AlaskaCare

Retiree Health Plan

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Retiree Insurance Information Booklet

September 2018

AlaskaCare

Retiree Health Plan

Retiree Insurance Information Booklet

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Contact Information

AlaskaCare Plan Administrator

Telephone Numbers

State of Alaska, Division of Retirement and Benefits

Toll Free .....(800) 821-2251

In Juneau .....(907) 465-4460

TDD for hearing impaired .....(907) 465-2805

Mailing Address

State of Alaska
Division of Retirement and Benefits
P.O. Box 110203
Juneau, AK 99811-0203

Physical Address

333 Willoughby Avenue, 6th Floor
Juneau, AK 99801

Websites

AlaskaCare Health Plans

AlaskaCare.gov

Division of Retirement and Benefits

alaska.gov/drb

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The Alaska Department of Administration complies with Title II of the Americans with Disabilities Act (ADA) of 1990. This publication is available in alternative communication formats upon request. To make necessary arrangements, contact the ADA Coordinator for the Division of Retirement and Benefits at (907) 465-4460 or contact the TDD for the hearing impaired at (907) 465-2805.

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AlaskaCare Claim Administrator

Claims Mailing Addresses

Health claims, including medical, dental, vision, audio, and pharmacy are filed with the claims administrator:

Aetna Medical
P.O. Box 981106
El Paso, TX 79998-1106

Aetna Pharmacy
Attention: Claim Processing
P.O. Box 52444
Phoenix, AZ 85072-2444

Moda Health/Delta Dental of Alaska
P.O. Box 40384
Portland, Oregon 97240-0384

Long Term Care – CHCS Services, Inc.
P.O. Box 13431
Pensacola,FL 32591-3431

Telephone Numbers

Aetna Concierge ..... (855) 784-8646
TDD for hearing impaired ..... (800) 628-3323
Fax (for medical claims) ..... (859) 455-8650

24-Hour Nurse Line ..... (800) 556-1555
TDD/TTY ..... Dial 771

Moda Health/Delta Dental of Alaska ..... (855) 718-1768
TDD/TTY ..... Dial 771

Long Term Care – CHCS Services, Inc. ..... (888) 287-7116
Fax ..... (866) 383-5821

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Aetna
In Anchorage
4341 B Street, Suite 403
Anchorage, AK 99503

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Juneau, AK 99801

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Anchorage, AK 99501

DRAFT

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DRAFT

TABLE OF CONTENTS

HEALTH PLAN

1. BENEFIT SUMMARY

1.1. Medical Benefits 1

1.2. Prescription Drug Schedule 4

1.3. Dental Benefit Schedule (if elected) 4

1.4. Vision Benefit Schedule (if elected) 5

1.5. Audio Benefit Schedule (if elected) 5

2. MEDICAL PLAN COVERAGE

2.1. INTRODUCTION 7

2.2. WHO IS COVERED 7
2.2.1. Benefit Recipients 7
2.2.2. Dependents 8

2.3. HOW TO ELECT COVERAGE 10

2.4. CHANGING YOUR DEPENDENT COVERAGE 11

2.5. WHEN MEDICAL COVERAGE STARTS 12
2.5.1. New Benefit Recipients 12
2.5.2. Open Enrollment 12

DRAFT

2.5.3. Marine Engineers Beneficial Association Members . 12
2.5.4. Alternate Payee 13
2.5.5. Dependents 13

2.6. WHEN MEDICAL COVERAGE ENDS 13
2.6.1. Ineligible Retirees 13
2.6.2. Failure to Pay Premium 14
2.6.3. Dependents 14
2.6.4. Discontinuation of Coverage 14

3. MEDICAL PLAN

3.1. HOW MEDICAL BENEFITS ARE PAID 15
3.1.1. Benefit Year 15
3.1.2. Deductibles 15
3.1.3. Coinsurance 16
3.1.4 Recognized Charge 16
3.1.5. Lifetime Maximum 19
3.1.6. Pre-existing Conditions Limitation 19
3.1.7. Effect of Medicare 20

3.2. PRECERTIFICATION 21
3.2.1. The Precertification Process 22
3.2.2. Services Requiring Precertification 23
3.2.3. How Failure to Precertify Affects Your Benefits .. 25

3.3. COVERED MEDICAL EXPENSES 26
3.3.1. Medically Necessary Services and Supplies 28
3.3.2. Taxes 29
3.3.3. Provider Services 30
3.3.4. Nurse Advice Line 31
3.3.5. Hospitalization 31
3.3.6. Home Health Care 32
3.3.7. Hospice Services 34
3.3.8. Skilled Nursing Care 36

DRAFT

3.3.9. Skilled Nursing Facility.....38
3.3.10. Retiree-elected Second Opinions.....39

3.3.11. Radiation, X-rays, and Laboratory Tests 40
3.3.12. Rehabilitative Care 41
3.3.13. Outpatient Preoperative Testing.....42
3.3.14. Outpatient Ambulatory Surgery 43
3.3.15. Anesthetic 43
3.3.16. Pregnancy 43
3.3.17. Durable Medical Equipment/Supplies.....44
3.3.18. Travel 46
Emergencies.....47
Treatment Not Available Locally.....47
Second Surgical Opinions 48
Surgery In Other Locations 49
3.3.19. Mental Disorder and Chemical Dependency Treatment..... 49
Mental Disorders..... 49
Chemical Dependency 50
3.3.20. Medical Treatment of Mouth, Jaws, and Teeth 50
3.3.21. Treatment of Obesity..... 51
Medical Treatment 51
Surgical Treatment 52
Limitations 53
3.3.22. Plastic, Cosmetic, and Reconstructive Surgery 53
3.3.23. Mastectomy/Breast Reconstruction.....53
3.3.24. Transplant Services.....54
Covered Expenses.....54
Network Level of Benefits 55
Levels of Transplant Care.....56
Limitations.....57
Network of Transplant Facilities 58

DRAFT

3.4. PRESCRIPTION DRUGS 58
3.4.1. Card Program 59
3.4.2. Mail Order Program 59
3.4.3. Definitions 60
3.4.4. Exclusions 61

3.5. MEDICAL EXPENSES NOT COVERED 62
3.5.1. Limitations and Exclusions 62

3.6. INDIVIDUAL CASE MANAGEMENT 68

DENTAL-VISION-AUDIO (DVA) PLAN

4.1. INTRODUCTION 70

4.2. WHO MAY BE COVERED AND PREMIUM PAYMENT . 70
4.2.1. Benefit Recipients 70
4.2.2. Dependents 71

4.3. HOW TO ELECT COVERAGE 72

4.4. WHEN DVA COVERAGE STARTS 73
4.4.1. New Benefit Recipients 73
4.4.2. Open Enrollees 74
4.4.3. Marine Engineers Beneficial Association Members . 74
4.4.4. Dependents 74

4.5. WHEN DVA COVERAGE ENDS 74
4.5.1. Failure to Pay Premium 75
4.5.2. Ineligible Retirees 75
4.5.3. Discontinuance of Coverage 75
4.5.4. Dependents 75

DRAFT

4.6. CHANGING YOUR DVA COVERAGE 76

5. DENTAL BENEFITS

5.1. HOW DENTAL BENEFITS ARE PAID..... 78
5.1.1. Benefit Year.....78
5.1.2. Annual Maximum Benefit 78
5.1.3. Deductible.....78
5.1.4. Recognized Charge.....78

5.2. COVERED DENTAL SERVICES.....79
5.2.1. Class I Preventive Services 80
5.2.2. Class II Restorative Services.....81
5.2.3. Class III Prosthetic Services 83
5.2.4. General Limitations 87
5.2.5. Oral Health, Total Health Program and Benefits 87Diabetics 87
Pregnant Persons 87

6. VISION AND OPTICAL BENEFITS

6.1. HOW VISION BENEFITS ARE PAID 89
6.1.1. Benefit Year.....89
6.1.2. Deductible.....89
6.1.3. Coinsurance 89
6.1.4. Recognized Charge.....90

6.2. COVERED VISION AND OPTICAL SERVICES.....90

6.3. VISION AND OPTICAL SERVICES NOT COVERED...91

7. AUDIO BENEFITS

7.1. HOW THE AUDIO BENEFITS ARE PAID 94
7.1.1. Benefit Year.....94

DRAFT

7.1.2. Maximum Benefit 94
7.1.3. Deductible 94
7.1.4. Coinsurance 94
7.1.5. Recognized Charge 95
7.2. COVERED AUDIO SERVICES 95
7.3. AUDIO SERVICES NOT COVERED 96

HOW TO FILE A CLAIM

8.1. CLAIM FILING DEADLINE 99
8.2. HOSPITAL SERVICES 99
8.3. PHYSICIAN AND OTHER PROVIDER SERVICES 99
8.4. DENTAL SERVICES 100
8.5. VISION SERVICES 100
8.6. AUDIO SERVICES 100
8.7. PRESCRIPTION DRUGS 100
8.8. MEDICAL BENEFITS 100
8.9. OTHER CLAIM FILING TIPS 102
8.10. BENEFIT PAYMENTS 103
8.11. BEFORE FILING A CLAIM 103
8.12. RECORDKEEPING 104
8.13. PHYSICAL EXAMINATIONS 104
8.14. APPEALS 104

DRAFT

8.14.1. If a Claim is Denied 104
8.14.2. Initial Claim for Health Plan Benefits 104
8.14.3. Initial Review of Health Plan Claims 105
8.14.4. Initial Denial of Health Plan Claims.....106
8.14.5. Ongoing Treatments.....108
8.14.6. First Level Appeal of Health Plan Claim Denial .108
8.14.7. Decision on First Level of Appeal of Health Plan Claim Denial 109
8.14.8. Second Level Appeal of Denial of Claim 111
8.14.9. Decision on Second Level Appeal of Denial of Claim 111
8.14.10. Application and Scope of External Review Process for Benefits Under the Health Plan.....112
8.14.11. Standard External Review Process for Claims for Benefits under the Health Plan.....112
8.14.12. Expedited External Review Process for Health Plan 116
8.14.13. Third Level – Division of Retirement and Benefits Appeal 117
8.14.14. Fourth Level – Office of Administrative Hearings Appeal 118

CONTINUED HEALTH COVERAGE

9.1. LENGTH OF COVERAGE..... 122
Ineligibility for Retirement Benefits..... 122
Dependents 122
Disabled Employees and Dependents 122

9.2. ELECTING COVERAGE..... 123

9.3. PREMIUM PAYMENT.....123

DRAFT

9.4. WHEN CONTINUATION ENDS 123

9.5. DISABLED RETIREES OR DEPENDENTS..... 124

GENERAL PROVISIONS

10.1. COORDINATION OF BENEFITS..... 126
10.1.1. How Benefits are Coordinated When a Claim is Made 127
10.1.2.Determining Order of Payment 128

10.2. REIMBURSEMENT PROVISION..... 130

10.3. ACCESS TO RECORDS..... 130

10.4. APPLICABLE LAW AND VENUE..... 130

10.5. CHANGES TO PLAN 131

10.6. CONTRACT LIABILITY..... 131

10.7. FACILITY OF PAYMENT 131

10.8. FREE CHOICE OF HOSPITAL AND PROVIDER..... 132

10.9. NOTICE 132

10.10. PLAN MUST BE EFFECTIVE 133

10.11. LEGAL ACTION..... 133

10.12. MEDICAL OUTCOMES..... 133

10.13. PREMIUMS..... 133

10.14. RIGHT OF RECOVERY 134

DRAFT

10.15. RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION 134

10.16. TRANSFER OF BENEFITS, ASSIGNMENT, GARNISHMENT, AND ATTACHMENT 134

10.17. VESTED RIGHTS 135

GROUP LIFE INSURANCE PLAN

11.1. INTRODUCTION 136

11.2. WHO MAY BE COVERED 136
11.2.1. Benefit Recipients 136
11.2.3. Dependents 137

11.3. HOW TO ELECT COVERAGE 137

11.4. PREMIUMS 137

11.5. WHEN LIFE COVERAGE STARTS 138

11.6. WHEN LIFE COVERAGE ENDS 138
11.6.1. Failure to Pay Premium 138
11.6.2. Plan Discontinued 138
11.6.3 Dependents 138

11.7. AMOUNT OF COVERAGE 139
11.7.1 Benefit Recipients 139

12. GENERAL GROUP LIFE PROVISIONS

12.1.APPLICABLE LAW AND VENUE 140

DRAFT

12.2. ASSIGNMENT 140

12.3. BENEFICIARY 140

12.4. CANCELLATION 141

12.5. CLERICAL ERROR 141

12.6. CONVERSION PRIVILEGE.....142

12.7. ENTIRE CONTRACT 143

12.8. FACILITY OF PAYMENT 143

12.9. INCONTESTABILITY 144

12.10. MISSTATEMENT OF AGE 144

12.11. NOTICE OF DEATH.....144

12.12. PAYMENT OF CLAIMS 144

12.13. RIGHT OF EXAMINATION.....145

12.14. WAIVER OF PREMIUM WITH
PERMANENT TOTAL DISABILITY 145

DRAFT

1. HEALTH PLAN

BENEFIT SUMMARY

This information is only intended to be a summary of coverages provided. Please refer to the booklet for additional information or exclusions.

1.1. Medical Benefits

Deductibles	
Annual individual deductible	$150
Annual family unit deductible	3 per family
Coinsurance	
Most medical expenses	80%
Most medical expenses after out-of-pocket limit is satisfied	100%
Second surgical opinions • No deductible applies	100%
Preoperative testing • No deductible applies	100%
Outpatient testing/surgery • No deductible applies	100%
Skilled nursing facility	100%
In-patient mental disorder treatment without precertification	50%

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Transplant services at an Institute of Excellence™ (IOE) facility	80%
Transplant services at a non-Institute of Excellence™ (IOE) facility or when out-of-network provider is used	60%
Out-of-Pocket Limit	
Annual individual out-of-pocket limit • Applies after the deductible is satisfied • Expenses paid at a coinsurance rate different than 80% do not apply against the out-of-pocket limit	$800
Benefit Maximums	
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	$2,000,000
Individual limit per benefit year on substance abuse treatment without precertification. *Subject to change every three years.*	$12,715
Individual lifetime maximum on substance abuse treatment without precertification. *Subject to change every three years.*	$25,430
Limit on travel for transplant services	$10,000 per transplant occurrence
Travel benefits without precertification	No benefits will be paid

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Visit Limits	
Home health care.	120 visits per benefit year Up to 4 hours = 1 visit
Outpatient hospice expenses	Up to 8 hours per day
Cognitive therapy, physical therapy, occupational therapy, and speech therapy rehabilitation benefits	No more than 2 hours of combined therapy in a 24 hour period
Travel Benefits: Therapeutic treatments	one visit and one follow-up per benefit year
Travel Benefits: • Prenatal/postnatal maternity care • Maternity delivery • Presurgical or postsurgical • Surgical procedure	one visit per benefit year
Travel Limitations	
Non-overnight stay traveling expenses	$31/day
Overnight lodging	$80/night
Overnight lodging (Transplants)	$50/person/night $100/night maximum
Companion expenses	$31/night
Precertification Penalties	
A $400 benefit reduction applies if you fail to obtain precertification for certain medical services.	

1.2. Prescription Drug Schedule

	Generic up to 90 Day or 100 Unit Supply	Brand Name up to 90 Day or 100 Unit Supply
Network pharmacy copayment	$4	$8
Mail order copayment	$0	$0
Supply Limit		
Depo-Provera (injectable contraceptive)	5 vials per benefit year	

1.3. Dental Benefit Schedule (if elected)

Deductibles	
Annual individual deductible • Applies to Class II (restorative) and Class III (prosthetic) services	$50
Coinsurance	
Class I (preventive) services	100%
Class II (restorative) services	80%
Class III (prosthetic) services	50%
Benefit Maximums	
Annual individual maximum	$2,000

DRAFT

1.4. Vision Benefit Schedule (if elected)

Coinsurance	
All services	80%
Benefit Maximums	
Examinations	one per benefit year
Lenses	two per benefit year
Frames	one set every two benefit years
Aphakic and contact lens lifetime maximum	$400

1.5. Audio Benefit Schedule (if elected)

Coinsurance	
All services	80%
Benefit Maximums	
Individual limit • Maximum applies to a rolling 36 month period	$2,000

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MEDICAL PLAN COVERAGE

2.1. INTRODUCTION

The State of Alaska retirement systems provide extensive and valuable benefits for you and your family including hospitalization, medical, surgical, maternity care, and other services necessary for the diagnosis and treatment of an injury or disease. Your health care coverage is good worldwide. These benefits may change from time to time. You should ensure that you have the current booklet by contacting the Division of Retirement and Benefits.

2.2. WHO IS COVERED

2.2.1. Benefit Recipients

Except as provided below the plan covers, automatically at no cost, eligible benefit recipients of the Public Employees' Retirement System (PERS), and the Teachers' Retirement System (TRS), who were first hired under the PERS or TRS prior to July 1, 2006. Except as provided below the plan also covers, automatically at no cost, eligible benefit recipients of the Elected Public Officers Retirement System, and the Judicial Retirement System, as well as benefit recipients of the Marine Engineers Beneficial Association who retired from the State of Alaska after July 1, 1986.

The following must elect coverage and pay a premium:

- Benefit recipients of the Public Employees' Retirement System (PERS) if they were first hired under the PERS on or after July 1, 1986, who are under age 60 and are not receiving a disability benefit.

DRAFT

- Benefit recipients of the Teachers' Retirement System (TRS) if they were first hired under the TRS on or after July 1, 1990, who are under age 60 and are not receiving a disability benefit.

- Benefit recipients of the Public Employees' Retirement System (PERS) if they were first hired under the PERS on or after July 1, 1996, are age 60 or older and who do not have at least 10 years of credited service.

- Benefit recipients under a Qualified Domestic Relations Order (alternate payee). Premium payments made by an alternate payee must be made directly to the third-party administrator.

If coverage is elected, the premiums are paid by deductions from your retirement check. If the retirement check is insufficient to permit the deduction of the full monthly premium, the premium must be made directly to the third-party administrator.

Enrollment periods are described on page 10.

2.2.2. Dependents

The following dependents may be covered:

- Your spouse. You may be legally separated but not divorced.

- Grandfathered same-sex partners as defined and documented by 2 AAC 38.010 – 2 AAC 38.100.

- Your children from birth (exclusive of hospital nursery charges at birth and well-baby care) up to 23 years of age *only* if they are:

  — Your natural children, stepchildren, children of your grandfathered same-sex partner as defined and documented by 2 AAC 38.01 – 2 AAC 38.100, foster children placed through a State foster child program,

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legally adopted children, children in your physical custody and for whom bona fide adoption proceedings are underway, or children for whom you are the legal, court-appointed guardian;

— Unmarried and chiefly dependent upon you for support; and

— Living with you in a normal parent-child relationship.

- This provision is waived for natural/adopted children of the benefit recipient who are living with a divorced spouse, assuming all other criteria are met.

- Only stepchildren living with the retiree more than 50% of the time are covered under this plan.

Children incapable of employment because of a mental or physical incapacity are covered even if they are past age 23. However, the incapacity must have existed before age 23 and the children must continue to meet all other eligibility criteria. You must furnish the Division evidence of the incapacity, proof that the incapacity existed before age 23 and proof of financial dependency. This proof must be provided no later than 60 days after their 23rd birthday or after the effective date of your retirement, whichever is later. Children are covered as long as the incapacity exists, they meet the definition of children except for age, and you continue to provide periodic proof of the continued incapacity as required.

IMPORTANT NOTICE:
In accordance with Alaska Statutes 39.35.680(12) and 14.25.220(13):

- If your dependent child is under 23 years old, they are required to be registered at and attending on a full-time basis an accredited educational or technical institution recognized by the Department of Education and Early Development.

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- If your dependent child is age 19 or older and is not a full-time student, then the dependent is eligible for coverage only if he or she is totally and permanently disabled. Please contact the Division for additional information about eligibility, and for information about how to provide proof of your dependent's disability.

When you retire, you must list your dependents under the health plan so claims may be paid. If your dependents change later, you must complete a form to add or delete dependents from your account.

