2014/2015
Benefits Plus Guide

ANCHORAGE SCHOOL DISTRICT EMPLOYEES

Public Employees
Local 71 Trust Fund

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This Benefits Plus Guide provides an overview of the benefits available to members of the Public Employees Local 71 Trust Fund. If there is a conflict between this information and the contracts that govern the plans, or if additional information is contained in those contracts regarding services, exclusions, limitations or other provisions, the official contracts will be regarded as the plans' final authority. Legal regulations relating to the plans will supersede contracts or other information in this Benefits Plus Guide.

Although Public Employees Local 71 Trust intends to maintain these plans indefinitely, the Board of Trustees for the Public Employees Local 71 Trust Fund in their sole discretion reserve the right to amend, delete, cancel, or otherwise change the flexible benefit program or any individual benefit plan.

About Your Benefits

Benefits That Work for You

The Public Employees Local 71 Health Trust offers you many benefit choices, so that you can select the options that meet your and your family's needs. Whatever your situation—single, married, with or without children—Benefits Plus protects you and your family with benefits you can count on.

What Is Benefits Plus?

Benefits Plus is the complete package of benefits available to members of the Public Employees Local 71 Trust:

- You choose the Basic Benefit (Health Plan) that works best for you.

New For the 2014/2015 Plan Year

Effective July 1, 2014

Look for this icon throughout this Benefit Guide for important key information that you need to know about plan changes for 2014/2015!

For the next Plan Year, the PE 71 Trust Fund is changing all of its Health Plans, including contribution rates. Please read this Benefit Guide carefully to understand your benefit coverage for the next Plan Year.

Make the Most of This Benefits Plus Guide

If you have a benefit question, chances are you'll find the answer right here. You can use your Benefits Plus Guide to:

- Help you choose the benefits that are best for you; for example, which Health Plan is best for your family.
- Find out how to make the best use of your benefits; for example, when to use a Preferred Provider Organization (PPO), or how to preauthorize travel expenses.
- Look up details about your coverage; for example, when the Vision Plan covers a new set of glasses.

Please keep your Benefits Plus Guide in a handy place, so you can refer to it all year long. You'll find a Key Contacts page on the back cover with information about who to contact when you have questions.

Eligibility Guidelines

Who can enroll in Benefits Plus?

To participate in Benefits Plus, you must be:

- An eligible employee working in a job classification as described in the collective bargaining agreement or special agreement with Public Employees Local 71, for whom the Trust receives contributions for coverage.
- On a COBRA self-pay plan (you may enroll in Basic Benefits; contact the Trust Administrative Office for details)
- On Family Medical Leave (FMLA) (you may enroll in Basic Benefits; contact the Trust Administrative Office for details)

Which family members can you sign up for benefits?

You may sign up these dependents (family members) for Benefits Plus:

- Your spouse (husband or wife); you may be legally separated, but not divorced
- Your same-sex partner (contact the Trust Administrative Office for qualification requirements)

- Your children up to their 26th birthday, if they are:
  - Your natural children or legally adopted children
  - Stepchildren, children of a same-sex partner, foster children placed through a state foster child program, or children for whom you are the legal, court-appointed guardian,
  - Children who are mentally or physically handicapped who reach age 19 while covered under the Plan may be eligible past the child's 26th birthday if the child is chiefly dependent on you for support and not capable of self-sustaining employment. You must provide proof of the handicap within 31 days of the child's 19th birthday and as the Trust Administrative Office requires, up to once every two years.
  - If each parent enrolls in Benefits Plus as a member/employee, they may each list their eligible children as dependents

You may NOT include the following individuals as dependents:

- A former spouse from whom you are divorced
- A child who has been legally adopted by another person (custody ends on the date custody is assumed by the adoptive parents)
- A child who has attained the limiting age, which is the child's 26th birthday

What do I need to do when my dependent is no longer eligible for health benefits?

You must notify the Trust Administrative Office within 60 days when a dependent no longer meets the eligibility requirements stated on pages 2 and 3.

If you a) enroll a dependent who does not meet the eligibility requirements of this plan; or b) fail to notify the plan of your divorce or other loss of dependent eligibility within 60 days of the event; you are intentionally misrepresenting a material fact and the plan will retroactively terminate coverage for your ineligible dependent. If the plan pays claims based on your misrepresentation, you may be responsible for any claims paid on your dependent's behalf.

Are there tax issues for same-sex partners, who are not legally married?

Yes. A portion of your employee contribution may be taken on an after-tax basis, rather than pretax, depending on the benefit choices you make. In addition, the cost of providing benefits may be considered ordinary or "imputed income" and therefore, may be subject to taxes. It is strongly recommended that you contact your tax advisor about the tax implications of enrolling your same-sex partner, and the Trust Administrative Office for enrollment details, before enrolling for benefits.

When do I sign up for my Benefits Plus choices?

New employees: You must enroll within 30 days of the date the Trust sends you enrollment forms. If you are a full-time employee and you do not submit an enrollment form with your Health Plan choice, you will be automatically enrolled in the Yellow Family Plan.

Coverage begins on the first of the month which coincides with or follows your first day of active employment in a benefits eligible class, provided you are actively at work on that day. If you are not actively at work on that day, your coverage begins on the first day of the month which coincides with or follows the day you return to active work.

Current employees: Every year during Open Enrollment (during a specific period, generally between April and June) you may make benefit choices for the next Plan Year (July 1-June 30). Be sure to choose carefully because you cannot change your choices until the next year's Open Enrollment, unless you experience a Qualifying Event/change in family status (see details on page 5).

