AlaskaCare Defined Contribution Plan
Retiree Insurance Information Booklet

EFFECTIVE JANUARY 1, 2025

Contact Information for 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

EMAIL ADDRESS

Division of Retirement and Benefits
Member Services Center ..... doa.drb.mscc@alaska.gov

WEBSITES

AlaskaCare Plans ..... *AlaskaCare.gov*
Division of Retirement and Benefits ..... *drb.alaska.gov*

AlaskaCare Claims Administrators

MEDICAL CLAIMS ADMINISTRATOR

Aetna Life Insurance Company
P.O. Box 14079
Lexington, KY 40512-4079
aetna.com

Customer Service/Provider Locator ..... (855) 784-8646
TDD *for hearing impaired* ..... (800) 628-3323
24-Hour Nurse Line ..... (800) 556-1555

PRESCRIPTION DRUG CLAIMS ADMINISTRATOR

OptumRx Pharmacy
PO Box 650629
Dallas, Tx 75265-0629

OptumRx Health Care Advocate ..... (855) 409-6999
TDD *for hearing impaired* ..... Dial 711
Fax (for pharmacy claims) ..... (866) 713-6511

Optum Specialty Pharmacy ..... (855) 427-4682
TDD *for hearing impaired* ..... Dial 711

DENTAL CLAIMS ADMINISTRATOR

Delta Dental of Alaska
P.O. Box 40384
Portland, OR 97240

deltadentalak.com
Customer Service ..... (855) 718-1768
Customer Service–Spanish ..... (877) 299-9063

LEGACY PLAN VISION CLAIMS ADMINISTRATOR

Aetna Life Insurance Company
P.O. Box 14079
Lexington, KY 40512-4079

aetna.com
Customer Service ..... (855) 784-8646

STANDARD PLAN VISION CLAIMS ADMINISTRATOR

Vision Service Plan (VSP)
vsp.com
Customer Service ..... (800) 877-7195

AUDIO CLAIMS ADMINISTRATOR

Aetna Life Insurance Company
P.O. Box 14079
Lexington, KY 40512-4079
aetna.com
Customer Service ..... (855) 784-8646

DIRECT BILL AND COBRA ADMINISTRATOR

Inspira Financial
P.O. Box 953374
St. Louis, MO 63195
alaskacare.payflexdirect.com

Customer Service ..... (800) 416-7053
Direct Bill and COBRA ..... (800) 359-3921

Lantern Care Advocate ..... (855) 715-1680

Hinge Health ..... (855) 907-2777

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.

You may access the **Aetna** Clinical Policy Bulletins at *aetna.com/health-care-professionals/clinical-policy-bulletins.html*.

You may access the list of medical services requiring precertification at aetna.com/health-care-professionals/precertification/precertification-lists.html.

Adoption Order

Paula Vrana, Commissioner Department of Administration, hereby adopts, pursuant to the authority under AS 39.30.090-098, the **AlaskaCare Defined Contribution Plan Retiree Insurance Information Booklet**, dated January 1, 2025 as the official AlaskaCare Defined Contribution Plan (Plan) document governing the benefits contained therein. The **Plan** Booklet is effective January 1, 2025 and applies to claims submitted for payment with dates of service on or after the effective date. All prior Plan Booklets, documents and related amendments are hereby repealed in their entirety.

Dated: 02/07/2025

Paula Vrana, Commissioner
Department of Administration
State of Alaska

Table of Contents

1 INTRODUCTION TO HEALTH PLAN 13

1.1 PLAN BENEFITS 13
1.2 DEFINED TERMS 13
1.3 ELIGIBILITY FOR COVERAGE 13
1.3.1 Eligibility for coverage under the health plan 13
1.3.2 Eligible Dependents 14
1.3.3 Qualified Domestic Relations Order Coverage Requirements 14
1.3.4 Dual Coverage 15
1.4 INITIAL COVERAGE ELECTIONS 15
1.4.1 Electing Coverage 15
1.4.2 Coverage Level and Premiums 15
1.5 WHEN COVERAGE BEGINS 16
1.5.1 New Benefit Recipients 16
1.5.2 Dependents 16
1.6 CHANGING YOUR COVERAGE 16
1.6.1 Open Enrollment 16
1.6.2 Decreasing Coverage 17
1.6.3 Increasing Dependent Coverage 17
1.7 WHEN COVERAGE ENDS 17
1.7.1 For Retirees 17
1.7.2 For Dependents 18
1.7.3 Continued Coverage 18
1.8 RECEIPT OF DOCUMENTS 18
1.9 FUTURE OF THE PLAN 18
1.10 ADMINISTRATION OF THE PLAN 19

2 HEALTH PLAN – BENEFIT SCHEDULES 19

2.1 MEDICAL AND PRESCRIPTION DRUG BENEFITS 19
2.1.1 Medical Benefit Schedule 19
2.1.2 Standard Prescription Drug Schedule 22
2.1.3 Opt-Out Prescription Drug Schedule 23
2.2 DENTAL BENEFIT SCHEDULE (IF ELECTED) 24
2.3 STANDARD PLAN VISION BENEFIT SCHEDULE (IF ELECTED) 25
2.4 LEGACY PLAN VISION BENEFIT SCHEDULE (IF ELECTED) 26
2.5 AUDIO BENEFIT SCHEDULE (IF ELECTED) 26

3 MEDICAL PLAN 26

3.1 ABOUT YOUR MEDICAL PLAN 26
3.1.1 Introduction 26
3.1.2 Lifetime Maximum 27
3.1.3 Common Accident Deductible Limit 27
3.2 HOW THE MEDICAL PLAN WORKS WHEN YOU OR YOUR DEPENDENTS ARE NOT MEDICARE AGE ELIGIBLE 27
3.2.1 Network Benefits 27
3.2.2 Accessing Network Providers and Benefits 27
3.2.3 Cost Sharing for Network Benefits 28

3.2.4 Accessing Out-of-Network Providers and Benefits 29
3.2.5 Cost Sharing for Out-of-Network Benefits 30
3.2.6 Availability of Providers 30
3.2.7 Recognized Charge 31
3.3 How The Medical Plan Works When You or Your Dependent are Medicare Age Eligible 31
3.3.1 Eligibility for Medicare 31
3.3.2 Secondary Coverage to Medicare 31
3.3.3 Medicare Coverage Election 31
3.3.4 Which Plan Pays First 32
3.3.5 Employer Group Waiver Program (EGWP) 32
3.3.6 Recognized Charge 32
3.4 Understanding Precertification 33
3.4.1 Precertification 33
3.4.2 The Precertification Process 33
3.4.3 Services Requiring Precertification 34
3.4.4 How Failure to Precertify Affects your Benefits 35
3.5 Covered Medical Expenses 36
3.5.1 Medically Necessary Services and Supplies 36
3.5.2 Physician Services 37
3.5.3 Nurse Advice Line 38
3.5.4 Hospital Expenses 39
3.5.5 Facility-Only Preferred Provider Agreement 40
3.5.6 Alternatives to Hospital Stays 41
3.5.7 Home Health Care 41
3.5.8 Private Duty Nursing 43
3.5.9 Skilled Nursing Facility 43
3.5.10 Hospice Care 44
3.5.11 Second Surgical Opinions 46
3.5.12 Diagnostic and Preoperative Testing 46
3.5.13 Preventive Care and Screening Services 47
3.5.14 Immunizations 54
3.5.15 Cognitive Therapy, Physical Therapy, Occupational Therapy, and Speech Therapy Rehabilitation Benefits 54
3.5.16 Medical Massage Therapy 55
3.5.17 Anesthetic 56
3.5.18 Pregnancy Related Expenses 56
3.5.19 Newborn Care 56
3.5.20 Durable Medical and Surgical Equipment 56
3.5.21 Experimental or Investigational Treatment 57
3.5.22 Prosthetic Devices 58
3.5.23 Ambulance Services 58
3.5.24 Travel 59
3.5.25 Gene Based, Cellular and other Innovative Therapies (GCIT) 60
3.5.26 Transplant Services 61
3.5.27 Mental Disorder and Substance Abuse Treatment 65
3.5.28 Treatment of Spinal Disorders 67
3.5.29 Medical Treatment of Mouth, Jaws, and Teeth 67
3.5.30 Medical Treatment of Obesity 67
3.5.31 Reconstructive or Cosmetic Surgery and Supplies 68

3.5.32 Supplemental Surgery and Travel 68
3.5.33 Virtual Physical Therapy 70
3.6 YOUR PRESCRIPTION DRUG BENEFITS 71
3.6.1 Accessing Pharmacies and Benefits 71
3.6.2 Accessing Network Pharmacies and Benefits 72
3.6.3 Emergency Prescriptions 72
3.6.4 Availability of Providers 72
3.6.5 Cost Sharing for Prescription Drug Tiers 72
3.6.6 Cost Sharing for Network Benefits 73
3.6.7 When You Use an Out-of-Network Pharmacy 73
3.6.8 Cost Sharing for Out-of-Network Pharmacy Benefits 73
3.6.9 Pharmacy Benefit 74
3.6.10 Retail Pharmacy Benefits 74
3.6.11 Home Delivery Pharmacy 74
3.6.12 Specialty Prescriptions 75
3.6.13 Vaccines Covered Under the Pharmacy Benefit 75
3.6.14 Other Covered Expenses 75
3.6.15 Medicare Prescription Drug Plan 77
3.6.16 Covered Vaccines 78
3.6.17 Medicare Part D Premium Surcharge 78
3.6.18 Opting-Out of the Enhanced EGWP 79
3.6.19 Definitions 79
3.6.20 Pharmacy Benefit Limitations 79
3.6.21 Pharmacy Benefit Exclusions 80
3.7 MEDICAL BENEFIT EXCLUSIONS 84
3.8 INDIVIDUAL CASE MANAGEMENT 91
4 HEALTH REIMBURSEMENT ARRANGEMENT (HRA) 92
4.1 INTRODUCTION 92
5 DENTAL, VISION, AUDIO (DVA) PLAN 94
5.1 INTRODUCTION 94
5.2 ELIGIBILITY FOR DVA COVERAGE 94
5.2.1 Eligibility for coverage under the DVA plan 94
5.2.2 Eligible Dependents 94
5.2.3 Qualified Domestic Relations Order DVA Coverage Requirements 95
5.2.4 Dual DVA Coverage 95
5.3 INITIAL DVA COVERAGE ELECTIONS 95
5.3.1 Electing DVA Coverage 95
5.3.2 DVA Coverage Level and Premiums 96
5.4 WHEN DVA COVERAGE BEGINS 96
5.4.1 New Benefit Recipients 96
5.4.2 Dependents 96
5.5 CHANGING YOUR DVA COVERAGE 97
5.5.1 Open Enrollment 97
5.5.2 Decreasing DVA Coverage 97
5.5.3 Increasing Dependent DVA Coverage 97
5.6 WHEN DVA COVERAGE ENDS 98
5.6.1 For Retirees 98

5.6.2 For Dependents *98*
5.6.3 Continued Coverage *98*

6 STANDARD PLAN DENTAL BENEFITS 99

6.1 INTRODUCTION 99
6.2 HOW DENTAL BENEFITS ARE PAID 100
6.2.1 Deductible *100*
6.2.2 Coinsurance *100*
6.2.3 Network and Out-of-Network Coverage *100*
6.2.4 Availability of Providers *100*
6.2.5 Out-of-Network Recognized Charge *100*
6.2.6 Annual Maximum *101*
6.3 COVERED DENTAL SERVICES 101
6.3.1 Class I Preventive Services *101*
6.3.2 Class II Restorative Services *102*
6.3.3 Class III Prosthetic Services *103*
6.3.4 General Limitation – Optional Services *105*
6.4 ORAL HEALTH, TOTAL HEALTH PROGRAM AND BENEFITS 105
6.4.1 Diabetics *105*
6.4.2 Pregnant Persons *105*
6.5 ORTHODONTIC BENEFITS 106
6.6 ADVANCE CLAIM REVIEW FOR DENTAL CLAIMS 106

7 LEGACY PLAN DENTAL BENEFITS 106

7.1 DENTAL PLAN HIGHLIGHTS 106
7.2 HOW DENTAL BENEFITS ARE PAID 106
7.3 BENEFIT YEAR 107
7.4 ANNUAL MAXIMUM BENEFIT 107
7.5 DEDUCTIBLE 107
7.6 RECOGNIZED CHARGE 107
7.7 ADVANCE CLAIM REVIEW 108
7.8 COVERED DENTAL SERVICES 109
7.8.1 Class I Preventive Services *109*
7.8.2 Class II Restorative Services *109*
7.8.3 Class III Prosthetic Services *110*
7.9 DENTAL SERVICES NOT COVERED 110

8 STANDARD PLAN VISION BENEFITS 111

8.1 INTRODUCTION 111
8.2 HOW VISION BENEFITS ARE PAID 111
8.2.1 Deductible *111*
8.2.2 Benefit Year *111*
8.2.3 Copayment *112*
8.2.4 Annual Allowances *112*
8.2.5 Network Providers *112*
8.2.6 Benefit Maximum *112*
8.3 COVERED VISION SERVICES 112
8.3.1 Vision Exam *112*
8.3.2 Vision Supplies *112*

8.3.3 Prescription Lenses *112*
8.3.4 Frames *113*
8.3.5 Additional Services *113*
8.3.6 Contact Lenses *113*
8.3.7 Low Vision Benefit *113*
8.4 Standard Plan Vision and Optical Services Not Covered 113
8.4.1 Vision Plan Exclusions *114*
8.5 Benefits for Vision Care Supplies After Your Coverage Terminates 115

9 LEGACY PLAN VISION BENEFITS 115

9.1 Introduction 115
9.2 How Vision Benefits Are Paid 115
9.2.1 Deductible *115*
9.2.2 Coinsurance *115*
9.2.3 Accessing Coverage *115*
9.2.4 Recognized Charge *116*
9.2.5 Benefit Maximum *116*
9.3 Covered Vision Services 116
9.3.1 Vision Exam *116*
9.3.2 Vision Supplies *116*
9.4 Vision Plan Exclusions 116
9.5 Benefits for Vision Care Supplies After Your Coverage Terminates 118

10 AUDIO PLAN 118

10.1 Introduction 118
10.2 How Audio Benefits Are Paid 118
10.2.1 Deductible *118*
10.2.2 Coinsurance *118*
10.2.3 Recognized Charge *118*
10.2.4 Maximum Benefit *118*
10.3 Covered Audio Services 118
10.4 Audio Plan Exclusions 119

11 HOW TO FILE A HEALTH PLAN CLAIM 120

11.1 Claim Filing Deadline 120
11.2 Hospital Services 120
11.3 Physician and Other Provider Services 120
11.4 Dental Services 120
11.5 Vision Services 120
11.6 Audio Services 121
11.7 Prescription Drugs 121
11.8 Medical Benefits 121
11.9 Other Claim Filing Tips 122
11.10 Benefit Payments 122
11.11 Before Filing a Claim 122
11.12 Recordkeeping 123
11.13 Physical Examinations 123
11.14 If a Claim Is Denied 123
11.14.1 Initial Claim for Benefits *123*

11.14.2 Initial Review of Claim *123*
11.14.3 Initial Denial of Claim *124*
11.14.4 Ongoing Treatments *125*
11.14.5 First Level Appeal of Initial Denial of Claim *126*
11.14.6 Decision on First Level of Appeal of Initial Denial of Claim *126*
11.14.7 Second Level Appeal of Denial of Claim *127*
11.14.8 Decision on Second Level Appeal of Denial of Claim *127*
11.14.9 Application and Scope of External Review Process for Benefits Under the Medical Plan *127*
11.14.10 Standard External Review Process for Claims under the Medical Plan *128*
11.14.11 Expedited External Review Process for Medical Plan *130*
11.14.12 Third Level – Division of Retirement and Benefits Appeal *131*
11.14.13 Fourth Level - Appeal to Office of Administrator Hearings *132*
11.15 Claims Procedures Applicable to All Claims 132
11.15.1 Authorized Representative *132*
11.15.2 Calculating Time Periods *132*
11.15.3 Full and Fair Review *133*
11.15.4 Exhaustion of Remedies *133*

12 CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) AND EXTENDED HEALTH COVERAGE 134

12.1 Introduction 134
12.2 Right to Continuation Coverage 134
12.3 Election of Continuation Coverage 135
12.4 Period of Continuation Coverage 135
12.5 End of Continuation Coverage 135
12.6 Cost of Continuation Coverage 136
12.7 Notification Requirements 136
12.7.1 General Notice to Covered Retiree and Spouse *136*
12.7.2 Covered Eligible Retiree/Qualified Beneficiary Notice to Administrator *136*
12.7.3 Division's Notice to Qualified Beneficiary *137*
12.7.4 Unavailability of Coverage *137*
12.7.5 Notice of Termination of Coverage *137*
12.7.6 Use of a Single Notice *137*
12.8 Continuation Health Benefits Provided 137
12.9 Extended Coverage for Disabled Retirees or Dependents 138

13 COORDINATION OF BENEFITS 138

13.1 When Coordination of Benefits Applies to the medical plan 138
13.2 How Coordination of Benefits Works 138
13.3 Defined Terms 140
13.4 Which Plan Pays First 141
13.5 Right to Receive and Release Necessary Information 143
13.6 Facility of Payment 143
13.7 Right of Recovery 143

14 SUBROGATION AND REIMBURSEMENT RIGHTS 144

14.1 Right of Subrogation and Reimbursement 144
14.2 Funds to Which Subrogation and Reimbursement Rights Apply 144
14.3 Agreement to Hold Recovery in Trust 144
14.4 Disclaimer of Make Whole Doctrine 144

