Benefits Plus Guide
2020/2021

HAINES BOROUGH
EMPLOYEES

Public Employees
Local 71 Trust Fund

111 West Cataldo Ave. #220
Spokane, WA 99201

800-557-8701, option 2, then 2 (toll-free)

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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.
- You may also sign up for Voluntary Benefits (Member and Dependent Life, Accidental Death & Dismemberment (AD&D), Disability Insurance and Health Care and Dependent Care Flexible Spending Accounts). Note: Voluntary Benefits are available only to represented employees.

What's New for 2020/2021

NEW

Please read this Benefit Guide carefully to understand your benefit coverage for the next Plan Year. Watch for the NEW icon to see what's changed for 2020/2021.

Optional ONLINE Enrollment—A Few Clicks and You're Done

You have the option to enroll online (or, if you prefer, you can mail in your enrollment forms). You'll login with your own password (sent under separate mailing), keeping your personal information secure and confidential.

- Online enrollment is quick and easy for you, and saves time and increases accuracy:
- You'll find all the details in this packet
- The online process will be "live" when Open Enrollment begins on May 18, 2020
- If you enroll online and need to change your personal information, you will need to complete and fax or mail the first page of the enrollment form
- As an added plus, you can make changes online until the last day of Open Enrollment. *Note*: if you log in multiple times and make changes, the Trust will accept the last forms submitted.

Did You Know?

You can go to zenith-american.com and login with your secure password to view your claim status and access information about your account. Don't have a username and password? Register now!

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 or what level of Life Insurance to select.
- 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 or when you need to turn in a Flexible Spending Account claim.

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 Zenith American Solutions for details)
- On Family Medical Leave (FMLA) (you may enroll in Basic Benefits; contact Zenith American Solutions 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 children up to their 26th birthday, if they are:
  - Your natural children or legally adopted children
  - Stepchildren, 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 Zenith American Solutions 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?

Notify Zenith American Solutions within 60 days when a dependent no longer meets the eligibility requirements.

The Trust will retroactively terminate coverage for ineligible dependents. You may be responsible for any claims paid for an ineligible dependent, if you knowingly:

- Enroll someone who does not meet the Plan's eligibility requirements
- Do not notify Zenith American Solutions when a dependent loses eligibility

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 Employee and Family Plan. A part-time employee will have no health coverage if he or she does not enroll timely.

Coverage begins on the first of the month following 30 calendar days of employment, 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 4–5).

How do I know I am enrolled correctly?

Zenith American Solutions 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 4–5)
- Enroll during Open Enrollment

Please compare the Verification Form to your copy of the enrollment forms, or your printout if you enrolled

HEALTH PLAN CHOICES

	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.	Want to save money in payroll deductions? You'll pay for health care services as you need 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. 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/ Employee Only coverage and $2,000/ Employee and Family coverage to help pay out-of-pocket costs. (See details on page 5–6.)
Monthly contribution...	Employee Only: $180 Employee and Family: $390 NEW	Employee Only: $0 Employee and Family: $100

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

online. 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 Zenith American Solutions. (This is *not* an opportunity to change your elections. These are the benefits you will have throughout the 2020/2021 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 15, the Trust must have your letter by October 31.)
- The Board of Trustees will review appeals that are received by Zenith American Solutions at least 20 business days prior to the next scheduled Board meeting. You may call Zenith American Solutions 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 Zenith American Solutions 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
- 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.

Coverage for some voluntary benefits may end on the last day you worked or the last day you are an eligible participant in the plan.

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 Zenith American Solutions for more details.

Did You Know? No matter which Plan you choose, you do not pay a deductible or copay for these basic services:

- $0 for covered preventive services received from any provider
- $0 for routine care at the Coalition Health Centers
- $0 for Teladoc virtual visits

Basic Benefits

What are Basic Benefits?

This is your health care coverage, which includes medical, prescription, hearing, dental and vision benefits. You have two medical plan choices: the Blue Plan or the Yellow Plan. (See the Medical Plan Benefit Overview chart on page 7 for more information.)

What are the advantages of the Yellow Plan?

Here are four great reasons to consider choosing the Yellow Plan:

1 Annually you'll save $2,160 for Employee Only coverage or $3,480 for Employee and Family coverage in payroll deductions.

2 You get a Health Reimbursement Arrangement (HRA) which you can use to help pay your out of pocket costs (deductible, copays, and coinsurance) on covered services. The Employee Only HRA is $1,000. The Employee and Family HRA is $2,000.

3 Your unused HRA funds roll over to the following Plan Year. That can help you save for unexpected medical expenses.

4 If you are enrolled in another health plan (for example, through your spouse's employer or Indian Health Services), your combined benefits may cover 100% of your out-of-pocket costs. However, you do not need to have other health coverage to enroll in the Yellow Plan.

Here's how it works: Once you reach the deductible, the Yellow Plan pays a percentage of covered services. And, after you reach the out-of-pocket maximum, the Plan pays 100% of covered expenses.

The Yellow Plan may be right for you if you and your dependents are in good health and only expect to go to the doctor for routine and preventive health care next year. Then, if a serious health issue comes up, the Yellow Plan provides dependable coverage you can count on.