How do I know I am enrolled correctly?

The Health Trust will mail you a Verification of Election Form, which lists your benefit choices, when you:

- Enroll as a new employee
- Make changes when you have a Qualifying Event (see details on page 5)
- Enroll during Open Enrollment

HEALTH PLAN CHOICES FOR 2014/2015

	BLUE PLAN	YELLOW PLAN
Benefits provided...	Both Plans provide comprehensive coverage, which includes medical and prescription benefits. Hearing, dental and vision benefits are provided to participants in both Plans at no additional cost. And, both Plans cover preventive care at 100%, with no deductible required.	
Highlights...	Pays benefits after you pay the annual deductible. After you pay the deductible, the Plan pays 80% for most health care services (60% for services received at a non-PPO). You pay a higher monthly contribution but have a low annual deductible and out-of-pocket limit.	Pays benefits after you pay an annual deductible. After you pay the deductible, the Plan pays 70% for most health care services (50% for services received at a non-PPO). You pay a lower monthly contribution, but have a higher annual deductible and out-of-pocket limit.
This would be a good choice if you...	Prefer to pay a higher monthly contribution but have a low deductible. Access health care services regularly and/or expect to have major procedures in the next Plan Year.	Prefer to have a lower monthly contribution, pay for health care services as you receive them and have coverage in case of a catastrophe. Are in good health, use health care services infrequently, and do not expect any major medical procedures in the next Plan Year. Have other health coverage (for example, through Indian Health Services or a spouse's employer); the Yellow Plan supplements other coverage. This is a good plan option for anyone who is currently in Plan 102. However, you do not have to have other health coverage in order to enroll in the Yellow Plan.
Health Reimbursement Arrangement (HRA)...	No HRA provided	The Trust provides a $1,000 HRA (details on page 5) per employee to help pay out-of-pocket costs.
Monthly contribution...	Employee only: $50 Family: $125	Employee only: $0 Family: $75

(Please see the overview chart on page 7 for coverage details.)

Please compare the Verification Form to your copy of the enrollment forms. If there is a mistake on the Verification Form, write in what you chose on the enrollment form, and send the corrected Verification Form to the Trust Administrative Office. (This is *not* an opportunity to change your elections. These are the benefits you will have throughout the 2014/2015 Plan Year unless you experience a qualifying event, which is explained on page 5.)

Please double check your enrollment forms to make sure everything is accurate. If you list incorrect information or if you fail to notify the Trust when your information changes and the Trust has to correct your enrollment from the start of the Plan Year, you will have to pay the cost difference, if any.

Do I have the right to appeal my benefit choices?

Yes. Here are the appeal procedures you must follow:

- Write a letter explaining why you want to change your benefits. You may include copies of letters, forms or other documents that support your request.
- Your letter must be postmarked within 45 days after your first paycheck that has the new benefit deductions. (For example, if that payday is September 5, the Trust must have your letter by October 19.)
- The Board of Trustees will review appeals that are received in the Trust Administrative office at least 20 business days prior to the next scheduled Board meeting. You may call the Trust Administrative Office to find out when the next meeting will take place.

What is a Qualifying Event?

A Qualifying Event is a change in your family status or benefit plan coverage that allows you to make a change in your elections.

Contact the Trust Administrative Office if you experience one of the following Qualifying Events (you must notify the Trust, complete new enrollment forms, and provide proof of the event within 60 days of the event):

- You get married, divorced or legally separated
- You have a baby or adopt a child
- Your dependent dies
- You add or lose a same-sex partner or same-sex partner's child (plan changes may be limited by Federal regulations)
- Your dependent is no longer eligible or becomes eligible
- You or your dependent loses, gains or a has a significant change in your other health insurance
- Your work status changes from full-time to part-time or vice versa

Changes will be effective on the first day of the month after the Trust receives your revised enrollment forms and proof of the qualifying event. Health plan coverage for newborns or newly adopted children will be provided retroactively to the date of birth or adoption if you enroll the child within 60 days of birth or adoption.

When does my coverage end?

Benefit coverage for yourself and your dependents ends on the last day of the month in which you are no longer eligible to participate. For example, if you are on leave without pay, your coverage ends on the last day of the month worked.

Can I continue my same coverage when I am no longer eligible?

Yes, you may be able to pay for continuation health care coverage for yourself and your dependents.

If you have Life Insurance coverage, you may convert to a self-pay policy within 31 days after active coverage terminates.

Refer to your Benefits Booklet or contact the Trust Administrative Office for more details.

Basic Benefits

What are Basic Benefits?

This is your health care coverage, which includes medical, prescription, hearing, dental and vision benefits. Your choices are shown in the chart on page 7.

Why are the plans called Blue and Yellow?

Those are the colors of the Alaska state flag.

Why did the Trust add the new Yellow Plan?

The Trust can no longer offer Plan 102, due to new Affordable Care Act (ACA) requirements. When the Board of Trustees considered alternative plan options, they designed a plan that responded to member requests:

- The Yellow Plan is less expensive. The Trust is charging $0 contribution for Employee Only Coverage, and a lower contribution rate for Family Coverage.
- You don't need to have other health coverage to elect the Yellow Plan. It is open to all Trust members.
- Although the Yellow Plan has a higher deductible than the Blue Plan, the Yellow Plan covers many services without having to meet the deductible:
  - The Yellow Plan provides 100% coverage for preventive care services, no deducible.
  - All generic prescriptions are covered at 100%, no deductible.
  - AND you can use the $1,000 HRA money provided by the Trust to pay for the first $1,000 in medical, prescription, dental, vision, and hearing expenses, even if some of those charges apply to the deductible.