If more than one family member is retired under a retirement plan sponsored by the State of Alaska, each eligible family member may be covered by this program both as a benefit recipient and as a dependent, or as the dependent of more than one benefit recipient.

2.3. HOW TO ELECT COVERAGE

You must apply for coverage on a form provided by the Division of Retirement and Benefits. The date of the postmark of the application, or if the postmark is illegible or the application does not bear a dated postmark, the postmark is rebuttably presumed to be five working days before the date the application is received by the Division of Retirement and Benefits.

Benefit recipients who must pay a premium (see pages 7-8) must elect coverage either:

- Before the effective date of their retirement benefit,
- With their application for survivor benefits, **or**
- During the annual open enrollment period.

Coverage may be elected for:

- Retiree only,
- Retiree and spouse,

DRAFT

- Retiree and child/children, or
- Retiree and family (spouse and child/children).

An alternate payee who elects coverage, must apply on a form provided by the Division of Retirement and Benefits within 60 days after the first monthly benefit paid under a qualified domestic relations order is mailed or otherwise delivered to the alternate payee. Failure to make timely application will result in the loss of all rights to apply for or obtain medical coverage under the Plan.

Coverage for an alternate payee may be elected for:

- Alternate payee only, or
- Alternate payee and child/children

2.4. CHANGING YOUR DEPENDENT COVERAGE

Benefit recipients who are paying premiums for their health coverage may decrease their level of coverage at any time. For example, you may change from retiree and family coverage to retiree and spouse coverage at any time. To decrease your coverage, submit a written request to the Division of Retirement and Benefits stating the level of coverage you would like. Once you decrease your coverage, you cannot reinstate it except as described below.

You may increase dependent coverage only:

- During an open enrollment period,
- Upon marriage, or
- Upon birth or adoption of your child.

If you want to increase coverage due to marriage or birth or adoption of your child, your written request to increase coverage must be postmarked or received within 120 days of the date of the event. Your request must include the level of coverage you would like, the new dependents to be covered, the reason for the change,

DRAFT

and the date the event occurred.

Changes in coverage are effective on the first of the month following the receipt of your written request. **Changes in coverage are effective only after receipt of your written request and are not retroactive.**

You should notify the Division of Retirement and Benefits any time your dependents change so your coverage level can be adjusted if necessary. For example, if you divorce or your only child ceases to meet the eligibility requirements, you should request the Division to discontinue coverage for them.

Please note: the retirement system cannot make changes in coverage levels without a written request from you.

2.5. WHEN MEDICAL COVERAGE STARTS

2.5.1. New Benefit Recipients

New benefit recipients will be covered under this plan on the date of appointment to receive retirement, disability, or survivor/death benefits. Those who must pay for coverage are also covered on their appointment date if they elect coverage prior to retirement.

2.5.2. Open Enrollment

Benefit recipients who are eligible for and elect coverage during open enrollment (see pages 7-8) are covered on January 1 of the year following the open enrollment, assuming they pay the required premium.

2.5.3 Marine Engineers Beneficial Association Members

Eligible benefit recipients of the Marine Engineers Beneficial Association (MEBA) are covered on the date of their appointment

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to receive benefits from MEBA.

2.5.4. Alternate Payees

Alternate payees who elect coverage, are covered on the first day of the month following receipt of the qualified domestic relations order by the Division of Retirement and Benefits.

2.5.5. Dependents

Eligible dependents are covered on the dates specified below.

If you elect or are provided with coverage for dependents, your dependents are eligible for benefits on the same day you are eligible if they meet all eligibility requirements. If you add new dependents, they will be covered under this plan immediately.

If you elect dependent coverage during an open enrollment period, your dependents are covered on January 1, assuming you pay the required premium.

If you increase your coverage to include dependents following marriage or birth of a child, their coverage begins on the first of the month following receipt of your written request.

2.6. WHEN MEDICAL COVERAGE ENDS

Coverage under the Medical Plan ends at the earliest time one of the following occurs:

2.6.1. Ineligible Retirees

Coverage ends on the last day of the calendar month in which you cease to be eligible for a benefit from any retirement system.

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2.6.2. Failure to Pay Premium

If you are required to pay a premium for coverage, coverage ends on the last day of the calendar month in which you last make the required monthly premium. You lose the right to participate in the Plan if a premium payment is delinquent by more than 60 days, or premium payments are delinquent by more than 31 days twice in any one calendar year.

2.6.3. Dependents

If you are provided with or have elected coverage for your dependents, their coverage ends on the same day as your coverage ends, unless:

- You divorce. Coverage for your spouse ends on the date the divorce is final.
- Your child no longer meets all eligibility requirements. Coverage ends at the end of the month in which your child first fails to meet these requirements.
- Coverage is discontinued for all dependents.

Health coverage may be continued if one of the above situations (except for failure to pay a premium) occurs. Please see the "Continued Health Coverage" section on pages 121-124.

2.6.4. Discontinuation of Coverage

If you are required to pay a premium for coverage, you may discontinue your participation in coverage at any time by submitting a signed, written request to the Division of Retirement and Benefits. Your premium deductions will be stopped and your coverage will end on the last day of the month the written request to discontinue coverage was received or postmarked. **If you discontinue participation, you waive all rights to future coverage and you are not eligible to re-enroll.**

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MEDICAL PLAN

MEDICAL PLAN HIGHLIGHTS

- Requires an annual deductible of $150 per person, with a maximum of three deductibles per family per year.
- Pays 80% of first $4,000 in covered expenses for each person, then pays 100% of all covered expenses for the remainder of the benefit year.
- Requires precertification from the claims administrator for all inpatient stays, home health care, and other services, and procedures as outlined on pages 21-26.
- Lifetime maximum benefit is $2,000,000 per person.

3.1. HOW MEDICAL BENEFITS ARE PAID

3.1.1. Benefit Year

The benefit year for this plan begins January 1 and ends December 31. All benefits limited in a benefit year are reset on January 1 each year.

3.1.2. Deductibles

You must first meet the annual deductible of $150 per person, before the medical plan starts to pay benefits. Once your family has

met the maximum of three deductibles no further deductibles are required for that benefit year. In the event of a common accident involving two or more family members, only one deductible is required.

Any portion of the deductible satisfied in the last three months of the benefit year will be carried over and applied to the following year's deductible. For example, if you satisfy your entire $150 deductible in November, you will not have to satisfy another deductible the following year.

3.1.3. Coinsurance

After you meet the annual deductible, the Medical Plan pays 80% for most covered expenses up to the next $4,000. Your out-of-pocket expense—the amount you must pay in addition to the deductible—is 20% of the first $4,000 or $800. When your out-of-pocket expenses, the 20% payments, total $800 for any one person, the Medical Plan pays 100% of most covered medical expenses, rather than 80%, for that person for the rest of the benefit year. This out-of-pocket limit does not apply to expenses paid at a rate other than 80%, to expenses applied against deductibles or copayments, or to benefits not payable because of failure to precertify.

3.1.4. Recognized Charge

"Recognized Charge" means the negotiated charge contained in an agreement the claims administrator has with the provider either directly or through a third party. If there is no such agreement, the Recognized Charge is determined in accordance with the provisions of this section.

- **Medical Expenses**

  As to medical services or supplies, the Recognized Charge for each service or supply is the lesser of:

  ~ What the provider bills or submits for that service or supply; or

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~ the 90th percentile of the prevailing charge rate for the geographic area where the service is furnished as determined by Aetna in accordance with Aetna reimbursement policies.

- **Prescription Drug Expenses**

  As to prescription drug expenses, the Recognized Charge for each service or supply is the lesser of:

  ~ What the provider bills or submits for that service or supply; or

  ~ 110% of the average wholesale price or other similar resource.

- **Other Relevant Information About the Calculation of Medical/Dental/Vision/Audio/Prescription Drug Expenses**

  A service or supply (except as otherwise provided in this section) will be treated as a covered expense under the other health care benefits category when Aetna determines that a network provider is not available to provide the service or supply. This includes situations in which you are admitted to a network hospital and out-of-network providers, who provide services to you during your stay, bill you separately from the network hospital. In those instances, the Recognized Charge for that service or supply is the lesser of:

  ~ What the provider bills or submits for that service or supply; and

  ~ For professional services: the 90th percentile of the prevailing charge rate; for the geographic area where the service is furnished as determined by Aetna in accordance with Aetna reimbursement policies.

  If Aetna has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply, then the Recognized Charge is the rate established in such agreement.

DRAFT

Aetna may also reduce the Recognized Charge by applying Aetna reimbursement policies. Aetna reimbursement policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- the duration and complexity of a service
- with the exception of multiple physical therapy modalities, whether multiple procedures are billed at the same time, but no additional overhead is required
- whether an assistant surgeon is involved and necessary for the service
- if follow up care is included
- whether there are any other characteristics that may modify or make a particular service unique
- when a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided

Aetna reimbursement policies are based on Aetna's review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with physician or dental specialty society recommendations; and the views of physicians and dentists practicing in the relevant clinical areas. Aetna uses a commercial software package to administer some of these policies.

Aetna periodically updates its systems with changes made to the prevailing charge rates. What this means to you is that the Recognized Charge is based on the version of the rates that is in use by Aetna on the date that the service or supply was provided.

- **Additional Information**

DRAFT

Aetna's website **www.aetna.com** may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools, or contact our Customer Service Department for assistance.

3.1.5. Lifetime Maximum

The maximum lifetime benefit for each person for all covered medical expenses is $2,000,000.

At the end of each benefit year, up to $5,000 of medical benefits used is automatically restored regardless of your physical condition. If you have received more than $5,000 of covered medical benefits, your full annual spent maximum may be restored when you submit proof of good health satisfactory to the claims administrator within the following year. This provision will not provide benefits for covered expenses incurred before the date the maximum is restored.

Example

Assume you have used $3,000 of medical benefits during the year and your lifetime benefit is decreased to $925,000. At the end of the year, the $3,000 would be restored and your maximum lifetime benefit available would be $928,000. If you had used $6,000 of medical benefits, your maximum lifetime benefit would be reset to $930,000, unless you submitted proof of your good health and were approved for a full reinstatement.

3.1.6. Pre-existing Conditions Limitation

This provision applies only to benefit recipients who are selecting coverage for themselves or their dependents during an open enrollment period (see pages 7-8).

Pre-existing conditions are conditions, excluding pregnancy, for which you received diagnosis, tests, or treatment (including taking

medication) during the three consecutive months before the most recent day you became covered under this plan.

Only the first $1,000 of covered medical expenses are paid by the Medical Plan for pre-existing conditions. However, once you have been covered for 12 consecutive months, this limitation is cancelled and claims incurred after the 12-month period are covered the same as all other services with no pre-existing limitation.

The limitation does not apply to a child who meets the definition of dependent and:

- For whom you are required to provide health coverage as a result of a qualified medical child support order (QMCSO) issued on or after the date your coverage becomes effective, provided you make a written request for the child's coverage within 31 days of the court order.

- Who is placed for adoption, meaning assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption, provided such placement takes effect on or after the date your coverage is effective and you make a written request for coverage within 31 days of the placement.

If you or your dependent was covered under another group health plan as defined by Alaska Statute 21.54.500 that either ended less than 90 days before the waiting period or coverage under this plan started or that continues to cover you or your dependent, some or all of the pre-existing condition limitation may be waived. Contact the Division for information on obtaining this waiver.

3.1.7. Effect of Medicare

You or your eligible dependent must elect Medicare Part A and B at age 65, regardless of any other coverage you have. If you or your eligible dependent is eligible for Medicare coverage (and most people are eligible at age 65), the benefits available under this Plan

DRAFT

become supplemental to your Medicare coverage. The claims administrator will assume you and/or your dependents have coverage under Medicare Part A when you or your dependent reach age 65. If you are not provided with Medicare Part A free of charge, you should submit a copy of your letter from Medicare stating that you are not eligible to the Division. **Everyone is eligible for Medicare Part B.**

If you do not enroll in Medicare coverage, the estimated amount Medicare would have paid will be deducted from your claim before processing by this Plan. Relevant deductibles, coinsurance amounts and out-of-pocket limits continue to apply to both Medicare and the Plan. If you receive care outside the United States, Medicare does not cover your expenses; the retiree plan will take this into account. If you enter into a private contract with a provider that has opted out of Medicare, neither Medicare nor the Retiree Health Plan will pay benefits for their services.

If you or your eligible dependent become eligible for Medicare prior to age 65 and enrolled in Medicare A and/or B, the plan becomes supplemental to your Medicare coverage. The plan will not estimate the amount Medicare would have paid prior to age 65, unless you or your eligible dependent are actually enrolled in Medicare A and/or B.

3.2. PRECERTIFICATION

Certain services, such as inpatient stays, certain tests and procedures, and outpatient surgery require precertification. Precertification is a process that helps you and your physician determine whether the services being recommended are covered expenses under the plan. It also allows Aetna to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

You do not need to precertify services if the plan is secondary to coverage you have from another health plan, including Medicare.

DRAFT

You do not need to precertify services provided by a network provider. Network providers will be responsible for obtaining the necessary precertification for you. Since precertification is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a network provider's failure to precertify services.

When you receive services from an out-of-network provider, you are responsible for obtaining the necessary precertification from Aetna for any services or supplies that require precertification as described under *Services Requiring Precertification*. If you do not precertify, your benefits may be reduced or the medical plan may not pay any benefits.

3.2.1. The Precertification Process

Prior to being hospitalized or receiving certain other medical services or supplies, there are certain precertification procedures that must be followed.

You or a member of your family, a hospital staff member, or the attending physician, must notify Aetna to precertify the admission or medical services and expenses prior to receiving any of the services or supplies that require precertification under the medical plan. To obtain precertification, call Aetna at the telephone number listed on your ID card in accordance with the following timelines:

For non-emergency admissions:	You, your physician or the facility to call and request precertification at least 14 days before the date you
For an emergency outpatient medical condition:	You or your physician must call prior the outpatient care, treatment or procedure, if possible, or as soon as reasonably possible.
For an emergency admission:	You, your physician or the facility call within 48 hours or as soon as reasonably possible after you have been admitted.

DRAFT

For an urgent admission:	You, your physician or the facility must call before you are scheduled to be admitted.
For outpatient non-emergency medical services requiring precertification:	You or your physician must call at 14 days before the outpatient care is provided, or the treatment or is scheduled.

Aetna will provide a written notification to you and your physician of the precertification decision. If Aetna precertifies your supplies or services, the approval is good for 60 days as long as you remain enrolled in the medical plan.

When you have an inpatient admission to a facility, Aetna will notify you, your physician and the facility about your precertified length of stay. If your physician recommends that your stay be extended, additional days will need to be precertified. You, your physician, or the facility must call Aetna at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. Aetna will review and process the request for an extended stay. You and your physician will receive a notification of an approval or denial.

If Aetna determines that the stay or services and supplies are not covered expenses, the notification will explain why and how Aetna's decision can be appealed. You or your provider may request a review of the precertification decision in accordance with the claim review procedures of the Plan Booklet.

3.2.2. Services Requiring Precertification

The following list identifies those services and supplies requiring precertification under the medical plan. Language set forth in parenthesis in the precertification list is provided for descriptive purposes only and does not serve as a limitation on when precertification is required.

Precertification is required for the following types of medical expenses:

- Stays in a hospital

DRAFT

- Stays in a skilled nursing facility
- Stays in a rehabilitation facility
- Stays in a hospice facility
- Outpatient hospice care
- Stays in a residential treatment facility for treatment of mental disorders and substance abuse
- Partial confinement treatment for treatment of mental disorders and substance abuse
- Home health care
- Private duty nursing care
- Transportation (non-emergent) by fixed wing aircraft (plane)
- Transportation (non-emergent) by ground ambulance
- Autologous chondrocyte implantation, Carticel (injection into the knee of cartilage cells grown from tissue cultures)
- Cochlear implant (surgical implant of a device into the ear to try to improve hearing)
- Cognitive skills development
- Customized braces (physical – i.e., non-orthodontic braces)
- Dental implants and oral appliances
- Dialysis visits
- Dorsal column (lumbar) neurostimulators: trial or implantation (for relief of severe pain)
- Electric or motorized wheelchairs and scooters
- Gastrointestinal tract imaging through capsule endoscopy
- Hyperbaric oxygen therapy
- Limb prosthetics
- Oncotype DX (a method for testing for genes that are in cancer cells)

DRAFT

- Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (reconstructive surgeries to attempt to correct structural abnormalities of the jaw bones)
- Organ transplants
- Osseointegrated implant
- Osteochondral allograft/knee (grafting of cartilage and bone from a cadaver to the knee joint)
- Proton beam radiotherapy
- Reconstruction or other procedures that may be considered cosmetic
- Surgical spinal procedures
- Uvulopalatopharyngoplasty, including laser-assisted procedures (surgery to reconfigure the soft palate to try to help with sleep apnea)
- Ventricular assist devices
- MRI-knee
- MRI-spine
- Intensive outpatient programs for treatment of mental disorders and substance abuse, including:
  - ~ Psychological testing
  - ~ Neuropsychological testing
  - ~ Outpatient detoxification
  - ~ Psychiatric home care services
- Travel

3.2.3. How Failure to Precertify Affects Your Benefits

A precertification benefit reduction will be applied to the benefits paid if you fail to obtain a required precertification prior to incurring medical expenses. This means that Aetna will reduce the

DRAFT

amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

You are responsible for obtaining the necessary precertification from Aetna prior to receiving services from an out-of-network provider. Your provider may precertify your treatment for you; however, you should verify with Aetna prior to the procedure that the provider has obtained precertification from Aetna. If your treatment is not precertified by you or your provider, the benefit payable will be reduced as follows:

- Except as otherwise provided below, Aetna will apply a $400 benefit reduction for failure to obtain precertification for the medical services listed in section 3 above, Services Requiring Precertification.
- If precertification of inpatient treatment for a mental disorder was not requested, your coinsurance for mental disorder benefits will be 50%.
- If precertification of travel expenses was not requested, no travel benefits will be paid.

3.3. COVERED MEDICAL EXPENSES

Benefits are available for medically necessary services and supplies necessary to diagnose, care for, or treat a physical or medical condition.

To be medically necessary, the service or supply must be:

- Care or treatment which is expected to improve or maintain your health or to ease pain and suffering without aggravating the condition or causing additional health problems;
- A diagnostic procedure indicated by the health status of the patient and expected to provide information to determine the course of treatment without aggravating the condition or

DRAFT

causing additional health problems; and

- No more costly than another service or supply (taking into account all health expenses incurred in connection with the service or supply) which could fulfill these requirements.

In determining if a service or supply is medically necessary, the claims administrator will consider:

- Information provided on the affected person's health status;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- The opinion of health professionals in the generally recognized health specialty involved; and
- Any other relevant information brought to the claims administrator's attention.

In no event will the following services or supplies be considered medically necessary:

- Those that do not require the technical skills of medical, mental health or dental professionals who are acting within the scope of their license;
- Those furnished mainly for the personal comfort or convenience of the person, the person's family, anyone who cares for him or her, a health care provider, or health care facility;
- Those furnished only because the person is an inpatient on a day when the person could safely and adequately be diagnosed

DRAFT

or treated while not confined; or

- Those furnished only because of the setting if the service or supply can be furnished in a doctor's or dentist's office or other less costly setting.

3.3.1. Medically Necessary Services and Supplies

The medical plan pays only for medically necessary services and supplies. The medical plan will utilize Aetna's current Medical and Pharmacy Clinical Policy Bulletins for purposes of determining medical necessity. You may access Aetna's Clinical Policy Bulletins at: **www.aetna.com/healthcare-professionals/policies-guidelines/clinical_policy_bulletins.html**

When Aetna's Clinical Policy Bulletins do not address the specific service or supply under review, a determination of medical necessity will be made when Aetna determines that the medical services and supplies or prescription drugs would be given to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, an injury, a disease, or its symptoms by a physician or other health care provider, exercising prudent clinical judgment.

In making a determination of medical necessity when there is no applicable Clinical Policy Bulletin, the provision of the service, supply or prescription drug must be:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;
- not mostly for the convenience of the patient or physician or other health care provider; and
- not more costly than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that

DRAFT

patient's illness, injury, or disease. This provision does not require the use of generic drugs.

"Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community. Otherwise, the standards must be consistent with physician specialty society recommendations. They must be consistent with the views of physicians practicing in relevant clinical areas and any other relevant factors.

IMPORTANT: Not every service, supply or prescription drug that fits the definition of medical necessity is covered by the medical plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example, some benefits are limited to a certain number of days, visits, or a dollar maximum.

In no event will the following services or supplies be considered medically necessary:

- Those that do not require the technical skills of a medical professional who is acting within the scope of his or her license
- Those furnished mainly for the comfort or convenience of the person, the person's family, anyone who cares for him or her, a health care provider or health care facility
- Those furnished only because the person is in the hospital on a day when the person could safely and adequately be diagnosed or treated while not in the hospital; or
- Those furnished only because of the setting if the service or supply can be furnished in a doctor's office or other less costly setting.

3.3.2. Taxes

Subject to applicable Plan provisions, any portion of a claim that is itemized as sales, excise, or other tax, and that relates to an otherwise covered expense, is reimbursable.

DRAFT

3.3.3. Provider Services

The Medical Plan pays for covered medical treatment and surgery performed by a qualified provider. Providers who are covered by the plan are people licensed to practice:

- Medicine and surgery (M.D.)
- Osteopathy and surgery (D.O.)
- Dentistry (D.D.S. or D.M.D.)

Also covered are:

- Physician's assistants
- Psychologists
- Occupational therapists
- Physical therapists
- Licensed clinical social workers
- Licensed family and marital therapists
- Audiologists
- Optometrists
- State-certified nurse midwives or registered midwives
- Naturopaths
- Ophthalmologists
- Chiropractors
- Podiatrists
- Christian Science Practitioners authorized by the Mother Church, First Church of Christ Scientist, Boston, Massachusetts
- Nurse practitioners
- Psychological associates
- Practitioners with a master's degree in psychology or social work if supervised by a psychologist, medical doctor, or licensed clinical social worker

All providers must be licensed by the state in which they practice and practicing within the scope of their license.

DRAFT

3.3.4. Nurse Advice Line

A registered nurse is available to you by phone 24 hours a day, free of charge. Simply call the claims administrator's number listed in the front of this booklet. The nurses can be a resource in considering options for care or helping you decide whether you or your dependent needs to visit your doctor, an urgent care facility, or the emergency room. They can also provide information on how you can care for yourself or your dependent. Information is available on prescription drugs, tests, surgery, or any other health-related topic. You need only call to discuss any health concerns. This service is confidential.

3.3.5. Hospitalization

Important: Precertification is required for all hospital stays. (This requirement is waived if the patient is covered by Medicare.) If preertification is not obtained, a $400 penalty may be assessed before any benefits may be paid. Please refer to the "Preertification" section on pages 21-26.

The Medical Plan covers hospital room and board charges only while you are necessarily confined as a registered bed patient under the care of a physician. Coverage includes room, board, general duty nursing, progressive care, intensive care and other services regularly rendered by the hospital to its occupants **but** does not include private duty or special nursing services rendered outside an intensive or progressive care unit. You must pay the difference in charges between a private room and a semiprivate room, unless the claims administrator determines a private room is medically necessary.

The Plan also provides for hospital services and supplies which includes charges made by a hospital on its own behalf for necessary medical services and supplies actually administered during a hospital confinement, other than for room and board, intensive care unit, private duty nursing, or physicians' services. Services of a personal nature, including radio, television, and guest trays, are **not** included.

DRAFT

If benefits change during your stay, the benefits that are in effect the day you were hospitalized will apply. The new benefits are effective the day after you are discharged from the hospital.

If the claims administrator changes during the time you are hospitalized, benefits for the entire period of confinement are paid by the previous claims administrator. The new administrator is effective the day after you are discharged.

A hospital is an institution providing inpatient medical care and treatment of sick and injured people. It must:

- Be accredited by the Joint Commission on Accreditation of Hospitals, be a psychiatric or tuberculosis hospital as defined by Medicare, or have a staff of qualified physicians treating or supervising treatment of the sick and injured; and

- Have diagnostic and therapeutic facilities for surgical and medical diagnosis on the premises, 24-hour-a-day nursing care provided or supervised by registered graduate nurses, and continuously maintain facilities for operative surgery on the premises.

3.3.6. Home Health Care

Important: Precertification is required before any home health care is received. (This requirement is waived if the patient is covered by Medicare.) If precertification is not obtained, a $400 penalty will be assessed before any benefits may be paid. Please refer to the "Precertification" section on pages 21-26.

The Medical Plan covers a home health care agency for services and supplies furnished to you at home for care in accordance with a home health care plan.

A home health care agency is an organization:

- Providing skilled nursing and other therapeutic services in the

DRAFT

patient's home;

- Associated with a professional policy-making group of at least one physician and one registered nurse supervising full-time;
- Keeping complete medical records on each patient;
- Staffed by a full-time administrator; and
- Meeting licensing standards.

A home health care plan provides for the treatment of a disease or injury in a place of confinement other than a hospital or skilled nursing facility. The attending physician must prescribe care and treatment in writing. Treatment may include:

- Part-time or intermittent nursing care by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.);
- Part-time or intermittent home health aide services which consist primarily of caring for you;
- Physical, occupational, or speech therapy;
- Medical supplies, drugs, and medicines prescribed by a physician if they would have been covered had you been confined in a hospital or skilled nursing facility; and
- Laboratory services provided by or on behalf of a home health care agency if they would have been covered had you been confined in a hospital or skilled nursing facility.

Up to 120 home health care visits to your home are covered in any one calendar year. A single visit may include any or all of the following:

- A visit by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) to provide skilled nursing care,

DRAFT

- A visit from a therapist to provide physical, occupational, or speech therapy, **and**

- Up to four hours of assistance by a home health aide.

Skilled nursing care:

- Includes those services provided by a visiting R.N. or L.P.N. These visits may not last more than two hours and must be for the purpose of performing specific skilled nursing tasks, and

- May be defined as private duty nursing services provided by an R.N. or L.P.N. if the individual's condition requires skilled nursing services and visiting nursing care is not adequate.

Home health care expenses which are **not** covered include:

- Services or supplies not included in the home health care plan;

- Services of a person who ordinarily resides in your home or is a member of your family or the family of your spouse;

- Services of any social worker; and

- Transportation services.

3.3.7. Hospice Services

Important: Precertification is required before any hospice service is received. (This requirement is waived if the patient is covered by Medicare.) If precertification is not obtained, a $400 penalty may be assessed before any benefits may be paid. Please refer to the "Precertification" section on pages 21-26.

Covered expenses include charges made by the following furnished to you for hospice care when given as part of a hospice care program.

Facility Expenses

DRAFT

Covered expenses include charges made by a hospital, hospice facility or skilled nursing facility for:

- Room and board and other services and supplies furnished during a stay for pain control and other acute and chronic symptom management
- Services and supplies furnished to you on an outpatient basis

Outpatient Hospice Expenses

Covered expenses include charges made on an outpatient basis by a hospice care agency for:

- Part-time or intermittent nursing care by a registered nurse or licensed practical nurse for up to eight hours a day
- Part-time or intermittent home health aide services to care for you up to eight hours a day
- Medical social services under the direction of a physician. These include but are not limited to:
  - ~ Assessment of your social, emotional and medical needs, and your home and family situation
  - ~ Identification of available community resources
  - ~ Assistance provided to you to obtain resources to meet your assessed needs.
- Physical and occupational therapy
- Consultation or case management services by a physician
- Medical supplies
- Prescription drugs
- Dietary counseling
- Psychological counseling

Charges made by the providers below if they are not an employee of a hospice care agency and such agency retains responsibility for your care:

- A physician for a consultation or case management

DRAFT

- A physical or occupational therapist
- A home health care agency for:
  - ~ Physical and occupational therapy
  - ~ Part-time or intermittent home health aide services for your care up to eight hours a day
  - ~ Medical supplies
  - ~ Prescription drugs
  - ~ Psychological counseling
  - ~ Dietary counseling

Unless specified above, not covered under this benefit are charges for:

- 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, or maintenance of the house.

3.3.8. Skilled Nursing Care

Important: Precertification is required before any skilled nursing care is received. (This requirement is waived if the patient is covered by Medicare.) If precertification is not obtained, a $400 penalty will be assessed before any benefits may be paid. Please refer to the "Precertification" section on pages 21-26.

The Medical Plan pays for charges by a registered nurse (R.N.),

DRAFT

licensed practical nurse (L.P.N.), or nursing agency for skilled care.

Covered services are:

- Visiting nursing care by an R.N. or L.P.N. of not more than four hours to perform specific skilled nursing tasks; and

- Private duty nursing by an R.N. or L.P.N. if your condition requires skilled nursing services and visiting nursing care is inadequate.

Skilled nursing services which are **not covered** include:

- Nursing care that does not require the education, training, and technical skills of an R.N. or L.P.N., such as transportation, meal preparation, charting of vital signs, and companionship activities;

- Private duty nursing care given while the person is receiving inpatient care in a hospital or other health care facility;

- Care provided to help a person in the activities of daily living, such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting;

- Care provided solely for skilled observation except for no more than 4 hours per day for a period of no more than 10 consecutive days following the occurrence of:

    — Change in patient medication.

    — Need for urgent or emergency medical services provided by a physician, or the onset of symptoms indicating the likely need for those services.

    — Surgery.

    — Release from inpatient confinement.
- Any service provided solely to administer oral medicines,

DRAFT

except where applicable law requires that those medicines be administered by an R.N. or L.P.N.

3.3.9. Skilled Nursing Facility

Important: Precertification is required before any skilled nursing facility care is received. (This requirement is waived if the patient is covered by Medicare.) If precertification is not obtained, a $400 penalty will be assessed before any benefits may be paid. Please refer to the "Precertification" section on pages 21-26.

The Medical Plan pays 100% of covered expenses, after the deductible, for charges of a skilled nursing facility while you are confined for recovery from a disease or injury. Specifically covered are:

- Room and board, including charges for services such as general nursing care in connection with room occupancy, except charges for a private room exceeding the facility's semiprivate room rate;
- Use of special treatment rooms; X-ray and laboratory examinations; physical, occupational, or speech therapy; oxygen and other gas therapy; and other medical services that a skilled nursing facility customarily provides, except private duty or special nursing services or physician's services; and
- Medical supplies.

A skilled nursing facility is a licensed institution providing the following on an inpatient basis for persons convalescing from disease or injury:

- 24-hour professional nursing care by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), if directed by a full-time R.N.;
- Physical restoration services to help a patient meet a goal of

DRAFT

self-care in daily living activities;

- Full-time supervision by a physician or R.N.;
- A complete medical record on each patient; and
- A utilization review plan.

It is **not** an institution for rest or care of the aged, people with mental disorders, or people who are chemically dependent or mentally retarded.

3.3.10. Retiree-elected Second Opinions

The Plan pays 100% of covered expenses with no deductible for obtaining a second surgical opinion when the first surgeon has recommended nonemergency (see below for definition of emergency) surgery.

Charges for X-rays and diagnostic tests required in connection with second opinions are included. However, to avoid duplication, the attending physician is encouraged to share the X-ray and test results with the consulting physician(s). If the first and second opinions differ, you may seek a third opinion. The Plan pays benefits for a third opinion the same as for a second opinion.

To qualify for second opinion benefits, the physician may not be in practice with the physician who provided the first or second opinion and the proposed surgery:

- Must be recommended by the physician who plans to perform it;
- Will, if performed, be covered under this Medical Plan;
- Require general or spinal anesthesia; and
- The second opinion must be obtained before you are hospitalized.

DRAFT

You may choose your consulting physician. If you desire, the claims administrator can provide you with a list of names of qualified physicians.

An emergency is a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson with average knowledge of medicine and health to believe their condition, sickness, or injury requires immediate medical care to prevent:

- Placing their health in serious jeopardy.
- Serious impairment to bodily function.
- Serious dysfunction of a body part or organ.
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

3.3.11. Radiation, X-rays, and Laboratory Tests

The Medical Plan pays normal benefits for X-rays, radium treatments, and radioactive isotope treatments if you have specific symptoms. This includes diagnostic X-rays, lab tests, TENS therapy, and analyses performed while you are an inpatient. Charges for these services **are not** paid if related to a routine physical examination except as noted below.

The plan provides coverage for the following routine lab tests:

- One pap smear per year for all women age 18 and older. Charges for a limited office visit to collect the pap smear are also covered.
- Prostate specific antigen (PSA) tests as follows:

DRAFT

— One annual screening PSA test for men between ages 35 and 50 with a personal or family history of prostate cancer, and

— One annual screening PSA test for men 50 years and older.

- Mammograms as follows:

  — One baseline mammogram between age 35 and 40,

  — One mammogram every two years between age 40 and 50, and

  — an annual mammogram at age 50 and above and for those with a personal or family history of breast cancer.

These tests will be paid at normal plan benefits following the deductible. Other incidental lab procedures in connection with pap smears, PSA tests, and mammograms are not covered.

3.3.12. Rehabilitative Care

The Medical Plan covers **outpatient** rehabilitative care designed to restore and improve bodily functions lost due to injury or illness. This care is considered medically necessary only if significant improvement in body function is occurring and is expected to continue. Care (excluding speech therapy) aimed at slowing deterioration of body functions caused by neurological disease is also covered.

Rehabilitative care includes:

- Physical therapy and occupational therapy.

- Speech therapy if existing speech function (the ability to express thoughts, speak words, and form sentences) has been lost and the speech therapy is expected to restore the level of speech the individual had attained before the onset of the disease or injury.

DRAFT

- Rehabilitative counseling or other help needed to return the patient to activities of daily living but excluding maintenance care or educational, vocational, or social adjustment services.

Rehabilitative care must be part of a formal written program of services consistent with your condition. Your physician or therapist must submit a statement to the claims administrator outlining the goals of therapy, type of program, and frequency and duration of therapy.

3.3.13. Outpatient Preoperative Testing

If you have a specific illness, disease, or injury, the Plan pays 100% of covered expenses with no deductible for pre-operative testing performed while you are an outpatient before a scheduled surgery, if the surgery will be covered by the Plan.

To be covered, the tests:

- Must be related to the scheduled surgery.
- Are done within 7 days prior to the scheduled surgery.
- Are done while you are not confined as an inpatient in a hospital.
- Would have been covered if you were confined in a hospital.
- Must not be repeated by the hospital or surgery center where the surgery is done.

The test results must appear in your medical records kept by the hospital or surgery center where the surgery is performed. You must have the scheduled surgery in a hospital or surgery center unless your physical condition prevents the surgery. If you cancel the surgery (other than when your physical condition prevents it), the testing is paid at normal plan benefits.

DRAFT

3.3.14. Outpatient Ambulatory Surgery

The Medical Plan pays 100% of covered expenses for same day ambulatory surgery with no deductible if you are an outpatient. The surgery must take place in a freestanding surgical facility or outpatient department of a hospital. It does not include surgeries which are normally performed in a doctor's office. An outpatient is defined as a person receiving treatment in a hospital, but not registered as a bed patient.

3.3.15. Anesthetic

The cost of anesthetic and its administration is covered. This includes injections of muscle relaxants, local anesthesia, and steroids. When billed by a hospital or physician, the services of an anesthetist are covered.

3.3.16. Pregnancy

Pregnancy and childbirth are covered like any other medical condition only as long as you are covered under the Medical Plan. No pre-existing condition limitations are applied.

Coverage is provided for a hospital stay for childbirth for at least 48 hours following a normal delivery or 96 hours following a caesarean delivery. Charges for a newborn are not covered unless the infant suffers an accidental injury, sickness, premature birth or abnormal condition; routine care such as nursery charges are not covered

Pregnant women may get screening for high-risk pregnancy factors and receive special counseling about those risks. If you are pregnant or considering having a child, call the claims administrator as soon as possible for advice and counseling on having a healthy pregnancy. A nurse consultant will assess the risk factors in your pregnancy and discuss them and ways to reduce them with you. You can ask to be referred to a doctor for prenatal care.

DRAFT

If you are totally disabled as a result of a pregnancy problem and your coverage ends, you may be eligible for extended benefits. See the “Continued Health Coverage” section on pages 121-124. Totally disabled means the complete inability of an individual to perform everyday duties appropriate for your occupation, employment, age, or sex. The inability may be due to disease, illness, injury, or pregnancy. The Plan reserves the right of determination of total disability based upon the report of a duly qualified physician, or physicians, chosen by the Plan.

3.3.17. Durable Medical Equipment/Supplies

When medically necessary, the Medical Plan covers supplies prescribed by a provider, including:

- Artificial limbs and eyes.
- Bandages and surgical dressings.
- Purchase or rental of autorepositioning appliances, casts, splints, trusses, braces, crutches, and other similar, durable medical or mechanical equipment.
- Orthotics and supportive devices of the feet.
- Rental or purchase of a wheelchair or hospital-type bed.
- Rental or purchase of iron lungs or other mechanical equipment required for respiratory treatment.
- Blood transfusions, including the cost of blood and blood derivatives.
- Oxygen or rental of equipment for the administration of oxygen.

Charges for the purchase or replacement of durable medical and post-surgical equipment will be included as covered medical expenses as follows:

DRAFT

- The initial purchase of such equipment and accessories to operate the equipment are covered only if the claims administrator is shown that:

  — Long-term use is planned; and

  — The equipment cannot be rented; or

  — It is likely to cost less to buy it than to rent it.

- Repair or replacement of purchased equipment and accessories will be covered only if the claims administrator is shown that:

  — It is needed due to a change in the person's physical condition; or

  — It is likely to cost less to buy a replacement than to repair the existing equipment or to rent similar equipment.

Not included are charges for more than one item of equipment for the same or similar purpose.

Durable medical and surgical equipment is equipment that is:

- Made to withstand prolonged use.
- Made for and mainly used in the treatment of a disease or injury.
- Suited for use in the home.
- Not normally of use to persons who do not have a disease or injury.
- Not for use in altering air quality or temperature.
- Not for exercise or training.

DRAFT

3.3.18. Travel

Travel must be precertified to receive reimbursement under the Medical Plan. Contact the claims administrator for precertification before you or your dependent travel.

The Medical Plan pays travel and ambulance costs within the contiguous limits of the United States, Alaska, and Hawaii. This includes:

- Transportation to the nearest hospital by professional ambulance. A professional ambulance is a land or air vehicle specially equipped to transport injured or sick people to a destination capable of caring for them upon arrival. Specially equipped means the vehicle contains the appropriate stretcher, oxygen, and other medical equipment necessary for patient care enroute. A medical technician trained in lifesaving services accompanies the transported patient.

- Round-trip transportation, not exceeding the cost of coach class commercial air transportation, from the site of the illness or injury to the **nearest** professional treatment. If you use ground transportation and the most direct one-way distance exceeds 100 miles, the Medical Plan pays $31 per day without overnight lodging or $80 per day if overnight lodging is required while enroute, for the most direct route. Only eligible persons are reimbursed. If a parent or legal guardian accompanies a child under age 18, the plan will pay an additional $31 per day per diem for ground transportation.

Travel does not include reimbursement of airline miles to purchase tickets, the cost of lodging, food, or local ground transportation such as airport shuttles, cabs, or car rental.

If the patient is a child under 18 years of age, a parent or legal guardian's travel charges are allowed. Also, when authorized by the claims administrator, travel charges for a physician or a registered nurse are covered.

DRAFT

Travel benefits apply only to the conditions covered under the Medical Plan. They do not apply to the audio, dental, or vision plans.

Travel, as described above, is covered **only** in the circumstances set forth in the following sections. Travel is not covered for diagnostic purposes.

Emergencies

Travel is covered if you have an emergency condition requiring immediate transfer to a hospital with special facilities for treating your condition. Precertification is waived if you are immediately transferred in a ground or air ambulance; you do not need to call the claims administrator before this occurs.

An emergency condition is a recent, severe medical condition, including but not limited to severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health to believe their condition, sickness or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the person's health in serious jeopardy.
- Serious impairment to bodily function.
- Serious dysfunction of a body part or organ.
- In the case of a pregnant woman, serious injury to the health of the fetus.