14.5 Disclaimer of Common Fund Doctrine 144
14.6 Obligations of the Covered Person 145
14.7 Plan's Right to Subrogation 145
14.8 Enforcement of Plan's Right to Reimbursement 145
14.9 Failure to Comply 145
14.10 Discretionary Authority of Administrator 145

15 PROTECTED HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) 146

15.1 Use and Disclosure of Protected Health Information 146
15.2 Plan Documents 146
15.3 Disclosures by the Plan to the State 146
15.4 Uses and Disclosures by State 147
15.5 Certification 147
15.6 Conditions Agreed to by the State 147
15.7 Adequate Separation Between the Plan and the State 148
15.8 Limitations of Access and Disclosure 148
15.9 Noncompliance 148

16 OTHER MANDATED COVERAGES 149

16.1 Genetic Information Nondiscrimination Act of 2008 (GINA) 149
16.2 Statement of Rights Under the Newborns' and Mothers' Health Protection Act 149
16.3 Eligibility for Medicaid Benefits 149
16.4 Dependent Students on Medically Necessary Leave of Absence 150

17 OTHER PLAN PROVISIONS 150

17.1 Access to Records 150
17.2 Health Plan Liability 150
17.3 Free Choice of Hospital and Provider 150
17.4 Plan Must Be Effective 151
17.5 Medical Outcomes 151
17.6 Epidemics and Public Disasters 151
17.7 Vested Rights 151

18 GENERAL PROVISIONS 152

18.1 Amendment or Termination Procedure 152
18.2 Cancellation 152
18.3 Right to Receive and Release Necessary Information 152
18.4 Nonalienation 152
18.5 Additional Taxes or Penalties 152
18.6 No Guarantee of Tax Consequences 153
18.7 Employment of Consultants 153
18.8 Designation of Fiduciaries 153
18.9 Fiduciary Responsibilities 153
18.10 Allocation of Fiduciary Responsibilities 153
18.11 Limitation of Rights and Obligations 153
18.12 Notice 154
18.13 Disclaimer of Liability 154
18.14 Right of Recovery 154

18.15 Legal Counsel 154
18.16 Evidence of Action 154
18.17 Protective Clause 154
18.18 Receipt and Release 154
18.19 Legal Actions 155
18.20 Reliance 155
18.21 Misrepresentation 155
18.22 Entire Plan 155
18.23 Applicable Law and Venue 155
18.24 Changes to the Plan 155
18.25 Facility of Payment 155
18.26 Premiums 156

19 DEFINITIONS 156

20 VERSION HISTORY 181

1 INTRODUCTION TO HEALTH PLAN

1.1 PLAN BENEFITS

The State of Alaska ("**State**") retirement systems provide comprehensive benefits under the AlaskaCare Defined Contribution Retiree (DCR) Benefit Plan ("**plan**") for you and your family. The **health plan** includes the **medical plan** and the **dental plan**, **vision plan**, and **audio plan** (collectively, the "**DVA plan**"**)**. Your coverage under the **health plan** is good worldwide.

This **health plan** shall be updated from time to time to reflect changes in benefits, including annual adjustments to the premium, **deductible**, **coinsurance**, medical **out-of-pocket limit**, and **prescription drug out-of-pocket limit**. The premium and cost sharing applicable to you is the premium and cost sharing in effect at the time you receive medical services or purchase **prescription drugs** under the **health plan**. You should make sure that you are referencing the most current edition of the *AlaskaCare DCR Benefit Plan* booklet, which is available from the Division of Retirement and Benefits ("**Division**") or AlaskaCare.gov.

This document is only intended to be a summary of the benefits available to you under the **health plan**, and it is not possible to address every individual circumstance. If you have questions about how any provision under the **health plan** pertains specifically to your situation, please contact the **claims administrators** or **pharmacy benefit manager.**

1.2 DEFINED TERMS

Bolded words in the **plan** are defined in section 19, *Definitions*.

1.3 ELIGIBILITY FOR COVERAGE

1.3.1 Eligibility for coverage under the health plan

A **member** is eligible to elect coverage under the **medical plan** if he or she retires directly from the **DCR Plan**, was an active member in the **DCR Plan** for at least 12 months immediately before application for retirement, and

a) has at least 25 years of **membership service** as a peace officer or firefighter,

b) for any other employee, has at least 30 years of **membership service**, or

c) has at least 10 years of **membership service** and reaches Medicare age.

A disabled **member** receiving an occupational disability benefit at the time of conversion to a normal retirement benefit under the **DCR Plan** is considered to have retired directly from the **DCR Plan**, and the period of disability constitutes **membership service** for purposes of determining the **member's** eligibility to elect coverage under the **medical plan**.

A disabled **member** who dies while receiving an occupational disability benefit or a deceased **member** whose **surviving spouse** receives an occupational death benefit is considered to have retired directly from

the **DCR Plan** on the date that the **member** would have been eligible for normal retirement if he or she had lived. The period of disability and the period during which a **surviving spouse** receives an occupational death benefit each constitute **membership service** for purposes of determining the **surviving spouse's** eligibility to elect coverage under the **medical plan**.

1.3.2 Eligible Dependents

You may enroll the following **dependents** in coverage under the **medical plan**:

a) Your **spouse**. You may be legally separated but not divorced.

b) Your **children** up to age 19 if they (i) are unmarried, (ii) provide less than one-half of their own support, and (iii) share your principal place of residence for more than one-half of the year (unless the **child** is your natural or adopted **child** and is living with your ex-**spouse**).

c) Your **children** up to age 23 if they meet the criteria listed above and are registered at and attending on a full-time basis an accredited educational or technical institution recognized by the Department of Education and Early Development.

d) 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 past age 23 who are incapable of employment because of a mental or physical incapacity can still be covered. The incapacity must have existed before age 23 and the children must continue to meet all other eligibility criteria, except for age. You must furnish the Division evidence of the incapacity and proof that the incapacity existed before age 23. 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. Incapacitated children remain covered as long as the incapacity exists, and you continue to provide periodic proof of the continued incapacity as required.

Your **dependent children's** spouse or **children** are <u>not</u> eligible for coverage under the **medical plan.**

When you enroll in the **medical plan**, you must also enroll each of your **dependents** in order for their claims to be paid. If your **dependents** subsequently change, you must notify the Division within 30 days, as provided under section 1.6, *Changing Your Coverage.*

1.3.3 Qualified Domestic Relations Order Coverage Requirements

If an **alternate payee** becomes a **benefit recipient** due to a **qualified domestic relations order**, then the **alternate payee** may enroll in coverage in accordance with the order, subject to the provisions of the **medical plan**. The **alternate payee** must present the order to the **Division**, enroll in coverage within 60 days of the order, and pay the required premium. These requirements apply regardless of the retirement plan to which the order applies.

1.3.4 Dual Coverage

You cannot receive coverage under the **medical plan** as both a **DCR Plan retiree** and a **dependent** of a **DCR Plan retiree**, or as a **dependent** of more than one **DCR Plan retiree**. If a **retiree** has elected to have access to benefits as a **dependent** of a **spouse** who is also a **retiree**, upon the death of the **spouse**-**retiree**, the **dependent**-**retiree**'s status reverts to that of a **retiree** under the plan.

1.4 INITIAL COVERAGE ELECTIONS

1.4.1 Electing Coverage

Benefit recipients who are eligible to be covered under the **medical plan**, as described in Section 1.3.1, *Eligibility for coverage under the health plan*, may voluntarily elect coverage under the **medical plan**. Each plan requires monthly premium payments.

Benefit recipients who voluntarily choose to elect coverage under the **medical plan**, may only elect coverage during the following events:

a) prior to the effective date of their retirement benefit under the **DCR Plan**;

b) with their application for survivor benefits; or

c) if you are not yet 70 ½ year of age, during the annual open enrollment period.

1.4.2 Coverage Level and Premiums

Coverage under the **medical plan** may be elected for:

a) retiree or surviving spouse only,

b) retiree and spouse,

c) retiree and child/children or surviving spouse and child/children, or

d) retiree and family (spouse and child/children).

Premiums may be paid by deductions from your HRA as described in section 4.5, *Submitting Claims for Reimbursement*. If you are not eligible for Medicare, you must pay the full monthly premium for the coverage elected under the **medical plan**. If you are eligible for Medicare, you must pay a percentage of the monthly premium for coverage elected under the **medical plan**, as follows:

a) 30 percent if the **member** had 10 or more, but less than 15, **years of service**;

b) 25 percent if the **member** had 15 or more, but less than 20, **years of service**;

c) 20 percent if the **member** had 20 or more, but less than 25, **years of service**;

d) 15 percent if the **member** had 25 or more, but less than 30, **years of service**; and

e) 10 percent if the **member** had 30 or more **years of service**.

An **alternate payee** must pay the full monthly premium for coverage elected under the **medical plan.**

You must pay the premium directly to the **direct bill administrator** to maintain coverage. Contact the HRA claims administrator for information on ways to set up payment for your premiums from your HRA to the direct bill administrator.

1.5 When Coverage Begins

1.5.1 New Benefit Recipients

If you timely elect coverage, you will be covered under the **DCR medical plan** on the first day of the month of your retirement, disability, or survivor/death benefits.

1.5.2 Dependents

Eligible dependents are covered on the dates specified below.

a) If you elect coverage for dependents, your dependents are eligible for benefits on the same day you are eligible if they meet all eligibility requirements.

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

c) If you increase your coverage to include dependents following marriage, birth, or adoption of a child, their coverage begins on the date of the qualifying event if the request is postmarked or received within 120 days of the qualifying event.

Newborns are automatically covered under the **medical plan** for the first 31 days after birth. To continue coverage after 31 days, you will need to enroll the **child** under the **medical plan** within 30 days after birth. New **dependent children** will be covered under the **plan** immediately if you have elected a level of coverage that covers the new **dependent** and you timely enroll the **child** in the **medical plan.**

1.6 Changing Your Coverage

You may elect, change, or terminate coverage under the **medical plan** as described in this section.

1.6.1 Open Enrollment

Open enrollment will be held annually. During open enrollment you may:

a) elect to begin coverage under the **medical plan** if you are not yet 70 ½ years of age and electing **medical plan** coverage for the first time,

b) change your coverage options by either increasing or decreasing your coverage levels,

c) terminate coverage under the **medical plan**.

1.6.2 Decreasing 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 at any time. To decrease your coverage, you must submit a written request to the **Division** electing the level of coverage you would like. Once you decrease your coverage, you cannot reinstate it except as described in section 1.6.3, *Increasing Dependent Coverage*.

You are required to notify the **Division** within 30 days that your **dependent** is no longer eligible under the **medical plan**. For example, if you divorce or your **child** ceases to meet the eligibility requirements, you must notify the **Division** so that coverage can be terminated. If you fail to timely notify the **Division**, you may be required to repay the benefits which you or your **dependent** were not eligible to receive, and you may also forfeit your right to ongoing and future coverage, at the **State's** discretion.

1.6.3 Increasing Dependent Coverage

You may increase **dependent** coverage only:

a) During an open enrollment period,

b) Upon marriage; or

c) Upon birth or adoption of your **child**.

For all benefit recipients, if you want to increase coverage due to marriage, 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, and the date the event occurred.

Changes in coverage are effective retroactive to the date of the qualifying event if the request is postmarked or received within 120 days of the qualifying event.

1.7 When Coverage Ends

1.7.1 For Retirees

Coverage under the **health plan** terminates for **retirees** as of the date that is the earliest of:

a) The date that any **benefit option** under the **health plan** is terminated.

b) The date that your coverage terminates.

c) The date you die.

d) The last day of the month in which you last paid the required monthly premium.

You may submit a written request to the **Division** to terminate your coverage. Coverage will end on the last day of the month in which the last premium was paid or deducted. 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.

1.7.2 For Dependents

Coverage under the **health plan** terminates for **dependents** as of the date that is the earliest of:

a) The date that any **benefit option** under the **health plan** is terminated.

b) You divorce. Coverage for your spouse ends on the date the divorce is final.

c) The last day of the month in which a **dependent child** ceases to satisfy the eligibility requirements for a **dependent** under the **medical plan**.

d) The date a **dependent** dies.

e) The date that your coverage terminates, or for a **dependent** in the event of your death, the last day of the month in which you die.

f) The last day of the month in which you last paid the required monthly premium on behalf of your **dependents**.

g) The date that you terminate coverage for your **dependents.**

You may submit a written request to the **Division** to terminate coverage for your **dependents**. Premium reductions are effective only after your written request is received by the **Division** and the **Division** cannot make changes in the coverage level for you. Coverage will end on the last day in which the last premium was paid or deducted.

1.7.3 Continued Coverage

Your **dependents** may be eligible for continued health benefits when coverage ends under the **medical plan**. See section 12, *Consolidated Omnibus Budget Reconciliation Act (COBRA) and Extended Health Coverage.*

1.8 Receipt of Documents

If the **Division** has no written record of receipt of an application, election, or claim, such document will have no effect unless you can provide reasonable proof that it was sent to the **Division**. Reasonable proof includes such items as a certified mail receipt or a receipt stamp from the **Division**.

All **Division** documents should be sent directly to the **Division**, or in the case of a claim, to the appropriate **claims administrators'** or **pharmacy benefit manager's** address in the front of this **health plan**. The **Division** will not be bound to any action due to receipt of a document at a location other than the **Division** or appropriate **claims administrator**.

1.9 Future of the Plan

The **State** reserves the right, in its sole discretion, to alter, amend, delete, cancel, or otherwise change the terms of the **health plan** or any premium payments for the **health plan** at any time, and from time to time, and to any extent that it deems advisable. No **retiree**, **dependent**, or **covered person** will have any

vested interest in the **health plan** or the **benefit options** under the **health plan** other than as provided under **State** law.

1.10 Administration of the Plan

The **Commissioner** is the administrator of the **health plan**, although the **Commissioner** has delegated to **claims administrators** the performance of certain responsibilities of the administrator. The **Commissioner** has full, discretionary authority to control and manage the operation of the **health plan**, and has all power necessary or convenient to enable it to exercise such authority. The **Commissioner** may provide rules and regulations, not inconsistent with the provisions hereof, for the operation and the management of the **health plan**, and may from time to time amend or **rescind** such rules or regulations.

Except as may be otherwise specifically provided in the **health plan**, the **Commissioner** has full, discretionary authority to enable it to carry out its duties under the **health plan**, including, but not limited to, the authority to determine eligibility under the **health plan** and to construe the terms of the **plan** and to determine all questions of fact or law arising hereunder. The **Commissioner** has all power necessary or convenient to enable it to exercise such authority. Notwithstanding the provisions of AS 39.35.006 permitting retirees to **appeal** a decision of the administrator all such determinations and interpretations will be final, conclusive, and binding on all persons affected thereby. The **Commissioner** has full, discretionary authority to correct any defect, supply any omission or reconcile any inconsistency and resolve ambiguities in the **health plan** in such manner and to such extent as it may deem expedient, and the **Commissioner** will be the sole and final judge of such expediency.

2 Health Plan – Benefit Schedules

2.1 Medical and Prescription Drug Benefits

2.1.1 Medical Benefit Schedule

The dollar amounts for deductibles, **coinsurance**, medical out-of-pocket limits, and prescription drug out-of-pocket limits are subject to adjustment annually.