How does the HRA work with the Yellow Plan?

The Health Trust gives you a Health Reimbursement Arrangement (HRA) of $1,000 if you have Employee Only coverage or $2,000 if you have Employee and Family coverage to help you pay for out-of-pocket costs, which includes your deductible, copays and

coinsurance, as well as any eligible expenses allowed under the Health Care Flexible Spending Account (FSA) (see page 19).

You can now use your HRA funds to help you pay for menstrual supplies and non-prescription, over-the-counter medications.

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.

Can I have a Flexible Spending Account (FSA) and an HRA?

Yes. You may use your HRA to pay for any of the eligible expenses allowed with a Flexible Spending Account (FSA). However, if you have both a FSA and an HRA, you must use your annual FSA amount before the HRA reimburses your eligible expenses.

How do I choose a coverage level?

- **Employee and Family coverage** pays benefits for yourself plus one or more eligible dependents (see eligibility definition on page 3).
- **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 Zenith American Solutions and enroll in a Employee and 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 Employee and Family Plan and part-time employees will not have any coverage..

If you enroll in Employee Only coverage and fail to provide other coverage information for all eligible family members in a timely manner, you will be placed into the Employee and Family Plan that corresponds with your election (Blue or Yellow).

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 Zenith American Solutions.

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?

This review provides an estimate of what the Plan will pay and what you will pay for inpatient or outpatient medical procedures expected to cost more than $1,000, such as surgery, diagnostic tests or treatment plans.

Before you receive the service, ask your doctor to submit the Medical Pre-treatment Estimate form (available from Zenith American Solutions). Zenith will then provide an estimate of the Plan benefits and your costs.

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/Page/Name/uspstf-a-and-b-recommendations/

Continued on page 8

MEDICAL PLAN BENEFIT OVERVIEW

	BLUE PLAN		YELLOW PLAN	
Per Plan Year, July 1–June 30	**PPO**	**NON-PPO**	**PPO**	**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	$600/person $1,200/family	$1,200/person $2,400/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)	$2,000/person $4,000/family	$4,000/person $8,000/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 60% You pay 40%*	Plan pays 70% You pay 30%	Plan pays 50% You pay 50%*
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% No copay required Not subject to deductible		Plan pays 100% No copay required 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%
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 60% You pay 40%*	Plan pays 70% You pay 30%	Plan pays 50% You pay 50%*
Hospice Care	Plan pays 80% You pay 20%	Plan pays 60% You pay 40%*	Plan pays 70% You pay 30%	Plan pays 50% You pay 50%*
Treatment of Spinal Disorders and Acupuncture	Plan pays 80% You pay 20% Limited to 16 visits per Plan Year	Plan pays 60% You pay 40%*	Plan pays 70% You pay 30% Limited to 16 visits per Plan Year	Plan pays 50% You pay 50%*
Mental Health	Plan pays 80% You pay 20% Limited to 30 inpatient days and 30 outpatient visits per Plan Year	Plan pays 60% You pay 40%*	Plan pays 70% You pay 30% Limited to 30 inpatient days and 30 outpatient visits per Plan Year	Plan pays 50% You pay 50%*
Substance Abuse Treatments	Plan pays 80% You pay 20% Limited to 30 inpatient days and 30 outpatient visits per Plan Year	Plan pays 60% You pay 40%*	Plan pays 70% You pay 30% Limited to 30 inpatient days and 30 outpatient visits per Plan Year	Plan pays 50% You pay 50%*

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

***Non-PPO coverage applies to the following services in specific geographical areas** (see page 9 for details):

- **Within the Municipality of Anchorage:** All inpatient and outpatient hospital services, orthopedic services and physical therapy services
- **In the Mat-Su Borough:** All inpatient and outpatient hospital services
- **Outside the State of Alaska:** All providers and facilities

- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC (view details at immunize.org/acip)
- 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/Page/Name/uspstf-a-and-b-recommendations/)
- Preventive care and screenings for women which are included in guidelines of the Health Resources and Services Administration (view details at uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/)

The Coalition Health Centers

There is no cost to you when you receive health care at the Coalition Health Centers in Anchorage and Fairbanks. You do not have to pay a copay or meet the annual deductible for services you receive at the Centers.

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

- **Routine 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.
- **Urgent Care:** Walk-in for help with urgent, but not life-threatening situations, such as cuts that need stitches, broken bones and serious illnesses.
- **Health Management:** Get help managing your chronic health conditions and improving your overall health.
- **Pharmacy:** The Centers can fill many prescriptions for conditions that are being treated there. This saves you a trip to the pharmacy and you don't have to pay a copay for generics. (However, the Centers cannot fill prescriptions that are prescribed by other physicians.)

It's easy to get care at the Centers:

Important Note: The Coalition Health Centers have changed their delivery of care during the COVID-19 crisis. Please check their website (coalitionhealthcenter.org) for temporary, updated hours of operation.

