Plan.

When a properly filed request for external review is referred, the Fund will provide the Independent Review Organization the required documentation in the time required by applicable federal regulations. The Independent Review Organization will provide a decision to the participant within 45 days after it has received the request to review.

If the Independent Review Organization directs that benefits be paid, the Fund shall provide benefits under its Plan in accordance with the decision. If the decision continues to be adverse, the participant has the right to bring suit pursuant to 29 U.S.C. § 1132(a). Any legal action seeking to overturn a denial or other decision that has adversely impacted a participant must be brought within 180 days of the latest of the following events; the initial denial with no appeal being made, the final adverse benefit determination by the Fund, or the Independent Review Organization's denial.

## Notice About the Early Retiree Reinsurance Program

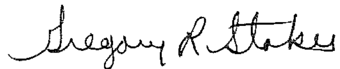
The Alaska Electrical Health and Welfare Fund has been certified for participation in the Early Retiree Reinsurance Program ("ERRP"). ERRP is a Federal program that was established under the Affordable Care Act. Under ERRP, the Federal government reimburses a plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, ERRP expires on January 1, 2014.

The Board of Trustees, as the plan sponsor has chosen to use any reimbursements it receives from ERRP to offset future increases in the costs of maintaining your health benefits coverage. This may benefit you by increasing the likelihood that the Fund will continue to offer health coverage to its retirees and employees and their families. It also may result in avoiding future increases to your contributions. This may be advantageous to you for so long as the reimbursements under ERRP are available and the Board of Trustees chooses to use the reimbursements for this purpose.

If you have received this notice, you are responsible for providing a copy of this notice to your family members who are participants in this plan.

Please call the Administrative Office if you have any questions. Thank you.

Sincerely,



Gregory R. Stokes
Administrator