Deductibles	
Annual individual **deductible**	$300
Annual family **deductible**	$600

Coinsurance	
Most medical expenses • $100 penalty if seek non-**emergency care** at emergency room of a **hospital**	80%
Most medical expenses after **out-of-pocket limit** is satisfied	100%
Facility services with a **network provider**	80%

Coinsurance	
Facility services provided to a non-Medicare age eligible **benefit recipient** or **dependent** with an out-of-**network hospital**, **surgery center**, **rehabilitative facility,** or free-standing imaging center in other 49 states or non-preferred provider **hospital**, **surgery center**, **rehabilitative facility,** or free-standing imaging center in Anchorage	60%
Transplant services if using an Institute of Excellence facility as contracted and designated by the **claims administrator**	80%
Transplant services if not using a Center of Excellence facility as contracted and designated by the **claims administrator**	60%
Preventive care provided to a non-Medicare age eligible dependent by a **network provider** or when use of an out-of-**network provider** has been **precertified.**	100%, deductible does not apply
Preventive care provided to a non-Medicare age eligible **benefit recipient** or **dependent** from an out-of-**network provider**, or to a Medicare age eligible **benefit recipient** or **dependent** seeing any covered provider	80%
Inpatient **mental disorder** treatment with a **network provider**	80%
Inpatient **mental disorder** treatment provided to a non-Medicare age eligible **benefit recipient** or **dependent** from an out-of-**network provider**	60%
Inpatient **substance abuse** disorder treatment with a **network provider**	80%
Inpatient **substance abuse** disorder treatment provided to a non-Medicare age eligible **benefit recipient** or **dependent** from an out-of-**network provider**	60%
Episode of Care received through Lantern benefits	100%

Out-of-Pocket Limit	
Annual individual **out-of-pocket limit**	$1,500
Annual family **out-of-pocket limit**	$3,000
The following expenses do not apply toward the **out-of-pocket limit**: • charges over the **recognized charge**; • non-**covered expenses**; • premiums; • $100 penalty for non-**emergency care** at emergency room of a **hospital** • pharmacy plan expenses	$3,000 individual / $6,000 family if non-Medicare age eligible **benefit recipient** or **dependent** use out-of-**network hospital**, **surgery center**, **rehabilitative facility,** or free-standing imaging center for **facility** services outside Alaska, or non-preferred provider **hospital**, **surgery center**, **rehabilitative facility,** or free-standing imaging center in Anchorage

Visit/Service Limits	
Spinal manipulations including medical massage therapy when done in conjunction with spinal manipulations	20 visits per **benefit year**
Home health care. See section 3.5.7, *Home Health Care*, for exceptions.	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 therapy visits in a 24-hour period Up to 1 hour = 1 visit
Travel Benefits: Therapeutic treatments	One visit and one follow-up per **benefit year**
Travel Benefits: • Prenatal/postnatal maternity care • Maternity delivery • Presurgical or postsurgical or second surgical opinion • Surgical procedure • Allergic condition	One visit per **benefit year** in each category
Travel Per Diems and Limitations	
Travel per diem without overnight lodging. See section 3.5.24, *Travel*, for applicable criteria.	$51/day
Travel per diem with overnight lodging. See section 3.5.24, *Travel*, for applicable criteria.	$89/night
Companion for **children** under age 18 per diem. See section 3.5.24, *Travel*, for applicable criteria.	$31/day
Overnight lodging for transplant services, in lieu of other travel per diems. See section 3.5.25, *Transplant Services*, for other applicable criteria.	$50 per person/night, up to $100/night
Limit on travel for transplant services	$10,000 per transplant occurrence
Travel benefits without **precertification**	Up to $500, not to exceed eligible travel costs

Lantern Daily per diem for benefits under section 3.5.32 Supplemental Surgery and Travel	$25 per patient per day Or $50 per patient and companion per day Begins the first day of authorized travel – ends last day of authorized travel

2.1.2 Standard Prescription Drug Schedule

Prescription Tier	Coinsurance	Minimum Covered Person Payment	Maximum Covered Person Payment
Retail 30 Day at Network Pharmacy			
Generic prescription drug	80%	$10	$50
Preferred brand-name prescription drug	75%	$25	$75
Non-preferred brand-name prescription drug	65%	$80	$150
Home Delivery 31-90 Day at Network Pharmacy			
Prescription Tier		**Copayment**	
Generic prescription drug		$20	
Preferred brand-name prescription drug		$50	
Non-preferred brand-name prescription drug		$100	
Out-of-Network Pharmacy			
Coinsurance for all **prescription drugs**		60%	
Out-of-Pocket Limit			
Annual individual **out-of-pocket limit**		$1,000	
Annual family **out-of-pocket limit**		$2,000	
Special Note			
Insulin member cost sharing maximum of $35 per 30-day supply.			

2.1.3 Opt-Out Prescription Drug Schedule

Prescription Tier	Coinsurance	Minimum Covered Person Payment	Maximum Covered Person Payment
Retail 30 Day at Network Pharmacy			
Generic prescription drug	70%	$15	$75
Preferred brand-name prescription drug	65%	$30	$90
Non-preferred brand-name prescription drug	55%	$90	$175
Home Delivery 31-90 Day at Network Pharmacy			
Prescription Tier		**Copayment**	
Generic prescription drug		$35	
Preferred brand-name prescription drug		$75	
Non-preferred brand-name prescription drug		$125	
Out-of-Network Pharmacy			
Coinsurance for all **prescription drugs**		50%	
Out-of-Pocket Limit			
Annual individual **out-of-pocket limit**		$2,000	
Annual family **out-of-pocket limit**		$4,000	
Special Note			
Coordination of Benefits		The opt-out benefits are exempt from *section 11, Coordination of Benefits*	

2.2 Dental Benefit Schedule (if elected)

	Standard Plan	Legacy Plan
Deductibles		
Annual individual **deductible** • Applies to Class II (restorative) and Class III (prosthetic) services	$50	$50
Coinsurance		
Class I (preventive) services	100%	100%
Class II (restorative) services	80%	80%
Class III (prosthetic) services	50%	50%
Benefit Maximums		
Annual individual maximum	$3,000	$2,000

2.3 Standard Plan Vision Benefit Schedule (if elected)

Service or Supply	Network Provider	Out-of-Network Provider
Exam	One per calendar year $10 copayment 100% after copayment	One per calendar year $10 copayment Maximum reimbursement limit of $100
Lenses • Single vision • Lined bifocal • Lined trifocal • Lenticular • Progressive	One pair per calendar year $10 copayment 100% after copayment	One pair per calendar year $10 copayment Maximum reimbursement limit of: Single vision: $75 Lined bifocal: $115 Lined trifocal: $130 Lenticular: $185 Progressive: $165
Lens options • Anti-reflective coating • Polycarbonate • Scratch resistant coating	Once per calendar year 100%	Not covered
Frames	One every two calendar years $10 copayment 100% after copayment up to the following frame allowances: Retail frame: $200 Featured frame brand: $220 Walmart/Costco: $200	One every two calendar years $10 copayment Maximum reimbursement limit of $70
Contact lenses Exam (fitting and evaluation)	Maximum $60 copayment 100% after copayment	No separate coverage. Allowance is shared with Contact Lenses.
Contact lenses (elective and in lieu of lenses and frame)	Once per calendar year $150 contact lens allowance	Once per calendar year Maximum reimbursement of $135 for fitting and evaluation and materials

2.4 Legacy Plan Vision Benefit Schedule (if elected)

Coinsurance	
All services (exam, lenses, frames)	80%
Benefit Maximums	
Exam	One per **benefit year**
Lenses	Two per **benefit year**
Frames	One set every two **benefit years**
Contact lenses in lieu of lenses and frames	Two per **benefit year**
Aphakic and **medically necessary** contact lens lifetime maximum	80% up to $400 lifetime maximum; thereafter 80% subject to elective contact lens benefit

2.5 Audio Benefit Schedule (if elected)

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

3 Medical Plan

3.1 About Your Medical Plan

3.1.1 Introduction

The **medical plan** provides coverage for a wide range of medical expenses for the treatment of **illness** or **injury**. With the **medical plan**, you can directly access any **network provider** or out-of-**network provider** for services and supplies covered under the **medical plan**. The **medical plan** pays benefits differently when services and supplies are obtained by non-Medicare eligible **benefit recipients** and **dependents** through **network providers** and out-of-**network providers**.

The **medical plan** will pay for **covered expenses** up to the maximum benefits shown in section 2.1, *Medical and Prescription Drug Benefits*.

Coverage is subject to all the terms, policies and procedures outlined in the **medical plan**. Not all medical expenses are covered under the **medical plan**. Exclusions and limitations apply to certain medical services, supplies and expenses. See section 3.5, *Covered Medical Expenses*, section 3.6.15, *Pharmacy Benefit*

Limitations, section 3.6.21, *Pharmacy Benefit Exclusions*, and section 3.7, *Medical Benefit Exclusions* to determine if medical services are covered, excluded or limited.

3.1.2 Lifetime Maximum

There is no overall lifetime maximum that applies to **covered expenses** under the **medical plan.**

3.1.3 Common Accident Deductible Limit

The common **accident deductible** limit applies when two or more family members are injured in the same **accident**. The common **accident deductible** limit places a limit on your **deductible** for the **benefit yea**r when **covered expenses** are applied toward the separate individual **deductibles** for the **benefit year**. When all **covered expenses** related to the **accident** in that **benefit year** exceed the common **accident deductible** limit, the **medical plan** will then begin to pay for **covered expenses** based on the applicable **coinsurance**.

The common **accident deductible** limit is a single annual individual **deductible**.

3.2 How The Medical Plan Works When You or Your Dependents are not Medicare Age Eligible

3.2.1 Network Benefits

The **medical plan** provides access to covered benefits through a network of health care **providers** and facilities for **benefit recipients** or **dependents** who are not Medicare age eligible. The **medical plan** is designed to lower your out-of-pocket costs when you use **network providers** for **covered expenses**. The **coinsurance** paid by the **plan** will generally be higher when you use **network providers** and facilities.

You also have the choice to access licensed **providers**, **hospitals** and other facilities outside the network for **covered expenses**. Your out-of-pocket costs will generally be higher when you use out-of-**network providers** because the **coinsurance** that you are required to pay is usually higher when you use out-of-**network providers**. Out-of-**network providers** have not agreed to accept the **negotiated charge** and may balance bill you for charges over the amount the **medical plan** pays. Additionally, when receiving services at an out-of-**network hospital** or other **facility** in the Municipality of Anchorage or outside of Alaska, the **recognized charge** is reduced to a percentage of Medicare that most closely reflects the aggregate contracted rate at the preferred **hospital** or other **facility** in the Anchorage area. See section 3.2.4, *Accessing Out-of-Network Provider and Benefits* and section 3.2.5, *Cost Sharing for Out-of-Network Benefits*, for additional information.

Some services and supplies may only be covered through **network providers**. See section 3.5, *Covered Medical Expenses* to determine if any services are limited to network coverage only.

Your out-of-pocket costs may vary between network and out-of-network benefits. Read the **medical plan** carefully to understand the cost sharing charges applicable to you.

3.2.2 Accessing Network Providers and Benefits

You may select any **network provider** from the **claims administrator's provider** directory. You can access the **claims administrator's** online **provider** directory at AlaskaCare.gov for the names and locations

of **physicians, hospitals** and other health care **providers** and facilities. Due to AlaskaCare having a custom provider network it is important that you use the AlaskaCare specific DocFind® tool rather than Aetna's public DocFind® tool to get accurate results. You can change your health care **provider** at any time.

If a service or supply you need is covered under the **medical plan** but not available from a **network provider**, please contact the **claims administrator** at the toll-free number on your ID card for assistance.

Some health care services such as hospitalization, outpatient surgery and certain other outpatient services, require **precertification** with the **claims administrator** to verify coverage for these services. 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. See section 3.4, *Understanding Precertification,* for more information.

You will not have to submit medical claims for treatment received from **network providers**. Your **network provider** will take care of claim submission. The **medical plan** will directly pay the **network provider** less any cost sharing required by you. You will be responsible for **deductibles**, **coinsurance**, and **copayments**, if any.

You will receive notification of what the **medical plan** has paid toward your **covered expenses**. It will indicate any amounts you owe toward any **deductible**, **copayment**, **coinsurance**, or other non-**covered expenses** you have incurred. You may elect to receive this notification by e-mail or through the mail. Contact the **claims administrator** if you have questions regarding this notification.

3.2.3 Cost Sharing for Network Benefits

Network providers have agreed to accept the **negotiated charge.** The **medical plan** will reimburse **covered expenses** incurred from a **network provider**, subject to the **negotiated charge** and the maximum benefits under the **medical plan**, less any cost sharing required by you such as **deductibles, copayments** and **coinsurance**. Your **coinsurance** is based on the **negotiated charge**. You will not have to pay any balance bills above the **negotiated charge** for that covered service or supply.

You must satisfy any applicable **deductibles** before the **medical plan** begins to pay benefits.

Coinsurance paid by the **medical plan** is usually higher when you use **network providers** than when you use out-of-**network providers**.

After you satisfy any applicable **deductible**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur up to the applicable **out-of-pocket limit**.

Once you satisfy any applicable **out-of-pocket limit**, the **medical plan** will pay 100% of the **covered expenses** that apply toward the limit for the rest of the **benefit year**. Certain out-of-pocket costs may not apply to the **out-of-pocket limit**. See section 2.1, *Medical and Prescription Drug Benefits,* for information on what **covered expenses** do not apply to the **out-of-pocket limits** and for the specific **out-of-pocket limits** under the **medical plan**.

The **medical plan** will pay for **covered expenses**, up to the maximums shown in section 2.1, *Medical and Prescription Drug Benefits.* You are responsible for any expenses incurred over these maximum limits.

You may be billed for any **deductible**, **copayment**, or **coinsurance** amounts, or any non-**covered expenses** that you incur.

3.2.4 Accessing Out-of-Network Providers and Benefits

You have the choice to directly access out-of-**network providers**. You will still be covered when you access out-of-**network providers** for covered benefits. When your medical service is provided by an out-of-**network provider,** the level of reimbursement from the **medical plan** for some **covered expenses** will usually be lower. This means your out-of-pocket costs will generally be higher. Some health care services, such as hospitalization, outpatient surgery and certain other outpatient services, require **precertification** with the **claims administrator** to verify coverage for these services. When you receive services from an out-of-**network provider**, you are responsible for obtaining the necessary **precertification** from the **claims administrator**. Your **provider** may **precertify** your treatment for you. However, you should verify with the **claims administrator** prior to receiving the services that the **provider** has obtained **precertification**. If the service is not **precertified**, the benefit payable may be significantly reduced or may not be covered. This means you will be responsible for the unpaid balance of any bills. You must call the **claims administrator** to **precertify** services. See section 3.4, *Understanding Precertification*, for more information on the **precertification** process and what to do if your request for **precertification** is denied.

When you use out-of-**network providers**, you may have to pay for services at the time they are rendered. You may be required to pay the charges and submit a claim form for reimbursement. When you pay an out-of-**network provider** directly, you will be responsible for completing a claim form to receive reimbursement of **covered expenses** under the **medical plan**. You must submit a completed claim form and proof of payment to the **claims administrator**. See section 11, *How to File a Health Plan Claim*, for a complete description of how to file a claim under the **medical plan**.

Important note regarding out-of-network **hospital** emergency **facility** services: If the emergency room providers are not **network providers**, you may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the **medical plan**. If the **provider** bills you for an amount above the **recognized charge** for a **covered expense**, you are not responsible for paying the bill. To resolve this payment dispute, you must contact the **claims administrator**.

You will receive notification of what the **medical plan** has paid toward your **covered expenses**. It will indicate any amounts you owe toward your **deductible**, **coinsurance**, or other non-**covered expenses** you have incurred. You may elect to receive this notification by e-mail or through the mail. Contact the **claims administrator** if you have questions regarding this notification.

IMPORTANT: Failure to precertify services and supplies provided by an out-of-network provider will result in a reduction of benefits or no coverage for the services and supplies under this medical plan. See section 3.4, *Understanding Precertification,* for information on how to request precertification and the applicable precertification benefit reduction.

3.2.5 Cost Sharing for Out-of-Network Benefits

Out-of-**network providers** have not agreed to accept a **negotiated charge.** The **medical plan** will reimburse you for a **covered expense** incurred from an out-of-**network provider**, subject to the **recognized charge** and the maximum benefits under the **medical plan**, less any cost sharing required by you such as **deductibles, copayments,** and **coinsurance**. The **recognized charge** is the maximum amount the **medical plan** will pay for a **covered expense** from an out-of-**network provider**. Your **coinsurance** is based on the **recognized charge**. If your out-of-**network provider** charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**. Except for **emergency** services, the **medical plan** will only pay up to the **recognized charge.**

When receiving services at an out-of-**network hospital** or **facility** in the Municipality of Anchorage or outside of Alaska, the **recognized charge** for the out-of-**network hospital** or **facility** services is reduced to a percentage of Medicare that most closely reflects the aggregate contracted rate at the preferred **hospital** or **facility** in the Anchorage area.

You must satisfy any applicable **deductibles** before the **medical plan** begins to pay benefits.

Coinsurance paid by the **medical plan** is usually lower when you use out-of-**network providers** than when you use **network providers**.

For certain types of services and supplies, you will be responsible for a **copayment.** The **copayment** will vary depending upon the type of service.

After you satisfy any applicable **deductible**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur up to the applicable **out-of-pocket limit.**

Once you satisfy any applicable **out-of-pocket limit**, the **medical plan** will pay 100% of the **covered expenses** that apply toward the limit for the rest of the **benefit year**. Certain out-of-pocket costs may not apply to the **out-of-pocket limit**. See section 2.1, *Medical and Prescription Drug Benefits,* for information on what **covered expenses** do not apply to the **out-of-pocket limit** and for the specific **out-of-pocket limits** under the **medical plan**.

The **medical plan** will pay for **covered expenses**, up to the maximums shown in section 2.1, *Medical and Prescription Drug Benefits*. You are responsible for any expenses incurred over these maximum limits.

You may be billed for any **deductible**, **copayment,** or **coinsurance** amounts, or any non-**covered expenses** that you incur.

3.2.6 Availability of Providers

The **claims administrator** cannot guarantee the availability or continued network participation of a particular **provider** (*e.g.* **physician** or **hospital**). Either the **claims administrator** or any **network provider** may terminate the **provider** contract. To identify **network providers**, visit AlaskaCare.gov for the **claims administrator's** online **provider** directory.

3.2.7 Recognized Charge

The **recognized charge** is the charge contained in an agreement the **claims administrator** has with a **network provider**. If you use an out-of-**network provider**, the **covered expense** is the part of a charge which is the **recognized charge** as described in section **19, *Definitions – "Recognized Charge"***. If you use an out-of-**network provider** and the charge exceeds the **recognized charge**, the amount above the **recognized charge** is not covered by the **medical plan**, and is your responsibility to pay. You are not responsible for charges exceeding the **recognized charge** when you use a **network provider**.

If two or more surgical procedures are performed through the same site or bilaterally (on two similar body parts, such as two feet) during a single operation, the **claims administrator** will determine which procedures are primary, secondary and tertiary, taking into account the billed charges, and payment for each procedure will be made at the lesser of the billed charge or the following percentage of the **recognized charge**:

a) Primary: 100%

b) Secondary: 50%

c) All others: 25%

Incidental procedures, such as those that take little or no additional resources or time when performed at the same time as another procedure, are not covered by the **medical plan**.

3.3 How The Medical Plan Works When You or Your Dependent are Medicare Age Eligible

3.3.1 Eligibility for Medicare

You and your **dependents** are considered eligible for all parts of Medicare for the purposes of the **medical plan** during any period you or your **dependents** have coverage under Medicare or, while otherwise qualifying for coverage under Medicare, do not have such coverage solely because you or your **dependents** have refused, discontinued, or failed to make any necessary application for Medicare Part A or Part B coverage.

