ALASKA
ELECTRICAL TRUST FUNDS

Summary Plan Description

January 2024

To All Covered Persons:

We are pleased to present this updated booklet describing the benefits provided by your Alaska Electrical Retiree Health Reimbursement Arrangement Plan effective January 1, 2024.

At the end of 2023, the Trustees decided to move forward with a new retiree medical program. Effective January 1, 2024, retired members who were covered by the Fund's plan for active employees will be able to choose from the marketplace of individual health plans, the health care coverage that best suits their family's needs with the assistance of Via Benefits. The Fund has established this Retiree HRA Plan to help offset retiree medical costs, for eligible retirees, spouses and dependents.

Retirees who are under age 65 and not Medicare-eligible may also be eligible for a Premium Tax Credit (PTC) or Cost-Sharing Reduction (CSR) provided by the federal government. The PTC and CSR reduce the amount of the premium and out-of-pocket costs you pay. If you qualify, you will need to decide each year whether to accept the HRA from the Fund or take a federal subsidy. By law, you are not allowed to use an HRA and federal subsidy in the same year.

The Board has contracted with Via Benefits to help you understand the differences in your funding options and help you select an individual plan best suited to your situation.

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

QUICK TIP

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

IMPORTANT NOTICE

The Alaska Electrical Health and Welfare Fund (Fund) is committed to maintaining this Alaska Electrical Retiree Health Reimbursement Arrangement Plan. However, the Board of Trustees (Trustees) reserves the right to amend or terminate the Plan 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. 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.

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Introduction

Introduction

This Retiree Health Reimbursement Arrangement (Retiree HRA) Summary Plan Description (Retiree HRA SPD) describes the Alaska Electrical Retiree Health Reimbursement Arrangement Plan (Retiree HRA Plan).

The purpose of the Retiree HRA Plan is to reimburse eligible retirees for certain health care expenses and health insurance premiums that are not otherwise reimbursed.

Effective January 1, 2024, current retirees and future eligible retirees who were covered by the Fund's plan for active members will be able to choose from the marketplace of individual health plans that best suits their needs. The Board has contracted with Via Benefits to help eligible retirees understand the differences in funding options (see next paragraph) and to assist in this process. The Fund has established this Retiree HRA Plan to help offset retiree medical costs, for eligible retirees, spouses and dependents. To simplify things, this booklet will refer to the account established for you by the Retiree HRA Plan as your "HRA" or "Fund Subsidy."

Retirees who are not yet Medicare-eligible may be eligible for an alternative funding option other than the Trust Subsidy: the Premium Tax Credit (PTC) or Cost-Sharing Reduction (CSR) provided by the federal government. The PTC and CSR are funded by taxpayer dollars and reduce the amount of the premium and out-of-pocket costs you pay. If you qualify, you will need to decide whether to accept the Fund Subsidy (HRA) or take the PTC and CSR federal subsidy. By law, you are not allowed to use an HRA and federal subsidy in the same year. You can make a different choice each year you are eligible.

Read this Summary carefully so you understand the provisions of the HRA and how you can use the Retiree HRA Plan to your advantage.

Note that terms used in this SPD are defined the first time they are used. Please note that "you," "your" and "my" when used in this SPD refer to you, the retiree.

How the HRA Works

How the HRA Works

A Health Reimbursement Arrangement (HRA) is a reimbursement account the Fund establishes on your behalf. Each year, the Fund credits a specific dollar amount to your HRA to help cover the cost of eligible health care expenses for you and your eligible dependents. These expenses must be incurred while the Plan remains in effect, you are eligible, qualified, and participating in the Plan. You may not use the HRA to be reimbursed for expenses incurred by your domestic partner.

You can use the HRA to help pay for certain eligible health care expenses, including premiums for health care coverage, as well as copays, deductibles, and other out-of-pocket expenses that are not covered under your medical plan.

The HRA is a bookkeeping account on the Fund's records only, with all reimbursements being paid by the Fund from trust assets. Only the Fund can contribute to your HRA. You cannot contribute your own money to your HRA. Your HRA does not earn interest or earnings of any kind. Reimbursements under the HRA are paid from the Fund based on available balance in your HRA.

You do not pay taxes on the HRA contributions or the amounts you are reimbursed from the HRA for eligible health care expenses.

Your Eligibility

Your Eligibility

If you retire from the Fund's Plan for active members you are eligible to participate in the Retiree HRA Plan if you have satisfied the following requirements:

Retirees Aged 48 and Older

A Retired employee who has **attained age 48** will be eligible to enroll on the first of the month coinciding with the date of retirement (or on the first of the month following the termination of your coverage in the Fund's Plan for active employees, if later), provided you satisfy one of the following rules:

- In the 84 months immediately preceding retirement, you had 60 months of active health and welfare eligibility with this Fund, for which Retiree funding has been paid, or
- In the 84 months immediately preceding retirement, you had 10,400 hours of health and welfare contributions reported to this Fund, for which Retiree funding has been paid, or
- Any time prior to retirement, 25,000 hours of contributions reported to this Fund, for which Retiree funding has been paid.