- Extended Hours—The clinics are open for appointments 7:30 a.m. to 6:30 p.m., Monday–Friday and 8:00 a.m. to 2:00 p.m., Saturday.
- Walk-In Care—No appointment needed from 8:30 a.m. to 4:30 p.m., Monday–Friday for unexpected and sudden onset of illness or injury.
- Schedule Ahead—Whenever possible, make an appointment. Appointments are required for routine or preventive care. If you are unable to keep your scheduled appointment, you must cancel at least 24 hours in advance or a "no-show" fee will be assessed.
- Website—Schedule appointments online.

Coalition Health Center Locations
Website: coalitionhealthcenter.org

Anchorage CHC
Phone: (907) 264-1370
Address: Alaska Regional Hospital Campus,
2741 DeBarr Road, Suite C210, Anchorage

Fairbanks CHC
Phone: (907) 450-3300
Address: Ridgeview Business Park,
575 Riverstone Way, Unit 1
(near Parks Hwy. and Geist Rd. Intersection)

What is Teladoc?

You and your eligible dependents have access to a doctor by phone, online video or mobile app anytime—at no cost to you through Teladoc. Here's how to use it:

1 Set up a secure online account with your medical information in advance at teladoc.com or call toll-free 1-800-TELADOC (835-2362).

2 Then, when you have a minor illness (such as sinus problems, bronchitis, allergies, cold and flu symptoms, or respiratory or ear infection), request a doctor's visit by web, phone or mobile app.

3 A qualified doctor will contact you to diagnose your condition, recommend treatment and prescribe medication, if appropriate.

What is BridgeHealth?

This benefit gives you the option to have many non-urgent surgeries—like total hip or knee replacement, coronary artery bypass graft or spinal fusion—performed by top-rated surgeons in premier facilities across the country at no cost to you. Through BridgeHealth, the Health Plan:

- Pays for a second opinion, if you choose to get one

- Covers ALL costs for your surgery: You do not pay a deductible, copay or coinsurance for the surgery
- Pays for your travel expenses, including first-class airfare, lodging and food
- Pays the travel expenses for a companion (whom you choose) to go with you as your caregiver

When you have surgery done through BridgeHealth, you'll work with a Care Coordinator, who will guide you every step of the way by helping you understand your treatment options, choose a surgeon and facility, make your travel arrangements, and much more.

Upon your return home, the Health Trust covers follow-up care as a regular medical expense. You will pay your normal copay or coinsurance after you meet the annual deductible. This includes follow-up doctor visits, medications, tests, physical therapy, etc. To keep your out-of-pocket costs down, be sure to use PPOs within the Municipality of Anchorage.

If your doctor recommends surgery, contact BridgeHealth first to ask if it is a covered procedure.

- Your group code is PE71L
- Phone: 844-249-8108 (toll-free)
- Email: Alaskacoalition@bridgehealth.com
- Online: bridgehealth.com

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
- Surgery Center of Anchorage
- Anchorage Fracture and Orthopedic Clinic/ Alaska Medical Alliance (AFOC/AMA)

You do not have to use one of the PPO providers listed above when you seek services, but if you use another provider 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.

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.

How does the PPO work outside Alaska?

For services received outside of Alaska, Aetna is the Plan's PPO.

If you choose a non-Aetna PPO provider for care outside of Alaska, your out-of-pocket costs will be higher: the Plan's non-PPO provisions (deductible, reimbursement rate and out-of-pocket maximum) will apply.

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

Continued on page 11

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 Covered 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	$600/person $1,200/family	$1,200/person $2,400/family	$2,500/person $5,000/family	$5,000/person $10,000/family
Annual Out-of-Pocket Limit: the most you pay of the Covered Expenses, not including your deductible, after which the Plan pays 100%	$2,000/person $4,000/family	$4,000/person $8,000/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
Actual Amount Billed	$30,000	$30,000
Discount Amount	**$15,000**	**$0** (no PPO discount)
Allowed Amount	**$15,000**	**$15,000** (Non-PPO penalty reduces the allowed amount to the PPO allowed amount.)
Plan Payment	**$12,400** (80% of the allowed amount after the $600 deductible and until the $2000 out-of-pocket limit is reached; 100% thereafter)	**$9,800** (60% of the allowed amount after the $1,200 deductible and until the $4,000 non-PPO out-of-pocket limit is reached; 100% thereafter)
AMOUNT YOU PAY	**$2,600** (Allowed amount minus Plan payment)	**$20,200** (Billed amount minus Plan payment)

To locate an Aetna provider or facility, go to aetna.com. Click Log In/Register and follow the prompts. You can also search for providers on Aetna's public website at aetna.com/docfind. Select the "Aetna Choice POS II (OpenAccess)" network.

Tip: Since Aetna charges a discounted rate, you'll always save money for yourself and the Health Trust when you choose an Aetna provider. (You can use Aetna providers at home, too, although you won't pay a penalty if don't choose an Aetna provider within Alaska.)

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.

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 Zenith American Solutions. 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 covered 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.

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

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, 2020 and ending June 30, 2021. The election may be renewed for subsequent plan years.

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 medical and prescription out-of-pocket limit.

Why are generics low-cost?

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.