It is a great option for participants who don't need Trust coverage, or who don't meet their annual out-of-pocket maximum each year.

How does the HRA work with the Yellow Plan?

The Health Trust provides a $1,000 (per employee) Health Reimbursement Arrangement (HRA) to help you pay for out-of-pocket costs, which includes your deductible, copays and coinsurance.

If there are unused funds in your HRA at the end of the Plan Year, these funds are rolled over, for you, to the following Plan Year. If you select a different Plan or are no longer eligible for Health Trust benefits, you must forfeit any remaining funds in your HRA.

How do I choose a coverage level?

- **Family coverage** pays benefits for yourself plus one or more eligible dependents (see eligibility definition on page 2).
- **Employee Only** coverage pays benefits only for you. You may only select this option if you are single and have no eligible dependents, or your eligible dependents have other health coverage. If you enroll in Employee Only coverage and any of your dependents loses their other coverage, you must notify the Trust Administrative Office and enroll in a Family Plan within 60 days of the date the other coverage is lost.

What is the default Health Plan enrollment?

If you do not enroll in a Basic Benefit option at initial enrollment, newly eligible full-time employees will default into the Yellow Family Plan.

For the July 1, 2014 Open Enrollment, your current coverage will default as shown below:

- Plan 101 will default into the Blue Family Plan
- Plan 105 will default into the Blue Employee Only Pan
- Plan 102 will default into the Yellow Family Plan

Can I choose to decline part of the coverage?

Yes, you may decline coverage for dental, vision and hearing benefits. However, your monthly contribution will NOT be reduced if you decline coverage, as the Trust does not charge an additional contribution for these benefits. If you would like to decline this coverage, please contact the Trust Administrative Office.

Your Medical Plan

About Your Medical Plan Benefits

You may choose any licensed health care provider. Your Medical Plan covers services that are medically necessary for the diagnosis and treatment of an illness or injury. The Plan pays 100% of the allowed amount, with no deductible required, for preventive care.

How does the deductible work?

You must meet the Blue or Yellow Plan annual deductible before the Plan pays benefits for Medical services, except as noted in the chart on page 7.

All of your and your dependents' payments toward the deductible are added together. When you collectively meet the annual family deductible, the Plan pays benefits for each family member, whether each person has met the per person deductible or not.

What is a Medical Pre-treatment Estimate review?

When you need any inpatient or outpatient medical procedure expected to cost $1,000 or more, you may ask your Physician to file a "Medical Pre-Treatment Estimate Form". Zenith will then provide an estimate of our benefit coverage before the work begins, so you will know what you pay. You may obtain this form from Zenith American Solutions or your Trust Administrative office.

How does the Plan cover preventive care?

The Plan pays 100% of the allowed amount, with no deductible required, for preventive care. The preventive care must meet the standard recommendations required by the Affordable Care Act, in keeping with the U.S. Preventive Services Task Force Recommendations.

- A or B rated services by the US Preventive Services Task Force (view details at uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm)
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC (view details at immunize.org/acip)

MEDICAL PLAN BENEFIT OVERVIEW • Effective July 1, 2014

Per Plan Year, July 1–June 30	BLUE PLAN PPO	BLUE PLAN NON-PPO	YELLOW PLAN PPO	YELLOW PLAN NON-PPO
Plan Maximum: The limit the Plan will pay	Unlimited	Unlimited	Unlimited	Unlimited
Annual Deductible: The amount you pay before the Plan begins to pay for services	$300/person $600/family	$600/person $1,200/family	$2,500/person $5,000/family	$5,000/person $10,000/family
Coinsurance: The percentage you and the Plan pay (based on the Plan's allowable expense)	Plan pays 80% You pay 20%	Plan pays 60% You pay 40%	Plan pays 70% You pay 30%	Plan pays 50% You pay 50%
Annual Out-of-Pocket Limit: The most that you pay in coinsurance in one year, after which the Plan pays 100% (does not include deductible)	$1,200/person $2,400/family	$2,400/person $4,800/family	$2,350/person $4,700/family	$4,700/person $9,400/family
Physician Services: Office visits, specialists, surgery	Plan pays 80% You pay 20%		Plan pays 70% You pay 30%	
Preventive Care: Physical exams, routine tests, immunizations	Plan pays 100% as required by Affordable Care Act Not subject to deductible		Plan pays 100% as required by Affordable Care Act Not subject to deductible	
Coalition Health Center: Primary care, chronic condition care, wellness services, and more	Plan pays 100% after you pay a $10 copay No copay for preventive services Not subject to deductible		Plan pays 100% after you pay a $10 copay No copay for preventive services Not subject to deductible	
Hospital Services: See Preferred Provider Organizations (on page 9) regarding services received within the Municipality of Anchorage	Plan pays 80% You pay 20%	Plan pays 60% You pay 40%	Plan pays 70% You pay 30%	Plan pays 50% You pay 50%
NEW Outpatient Surgery: See Preferred Provider Organizations (on page 9) regarding services received within the Municipality of Anchorage	Plan pays 80% You pay 20%	Plan pays 60% You pay 40%	Plan pays 70% You pay 30%	Plan pays 50% You pay 50%
Skilled Nursing Facility	Plan pays 100%		Plan pays 100%	
Home Health Care: Limited to 120 visits per Plan Year	Plan pays 80% You pay 20%		Plan pays 70% You pay 30%	
NEW Hospice Care	Plan pays 80% You pay 20%		Plan pays 70% You pay 30%	
Treatment of Spinal Disorders and Acupuncture	Plan pays 80% You pay 20% Limited to 16 visits per Plan Year		Plan pays 70% You pay 30% Limited to 16 visits per Plan Year	
Mental Health	Plan pays 80% You pay 20% Limited to 30 inpatient days and 30 outpatient visits per Plan Year		Plan pays 70% You pay 30% Limited to 30 inpatient days and 30 outpatient visits per Plan Year	
Substance Abuse Treatments	Plan pays 80% You pay 20% Limited to 30 inpatient days and 30 outpatient visits per Plan Year		Plan pays 70% You pay 30% Limited to 30 inpatient days and 30 outpatient visits per Plan Year	