If you had monthly eligibility in the Fund's plan for active employees, each month will be valued at 173.33 hours a month for the hours requirements above.

Disability Retirees Not Yet Age 48

If you retire because you are Totally Disabled and you are under **age 48**, you will be eligible to enroll on the first of the month coinciding with your date of retirement (or on the first of the month following the termination of eligibility in the Fund's Plan for active employees, if later) if you are either:

- Totally Disabled and are receiving a Disability Retirement Benefit from the Alaska Electrical Pension Plan, or
- Totally Disabled as defined by the Alaska Electrical Pension Plan and worked for at least 5 years in a bargaining unit represented by IBEW Local 1547 or a under a special agreement.

To be "Retired" or in retirement status you must be receiving a monthly pension benefit from the Alaska Electrical Pension Plan or a similar plan provided by an employer contributing to the Alaska Electrical Health and Welfare Fund or you must provide proof of retirement acceptable to the Fund.

Dependent Eligibility — Non-Medicare-Eligible Participants Only

The Fund makes separate Contributions for you and your spouse, but does not make an additional contribution your covered dependents.

If you are under age 65 and not yet Medicare-eligible, your spouse and your dependents (as determined by the individual plan you choose to enroll in with the assistance of Via Benefits or otherwise in the individual plan market) generally are eligible when you are eligible.

If you are Medicare-eligible, your dependents other than your spouse **cannot** participate in a plan purchased on the Via Exchange with your HRA.

When the surviving spouse becomes eligible for another source of health coverage (other than Medicare or Indian Health Services coverage), he/she will no longer be covered under the Retiree HRA Plan. If the surviving spouse loses other coverage, he/she will be allowed re-entry into the Retiree HRA Plan at normal retirement age (currently age 58) or when he/she becomes Medicare eligible.

Surviving Spouse

A spouse covered under the Plan at the time of the Retiree's death shall remain eligible for the Retiree HRA Plan for the remainder of his/her lifetime, subject to the same eligibility rules as the retiree.

If an employee dies before retiring, his/her surviving spouse will be eligible for the Retiree HRA Plan if at the time of death:

- the employee would have qualified for the Retiree HRA;
- the employee was age 58 or older; and
- the surviving spouse and employee were married for at least 3 years.

Qualified Medical Child Support Order (QMSCO)

In accordance with federal law, the Plan also provides 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.

Enrollment

Enrollment

You must enroll with the Retiree HRA Plan to be eligible for benefits. Enrollment forms are available at the Administrative Office and must be completed at the time of retirement.

If you do not enroll while you meet the eligibility requirements above, you will not be eligible to enroll in the future unless you elect to defer coverage as outlined below.

Deferred Enrollment

You can choose to not enroll in the Retiree HRA Plan if you have other coverage. If you choose to not enroll, you must provide proof of the other coverage and complete a deferral form within 60 days of your retirement. Deferral forms are available from the Administrative Office. If you have deferred coverage, you may be allowed to enroll at a later date, but **only** if you enroll within 60 days after the other coverage is lost and the loss is due to one of the following reasons:

- The loss of eligibility for the other coverage was a result of termination of employment, reduction in the number of hours of employment, death, divorce, or legal separation;
- The termination of employer contributions toward the other coverage; or
- If the other coverage was COBRA coverage, the exhaustion of that coverage. COBRA coverage is "exhausted" if it ceases for any reason other than failure to pay premiums on a timely basis.

At the end of your deferral you must submit a Retiree enrollment form within 60 days after the other coverage is lost in order to be covered; contact the Administrative Office for a copy of the form.

When Participation Begins

When Participation Begins

An Eligible Retiree and Eligible spouse becomes a Participant in the Retiree HRA Plan on the later of the Effective Date of the Plan, January 1, 2024, or the date all requirements below are satisfied and the enrollment process is completed:

Medicare-Eligible Retirees Over Age 65

- Retiree is over age 65 and has become eligible for Medicare and enrolled in both Parts A and B.
- Retiree has obtained an individual health insurance policy through Via Benefits (or any of its affiliates) or Retiree has provided satisfactory evidence to the Plan Administrator that the Retiree has other coverage permissible to the Plan Administrator.
- Retiree has completed any enrollment forms or procedures required by the Plan Administrator

Retirees Under Age 65 and Not Medicare-Eligible

- The effective date that the Retiree has opted into receiving Contributions from the Fund.
- Retiree has elected NOT to receive federal Advance Premium Tax Credit (APTC) for the applicable time period.

Note: *For any applicable time period, a non-Medicare eligible individual cannot receive both the APTC and Contributions under this Plan. A Retiree who elects to receive the APTC remains eligible to opt into receiving Contributions in future applicable time periods.*

Returning to Active Employment After Retirement May Terminate your HRA

Returning to Active Employment After Retirement May Terminate your HRA

If you return to work (other than Active Employment) after becoming eligible for Retiree HRA Plan benefits and your employer offers a group health plan other than the active plan provided by this Fund, your Retiree HRA is suspended during the period that you are covered by the employer's health plan. Contact the Administrative Office for assistance.