3.3.2 Secondary Coverage to Medicare

To the extent allowable under applicable law, coverage under the **medical plan** for you and your **dependents** who are eligible to be covered under Medicare will be secondary to coverage of you and your **dependents** under Medicare.

Note: If you enter into a private contract with a **provider** that has opted out of Medicare, neither Medicare nor the **plan** will pay benefits for their services.

3.3.3 Medicare Coverage Election

If you and your **dependents** choose not to be covered by the **medical plan** and elect to be covered by Medicare, Medicare will provide the coverage and coverage under the **medical plan** will terminate.

3.3.4 Which Plan Pays First

General rules for determining the order of payment are as follows:

a) If you are a **covered person** under the **medical plan** only and are Medicare-eligible, Medicare will pay as primary.

b) If you are also a **dependent** under another person's health plan through their active employment, that plan will pay as primary, Medicare will pay as secondary, and the **medical plan** will pay as tertiary.

c) If you are also covered under another health plan through your active employment, then your other health plan will pay as primary, Medicare will pay as secondary, and the **medical plan** will pay as tertiary.

If you are only enrolled in Medicare Part B, and/or enrolled in Medicare Part A on a premium-paying basis, the standard Medicare coordination of benefit provisions do not apply. Contact the claims administrator for additional information.

Relevant deductibles, coinsurance and out-of-pocket limits continue to apply to both Medicare and the **Plan**.

The order of coordination does not change for services covered under Medicare, even though you may not be enrolled in all Medicare plans.

3.3.5 Employer Group Waiver Program (EGWP)

Beginning January 1, 2019 if you or your eligible **dependent** are, or become eligible for Medicare, the plan will enroll you or your **dependent** into an enhanced Employer Group Waiver Program (EGWP) for your **prescription drug** benefits. This will not change the benefits outlined in section 3.6, *Your Prescription Drug Benefits* unless you chose to opt-out of the **enhanced EGWP**. If you are assessed an Income Related Monthly Adjustment Amount (IRMAA) surcharge on your Medicare Part B premium, you will be assessed a similar surcharge for your Medicare Part D. The plan will reimburse you for the Medicare Part D IRMAA surcharge. See section 3.6.16, *Medicare Part D Premium Surcharge* for additional information.

3.3.6 Recognized Charge

The **recognized charge** when Medicare is primary and you are receiving a Medicare covered service is assumed to be the Medicare allowed rate and will be determined by Medicare. If you receive services that are not covered by Medicare, and the charge exceeds the **recognized charge** as described in section 19**, *Definitions – "Recognized Charge"***, the amount above the **recognized charge** is not covered by the **medical plan** and is your responsibility to pay. If you receive Medicare covered services with a provider who has opted out of Medicare, neither Medicare nor the **plan** will pay benefits for their services.

3.4 UNDERSTANDING PRECERTIFICATION

3.4.1 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 **medical plan**. It also allows the **claims administrator** 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 **medical plan** is secondary to coverage you have from another health plan, including Medicare.

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 the **claims administrator** for any services or supplies that require **precertification** as described in section 3.4.3, *Services Requiring Precertification*. If you do not **precertify**, your benefits may be reduced, or the **medical plan** may not pay any benefits.

You may request precertification of use of an out-of-network provider for eligible preventive services if there are no network provider options in your area.

3.4.2 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 the **claims administrator** 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, fax or mail the medical claims administrator at the telephone number or address listed on your ID card in accordance with the following timelines:

For non-**emergency** admissions:	You, your **physician** or the **facility** must call and request **precertification** at least 15 days before the date you are scheduled to be admitted.
For an **emergency** outpatient medical condition:	You or your **physician** must call prior to the outpatient care, treatment or procedure, if possible, or as soon as reasonably possible.
For an **emergency** admission:	You, your **physician** or the **facility** must call within 48 hours or as soon as reasonably possible after you have been admitted.
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 least 15 days before the outpatient care is provided, or the treatment or procedure is scheduled.

The **claims administrator** will provide a written notification to you and your **physician** of the **precertification** decision. If the **claims administrator 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, the **claims administrator** 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 the **claims administrator** at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. The **claims administrator** will review and process the request for an extended **stay**. You and your **physician** will receive a notification of an approval or **denial**.

If the **claims administrator** determines that the **stay** or services and supplies are not **covered expenses**, the notification will explain why and how the **claims administrator**'s decision can be **appeal**ed. You or your **provider** may request a review of the **precertification** decision in accordance with ***section 11, How to File a Health Plan Claim***.

You are responsible for requesting precertification for eligible travel expenses. See *Section 3.5.24 Travel*. Your provider (both network and out-of-network) is not responsible for requesting precertification for any eligible travel expenses.

3.4.3 Services Requiring Precertification

Precertification is handled by the medical plan administrator and the full list of services requiring precertification can be located at: aetna.com/health-care-professionals/precertification/precertification-lists.html. All in-patient hospital, rehabilitation facility and skilled nursing facility admissions require precertification. Certain outpatient surgery and other outpatient services may also require Precertification.

In addition to the medical services listed on the medical claims administrator's website, travel expenses must be precertified. You are responsible for requesting **precertification** for eligible travel expenses.

The following list identifies some, but not all, of the services and supplies that may require **precertification** under the **medical plan**. Services requiring precertification are subject to change. **Precertification** is required for the following types of medical expenses:

- Stays in a hospital
- Stays in a **skilled nursing facility**
- Stays in a rehabilitation facility
- Private duty nursing care
- Transportation by fixed wing aircraft (plane)
- Arthroscopic hip surgery to repair impingement syndrome including labral repair
- Autologous chondrocyte implantation, Carticel (injection into the knee of cartilage cells grown from tissue cultures)
- Chiari malformation decompression surgery
- Cochlear implant (surgical implant of a device into the ear to try to improve hearing)
- 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
- Endoscopic nasal balloon dilation procedures
- Functional endoscopic sinus surgery (FESS)
- Gender affirmation surgery
- Hyperbaric oxygen therapy
- Lower Limb prosthetics
- Nonparticipating freestanding ambulatory surgical facility services, when referred by a participating provider
- Oncotype DX (a method for testing for genes that are in cancer cells)
- Organ transplants
- 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)
- Osseointegrated implant
- Osteochondral allograft/knee (grafting of cartilage and bone from a cadaver to the knee joint)
- Power morcellation with uterine myomectomy, with hysterectomy or for removal of uterine fibroids
- Proton beam radiotherapy
- Reconstructive or other procedures that may be considered cosmetic
- Shoulder arthroplasty including revision procedures
- Surgical spinal procedures
- Uvulopalatopharyngoplasty, including laser-assisted procedures (surgery to reconfigure the soft palate to try to help with sleep apnea)
- Ventricular assist devices
- Use of an out-of-**network provider** for preventive care services.
- Whole exome sequencing

3.4.4 How Failure to Precertify Affects your Benefits

If you fail to obtain a required precertification prior to incurring medical expenses from an out-of-network provider, your benefits will be paid in accordance with the terms of the plan, however your

expenses may not be covered if they do not meet the criteria in Section 3 Medical Plan. You will be responsible for all expenses that are not covered.

You are responsible for obtaining the necessary precertification from the medical claims administrator prior to receiving services from an out-of-network provider. Your provider may pre-certify your treatment for you; however, you should verify with the medical claims administrator prior to the procedure that the provider has obtained precertification from the medical claims administrator.

If precertification of travel expenses was not requested, maximum reimbursement for travel expenses will be limited to $500 per round trip travel claim, not to exceed eligible travel costs.

3.5 Covered Medical Expenses

The **medical plan** provides coverage for a wide range of medical expenses for the treatment of **illness** or **injury** for you and your **dependents**. It does not provide benefits for all medical care. The service, supply or **prescription drug** must meet all of the following requirements:

a) Be included as a **covered expense** under the **medical plan**.

b) Not be an excluded expense under the **medical plan**. See section 3.7, *Medical Benefit Exclusions*, for a list of services and supplies that are excluded, and section 3.6.21, *Pharmacy Benefit Exclusions*, for additional exclusions that apply with respect to the **prescription drug** benefit under the **medical plan**.

c) Not exceed the maximums and limitations outlined in the **medical plan**. See section 2.1, *Medical and Prescription Drug Benefits*, and section 3.2, *How the Medical Plan Works When You or Your Dependents are not Medicare Age Eligible*, for information about certain maximums and limits.

d) Be obtained in accordance with all the terms, policies and procedures outlined in the **medical plan**.

e) Be provided while coverage is in effect. See section 1.5, *When Coverage Begins,* and section 1.7, *When Coverage Ends,* for details on when coverage begins and ends.

This section describes **covered expenses** under the **medical plan**.

3.5.1 Medically Necessary Services and Supplies

The **medical plan** pays only for **medically necessary** services and supplies. A service, supply or **prescription drug** will be deemed **medically necessary** if the **claims administrator** or **pharmacy benefit manager** determines that the service, supply or **prescription drug** would be given to a patient for the purpose of 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.

If the **medical plan** is secondary to coverage you have from another health plan, including Medicare, the **Plan** will use the primary plans determination, unless the service is specifically excluded under the **Plan.**

When the **Plan** is primary, for the **claim administrator** or **pharmacy benefit manager** to determine if a service, supply or **prescription drug** is **medically necessary**, it must be:

a) in accordance with generally accepted standards of medical practice;
b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease;
c) not mostly for the convenience of the patient or **physician** or **other health care provider**;
d) not **experimental or investigational** and not excessive in scope, duration or intensity; and
e) no 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 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 or visits, or to a dollar maximum.

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

a) Those that do not require the technical skills of a medical professional who is acting within the scope of their license.
b) 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**.
c) 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**.
d) 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.

3.5.2 Physician Services

3.5.2.1 Physician Visits

Covered expenses include charges made by a **physician** during a visit to treat an **illness** or **injury**. The visit may be at the **physician's** office, in your home, in a **hospital** or other **facility** during your **stay**, or in an outpatient **facility**.

3.5.2.2 Surgery

Covered expenses include charges made by a **physician** for:

a) performing your surgical procedure;
b) pre-operative and post-operative visits; and

c) consultation with another **physician** to obtain a second opinion prior to the surgery.

3.5.2.3 Providers

Providers who are covered by the **medical plan** are individuals licensed to practice in:

a) Dentistry (D.D.S. or D.M.D.)
b) Medicine and surgery (M.D.)
c) Osteopathy and surgery (D.O.)

The following **providers** are also covered by the **medical plan**:

a) Acupuncturists
b) Advanced nurse practitioners
c) Audiologists
d) Chiropractors
e) Christian Science practitioners authorized by the Mother Church, First Church of Christ Scientist, Boston, Massachusetts
f) Dieticians
g) Licensed clinical social workers
h) Licensed marital and family counselors
i) Massage therapists
j) Naturopaths
k) Nutritionists
l) Occupational therapists
m) Ophthalmologists
n) Optometrists
o) Physical therapists
p) Physician assistants
q) Podiatrists
r) Practitioners with a master's degree in psychology or social work, if supervised by a psychologist, medical doctor or licensed clinical social worker
s) Psychological associates
t) Psychologists
u) State-certified nurse midwives or registered midwives

All **providers** must be (i) licensed as a health care practitioner by the state in which they practice, (ii) practicing within the scope of that license, and (ii) providing a service that is covered under the **medical plan**. If a state does not issue licenses with respect to a category of health care practitioners, the **provider** must be supervised by a **provider** practicing within the scope of their license.

3.5.3 Nurse Advice Line

A registered nurse is available to you by phone 24 hours a day, free of charge by calling the **claims administrator**'s number listed in the front of the **medical plan**. The nurse 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. The nurse 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. This service is confidential.

3.5.4 Hospital Expenses

Covered expenses include services and supplies provided by a **hospital** during your **stay**.

3.5.4.1.1 Room and Board

Covered expenses include charges for **room and board** provided at a **hospital** during your **stay**. Private room charges that exceed the **hospital's** semi private room rate are not covered unless a private room is required because of a contagious **illness** or immune system problem.

Room and board charges also include:

a) Services of the **hospital's** nursing staff
b) Admission and other fees
c) General and special diets
d) Sundries and supplies

3.5.4.1.2 Other Hospital Services and Supplies

Covered expenses include charges made by a **hospital** for services and supplies furnished to you in connection with your **stay**. **Covered expenses** include **hospital** charges for other services and supplies provided, such as:

a) **Ambulance** services
b) **Physicians** and surgeons
c) Operating and recovery rooms
d) Intensive or special care facilities
e) Administration of blood and blood products, but not the cost of the blood or blood products
f) Radiation therapy
g) Speech therapy, physical therapy and occupational therapy
h) Oxygen and oxygen therapy
i) Radiological services, laboratory testing and diagnostic services
j) Medications
k) Intravenous (IV) preparations
l) Discharge planning

3.5.4.1.3 Outpatient Hospital Expenses

Covered expenses include **hospital** charges made for covered services and supplies provided by the outpatient department of a **hospital**.

The **medical plan** will only pay for nursing services provided by the **hospital** as part of its charge. The **medical plan** does not cover **private duty nursing** services as part of an inpatient **hospital stay**.

If a **hospital** or other health **facility** does not itemize specific **room and board** charges and other charges, the **claims administrator** will assume that 40% of the total is for **room and board** charge and 60% is for other charges.

In addition to charges made by the **hospital**, certain **physicians** and other **providers** may bill you separately during your **stay**.

3.5.4.1.4 Coverage for Emergency Medical Conditions

Covered expenses include charges made by a **hospital** or a **physician** for services provided in an **emergency** room to evaluate and treat an **emergency** medical condition. The **emergency care** benefit covers:

a) Use of emergency room facilities
b) Emergency room **physician** services
c) **Hospital** nursing staff services
d) Radiologists and pathologists services

3.5.4.1.5 Coverage for Urgent Conditions

Covered expenses include charges made by a **hospital** or **urgent care provider** to evaluate and treat an **urgent condition**. Your coverage includes:

a) Use of emergency room facilities when network urgent care facilities are not in the **service area** and you cannot reasonably wait to visit your **physician**
b) Use of urgent care facilities
c) **Physicians** services
d) Nursing staff services
e) Radiologists and pathologists services

3.5.5 Facility-Only Preferred Provider Agreement

The **medical plan** has a **facility**-only preferred provider agreement for **facility s**ervices provided in the municipality of Anchorage to a non-Medicare age eligible **benefit recipient** or **dependent**. The preferred facilities in the Municipality of Anchorage are Alaska Regional Hospital, Providence Alaska Medical Center, and in-network ambulatory surgery centers.

The preferred provider **facilities** have agreed to charge a rate for services which results in lower costs to the covered person and the **Plan**. Non-preferred providers, and non-**network providers**, are **facilities** within the Anchorage area have not agreed to charge a lower rate for services. Coverage for services for a non-Medicare age eligible **benefit recipient** or **dependent** will be reduced by 20% when provided by a non-preferred **hospital**, **surgery center**, **rehabilitative facility** or free-standing imaging center within the Anchorage municipal area, or a non-network **hospital**, **surgery center**, **rehabilitative facility** or free-standing imaging center in the other 49 states.

When receiving services at an out-of-**network hospital** or other type of **facility**, the **recognized charge** for the out-of-**network facility** services to a non-Medicare age eligible **benefit recipient** or **dependent** is reduced to the percentage of Medicare that most closely reflects the aggregate contracted rate at the preferred **hospital** or **facility** in the Municipality of Anchorage.

In addition, the **out-of-pocket limit** that otherwise applies under the medical option you are covered by will be doubled for a non-Medicare age eligible **benefit recipient** or **dependent**. All services provided by a **hospital**, **surgery center**, **rehabilitative facility,** or free-standing imaging center, including imaging, testing or outpatient surgery, are subject to this provision except for:

a) services that cannot be performed at a preferred provider **hospital** or **facility**; and

b) **emergency** services.

3.5.6 Alternatives to Hospital Stays

IMPORTANT NOTE: The medical plan will reduce benefits by 20% if a non-Medicare age eligible **benefit recipient** or **dependent** receives services from a non-preferred hospital, **surgery center**, rehabilitative facility, or free-standing imaging center in the Municipality of Anchorage or from an out-of-network hospital, **surgery center**, rehabilitative facility, or free-standing imaging center provider in the other 49 states. In addition, when receiving services at an out-of-network hospital or other type of facility, the recognized charge for the out-of-network facility services is reduced to a percentage of Medicare that most closely reflects the aggregate contracted rate at the preferred hospital or facility in the Municipality of Anchorage.

3.5.6.1.1 Surgery Centers

Covered expenses include charges for services and supplies furnished in connection with outpatient surgery made by a **surgery center**. The surgery must be able to be performed adequately and safely in a **surgery center** and must not be a surgery that is normally performed in a **physician's** or **dentist's** office.

The following **surgery center** expenses are covered:

a) Services and supplies provided by the **surgery center** on the day of the procedure.
b) The operating **physician's** services for performing the procedure, related pre- and post-operative care, and administration of anesthesia.
c) Services of another **physician** for related post-operative care and administration of anesthesia. This does not include a local anesthetic.

3.5.6.1.2 Birthing Centers

Covered expenses include charges made by a **birthing center** for services and supplies related to your care in a **birthing center** for:

a) prenatal care;
b) delivery; and
c) postpartum care within 48 hours after a vaginal delivery and 96 hours after a cesarean delivery.

3.5.7 Home Health Care

Covered expenses include charges made by a **home health care agency** for home health care, and the care:

a) is given under a **home health care plan**; and
b) is given to you in your home while you are **homebound**.