The chart provides an overview. For details, please refer to the Basic Benefits Booklet.

- Preventive care and screenings for infants, children and adolescents which are included in guidelines of the Health Resources and Services Administration, including vision and hearing screening and oral health risk assessments (view details at uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm)
- Preventive care and screenings for women which are included in guidelines of the Health Resources and Services Administration (view details at uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm)

How does the Plan cover mental health and alcohol and drug-abuse treatment?

The Plan covers up to 30 inpatient days and 30 outpatient visits per Plan Year for mental health treatment and up to 30 inpatient days and 30 outpatient visits per Plan Year for alcohol and drug-abuse treatment.

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with certain requirements. However, the law also permits State and local governmental employers that sponsor health plans, including plans that are offered as part of a collective bargaining agreement, to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy.

The Board of Trustees of Public Employees Local 71 Trust Fund, with the approval of Public Employees Local 71, has elected to exempt the plan from the following requirement: Parity in the application of certain limits to mental health benefits. Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan. The exemption from this Federal requirement will be in effect for the plan year beginning July 1, 2014 and ending June 30, 2015. The election may be renewed for subsequent plan years.

Does the Plan cover Hospice Care?

NEW

Yes, effective July 1, 2014, the Plan provides Hospice Care benefits for participants with a life expectancy of 6-months or less.

Hospice care provides medical services, emotional support, and spiritual resources for people who are in the last stages of a serious illness, such as cancer or heart failure. Hospice care also helps family members manage the practical details and emotional challenges of caring for a dying loved one.

The Plan pays for services provided in a hospice center, including room and board, medical equipment and supplies, prescriptions, physician services, nursing care, home health aide services, nutrition services and respite care.

The attending physician must submit a written hospice care program to the Health Trust Administrator every 30 days. Following is a list of limitations.

Unless specified above, charges for the following will not be covered:

- Daily room and board charges over the semi-private room rate
- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.

Does the Plan cover costs associated with clinical trials?

NEW

Although the Plan does not cover services provided as part of a clinical trial, the Plan will not:

- deny a qualified individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition;
- deny, limit, or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the trial; or
- discriminate against the individual on the basis of the individual's participation in the trial.

A "Qualified Individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the participant provides medical and scientific information establishing that their participation is appropriate.

An "Approved Clinical Trial" is defined as a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition or disease (or other condition described in ACA, such as federally funded trials, trials conducted under an investigational new drug application reviewed by the FDA or drug trials exempt from having an investigational new drug application). A life-threatening condition is any disease from which the likelihood of death is probable unless the course of the disease is interrupted.

"Routine Patient Costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis.

Does the Plan cover preexisting conditions?

In compliance with the ACA, the medical plan's Preexisting Conditions Benefit Limitation is eliminated, effective July 1, 2014.

Preferred Provider Organizations (PPOs)

A PPO is a network of health care providers that agree to charge discounted rates for the services they provide. Because of these reduced rates, PPOs help the Health Trust keep costs down for everyone.

The Health Plan gives you the flexibility to choose any health care provider. However, when you choose a PPO provider when one is available, you may save money and receive better Plan benefits.

What are the Plan's PPO facilities within the Municipality of Anchorage?

- Alaska Regional Hospital for all inpatient and outpatient hospital services
- Geneva Woods Birth Center
- Physical therapy providers in Anchorage:
  - Chugach Physical Therapy
  - Ascension Physical Therapy
  - Alaska Hand Rehabilitation

You do not have to use one of the PPO facilities listed above when you seek services, but if you use another facility within the Municipality of Anchorage, your benefits will be reduced.

Do I have to choose a doctor from a PPO network?

No. You may choose any doctor (there is no PPO for doctor services). However, in order to receive favorable pricing, you may consider using a doctor in the Aetna network. (More information on page 11.)

What if I choose a non-PPO facility when a PPO is available?

PPO penalties, or a reduction in benefits, will apply if you use a non-PPO facility within the Municipality of Anchorage as shown in the chart on page 10.

Will the PPO penalties apply in an emergency?

The Plan pays emergency benefits with no penalty at any hospital as long as the patient is transferred to Alaska Regional Hospital as soon as medically possible.

PPO vs. Non-PPO: What do I pay?

See the example on page 10 of how the Plans would pay benefits for an inpatient hospital stay within the Municipality of Anchorage.

How does the PPO work outside the Municipality of Anchorage?

In the Mat-Su Borough, Mat Su Regional Hospital is the PPO facility.

You also have access to a nationwide network of physicians, hospitals and specialty providers through the Aetna PPO.