If you return to Active Employment as an employee eligible for active coverage in this Fund, your Retiree HRA is suspended during the period that you are covered as an active employee by this Fund. Your Retiree HRA Plan eligibility will automatically resume upon termination of your active coverage through the Fund.

If you return to Active Employment after retirement and you do not have group health coverage through your employer, your eligibility for the Retiree HRA Plan will terminate. Depending on the circumstances, you may be able to re-enter the Plan at a later date.

For the purposes of this section "Active Employment" means more than 40 hours of employment in a calendar month or in a four or five week pay period ending in a calendar month:

- in the State of Alaska; and
- in a job classification, the core skills of which are the same as or similar to those of employment in which the employee was engaged at any time while accruing a benefit under the Plan, whether or not such employment is under the terms of a collective bargaining agreement or special agreement, or in a supervisor capacity over such job classification; and
- in the industry in which the contributing employers participate (i.e. any business activity of the type engaged in by the employers maintaining the Plan).

If Your HRA Eligibility is Terminated, You May be Eligible to Resume Participation

If your HRA is terminated because you have returned to work, you will only be able to re-enroll if you have reached at least age 58 or you have become Medicare-eligible and you meet one of the following:

- Your initial Retiree HRA Plan eligibility was based upon 25,000 hours of contributions reported to this Fund prior to retirement, for which Retiree funding has been paid; or
- Your initial Retiree HRA Plan eligibility was based on 60 months of health and welfare eligibility with this Fund or 10,400 hours of contributions reported to this Fund in the 84 months immediately preceding retirement, and as of your Retiree HRA re-enrollment date, you continue to have 60 months of health and welfare eligibility with this Fund or 10,400 hours of contributions reported to this Fund in the 84 months immediately preceding your new enrollment date.

Contributions

Contributions

Each year, the Board of Trustees will determine the amount to be contributed to the HRA. One HRA will be established for you and your eligible spouse. Contributions will be credited to your HRA quarterly on the first day of each calendar quarter. If you retire mid-year, your HRA will be established and a pro-rated contribution made for the calendar quarter when you first begin participation.

Note: *You are not permitted to make any contributions to your HRA.*

Medicare-Eligible Retirees

For eligible Retirees aged 65 or older who are Medicare-eligible, the Board of Trustees determines an annual contribution which takes into account your service for which Retiree funding has been paid to the Fund.

For 2024, the Annual HRA Dollar Funding for an eligible Retiree and separately for an eligible Retiree's spouse, are as follows:

HRA Dollar Amount Funding for 2024 Calendar Year					
Months of Service	**60-119 months**	**120-179 months**	**180-239 months**	**240-299 months**	**300+ months**
	$0	$884	$1,415	$1,768	$1,768

Under 65 and Not Medicare-Eligible Retirees

For eligible Retirees under 65 who are not Medicare-eligible, the Board of Trustees determines an annual contribution which considers your attained age and service for which Retiree funding has been paid to the Fund.

For 2024, the Annual HRA Dollar Funding for an eligible Retiree and separately for an eligible Retiree's spouse, are as follows:

HRA Dollar Amount Funding for 2024 Calendar Year					
Retiree's Attained Age	**60-119 months**	**120-179 months**	**180-239 months**	**240-299 months**	**300+ months**
48-54	$0	$0	$0	$0	$0
55	$0	$0	$0	$0	$3,017
56	$0	$0	$0	$3,017	$5,029
57	$0	$0	$3,017	$5,029	$6,034
58	$0	$3,017	$5,029	$6,034	$10,057
59	$0	$5,029	$6,034	$8,046	$10,057
60 - 65	$0	$5,029	$8,046	$10,057	$10,057

Your HRA account balance will be reduced from time to time by the amount of any eligible health care expenses for which an eligible Retiree or dependent is reimbursed by the Retiree HRA Plan. At any time, the participant may receive reimbursement for eligible health care expenses up to the full amount in his or her HRA.

Unused contributions remaining in your HRA for the plan year will be available to reimburse eligible health care expenses incurred during the plan year until June 30 of the following plan year.

Remaining HRA contributions can only be distributed through reimbursement of actual eligible health care expenses incurred while you are eligible. You may opt out of future contributions to the HRA at least annually.

Eligible and Ineligible Expenses

Eligible and Ineligible Expenses

When you have an eligible health care expense that is not paid by your medical plan, you may submit a claim for reimbursement from your HRA. Only eligible health care expenses incurred while you are a Participant in the Retiree HRA Plan may be reimbursed from your HRA.

Eligible Expenses

Health care expenses include the premiums you pay for insurance as well as eligible Out-of-Pocket expenses.

Premium expenses for: medical, prescription drug, Medicare Part B, incurred while you are eligible for your funding program can be submitted for reimbursement.