PRESCRIPTION DRUG PLAN BENEFIT OVERVIEW

	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 the Plan pays and You pay, based on the Plan's allowable expense	**Generic drugs:** Plan pays 90%—You Pay 10% up to $50 per prescription	
	Brand-name formulary: Plan pays 70%; You Pay 30% (plus $50 penalty if there is a generic equivalent available)	**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). Some medications may be excluded from coverage.	
	Specialty medications (30-day limit): Plan pays 90%; You pay 10% up to $200 per prescription	
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.

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

The Plan uses Caremark's Advance Control Formulary, with exclusions. This means that some medications may be excluded from coverage.

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 Caremark.com or Zenith American Solutions).

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.

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.

- You'll receive your prescription in the mail—and there is no charge for standard delivery.

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 Zenith American Solutions.

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 a 30-day supply and require prior authorization. For more information, and a list of covered specialty medications, contact Caremark (see contact information on the back cover).

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 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.

- 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 can submit your claim online: log in to vsp.com, click on Benefits & Claims, then click on Start New Claim. Complete the field and follow the prompts to upload your receipts. Or, you can submit a paper claim (see Key Contacts on the back cover).

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

Voluntary Benefits

What are Voluntary Benefits?*

These are options that help provide financial security for you and your family. As a Health Trust member, you may choose to participate in these programs:

- Member and Dependent Life Insurance
- Accidental Death and Dismemberment (AD&D) Insurance
- Short-Term Disability Insurance
- Long-Term Disability Insurance

**Note: Voluntary Benefits are only available to represented employees.*

- Flexible Spending Accounts (FSAs) (Health Care FSA and/or Dependent Care FSA)

NEW Life, AD&D, and Disability benefits are insured by The Hartford.

Voluntary Benefit premiums are taken out of your paycheck.

If you do not enroll in Voluntary Benefits at initial enrollment, you will have no coverage by default. If you are already enrolled in Voluntary Benefits, your current elections will roll over. Exception: you must enroll in the Flexible Spending Accounts each year. See page 19 for more details.

Do I need to choose a beneficiary?

Yes, you must choose a beneficiary if you enroll in Life or AD&D Insurance.

A beneficiary is the person(s) you choose who will receive benefits in the event of your death. This may be your husband or wife, your child or anyone you choose.

Simply fill out a Beneficiary Form when you first enroll or when you need to change a beneficiary.

Do I need to provide Evidence of Insurability?

Yes, in some cases, you will need to provide Evidence of Insurability to enroll in Voluntary Benefits. This simply means that you fill out a form that asks questions about your health. The insurance company then reviews the form before approving you for coverage.

You do not have to provide Evidence of Insurability when:

- You are a new employee enrolling in Voluntary Benefits for the first time. (You can enroll in up to $98,000 Member or $25,000 Spouse Dependent Life Insurance, AD&D and Disability coverage.)
- You enroll for the minimum $10,000 in Member Life or up to $25,000 spouse Dependent Life Insurance when you have a Qualifying Event. Coverage level is dependent upon event type.
- You increase Member or Dependent Life Insurance to the next coverage amount during Open Enrollment; for example, your current coverage is $10,000 and you enroll in $20,000. (Exception: if you are enrolled in $50,000 of Additional Member Life, and wish to increase to $100,000 of Additional Member Life, you must provide Evidence of Insurability.) The maximum amount of Dependent Life Insurance you can purchase without Evidence of Insurability is $25,000.
- You enroll in AD&D.

While the insurance company reviews your Evidence of Insurability form, the Trust will enroll you in the closest benefit that you can have without approval of insurability by the insurance company. If the insurance company approves your request, any additional benefit amount will begin on the first of the month following the date you are approved.

Life Insurance

Life insurance gives you and/or your family protection against financial loss when you or your covered family member dies. When you enroll, you choose a coverage amount; if the covered person dies, the insurance company pays the beneficiary that amount.

Life Insurance allows you to prepare financially for your family after your death and/or your spouse's death. Here are some reasons people have Life Insurance:

- Replace income for your family. Life Insurance can help you or your spouse with financial needs after the loss of one of your incomes.
- Pay final expenses. Life Insurance can pay funeral and burial costs, debts and other expenses.
- Create an inheritance. Even if you have no other assets to pass to your heirs, you and your spouse can create an inheritance by naming them as your Life Insurance beneficiaries.
- Pay taxes. Life Insurance benefits can pay estate taxes so that your heirs will not have to come up with these funds.

Member Life Insurance: What amounts can I choose from?

1. Member Life Insurance Options (Pretax)

- $10,000
- $20,000
- $30,000
- $40,000
- $48,000
- No coverage

2. Additional Member Life Insurance Options (After-Tax)

You must choose $48,000 in Pretax Member Life Insurance in order to select one of these After-Tax Member Life Insurance options:

- $25,000
- $50,000
- $100,000
- $150,000
- $200,000
- No additional coverage

Your After-Tax Member Life Insurance is added to your Pretax Member Life Insurance. The most you can have is $248,000 of Member Life Insurance: $48,000 Pretax and $200,000 After-Tax. (Participants over age 65 are not eligible for full coverage. Call Zenith American Solutions for specific details.)