PPO WITHIN THE MUNICIPALITY OF ANCHORAGE

	BLUE PLAN		YELLOW PLAN	
Description	**PPO Benefit**	**Non-PPO Benefit**	**PPO Benefit**	**Non-PPO Benefit**
Covered Expense: the amount the Plan allows for a service; also called Allowable Expense	PPO contract rate: the discounted amount the PPO charges	Outpatient services: the PPO case rate (the discounted total cost for the procedure) or 50% of billed charges Inpatient services: the PPO contract rate	PPO contract rate: the discounted amount the PPO charges	Outpatient services: the PPO case rate (the discounted total cost for the procedure) or 50% of billed charges Inpatient services: the PPO contract rate
Percent the Plan Pays: (of the Allowable Expense)	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%
Annual Deductible: the amount you pay each year before the Plan pays benefits	$300/person $600/family	$600/person $1,200/family	$2,500/person $5,000/family	$5,000/person $10,000/family
Annual Out-of-Pocket Limit: the most you pay of the Allowable Expenses, not including your deductible, after which the Plan pays 100%	$1,200/person $2,400/family	$2,400/person $4,800/family	$2,350/person $4,700/family	$4,700/person $9,400/family

PPO VS. NON-PPO: WHAT DO YOU PAY?

Here is an example of how the Blue Plan would pay benefits for an inpatient hospital stay within the Municipality of Anchorage:

PPO		NON-PPO	
AK Regional Hospital Bill	$15,000	Non-PPO Hospital Bill	$30,000
Less Non-Covered Expense	-$0	Less Non-Covered Expense	-$15,000
Equals Covered Expense	$15,000	Equals Covered Expense at PPO Hospital	$15,000
Less Deductible	-$300	Less Non-PPO Deductible	-$600
Equals	$14,700	Equals	$14,400
Multiplied by % Payable 80% to maximum Out-of-Pocket; 100% of remainder		Multiplied by % Payable 60% to maximum Out-of-Pocket; 100% of remainder	
Equals Total Payment Made	$13,500	Equals Total Payment Made	$12,000
Your Out-of-Pocket Expense (Total Hospital Bill less payment made by the Plan)	$1,500	Your Out-of-Pocket Expense (Total Hospital Bill less payment made by the Plan)	$18,000

- Your Plan benefits are the same, whether or not you choose an Aetna PPO provider.
- Since the PPO charges a discounted rate, you'll save yourself and the Health Trust money when you choose an Aetna provider.
- To locate an Aetna provider or facility, go to aetna.com. Register using your Trust ID number on the front of your ID card, underneath your name. Select "LogIn/Register" at the top of the page, and then select "Sign Up Now." You can also search for providers on Aetna's public website at aetna.com/docfind. Select the "Aetna Choice POS II (Open Access)" network.

Important: The Aetna PPO does NOT replace the Trust's PPOs in the Municipality of Anchorage and Mat-Su Borough.

How does the Plan cover services received outside of the U.S.?

In an emergency, you may obtain health care services in any licensed facility outside the U.S. You may be required to pay the full cost for care and then submit a claim for reimbursement for the Plan's coinsurance amount.

For non-emergency or elective hospital services outside the U.S., the Plan will only cover eligible services if the hospital is accredited by the Joint Commission International. This requirement ensures that participants receive services at facilities that meet certain standards. You can view a list of accredited facilities on the JCI website at http://jointcommissioninternational.org/JCI-Accredited-Organizations.

The Coalition Health Center

The Coalition Health Center in Anchorage makes getting health care easy and very affordable. **You only pay a $10 copay per visit (no copay for preventive care) and your annual deductible does not apply.** The Center submits claims for you and never charges more than your Health Plan's allowed amount. By using the clinic you won't experience any additional provider costs for charges "Over UCR" (Usual, Customary and Reasonable).

The Center is staffed by professional health care providers, such as fully qualified nurse practitioners and physician assistants, who offer:

- Primary Care: Get treatment for an illness or injury (and referral to a specialist when needed).
- Preventive Care: Get routine exams and preventive tests, children's wellness visits, annual physicals, immunizations and lab tests.
- Health management: Get help managing your chronic health conditions and improving your overall health
- Pharmacy: Get many common generic prescriptions filled at the Coalition Health Center as well as pre-packaged medications.
- Remember! The Coalition Health Center saves YOU money and saves YOUR Health Trust money!

You can drop in and see a provider anytime, call ahead (907) 264-1370, or go online at coalitionhealthcenter.com to make an appointment. The Center is open Mon-Fri: 7 a.m.–7 p.m.; Sat: 8 a.m.-12 noon, and is located on the Alaska Regional Hospital campus at 2741 DeBarr Road, Suite C210, Anchorage.

Preauthorization and Other Plan Rules

The Medical Plan has some rules that help make sure everybody gets the care they need—at a reasonable cost. Please read more about these rules, also called Utilization Management Provisions, in the Basic Benefit Booklet, available from the Trust Administrative Office. Contact information is available on the back cover.

Do I need to precertify hospital stays and other procedures?

Precertification is required for inpatient hospitalizations and certain outpatient procedures. You can obtain a copy of these outpatient procedures on the Union website at local71.com or by calling Zenith American Solutions or going to zenith-american.com. When precertification is required, your doctor is responsible for contacting Aetna by calling the physician provider precertification phone number on your ID card.

If you receive a service that was not precertified (when the Plan requires it), here's what will happen:

- If your doctor IS in the Aetna PPO network, the Plan will pay your benefits as usual, but limit the provider's reimbursement. The provider cannot balance-bill you for his or her failure to precertify.
- If your doctor is NOT in the Aetna PPO network, the Plan will pay your benefits as usual providing the service was medically necessary, but you will have a $400 penalty for a non-precertified hospitalization.