Out of Pocket expenses for: Health care, prescription and over-the-counter drugs and supplies, and hearing incurred while you are eligible for your funding program can be submitted for reimbursement.

The following are examples of eligible health care expenses when they are incurred by you or your dependents and are not reimbursed under another health plan:

- Acupuncture services related to the diagnosis, cure, mitigation, treatment, or prevention of disease
- Ambulance expenses
- Chiropractor fees
- Cosmetic surgery — only if directly related to a congenital abnormality, a personal injury from an accident or trauma or a disfiguring disease
- Dental care
- Diagnostic services, including laboratory and X-ray services
- Inpatient and outpatient hospital fees
- Insulin
- Medical appliances, such as artificial teeth or limbs, crutches, elastic stockings and hearing aids
- Prescription drugs
- Over-the-counter medicines or drugs that are legally purchased, such as antacids, allergy medicine, vitamins, pain relievers and cold medicine
- Nurse fees
- Oxygen equipment and oxygen
- Physician fees
- Psychiatric care
- Psychologist fees
- Surgical fees
- Travel related to your health care

Another resource that may be helpful is IRS publication 502 — that explains the itemized deduction for medical and dental expenses that you claim on Schedule A (Form 1040).

Ineligible Expenses

Health care expenses do not include the following types of expenses under this Retiree HRA Plan.

Some expenses may be covered if you provide a Letter of Medical Necessity from your doctor or health care provider, that verifies the services or items you are purchasing are for the diagnosis, treatment, mitigation, or prevention of a disease or medical condition.

- The cost of most types of cosmetic surgery, including breast augmentation, face lifts, hair transplants, hair removal (electrolysis) and liposuction (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident, or disfiguring disease)
- Certain vitamins
- Health spas, health club dues and exercise classes; (with a Letter of Medical Necessity stating the medical condition and the exercise program designed to treat the condition, the expenses may be reimbursable)
- Weight reduction classes, (except as part of the treatment of a specific disease diagnosed by a physician, such as obesity, hypertension, or heart disease)
- Babysitting expenses to enable you to get to a doctor's appointment
- Controlled substances (such as marijuana, laetrile, etc.) that aren't legal under federal law, even if such substances are legalized by state law
- Massage therapy
- Funeral or burial expenses
- Household and domestic help
- Cosmetics, toiletries, toothpaste, etc.

The following expenses are not reimbursed from an HRA:

- Expenses incurred for covered Part D prescription drugs;
- Expenses incurred *prior to the date* that you became a participant in the Retiree HRA Plan.
- Expenses incurred *after the date* that you cease to be a participant in the Retiree HRA Plan.
- Expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan; and
- Vision care, eyeglasses and contact lenses
- Dental services

If you need more information regarding whether an expense is an eligible health care expense under the Retiree HRA Plan, contact representatives at Via Benefits.

Pre-65 Non-Medicare	Medicare age (65 and up)
(800) 849-4163 www.marketplace.viabenefits.com/Alaska	**(800) 849-4158** www.my.viabenefits.com/Alaska

Phone lines are open from Monday-Friday: 4am – 3pm AKDT

The Fund (and its delegates) solely determine what qualifies as an eligible health care expense.

Even though your eligible non-spouse dependent does not receive their own contribution, you are entitled to obtain reimbursement from your HRA for eligible health care expenses incurred by themyour non-spouse dependents, as defined in this SPD are eligible for reimbursement by your HRA.

When Expenses Are Considered to be Incurred

Eligible health care expenses are incurred when the covered individual is provided the health care that gives rise to the expense, and not when the amount is billed or paid. An expense that has been paid but not incurred (e.g., pre-payment to a physician or for premiums) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

Health insurance premiums are incurred on the first day of each month of coverage on a pro rata basis, the first day of the period of coverage, or the date the premium is paid even if the covered individual paid the premium for the coverage prior to the first day of the plan year.

The federal government permits you to take a deduction on your income tax return for certain health care expenses. You should remember that you cannot claim the same expense twice, once through the HRA and also as a tax deduction. For specific advice about your situation, you may want to consult a tax advisor. The Fund cannot advise you regarding tax, investment or legal considerations relating to the HRA.

You may not submit a claim for an amount that was incurred prior to the time the HRA became effective (typically the first day of the plan year or the first day your election for HRA coverage is effective, if later). In addition, you cannot submit a claim for any expenses that have been paid in-full through any other health insurance plan, Section 125 "cafeteria" plan or other similar health care expense reimbursement arrangement.

How to Use the HRA

How to Use the HRA

When you pay for an eligible health care expense, you want to put your HRA to work right away. Via Benefits gives you several options to use your money the way you choose.

Using Your Smartphone or Mobile Device

Using the Via Benefits mobile app, you can submit claims, upload, and submit receipts, and check your account balance any time.

To use the Via Benefits mobile app:

- Visit App Store or Google Play Store to download the Via Benefits Accounts mobile app.
- Log in to your account. If you normally access the website through the Fund (using single sign-on), you'll need to create a login ID and password to use the mobile app.
- Check your balance, request reimbursement, upload receipts and check claim status, among other activities. All activities are easily accessible from the app home screen.