Treatment Not Available Locally

Travel is covered for you to receive treatment which is not available in the area you are currently located in. Treatment is defined as a service or procedure, including a new prescription, which is medically necessary to correct or alleviate a condition or specific symptoms of an illness or injury. It does not include any diagnostic procedures or follow-up visits to monitor a condition. **Treatment must be received for travel to be covered.**

DRAFT

Benefits for travel to receive treatment which is not available locally are limited during each benefit year to:

- One visit and one follow-up visit for a condition requiring therapeutic treatment;
- One visit for prenatal **or** postnatal maternity care and one visit for the actual maternity delivery;
- One pre-surgical **or** post-surgical visit and one visit for the surgical procedure; and
- One visit for each allergic condition.

If you need transportation for a nonemergency condition which cannot be treated locally, you must contact the claims administrator **prior** to traveling. The claims administrator will provide you with written acknowledgement of your request. Failure to precertify travel will result in a denial of travel benefits.

If you do not have time to received written acknowledgement, you **must** call the claims administrator **before** you travel.

Second Surgical Opinions

Travel is covered if you require a second surgical opinion which cannot be obtained where you are currently located. This will count as a presurgical trip as shown above.

If you require transportation for a second surgical opinion which cannot be obtained locally, you must contact the claims administrator prior to traveling. The claims administrator will provide you with written acknowledgement of your request. Failure to precertify travel will result in a denial of travel benefits.

If you do not have time to received written acknowledgement, you **must** call the claims administrator **before** you travel.

DRAFT

Surgery In Other Locations

Travel is covered if you have surgery which is provided less expensively in another location.

If the actual cost of surgery, hospital room and board, and travel to another location for the surgery is less expensive than the recognized charge for the same expenses at the nearest location you could obtain the surgery, your travel costs may be paid. The amount of travel costs paid cannot exceed the difference between the cost of surgery and hospital room and board in the nearest location and those same expenses in the location you choose. Travel costs include round trip coach airfare or actual expenses for ground transportation if the most direct route exceeds 100 miles.

Precertification from the claims administrator is not required for this situation. Submit receipts for the travel costs to the claims administrator and the amount of reimbursement, if any, will be determined when the claim is processed.

3.3.19. Mental Disorder and Chemical Dependency Treatment

Important: Precertification is required for all treatment in order to receive maximum Plan benefits. If precertification is not obtained, benefits will be reduced. Please refer to the "Precertification" section on pages 21-26.

Mental Disorders

Provider services that are precertified are covered at normal plan benefits following the deductible. Provider services received without precertification are covered at normal plan benefit after a $400 penalty and the deductible.

Inpatient treatment that are precertified, excluding provider services which are described above, is covered at normal plan benefits. Inpatient treatment received without precertification is paid at 50% after the deductible.

DRAFT

A mental disorder is a disease commonly understood to be a mental disorder, whether or not it has a physiological or organic basis, and/or for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist or psychologist. A mental or nervous disorder includes but is not limited to:

- Schizophrenia,
- Bipolar disorder (manic/depressive),
- Pervasive mental development disorder (autism),
- Panic disorder,
- Major depressive disorder,
- Psychotic depression, or
- Obsessive compulsive disorder.

Chemical Dependency

Treatment of chemical dependency is paid at normal Plan benefits following the deductible. If treatment is received without precertification, the first $400 of inpatient treatment expenses and outpatient treatment expenses will not be covered.

Benefits for chemical dependency treatment received are limited to the maximums shows in the Benefit Summary.

These amounts are subject to change. Please check with the claims administrator or the Division for the most current maximum. Treatment of medical complications of chemical dependency does not count towards the maximum.

3.3.20. Medical Treatment of Mouth, Jaws, and Teeth

The Plan pays for medical conditions of the teeth, jaw, and jaw joints as well as supporting tissues including bones, muscles, and nerves. Medical services include:

- Inpatient hospital care to perform dental services if required due to an underlying medical condition.

- Surgery needed to treat wounds, cysts, or tumors or to alter

DRAFT

the jaw, jaw joint, or bite relationships when appliance therapy alone cannot provide functional improvement.

- Nonsurgical treatment of infections or diseases not related to the teeth, supporting bones, or gums.

- Dental implants if necessary due to disease, including periodontal disease, or accident but only if dentures or bridges are inappropriate or ineffective. False teeth for use with the implants are covered only under the dental plan as a Class III service.

- Services needed to treat accidental fractures or dislocations of the jaw, or injury to natural teeth if the accident occurs while the individual is covered by the Plan. Treatment must begin during the year the accident occurred or the year following. The teeth must have been firmly attached to the jaw bone at the time of injury, damaged or lost other than in the course of biting or chewing and must have been free of decay or in good repair.

- Removal of impacted or unerupted teeth (unless this coverage is available under the dental plan).

- Diagnosis, appliance therapy (excluding braces), nonsurgical treatment, and surgery by a cutting procedure which alters the jaw joints or bite relationship for temporomandibular joint disorder or similar disorder of the jaw joint.

Myofunctional therapy is not covered. This includes muscle training or in-mouth appliances to correct or control harmful habits.

3.3.21. Treatment of Obesity

Medical Treatment of Obesity

Medically necessary expenses for medical treatment of obesity will

DRAFT

be covered as any other medical condition when the following criteria are met.

- Body Mass Index (BMI) greater than or equal to 30kg/m2, or

- BMI greater than or equal to 27kg/m2 with underlying comorbidities, including but not limited to, cardiopulmonary complications, diabetes, hypertension and obstructive sleep apnea.

Surgical Treatment of Obesity

Medically necessary expenses for surgical treatment of obesity will be covered as any other medical condition when the following criteria are met.

- Body Mass Index (BMI) greater than **or** equal to 40kg/m2 or BMI greater than or equal to 35kg/m2 with underlying comorbidities, including but not limited to, cardiopulmonary complications, diabetes, hypertension and obstructive sleep apnea; **and**
- Completion of bone growth; **and**
- Drug/alcohol screen with either no drug/alcohol abuse by history or alcohol and drug free period for greater than or equal to one year; **and**
- Continued obesity despite medically supervised weight loss treatment for at least six months cumulatively, during the two years prior to surgery, **or**
- Documentation in the medical record of the member's participation in a multidisciplinary surgical preparatory regimen of at least three months duration, completed prior to the time of surgery, meeting all of the following criteria:
  - Consultation with a dietician or nutritionist; and
  - Reduced calorie diet program supervised by a dietician or

DRAFT

nutritionist; and

— Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to the surgery, supervised by exercise therapist or other qualified professional; and

— behavior modification program supervised by qualified professional; and

— Documentation in the medical record of the member's participation in the multidisciplinary surgical preparatory regimen

Covered surgical obesity procedures are limited to:

- Lap Band Gastric Banding; Roux-en Y Gastric Bypass and Vertical Banded Gastroplasty when all selection criteria are met.

3.3.22. Plastic, Cosmetic, and Reconstructive Surgery

The plan covers plastic, cosmetic, or reconstructive surgery **only** as needed to:

- Improve the function of a part of the body (excluding teeth or any structure that supports the teeth) and that is malformed as a result of:

  — A severe birth defect, including harelip or webbed fingers or toes.

  — Disease, or surgery performed to treat a disease or injury.

- Repair an injury sustained in an accident which occurs while you are covered under the plan, provided surgery is performed within the calendar year the accident occurred or the calendar year following.

3.3.23. Mastectomy/Breast Reconstruction

Any person who receives benefits for a medically necessary mastectomy may also receive benefits for:

DRAFT

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complication of all stages of mastectomy, including lymphedemas.

3.3.24. Transplant Services

Important: Precertification is required before any transplant services are received. (This requirement is waived if the patient is covered by Medicare.) If precertification is not obtained, a $400 penalty may be assessed before any benefits may be paid. Please refer to the "Precertification" section on pages 21-26.

Covered Expenses

Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ, stem cell, bone marrow, and tissue.

- Heart
- Lung
- Heart/lung
- Simultaneous pancreas kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine

DRAFT

- Bone marrow/stem cell
- Multiple organs replaced during one transplant surgery
- Tandem transplants (stem cell)
- Sequential transplants
- Re-transplant of same organ type within 180 days of the first transplant
- Any other single organ transplant, unless otherwise excluded under the medical plan.

The following will be considered to be more than one transplant occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant)
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant)
- Re-transplant after 180 days of the first transplant
- Pancreas transplant following a kidney transplant
- A transplant necessitated by an additional organ failure during the original transplant surgery/process
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant)

Network Level of Benefits

The network level of benefits is paid only for a treatment received at a facility designated by the medical plan as an Institute of Excellence™ (IOE) for the type of transplant being performed. Each IOE facility has been selected to perform only certain types of transplants. Services obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as out-of-network services and supplies, even if the facility is a

DRAFT

network provider or IOE for other types of services.

The medical plan covers:

- Charges made by a physician or transplant team
- Charges made by a hospital, outpatient facility or physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another health plan or program
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio- medicals and immunosuppressants; and home health care expenses and home infusion services
- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an “immediate” family member is defined as a first-degree biological relative. These are your biological parents, siblings or children
- Inpatient and outpatient expenses directly related to a transplant.

Levels of Transplant Care

Covered expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant or upon the date you are discharged from the hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of

DRAFT

covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.
2. Pre-transplant/candidacy screening: Includes Human Leukocyte Antigen (HLA) typing/compatibility testing of prospective organ donors who are immediate family members.
3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement.
4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

If you are a participant in the Institute of Excellence™ (IOE) program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any covered expenses you incur from an IOE facility will be considered network services and supplies.

Limitations

Unless specified above, not covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence
- Services that are covered under any other benefit under this medical plan

DRAFT

- Services and supplies furnished to a donor when the recipient is not covered under the medical plan
- Home infusion therapy after the transplant occurrence
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Aetna.

Network of Transplant Specialist Facilities

Through the IOE network, you will have access to a provider network that specializes in transplants. Benefits will be reduced by 20% if a non-IOE or out of network provider is used. In addition, some expenses are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

3.4. PRESCRIPTION DRUGS

The Plan pays for prescription drugs for the treatment of an illness, disease, or injury if dispensed upon prescription of a provider acting within the scope of their license. This includes needles and syringes purchased simultaneously with insulin, as well as other diabetic supplies.

For any drug provided while you are a registered bed-patient in a hospital, skilled nursing facility, psychiatric facility, or any similar institution or administered in a provider's office, the Medical Plan

DRAFT

pays normal plan benefits for covered expenses after the annual deductible is satisfied.

Prescriptions for self-injectable medications, such as testosterone, Cyanocobalamin (B12), Methotrexate, Depo-Estradial and Dexamethasone are covered under the pharmacy benefit.

You may obtain your medications from a participating pharmacy, the mail order program, or any other provider. For prescription drug benefits, a provider is defined as a pharmacy, physician, dentist, or other legally authorized dispenser of drugs.

3.4.1. Card Program

If you obtain your prescription drugs from a participating pharmacy, you will only need to pay the copayment shown in the Benefit Summary for each prescription. The pharmacy will file a claim for you so that you don't have to pay for the prescription and file a claim for reimbursement.

To use the drug card program, you must present your health plan identification card to a participating pharmacy. A list of participating pharmacies is available from the claims administrator, the AlaskaCare Web site or the Division of Retirement and Benefits.

The plan allows you to fill up to a 90-day or 100-unit supply, whichever is greater, at one time.

3.4.2. Mail Order Program

If you take maintenance medication, you can take advantage of this optional program. The mail order pharmacy provider is listed in the front of this booklet.

There is no cost to you for drugs filled through the mail order program. The program bills the medical plan for the full cost.

To use this program, use the order form in your welcome kit or obtain an order form from the claims administrator, the mail order pharmacy provider, the Division of Retirement and Benefits, or the Division's Web site. Send it in with your prescription. Unless

DRAFT

indicated by the provider, you will receive the generic equivalent when available and permissible by law.

The mail order copayment will apply to specialty medication obtained through the mail direct to the member.

You may order up to a 90-day or 100-unit supply, whichever is greater, per prescription or refill. Certain controlled substances are subject to quantity limitations.

3.4.3. Definitions

Prescription drugs are medical substances which must bear a label that states, "Caution: Federal law prohibits dispensing without a prescription." Coverage includes prescription drugs, prescribed by a provider that may have an over-the-counter (OTC) equivalent, or covered medical foods that bear the same label. The plan may cover prescription compounds that contain a bioidentical hormone, an active ingredient that is a bulk chemical powder which is not an FDA approved medication, and thyroid compounds containing a bulk chemical active ingredient. Diabetic supplies are defined as sugar test tablets, sugar test tape, acetone test tablets, and Benedict's solution or the equivalent. A generic drug is:

- Produced and sold under the chemical name or shortened version.
- Approved by the U.S. Food and Drug Administration as safe and effective.
- Produced after the original patent expires.
- Produced by a company different from the one that first patented the chemical formulation.
- Priced less than the product produced by the company that first patented the formulation.

DRAFT

3.4.4. Exclusions

Benefits are not payable for:

- A device of any type.
- Any drug entirely consumed at the time and place it is prescribed.
- The administration or injection of any drug.
- More than the number of refills specified by the prescriber. The claims administrator, before paying the claim, may require a new prescription, or evidence as to need. For example, the need may be questioned if the prescriber did not specify the number of refills, or if the frequency or number of prescriptions or refills appears excessive under accepted medical practice standards.
- Any refill of a drug dispensed more than one year after the latest prescription for it.
- Any refill to cover a replacement for covered prescription medication(s) in a signal instance due to loss, theft or damage in excess of one incident in a benefit year.
- Drugs which do not, by federal or state law, need a prescription order (i.e. over-the-counter drug), even if a prescription is written.
- Smoking cessation drugs with the exception of Chantix, Nicotrol Ihaler, Nicotrol Nasal Spray, Zyban or their generic equivalents. Additionally, no more than two courses of treatment for covered smoking cessation drugs as recommended by a physician.

DRAFT

3.5. MEDICAL EXPENSES NOT COVERED

3.5.1. Limitations and Exclusions

The Medical Plan does not cover any condition, illness, or injury for which you receive:

- Benefits from your employer's liability plan, federal, or state workers' compensation, or similar law.

- Benefits available under any law of government, federal, or state act (excluding services received from Alaska Native Health, a plan established by government for its own employees or their dependents or Medicaid), even though you waive rights to those benefits.

The following is a list of services and supplies that are **not covered** and are not included when determining benefits:

- Those furnished, paid for or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

- Charges for plastic, cosmetic, and reconstructive surgery; services or supplies which improve, alter, or enhance appearance are not covered, even if they are for psychological or emotional reasons, except as listed on page 53.
- Charges in connection with an occupational injury or illness. An occupational injury or illness is one that arises out of (or in the course of) any work for pay or profit, or in any way results from any injury or illness which does. However, if proof is furnished that an individual is covered under workers' compensation or similar law, but is not covered for a particular illness under such law, that illness will not be considered occupational regardless of cause.

DRAFT

- Services provided in an institution which is primarily a rest home, home for the aged, or nursing home.

- Custodial care regardless of where services are provided, or any portion of a hospital stay which is primarily custodial. Custodial care is comprised of services and supplies, including room and board and other institutional services, whether or not the individual is disabled, primarily to assist in the activities of daily living. These services and supplies are designated as custodial care without regard to the prescription, recommendation, or performance of the practitioner or provider.

- Education, training, and room and board while confined in an institution which is primarily a school or other institution for training.

- Hospital admission or inpatient treatment primarily for rehabilitative care (see outpatient rehabilitative care benefits on page 41-42).

- Hospitalization primarily for physiotherapy or diagnostic studies.

- Routine physical and marital examinations except as provided on pages 40-41.

- Medical examinations or tests for diagnostic purposes unless related to a specific illness, disease, or injury.
- Artificial insemination, in vitro fertilization, or embryo transfer procedures.

- Speech therapy, except as provided on page 41-42.

- Special diet supplements, vitamin injections, hospital confinement for weight reduction programs, exercise club membership fees, exercise equipment, whole body calorimeter studies, biofeedback and hypnosis.

DRAFT

- Sterilization or reversal of a sterilization procedure.
- Abortions.
- Charges that the claims administrator determines exceed the recognized charge (see pages 16-19).
- X-ray, laboratory, pathological services, and machine diagnostic tests, unless related to a specific illness, injury or a definitive set of symptoms, except as provided on pages 40-41.
- Services or supplies that are not medically necessary as determined by a medical review by the claims administrator for the diagnosis or treatment of a physical or mental condition even if prescribed, recommended, or approved by a physician.
- Marriage, child, career, social adjustment, pastoral, financial, sexual, or family counseling.
- Charges for or related to eye surgery mainly to correct refractive errors.
- Treatment of mental, neuropsychiatric and personality disorders, except as described under the "Mental and Nervous Disorders" section on pages 49-50.
- Any treatment, drug (excepting hormones and hormone therapy) and, service or supply related to changing sex or sexual characteristics, including: surgical procedures to alter the appearance or function of the body, and prosthetic devices.
- Services, therapy, drugs, or supplies for sexual dysfunctions or inadequacies, including services or supplies for a prosthesis in connection with impotency.
- Visual analysis, therapy or training relating to muscular imbalance of the eye (orthoptics).

DRAFT

- Routine foot care procedures, such as
  - The trimming of nails, corns or calluses,
  - Fallen arches,
  - Other symptomatic complaints of the feet, or
  - Routine hygienic care.
- Treatment designed primarily to provide a change in environment or a controlled environment (milieu therapy).
- Care furnished mainly to provide surroundings free from exposure that can worsen the person's condition, disease, or injury.
- Those charges you would not pay if you did not have health care coverage, except those for covered services furnished, paid for or reimbursed under the Maternal/Child Health Unit and Handicapped Children's Program Section,
  Division of Public Health, Department of Health and Social Services of the State of Alaska.
- Any services or supplies for which no charge is made or would not be made if this Medical Plan were not in effect, nor for services or supplies for which you would not be legally liable if this Plan were not in effect.
- Services or supplies that are, as determined by the claims administrator, experimental or investigational. A drug, device, procedure, or treatment **will be** determined to be experimental or investigational if:
  - There is insufficient data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;

DRAFT

— Approval, as required by the FDA, has not been granted for marketing;

— A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or

— The written protocols or informed consent used by the treating facility or any other facility studying substantially the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

However, this exclusion **will not apply** to charges made for experimental or investigational drugs, devices, treatments or procedures, provided that all of the following conditions are met:

— You have been diagnosed with cancer or you are terminally ill

— Standard therapies have not been effective or are inappropriate

— Aetna determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment

— There is an ongoing clinical trial. You are enrolled in a clinical trial that meets these criteria:

~ The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or group c/ treatment IND status

~ The clinical trial has passed independent scientific scrutiny and has been approved by an institutional review board that will oversee the investigation

~ The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food and Drug Administration or the Department of Defense) and conforms to the NCI standards

DRAFT

~ The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI designated cancer center

~ You are treated in accordance with protocol.

- Injury or other loss sustained as a result of war, or an act of war, or any international armed conflict, whether declared or not.
- Services, treatment, education, testing, or training related to learning disabilities or developmental delay.
- Services of a resident physician or intern rendered in that capacity.
- Orthopedic shoes.
- Primal therapy, rolfing, psychodrama, megavitamin therapy, or carbon dioxide therapy.
- Acupuncture therapy, unless performed by a physician as a form of anesthesia in connection with surgery covered under the plan.
- Eye refractions or hearing aids, or the fitting of eye glasses or hearing aids, except as described under *Vision and Optical Benefits* and *Audio Benefits* sections.
- Services or supplies which any school system is legally required to provide.
- Services or supplies not specifically listed as a covered benefit under the Medical Plan.
- Services or supplies for education, special education, or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Charges you incur during a hospital confinement beginning prior to the date you became covered under the Medical Plan.

DRAFT

- Charges for treatment of employees who specialize in the mental health care field and who receive treatment as a part of their training in that field.

- Changes incurred by a Medicare eligible member under a private contract with a provider.

3.6. INDIVIDUAL CASE MANAGEMENT

If you have an illness or accident that may extend for some time, the Medical Plan provides for alternate means of care through individual case management (ICM). For example, if you are facing an extended period of care or treatment, this may be provided in a skilled nursing or convalescent facility or in your home. These settings offer cost savings as well as other advantages to you and your family.