If the hospitalization was not medically necessary, the Plan will not pay any benefits.

Important: Precertification only determines medical necessity; it does not automatically mean benefits are payable. Eligibility, deductibles, limitations, and exclusions may apply. Please contact Zenith American Solutions for specific information about your benefits.

Does the Plan cover preadmission testing?

Yes, if your doctor requires tests prior to surgery, you may be able to have them done before you are admitted to the hospital. Preadmission testing is covered at 100% of the allowable expense.

Do I need to preauthorize travel expenses?

Yes, if you must travel for services that you cannot get locally, the Plan may cover some travel expenses, but you must contact Zenith American Solutions for preauthorization before your trip.

What is the Case Management program?

Your Medical Plan provides case management services that can help with complicated medical issues that require an extended period of care and treatment. A case manager works with you, your family and your doctor to help you:

- Understand the treatment plan
- Be aware of alternative care options
- Make cost-effective and high-quality care choices

Case management is voluntary; there is no penalty if you do not participate. Contact Zenith American Solutions for more information.

What is the Disease Management program?

This program helps members and dependents with the conditions listed below learn to better manage their health—and stay healthier, feel better and enjoy the best quality of life possible:

- Diabetes
- Asthma
- Coronary Artery Disease (CAD)
- Heart Failure
- Chronic Obstructive Pulmonary Disease (COPD)

The program is free, voluntary and confidential. Participants get information about their condition and one-on-one support and advice from an experienced nurse who can help them achieve healthy lifestyle goals.

Alere provides these services for the Health Trust and will contact people who are candidates for the program. Contact Alere for more information at 855-738-1764 (toll-free).

Your Prescription Drug Plan

About Your Prescription Drug Plan Benefits

Your Health Plan covers medically necessary drugs and medicine when you have a doctor's written prescription. There are two ways you can fill your prescriptions:

- At a retail pharmacy
- Through mail order

You'll save money when you choose a participating Caremark pharmacy and/or use the mail service program, because Caremark charges a discounted rate.

Find a Caremark network pharmacy near you at caremark.com or by calling Caremark at 866-818-6911 (toll-free).

What if I want to use a brand-name drug instead of the generic equivalent?

If you select a brand-name drug when a generic equivalent is available, the Plan requires you to pay a $50 penalty plus the copay. The $50 penalty will not apply to the out-of-pocket limit.

Why are generics drugs free?

Generic drugs are copies of brand-name drugs and are the same in dosage, safety, strength, quality and performance. Because generics must be approved by the Food and Drug Administration, you can be sure that they are safe and effective. Since generic drugs are available at a lower cost than brand-name drugs, all participants are encouraged to consider generics when they are available.

What is the brand-name formulary?

The brand-name formulary is a list of medications that are on a preferred drug list. This list helps ensure that you have access to quality, affordable, prescription drug benefits.

Drugs chosen for the formulary have gone through an extensive review process. This process is structured

PRESCRIPTION DRUG PLAN BENEFIT OVERVIEW • EFFECTIVE JULY 1, 2014

	RETAIL PHARMACY	MAIL SERVICE PROGRAM
	The coverage is the same for the Blue Plan and the Yellow Plan. The medical deductible and medical out-of-pocket limit do not apply to prescription drugs	
Coinsurance The percentage you and the Plan pay (based on the Plan's allowable expense)	Generic drugs: Plan pays 100%—You Pay 0% Brand-name formulary: Plan pays 70% You Pay 30% (plus $50 penalty if there is a generic equivalent available) Brand-name NON-formulary: Plan pays 50% You Pay 50% (plus $50 penalty if there is a generic equivalent available) Specialty medications: You pay $100 copay	Generic drugs: Plan pays 100%—You Pay 0% Brand-name formulary: Plan pays 80% You Pay 20% (plus $50 penalty if there is a generic equivalent available) Brand-name NON-formulary: Plan pays 50% You Pay 50% (plus $50 penalty if there is a generic equivalent available) Specialty medications: You pay $100 copay
Out-of-Pocket Limit The most that you pay in coinsurance in one year, after which the Plan pays 100%	$1,500/person $3,000/family	

Plan payment is based on the allowable expense (equal to Caremark's discounted rate), not the provider's billed amount.

so that there are internal and external physicians and pharmacists offering clinical input about the medications under consideration.

The drugs listed in the brand-name formulary either represent an important therapeutic advance, or are clinically equivalent and possibly more cost-effective than other drugs that are not on the preferred drug list.

Non-formulary brand-name drugs (drugs that are not on the formulary list) are considered to be less cost-effective, but usually have generic equivalents available. Check with your physician about switching to a generic equivalent.

To find out if your prescription is on the brand-name formulary, please contact Caremark at 866-818-6911 (toll-free).

What are my benefits at a retail pharmacy?

The Plan pays for up to a 90-day supply of medication at a retail pharmacy. Although you may use any retail pharmacy, you will save money by choosing a pharmacy within the Caremark network (this list is available from your Trust Administrative office).

If you choose a pharmacy in the Caremark network:

- Simply show your Health Plan ID card and pay your coinsurance amount.
- The allowable expense is the participating pharmacy rate.

If you choose a non-network pharmacy:

- You will be required to pay the full amount at the time of purchase.
- Submit a claim to Caremark for reimbursement.
- The allowable expense is the discounted Caremark rate, not the amount you are charged.
- Non-network pharmacy prescriptions will not apply to your out-of-pocket limit.