Using the Via Benefits Website

Using the Via Benefits website means you will never need to fill out a paper claim form again. It's quick, easy, secure, and available 24/7/365.

Once you've logged in:

- You'll be asked to provide details about the claim, including date of service, reimbursement/payment amount, and provider. You'll also choose whether to reimburse yourself or pay the provider and you'll upload/attach your receipt or EOB.

Paper Claim

You can also download the Via Benefits claim form from viabenefitsaccounts.com and fax or mail your claim to the address on the form.

What to Include in a Claim

Regardless of the method you choose to submit a claim, make sure your documentation includes the five following pieces of information required by the IRS:

- Date of service or purchase
- Patient name
- Detailed description
- Patient portion or amount owed
- Provider or merchant name

For premium expenses, make sure your supporting documents show:

- Insurance carrier/COBRA (the name of your medical insurance provider)
- Premium type (e.g., medical, prescription drug)
- Premium amount (proof of total amount you paid for premiums)
- Individual covered (e.g., your name and names of all covered dependents)
- Premium coverage period (e.g., January 1 – January 31 for monthly premiums)

You may submit a claim for reimbursement for an eligible health care expense arising during the plan year at any time during the year. Most claims are processed within one to two business days after they are received, and payments are sent shortly thereafter.

Via Benefits may establish an automatic premium reimbursement process for the payment of certain health insurance premiums. Automatic premium reimbursements shall not be considered to be claims for benefits and shall not be subject to the procedures described in the “Claims and Appeals Procedures” section of this SPD. In establishing and operating any automatic premium reimbursement process, the Via Benefits may establish a process to remove and/or prevent duplicate reimbursements. Removal of duplicate reimbursements and following procedures to prevent duplicate reimbursements shall also not be considered to be claims for benefits and shall not be subject to the procedures described in the “Claims and Appeals Procedures” section of this SPD.

More About Claims

More About Claims

Via Benefits will process your claim, and if the request is for eligible health care expenses, Via Benefits will deduct the money from your HRA and pay you by direct deposit or check. If your claim request is denied, you will be notified as described below.

Amounts in your HRA at the end of a plan year are not carried over to the next plan year. You may submit requests for reimbursement of Eligible Health Care Expenses by June 30 following the plan year in which the expense is incurred. Any claims submitted after that date will not be reimbursed. Any balance remaining in your account for that plan year will be forfeited back to the Fund.

Initial Claims Process and Timing

Claims for expenses covered under a group health plan must be submitted to that group health plan first, and then submitted to the HRA after the group health plan has determined whether the claim is payable.

If you make a claim for health care expenses under the HRA, the following timetable for claims decisions applies (references to "days" below indicate calendar days):

Notification of whether claim is denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information to process the claim	15 days
Notification to Participant	15 days
Response by Participant	45 days
Response to claim	15 days

If a claim under the HRA is denied in whole or in part, the Participant will receive electronic or written notification based on the Participant's setting. The notification will include:

- The specific reason(s) for the denial
- Reference to the specific plan provisions on which the denial was based
- A description of any additional material or information needed to further process the claim, and an explanation of why such material or information is necessary
- A description of the Plan's internal review procedures, and time limits applicable to such procedures, available external review procedures, as well as your right to bring a civil action under Section 502 of ERISA following a final appeal
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim

- A description of any internal rule, guideline, protocol, or similar criteria used in the decision OR statement that if the denial was based on an internal rule, guideline, protocol, or similar criteria, a copy of such rule, guideline, protocol, or other similar criteria will be provided, free of charge, upon request
- An explanation of the scientific or clinical judgment used in the decision in the case of a decision regarding medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the plan to your medical circumstances, OR a statement that such explanation will be provided upon request, free of charge
- The availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793

Claims Appeals Process

Claims Appeals Process

First Level Appeal to Via Benefits

If you receive a claim denial, you will have 180 days following the receipt of the notification in which to appeal the decision, by making a written request for consideration to Via Benefits. You have the right to:

- Submit written comments, documents, records, and other information relating to the reimbursement claim for benefits
- Request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as "relevant" to your claim request if it:
  - Was relied upon in making the benefit determination
  - Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record, or other information was relied upon in making the benefit determination
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
  - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination
- A review that takes into account, all comments, documents, records, and other information related to the claim that you submitted, regardless of whether the information was submitted or considered in the initial benefit determination.
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination nor by that person's subordinate
- If the appeal involves a denial based on a medical judgment, a review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental)
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision.

If sufficient information is available to decide the first level appeal, Via Benefits will resolve your first level appeal within a reasonable period of time but not later than 30 days from receipt of the first level

appeal request. If, for reasons beyond Via Benefits' control, more time is needed to review a request, Via Benefits may extend the time period up to an additional 15 days. If more information is needed to make a decision on your appeal, Via Benefits shall send a written request for the information after receipt of the appeal. If the additional information requested is not received within 45 days of the appeal request, Via Benefits shall conduct its review based upon the available information.