Home health care expenses include charges for:

a) Part-time or intermittent care by a registered nurse or by a licensed practical nurse if a registered nurse is not available.
b) Part-time or intermittent home health aide services provided in conjunction with and in direct support of care by a registered nurse or a licensed practical nurse.
c) Physical, occupational, and speech therapy.
d) Part-time or intermittent medical social services by a social worker when provided in conjunction with and in direct support of care by a registered nurse or a licensed practical nurse.
e) Medical supplies, **prescription drugs** and lab services by or for a **home health care agency** to the extent they would have been covered under the **medical plan** if you had a **hospital stay**.

Benefits for home health care visits are payable up to the home health care maximum of 120 visits per **benefit year**. In determining the **benefit year** maximum visits, each visit of up to four hours is one visit. This maximum will not apply to care given by a registered nurse or licensed practical nurse when:

a) care is provided within 10 days of discharge from a **hospital** or **skilled nursing facility** as a full time inpatient; and

b) care is needed to transition from the **hospital** or **skilled nursing facility** to home care.

When the above criteria are met, **covered expenses** include up to 12 hours of continuous care by a registered nurse or licensed practical nurse per day.

Coverage for home health care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or **custodial care** service does not cause the service to become covered. If the **covered person** is a minor or an adult who is dependent upon others for non-skilled care (*e.g.* bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.

Unless specified above, <u>not</u> covered under this benefit are charges for:

a) Services or supplies that are not a part of the **home health care plan.**
b) Services of a person who usually lives with you, or who is a member of your or your **spouse's** family.
c) Services of a certified or licensed social worker.
d) Services for infusion therapy.
e) Transportation.
f) Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
g) Services that are **custodial care**.

IMPORTANT: The medical plan does not cover custodial care, even if care is provided by a nursing professional and family members or another caretaker cannot provide the necessary care.

3.5.8 Private Duty Nursing

Covered expenses include private duty nursing provided by a registered nurse or licensed practical nurse if the person's condition requires **skilled nursing care** and visiting nursing care is not adequate.

The **medical plan** also covers skilled observation for up to one four hour period per day for up to ten consecutive days following:

a) A change in your medication.
b) Treatment of an urgent or **emergency** medical condition by a **physician**.
c) The onset of symptoms indicating a need for **emergency** treatment.
d) Surgery.
e) An inpatient **stay**.

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

a) Nursing care that does not require the education, training and technical skills of a registered nurse or licensed practical nurse.

b) Nursing care assistance for daily life activities, such as:

- transportation
- meal preparation
- vital sign charting
- companionship activities
- bathing
- feeding
- personal grooming
- dressing
- toileting
- getting in/out of bed or a chair

c) Nursing care provided for skilled observation.

d) Nursing care provided while you are an inpatient in a **hospital** or health care **facility**.

e) A service provided solely to administer oral medicine, except where law requires a registered nurse or licensed practical nurse to administer medicines.

3.5.9 Skilled Nursing Facility

IMPORTANT NOTE: The medical plan will reduce benefits by 20% if a non-Medicare age eligible **benefit recipient** or **dependent** receives services from a non-preferred hospital, **surgery center**, rehabilitative facility, or free-standing imaging center in the Municipality of Anchorage or from an out-of-network hospital, **surgery center**, rehabilitative facility, or free-standing imaging center provider in the other 49 states. In addition, when receiving services at an out-of-network hospital or other type of facility, the recognized charge for the out-of-network facility services is reduced to a percentage of Medicare that

most closely reflects the aggregate contracted rate at the preferred hospital or facility in the Municipality of Anchorage.

Covered expenses include charges made by a **skilled nursing facility** during your **stay** for the following services and supplies.

The following services at a **skilled nursing facility** are covered:

a) **Room and board**, up to the semi-private room rate. The **medical plan** will cover up to the private room rate if it is needed due to an infectious **illness** or a weak or compromised immune system.
b) Use of special treatment rooms.
c) Radiological services and lab work.
d) Physical, occupational, or speech therapy.
e) Oxygen and other gas therapy.
f) Other medical services and general nursing services usually given by a **skilled nursing facility** (not including charges made for private or special nursing or **physician's** services).
g) Medical supplies.

Unless specified above, not covered under this benefit are charges for the treatment of drug addiction, alcoholism, senility, intellectual disability or any other mental illness.

3.5.10 Hospice Care

Covered expenses include charges for hospice care when furnished under a hospice care program.

3.5.10.1 Facility Expenses

IMPORTANT NOTE: The medical plan will reduce benefits by 20% if a non-Medicare age eligible **benefit recipient** or **dependent** receives services from a non-preferred hospital, **surgery center**, rehabilitative facility, or free-standing imaging center in the Municipality of Anchorage or from an out-of-network hospital, **surgery center**, rehabilitative facility, or free-standing imaging center provider in the other 49 states. In addition, when receiving services at an out-of-network hospital or other type of facility, the recognized charge for the out-of-network facility services is reduced to a percentage of Medicare that most closely reflects the aggregate contracted rate at the preferred hospital or facility in the Municipality of Anchorage.

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

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

3.5.10.2 Outpatient Hospice Expenses

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

a) Part-time or intermittent nursing care by a registered nurse or licensed practical nurse for up to eight hours a day.

b) Part-time or intermittent home health aide services to care for you up to eight hours a day.

c) Medical social services under the direction of a **physician**, including but not limited to:

- assessment of your social, emotional and medical needs, and your home and family situation;
- identification of available community resources; and
- assistance provided to you to obtain resources to meet your assessed needs.

d) Physical and occupational therapy.

e) Consultation or case management services by a **physician**.

f) Medical supplies.

g) Prescription drugs.

h) Dietary counseling.

i) 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) A **physician** for a consultation or case management.

b) A physical or occupational therapist.

c) 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; and
- Dietary counseling.

Unless specified above, <u>not</u> covered under this benefit are charges for:

a) Daily **room and board** charges over the semi-private room rate.
b) Funeral arrangements.
c) Pastoral counseling.
d) Financial or legal counseling. This includes estate planning and the drafting of a will.
e) 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 a house.

f) Services that are **custodial care**.

3.5.11 Second Surgical Opinions

Covered expenses include obtaining a second surgical opinion when a surgeon has recommended non-**emergency** surgery.

Charges for complex imaging services, radiological services and diagnostic tests required in connection with the second opinion are covered by the **medical plan**. However, to avoid duplication, the attending **physician** is encouraged to share X-ray and test results with the consulting **physician(s)**.

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:

a) Must be recommended by the **physician** who plans to perform it;
b) Will, if performed, be covered under this **medical plan**; and
c) Must require general or spinal anesthesia.

The second opinion must be obtained before you are hospitalized. You may choose your consulting **physician**. If you desire, the **claims administrator** can provide you with a list of names of qualified **physicians**.

If the first and second opinions differ, you may seek a third opinion. The **medical plan** pays benefits for a third opinion the same as for a second opinion.

3.5.12 Diagnostic and Preoperative Testing

IMPORTANT NOTE: The medical plan will reduce benefits by 20% if a non-Medicare age eligible beneficiary or dependent receives services from a non-preferred hospital, **surgery center**, rehabilitative facility, or free-standing imaging center in the Municipality of Anchorage or from an out-of-network hospital, **surgery center**, rehabilitative facility, or free-standing imaging center provider in the other 49 states. In addition, when receiving services at an out-of-network hospital or other type of facility, the recognized charge for the out-of-network facility services is reduced to the percentage of Medicare that most closely reflects the aggregate contracted rate at the preferred hospital or facility in the Municipality of Anchorage.

3.5.12.1.1 Diagnostic Complex Imaging Expenses

Covered expenses include charges made on an outpatient basis by a **physician**, **hospital** or a licensed imaging or radiological **facility** for complex imaging services to diagnose an **illness** or **injury**, including:

a) Computed Tomography (CAT or CT) scans.
b) Magnetic Resonance Imaging (MRI).
c) Positron Emission Tomography (PET) scans.
d) Any other outpatient diagnostic imaging service costing over $500.
e) Complex imaging expenses for preoperative testing.

The **medical plan** does not cover diagnostic complex imaging expenses under this benefit if such imaging expenses are covered under any other part of the **medical plan**.

3.5.12.1.2 Outpatient Diagnostic Lab Work and Radiological Services

Covered expenses include charges for radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests provided to diagnose an **illness** or **injury**. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a **physician**. The charges must be made by a **physician**, **hospital** or licensed radiological **facility** or lab.

3.5.12.1.3 Outpatient Preoperative Testing

Prior to a scheduled covered surgery, **covered expenses** include charges made for tests performed by a **hospital**, **surgery center**, **physician** or licensed diagnostic laboratory provided the charges for the surgery are **covered expenses** and the tests are:

a) related to your surgery, and the surgery takes place in a **hospital** or **surgery center**;
b) completed within 14 days before your surgery;
c) performed on an outpatient basis;
d) covered if you were an inpatient in a **hospital**; and
e) not repeated in or by the **hospital** or **surgery center** where the surgery will be performed.

Test results should appear in your medical record kept by the **hospital** or **surgery center** where the surgery is performed.

The **medical plan** does not cover diagnostic complex imaging expenses under this benefit if such imaging expenses are covered under any other part of the **medical plan**.

If your tests indicate that surgery should not be performed because of your physical condition, the **medical plan** will pay for the tests, but surgery will not be covered.

3.5.13 Preventive Care and Screening Services

The purpose of providing preventive care services is to promote wellness, disease prevention and early detection by encouraging **covered persons** to have regular preventive examinations to identify potential health risks and provide the opportunity for early intervention. This section describes **covered expenses** for preventive care services and supplies when you are well.

The recommendations and guidelines referenced in this Section 3.5.13, *Preventive Care and Screening Services* will be updated periodically. This plan is subject to updated recommendations or guidelines that are issued by the following organizations beginning on the first day of the **benefit year**, one year after the recommendation or guideline is issued:

a) Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
b) United States Preventive Services Task Force;
c) Health Resources and Services Administration; and
d) American Academy of Pediatric/Bright Futures Guidelines for Children and Adolescents.

3.5.13.1 Scope of Preventive Care Services

Services are considered preventive care when a **covered person**:

a) does not have symptoms or any abnormal studies indicating an abnormality at the time the service is performed;
b) has had a screening done within the age and gender guidelines recommended by the U.S. Preventive Services Task Force with the results being considered normal;
c) has a diagnostic service with normal results, after which the **physician** recommends future preventive care screening using the appropriate age and gender guidelines recommended by the U.S. Preventive Services Task Force; or
d) has a preventive service done that results in a diagnostic service being done at the same time because it is an integral part of the preventive service (e.g. polyp removal during a preventive colonoscopy)

If a heath condition is diagnosed during a preventive care exam or screening the preventive exam or screening still qualifies for preventive care coverage.

Services are considered diagnostic care, and not preventive care, when:

a) abnormal results on a previous preventive or diagnostic screening test requires further diagnostic testing or services;
b) abnormal test results found on a previous preventive or diagnostic service requires the same test be repeated sooner than the normal age and gender guidelines as recommended by the U.S. Preventive Services Task Force would require; or
c) services are ordered due to current symptoms that require further diagnosis.

3.5.13.2 Coverage

Unless otherwise specified, if you or your dependent is not yet Medicare age eligible, preventive care services are not subject to a **copayment** or **deductible**, and will be paid at 100% of the **provider's** rate, if the **provider** is a **network provider**. Preventive care services provided by an out-of-**network provider** are subject to payment under **medical plan** provisions governing non-preventive care services. Any portion of preventive care services provided to a Medicare age eligible **benefit recipient**, which are not covered by Medicare, are subject to payment under **medical plan** provisions governing non-preventive care services.

If you or your dependent are not yet Medicare age eligible and there are no network providers in the area where you live, you may contact the **claims administrator** and request to use an out-of-**network provider** for preventive care services under this section. Your request must be precertified by the **claims administrator** before you may utilize an out-of-**network provider**. If your request to use an out-of-**network provider** is authorized, the preventive care services you receive will not be subject to a **copayment** or **deductible**, and will be paid at 100% of the **recognized charge**. If your request to use an out-of-**network provider** is denied, or if you fail to request **precertification**, all charges incurred for preventive care services will be subject to payment under the **medical plan** provisions governing non-preventive care services.

Unless otherwise specified, preventive care services under this section 3.5.13, *Preventive Care and Screening Services*, are limited to once per **benefit year**.

3.5.13.3 Routine Physical Exams

Covered expenses include charges made by your **primary care physician, primary care provider**, or other health professional for routine physical exams. This includes routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a **physician** or other health professional for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

a) Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
b) Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration Guidelines for Children and Adolescents.
c) Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include, but are not limited to:
    - Screening and counseling services, such as:
        - Interpersonal and domestic violence;
        - Sexually transmitted diseases; and
        - Human Immune Deficiency Virus (HIV) infections.
    - Screening for gestational diabetes for women.
    - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older.
d) X-rays, lab and other tests given in connection with the exam.
e) For covered children, from birth to age 2:
    - an initial **hospital** checkup
    - periodic well child exams
    - consultation between the health professional and a parent

3.5.13.4 Newborn hearing screening exam

Covered expenses include screening test for hearing loss prior to the date the child is 30 days old and diagnostic hearing evaluation if the initial screening test shows the child may have a hearing impairment.

3.5.13.5 Preventive Care Immunizations

Covered expenses include charges made by your **physician** or a **provider** for immunizations for infectious diseases that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention:

a) Immunizations for infectious disease; and
b) The materials for administration of immunizations.

3.5.13.6 Well Woman Preventive Visits

Covered expenses include charges made by your **physician** obstetrician, or gynecologist for:

a) A routine well woman preventive exam office visit, including Pap smears. A routine well woman preventive exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**.
b) Routine preventive care breast cancer genetic counseling and breast cancer (BRCA) gene blood testing.
c) **Covered expenses** include charges made by a **physician** and lab for the BRCA gene blood test and charges made by a genetic counselor to interpret the test results and evaluate treatment.

These benefits will be subject to any age; family history; and frequency guidelines that are:

a) Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
b) Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

3.5.13.7 Routine Cancer Screenings

Covered expenses include, but are not limited to, charges incurred for routine cancer screening as follows:

a) Colonoscopies (removal of polyps performed during a screening procedure is a covered expense);
b) Digital rectal exams;
c) Double contrast barium enemas (DCBE)
d) Fecal occult blood tests;
e) Lung cancer screening
f) Mammograms;
g) Prostate specific antigen (PSA) tests; and
h) Sigmoidoscopies;

These benefits will be subject to any age; family history; and frequency guidelines that are:

a) Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
b) Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration
c) Found in the American Cancer Society guidelines for colorectal cancer screening

3.5.13.8 Screening and Counseling Services

Covered expenses include screening and counseling by your **health professional** for some conditions.

a) **Obesity and/or Healthy Diet**

Screening and counseling services to aid in weight reduction due to obesity. **Covered expenses** include:

- Preventive counseling visits and /or risk factor reduction intervention;
- Nutrition counseling; and
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related disease.

For persons age 22 and older, the **medical plan** will cover up to 26 visits per 12 consecutive months. However, of these only 10 visits will be allowed under the **medical plan** for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet related chronic disease. In determining the maximum visits, each session of up to one hour is equal to one visit.

b) **Misuse of Alcohol and/or Drugs**

Screening and counseling services to aid in prevention or reduction of the use of an alcohol agent or controlled substance. **Covered expenses** include preventive counseling visits, risk factor reduction intervention and a structured assessment.

The **medical plan** will cover a maximum of five visits of up to one hour in a 12 consecutive month period. These visits are separate from outpatient treatment visits.

c) **Use of Tobacco Products**

Screening and counseling services to aid in the cessation of the use of tobacco products. A tobacco product means a substance containing tobacco or nicotine including cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco, and candy-like products that contain tobacco. Coverage includes the following to aid in the cessation of the use of tobacco products:

- Preventive counseling visits;
- Treatment visits; and
- Class visits.
- Tobacco cessation prescription and over-the-counter drugs
    - **Eligible health services** include FDA- approved **prescription drugs** and over-the-counter (OTC)drugs to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

The **medical plan** will cover a maximum of eight visits of up to one hour in a 12 consecutive month period.

d) **Sexually Transmitted Infections**

Covered expenses include the counseling services to help you prevent or reduce sexually transmitted infections.

e) **Genetic Risks for Breast and Ovarian Cancer**

Covered expenses include counseling and evaluation services to help you assess whether or notyou are at increased risk for breast and ovarian cancer.

f) **Prenatal Care**

Prenatal care will be covered as preventive care for pregnancy-related **physician** office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check, and fundal height) received in a **physician**'s, obstetrician's, or gynecologist's office.

g) Comprehensive Lactation Support and Counseling Services

- **Lactation Support**

  Covered expenses include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy, or at any time following delivery, for breast-feeding by a certified lactation support provider.

  Covered expenses also include the rental or purchase of breast feeding equipment as described below.

  Lactation support and lactation counseling services are **covered expenses** when provided in either a group or individual setting. Benefits for lactation counseling services are subject to a maximum of 6 visits in a 12 consecutive month period**.**

  Visits in excess of the lactation counseling maximum as shown above, are subject to the cost sharing provisions outlined in section 3.2.3, *Cost Sharing for Network Benefits* or section 3.2.5, *Cost Sharing for Out-of-Network Benefits*.

- **Breast Feeding Durable Medical Equipment**

  Coverage includes the rental or purchase of breast feeding **durable medical equipment** for the purpose of lactation support (pumping and storage of breast milk) as follows.