When reviewing claims for the ICM program, the claims administrator always works with you, your family, and your physician so you receive close, personal attention. The claims administrator identifies and evaluates potential claims for ICM, always keeping in mind that **alternative care must result in savings without detracting from the quality of care.**

Through ICM, the claims administrator can consider recommendations involving expenses usually not covered for reimbursement. This includes suggestions to use alternative medical management techniques or procedures or suggestions for cost-effective use of existing plan provisions such as home health care and convalescent facilities.

Examples of conditions that may qualify for ICM include:

- Spinal cord injuries with paralysis.

- High-risk infants undergoing neonatal care.

DRAFT

- Traumatic brain injury resulting from accidents.
- Severe burns.
- Multiple fractures.
- Stroke.
- Any confinement exceeding 30 days; and
- Conditions or injuries requiring substantial medical resources over a long period of time, or those where another cost-effective alternative may be implemented.

If you have questions regarding ICM and its possible application to you, call the claims administrator. All parties must approve alternate care before it is provided.

DRAFT

DENTAL-VISION-AUDIO PLAN

4.1. INTRODUCTION

The State of Alaska is pleased to be able to offer this voluntary Dental-Vision-Audio (DVA) Plan for benefit recipients and their eligible dependents. These benefits may change from time to time. You should ensure that you have the current booklet by contacting the Division of Retirement and Benefits.

4.2. WHO MAY BE COVERED AND PREMIUM PAYMENT

The following individuals may elect coverage:

4.2.1. Benefit Recipients

- People receiving a benefit from the Public Employees', Teachers', Judicial, or Elected Public Officers' Retirement Systems (excluding alternate payees under a Qualified Domestic Relations Order). If coverage is elected, the premiums are paid by deductions from your retirement check. If the retirement check is insufficient to permit the deduction of the full monthly premium, the premium must be made directly to the third-party administrator.

- People receiving a benefit from the Marine Engineers Beneficial Association (MEBA) who retired from the State of Alaska after July 1, 1983. If coverage is elected, the premium is paid annually by the member.

DRAFT

4.2.2. Dependents

You may elect to cover the following dependents:

- Your spouse. You may be legally separated but not divorced.

- Grandfathered same-sex partners as defined and documented by 2 AAC 38.010 – 2 AAC 38.100.

- Your children from birth up to 23 years of age *only* if they are:

  — Your natural children, stepchildren, children of your grandfathered same-sex partner as defined and documented by 2 AAC 38.01 – 2 AAC 38.100, foster children placed through a State foster child program, legally adopted children, children in your physical custody and for whom bona fide adoption proceedings are underway, or children for whom you are the legal, court-appointed guardian;

  Unmarried and chiefly dependent upon you for support; and

  — Living with you in a normal parent-child relationship.

  - This provision is waived for natural/adopted children of the benefit recipient who are living with a divorced spouse, assuming all other criteria are met.

  - Only stepchildren living with the retiree more than 50% of the time may be insured under this plan.

  IMPORTANT NOTICE:

  In accordance with Alaska Statutes 39.35.680(12) and 14.25.220(13):

  - If your dependent child is under 23 years old, they are required to be registered at and attending on a full-time basis an accredited educational or technical institution

DRAFT

recognized by the Department of Education and Early Development.

- If your dependent child is age 19 or older and is not a full-time student, then the dependent is eligible for coverage only if he or she is totally and permanently disabled. Please contact the Division for additional information about eligibility, and for information about how to provide proof of your dependent's disability.

Children incapable of employment because of a mental or physical incapacity are covered even if they are past age 23. However, the incapacity must have existed before age 23 and the children must continue to meet all other eligibility criteria. You must furnish the Division evidence of the incapacity, proof that the incapacity existed before age 23, and proof of financial dependency. This proof must be provided no later than 60 days after their 23rd birthday or after the effective date of your retirement, whichever is later. Children are covered as long as the incapacity exists, they meet the definition of children, except for age and you continue to provide periodic proof of the continued incapacity as required.

If more than one family member is retired, each eligible family member may be covered by this program both as a benefit recipient and as a dependent, or as the dependent of more than one benefit recipient.

4.3. HOW TO ELECT COVERAGE

If you elect dental-vision-audio coverage you must apply for that coverage on a form provided by the Division of Retirement and Benefits. The date of the postmark of the application, or if the postmark is illegible or the application does not bear a dated postmark, the postmark is rebuttably presumed to be five working days before the date the application is received by the Division of Retirement and Benefits.

DRAFT

DVA coverage may be elected for:

- Retiree only
- Retiree and spouse
- Retiree and child/children
- Retiree and family (spouse and child/children)

If you are covered by the medical plan automatically at no cost to you (see page 7), you must elect DVA coverage:

- Before the effective date of your retirement benefit,
- With your application for survivor benefits, or
- Within 60 days of your approval for a disability benefit.

If you do not elect coverage at this time, you waive the right to elect coverage at a later date.

If you are required to pay premiums for your medical coverage (see pages 7-8), you may elect DVA coverage when you become eligible for premium free medical benefits at age 60, at the times shown above or during an annual open enrollment period. However, DVA may be elected during open enrollment only if the same or increased level of medical coverage is being elected for the first time during that open enrollment. For example, a retiree who has no medical or DVA coverage may elect medical for self and spouse and DVA for self only during an open enrollment. However, a retiree who is already enrolled in medical coverage may not elect to add DVA coverage during the open enrollment.

4.4. WHEN DVA COVERAGE STARTS

4.4.1. New Benefit Recipients

New benefit recipients who elect coverage at retirement will be covered under this plan on the date of their appointment to receive retirement, disability, or survivor/death benefits.

DRAFT

4.4.2. Open Enrollees

Benefit recipients who are eligible for and elect coverage during an open enrollment are covered on January 1 of the year following the open enrollment, assuming they pay the required premium.

4.4.3. Marine Engineers Beneficial Association Members

Eligible benefit recipients of the Marine Engineers Beneficial Association (MEBA) who elect coverage at retirement and pay the required premium will be covered on the date of their appointment to receive benefits from MEBA.

4.4.4. Dependents

If you elect coverage for dependents, your eligible dependents are covered on the dates specified below. Note that the level of coverage you elect must cover the dependent. In order to have coverage for your children, for example, you must elect coverage for retiree and children or for retiree and family.

Your dependents are eligible for benefits on the same day you are eligible if they meet all eligibility requirements. If you add new dependents, they will be covered under this plan immediately assuming the level of coverage you have covers the new dependent as specified above.

If you increase your coverage to include dependents following marriage or birth of a child, their coverage begins on the first of the month following receipt of your written request, assuming the level of coverage you elect covers the new dependent.

4.5. WHEN DVA COVERAGE ENDS

Coverage under the DVA plan ends at the earliest time that one of the following occurs:

DRAFT

4.5.1. Failure to Pay Premium

Coverage ends at the end of the month in which you fail to pay the required premium. If at any time your benefit check is insufficient to pay the monthly premium, you may pay the premium directly to the claims administrator. You forfeit your right to participate in the plan if a premium payment is delinquent by more than 60 days, or the premium payments are delinquent twice in any one calendar year by more than 31 days. Contact the Division of Retirement and Benefits for more information. MEBA members pay premiums directly to the MEBA office.

4.5.2. Ineligible Retirees

Coverage ends at the end of the month in which you become ineligible to receive a benefit from the retirement system.

4.5.3. Discontinuance of Coverage

You may discontinue your participation in DVA coverage at any time by submitting a signed, written request to the Division of Retirement and Benefits. Your premium deductions will be stopped and your coverage will end on the last day of the month the written request to discontinue coverage was received or postmarked.

If you discontinue participation, you waive all rights to future coverage and you are not eligible to re-enroll.

4.5.4. Dependents

If you have elected to cover your dependents, coverage will end for those dependents on the same day as your coverage ends, unless:

- You divorce. Coverage for your spouse ends on the date the divorce is final,
- Your child no longer meets all eligibility requirements. Coverage ends at the end of the month in which the child first

DRAFT

fails to meet these requirements,

- You discontinue coverage for your dependents, or
- Coverage is discontinued for all dependents.

You should notify the Division of Retirement and Benefits any time your dependents change so your coverage level can be adjusted if necessary. For example, if you divorce or your only child ceases to meet the eligibility requirements, you should request the Division to discontinue coverage for them. **Changes in coverage are effective only after your written request is received by the Division.**

Please note: the health plan cannot make changes in coverage levels for you.

There may be options available for continuing DVA coverage if some of the above situations occurs. These are described in the "Continued Health Coverage" section on pages 121-124.

4.6. CHANGING YOUR DVA COVERAGE

You may decrease your level of coverage at any time. For example, you may change from retiree and family coverage to retiree and spouse coverage any time. To decrease your coverage, submit a written request to the Division of Retirement and Benefits stating the level of coverage you would like. Once you decrease your coverage you cannot reinstate it except as described below.

You may increase coverage only:

- Within 120 days after marriage or the birth or adoption of your child, or
- During an open enrollment period, if you are eligible as noted

DRAFT

on pages 73.

Your written request to increase coverage must be postmarked or received within 120 days after the date one of the above events occurs. You should state the level of coverage you would like, the reason for the change, and the date the event occurred.

Changes in coverage are effective on the first of the month following the receipt of your written request.

Changes in coverage are effective only after receipt of your written request and are not retroactive.

DENTAL BENEFITS

DENTAL PLAN HIGHLIGHTS

- Pays 100% of the recognized charge for most preventive services (X-rays, exams, cleaning, etc.) with no deductible.
- Pays 80% of the recognized charge for most restorative services (fillings, extractions, etc.) after the annual deductible is met.
- Pays 50% of the recognized charge for most prosthetic services (crowns, dentures, etc.) after the annual deductible is met.
- Requires an annual deductible of $50 per person for restorative or prosthetic services.
- Pays up to $2,000 of covered expenses per person per year.

5.1. HOW DENTAL BENEFITS ARE PAID

To determine whether dental needs and treatment are within Plan limitations and exclusions, the claims administrator reserves the right to review your dental records, including X-rays, photographs, and models. The claims administrator also has the right to request that you obtain an oral examination, at its expense, by a dentist of its choice.

5.1.1. Benefit Year

The benefit year for this Plan begins January 1 and ends December 31. All benefits limited in a benefit year are reset on January 1 each year.

5.1.2. Annual Maximum Benefit

The State's Dental Plan pays up to $2,000 for all covered dental services for each eligible person during the benefit year.

The claims administrator may, at its discretion, make benefit payments directly to either the dentist or other provider furnishing the service, the retiree, or both.

5.1.3. Deductible

You pay a $50 deductible per person for Class II restorative and Class III prosthetic services each benefit year.

5.1.4. Recognized Charge

"Recognized Charge" means the negotiated charge contained in an agreement the claims administrator has with the provider either directly or through a third party. If there is no such agreement, the Recognized Charge is determined in accordance with the provisions of this section.

DRAFT

As to dental expenses, the Recognized Charge for each service or supply provided by a network dentist, is the lesser of:

~ 100% of the covered expense;

~ 100% of the dentist's accepted filed fee with Delta Dental; or

~ 100% of the dentist's billed charge.

For out-of-network dentists or dental care providers in the State, the Recognized Charge is the lesser of:

~ what the dentist bills or submits for that service or supply; or

~ 75% of the 80th percentile of the prevailing charge rate as determined by Delta Dental in accordance with its reimbursement policies; except in the case of services rendered by an endodontist, 100% of the 80th percentile of the prevailing charge rate as determined by Delta Dental in accordance with its reimbursement policies.

For out-of-network dentists or dental care providers outside the State, the Recognized Charge is the lesser of:

~ what the dentist bills or submits for that service or supply; or

~ the prevailing charge rate as determined by Delta Dental in accordance with its reimbursement policies.

An out-of-network dentist or dental care provider has the right to bill the difference between the Recognized Charge and the actual charge. This difference will be the covered person's responsibility.

5.2. COVERED DENTAL SERVICES

The dental coverage portion of the DVA plan covers Class I preventive, Class II restorative, and Class III prosthetic services. The following services and supplies are covered in each class when performed by a dentist or dental care provider and when determined to be dentally necessary.

DRAFT

5.2.1. Class I Preventive Services

The Dental Plan covers 100% of the recognized charge.

- Diagnostic Services and Limitations

  Services:

  — Examination
  — Intra-oral x-rays to assist in determining required dental treatment.

  Limitations:

  — Periodic (routine) or comprehensive examinations or consultations are covered up to 2 times per benefit year
  — Complete series x-rays or a panoramic film is covered once in any 5-year period
  — Supplementary bitewing x-rays are covered once per benefit year
  — Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered
  — Only the following x-rays are covered by the DVA plan: complete series or panoramic, periapical, occlusal, and bitewing

- Preventive Services and Limitations

  Services:

  — Prophylaxis (cleanings)
  — Periodontal maintenance
  — Topical application of fluoride
  — Sealants
  — Space maintainers

  Limitations:

DRAFT

— Prophylaxis (cleaning) or periodontal maintenance is covered up to 2 time per benefit year for most people, or up to 4 times per year for those with periodontal disease. Additional cleaning benefit is available for covered persons with diabetes, and covered persons in their third trimester of pregnancy under the DVA plan's Oral Health, Total Health program (see below, *Oral Health, Total Health Program and Benefits*). Other exceptions can be made when determined dentally necessary by Moda/Delta Dental.
— Topical application of fluoride is covered up to 2 times per benefit year for covered persons age 18 and under. For covered persons age 19 and over, topical application of fluoride is covered up to 2 times per benefit year if there is recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment (poor diet or oral hygiene does not constitute a medical disease).
— Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant per tooth, during any 5-year period.
— Space maintainers are limited to once per space. Space maintainers for primary anterior teeth, missing permanent teeth or for covered persons age 14 or over are not covered.

5.2.2. Class II Restorative Services

Covered expenses are paid at 80% of the recognized charge.

- Restorative Services and Limitations

Services:

— Fillings on teeth for the treatment of decay.

Limitations:

— Inlays are considered an optional service; an alternate benefit of a composite filling will be provided.
— Crown buildups are considered to be included in the crown

DRAFT

restoration cost. A buildup will be a benefit only if necessary for tooth retention.

— Additional limitations when teeth are restored with crowns or cast restorations are in under *Class III Prosthetic Services.*
— A separate charge for general anesthesia and/or IV sedation when in conjunction with non-surgical procedures is not covered.

- Oral Surgery Services and Limitations

Services:

— Extractions (including surgical)
— Other minor surgical procedures

Limitations:

— A separate, additional charge for alveoloplasty done in conjunction with surgical removal of teeth is not covered.
— Surgery on larger lesions or malignant lesions is not considered minor surgery.
— Brush biopsy is covered once in any 6-month up to 2 times per benefit year. Benefits are limited to the sample collection and do not include coverage for pathology (lab) services.

- Endodontic Services and Limitations

Services:

— Procedures for treatment of teeth with diseased or damaged nerves (for example, pulpal therapy and root canal filling).

Limitations:

— A separate charge for cultures is not covered.
— Pulp capping is covered only when there is exposure of the pulp.
— Cost of retreatment of the same tooth by the same dentist within 24 months of a root canal is not eligible for additional

DRAFT

coverage.

- Periodontic Services and Limitations

  Services:

  Treatment of diseases of the gums and supporting structures of the teeth and/or implants.

  Limitations:

  — Periodontal scaling and root planing is limited to once per quadrant in any 24-month period.
  — Coverage for periodontal maintenance procedure under Class I, Preventive.
  — A separate charge for post-operative care done within 3 months following periodontal surgery is not covered.
  — Full mouth debridement is limited to once in a 3-year period and only if there has been no cleaning (prophylaxis, periodontal maintenance) within 24 months.

- Anesthesia Services

  — Nitrous oxide when in conjunction with a covered dental service.
  — General anesthesia or IV sedation in conjunction with covered surgical procedures performed in a dental office.
  — General anesthesia or IV sedation when necessary due to concurrent medical conditions.

5.2.3. Class III Prosthetic Services

Covered expense are paid at 50% of the recognized charge.

- Restorative Services and Limitations

  Services:

  — Cast restorations, such as crowns, onlays or lab veneers, necessary to restore decayed or broken teeth to a state of

DRAFT

functional acceptability.

Limitations:

— Cast restorations (including pontics) are covered once in a 7-year period on any tooth.
— Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and the covered person is responsible for paying the difference.

- Prosthodontic Services and Limitations

Services:

— Bridges
— Partial and complete dentures
— Denture relines
— Repair of an existing prosthetic device
— Implants

Limitations:

— A bridge or denture (full or partial denture) will be covered once in a 7-year period and only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the last 7 years.
— Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
— Partial dentures: A temporary (interim) partial denture is only a benefit when placed within 2 months of the extraction of an anterior tooth or for missing anterior permanent teeth of covered persons age 16 or under. If a specialized or precision device is used, covered expense will be limited to the cost of a standard cast partial denture. No payment is provided for cast restorations for partial denture retainer

DRAFT

teeth unless the tooth requires a cast restoration due to decayed or broken teeth.

— Denture adjustments, repairs, and relines: A separate, additional charge for denture adjustments, repairs, and relines done within 6 months after the initial placement is not covered. Subsequent relines will be covered once per denture in a 12-month period. Subsequent adjustments are limited to 2 adjustments per denture in a 12-month period.
— Tissue conditioning is covered no more than twice per denture in a 36-month period.
— Surgical placement and removal of implants are covered. Implant placement and implant removal are limited to once per lifetime per tooth space. The DVA plan will also cover:

  - The final crown and implant abutment over a single implant. This benefit is limited to once per tooth or tooth space over the lifetime of the implant; or
  - Provide an alternate benefit per arch of a full or partial denture for the final implant-supported prosthetic when the implant is placed to support a prosthetic device. The frequency limitation for prosthetic devices will apply to this alternate benefit (once in any 7-year period); or
  - The final implant-supported prosthetic bridge retainer and implant abutment, or pontic. The benefit is limited to once per tooth or tooth space in any 7-year period.
  - Implant-supported prosthetic bridges are not covered if one or more of the retainers is supported by a natural tooth.
  - These benefits or alternate benefits are not provided if the tooth, implant, or tooth space received a cast restoration or prosthodontic benefit, including a pontic, within the previous 7 years.

— Fixed bridges or removable cast partial dentures are not covered for covered persons under age 16.
— Porcelain restorations are considered cosmetic if placed on the upper second or third molars or the lower first, second, or third molars. Coverage is limited to a corresponding metallic prosthetic. The covered person is responsible for

DRAFT

paying the difference.

- Other Services and Limitations

DRAFT

Services:

— Athletic mouthguard

Limitations:

— An athletic mouthguard is covered once in any 12 month period for covered persons age 15 and under and once in any 24-month period age 16 and over.

5.2.4. General Limitations – Optional Services

Covered expenses are paid at 50% of the recognized charge.

If a more expensive treatment than is functionally adequate is performed, the DVA plan will pay the applicable percentage of the recognized charge for the least costly treatment. The covered person will be responsible for the remainder of the dentist's fee.

5.2.5. Oral Health, Total Health Program and Benefits

Covered expenses are paid at 50% of the recognized charge.

The dental coverage portion of the DVA plan covers additional cleanings (prophylaxis or periodontal maintenance) for certain covered persons. This benefit is for the cleaning only. Coverage for a routine exam and other services is subject to the frequency limitations outlined above.

The following covered persons should consider enrolling this program:

Diabetics

For covered persons with diabetes, elevated blood sugar levels can have a negative effect on oral health. Diabetes

DRAFT

increases the risk of cavities, gum disease, tooth loss, dry mouth and infection. Conversely, poor oral health can make diabetes more difficult to manage. Infections may cause blood sugar to rise and require more insulin to keep it under control. Research confirms that regular visits to the dentist may help in the diagnosis and management of diabetes. Diabetic covered persons are eligible for a total of four cleanings per calendar year.

Pregnant Persons

Keeping the mouth healthy during a pregnancy is important for a covered person and the baby. According to the American Dental Association, pregnant women who have periodontal (gum) disease are more likely to have a baby that is born too early and too small.