Notice of an adverse benefit determination on appeals will contain all of the following information:

- The specific reasons for the denial
- Information sufficient to identify the claim involved, including the date of the service, the health care provider, and the claim amount (if applicable)
- The specific Retiree HRA Plan provisions on which the decision is based, including the denial code and its corresponding meaning, a description of the plan's standard, if any, used in denying the claim, and in the case of a final adverse determination, a discussion of the decision
- A description of any additional material or information necessary for the claim to be completed and an explanation of why such material or information is necessary
- A description of the Plan's external review procedures and a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures; including your right to bring a civil action in federal court following a claims denial on review
- A description of any internal rules, guidelines, protocols, or other similar criteria that were relied upon in the decision-making, OR a statement that the decision was based on the applicable items mentioned above, and that copies of the applicable material, will be provided upon request, free of charge
- An explanation of the scientific or clinical judgment used in the decision in the case of a decision regarding medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the plan to your medical circumstances, OR a statement that such explanation will be provided upon request, free of charge, and
- The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

If you have any questions about a denied claim, you should contact Via Benefits. Via Benefits' decisions are conclusive and binding.

Appeal to the Board of Trustees

If you are not satisfied with the decision made on the first level appeal, you may request in writing, within 90 days of receipt of the notice of the decision, a second level appeal. A second level appeal may be initiated by you or your authorized representative to the Board of Trustees of the Fund. Instructions for contacting the Administrative Office will be included in the notice of adverse benefit determination.

An appeal must submitted by you or an authorized representative in writing. It must be submitted to the proper address for either the Administrative Office or Via Benefits. Appeals will be accepted from your authorized representative only if accompanied by a written statement signed by you or your adult dependent that identifies the representative and authorizes him or her to seek benefits for you or your dependent. 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. An appeal must identify the benefit determination involved, set forth the reasons for the appeal and provide any information you believe is pertinent.

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

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.

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.

Overpayments

If it is later determined that you and/or your covered eligible dependent(s) received an overpayment or a payment was made in error, you (or your covered eligible dependents) will be required to refund the overpayment or erroneous reimbursement to the HRA. An example of an overpayment is being reimbursed for an expense under the HRA that is later determined to be ineligible or paid for by some other health care plan.

If you do not refund the overpayment or erroneous payment, the Fund reserves the right to offset future Retiree HRA Plan reimbursements equal to the overpayment or erroneous payment. The Fund may set off, recoup or recover the amount of overpayment or excess credit accrued and take such further action as the Board of Trustees shall determine. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may include the amount on an IRS Form 1099 as income. In addition, if the Plan Administrator determines that you have submitted a fraudulent claim, the Plan Administrator may terminate your coverage under the HRA.

Unclaimed Payments

Any HRA payments that are unclaimed (e.g., uncashed benefit checks or unclaimed electronic transfers) will automatically forfeit 18 months from the date set forth on the check or from the date the payment was otherwise approved.

If the participant or other authorized person does not contact Via Benefits prior to the 18-month forfeiture time frame, the unclaimed reimbursement will be voided, and the amount of the voided check will be forfeited.

If the Participant or other authorized person contacts Via Benefits within six months, Via Benefits may cancel and void the original check or payment and re-issue a new check or as otherwise determined by Via Benefits.

If the Participant or other authorized person contacts Via Benefits after six months, Via Benefits will cancel and void the original check or payment and shall re-issue the payment by direct deposit, or as otherwise determined by Via Benefits.

Continuation of Coverage Under COBRA

Continuation of Coverage Under COBRA

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your covered spouse and dependent children, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose coverage under the Plan. It can also become available to your spouse and dependent children who are covered under the Plan when they would otherwise lose such coverage.

What Is COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Retiree HRA Plan coverage when you would otherwise lose such coverage because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You and your covered spouse could become qualified beneficiaries if covered under the Plan at the time of a qualifying event, and such coverage is lost because of the qualifying event. Under the Plan, qualified beneficiaries must pay for the COBRA continuation coverage they elect, as described in the "Paying for COBRA Continuation Coverage" section.

COBRA Qualifying Events

If you are the covered spouse of a retiree, you will become a qualified beneficiary if you lose coverage under the Retiree HRA Plan because any of the following qualifying events happens:

- Your spouse dies
- You become divorced or legally separated from your spouse.

If you are the covered dependent child of a retiree, you will become a qualified beneficiary if you lose coverage under the Retiree HRA Plan because any of the following qualifying events happens:

- Your retiree parent dies
- Your retiree parent becomes divorced or legally separated from his or her spouse
- You no longer meet the definition of dependent child under the Retiree HRA Plan

For this purpose, "lose coverage" means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event.

Giving Notice that a COBRA Qualifying Event Has Occurred

The Retiree HRA Plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the retiree's death or the employer's bankruptcy filing, the employer must notify the Plan administrator of the qualifying events.