- **Breast Pump**, once every 12 months

  Covered expenses include the following:

  - The rental of a hospital-grade electric pump for a newborn **child** when the newborn **child** is confined in a **hospital**.
  - The purchase of:
    - An electric breast pump (non-hospital grade). A purchase will be covered once every 12 months; or
    - A manual breast pump. A purchase will be covered once per pregnancy.

- If an electric breast pump was purchased within the previous 12 month period, the purchase of another breast pump will not be covered until a 12 month period has elapsed from the last purchase.

- **Breast Pump Supplies**

  Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

  Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

The **plan** reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided, as determined by the **claims administrator**.

3.5.13.9 Family Planning Services – Female Contraceptives

For females with reproductive capacity, covered expenses include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this preventive care benefit must be approved by the U.S. Food and Drug Administration (FDA).

Coverage includes counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist. Such counseling services are covered expenses when provided in either a group or individual setting. Contraceptive counseling services are subject to a two visit maximum in a 12 consecutive month period. Visits in excess of this maximum are subject to the cost sharing provisions outlined in section 3.2.3, *Cost Sharing for Network Benefits* or section 3.2.5, *Cost Sharing for Out-of-Network Benefits*.

The following contraceptive methods are **covered expenses**:

a) Voluntary Sterilization

Covered expenses include charges billed separately by the provider for female and male voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants for women. **Covered expenses** do not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the **provider** or because it was not the primary purpose of a confinement.

b) Contraceptives

Contraceptives can be paid either as a medical benefit or **pharmacy** benefit depending on the type of expense and how and where the expense is incurred. Benefits are paid as a medical benefit for female contraceptive **prescription drugs** and devices (including any related services and supplies) when they are provided, administered, or removed, by a **physician** during an office visit.

3.5.13.10 Limitations

Unless specified above, preventive care services do not include:

a) Diagnostic, lab, or other tests or procedures ordered, or given, in connection with any of the preventive care benefits described above;
b) Exams given during your stay for medical care;
c) Services not given by a **physician** or under their direction;
d) Immunizations that are not considered preventive care such as those required due to your employment or travel;
e) Pregnancy expenses (other than prenatal care as described above);
f) Services and supplies incurred for an abortion;
g) Services as a result of complications resulting from voluntary sterilization procedure and related follow-up care;
h) Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;
i) Male contraceptive methods, sterilization procedures or devices;
j) The reversal of voluntary sterilization procedures, including any related follow-up care; or
k) Charges incurred for family planning services while confined as an inpatient in a hospital or other **facility** for medical care.

3.5.14 Immunizations

In addition to the immunizations covered under section 3.5.13, *Preventive Care and Screening Services*, **covered expenses** include other immunizations for communicable diseases, including serums administered by a nurse or **physician**. Other commercially available vaccines (like the shingles vaccine) are covered when **medically necessary** to prevent **illness**. Charges for office visits in connection with the immunizations are not covered.

3.5.15 Cognitive Therapy, Physical Therapy, Occupational Therapy, and Speech Therapy Rehabilitation Benefits

Covered expenses include the services listed in this section in either an inpatient or outpatient setting. If provided on an inpatient basis, such services will be paid as part of your inpatient **hospital** and **skilled nursing facility** benefits under the **medical plan**. Coverage is subject to the limits, if any, shown in section 2.1.1, *Medical Benefit Schedule*.

a) Physical therapy is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness**, **injury** or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.

b) Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness**, **injury** or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.

c) Speech therapy is covered for non-chronic conditions and acute **illnesses** and **injuries** and expected to restore the speech function or correct a speech impairment resulting from **illness** or

injury; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.

d) Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

A visit consists of no more than one hour of therapy. **Covered expenses** include charges for no more than two therapy visits in a 24 hour period.

The therapy should follow a specific treatment plan that:

a) details the treatment, and specifies frequency and duration; and

b) provide for ongoing reviews and is renewed only if continued therapy is appropriate.

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

a) Therapies for the treatment of delays in development, unless resulting from acute **illness** or **injury**, or congenital defects amenable to surgical repair (such as cleft lip/palate). Examples of non-covered diagnoses include Down's syndrome and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.
b) Any services which are **covered expenses** in whole or in part under any other group plan sponsored by an employer.
c) Any services unless provided in accordance with a specific treatment plan.
d) Services for the treatment of delays in speech development, unless resulting from **illness**, **injury**, or congenital defect.
e) Services provided during a **stay** in a **hospital**, **skilled nursing facility**, or **hospice facility** except as stated above.
f) Services not performed by a **physician** or under the direct supervision of a **physician**.
g) Treatment covered as part of spinal manipulation treatment. This applies whether or not benefits have been paid under that section.
h) Services provided by a **physician** or physical, occupational or speech therapist who resides in your home, or who is a member of your family, or a member of your **spouse**'s family.
i) Special education to instruct a person whose speech has been lost or impaired to function without that ability. This includes lessons in sign language.

3.5.16 Medical Massage Therapy

Covered expenses include the services listed in this section in an outpatient setting. Coverage is subject to the limits and **copayments**, if any, shown in section 2.1.1, *Medical Benefit Schedule*.

a) Medical massage therapy is covered in conjunction with and for the purpose of making the body more receptive of spinal manipulation provided under section 3.5.28, *Treatment of Spinal Disorders*.

b) Medically necessary massage therapy is a **covered expense** if it is part of a specific treatment plan for physical or occupational rehabilitative therapy as outlined in 3.5.15, *Cognitive Therapy, Physical Therapy, Occupational Therapy, and Speech Therapy Rehabilitation Benefits.*

3.5.17 Anesthetic

Covered expenses include the cost of administration of anesthetics and oxygen by a **physician**, other than the operating **physician**, or a certified registered nurse anesthetist (C.R.N.A.) in connection with a covered procedure. This includes injections of muscle relaxants, local anesthesia, and steroids. When billed by a **hospital** or **physician**, the services of an anesthetist are covered.

3.5.18 Pregnancy Related Expenses

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits. Prenatal care office visits are covered under section 3.5.13, *Preventive Care and Screening Services.*

For inpatient care of the mother and newborn **child**, **covered expenses** include charges made by a **hospital** for a minimum of:

a) 48 hours after a vaginal delivery;
b) 96 hours after a cesarean section; and
c) a shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

Covered expenses also include charges made by a **birthing center** as described under alternatives to **hospital** care.

Covered expenses also include services and supplies provided for circumcision of the newborn during the **stay**.

If you are **totally disabled** as a result of a problem with your pregnancy and your coverage under the **medical plan** ends, you may be eligible for extended benefits. See section 12, *Consolidated Omnibus Budget Reconciliation Act* (*COBRA) and Extended Health Coverage*.

3.5.19 Newborn Care

Covered expenses include newborn care provided within the first 31 days after birth. Newborn services provided after 31 days are not covered, unless you enroll your **child** under the **medical plan** within 30 days of birth. See section 1.5.2, *Dependents.*

Charges for a newborn who has suffered an accidental **injury**, **illness**, or premature birth are covered like any other **medically necessary** services.

3.5.20 Durable Medical and Surgical Equipment

Covered expenses include durable medical equipment prescribed by a physician, including:

a) Bandages and surgical dressings.
b) Rental or purchase of autorepositioning appliances, casts, splints, trusses, braces, crutches, and other similar, durable medical or mechanical equipment.

c) Rental or purchase of a wheelchair or **hospital**-type bed.
d) Rental or purchase of iron lungs or other mechanical equipment required for respiratory treatment.
e) Blood transfusions, including the cost of blood and blood derivatives.
f) Oxygen or rental of equipment for the administration of oxygen.
g) Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps.

Charges for the purchase, repair or replacement of **durable medical equipment** will be included as **covered expenses** as follows:

a) The initial purchase of such equipment and accessories to operate the equipment is 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 the equipment than to rent it.
b) Maintenance and repair of purchased equipment is covered unless needed due to misuse or abuse of the equipment.
c) Replacement of purchased equipment and accessories is 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.

The **medical plan** does not cover charges for more than one item of equipment for the same or similar purpose. The **medical plan** may limit the **payment** of charges to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided.

3.5.21 Experimental or Investigational Treatment

Covered expenses include charges made for **experimental or investigational** drugs, devices, treatments or procedures, provided that all of the following conditions are met:

a) You have been diagnosed with cancer or you are **terminally ill**.

b) Standard therapies have not been effective or are inappropriate.

c) The **claims administrator** determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment.

d) You are enrolled in an ongoing clinical trial that meets all of the following 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.

- 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.

3.5.22 Prosthetic Devices

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness**, **injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

The **medical plan** covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of **illness** or **injury** or congenital defects as described in the list of covered devices below, for an:

a) internal body part or organ; or
b) external body part.

Covered expenses also include replacement of a prosthetic device if:

a) the replacement is needed because of a change in your physical condition, or normal growth or wear and tear;
b) it is likely to cost less to buy a new prosthetic device than to repair the existing one; or
c) the existing prosthetic device cannot be made serviceable.

The list of covered devices includes, but is not limited to:

a) An artificial arm, leg, hip, knee or eye.
b) Eye lens.
c) An external breast prosthesis and the first bra made solely for use with it after a mastectomy.
d) A breast implant after a mastectomy.
e) Ostomy supplies, urinary catheters and external urinary collection devices.
f) Speech generating device.
g) A cardiac pacemaker and pacemaker defibrillators.
h) A durable brace that is custom made for and fitted for you.

The **medical plan** will not cover expenses and charges for, or expenses related to:

a) Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless the orthopedic shoe is an integral part of a covered leg brace.
b) Trusses, corsets, and other support items.
c) Repair and replacement due to loss, misuse, abuse or theft.
d) Any item listed in section 3.7, *Medical Benefit Exclusions*.

3.5.23 Ambulance Services

Covered expenses include charges made by a professional **ambulance** as follows:

a) Ground **Ambulance. Covered expenses** include charges for transportation:

- To the first **hospital** where treatment is given in a medical **emergency**.
- From one **hospital** to another **hospital** in a medical **emergency** when the first **hospital** does not have the required services or facilities to treat your condition.
- From **hospital** to home or to another **facility** when other means of transportation would be considered unsafe due to your medical condition.
- From home to **hospital** for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition.
- When during a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, an **ambulance** is required to safely and adequately transport you to or from inpatient or outpatient **medically necessary** treatment.

b) Air or Water **Ambulance. Covered expenses** include charges for transportation to a **hospital** by air or water **ambulance** when:

- ground **ambulance** transportation is not available;
- your condition is unstable, and requires medical supervision and rapid transport; and
- in a medical **emergency**, transportation from one **hospital** to another **hospital**, when the first **hospital** does not have the required services or facilities to treat your condition and you need to be transported to another **hospital** and the two conditions above are met.

Unless specified above, not covered under this benefit are charges incurred to transport you:

- if an **ambulance** service is not required for your physical condition;
- if the type of **ambulance** service provided is not required for your physical condition; or
- by any form of transportation other than a professional **ambulance** service.

3.5.24 Travel

Travel is a **covered expense** only in the circumstances set forth in this section. Travel for transplant services is set forth in section 3.5.25, *Transplant Services*. Travel for Lantern benefits is set forth in section 3.5.32 Supplemental Surgery and Travel.

3.5.24.1 Treatment Not Available Locally

Travel is a **covered expense** if necessary for you to receive treatment which is not available in the area you are located when the need for treatment occurs. Treatment must be received for travel to be covered.

If you require treatment that is not available locally, **covered expenses** include 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 the per diem set forth below.

Travel benefits for treatment which is not available locally are limited during each **benefit year** to:

a) One visit and one follow-up visit for a condition requiring therapeutic treatment.
b) One visit for prenatal or postnatal maternity care and one visit for the actual maternity delivery.

c) One presurgical or postsurgical visit and one visit for the surgical procedure. In no instance will two postsurgical visits be covered for the same surgery.
d) Second surgical opinions which cannot be obtained locally (this will count as a presurgical trip).
e) One visit for each allergic condition.

3.5.24.2 Surgery or Diagnostic Procedures In Other Locations

Travel is a **covered expense** if you have surgery or a diagnostic procedure which is provided less expensively in another location.

If the actual cost of surgery or diagnostic procedure, and all associated costs related to the surgery or diagnostic procedure, including travel, is less expensive than the **recognized charge** for the same expenses at the nearest location you could obtain the surgery or diagnostic procedure, your travel costs may be paid. The amount of travel costs paid cannot exceed the difference between the cost of surgery or diagnostic procedure and associated expenses in the nearest location and those same expenses in the location you choose.

If you require preoperative testing and surgery more than 100 miles from your home, the per diem rate set forth below is paid only for the day(s) on which you actually receive preoperative testing. Preoperative testing is testing performed within seven days prior to surgery.

Contact the **claims administrator** for assistance with identifying less expensive options for surgery or diagnostic procedures.

3.5.24.3 Limitations

Travel benefits apply only with respect to conditions covered under the **medical plan**. They do not apply to the **DVA plan**.

Travel does not include reimbursement of airline miles used to obtain tickets.

Travel does not include the cost of lodging, food, or local ground transportation such as airport shuttles, cabs or car rental. The **medical plan** does, when applicable, pay a per diem in lieu of these expenses.

If the patient is a **child** under 18 years of age, a parent or legal guardian's transportation charges are allowed.

3.5.24.4 Per Diem

The **medical plan** will pay $51 per day without overnight lodging or $89 per day if overnight lodging is required. If a parent or legal guardian accompanies a **child** under the age of 18, the **medical plan** pays an additional $31 per day.

3.5.25 Gene Based, Cellular and other Innovative Therapies (GCIT)

GCIT services help patients who have been diagnosed with certain genetic conditions that may be treated with the use of innovative FDA-approved GCIT products. GCIT services include cellular immunotherapy, genetically modified viral therapy and cell and tissue therapy.

GCIT Designated Network program

The medical claims administrator's GCIT Designated Network program provides benefits for specific GCIT services at GCIT-designated facilities as well as additional care coordination and support from a clinical team with specific GCIT experience. The medical claims administrator's GCIT Designated Network program **covered services** include charges incurred for certain GCIT services and supplies provided by GCIT-designated facility and provider and certain travel and lodging expenses.

GCIT therapies covered by the medical claims administrator's GCIT Designated Network program include but are not limited to the following:

- Zolgensma
- Spinraza
- Luxturna
- Zyntelgo
- Hemgenix
- Skysona

For the current list of services included in the medical claims administrator's GCIT Designated Network program, call the number on the back of your insurance ID card.

The medical claims administrator's GCIT Designate Network program's **covered services** also include:

- Travel and lodging expenses
    - If you receive care at a GCIT-designated facility that is 100 or more miles away from where you live, travel and lodging expenses are **covered services** for you and a companion, to travel between home and the GCIT facility.
    - Expenses incurred by the patient and one adult companion for hotel lodging is reimbursed at a rate of $50 per night per person (or $100 per night total). The total travel and lodging benefit payable will not exceed $10,000 per episode of care.

All other associated expenses, such as any inpatient charges or travel expenses are subject to all plan provisions.

Other GCIT Services

Some GCIT services are not included in the Aetna GCIT Designated Network program. These services will be covered according to the plan's provisions, based on the type of service and where it is received.

GCIT products that appear on the Medicare Part D formulary (list of covered drugs) may still be eligible for coverage under the AlaskaCare EGWP benefit.

Limitations

Aetna GCIT Designated Network program **covered services** received from non GCIT-designated facilities and providers, including providers who are otherwise part of the network are not covered.

3.5.26 Transplant Services

3.5.26.1 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.

a) Heart
b) Lung
c) Heart/lung
d) Simultaneous pancreas kidney (SPK)
e) Pancreas
f) Kidney
g) Liver
h) Intestine
i) Bone marrow/stem cell
j) Multiple organs replaced during one transplant surgery
k) Tandem transplants (stem cell)
l) Sequential transplants
m) Re-transplant of same organ type within 180 days of the first transplant
n) Any other single organ transplant, unless otherwise excluded under the **medical plan**

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

a) Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant).
b) Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant).
c) Re-transplant after 180 days of the first transplant.
d) Pancreas transplant following a kidney transplant.
e) A transplant necessitated by an additional organ failure during the original transplant surgery/process.
f) 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).

3.5.26.2 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 (COE) as contracted and designated by the **claims administrator** for the type of transplant being performed. Each COE facility has been selected to perform only certain types of transplants. Services obtained from a **facility** that is not designated as a COE for the transplant being performed will be covered as out-of-**network services and supplies**, even if the **facility** is a **network provider** or COE for other types of services.

The **medical plan** covers:

a) Charges made by a **physician** or transplant team.
b) 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.
c) 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.
d) Charges for activating the donor search process with national registries.

e) 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.
f) Inpatient and outpatient expenses directly related to a transplant.

3.5.26.3 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 covered transplant expenses during each phase are:

a) 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.
b) Pre-transplant/candidacy screening: Includes Human Leukocyte Antigen (HLA) typing/compatibility testing of prospective organ donors who are immediate family members.
c) 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.
d) 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 Center of Excellence(COE) program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any **covered expenses** you incur from a COE facility will be considered **network services and supplies**.

3.5.26.4 Limitations

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

a) Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence.
b) Services that are covered under any other benefit under this **medical plan**.
c) Services and supplies furnished to a donor when the recipient is not covered under the **medical plan**.
d) Home infusion therapy after the transplant occurrence.

e) Harvesting or storage of organs, without the expectation of immediate transplantation for an existing **illness**.
f) Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing **illness**.
g) Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the **claims administrator**.

3.5.26.5 Network of Transplant Specialist Facilities

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

3.5.26.6 Travel Expenses

Travel is a **covered expense** for transplant services only in the circumstances set forth in this section.