If there are no Caremark network pharmacies within 25 miles:

- Pay for the prescription yourself.
- Submit the claim to Zenith American Solutions for reimbursement.
- The claim will be processed under the Medical Plan.

What is the Caremark Mail Service Program?

This is a convenient way to buy long-term or maintenance medications that you take regularly (for example, drugs that control blood pressure or lower cholesterol).

- You may purchase up to a 90-day supply through the Mail Service Program.
- You will usually save money—typically up to 25%—with the discounted Caremark price for most medications.
- You'll receive your prescription in the mail—and there is no charge for standard delivery.

NEW In order to encourage you to use the mail service program, the Plan's reimbursement is higher. The Plan will pay 80% of formulary brand-name medications, instead of 70% at a retail pharmacy

How do I buy prescriptions by mail?

There are three easy ways to get started:

1 Call Caremark toll-free at 800-875-0867 (TDD, call 800-231-4403).

2 Go to caremark.com, register and follow the online instructions.

3 Mail your prescription, along with an order form to Caremark. This form is available from your Trust administrative office.

You will need to provide the information on your Health Plan ID card, the names of the long-term medications you take, your doctor's name and phone number, and your mailing address.

Your medication will be mailed 10 to 14 days from the time your order is placed. For an extra charge, you can request faster delivery.

What is a "specialty" medication?

The term "specialty" means drugs that may have one or more of the following characteristics:

- Therapy of chronic or complex disease
- Specialized patient training and coordination of care(services, supplies or devices) required prior to therapy initiation and/or during therapy
- Unique patient compliance and safety monitoring requirements
- Unique requirements for handling, shipping and storage
- Potential for significant waste due to the high cost of the drug

Specialty medications are limited to 30 day supply and require prior authorization. For more information, and a list of covered specialty medications, contact Caremark (see contact information on inside back cover).

Because specialty medications are so expensive—sometimes thousands of dollars—your copay is a flat $100 per prescription and is not based on a percentage of the cost.

What is the Specialty Step-Therapy program?

NEW Starting July 1, 2014, the Plan has added a step-therapy program for certain specialty drugs, such as growth hormones or medications used to treat auto-immune diseases (such as rheumatoid arthritis), infertility, or multiple sclerosis.

Typically, specialty medications are very expensive and can have serious side effects. This step-therapy program requires members who are filling specialty prescriptions for the first time to try a preferred medication before trying other alternatives such as non-preferred medications. If you choose a non-preferred specialty drug without first trying the preferred medication, you may be responsible for the full cost of the non-preferred brand medication.

Anyone currently using a specialty medication (except for growth hormones and betaseron) is grandfathered for that medication, and does not need to complete the step-therapy program.

Your Dental Plan

About Your Dental Plan Benefits

You may choose any licensed dentist for your care. The Plan provides full dental benefit coverage for all four Plans.

Plan payment is based on the allowable expense (the amount the Plan allows for the service), not the provider's billed amount.

What is a Dental Advance Claim Review?

A Dental Advance Claim Review explains your benefit coverage before you receive services. When you need dental services over $500, ask your dentist to send Zenith American Solutions a description of the treatment and expected charges for dental services.

Zenith will then provide an estimate of your benefit coverage before the work begins. This way you will know how much the Plan pays and what you will pay.

Your Vision Plan

About Your Vision Plan Benefits

The Vision Services Plan (VSP) manages your vision care benefits. You have the choice of using any licensed vision care provider, but when you choose a VSP Provider, you will save money.

DENTAL PLAN BENEFIT OVERVIEW

	DENTAL PLAN COVERAGE
The coverage is the same whether you enroll in either the Blue Plan or the Yellow Plan for medical	
Annual Deductible (Note: The Dental deductible is separate from the annual Medical deductible)	$50/person $100/family Does not apply to preventive services.
Benefit Maximum	$2,000/person per year
Preventive Routine exams, cleanings, fluoride, X-rays, etc.	Plan pays 100% Deductible does not apply
Restorative Fillings, repair of dentures and bridges, extractions, root canals, periodontal services, etc.	Plan pays 85%
Prosthetic Dental implants, inlays, onlays, crowns, bridges, dentures, etc.	Plan pays 50%
Orthodontic Care, treatment, services and supplies (dependent children only)	Plan pays 50%; $500 Plan Year maximum, $1,000 lifetime maximum

VISION PLAN BENEFIT OVERVIEW

	VSP	NON-VSP
The coverage is the same whether you enroll in either the Blue Plan or the Yellow Plan for medical	$25 deductible / person, applies to lenses and frames only	
Routine Eye Exam One exam every 12 months	Plan pays 100%	Plan pays $50
Conventional Lenses Covered every 12 months, if necessary Single Vision Lined Bifocal Lined Trifocal	 Plan pays 100% Plan pays 100% Plan pays 100%	 Plan pays $50 Plan pays $75 Plan pays $100
Frames New frames covered once every 24 months	Plan pays $160	Plan pays $70
Contact Lenses* In lieu of lenses and frame benefit, covered every 12 months	Plan pays $170	Plan pays $170
Lasik Vision Services You may choose this instead of the exam/lenses/frames/contacts allowance; contact Zenith American Solutions for details	Plan pays flat fee of $275	Plan pays flat fee of $275

*If you choose contacts instead of frames/lenses.

- When you use a VSP Provider, the VSP charge is the Plan's allowed expense for the services you receive and the eyewear you choose.
- When you use a Non-VSP Provider, you must pay the Provider in full. Then you must submit the claim to VSP for reimbursement.