Research suggests that periodontal disease triggers increased levels of biological fluids that induce labor. Furthermore, data suggests that women whose periodontal condition worsens during pregnancy have an even higher risk of having a premature baby. Dental visits during a woman's third trimester of pregnancy may help prevent pre-term, low birth weight babies.

- Covered persons should talk to their dentist about scheduling a routine cleaning or periodontal maintenance during the third trimester of pregnancy. Pregnant covered persons are eligible for a cleaning in the third trimester of pregnancy regardless of normal plan frequency limits.

DRAFT

VISION BENEFITS

VISION PLAN HIGHLIGHTS

- Requires no deductible.
- Pays 80% of covered services.
- Covers one complete eye examination, including a required refraction, per year.
- Covers two lenses during each calendar year.
- Covers one set of frames during every two consecutive calendar years.

6.1. HOW VISION BENEFITS ARE PAID

6.1.1. Benefit Year

The benefit year for this Plan begins January 1 and ends December 31. All benefits limited in a benefit year are reset on January 1 each year.

6.1.2. Deductible

You pay no deductible under this plan.

6.1.3. Coinsurance

The Plan pays 80% of the recognized charge for vision and optical services.

6.1.4. Recognized Charge

"Recognized Charge" means the negotiated charge contained in an agreement the claims administrator has with the provider either directly or through a third party. If there is no such agreement, the Recognized Charge is determined in accordance with the provisions of this section.

- **Vision Expenses**

  As to vision services or supplies, the Recognized Charge for each service or supply is the lesser of:

  ~ What the provider bills or submits for that service or supply; or

  ~ the 90th percentile of the prevailing charge rate for the geographic area where the service is furnished as determined by Aetna in accordance with Aetna reimbursement policies.

6.2. COVERED VISION AND OPTICAL SERVICES

The following services and supplies are covered:

- One complete eye examination, including a required refraction, by a legally qualified ophthalmologist or optometrist, during a calendar year.

- Up to two single vision, bifocal, trifocal, or lenticular lenses per calendar year.

- Frames, but not more than one pair during any two consecutive calendar years.

- One pair of cosmetic contacts elected in lieu of glasses. These will be covered the same as any other single vision spectacle lenses appropriate to the member's vision prescription. This

DRAFT

means that you must pay the difference between the recognized charge for spectacle lenses and contact lenses.

- Contact lens fitting provided by an ophthalmologist or optometrist, or by a technician under the direct supervision of the prescribing practitioner, when contact lenses are elected in lieu of glasses.

- One pair of contact lenses required following cataract surgery or because visual acuity is correctable to 20/70 or better only with the use of contact lenses. The maximum lifetime amount payable for necessary contact lenses is $400. After you reach this maximum, necessary contacts are covered the same as cosmetic contacts.
- Certain lens options, limited to those listed below:

  — scratch resistant coating
  — antireflective coating
  — polycarbonate lenses

6.3. VISION AND OPTICAL SERVICES NOT COVERED

The Vision Plan does not provide benefits for:

- Tinting.

- Two pairs of glasses in lieu of bifocals.

- Nonprescription glasses or special purpose or subnormal vision aids, even if prescribed.

- Those charges that the claims administrator determines are not the recognized charge as defined in the health plan.

- Prescription sunglasses or light-sensitive lenses in excess of the amount which would be covered for nontinted lenses.

DRAFT

- Progressive lenses in excess of the amount which would be covered for basic bifocal or trifocal lenses as determined by the member's prescription.

- Medical or surgical treatment of the eyes.

- Services or supplies that are not necessary for diagnosis or treatment of vision condition as determined by the claims administrator even if prescribed, recommended, or approved by a vision professional.

- Eye examinations which a labor agreement requires the employer to provide, which are required as a condition of employment or which are required by any government law.

- Replacement or duplicate lenses if this benefit has been utilized in the current calendar year, regardless of the reason.
- Replacement or duplicate frames if this benefit has been utilized in the current or prior calendar year, regardless of the reason.

- Charges for special procedures such as orthoptics or vision training.

- Duplicate or spare eyeglasses, including lenses and frames.

- Services or supplies which are covered in whole or in part under any workers' compensation law or any other law of similar purpose, whether benefits are payable for all or part of the charges.

- Services or supplies you received prior to becoming eligible for coverage, including lenses and frames ordered as part of a prior examination, even if you receive the lenses and frames after becoming eligible for this plan.

- Services or supplies received after coverage terminates except for lenses and frames received due to an eye examination,

DRAFT

including refraction, performed within 30 days before coverage terminates. The examination must have resulted in a changed or new lens prescription and the lenses and/or frames must be received within 30 days of the date coverage ends.

- Charges in connection with an occupational injury or illness. An occupational injury or illness is one that arises out of or in the course of any work for pay or profit, or in any way results from any injury or illness which does. However, if proof is furnished that an individual is covered under workers' compensation or similar law, but is not covered for a particular illness under that law, that illness will not be considered occupational regardless of cause.

- Benefits available under any law of government (excluding a plan established by government for its own employees or their dependents or Medicaid), even though you waive rights to such benefits.
- Vision care services or supplies covered under the Medical Plan.

- Services or supplies not specifically listed as a covered benefit under the health plan.

- Services or supplies that are, as determined by the claims administrator, experimental or investigational as defined in the medical plan.

DRAFT

AUDIO BENEFITS

AUDIO PLAN HIGHLIGHTS

- Pays 80% of the recognized charge.
- Requires no deductibles.
- Allows a maximum benefit of $2,000 in a three-year period.

7.1. HOW THE AUDIO BENEFITS ARE PAID

7.1.1. Benefit Year

The benefit year for this Plan begins January 1 and ends December 31. All benefits limited in a benefit year(s) are reset on January 1.

7.1.2. Maximum Benefit

The Audio Plan pays up to $2,000 for each person in a covered three-year period consisting of the current and two previous years.

7.1.3. Deductible

You pay no deductible under this plan.

7.1.4. Coinsurance

The Plan pays 80% of the recognized charge for audio services.

DRAFT

7.1.5. Recognized Charge

"Recognized Charge" means the negotiated charge contained in an agreement the claims administrator has with the provider either directly or through a third party. If there is no such agreement, the Recognized Charge is determined in accordance with the provisions of this section.

- **Audio Expenses**

  As to audio services or supplies, the Recognized Charge for each service or supply is the lesser of:

  ~ What the provider bills or submits for that service or supply; or

  ~ the 90th percentile of the prevailing charge rate for the geographic area where the service is furnished as determined by Aetna in accordance with Aetna reimbursement policies.

7.2. COVERED AUDIO SERVICES

Following is a list of covered services:

- An otological (ear) examination by a physician or surgeon.
- An audiological (hearing) examination and evaluation by a certified or licensed audiologist, including a follow-up consultation.
- Evaluation and management services by a certified or licensed audiologist.
- A hearing aid (monaural or binaural) prescribed as a result of the examination. This includes ear mold(s), hearing aid instruments, initial batteries, cords, and other necessary supplementary equipment as well as warranty, and follow-up consultation within 30 days following delivery of the hearing

DRAFT

aid.

- Repairs, servicing, or alteration of hearing aid equipment.

You must provide the claims administrator with written certification from the examining physician. This certification should document your hearing loss that will be lessened by the use of a hearing aid.

7.3. AUDIO SERVICES NOT COVERED

The Audio Plan does not provide benefits for:

- Replacement of a hearing aid, for any reason, more than once in a three-year period.
- Batteries or other supplementary equipment other than those obtained upon purchase of the hearing aid.
- A hearing aid exceeding the specifications prescribed for correction of hearing loss.
- Expenses incurred after coverage ends, unless you order a hearing aid before the termination and receive it within 90 days of the end date.
- Services or supplies that are not necessary for diagnosis or treatment of an audio condition as determined by the claims administrator even if prescribed, recommended, or approved by a audio professional.
- Those charges that the claims administrator determines are not the recognized charge.
- Benefits available under any law of government (excluding a plan established by government for its own employees or their dependents or Medicaid), even though you waive rights to such benefits.

DRAFT

- Charges in connection with an occupational injury or illness. An occupational injury or illness is one that arises out of or in the course of any work for pay or profit, or in any way results from any injury or illness which does. However, if proof is furnished that an individual is covered under workers' compensation or similar law, but is not covered for a particular illness under that law, that illness will not be considered occupational regardless of cause.

- Medical or surgical treatment of the ears.

- Services or supplies provided under workers' compensation law or any law of similar purpose, whether benefits are payable for all or part of the charges.

- Audio examinations required as a condition of employment, under a labor agreement, or government law.

- Services or supplies not specifically listed as a covered benefit under the medical plan.
- Services or supplies that are, as determined by the claims administrator, experimental or investigational as defined in the health plan.

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HOW TO FILE A CLAIM

8.1. CLAIM FILING DEADLINE

To receive benefits, you should submit a claim as soon as possible, but not later than 12 months after the date you incurred the expenses.

8.2. HOSPITAL SERVICES

When you are admitted to the hospital, give your health identification card to the admitting clerk. The hospital may bill the claims administrator directly. The claims administrator will send you an *Explanation of Benefits* form that shows the amount charged and the amount paid to the hospital. If you already paid the hospital charges and this fact is shown clearly on the claim form, the claims administrator will send the benefits check to you, along with the *Explanation of Benefits* form.

8.3. PHYSICIAN AND OTHER PROVIDER SERVICES

The fastest way to process bills is to ask your provider to bill the claims administrator directly on a *Medical/Audio Benefits Claim Form* or a universal claim form. The Alaska claim forms are available from the Division of Retirement and Benefits, the claims administrator, or the AlaskaCare Web site.

If your provider does not bill directly, complete Part 1, Patient Information, and have your provider complete Part 2, Medical Information. Attach an itemized bill.

DRAFT

The itemized bill must include:

- Your provider's name.
- Your provider's IRS number.
- Your diagnosis (or the International Classification of Diseases diagnosis code).
- The date of service.
- An itemized description of the service and charges.

8.4. DENTAL SERVICES

You can get a *Dental Benefits Claim Form* from your dentist, the Division of Retirement and Benefits, the claims administrator, or the AlaskaCare Web site. Follow the instructions under Physician and Other Provider Services for completing the form.

8.5. VISION SERVICES

You can get a *Vision Benefits Claim Form* from your eye doctor, the Division of Retirement and Benefits, the claims administrator, or the AlaskaCare Web site. Follow the instructions under physician services for completing the form.

8.6. AUDIO SERVICES

You can get a *Medical/Audio Benefits Claim Form* from your physician, the Division of Retirement and Benefits, the claims administrator, or the AlaskaCare Web site. Follow the instructions under physician section for completing the form.

8.7. PRESCRIPTION DRUGS

DRAFT

No claim filing is necessary if you obtain your drugs from a participating pharmacy or the mail order program.

The Plan will pay benefits for prescription drugs purchased elsewhere only if actual drug receipts accompany your claim submission. If receipts are not submitted to the claims administrator, your claim will be returned to you for receipts.

If you do not use a participating pharmacy or the mail order program, be sure to obtain a receipt from the pharmacist. Cash register receipts are not acceptable. Medicines that do not require a prescription are not covered. Send the receipt with a *Prescription Drug Record* to the claims administrator. You can get these forms from the Division of Retirement and Benefits, the claims administrator, or the AlaskaCare Web site.

The receipt must include:

- Patient's name.
- Date of purchase.
- Prescription number.
- Purchase price itemized for each drug.
- Quantity.
- Name of drug.
- Name of pharmacy.

8.8. MEDICAL BENEFITS

For covered medical services, the following are examples of the information needed to process your claim:

- Nursing care. If you need special nursing services at home or in the hospital, your claim must include the date, hours worked,

DRAFT

and the name of the referring physician.

- Blood and blood derivatives. You are encouraged to replace blood or blood derivatives that you use. If you do not, you must get a bill from the blood bank which includes the date of service, location where the blood was transported, and the total charge.

- Appliances—braces, crutches, wheelchairs, etc. The bill must include a description of the item and indicate whether it was purchased or rented. Also, it must list the name of the physician who prescribed the item, and the total charge.
- Ambulance. The bill must include the date of the service, where you were transported to and from, and the total charge.

8.9. OTHER CLAIM FILING TIPS

You must list your participant account number on all bills or correspondence. The number is listed on your identification card. Send all bills to the claims administrator's address listed in the front of this booklet, in your welcome kit, and on your identification card.

If you have other health coverage in addition to this plan, you should submit your claims to the primary plan first. Then send a copy of the claim and the *Explanation of Benefits* from the primary plan to the secondary so that benefits will be coordinated properly between plans.

If you have claim problems, call or write to the claims administrator and a customer service professional will help you. When you call, be sure to have your identification card or *Explanation of Benefits* form available. Also, include your participant account number from your identification card on any letter you write. The claims administrator needs this information to identify your particular coverage.

DRAFT

8.10. BENEFIT PAYMENTS

Benefits are paid as soon as possible after all necessary written proof to support the claim is received. All benefits are payable to you. However, the claims administrator has the right to pay any health benefits to the provider. This will be done unless you have informed them you have already paid the provider.

The claims administrator may pay up to $1,000 of any benefit to any of your relatives whom it believes are fairly entitled to it if a benefit is payable to your estate.

8.11. BEFORE FILING A CLAIM

Before you file a claim:

- Check that your deductible has been paid (the deductible is the amount of covered expenses you must pay in a benefit year before your plan starts paying benefits).
- Save all bills until you meet your deductible.
- Once you meet your deductible, submit your bills with a claim form for each family member.
- Always check to make sure your doctor or dentist has not already submitted a claim on your behalf. If you give the physician permission to submit a claim, do not submit one yourself.

Complete the claim form fully and list any other group health care programs covering you and your dependents. If you have other coverage which should pay first before the retiree plan, include a copy of that plan's *Explanation of Benefits* showing the amount they paid for the services.

DRAFT

8.12. RECORDKEEPING

Keep complete records of expenses for each of your dependents. Important records include:

- Names of physicians and others who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

You should also keep **all** *Explanation of Benefits* forms sent to you.

8.13. PHYSICAL EXAMINATIONS

The claims administrator will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

8.14. APPEALS

8.14.1. If a Claim is Denied

If a claim or precertification is denied, in whole or in part, your Explanation of Benefits (EOB) or letter from the claims administrator will explain the reason for the denial. If you believe your claim or precertification should be covered under the terms of the health plan, you should contact the claims administrator to discuss the reason for the denial. If you still feel the claim or precertification denial should be covered under the terms of the health plan, you can take the following steps to file an appeal.

8.14.2. Initial Claim for Health Plan Benefits

Any claim to receive benefits under the health plan must be filed

DRAFT

with the claims administrator on the designated form as soon as possible, but no later than 12 months after the date you incurred the expenses, and will be deemed filed upon receipt.

If you fail to follow the claims procedures under the health plan for filing an urgent care claim or a pre-service claim, you will be notified orally (unless you request written notice) of the proper procedures to follow, not later than 24 hours for urgent care claims and five days for pre-service claims. This special timing rule applies only to urgent care claims and pre-service claims that:

(1) are received by the person or unit customarily responsible for handling benefit matters; and (2) specify a claimant, a medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

You must submit any required physician statements on the appropriate form. If the claims administrator disagrees with the physician statement, the terms of the health plan will be followed in resolving any such dispute.

8.14.3. Initial Review of Health Plan Claims

If you submit an incomplete claim, you will be notified of additional information required:

- orally (unless you request written notice) of the additional information needed to decide the initial claim, not later than 24 hours after the receipt of the incomplete claim by the claims administrator for urgent care claims;
- in writing no later than fifteen calendar days after the receipt of the incomplete claim by the claims administrator for pre-service claims; or
- in writing no later than thirty calendar days after the receipt of the incomplete claim by the claims administrator for postservice claims.

For urgent care claims you must submit the additional information not less than 48 hours after the receipt of the notice from the claims administrator. For pre-service or post-service incomplete claims, the claims administrator may or may not

DRAFT

allow an extension to the claims filing deadline, of up to 45 calendar days from receipt of the written notice, for you to provide additional information.

You will be notified of the approval or denial of an urgent care claim no later than 48 hours after the additional information is received by the claims administrator, or the end of the 48 hour time limit to submit the additional information whichever is earlier. You will be notified of the approval or denial of a pre-service or post-service claim no later than 15 calendar days after receipt of additional information requested, or the end of the time period given to you to provide the additional information, whichever is earlier.

When a claim for health benefits has been properly filed, you will be notified of the approval or denial:

- within 72 hours after receipt of claim by the claims administrator for urgent care claims;
- no later than 15 calendar days after receipt of claim by the claims administrator for pre-service claims; or
- no later than 30 calendar days after the receipt of claim by the claims administrator for post-service claims

For urgent care claims, the claims administrator will defer to the attending provider with respect to the decision as to whether a claim is an urgent care claim for purposes of determining the applicable time period.

For pre-service and post-service claims, the claims administrator will be granted a one-time 15-day extension if the circumstances are due to matters beyond the claim administrator's control, and the claims administrator notifies you before the end of the initial timeframe as outlined above, the circumstances requiring such extension and the date the claims administrator expects to render a decision.

8.14.4. Initial Denial of Health Plan Claims

If any claim for health plan benefits is partially or wholly denied, you will be given notice which will contain the following items:

DRAFT

- the specific reasons for the denial;
- references to health plan provisions upon which the denial is based;
- a description of any additional material or information needed and why such material or information is necessary;
- a description of the review procedures and time limits, including information regarding how to initiate an appeal, information on the external review process (with respect to benefits under the health plan);
- the specific internal rule, guideline, protocol, or other similar criterion, if any, relied upon in making the denial, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon, with a copy free of charge upon request;
- if the denial is based on a medical necessity or an experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request;
- for urgent care claims, a description of the expedited review process applicable to such claims; and
- for denials of benefits under the health plan, (A) information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning), (B) the denial code and its corresponding meaning, as well as a description of the claims administrator's standard, if any, that was used in the denial of the claim, and (C) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist

DRAFT

individuals with the internal claims and appeals and external review processes.

For urgent care claims, the information in the notice may be provided orally if you are given notification within three days after the oral notification.

8.14.5. Ongoing Treatments

If the claims administrator has approved an ongoing course of treatment to be provided to you over a certain period of time or for a certain number of treatments, any reduction or termination by the claims administrator under such course of treatment before the approved period of time or number of treatments end will constitute a denial. You will be notified of the denial, in accordance with the timelines outlined above in *Initial Review of Health Plan Claims*, before the reduction or termination occurs, to allow you a reasonable time to file an appeal and obtain a determination on the appeal. With respect to appeals for benefits under the health plan, coverage for the ongoing course of treatment that is the subject of the appeal will continue pending the outcome of such appeal.

For an urgent care claim, any request by you to extend the ongoing treatment beyond the previously approved period of time or number of treatments will be decided no later than 24 hours after receipt of the urgent care claim, provided the claim is filed at least 24 hours before the treatment expires.

8.14.6. First Level Appeal of Health Plan Claim Denial

You may initiate a first level of appeal of the denial of a claim by filing a written claim appeal with the claims administrator within 180 calendar days of the date the Explanation of Benefits or
pre-service denial letter was issued, which will be deemed filed upon receipt. If the appeal is not timely, the decision of the claims administrator will be the final decision under the health plan, and will be final, conclusive, and binding on all persons. For urgent care claims, you may make a request for an expedited appeal orally or in writing, and all necessary information will be

DRAFT

transmitted by telephone, facsimile, or other similarly expeditious method.

8.14.7. Decision on First Level of Appeal of Health Plan Claim Denial

If appealing a pre-service denial that is not eligible for external review as outlined below in *Application and Scope of External Review Process for Benefits Under the Health Plan*, you will receive notice of the claims administrator's decision on the first level of appeal within 15 calendar days of the claims administrators' receipt of your appeal. If appealing a pre-service denial that is eligible for external review, you will receive notice of the claim administrator's decision on the first level of appeal within 30 calendar days of the claim administrator's receipt of your appeal.