Dependent Life Insurance: What amounts can I choose from?

All options provide $5,000 coverage for dependent children 6 months to 19 years (up to 25 for full-time students) and $100 coverage for dependent children age 14 days to 6 months. If you do not have a spouse and only want to cover your children, choose the lowest option.

1 Even if you do not sign up for any Pretax Member Life Insurance options, you may choose $10,000 of Dependent Life Insurance. ■ $10,000/spouse plus $5,000/child

2 You MUST sign up for $48,000 in Pretax Member Life Insurance in order to choose $25,000 of Dependent Life Insurance. ■ $25,000/spouse plus $5,000/child

3 You MUST sign up for at least $98,000 in Member Life Insurance ($48,000 Pretax and at least $50,000 After-Tax) in order to choose $50,000 of Dependent Life Insurance (this option requires Evidence of Insurability). ■ $50,000/spouse plus $5,000/child

4 You may also choose no Dependent Life Insurance. ■ No coverage

If you choose a Dependent Life Insurance option, but do not sign up for the required Member Life Insurance option, the Trust will enroll you in the closest benefit option for which you do qualify.

For example, if you choose $25,000 spouse/$5,000 child option, but you did not enroll in at least $48,000 in Member Life Insurance, the Trust will enroll you in the $10,000 spouse/$5,000 child option.

Can I enroll my dependents but not myself?

Yes, only if you elect $10,000 dependent life, however, if you want to elect more than $10,000 dependent life, you must first enroll in the required minimum amount of member Life Insurance (this rule also applies to adding additional member Life Insurance.)

How much does it cost?

Member and Dependent Life Insurance rates are based on the member's age; the premium amount deducted from your paycheck is listed on the enrollment form.

Do I earn a cash value?

No, this Life Insurance plan does not allow you to accrue a cash value.

Accidental Death & Dismemberment (AD&D) Insurance

This insurance gives your family protection against financial loss if you and/or a covered family member dies or is seriously injured as the result of an accident.

Accidental Death and Dismemberment (AD&D) insurance allows you to prepare financially for your family in the event of an accidental death. Here are some reasons people choose to enroll in AD&D Insurance:

- Add to Life Insurance coverage: In the event of accidental death, AD&D coverage is paid in addition to Life Insurance coverage.
- You have a high risk for injury: This coverage may make sense if you have a high risk for the covered injuries because of your work or outside activities.
- Financial protection: If while insured you are no longer able to perform your job due to an injury, this coverage can help you financially as you retrain for another line of work.

You may enroll in AD&D benefits without Evidence of Insurability.

When you enroll, you choose a coverage amount; in the event of a serious injury, the amount the insurance company pays depends on the severity of the injury as follows:

FOR THE LOSS OF...	THE PLAN PAYS...
Life	100%
Both eyes, feet, hands, or any combination	100%
One eye, one foot, or one hand	50%
Thumb and index finger of the same hand	25%
Hearing in both ears or loss of speech	50%

The benefit amount for a family member depends on your family status at the time of the loss. Benefits are reduced when the member reaches age 65 and dependents age 65 or over are not eligible.

What coverage amounts can I choose from?

- Low Option Employee Only
  - $100,000 Employee
- Low Option Employee + Family
  - $100,000 Employee + $40,000 Spouse + $10,000 Child or
  - $100,000 Employee + $50,000 Spouse or
  - $100,000 Employee + $15,000 Child
- High Option Employee Only
  - $150,000 Employee
- High Option Employee + Family
  - $150,000 Employee + $60,000 Spouse + $15,000 Child or
  - $150,000 Employee + $75,000 Spouse or
  - $150,000 Employee + $22,500 Child

  - No coverage

For the family plans, the spouse and child benefits depend on the family status at the time of loss.

How are premiums paid?

AD&D premiums are paid on a pretax basis.

Short-Term Disability Insurance

Short-Term Disability can help replace a portion of your income when you are temporarily sick or injured.

Short-Term Disability Insurance can help you meet your financial needs if you become unable to work. One reason why people choose to enroll in Short-Term Disability Insurance is:

- To offset lost income: Short-Term Disability provides a small income that can help you pay bills in the event of unexpected events such as illness, complications during pregnancy or recovery from surgery.

How does it work?

If you become disabled (due to a non-occupationally related accident, illness or other physical problem) and cannot do your job, Short-Term Disability pays a weekly amount.

- First you must use all of your paid leave: Sick Pay, Vacation Pay and Personal Holiday Pay.
- Payments begin after you have been disabled (unable to do your job) for 30 days.
- You continue to receive weekly payments for up to 26 weeks from the date your disability began.
- These benefits are reduced by income from other sources, such as accumulated or donated leave, Workers' Compensation, Maintenance and Cure, retirement such as PERS disability benefits, Social Security, etc.

What amounts can I choose from?

- $250 a week
- No coverage

Long-Term Disability Insurance

Long-Term Disability Insurance pays a percentage of your income if you become disabled due to illness or injury.