Covered expenses include the following:

a) Transportation Expense

- Expenses incurred by a Centers of Excellence (COE) patient, and approved in advance by the **claims administrator**, for transportation between the patient's home and the COE to receive services in connection with any listed procedure or treatment.

- Expenses incurred by a companion and approved in advance by the **claims administrator** for transportation when traveling with a COE patient between the patient's home and the COE to receive such services.

b) Lodging Expenses

- Expenses incurred by a COE patient, and approved in advance by the **claims administrator**, for lodging away from home:

    - while traveling between the patient's home and the COE to receive services in connection with any listed procedure or treatment; or

    - to receive outpatient services from the COE in connection any listed procedure or treatment.

- Expenses incurred by a companion and approved in advance by the **claims administrator** for lodging away from home:

- while traveling with a COE patient between the patient's home and the COE to receive services in connection with any listed procedure or treatment; or

- when the companion's presence is required to enable a COE patient to receive such services from the COE on an inpatient or outpatient basis.

- The **medical plan** will pay $50 per night per person for overnight lodging, up to a $100 maximum.
- For purposes of determining travel expenses or lodging expenses, a **hospital** or other temporary residence from which a COE patient travels in order to begin a period of treatment at the COE, or to which the patient travels after dismissal from the COE at the end of a period of treatment, will be considered to be the patient's home.

c) Travel and Lodging Benefit Maximum

- For all travel expenses and lodging expenses incurred in connection with any one Institute of Excellence™ (IOE) procedure or treatment type:
  - The total benefit payable will not exceed $10,000 per transplant occurrence.
  - Benefits will be payable only for such expenses incurred during a period which begins on the day a **covered person** becomes a COE patient and ends on the earlier to occur of:
    - one year after the date the procedure is performed or;
    - the date the COE patient ceases to receive any services from the COE in connection with the procedure.

3.5.27 Mental Disorder and Substance Abuse Treatment

3.5.27.1 Mental Disorders

Covered expenses include charges incurred in a **hospital, psychiatric hospital, residential treatment facility**, or **behavioral health provider's** office for the treatment of **mental disorders** by **behavioral health providers** as follows:

a) Inpatient Treatment: **Covered expenses** include charges for **room and board** at the semi-private room rate, and other services and supplies provided during your **stay** in a **hospital, psychiatric hospital** or **residential treatment facility**. Inpatient benefits are available only if your condition requires services that are only available in an inpatient setting.

b) **Partial Confinement Treatment**: **Covered expenses** include charges made for **partial confinement treatment** provided in a **facility** or program for the intermediate short-term or medically-directed intensive treatment of a **mental disorder**. Such benefits are payable if your condition requires services that are only available in a **partial confinement treatment** setting.

c) Outpatient Treatment: **Covered expenses** include charges for treatment received while not confined as a full-time inpatient in a **hospital, psychiatric hospital** or **residential treatment facility**.

d) Outpatient habilitative therapy. Habilitative therapy services help those with pervasive developmental delays keep, learn, or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age). The services must follow a specific treatment plan, ordered by your physician. The services have to be performed by a:

- Licensed or certified physical, occupational, or speech therapist.
- Hospital, **skilled nursing facility**, or hospice facility.
- Home health care agency.
- Physician or behavioral health provider.

Outpatient physical, occupational and speech therapy covered services include:

- Physical therapy if it is expected to develop any impaired function.
- Occupational therapy (except for vocational rehabilitation or employment counseling) if it is expected to develop any impaired function.
- Speech therapy if it is expected to develop speech function (the ability to express thoughts, speak words and form sentences) that resulted from delayed development.

Eligible health services include certain early intensive behavioral interventions such as applied behavioral analysis, an educational service that is the process of applying interventions that systematically change behavior, and that is responsible for observable improvement in behavior.

3.5.27.2 Substance Abuse

Covered expenses include charges incurred in a **hospital**, **residential treatment facility**, or **behavioral health provider's** office for the treatment of **substance abuse** by **behavioral health providers** as follows:

a) Inpatient Treatment: **Covered expenses** include charges for **room and board** at the semi-private room rate, and other services and supplies provided during your **stay** in a **psychiatric hospital** or **residential treatment facility**, appropriately licensed by the state department of health or its equivalent. Inpatient benefits include treatment in a **hospital** for the medical complications of **substance abuse**. Medical complications include **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis. Treatment in a **hospital** is covered only when the **hospital** does not have a separate treatment **facility** section.

b) **Partial Confinement Treatment**: **Covered expenses** include charges made for **partial confinement treatment** provided in a **facility** or program for the intermediate short-term or medically-directed intensive treatment of **substance abuse**. Such benefits are payable if your condition requires services that are only available in a **partial confinement treatment** setting.

c) Outpatient Treatment: **Covered expenses** include charges for treatment received for **substance abuse** while not confined as a full-time inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**.

3.5.28 Treatment of Spinal Disorders

Covered expenses include charges made by a **physician** on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by or related to biomechanical or nerve conduction disorders of the spine.

3.5.29 Medical Treatment of Mouth, Jaws, and Teeth

Covered expenses include charges made by a **physician**, **dentist** and **hospital** for services and supplies for treatment of, or related conditions of, the teeth, mouth, jaw, and jaw joints, as well as supporting tissues including bones, muscles, and nerves. **Covered expenses** include:

a) Inpatient **hospital** care to perform dental services if required due to an underlying medical condition.
b) Surgery needed to treat wounds, cysts or tumors or to alter the jaw, joint or bite relationships when appliance therapy alone cannot provide functional improvement.
c) Nonsurgical treatment of infections or diseases not related to the teeth, supporting bones or gums.
d) Dental **implants** if necessary due to an underlying medical condition, **accident** or disease, other than periodontal disease. False teeth for use with the **implants** are covered only under the **dental plan** as a Class III service.
e) 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 **medical plan**. Treatment must begin during the year the **accident** occurred or the year following. The teeth must have been damaged or lost other than in the course of biting or chewing and must have been free of decay or in good repair.
f) 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 joint.

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

3.5.30 Medical Treatment of Obesity

Covered expenses include charges made by a **physician**, licensed or certified dietician, nutritionist or **hospital** for the non-surgical treatment of obesity for the following outpatient weight management services:

a) An initial medical history and physical exam
b) Diagnostics tests given or ordered during the first exam
c) Prescription drugs

Covered expenses include one morbid obesity surgical procedure within a two year period, beginning with the date of the first morbid obesity surgical procedure, unless a multi-stage procedure is planned.

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

a) Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regiments and supplements, food or food supplements, appetite suppressants and other medications.
b) Exercise programs, exercise or other equipment.
c) Other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

3.5.31 Reconstructive or Cosmetic Surgery and Supplies

Covered expenses include charges made by a **physician**, **hospital**, or **surgery center** for reconstructive services and supplies, including:

a) Surgery needed to improve a significant functional impairment of a body part.
b) Surgery to correct the result of an accidental **injury**, including subsequent related or staged surgery.
c) Surgery to correct the result of an **injury** that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original **injury**.

Note: **Injuries** that occur as a result of a medical (non-surgical) treatment are not considered accidental **injuries**, even if unplanned or unexpected.

a) Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an **illness** or **injury**) when the defect results in severe facial disfigurement, or the defect results in significant functional impairment and the surgery is needed to improve function.

Covered expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.

3.5.32 Supplemental Surgery and Travel

Covered Expenses

Covered expenses include travel and charges incurred during a covered Episode of Care with a Lantern surgeon and facility. Services received outside an Episode of Care or with a surgeon or facility outside the Lantern network will be subject to coverage under other provisions of the medical plan.

Services covered under this section are paid at 100%. Lantern negotiates all costs before you have surgery, then coordinates the payment for you.

Lantern travel benefits may not be used in conjunction with other AlaskaCare travel benefits provided in section 3.5.24, Travel and *section 3.5.26*, Transplant Services.

NOTE: The travel benefit available through Lantern, is only available through the Retiree Plan members' primary AlaskaCare health plan; it does not coordinate with additional AlaskaCare or other health plans.

Covered Services and Procedures

When your doctor recommends a surgery, the Lantern Benefit will assist you with both planning and paying for the covered medical procedure, including necessary travel associated with the covered procedure. A Lantern Care Advocate can help you find a board certified, high-quality surgeon for your procedure, set up an initial consultation, schedule your procedure appointments, make travel reservations (if required), transfer your medical records and coordinate all your surgery bills. You can utilize the Lantern benefit for the non-emergent procedures listed below. This is not an exhaustive list, but a general guideline of the types of procedures the benefit will cover. Please contact the Lantern Care Advocate at 855-715-1680 for additional information.

a)	Knee	Knee Replacement	Knee Arthroscopy
		Knee Replacement Revision	ACL/MCL/PCL Repair
b)	Hip	Hip Replacement	Hip Arthroscopy
		Hip Replacement Revision	
c)	Shoulder	Shoulder Replacement	Rotator Cuff Repair
		Shoulder Arthroscopy	Bicep Tendon Repair
d)	Foot and Ankle	Ankle Replacement	Ankle Fusion
		Bunionectomy	Ankle Arthroscopy
		Hammer Toe Repair	
e)	Spine	Laminectomy/Laminotomy	Anterior Cervical Disk Fusion
		Anterior Lumbar Interbody Fusion	360 Spinal Fusion
		Posterior Lumbar Interbody Fusion	Artificial Disk
f)	Wrist and Elbow	Elbow Replacement	Wrist Replacement
		Elbow Fusion	Carpal Tunnel Release
		Wrist Fusion	
g)	General Surgery	Gallbladder Removal	Thyroidectomy
		Hernia Repair	
h)	GI	Colonoscopy	
		Endoscopy	
i)	GYN	Hysterectomy	Hysteroscopy
		Bladder Repair	
j)	Bariatric	Gastric Bypass	Laparoscopic Sleeve Gastrectomy
		Laparoscopic Gastric Bypass	
k)	ENT	Ear Tube Insertion	Thyroidectomy
		Septoplasty	Sinuplasty

Limitations

Certain examinations, tests, treatments or other medical services may be required prior to, or following, a planned medical procedure with a Lantern provider. Any medical services performed by anyone other than a Lantern doctor, including pre- and post-care, shall be subject to the coverage limits and other terms on the **medical plan**.

Subsequent to an **Episode of Care**, if a member needs **emergency care** for any reason this would be subject to coverage under the **medical plan**.

The Lantern **Episode of Care** ends when the member is discharged from the **facility**.

The Lantern **Episode of Care** does not cover:

a) diagnostic testing in advance to determine whether a procedure is necessary;
b) convenience expenses;
c) procedures or care that are not **medically necessary**; and
d) Serious Reportable Events (SREs) as defined by the National Quality Forum at qualityforum.org/Home.aspx.

Travel Expenses

Your Lantern benefit will help pay for necessary travel associated with the covered procedure. Only travel arrangements made through the Lantern Care Advocate are eligible for coverage under the Lantern benefits. The specific travel benefit depends on the procedure, the provider and the distance between the provider and a member's residence.

Covered expenses may include the following as arranged by the Lantern Care Advocate:

a) Roundtrip coach class commercial air transportation for patient.
b) Roundtrip coach class commercial air transportation for one companion.
c) Mileage credit to/from airport to hotel and hotel to doctor's office or **facility**.
d) Lodging away from home while traveling to receive pre-operative consult services and procedures covered under the Lantern benefits and through post-procedural consult, or until such time as the provider has advised that the patient is cleared to travel and does not require a near term in-person visit with the treating provider, or in any case where the member does not have easy access to primary care.
e) Pre-loaded debit card to cover $25 per patient per day ($50 per day for patient & companion) for meals and incidental expenses traveling away from home to receive services covered under the Lantern benefits, during the stay to obtain a Lantern **Episode of Care** and for the travel from the place of care to the member's home of residence.
f) When member uses ground transportation in lieu of air travel, and the most direct one-way distance
    a. is less than 100 miles from the member's residence, a pre-loaded debit card of $25 to help with fuel;
    b. exceeds 100 miles but is less than 200 miles from the member's residence, a pre-loaded debit card of $50 to help with fuel;
    c. is 200 miles or more from the member's residence, a pre-loaded debit card of $100 to help with fuel.

3.5.33 Virtual Physical Therapy

Hinge Health Services

The Hinge Health Digital Clinic provides additional care and treatment programs for **musculoskeletal** conditions. Hinge Health services and equipment provided through an approved program of care are not subject to a **deductible**, **coinsurance**, or **copay**. The plan covers 100% of the cost for approved services received through Hinge Health. Any medical services for **musculoskeletal** conditions performed by anyone other than a Hinge Health provider are subject to coverage limits and other terms of the **medical plan**.

Areas eligible for treatment through Hinge Health include the neck/upper back, shoulder, elbow, lower back, forearm, hip, wrist, hand, thigh, knee, shin, calf, ankle, and foot. Prior to beginning a program of care, Hinge Health will perform a clinical suitability evaluation.

Hinge Health programs include:

1) Prevention – designed to increase education regarding strengthening and stretching exercises and healthy habits.
2) Chronic – designed to address long-term back and joint pain.
3) Acute – designed to address recent **musculoskeletal** injuries.
4) Surgery – designed to support pre- and post-surgery rehabilitation for common **musculoskeletal** surgeries.

Hinge Health programs may include the following services or equipment as appropriate:

a) Tablet computer
b) Wearable sensors
c) ENSO High Frequency Impulse Therapy™ pain management device
d) Live virtual sessions with a licensed physical therapist
e) Software guided rehabilitation
f) 1:1 access to a personalized health coach
g) Personalized educational content delivered via the Hinge Health software application or website

For applicable Hinge Health programs, members may obtain up to six virtual physical therapy sessions before an in-person healthcare provider or physical therapy care visit is required.

Services and equipment covered in this section are only considered covered services when offered through the Hinge Health program. All other plan exclusions apply.

Visit hingehealth.com/Alaska or call (855) 907-2777 to enroll.

Hinge Health Eligibility

Hinge Health's services are limited to AlaskaCare Retiree plan members and dependents age 18 or older, who have been approved through a clinical suitability evaluation performed by Hinge Health prior to enrollment in a program of care. Hinge Health's services are only available to members located in the United States.

3.6 YOUR PRESCRIPTION DRUG BENEFITS

Covered expenses do not include all **prescription drugs**, medications and supplies. The **medical plan** pays benefits only for **prescription drug** expenses that are **medically necessary**. **Covered expenses** are subject to cost sharing requirements as described in section 2.1.2, *Standard Prescription Drug Schedule* and section 2.1.3, *Opt-Out Prescription Drug Schedule*.

3.6.1 Accessing Pharmacies and Benefits

The **medical plan** provides access to covered benefits through a network of **pharmacies**, vendors and suppliers. The **pharmacy benefit manager** has contracted for these **network pharmacies** to provide

prescription drugs and other supplies to you, regardless of your eligibility for Medicare. You also have the choice to access state licensed **pharmacies** outside of the network for covered services.

Obtaining your benefits through **network pharmacies** has many advantages. Your out-of-pocket costs may vary between **network pharmacies** and out-of-**network pharmacies**. Benefits and cost sharing may also vary by the type of **network pharmacy** where you obtain your **prescription drug** and whether or not you purchase a preferred or **non-preferred brand name**, or **generic drug**.

3.6.2 Accessing Network Pharmacies and Benefits

You may select any **network pharmacy** from the **pharmacy benefit manager** Network Pharmacy Directory. You can access the **pharmacy benefit manager's** online **provider** directory at AlaskaCare.gov for the names and locations of **network pharmacies**. If you cannot locate a **network pharmacy** in your area, call the **pharmacy benefit manager**.

You must present your ID card to the **network pharmacy** every time you get a **prescription** filled to be eligible for network benefits. The **network pharmacy** will calculate your claim online. You will pay the **deductible**, **copayment** or **coinsurance**, if any, directly to the **network pharmacy**.

You do not have to complete or submit claim forms. The **network pharmacy** will take care of claim submission.

3.6.3 Emergency Prescriptions

When you need a **prescription** filled in an **emergency** or urgent care situation, or when you are traveling, you can obtain network benefits by filling your **prescription** at any network retail **pharmacy**. The **network pharmacy** will fill your **prescription** and only charge you the **medical plan's** cost sharing amount. If you access an out-of-**network pharmacy** you will pay the full cost of the **prescription** and will need to file a claim for reimbursement. You will be reimbursed for your **covered expenses** up to the cost of the **prescription** less the pharmacy benefit's cost sharing for network benefits.

3.6.4 Availability of Providers

The **pharmacy benefit manager** cannot guarantee the availability or continued network participation of a particular **pharmacy**. Either the **pharmacy benefit manager** or any **network pharmacy** may terminate the **provider** contract.

3.6.5 Cost Sharing for Prescription Drug Tiers

The **medical plan** provides a three-tier **prescription drug** program. Cost sharing amounts and provisions are described in section 2.1.2, *Prescription Drug Schedule*. Your **copayment** is based on the tier under which your **prescription drug** is categorized:

a) First Tier: **generic prescription drug** - You pay the lowest cost for **prescription drugs** in this level.
b) Second Tier: **preferred brand-name drug** – You pay a slightly higher cost for **prescription drugs** in this level.
c) Third Tier: **non-preferred brand-name drug** – You pay the highest cost for **prescription drugs** in this level.

You and your **physician** can search for a drug at AlaskaCare.gov, to verify that it is covered under the **plan,** and to determine what tier it is categorized under and if it is on the **Formulary**. You can also see if there are alternatives that cost less, or which drugs are excluded from coverage. Make sure your **physician** knows that you pay more for two- and three-tier drugs. He or she can consider this before writing a **prescription**.