If appealing a post-service claim denial that is not eligible for external review as outlined below in *Application and Scope of External Review Process for Benefits Under the Health Plan*, you will receive notice of the claim administrators' decision on the first level of appeal within 30 calendar days after the claims administrators' receipt of your appeal. If appealing a post-service claim denial that is eligible for external review, you will receive notice of the claim administrators' decision on the first level of appeal within 60 calendar days after the claims administrators' receipt of your appeal.

If the claim for benefits under the health plan is denied on the first level of appeal, the claims administrator will provide notice to you containing the information set forth below. If you do not file a timely second level of appeal, the decision on the first level of appeal will be final, conclusive, and binding on all persons.

With respect to claims for benefits under the health plan, the claims administrator will provide you with the following information free of charge as soon as possible and sufficiently in advance of the date on which the notice of final denial is required that you have a reasonable opportunity to respond prior to that date: (A) any new or additional evidence considered, relied upon, or generated by the claims administrator (or at the direction of the claims administrator) in connection with the claim, and (B)

DRAFT

any new or additional rationale that forms the basis of the claims administrator's final denial, if any.

In addition, if the claim under the health plan is denied on appeal (including a final denial), you will be given notice with a statement that you are entitled to receive, free of charge, access to and copies of all documents, records, and other information that apply to the claim. The notice will also contain:

- the specific reasons for the denial;
- references to applicable health plan provisions upon which the denial is based;
- a description of the review procedures and time limits, including information regarding how to initiate an appeal, and information on the external review process (with respect to benefits under the health plan);
- the specific internal rule, guideline, protocol, or other similar criterion, if any, relied upon in making the denial, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon, with a copy free of charge upon request;
- if the denial is based on a medical necessity or an experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request;
- for denials of benefits under the health plan, (i) information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning,

  and the treatment code and its corresponding meaning), (ii) the denial code and its corresponding meaning, as well as a description of the claims administrator's standard, if any,

DRAFT

that was used in the denial of the claim, and (iii) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist individuals with the internal claims and appeals and external review process; and

- for denials of benefits under the health plan, if the denial is a final denial, a discussion of the decision.
- The decision on review will be final, conclusive and binding on all persons.

8.14.8. Second Level Appeal of Denial of Claim

You may initiate a second level of appeal of the denial of a claim with the claims administrator, if the claim is not eligible for external review as outlined below in *Application and Scope of External Review Process for Benefits Under the Health Plan,* because it does not involve medical judgment or a rescission of coverage under the health plan.

You may initiate the second level of appeal by filing a written appeal with the claims administrator within 180 calendar days of the date the Level 1 decision letter was issued, which will be deemed filed upon receipt. If you do not file a timely second level of appeal, to the extent available under this section, the decision on the first level appeal will be the final decision, and will be final, conclusive and binding on all persons.

8.14.9. Decision on Second Level Appeal of Denial of Claim

The claims administrator will provide you with notice of its decision on the second level of appeal within 15 calendar days for precertification appeals or within 30 calendar days for post service appeals. If the claim is denied on the second level of appeal, the claims administrator will provide notice to you containing the information set forth above for *Decision on First Level of Appeal of Claim Denial*. The decision on the second level of appeal will be a final denial that is final, conclusive and binding on all persons.

DRAFT

8.14.10. Application and Scope of External Review Process for Benefits Under the Health Plan

Upon receipt of a final denial (including a deemed final denial) with respect to benefits under the health plan, you may apply for external review as provided below. Upon receipt of a denial with respect to benefits under the health plan that is not a final denial, you may only apply for external review as provided below regarding expedited external review for urgent care claims. The external review process will apply only to:

- a final denial with respect to benefits under the health plan that involves medical judgment, including but not limited to, those based on the health plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational; and
- a rescission of coverage under the health plan (whether or not the rescission has any effect on any particular benefit at that time).

8.14.11. Standard External Review Process for Claims for Benefits under the Health Plan

a. **Timing of Request for External Review.** You must file a request for external review of a benefit claim under the health plan with the claims administrator no later than the date which is four months following the date of receipt of a notice of final denial. If there is no corresponding date four months after the date of receipt of such notice, then the request must be filed by the first day of the fifth month following receipt of the notice (e.g., if a final denial is received on October 30, request must be made by the following March 1). If the last filing date would fall on a Saturday, Sunday, State holiday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, State holiday or Federal holiday.

b. **Preliminary Review.** The claims administrator shall

DRAFT

complete a preliminary review of the request for external review within five business days to determine whether (A) you are or were covered under the health plan at the time the covered service was requested or provided, as applicable; (B) the type of claim is eligible for external review; (C) you have exhausted (or are

deemed to have exhausted) the health plan's internal claims; and (D) you have provided all the information and forms required to process an external review. The claims administrator shall issue a notification to the claimant within one business day of completing the preliminary review. If the request is complete, but ineligible for external review, the notification shall include the reasons for its ineligibility. If the request is not complete, the notification shall describe the information or materials needed to make the request complete, and you will be allowed to perfect the request for external review by the later of the four-month filing period described above, or within the 48 hour period following the receipt of the notification.

c. **Referral to Independent Review Organization (IRO).** The claims administrator shall assign an independent review organization (IRO) to your request for external review. Upon assignment, the IRO will undertake the following tasks with respect to the request for external review:

Timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the IRO, within ten business days following the date of receipt of the notice, additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

Review all documents and any information considered in making a final denial received by the claims administrator. The claims administrator shall provide the IRO with such

DRAFT

documents and information within five business days after the date of assignment of the IRO. Failure by the claims administrator to timely provide the documents and information shall not delay the conduct of the external review. If the claims administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the final denial. In such case, the IRO shall notify you and the claims administrator of its decision within one business day.

Forward any information submitted by you to the claims administrator within one business day of receipt. Upon receipt of any such information, the claims administrator may reconsider its final denial that is the subject of the external review. Reconsideration by the claims administrator must not delay the external review. The external review may be terminated as a result of reconsideration only if the claims administrator decides to reverse its final denial and provide coverage or payment. In such case, the claims administrator must provide written notice of its decision to you and IRO within one business day, and the IRO shall then terminate the external review.

Review all information and documents timely received under a *de novo* standard. The IRO shall not be bound by any decisions or conclusions reached during the claims administrator's internal claims and appeals process. In addition to the information and documents provided, the IRO, to the extent the information and documents are available and the IRO considers them appropriate, shall further consider the following in reaching a decision: (i) your medical records; (ii) the attending health care professional's recommendation; (iii) reports from appropriate health care professionals and other documents submitted by the claims administrator, you, or your physician; (iv) the terms of the applicable health plan to ensure that the IRO's decision is not contrary to the terms of the health plan, unless the terms are inconsistent with applicable law; (v) appropriate practice

DRAFT

guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations; (vi) any applicable clinical review criteria developed and used by the health plan, unless the criteria are inconsistent with the terms of the health plan or with applicable law; and (vii) the opinion of the IRO's clinical reviewer(s) after considering the information described in this paragraph to the extent the information or documents are available and the clinical reviewer(s) consider appropriate.

d. **Notice of Final External Review Decision.** The IRO shall provide written notice of its decision within 45 days after the IRO receives the request for external review. Such notice shall be delivered to you and the claims administrator and shall contain the following: (A) a general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial); (B) the date the IRO received the assignment to conduct external review and the date of the decision; (C) references to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching the decision; (D) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied upon in making its decision; (E) a statement that the determination is binding except to the extent that other remedies may be available under state or Federal law to either the health plan or you; (F) a statement that you may file an administrative appeal to the Office of Administrative Hearing; and (G) current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under

DRAFT

Section 2793 of the Public Health Service Act.

e. **Reversal of Plan's Decision.** If the final denial of the claims administrator is reversed by the decision, the health plan shall immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for a claim, upon receipt of notice of such reversal.

f. **Maintenance of Records.** The IROs shall maintain records of all claims and notices associated with an external review for six years. An IRO must make such records available for examination by you, the claims administrator, or a State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

8.14.12. Expedited External Review Process for Health Plan

a. **Application of Expedited External Review.** The health plan shall allow you to make a request for expedited external review at the time you receive either:

A denial with respect to benefits under the health plan, if the denial involves a medical condition of you for which the timeframe for completion of an internal appeal of an urgent care claim would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an appeal of an urgent care claim; or

A final denial with respect to benefits under the health plan, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final denial concerns admission, availability of care, continued stay, or a health care item or service for which you received emergency services, but have not been discharged from a facility.

b. **Preliminary Review.** Immediately upon receipt of a request for expedited external review, the claims administrator must determine whether the request meets

DRAFT

the reviewability requirements set forth above. The claims administrator shall immediately send a notice that meets the requirements set forth for standard external review of you for its eligibility determination.

c. Referral to Independent Review Organization (IRO). Upon a determination that a request is eligible for expedited external review following the preliminary review, the claims administrator shall assign an IRO pursuant to the requirements set forth above for standard external review. The claims administrator must provide or transmit all necessary documents and information considered in making the denial or final denial determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, shall consider the information or documents described above under the procedures for standard external review. In reaching a decision, the assigned IRO shall review the claim de novo and is not bound by any decisions or conclusions reached during the claims administrator's internal claims and appeals process.

d. **Notice of Final External Review Decision.** The IRO shall provide notice of its decision, in accordance with the requirements set forth above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing such notice, the assigned IRO shall provide written confirmation of the decision to you and the claims administrator.

8.14.13. Third Level – Division of Retirement and Benefits Appeal

If the claim is denied on external review or, if not eligible for external review, on the second level of appeal, you may send a written appeal to the Division of Retirement and Benefits. If you

DRAFT

submit an appeal to the Division, your appeal must be postmarked or received within 60 calendar days of the date the final external review or second level claims administrator decision letter was issued. If you do not file a plan administrator appeal timely, to the extent available under this section, the decision on external review or, if not eligible for external review, the second level of appeal will be the final decision, and will be final, conclusive and binding on all persons.

Upon receipt of your request, the Division will request a copy of your claims administrator appeal file, including any documentation needed from your provider. You must submit any additional information not provided with the Level II or IRO level appeal that you wish considered with your written notice to the Division. The Division will review all information and documents to determine if it should be covered under the terms of the health plan. If the appeal involves medical judgment, including but not limited to, those based on the health plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational; the Division may refer your appeal to a second IRO in cases where the initial IRO is

deemed inadequate, or if substantial new clinical evidence is provided that was not available during the initial IRO review. Otherwise, the Division will make a decision solely based on the whether the initial IRO decision was compliant with the provisions of the plan.

The Division will issue a written decision at the third level appeal within 60 calendar days after receipt of your request of your third level appeal.

8.14.14. Fourth Level – Office of Administrative Hearings Appeal

If you are not satisfied with the final Level III decision, you may submit a Level IV appeal to the State of Alaska's Office of Administrative Hearings.

DRAFT

You must submit your request and the following forms (provided with your Level III response) to the Division of Retirement and Benefits within 30 calendar days of the date of the final Level III decision:

- AlaskaCare Retiree Health Plan Notice of Appeal
- AlaskaCare Authorization for the Use and Disclosure of Protected Health Information (PHI)

Send this material to:

State of Alaska
Division of Retirement and Benefits
Attention: Health Appeals
P.O. Box 110203
Juneau, AK 99811-0203

Your appeal file will be forwarded to the Office of Administrative Hearings (OAH).

DRAFT

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DRAFT

CONTINUED HEALTH COVERAGE

CONTINUED HEALTH COVERAGE HIGHLIGHTS

- Available to retirees and their dependents who lose coverage.
- Provides for no break in coverage.

You or your dependents may continue health coverage if you or your dependents lose coverage because:

- You become ineligible for retirement benefits;
- You die;
- You divorce; or
- A dependent child is no longer a dependent as defined by the Plan.

You or your dependents may continue the same coverage you/they had under the retiree plan. No proof of your good health is required. Coverage under the continuation plan is the same as that described in this booklet. Changes in coverage or premiums applied to the plan will apply to continuation participants.

DRAFT

9.1. LENGTH OF COVERAGE

The minimum length of continued coverage you (or your dependent) are eligible to purchase depends on the event which qualifies you (or your dependent) to elect coverage.

9.1.1. Ineligibility for Retirement Benefits

If you lose coverage because you are no longer eligible for a retirement benefit, you may continue coverage for yourself and your eligible dependents for up to 18 months.

9.1.2. Dependents

If your dependents lose coverage due to your death, divorce, or because they do not meet the eligibility requirements, they may continue coverage for up to 36 months. If this change occurs while covered under the continuation plan because you had already lost coverage, the amount of time they have been covered under the continuation plan is subtracted from the 36-month time period.

9.1.3. Disabled Retirees and Dependents

If you or your dependent are disabled when your continuation coverage begins, or within 60 days of that date, your length of coverage may be extended an additional 11 months. To elect this additional coverage, you must notify the Division of Retirement and Benefits of your status before the end of your first 18-month coverage period and within 60 days of your Social Security disability determination. The premium may increase for the additional 11 months of coverage. Coverage may be terminated if Social Security determines you are no longer disabled. In this case, you must notify the Division of Retirement and Benefits within 30 days of the final Social Security determination.

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9.2. ELECTING COVERAGE

If your retirement benefit terminates or you die, you or your family will be notified of the right to continue coverage and provided with the necessary forms and information. If you are divorced or your child loses coverage, you or your family must notify the Division of Retirement and Benefits within 60 days to receive information.

You have 60 days from the date coverage ends or the date you are notified of your right to continue coverage, whichever is later, to elect coverage.

9.3. PREMIUM PAYMENT

If you, your spouse, or dependents decide to continue coverage, the full premium cost must be paid each month. You have 45 days from the date you elect coverage to pay the required premium. Premiums are due retroactive to the date your coverage would have ended. Premiums are due monthly. The current premium rates are available from the Division of Retirement and Benefits.

9.4. WHEN CONTINUATION ENDS

Your continued health coverage ends:

- When the required premium is not paid on time.
- When the maximum period for continuing coverage ends.
- If the State of Alaska terminates all group health plans for all retirees.
- If you are disabled under the Social Security Act and have continued coverage for 29 months and you are determined to be no longer disabled by Social Security.

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9.5. DISABLED RETIREES OR DEPENDENTS

Disabled retirees or dependents who lose coverage are eligible for the plan described in this section. In addition, disabled retirees may be entitled to an extension of their benefits under the medical plan (not including the dental, vision, or audio portions).

A disabled individual (either you or your covered dependent) may be entitled to extended benefits if totally disabled due to injury, illness, or pregnancy when coverage terminates. Extended benefits for total disability are provided for the number of months you have been covered under the Plan, to a maximum of 12 months. However, only the condition which caused the disability is covered. Coverage is provided only while the total disability continues.

You or your covered dependent must be under a physician's care and submit evidence of disability to the claims administrator within 90 days after regular coverage ends. The physician must complete a *Statement of Disability* available from the Division of Retirement and Benefits or the claims administrator. You must satisfy any unpaid portion of the deductible within three months of the date your coverage terminates.

Totally disabled means the complete inability of an individual to perform everyday duties appropriate for their occupation, employment, age, or sex. The inability may be due to disease, illness, injury, or pregnancy. The Plan reserves the right of determination of total disability based upon the report of a duly-qualified physician, or physicians, chosen by the Plan.

This continuation of coverage terminates when the lifetime maximum benefit is paid or when the person becomes covered under any group plan with similar benefits.

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GENERAL PROVISIONS

10.1. COORDINATION OF BENEFITS

The Plan protects you and your family to the extent of covered costs incurred. If you are entitled to benefits from other sources, such as employer or government sponsored health plans, the Retiree Health Plan has the right to offset against or recover from those other plans or persons so that you do not duplicate recovery of covered medical expenses.

The Retiree Health Plan coordinates benefits with other group health care plans to which you or your covered dependents belong. Other group plans are defined as benefit sources recognized for coordination of benefits and are listed below; this list is non-exclusive:

- Group or blanket disability insurance or health care programs issued by insurers, health care services contractors, and health maintenance organizations.
- Labor-management trustee, labor organization, employer organization, or employee benefit organization plans.
- Governmental programs, including Medicare.
- Plans or programs required or provided by any statute.
- Group student coverage provided or sponsored by a school or policy, whether it is subject to coordination or not.
- The State of Alaska Group Health Plans.

You may be covered both as a retiree and as a dependent of another covered person or you may have more than one health

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plan. If that occurs, you will receive benefits from both plans. However, the benefits received will be subject to the coordination of benefits provisions as indicated in this section.

10.1.1. How benefits are coordinated when a claim is made

- The primary plan pays benefits first, without regard to any other plan.

- When the Retiree Health Plan is secondary, the amount it will pay will be figured by subtracting the benefits payable by the other plan from 100% of expenses **covered** by the retiree plan on that claim. The plan pays the difference between the amount the other plan paid and 100% of expenses the Retiree Health Plan would cover.

- In addition, when the retiree plan is the secondary plan, charges shall be applied to satisfy the retiree plan deductible in the order received by the claims administrator. Two or more charges received at the same time will be applied starting with the largest first.

- Neither plan pays more than it would without coordination of benefits. Benefits payable under another plan include the benefits that would have been payable whether or not a claim was actually submitted to the plan.

- Services which are limited to a maximum number of services in a year are not increased by having other coverage. For example, if you have two plans that each cover a single vision exam each year, the plans coordinate to cover up to 100% of a single vision exam; they do not pay for two vision exams in a year.

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Example

This example assumes that the retiree has Medicare so Medicare pays first.

	Medicare Health Plan	Retiree
Covered Expenses	$ 1,000	$ 1,000
Less Retiree Deductible[1]	- 166	-150
	= 834.00	= 850.00
Plan Coinsurance	x 80%	x 80%
Plan Payment without coordination	= 667.20	= 680.00
Plan Payment with coordination	= 667.20	= 332.80

1 Medicare deductible amount is governed by, and may change based on, federal statutes and regulations.

10.1.2. Determining Order of Payment

A plan without coordination provisions is always the primary plan. If all plans have a coordination provision:

- The Retiree Health Plan is secondary to Medicare except if Medicare is provided before age 65 due to end stage Renal disease. Then the Retiree Health Plan remains primary for 30 months after Medicare was effective. Relevant deductibles, coinsurance and out-of-pocket limits continue to apply to both Medicare and the Plan.

- Any active plan, whether it covers you as the retiree or a dependent, is primary to Medicare.

- The plan covering the retiree directly, rather than as a dependent, is the primary plan.

- A plan covering the person as a retired employee is secondary

to a plan that covers that person as an active employee.

- If a child is covered under both parents' plans, the plan of the parent whose birthday falls earlier in the year (not the oldest) is the primary plan. If both parents have the same birthday, the plan that has covered a parent longer is the primary plan.

Following are exceptions to this birthday rule:

- If the other plan does not have this birthday rule, the other plan's rule is used to decide which plan is primary.

- If you are separated or divorced, the plans pay in the following order:

  — First, the plan of the parent whom the court has established as financially responsible for the child's health care (The claims administrator must be informed of the court decree. However, even though you are divorced and required to pay for medical coverage, your dependents are not automatically eligible for this plan. See the sections on *Eligibility* on pages 7-10 and *Continued Health Coverage* on pages 121-124.

  — Second, the plan of the parent with custody of the child.

  — Third, the plan of the spouse of the parent with custody of the child.

  — Fourth, the plan of the parent who does not have custody of the child.

If none of the above rules apply, the plan that has covered the patient longer is primary.

It is your responsibility to report the existence of and the benefits payable to you under any plan and to file for those benefits in the interests of computing services or benefits due under this Plan.

When a plan provides benefits in the form of services rather

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than cash payments, the reasonable cash value of each service rendered is considered a covered service and a benefit paid. The reasonable cash value of any services that any service organization provides is considered an expense incurred by you or your covered dependent, and the liability under this Plan is reduced accordingly.

10.2. REIMBURSEMENT PROVISION

If you or a dependent suffers a loss or injury caused by the act or omission of a third party, medical benefits for the loss or injury will be paid only if the person suffering the loss or injury, or the legally authorized representative, agrees in writing:

- To pay the retiree health plan up to the amount of the benefits received under the plan if damages are collected from the third party or their representative. Damages may be collected by action at law, settlement, or otherwise.
- To provide the claims administrator a lien for the amount of the benefit paid or to be paid. This lien may be filed with the third party, his or her agent, or a court which has jurisdiction in the matter.