For all other qualifying events (divorce or legal separation), you are responsible to notify the Plan Administrator in writing within 60 days after the later of: 1) the date of qualifying event or 2) the date the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event. You must provide this notice in writing to:

Health & Welfare Fund Supervisor
Alaska Electrical Trust Funds
701 E. Tudor Suite 200
Anchorage, Alaska 99503

Office Phone Numbers:
(907) 276-1246
(800) 478-1246
Email: aetfhw@aetf.com

Once the plan administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered (through a "COBRA Continuation Coverage Election Notice") to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered retirees may elect COBRA continuation on behalf of their covered spouses or covered dependent children, but covered retirees cannot reject COBRA continuation on behalf of their covered spouses or covered dependent children.

If coverage under the Retiree HRA Plan is changed for retirees, the same changes will apply to individuals receiving COBRA continuation coverage.

Duration of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of HRA coverage.

When the qualifying event is the death of the retiree or divorce, COBRA continuation coverage for the retiree's covered spouse or covered dependent child(ren) (but not the retiree) under the Retiree HRA Plan lasts for up to a total of 36 months from the date of the qualifying event.

The table below provides a summary of the COBRA provisions outlined in this section.

	Maximum Continuation Period	
Qualifying Events That May Result in Loss of Coverage	**Employee**	**Spouse/dependent**
Retiree dies	N/A	36 months
Retiree and spouse or divorce	N/A	36 months

36-month period is counted from the date of retiree's death.

Electing COBRA Continuation Coverage

You, your covered spouse, or your covered dependent child(ren) must choose to continue coverage under the Retiree HRA Plan within 60 days after the later of the following dates:

- The date you, your covered spouse or covered dependent child would lose coverage under the Retiree HRA Plan as a result of the qualifying event, or
- The date the Company notifies you and/or your covered spouse and/or covered dependent child (through a "COBRA Continuation Coverage Election Notice") of your right to choose to continue coverage as a result of the qualifying event.

Paying for COBRA Continuation Coverage

Cost: Generally, each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage. The cost of COBRA continuation coverage is 102% of the cost of Retiree HRA Plan coverage.

Premium Due Dates: If you elect COBRA continuation coverage, you must make your initial payment for continuation coverage (including all contributions due but not paid) no later than 45 days after the date of your election. (This is the date the COBRA Election Notice is post-marked, if mailed.) If you do not make your initial payment for COBRA continuation coverage within 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Retiree HRA Plan. Payment is considered made on the date it is sent to the Retiree HRA Plan.

After you make your initial payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The contribution due date and exact amount due each coverage period for each qualified beneficiary will be shown in the COBRA Election Notice you receive. Although periodic payments are due on the dates shown in the COBRA Election Notice, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Retiree HRA Plan will be suspended as of the first day of the coverage period and then

retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you elect COBRA continuation coverage but then fail to make an initial or periodic payment before the end of the 45- or 30-day grace period ¾ respectively ¾ for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan, and such coverage will be terminated retroactively to the last day for which timely payment was made (if any).

When COBRA Continuation Coverage Ends

COBRA continuation coverage for any qualified beneficiary will end when the first of the following occurs:

- The applicable 36-month COBRA continuation coverage period ends
- Any required premium is not paid on time
- After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes covered (as a retiree or otherwise) under another group health Plan (not offered by the Company)
- After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes entitled to (that is, enrolled in) Medicare benefits (under Part A, Part B, or both). This does not apply to other qualified beneficiaries who are not entitled to Medicare and does not apply at all to end retiree COBRA continuation coverage if bankruptcy is the qualifying event
- The date the Company ceases to provide any group health plan for its employees and retirees

COBRA continuation coverage may also be terminated for any reason the Retiree HRA Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

Continuing Your HRA Account Under COBRA

If you elect to continue your HRA under COBRA, the HRA will provide for continuation of the maximum reimbursement available at the time of the qualifying event reduced by any claims reimbursed during the period of coverage.

If you continue your HRA under COBRA, any amounts that would otherwise have been contributed by the Company into the HRA will continue.

Marketplace Coverage as an Alternative to COBRA

As explained above, when you lose your coverage under the Retiree HRA Plan by reason of a COBRA qualifying event (e.g., your employment termination), you temporarily can elect to continue that coverage under the applicable health plan at your own expense at group rates (known as COBRA coverage). You also may have special enrollment rights to enroll under another group health plan

(such as your spouse's employer plan). You also have viable purchasing options for individual health insurance policies through the Health Insurance Marketplace ("Public Marketplace") or through other commercial insurance issuers outside of the Public Marketplace. The Public Marketplace may offer you less expensive premiums and out-of-pocket costs than any other health care coverage options, including COBRA coverage, especially in the event that you qualify for governmental subsidies (i.e., tax credits) that help you pay for your coverage purchased from the Public Marketplace.