Find a VSP provider near you at vsp.com or by calling 800-877-7195 (toll-free).

Your Hearing Plan

About Your Hearing Plan Benefits

You may choose any qualified health care provider for your hearing care. However, you are encouraged to use an EPIC Hearing Service Plan Preferred Provider to obtain quality services and discounted pricing on hearing exams, aids and devices. The Plan provides the same benefits regardless of whether you use a preferred EPIC provider. EPIC Hearing Health Care offers significant advantages such as:

- Referrals to qualified ear physicians and audiologists in your area
- Discounted prices on brand-name hearing aids and devices (usually 35% to 50% lower than retail prices)
- A 45-day trial period for all hearing aids, during which you pay nothing for needed adjustments and follow-up care
- Assistance in coordinating your Health Plan benefits to maximize your savings
- Knowledgeable hearing counselors who can provide information and assist you at any time

Find an EPIC provider near you by calling 866-956-5400 (toll-free).

HEARING PLAN BENEFIT OVERVIEW

	BLUE PLAN	YELLOW PLAN
$1,150 maximum every three consecutive years; not subject to deductible.	Plan pays 80% You pay 20%	Plan pays 70% You pay 30%

Claims and Appeals

How do I turn in claims for health care services?

In most cases, your provider will submit claims for you. However, sometimes you may need to pay for services when you receive them, then turn in a claim to get reimbursed for the amount the Plan covers.

Here's how to submit a Medical or Dental claim:

1 Use the Zenith American Solutions Medical/Dental claim form (you can obtain a claim form on the union website at local71.com under the Health Trust button, or from Zenith, or by contacting the Trust Administrative Office).

2 Fill it out, sign it and attach your itemized receipt.

3 Mail your claim form to the correct administrator:

Claims for your Medical, Prescription, Dental and Vision benefits are all handled separately (see the back cover for mailing addresses).

- Medical claims submitted by providers: Aetna
- Dental claims: Zenith American Solutions
- Member Reimbursement Claims (for claims and expenses where you made payment directly to the provider): Zenith American Solutions
- Prescription drug claims: Caremark
- Vision claims: Vision Service Plan (VSP)

How do I appeal a health care claim decision that I do not agree with?

You must appeal a post-service claim within 180 days of the claim denial. Please contact Zenith American Solutions regarding claims appeal questions.

The coverage provided through the Trust may not be regulated under Alaska insurance law and may not be covered by the Alaska Life and Health Guarantee Association under AS 21.79.

Key Contacts

IF YOU HAVE QUESTIONS ABOUT THESE TOPICS...	HERE'S WHERE TO GET INFORMATION...
General Trust Questions • Understanding your benefit coverage • Appeal process • Eligibility and enrollment • Case Management	**Trust Administrative Office** Public Employees Local 71 Trust Fund 2510 Arctic Blvd., Anchorage, AK 99503 **Phone:** In Anchorage 276-7611, option 6 Outside Anchorage 800-446-3671, option 6 (toll-free) Union website: local71.com; click Health Trust to download forms
Claims Administration—Medical Claims Submitted by Provider Only	**Aetna** PO Box 981106, El Paso, TX 7996-1106
Claims Administration • Dental claims • Member Reimbursement Claims (for claims and expenses where you made payment directly to the provider) • Travel preauthorization • COBRA/HIPAA	**Zenith American Solutions** PO Box 91013, Seattle, WA 98111-9103 **Phone:** Claims: 800-557-8701 (toll-free) **COBRA/HIPAA:** 800-757-0071, Option 1 or 800-426-5980, ask for COBRA Department (toll-free numbers) **Websites:** zenith-american.com
Precertification • All inpatient stays, to extend a stay, maternity stays • Outpatient medical procedures	**Aetna** When precertification is required, your doctor is responsible for calling the precertification phone number on your ID card
Health Care Services in Anchorage • Make an appointment online, by phone or just drop in.	**Coalition Health Center** 2741 DeBarr Road, Suite C210, Anchorage **Phone:** (907) 264-1370 **Website:** coalitionhealthcenter.org **Hours:** Mon-Fri: 7 a.m.–7 p.m.; Sat: 8 a.m.-12 noon
Prescription Drug Benefits • Locate a Caremark retail pharmacy • Using the retail or mail-order service • Brand name formulary • Specialty medications	**Caremark** **Phone:** 866-818-6911 (toll-free) **Website:** caremark.com **Specialty medications:** Call 800-237-2767 (toll-free) or go to CVSCaremarkSpecialtyRx.com
Vision Benefits • Locate a VSP provider • Vision services claims	**Vision Service Plan (VSP)** PO Box 997105 Sacramento, CA 95899 **Phone:** 800-877-7195 (toll-free) **Website:** vsp.com
Audio Benefits • Locate an EPIC Hearing Service Plan Preferred Provider	**EPIC Hearing Services** Phone: 866-956-5400 (toll-free) Email: hear@epichearing.com
Nationwide PPO network • Locate an Aetna network provider	**Aetna** **Website:** aetna.com Register using your Trust ID number on the front of your ID card, underneath your name. Select "LogIn/Register" at the top of the page, and then select "Sign Up Now." You can also search for providers on Aetna's public website at aetna.com/docfind. Select the "Aetna Choice POS II (Open Access)" network.
Disease Management • Get program information	**Alere** **Phone:** 855-738-1764 (toll-free) **Nurse Connections:** 866-676-0740 (toll-free) **Website:** pe71alerehealth.com