10.3. ACCESS TO RECORDS

All members of the Plan consent to and authorize all providers to examine and copy any portions of the hospital or medical records requested by the Plan when processing a claim, precertification, or claim appeal. Members are the retiree and eligible dependents covered by the Plan.

10.4. APPLICABLE LAW AND VENUE

This plan is issued and delivered in the State of Alaska, and is governed by the laws of the State of Alaska. Any and all suits or

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legal proceedings of any kind that are brought against the State must be filed in the First Judicial District, Juneau, Alaska.

10.5. CHANGES TO PLAN

Neither the claims administrator nor any agent of the claims administrator is authorized to change the form or content of this Plan in any way except by an amendment that becomes part of the plan over the signature of the Plan Administrator.

10.6. CONTRACT LIABILITY

The full extent of liability under this Plan and benefits conferred, including recovery under any claim of breach, will be limited to the actual cost of hospital and medical services as described here and will specifically exclude any claim for general or special damages that includes alleged "pain, suffering, or mental anguish."

10.7. FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan are made under other programs, this Plan has the right, at its discretion, to pay over to any organizations making other payments, any amounts it determines are warranted. These amounts are considered benefits paid under this Plan, and, to the extent of these payments, this Plan is fully discharged from liability under this plan.

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10.8. FREE CHOICE OF HOSPITAL AND PROVIDER

You may select any hospital who meets the criteria on pages 32. You may select any provider who meets the definition of provider on page 30.

The payments made under this Plan for services a provider renders are not construed as regulating in any way the fees that the provider charges.

Under this Plan, payments may be made, at the discretion of the claims administrator, to the provider furnishing the service or making the payment, or to the retiree, or to such provider and the retiree jointly.

The hospitals and providers that furnish hospital care and services or other benefits to members do so as independent contractors. The Plan is not liable for any claim or demand from damages arising from or in any way connected with any injuries that members suffer while receiving care in any hospital or services from any provider.

10.9. NOTICE

Any notice that the claims administrator is required to send is considered adequate if it is mailed to the member or to the State of Alaska, at the address appearing on the claims administrator's records. Any notice required of the member is considered adequate if mailed to the principal office of the claims administrator at the address on your identification card.

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10.10. PLAN MUST BE EFFECTIVE

Health coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that this plan will pay benefits only for expenses incurred while this coverage is in force. Except as described in the extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated, even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

10.11. LEGAL ACTION

No legal action can be brought to recover under any benefits after three years from the deadline for filing claims. The claims administrator will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect, if the loss occurs more than two years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

10.12. MEDICAL OUTCOMES

The claims administrator makes no express or implied warranties and assumes no responsibility for the outcome of any covered services or supplies.

10.13. PREMIUMS

The amount of the monthly premium may change. If you fail to pay any required premiums, your rights under this Plan will be terminated, except as provided under disability extended benefits. Benefits will not be available until you have been reinstated under the provisions of the plan as defined in this booklet.

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10.14. RIGHT OF RECOVERY

Whenever the Plan pays for covered services in excess of the maximum amounts payable, no matter to whom the benefits are paid, the Plan has the right:

- To require the return of the overpayment on request; or
- To reduce, by the amount of the overpayment, any future claim payment made to or on behalf of that person or another person in his or her family.

This right does not affect any other right of recovery this Plan may have with respect to the overpayment.

10.15. RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

The Plan may release or obtain information from any other insurance plan it considers relevant to a claim made under this Plan. This information may be released or obtained without the consent of, or notice to, you or any other person or organization. You must furnish the Plan with information necessary to implement the Plan's provisions.

10.16. TRANSFER OF BENEFITS, ASSIGNMENT, GARNISHMENT, AND ATTACHMENT

All rights to benefits under this Plan are personal and available only to you. They may not be transferred to anyone else without the approval of the Plan.

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10.17. VESTED RIGHTS

Except as cited under the *Continued Health Coverage* section on pages 121-124, this Plan does not confer rights beyond the date that coverage is terminated or the effective date of any change to the plan provisions, including benefits and eligibility provisions. For this reason, no rights from this Plan can be considered vested rights. You are not eligible for benefits or payments from this Plan for any services, treatment, medical attention, or care rendered after the date your coverage terminates.

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GROUP LIFE INSURANCE PLAN

OPTIONAL LIFE PLAN HIGHLIGHTS

- Premium is paid by the retiree.
- Available to retirees who had coverage as active employees.
- Provides lesser amounts of coverage for dependents.

11.1. INTRODUCTION

The State of Alaska is pleased to provide you with the opportunity to continue your Optional Life Insurance after retirement. The Accidental Death and Dismemberment benefit, however, is not available after retirement.

11.2. WHO MAY BE COVERED

11.2.1. Benefit Recipients

If you participated in the State's Select Life Insurance Plan as an active employee, you may elect to continue this coverage at the time you are appointed to receive a retirement benefit from the Public Employees', Teachers', Judicial, or Elected Public Officers' Retirement Systems.

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11.2.2. Dependents

If you elect to continue your Optional Life, you may also cover the following dependents:

- Your spouse. You may be legally separated but not divorced. You will receive $1,000 if your spouse pre-deceases you.
- Your children from 14 days old up to age 19, and 19-23 if they are a full-time student. You will receive $1,000 if your child under age 19, or 19-23 if they are full-time student, pre-deceases you.

11.3. HOW TO ELECT COVERAGE

You must elect this coverage before appointment to a retirement benefit. To meet this deadline, your *Retiree Optional Life Insurance Form*, available from the Division of Retirement and Benefits or its Web site, must be completed and postmarked or received by the above deadline. If you do not elect this coverage within this time frame, you waive your right to elect this coverage at a later date.

You may elect to discontinue this coverage at any time by notifying the Division of Retirement and Benefits in writing. Once you have dropped your coverage, you may not reinstate it.

11.4. PREMIUMS

Premiums for this insurance are deducted directly from your benefit check. The premiums are based on your age and, as your age changes, the amount of your premium will also be recalculated.

Premiums are subject to change. Please contact the Division of Retirement and Benefits for the current premium costs.

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11.5. WHEN LIFE COVERAGE STARTS

If you elect it, coverage under this plan for you and your eligible dependents is effective on the day you are appointed to receive a retirement benefit.

Coverage for a newborn child is effective from 14 days old. However, if a new dependent is confined in a hospital or a similar institution on the effective date of coverage, benefits will begin upon release from the facility.

11.6. WHEN LIFE COVERAGE ENDS

Coverage under this plan ends at the earliest time that one of the following occurs:

11.6.1. Failure to Pay Premium

Coverage ends at the end of the month in which you fail to pay the required premium.

11.6.2. Plan Discontinued

Coverage will end at any time this plan is discontinued by the State.

11.6.3. Dependents

Coverage for your dependents ends on the same day your retiree coverage ends, unless:

- You divorce. Coverage for your spouse ends on the date the divorce is final, or
- Your child no longer meets all eligibility requirements. Coverage ends at the end of the month in which your child first fails to meet these requirements, or

DRAFT

- Coverage is discontinued for all dependents.

If coverage ends, you may be eligible to convert to a private policy. This option is described in the *General Group Life Provisions* section on page 142.

11.7. AMOUNT OF COVERAGE

Optional Life Insurance is payable regardless of the cause of death. The following benefit amounts are provided:

11.7.1. Benefit Recipients

You are covered for the amount of Optional Life Insurance in effect at the time of your appointment to receive a retirement benefit. You may change your Optional Life Insurance coverage at the time of retirement or one time per benefit year. You may decrease coverage in increments of $5,000. Coverage may not decrease below $5,000. Once you decrease Optional Life Insurance, it may never be increased.

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GENERAL GROUP LIFE PROVISIONS

12.1. APPLICABLE LAW AND VENUE

This policy is issued and delivered in the State of Alaska and is governed by the laws of the State of Alaska. Any and all suits or legal proceedings of any kind that are brought against the State must be filed in the First Judicial District, Juneau, Alaska, within one year from the date of payment of the death claim.

12.2. ASSIGNMENT

You may assign your life insurance by completing a Transfer of Ownership form. This means that all rights and privileges of the policy transfer to the new owner. Since an assignment is irrevocable and new tax laws have a direct effect on assignment, consult your accountant or attorney before you assign your life insurance.

An assignment is not binding unless you file the appropriate form at the home office of the life carrier. The life carrier does not assume responsibility for the validity of any assignments of this Plan or any such rights.

12.3. BENEFICIARY

If you die, your life insurance benefits are paid to the beneficiary you designated on your continuation form.

If you want to change your beneficiary, you may do so without your beneficiary's consent by revising your continuation form and submitting it to the Division of Retirement and Benefits. The change is not effective until it is filed with the Division.

The term beneficiary means only that person or persons whom you

DRAFT

designate on your continuation card and file with the Division of Retirement and Benefits.

If you don't designate a beneficiary or if no beneficiary survives you, the death benefits are paid:

- To your spouse; or, if there is none surviving,
- To your children in equal parts; or, if there are none surviving,
- To your parents in equal parts; or, if there are none surviving,
- To your estate.

If you designate more than one beneficiary and do not specify the interest of each, the beneficiaries share equally. If any beneficiary dies before you, the interest of that beneficiary is paid in equal shares to any beneficiaries who survive you.

12.4. CANCELLATION

Either party may cancel this life insurance contract without the consent of the insured by written notice delivered to the other party not less than 60 days before the cancellation is effective.

12.5. CLERICAL ERROR

Your insurance cannot be invalidated by the State of Alaska's failure, through clerical error, to inform the life carrier of your insurance application.

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12.6. CONVERSION PRIVILEGE

If your insurance ends, you may convert your optional insurance to any form of individual policy of insurance (without double indemnity or disability riders) that the life carrier customarily issues, except a policy of term insurance. This coverage amount may not exceed the amount for which you were eligible when a retiree.

If you divorce or die, your spouse may convert his or her insurance to any form of individual policy of insurance (without double indemnity or disability riders) that the life carrier customarily issues, except a policy of term insurance. The amount that your spouse converts may not exceed the amount for which your spouse was eligible under the Life Plan, $1,000.

The conversion privilege is not available for children covered under the Life Plan.

If this Life Plan terminates or is amended to terminate your insurance, or the Life Plan is replaced and you have been insured under the Life Plan for at least five years, you may convert your insurance for an amount equal to the lesser of $2,000 or the amount of your terminated insurance, less any amount of life insurance for which you may be eligible under any other group policy which replaces it within 31 consecutive calendar days.

You have 31 consecutive calendar days from the date your coverage ends to apply for conversion and pay the required premium following termination. The premium reflects your attained age and class of risk. You do not have to provide evidence of insurability. If you or your spouse dies within this 31-day period, the amount of insurance you are entitled to convert is paid to you or your beneficiary even if you have not applied for conversion.

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12.7. ENTIRE CONTRACT

All statements that you and the State of Alaska make are, in absence of fraud, considered representations and not warranties. No statements are used in any contest unless contained in a written application, a copy of which is furnished to insured persons or their beneficiaries.

This Life Plan may be amended at any time by mutual agreement between the State of Alaska and the life carrier or cancelled without consent of the insureds and their beneficiaries, but such change will be without prejudice to any claim that originates before the effective date of change. No change in this Plan is valid unless an executive officer of the life carrier approves and the approval is endorsed or attached.

12.8. FACILITY OF PAYMENT

All sums that become payable because an insured person dies are paid as the Plan specifies. The payment sum will not exceed the amount specified in AS 21.48.160 to any persons that the life carrier determines are equitably entitled by reason of having incurred funeral or other expenses in conjunction with your last illness or death.

If the beneficiary cannot produce a valid receipt, the life carrier has the option of making payments that do not exceed $50 per month to any person or institution that assumes custody and principal support of the beneficiary, until a duly appointed guardian or committee for the beneficiary makes a claim. Any payment made in accordance with this provision discharges the life carrier to the extent of such payment.

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12.9. INCONTESTABILITY

The validity of the Life Plan will not be contested, except for nonpayment of premiums, after it has been in force for two years. No statement that any member insured under this Life Plan makes relating to insurability will be used to contest the validity of the insurance.

12.10. MISSTATEMENT OF AGE

If your age is misstated, the amount payable is the full amount of insurance to which you are entitled at your true age. A premium adjustment is made so that the actual premium required at your true age is paid.

12.11. NOTICE OF DEATH

Written notice of death must be given to the Division of Retirement and Benefits, State of Alaska, within 30 days, or as soon as reasonably possible.

12.12. PAYMENT OF CLAIMS

All amounts payable for loss of life are paid to the designated beneficiary in accordance with and subject to the provisions of the Life Plan. All other amounts payable under this provision are paid to you. Written notice of claim must be given to the Division of Retirement and Benefits, State of Alaska, within 30 days after the occurrence or the beginning of any loss that this provision covers, or as soon as is reasonably possible. Notice given by or on behalf of the claimant to any authorized life carrier agent, with sufficient information to identify the insured, is considered notice.

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12.13. RIGHT OF EXAMINATION

The life carrier has the right and opportunity to examine the person of the injured member as often as it may reasonably require during the pending claim, and also, where not forbidden by law, the right and opportunity to conduct an autopsy in case of death.

12.14. WAIVER OF PREMIUM WITH PERMANENT TOTAL DISABILITY

If, before age 60, you become totally disabled and unable to perform any work or engage in any occupation for wage or profit for nine consecutive months, you may apply for a premium waiver. If the waiver is granted, your insurance remains in force without any premium payment as long as you remain disabled.

After approval, you must furnish proof of disability during the three-month period immediately before each anniversary date, or discontinuance of your premium payment, to the life carrier. The life carrier has the right to have a designated physician examine you, but not more than once in any 12-month period, after your disability insurance has been in force for two years.

If you die while insured under this provision, the life carrier is liable only if written notice of the claim is given to the home office within one year from the date of your death. The notice must contain written proof that continuance of total disability existed until the date of death.

Total disability under this provision means you are unable to engage in any occupation for wage or profit. If you suffer the entire and irrecoverable loss by severance of both hands through or above the wrists, or the loss by severance of both feet through or above the ankles, or one hand through or above the wrist and one foot through or above the ankle, the disability is considered total unless and until you resume an occupation for wage or profit.

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If you elected coverage under the conversion privilege before you were eligible for the disability waiver, you are granted all benefits under this provision in exchange for surrendering your individual policy without claim except for refund of premium, less loans or premium refunds paid under the individual policy. Nothing in the disability waiver provision permits you to have a greater amount of insurance than the amount you had while employed.

All benefits under this provision terminate immediately on the earliest of:

- The first of the month following the date you reach age 65;
- The date your total disability ends;
- The anniversary of your discontinued premium payments, if your insurance ended before that and you failed to show proof of continued disability; or
- The date you fail to submit a medical examination that is requested by the life carrier.

After your coverage terminates, you become eligible for all rights and benefits provided under conversion privileges as though your employment had terminated, unless you go back to work and again become eligible for benefits under this Plan.

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INDEX

A

Abortion 63
Adding a dependent 11, 75
Ambulance 38, 48-50, 100
Ambulatory surgery 45
Anesthetic 46
Artificial insemination 63
Assignment of life insurance 139

B

Beneficiary for life insurance 139-142
Benefit payable
for loss of life 146
Blood transfusions 47
Brain injury 68
Bridges, dental 53, 83, 84
Burns 68

C

Case management 30, 35, 67-68
Cataract removal 89
Childbirth 46
Claim denial 102, 106-107, 108
120, 123
Contact lenses 88-89
Continuing coverage 120-123
Converting to an individual policy
optional life 141

DRAFT

Coordinating benefits 125-129
Crowns 76, 80, 82, 84
Custodial care 62

D

Death benefits 140
Deductibles
dental 4, 76-77
Deductibles, medical 1-2, 15-16, 21, 33-34, 40, 44-45, 52-53, 123, 126-127
Dental benefits 4, 38, 53-54, 69-86, 98
Dentures 53, 76, 83-84
Dependent benefits 6, 8, 9, 10, 11, 16, 17, 59, 60, 62, 63, 64
Disability 7-8, 10, 12, 47, 71-73, 121, 123, 125, 132, 141
Divorce 8, 9, 12, 14, 70, 74-75, 120-122, 128, 136, 137, 141

E

Ear examinations 93, 95
Effective dates of coverage
dental-vision-audio 71-73, 75-76
medical 12-13, 20
optional life 137
Eligibility 7-10, 119-122
Emergency 32, 34, 36, 50, 115
Emergency, definition of 35, 50
End of medical coverage 13-14
dependents 14
Endodontics 81
Endoscopy, upper GI 38
Enrollment in optional life benefits 136
Expenses not covered
audio 94-95
dental 79-85
drug 42-43

DRAFT

medical 61-67
vision 89-91
Experimental services or supplies 91-95
Extended illnesses 65-67, 123
Extending a hospital stay 37
Eye examinations 5, 87-
88, 90 Eyeglasses
frames 5, 87-91
lenses 5, 87-91

F

Filing a claim 97, 99-101
Fillings 76, 80
Fluoride treatment 79-80

G

Generic drugs 4, 24, 41-43

H

Hearing aids 93-94
Home health care 38, 59-60, 68
Hospital admission for lower back pain 62
Hospital, definition of 27
Hospital-related charges 26-27

I

Identification card 40-41, 97, 100
Individual case management (ICM) program 30, 35, 67-68
Ineligible retirees 74, 120
Inpatient treatment
certification 35-40
mental and nervous 52

DRAFT

substance abuse 53

K

Knee 38-39

L

Laboratory tests and services 28, 33, 43-44, 63
Legal action 132
Life Insurance 134-143
Limitations and exclusions
audio 94-95
dental 79-85
drug 42-43
medical 61-67
vision 89-91

M

Mail order drugs 4, 40-41, 99
Mammograms 44
Marine Engineers Beneficial Association Members 7, 12, 69, 73
Marriage 11, 13, 63, 73, 75
Medical equipment 47-49, 63
Medically necessary, definition of 21-24, 26, 44, 47, 50, 54,-56, 63
Medicare 20-21, 125, 127
Mental and nervous disorders 52-53
Mouth, jaw, and teeth treatment 53-54

N

Neonatal care 68
Nursing facility, skilled 1, 28, 30, 33-34, 37, 40

O

DRAFT

Occupational injury or illness 3, 28-31, 33, 44, 59, 60, 62, 90-91, 94
Optional life insurance 134-143
Oral surgery 80-81
Other group plans, description 125-126
Out-of-pocket maximum 2, 16, 21, 35, 127
Outpatient
ambulatory surgery 45
rehabilitative 44-45, 62

P

Pap smears 43-44
Payment of claims
dental 143
Physical examination 43, 102
Physician services, coverage of 25
Plastic surgery 56, 62
Pre-existing conditions 19-20, 46
Pre-operative testing 45
Precertification 35-40
home health care 27
hospice 29
hospital 26
mental disorder 1, 52
Other 35-40
skilled nursing care 31
skilled nursing facility 33
substance abuse 2, 53
travel 2, 48
Pregnancy 19, 46-47, 79, 86, 123
Prescription drugs 4, 17, 23-24, 26, 30-31, 41-43, 60, 99
Prophylaxis 79, 82, 85
PSA tests 43-44

DRAFT

R

Radiation 43
Recordkeeping 102
Rehabilitative care 44-45, 62
Reimbursement provisions
audio 129
dental 88
medical 17-18, 41, 48-49, 52, 68, 78
vision 129
Restorations, dental 80, 82-84
Room and board 26, 30-31, 33, 51-52, 62

S

Second surgical opinions 34, 51
Skilled nursing care 28-29, 31-33
Space maintainers, dental 79-80
Stroke 68

T

Teeth removal 76, 81, 83
Temporomandibular joint disorder 54
Totally disabled, definition of 46, 123, 144
Travel 2-3, 48-52
Travel preauthorization 39-40

U

Upper GI endoscopy 38

DRAFT

V

Vested rights 134
Vision benefits 5, 87-91

W

Wheelchairs 38, 47, 100

X

X-rays
  dental 76-79
  medical 43-44, 63

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