You should carefully and timely review all of your coverage options before making a final decision. If you decide to purchase other health coverage (e.g., through your spouse or through the Public Marketplace or other commercial insurance) and do not elect COBRA within the 60-day election period, you will no longer have the right to elect COBRA coverage under the health plans.

If you decide to elect COBRA coverage, you also should be aware that you are restricted in when you can enroll in an individual health insurance policy. For example, if you enroll in COBRA medical coverage under the plan but decide mid-year that you want to drop that coverage because it is not affordable to you, most insurance carriers will not permit you to enroll in an individual health insurance policy until the next open enrollment period. This restriction applies even though COBRA is no longer affordable to you (e.g., when your financial situation changes).

More information regarding COBRA coverage is included above and in the COBRA Notices available from the plan administrator. Additional information regarding Public Marketplace coverage is available by visiting **www.healthcare.gov** and also in the health plans' COBRA Notices.

If You Have Questions

Questions concerning your plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Website)

Additional Information

Additional Information

Plan Accounting

Via benefits will periodically furnish you with a statement of your HRA balance and reimbursements so you can track your account balance during the year. This will also help you budget for expense reimbursement needs in future plan years. You may also submit a written request to the plan administrator to receive a copy of your account information at any time.

Your Rights

Your Rights

As a participant in the Retiree HRA Plan, 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 plan administrator's office and at other specified locations such as work sites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a Plan 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 a copy of Plan documents or the latest annual report from the Plan 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 administrator.

If you have a claim for benefits that is denied, or ignored, in whole or in part, you may file a suit in a state or federal court but only after you have exhausted the Plan's claims and appeals procedure as described in this SPD or the claim and appeals sections in the materials prepared by your Plan

carrier. 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 a federal court. Any action at law or in equity must begin within three years after the denial of any appeal from an initial adverse benefit determination, regardless of any state or federal statutes establishing procedures relating to limitations of actions.

If it should happen that plan fiduciaries misuse the plan'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 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.

Qualified Medical Child Support Order

The Retiree HRA Plan will comply with all the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO is an order or judgment from a court or administrative body that directs the plan to cover a child of a participant under a health plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a qualified medical child support order. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the plan's procedure for determining if the order is valid. Coverage under the plan pursuant to a medical child support order will not become effective until the plan administrator determines that the order is a QMCSO. If you have any questions or if you would like to receive a copy of the written procedure for determining whether a QMCSO is valid, please contact:

Health & Welfare Fund Supervisor
Alaska Electrical Trust Funds
701 E. Tudor Suite 200
Anchorage, Alaska 99503

Office Phone Numbers:
(907) 276-1246
(800) 478-1246
Email: aetfhw@aetf.com

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Retiree HRA Plan is intended to comply with the privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA). The Company is required to provide notice of the ways that Protected Health Information (PHI) may be used in accordance with HIPAA. A copy of the HIPAA notice of privacy practices can be obtained by contacting the

Health & Welfare Fund Supervisor
Alaska Electrical Trust Funds
701 E. Tudor Suite 200
Anchorage, Alaska 99503

Office Phone Numbers:
(907) 276-1246
(800) 478-1246
Email: aetfhw@aetf.com

Assistance With Your Questions

Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. 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 (EBSA), 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 Ave. N.W. Washington, DC 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 at 1-866-EBSA (1-866-444-3272), logging on to **www.dol.gov** or by contacting the EBSA Field office nearest you.

Special Disclosure Information

Special Disclosure Information

Name of Plan

This Plan is known as the Alaska Electrical Retiree Health Reimbursement 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
2600 Denali Street, 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:

EMPLOYER TRUSTEES

Larry Bell
Alaska Chapter, NECA
712 West 36th Avenue
Anchorage, AK 99503

Andrew Biden
Fullford Electric
303 E. Van Horn Rd.
Fairbanks, AK99701

Blair Christensen
Alaska Communications
600 Telephone Avenue
Anchorage, AK 99503

Paul Lantz
CCI Electrical Services, LLC
5020 Fairbanks Street
Anchorage, AK 99507

Elliot Marlow
Endeavor Electric
3560 W 74th Avenue
Anchorage, AK 99502

UNION TRUSTEES

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

Pamela Cline
IBEW LU #1547
3333 Denali Street, Suite 200
Anchorage, AK 99503

Diana Ruhl
IBEW LU # 1547
3333 Denali Street, Suite 200
Anchorage, AK 99503

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

Doug Tansy
IBEW LU #1547
2000 Airport Way
Fairbanks, AK 99701

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 health 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

Retired employees are entitled to participate in this Plan, if they work under one of the collective bargaining agreements described above and if their employer made contributions to the Fund on their behalf during their active employment in the industry. 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 are received and held in trust by the Board of Trustees pending the payment of benefits, insurance premiums and reasonable administrative expenses. All benefits are self-funded and benefits are paid directly from the Fund.

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.

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.

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.

Limitation on Assignment

Your rights under the Retiree HRA Plan cannot be assigned, sold, or transferred to your creditors or anyone else. However, you may assign any benefit payments you may be entitled to the health care provider who provided the covered services.

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