Long-Term Disability Insurance can help you meet your financial needs if you become unable to work. Here are some reasons why people choose to enroll in Long-Term Disability Insurance:

- As a primary income replacement plan: This coverage is an ideal way to protect your income if you become disabled.
- To supplement other sources of income: In the event of disability, your other sources of income, such as a retirement plan, savings, private insurance or Workers' Compensation may not cover your financial needs.

How does it work?

If you are disabled (due to an accident, illness or other physical problem) for 180 days and cannot do your job, Long-Term Disability pays you a monthly benefit:

- As long as you are disabled, or
- Up to age 65 if you are disabled before age 60, or
- From one to four years if you are disabled after age 60
- For the first 24 months, benefits are paid if you have a loss of earnings because you are disabled and unable to perform your own occupation. After 24 months of long-term disability payments, in order to continue receiving benefits you must be unable to perform the duties of any occupation for which you are qualified or may become qualified.
- These benefits are reduced by income from other sources, such as accumulated or donated leave, Workers' Compensation, Maintenance and Cure, retirement such as PERS disability benefits, Social Security, etc.

What if I have a preexisting condition?

For the first 12 months after Long-Term Disability coverage becomes effective, a preexisting condition limit applies. This limits coverage for an illness or injury diagnosed, treated, or for which you have been taking medication in the three months before your coverage began.

No benefits are payable if you are disabled by a preexisting condition during the first 12 months of Long-Term Disability coverage.

What amounts can I choose from?

- 50% of your monthly base pay* up to a maximum monthly benefit of $5,000
- 70% of your monthly base pay* up to a maximum monthly benefit of $5,000
- No coverage

*Monthly base pay is your monthly wage, excluding overtime, shift pay, etc.

Choose how you pay

You must elect pretax OR after-tax; DO NOT choose both.

- Pretax means your monthly premium is deducted before taxes are taken out of your paycheck. However, you will have to pay taxes on any benefits you receive.
- After-Tax means your monthly premium is deducted after taxes are taken out of your paycheck. However, you will not have to pay taxes on any benefits you receive.

Federal tax laws are complicated and subject to change, so please review this option carefully and consult with your tax adviser before making a selection.

Flexible Spending Accounts

One of the best ways you can save money is by taking advantage of a Flexible Spending Account (FSA). An FSA reduces your taxable income by the amount you put into it so you can save money by paying less in payroll taxes.

There are two kinds of FSAs; you may enroll in either, both or none:

1 Use a Health Care FSA to pay for eligible health care expenses for you and/or your dependents (see page 20).

2 Use a Dependent Care FSA to pay for eligible dependent care/daycare expenses, such as child care while you work (see page 22). Note: **The Dependent Care FSA is NOT for use to obtain HEALTH care reimbursements for your spouse or other dependents.** Its primary use is for "daycare expenses".

Note: If you elected one of the Yellow Plans you automatically have a Health Reimbursement Arrangement (HRA). If you also elected a Health Care FSA, you must use your annual FSA amount before the HRA reimburses your eligible expenses.

How does an FSA reduce my taxes?

The key feature of an FSA is that it reduces your taxable income. You set aside part of your pay (you determine how much) before taxes are withheld from your paycheck.

As a result, your taxes are calculated on a smaller amount. Electing an FSA allows you to reduce your taxes and increase your net pay (sometimes by hundreds of dollars each year).

The example shown below assumes your income is $45,000 a year and you have $2,750 in eligible expenses during the year. With an FSA, your net pay for the year increases by $330!

FLEXIBLE SPENDING ACCOUNTS (FSA)

	WITH AN FSA	WITHOUT AN FSA
Annual Income	$45,000	$45,000
Your FSA Contributions	$2,750	$0
Taxable Income	$42,250	$45,000
Estimated Taxes*	$3,247	$3,577
After-tax Expenses	$0	$2,750
Net Pay (after eligible expenses)	$39,003	$38,673
Savings	$330	$0

*Using the 2020 Federal Tax Table—Married, Filing Jointly.

How does an FSA work?

It's like a checking account; you put money into it, then use that money to pay for eligible expenses.

1 You decide how much to put into your FSA every month (see details on following pages).

2 You pay for eligible expenses as they happen.

3 When you have an eligible expense, you have two options; manually complete an FSA claim form, attach your receipt and mail it to Zenith American Solutions, or logon to Zenith's website at: https://zenith-americansea.lh1ondemand.com/. Note: If you have no other insurance, the Trust provides you the option of automatic reimbursement. Contact the Zenith FSA Department for more information.

4 You get reimbursed from your own FSA.

Do I have to use my FSA money by a certain deadline?

Yes. You may incur eligible expenses up to two and a half months past the end of the Plan Year (until September 15). And then, you have four and a half months past the end of the Plan Year (by November 15) to submit your reimbursement claims.

The IRS has a "Use it or Lose it" rule that requires you to forfeit any money left in your account each Plan Year after the reimbursement deadline. All forfeited money belongs to the Public Employees Local 71 Health Trust. Contact Zenith's FSA Department for a list of IRS allowable expenses to help you prevent forfeiture of your FSA dollars.

Do I have to re-enroll every year during Open Enrollment?