If you have a medical need for a **non-preferred brand-name drug**, your doctor can ask for a medical exception. If the exception is granted, the drug will be subject to **preferred brand-name drug** cost sharing. Exceptions granted as a result of a medical exception shall be based on individual case by case **medical necessity** determinations and do not apply or extend to other covered persons.

Drugs may be added or removed from the **Formulary** by the **pharmacy benefit manager** for certain reasons. A **prescription drug** may also be moved from one tier to another. Here are some reasons why:

a) As **brand-name prescription drugs** lose their patents and generic versions become available, the **brand-name prescription drug** may be covered at a higher out-of-pocket cost while the **generic prescription drug** may be covered at a lower out-of-pocket cost.

b) The Food and Drug Administration (FDA) approves many new **prescription drugs** throughout the year.

c) Drugs can be withdrawn from the market or may become available without a **prescription**.

The most up-to-date formulary information can be found at AlaskaCare.gov – so please visit it often.

3.6.6 Cost Sharing for Network Benefits

You share in the cost of your benefits. Cost sharing amounts and provisions are described in section 2.1.2, *Standard Prescription Drug Schedule* and section 2.1.3, *Opt-Out Prescription Drug Schedule*. All cost sharing is payable directly to the **network pharmacy** at the time the **prescription** is dispensed. Network cost sharing for pharmacy benefits under 3.6, *Your Prescription Drug Benefits,* apply to both Medicare age eligible and non-Medicare age eligible **benefit recipients**.

3.6.7 When You Use an Out-of-Network Pharmacy

You can directly access an out-of-**network pharmacy** to obtain covered outpatient **prescription drugs**. You will pay the **pharmacy** for your **prescription drugs** at the time of purchase and submit a claim form to receive reimbursement from the **medical plan**. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to an out-of-**network pharmacy**. The **medical plan** will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required by you.

3.6.8 Cost Sharing for Out-of-Network Pharmacy Benefits

You share in the cost of your benefits. Cost sharing amounts and provisions are described in section 2.1.2, *Standard Prescription Drug Schedule* and section 2.1.3, *Opt-Out Prescription Drug Schedule*. When your **prescription drugs** are provided by an out-of-**network pharmacy**, the level of reimbursement from the **medical plan** for covered services will usually be lower. This means your out-of-pocket costs will generally

be higher. You will be responsible for any applicable **copayment** or **coinsurance** for **covered expenses** that you incur. Your **coinsurance** is based on the **recognized charge,** see section 17, *Definitions – "Recognized Charge"*. If the out-of-**network pharmacy** charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**. Cost sharing for out-of-**network pharmacy** benefits applies to both Medicare age eligible and non-Medicare age eligible **benefit recipients**.

3.6.9 Pharmacy Benefit

The **medical plan** covers charges for outpatient **prescription drugs** for the treatment of an **illness** or **injury**, subject to the limitations and maximums set forth in section 2.1.2, *Standard Prescription Drug Schedule,* section 2.1.3, *Opt-Out Prescription Drug Schedule* and the exclusions set forth in section 3.6.158*, Pharmacy Benefit Limitations,* section 3.6.21*, Pharmacy Benefit Exclusions,* and section 3.7*, Medical Benefit Exclusions.* **Prescriptions** must be written by a **provider** licensed to prescribe federal legend **prescription drugs**.

Generic prescription drugs will be automatically substituted and filled by your pharmacist for **brand-name prescription drugs** when the **generic prescription drug** is therapeutically equivalent. If your **provider** writes "dispense as written" on a prescription for a brand name medication that has a generic equivalent, the pharmacist will contact the **provider** to let them know of the **medical plan's** mandatory generics requirement. The **provider** must work with the **claims administrator** to receive an exception if the **provider** believes that the **prescription** should be filled as a brand name medication for clinical reasons. If the **provider** requires the **prescription** be filled as written and cannot meet the criteria for an exception, the **prescription** will be filled and the **covered person** will be charged the **copayment** required for that tier of medication, plus the cost differential between the generic and brand name medication. If the **covered person** requests brand name medication, he or she will be responsible for the applicable **copayment**, plus the cost differential between the generic and brand name medication.

Coverage of **prescription drugs** may be subject to the **medical plan's** requirements or limitations. **Prescription drugs** covered by the **medical plan** are subject to drug utilization review by the **claims administrator** and/or your **provider** and/or your **network pharmacy**.

Coverage for **prescription drugs** and supplies is limited to the supply limits as described below.

3.6.10 Retail Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a network retail **pharmacy**. Copay applies to each 30-day supply. Each **prescription** is limited to a maximum 90-day supply, as applicable, when filled at a **network pharmacy**.

3.6.11 Home Delivery Pharmacy

Outpatient **prescription drugs** are covered when dispensed by a network **home delivery pharmacy**. Each **prescription** is limited to a maximum 90-day supply when filled at a network **home delivery pharmacy**. **Prescriptions** for less than a 30-day supply or more than a 90-day supply are not eligible for coverage when dispensed by a network **home delivery pharmacy**.

The **medical plan** will not cover outpatient **prescription drugs** received through an out-of-network **home delivery pharmacy**.

3.6.12 Specialty Prescriptions

Outpatient specialty **prescription drugs** delivered by mail from a retail **pharmacy**, with the exception of the **pharmacy benefit manager**'s own specialty pharmacy, Optum Specialty Pharmacy, will be subject to the provisions applicable to retail pharmacies and are not considered to be dispensed by a **home delivery pharmacy**.

3.6.13 Vaccines Covered Under the Pharmacy Benefit

The **pharmacy** benefits under the **Plan** cover some vaccines regardless of whether you are eligible for Medicare. Vaccines covered under the **pharmacy** plan are those that fall on the Medicare Part D covered vaccine list that are:

a) Vaccines administered at the **pharmacy**.

b) Vaccines administered in a doctor's office **only if** they coordinate with a **pharmacy** to bill the **Plan** for the entire cost of the vaccination, including the injection of the vaccine.

If you receive a vaccination in a doctor's office that does not coordinate with a **pharmacy**, your **provider** will bill you for the entire cost of the vaccination. You will have to pay the entire bill up front and request reimbursement from the **pharmacy benefits manager**. It is important to know that your **provider** may charge you more than the **recognized charge** amount for the vaccination, but your **plan** will only reimburse up to the approved amount. You will be responsible for any amount you pay the **provider** above the **recognized charge**.

Vaccines that are covered as a medical benefit under 3.5, *Covered Medical Expenses* include:

a) Influenza (flu) shots, including seasonal flu vaccine and the H1N1 (swine flu) vaccine.

b) Pneumococcal (pneumonia) shot.

For a complete list of vaccines and participating pharmacies contact the **pharmacy benefit manager** 24 hours a day, 7 days a week or visit the **Division's** website at AlaskaCare.gov.

3.6.14 Other Covered Expenses

The following **prescription drugs**, medications and supplies are also **covered expenses** under the **medical plan**:

a) Self-administered injectable prescription medications.
Injectable medication that can be self-administered by the patient, and are not administered during an inpatient stay, in a provider's office or by a **health care professional.**

b) **Off-Label Use.** FDA approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be:

- recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations or the American Hospital Formulary Service Drug Information); or

- the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal.

Coverage of off-label use of these drugs may be subject to the **medical plan's** requirements or limitations.

c) **Diabetic Supplies.** The following diabetic supplies upon **prescription** by a **physician**:
   - Diabetic needles and syringes
   - Test strips for glucose monitoring and/or visual reading
   - Diabetic test agents
   - Lancets/lancing devices
   - Alcohol swabs

d) Preventive Care Drugs and Supplements

Covered expenses include preventive care drugs and supplements (including over-the-counter drugs and supplements) obtained at a **network pharmacy**. They will be covered at 100%, without a copayment **or coinsurance,** when they are:

- prescribed by a physician;
- obtained at a network pharmacy; and
- submitted to a pharmacist for processing.

The preventive care drugs and supplements covered under this **plan** include, but may not be limited to:

- Aspirin: Benefits are available to adults.
- Oral Fluoride Supplements: Benefits are available to children whose primary water source is deficient in fluoride.
- Folic Acid Supplements: Benefits are available to adult females planning to become pregnant or capable of pregnancy.
- Iron Supplements: Benefits are available to children without symptoms of iron deficiency. Coverage is limited to children who are at increased risk for iron deficiency anemia.
- Vitamin D Supplements: Benefits are available to adults to promote calcium absorption and bone growth in their bodies.
- Risk-Reducing Breast Cancer Prescription Drugs: **Covered expenses** include charges incurred for **generic prescription drugs** prescribed by a **physician** for a woman who is at increased risk for breast cancer and is at low risk for adverse medication side effects.

- FDA-approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products.

Coverage of preventive care drugs and supplements will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the U.S. Preventive Services Task Force.

e) Contraceptives

Covered expenses include charges made by a network **pharmacy** for the following contraceptive methods when prescribed by a **physician** and the **prescription** is submitted to the pharmacist for processing:

- Female oral and injectable contraceptives that are **generic prescription drugs** and **brand-name prescription drugs.**
- Female contraceptive devices.
- FDA-approved female generic emergency contraceptives.
- FDA-approved female generic over-the-counter (OTC) contraceptives.

The **plan** does not cover all contraceptives. A current listing of contraceptives that are covered under the **plan** is available from the **pharmacy benefit manager** and can be found by calling the toll-free number on the back of your pharmacy ID card or AlaskaCare.gov.

Cost Sharing Waiver for Prescription Drug Contraceptives

Contraceptives are covered at 100% without a **copayment** or **coinsurance** if they are:

- Female generic contraceptive **prescription drugs** or devices;
- FDA-approved female generic emergency contraceptives, when obtained at a **network pharmacy**.

With respect to **out-of-network pharmacy** contraceptive **prescription drugs** or devices, the per **coinsurance** will apply.

The **copayment** and **coinsurance** applies to contraceptive **prescription drugs** or devices that have a **generic equivalent prescription drug** or **generic alternative prescription drug** available within the same therapeutic drug class unless you are granted a medical exception, and the **prescription drugs** or devices are:

- brand-name prescription drugs and brand-name devices; or
- FDA-approved female brand-name emergency contraceptives when obtained at a network pharmacy.

3.6.15 Medicare Prescription Drug Plan

Beginning January 1, 2019, AlaskaCare will automatically enroll all Medicare eligible **benefit recipients** and **dependents** into an enhanced Medicare prescription drug plan called an Employer Group Waiver Program (**enhanced EGWP**). To be enrolled, the **benefit recipients** or **dependent** must be:

a) Enrolled in Medicare Part A or Part B;

b) Reside in the United States, District of Columbia, Puerto Rico or Guam; and

c) A United States citizen or lawfully present in the United States.

If you do not meet the above criteria, you will not be enrolled in the **enhanced EGWP** but you will continue to receive pharmacy drug benefits under the **Plan**.

There will be no interruption in coverage when a **benefit recipient** or **dependent** becomes eligible for Medicare and is enrolled in the **enhanced EGWP**. However, you will be sent a new ID card that you should present to your **pharmacy** when purchasing your first prescription after receipt of the card.

Medicare eligible **benefit recipients** and **dependents** enrolled in the **enhanced EGWP** will receive information that is required to be sent by Medicare. These communications largely reference the Medicare Part D plan portion of your coverage only, not the additional coverage provided by the AlaskaCare **enhanced EGWP**. Many of these documents use general language that is not specially designed to communicate AlaskaCare benefits and can be confusing. If you have questions, please call the **pharmacy benefit manager**, 24 hours a day, 7 days a week.

3.6.16 Covered Vaccines

Medicare Part D-Eligible Vaccines

The pharmacy benefits under the Plan cover some vaccines regardless of whether you are eligible for Medicare. Covered vaccines are listed in the formulary available at AlaskaCare.gov under the therapeutic drug class "viral vaccine". Vaccines covered under the pharmacy plan are those that fall on the Medicare Part D covered vaccine list that are:

a) Vaccines administered at the pharmacy.
b) Vaccines administered in a doctor's office **only if** they coordinate with a pharmacy to bill the Plan for the entire cost of the vaccination, including the injection of the vaccine.
c) If you receive a vaccination in a doctor's office that does not coordinate with a pharmacy, your provider will bill you for the entire cost of the vaccination. You will have to pay the entire bill up front and request reimbursement from the pharmacy benefits manager. It is important to know that your provider may charge you more than the recognized charge amount for the vaccination, but your plan will only reimburse up to the approved amount. You will be responsible for any amount you pay the provider above the recognized charge.

For a complete list of vaccines and participating pharmacies contact the pharmacy benefit manager 24 hours a day, 7 days a week or visit the Division's website at AlaskaCare.gov.

3.6.17 Medicare Part D Premium Surcharge

Benefit recipients or **dependents** with an income that exceeds an individual or household Modified Adjusted Gross Income amount (MAGI) level set by Social Security, will be required by Medicare to pay an additional premium based on your income called the Part D Income Related Monthly Adjustment Amount (IRMAA). You will be notified of this requirement in the same way you are notified of your Medicare B IRMAA, through an annual letter sent by Social Security each November. The MAGI and IRMAA surcharge amounts are set by Social Security and are subject to change annually.

For all Medicare plans, the IRMAA will be deducted directly from your monthly Social Security check (if you qualify for Social Security) or will otherwise be invoiced to you directly each month. If you are charged a Medicare Part D IRMAA for your prescription drug coverage, the Division of Retirement and Benefits will reimburse you for the full cost of the Medicare Part D premium surcharge each month, through a tax-advantaged Health Reimbursement Arrangement (HRA) account. If you receive a bill from Medicare, you should pay the bill timely, and contact the Division to learn about your reimbursement options. To receive reimbursement for the Part D IRMAA surcharge, you should submit the HRA claim as soon as possible, but not later than 12 months after the date you incurred the expenses.

3.6.18 Opting-Out of the Enhanced EGWP

When you are first enrolled under the **enhanced EGWP** you will be provided the option to opt-out of this enhanced Medicare prescription drug plan. If you opt-out, or disenroll, you will be placed into the opt-out plan. **This opt-out plan has a much different benefit structure than the plan offered under the enhanced EGWP and will result in you being responsible for greater portion of the cost for your pharmacy benefits.** See the benefit chart in **section 2.1.3, *Opt-Out Prescription Drug Schedule*** for additional information. In addition, the opt-out plan does not allow for coordination of benefits. If you opt-out, you can contact the **pharmacy benefit manager** at any time to reenroll in the **enhanced EGWP**.

3.6.19 Definitions

Prescription drugs are medical substances that, in accordance with 20 U.S.C. § 353(b)(1) and (4)(A), must bear a label that states, “Rx only.” The drug or active ingredient must be assigned a valid unique National Drug Code (NDC) identifier number by the FDA to be considered for coverage. If a prescription drug is prescribed and obtained outside of the United States and the drug or active ingredient does not have an NDC identifier number, it must have the same active ingredient as a drug with a valid NDC identifier number to be considered for coverage. 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.

Active ingredients are the chemical component(s) responsible for a drug’s intended therapeutic effect.

Other 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:

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

3.6.20 Pharmacy Benefit Limitations

a) A **network pharmacy** may refuse to fill a **prescription** order or refill when in the professional judgment of the pharmacist the **prescription** should not be filled.

b) The **medical plan** will not cover expenses for any **prescription drug** for which the actual charge to you is less than the required **copayment** or **deductible**, or for any **prescription drug** for which no charge is made to you.
c) You will be charged the **non-preferred brand-name drug prescription drug** cost sharing for **prescription drugs** recently approved by the FDA, but which have not yet been approved for inclusion under the **medical plan** by the **pharmacy benefit manager**.
d) The **pharmacy benefit manager** has the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to section 11.14, *If a Claim Is Denied*.
e) The number of **copayments** and/or **deductibles** you are responsible for per vial of Depo-Provera, an injectable contraceptive, or similar type contraceptive dispensed for more than a 30-day supply, will be based on the 90-day supply level.

3.6.21 Pharmacy Benefit Exclusions

Not every health care service or supply is covered by the **medical plan**, even if prescribed, recommended, or approved by your **provider**. The **medical plan** covers only those services and supplies that are **medically necessary** and included in section 3.5, *Covered Medical Expenses,* or section 3.6, *Your Prescription Drug Benefits*. Charges made for the following are not covered except to the extent listed under section 3.5, *Covered Medical Expenses,* or section 3.6, *Your Prescription Drug Benefits*.

The following **prescription drug** exclusions are in addition to the exclusions listed under section 3.7, *Medical Benefit Exclusions*.

1. Administration or injection of any drug, except for covered vaccines.

2. Allergy sera and extracts.

3. Any drugs or medications, services and supplies that are not **medically necessary** for the diagnosis, care or treatment of the **illness** or **injury** involved. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

4. Any drug coded as a pharmaceutical aid, such as bulk powders.

5. Any drugs or medications listed on the **pharmacy benefit manager's** current year *Exclusion Drug List*.

6. Biological sera, blood, blood plasma, blood products or substitutes or any other blood products.

7. Over-the-counter contraceptive supplies except as provided under section 3.5.13 *Preventive Care and Screening Services*, including but not limited to:

   - condoms
   - contraceptive foams
   - jellies
   - ointments

- services associated with the prescribing, monitoring and/or administration of contraceptives.

8. Compound drugs that do not meet all four of the following criteria:

   - the product contains at least one **prescription** ingredient;
   - the **prescription** ingredient is FDA-approved for medical use in the United States;
   - the compound product is not a copy of a commercially available FDA-approved drug product; and
   - the safety and effectiveness of use for the prescribed indication is supported by FDA-approval or by adequate medical and scientific evidence in medical literature.

9. