Alaska Electrical Trust Funds

PENSION FUND – HEALTH AND WELFARE FUND – LEGAL FUND
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November 2018

Re: **Alaska Electrical Health & Welfare Fund**
Summary of Material Modifications

Dear Plan Participant:

The Board of Trustees has made the following revisions to your medical plan.

TELEMEDICINE BENEFIT AND EXPERT SECOND OPINION SERVICES AVAILABLE THROUGH TELADOC™ AND BEST DOCTORS BEGINNING NOVEMBER 1

The Board of Trustees has added a new benefit starting **November 1, 2018** that provides telephone or video access to a doctor through **Teladoc**. Visits with Teladoc are **covered in full** by the Fund with no copayment or copremium. This benefit is available to all non-Medicare plan participants.

What is Teladoc?
Teladoc gives you 24/7/365 day access to U.S. board-certified doctors who can treat many of your medical issues by phone or video. Teladoc is an affordable alternative medical treatment option to costly urgent care or ER visits.

Get the Care You Need
Teladoc doctors can treat many medical conditions, including:
- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Respiratory infection
- Sinus problems
- And more!

Meet the Doctors
Teladoc is simply a new way to access qualified doctors. All Teladoc doctors:
- Are practicing primary care physicians (PCPs), pediatricians, and family medicine physicians
- Average 15 years' experience
- Are U.S. board-certified and licensed in your state

To set up a phone or video call with a Teladoc doctor:

- Visit www.Teladoc.com to set up an account
- Enter your information and complete the "My Medical History"
- To request a phone or video consult, log in at www.Teladoc.com or call (800) 835-2362.

Teladoc operates subject to state regulation and may not be available in certain states. Teladoc does not guarantee that a prescription will be written. Teladoc does not prescribe DEA controlled substances, nontherapeutic drugs and certain other drugs which may be harmful because of their potential for abuse.

GCC/IBT 722C

The Board also partnered with Teladoc Health's **Best Doctors expert second opinion program.** Best Doctors service tackles the most complex, critical, and costly cases, wherever they may occur.

As a Best Doctors member, you have the expertise of more than 50,000 of the world's best doctors at your fingertips! Simply by contacting Best Doctors, you can have your medical diagnoses and treatment plans reviewed by carefully selected expert physicians. All services are conveniently provided by phone or online, so there is no need for additional travel. And Best Doctors' services are confidential and completely free to you!

Services Available:

In-Depth Expert Medical Review - Best Doctors will collect your medical records, tests and samples and have them reviewed by a world-renowned expert physician who specializes in your condition. The expert will ensure your diagnosis is accurate and you have the best treatment options.

Critical Care Support™ - Call on Best Doctors for guidance if you experience a medical event that requires emergency treatment, intensive care or an extended hospital stay. Best Doctors gets an expert immediately involved in your case and works with your local medical team to get you the best care.

Medical Records eSummary™ - Best Doctors can collect and organize your medical records for you and provide them on an easy-to-access USB drive. You will also receive a personal Health Alert Summary based on the records collected, giving you a total snapshot of your medical wellness.

Ask the Expert™ - When you have a question about a medical condition, treatment option or symptom, Best Doctors will take the time to listen, and an expert physician will provide a personalized response. No needless worrying, wondering or wandering the web for answers.

FindBestDoc® - Best Doctors draws on more than 50,000 of the world's top physicians, including 40,000 in the U.S. If you need to visit a specialist, we will search to see if any of our doctors meet your criteria and practice within a distance that works for you.

Treatment Decision Support™ - The Best Doctors Treatment Decision Support (TDS) service is designed to help educate patients on their treatment options to achieve better health outcomes and when appropriate, avoid unnecessary, more costly inpatient surgical procedures.

For more information, or to take advantage of any of the Best Doctors services, call (866) 904-0910 or visit members.bestdoctors.com.

ADMINISTRATIVE CHANGES

Plan Description of Determination of "Usual, Customary and Reasonable charges"

The Fund pays the "Usual, Customary and Reasonable" charges of covered services. In general the Fund is bound by contract to a fixed charge for Covered Services provided by Preferred Providers (i.e., those with which the Fund contracts in the Anchorage-area via the Pacific Health Coalition (fka HCCMCA) and Aetna-contracted providers). For Providers that are not bound by such contractual arrangements, the Fund evaluates the Provider's billed charges and reduces the reimbursement available after review of a number of factors. To better reflect the strategies used to determine the "Usual, Customary And Reasonable" charge for Covered Services for non-Preferred Providers, the Trustees have replaced the definition of "Usual, Customary and Reasonable (UCR) charge" on page 119 of the Plan Booklet (p. 80 of the Retiree Medical Plan Booklet) with the following:

Usual, Customary and Reasonable (UCR) charge means the amount payable to a non-Preferred Provider as determined by the Board of Trustees or its designee for a particular service, and subject to the following:

- Charges for services or supplies that are not provided or billed in accordance with generally accepted professional standards and/or medical practice are not considered UCR regardless of the amount billed;
- In no event will the UCR charge exceed the amount billed or the amount for which the covered person is financially responsible;
- UCR may not reflect the actual billed charges and does not take into account the professional service provider's training, experience or category of licensure;
- The Fund's UCR methodology may vary between claims based on the facts and circumstance of the claim, the services provided and the expected savings;
- The Fund may hire a third-party reviewer to determine the UCR amount consistent with this provision; and
- Irrespective of the Fund's methodology or UCR determination, the Trustees reserve the right to negotiate an acceptable UCR amount directly with a provider.

For properly billed non-Preferred Provider professional service provider charges, the UCR amount shall be no higher than the 90th percentile identified by a commercially available database selected by the Fund. When there is, in the Fund's determination, minimal data available from the database for a covered service, the Fund will determine the UCR 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 Fund 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 Fund's determination applicable, the Fund will assign one.

For non-Preferred Provider professional services in excess of $5,000, the Fund may attempt to establish a negotiated rate that if accepted will result in no balance billing for the Participant or covered dependent beyond deductible and co-insurance.

For properly billed non-Preferred Provider facility charges, UCR means 200% of the Medicare reimbursements amount. For non-Preferred Provider facility services in excess of $10,000, the Fund reserves the right to attempt to establish a negotiated rate that if accepted will result in no balance billing for the Participant or covered dependent beyond deductible and co-insurance.

Non-Preferred Provider 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 Fund, notwithstanding any internal rules they may have to the contrary. In the event a non-Preferred Provider refuses or delays a reasonable audit request by the Fund, the Fund shall have the right to withhold payment to the said non-Preferred Provider on the claim in question and on other pending or future claims by said non-Preferred Provider.

For a Preferred Provider, Usual, Customary and Reasonable Charges are their contracted fee amount.

Assignment of Claims

Participants are able to assign payment of their Fund benefits to a Provider. This generally allows payment to be made directly to a Provider. An assignment cannot, however, confer to the Provider any right to the Provider to pursue an appeal on its own account (although the Provider may act as the Participant's authorized representative as described in the Plan Booklet). As a clarification with respect to assignment of claims, the Trustees have amended the paragraph labeled "3" on page 121 of the Plan Booklet (page 82 of the Retiree Plan Booklet) to read as follows:

3. All payments for services by Preferred Providers will be made directly to such providers.

   In the case of non-Preferred Providers payment 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 it is made before or after services are provided, of any amount payable according to the Plan shall be recognized or accepted as binding upon the Fund, unless otherwise required by federal law.

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

Sincerely,

Gregory R. Stokes
Administrator

Please read this notice carefully and keep it with your benefit booklet or insurance records for future reference.