Yes, even if you have an FSA for the current Plan Year, you MUST enroll every Plan Year to have an FSA in the next Plan Year. (You CANNOT roll over your FSA enrollment like other Voluntary Benefits).

Health Care FSA

You may use a Health Care FSA to pay for eligible health care expenses for you and/or your eligible dependents with tax-free dollars.

How do I get started with a Health Care FSA?

1 Estimate your expected health care eligible expenses carefully.

- Use the worksheet on page 21 to help you determine you (and your dependents') annual health care expenses for the Plan Year: July 1 through June 30. Do not include anything that is covered by other health insurance.
- Generally, eligible expenses are medically necessary out-of-pocket costs that your Health Plan does not cover (see examples below).

2 Decide how much you want to contribute to your Health Care FSA each month.

- The minimum is $20 per month ($240 per year), and the maximum is $229 per month ($2,750 per year).
- The amount you choose will be deducted directly from your paycheck before taxes are withheld, and put into your Health Care FSA.
- Remember, you cannot use money in your Health Care FSA to pay for eligible expenses from your Dependent Care FSA and vice versa, and you cannot transfer money between the accounts.

What are eligible expenses?

You can use your Health Care FSA for most medically necessary expenses as long as they are not covered by any health plan, for example:

- Annual deductible
- Copays (the dollar amount you pay when you receive services)
- Coinsurance (the percentage you pay for covered services)
- Non-PPO penalties
- Transportation to and from your health care provider
- Chiropractic, acupuncture and alternative health care provided by a licensed practitioner
- Medical equipment prescribed by a doctor
- Physical, occupational or speech therapy by a licensed therapist
- Ambulance fees
- Prescription copays and coinsurance
- Over-the-counter drugs or medications without a doctor's prescription, such as, pain relievers, cold and allergy medication, smoking cessation products, etc.
- Over-the-counter items in these eligible categories: bandages and wraps, menstrual supplies, birth control, braces and supports, catheters, contact lens supplies, denture adhesive, diagnostic tests and monitors, first-aid supplies, Insulin and diabetes supplies, ostomy products, reading glasses, wheelchairs, walkers and canes

HEALTH CARE EXPENSES WORKSHEET

Use this worksheet to estimate your eligible health care expenses for the upcoming Plan Year.

	PROJECTED PLAN YEAR EXPENSES
MEDICAL	
Annual deductible	
Coinsurance	
Services the Health Plan does not cover, such as those listed on page 20	
MEDICATIONS	
Prescription copays and coinsurance	
Over-the-counter drugs or medications without a doctor's prescription	
Over-the-counter items in eligible categories (see page 20)	
DENTAL	
Annual deductible	
Coinsurance for general and major services	
Orthodontia	
VISION	
Costs exceeding benefit coverage for exams, eyeglasses or contacts	
ANNUAL TOTAL (sum of above)	
YOUR MONTHLY CONTRIBUTION	
Divide your annual total by 12 (the number of monthly paycheck deductions)	

- Dental fees
- Orthodontia
- Vision exams, eyeglasses and contacts
- Radial Keratotomy/LASIK eye surgery
- Nursing service from a registered nurse or licensed practical nurse for medical care
- Psychologist—for services within scope of license

Examples of expenses that are not eligible for reimbursement:

- Monthly employee contributions toward your Health Plan
- Expenses reimbursed under any health plan
- Medical services that are not medically necessary
- Cosmetic surgery, supplies or treatment (unless medically necessary due to an injury, disease or birth defect)
- Health club dues and fees
- Teeth bleaching

Where can I get more information about eligible expenses?

Log on to Zenith American Solutions at zenith-americansea.lh1ondemand.com, then click "Which Expenses Qualify," or call the Zenith American Solutions FSA department at 800-757-0071 Option 2 or 800-426-5980, ask for FSA Department (both phone numbers are toll-free).

To protect the Plan's qualified tax-exempt status, the Trust will make the final determination on eligibility of an expense and/or provider requirements. If you have a question about whether or not a particular expense is eligible, call Zenith American Solutions at the numbers listed above.

Could a federal income tax deduction be better for me?

You may be able to take a tax deduction for eligible medical expenses on your federal income tax return. The deduction, however, is available only for expenses that total more than 7.5 percent of your adjusted gross income. The deduction is not available for expenses reimbursed through the FSA. For help determining which approach may be better for you, you may want to consult a professional tax advisor.

Dependent Care FSA

You may use this FSA to pay for eligible childcare/dependent care expenses with tax-free dollars. Do not confuse this FSA with the Health Care FSA. Dependent Care FSA's do not include dependent health care expenses. For dependent health care expenses, you must use the Health Care FSA benefit previously described.

How do I get started with a Dependent Care FSA?

1 Estimate your eligible childcare/dependent care expenses for the Plan Year: July 1–June 30.

- Generally, eligible expenses are childcare/dependent care expenses that allow you and your spouse to work.
- If your spouse is not working, you cannot be reimbursed for eligible expenses unless your spouse is a full-time student or mentally/physically incapable of self-care or caring for your dependents.

2 Decide how much you want to contribute to your Dependent Care FSA each month.

- The minimum is $25 per month ($300 per year), and the maximum is $416 per month ($5,000 per year), if you're single or married and file a joint tax return. (The maximum may be lower if you are married but file separate returns, or if your spouse is a full-time student or disabled.)
- The amount you choose will be deducted directly from your paycheck before taxes are withheld, and put into your Dependent Care FSA.

What dependents are eligible?

You may use your Dependent Care FSA to pay for:

- Childcare for dependent children age 12 and under, or
- Dependent care for adults, such as a parent or grandparent
- Care for dependents older than age 12, as long as your dependent meets all of these requirements:
  - Is physically or mentally unable to care for himself or herself
  - Spends at least 8 hours a day in your home
  - Depends on you for support
  - Is listed as a dependent on your federal income tax return

What providers may I use?

You may use your Dependent Care FSA to pay:

- Childcare or dependent care centers (must comply with all State and local laws)
- Services by individuals (including relatives, as long as they are over age 19 and not your dependents)
- Education institution for preschool children or expenses for non-school care are eligible

When submitting a claim to your Dependent Care FSA, you must include the care provider's tax identification number or Social Security number.

Where can I get more information about eligible dependents and providers?

Log on to Zenith American Solutions at zenith-americansea.lh1ondemand.com, then click "Which Expenses Qualify," or call the Zenith American Solutions FSA department at 800-757-0071 Option 2 or 800-426-5980, ask for FSA Department (both phone numbers are toll-free).

Could a federal income tax credit be better for me?

The federal tax credit for dependent care may offer you greater tax savings than an FSA. You cannot claim FSA-reimbursed expenses as a tax credit. Generally, if your household income is $28,000 or less, the tax credit is a better choice. Consult with a tax advisor to make the best choice for your family.

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. To obtain a copy:

- Go to the union website: local71.com, click Benefits, then choose Trust Forms, or
- Contact Zenith American Solutions (see contact information on the back cover)

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 file a claim for Voluntary Benefits?

Contact Zenith American Solutions as soon as reasonably possible (see the back cover for phone numbers).

How do I turn in claims for my Flexible Spending Account?

1 Log on to Zenith's website at zenith-americansea.lh1ondemand.com, select submit new claim and follow the instructions; or

2 Request an FSA claim form from Zenith American Solutions, or on the union website at local71.com under the Health Trust button.

3 Fill it out, sign it and attach your receipt.

4 Mail or upload your claim to Zenith American Solutions (see the back cover for mailing address).

5 Submit claims as soon as possible and no later than four and a half months past the end of the Plan Year (by November 15).

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.

Notes

Key Contacts

IF YOU HAVE QUESTIONS ABOUT THESE TOPICS...	HERE'S WHERE TO GET INFORMATION...
Claims Administration • Eligibility and enrollment • Open Enrollment • Medical/Dental coverage and claims • Travel preauthorization • COBRA/HIPAA • Flexible Spending Accounts (FSA) • Health Reimbursement Arrangement (HRA)	**Zenith American Solutions** 111 West Cataldo Ave., Suite 220, Spokane, WA 99201-3201 **Phone:** Claims: 800-557-8701, option 2, then 2 (toll-free) **Fax:** Claims: 206-282-0775 **Fax:** Eligibility/Enrollment: 509-534-5910 **Website:** zenith-american.com Login to view your claims information. **COBRA/HIPAA:** 800-757-0071, Option 1 or 800-426-5980, ask for COBRA Department (toll-free numbers)
General Trust Questions • Open Enrollment (general questions) • Understanding your benefit coverage	**Trust Administrative Office—Public Employees Local 71 Trust Fund** 2510 Arctic Blvd., Anchorage, AK 99503 **Phone:** In Anchorage 276-7611; Outside Anchorage 800-446-3671 (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 79996-1106
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 • Preventive Care • Routine Care • Treatment for illness or injury	**Coalition Health Centers** **Website:** coalitionhealthcenter.org • **Anchorage:** 2741 DeBarr Road, Suite C210 • Phone: 907-264-1370 • **Fairbanks:** 575 Riverstone Way, Unit 1 • Phone: 907-450-3300
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 385018, Birmingham, AL 35238-5018 **Phone:** 800-877-7195 (toll-free) **Website:** vsp.com
Nationwide PPO network • Locate an Aetna network provider	**Aetna** **Website:** aetna.com To locate an Aetna provider or facility, go to aetna. com. Click Log In/Register and follow the prompts. You can also search for providers on Aetna's public website at aetna.com/docfind. Select the "Aetna Choice POS II (OpenAccess)" network.
Disease Management • Get program information	**Optum** **Phone:** 855-738-1764 (toll-free) **Nurse Connections:** 866-676-0740 (toll-free) **Website:** pe71.optum.com
Access a Healthcare Provider • By phone, online video or mobile app	**Teladoc** **Phone:** 800-TELADOC (toll free) **Website:** Teladoc.com
Surgery Options Care Coordinator • Talk to a Care Coordinator about surgery options	**BridgeHealth** **Group Code:** PE71L **Phone:** 844-249-8108 **Email:** alaskacoalition@bridgehealth.com **Website:** bridgehealth.com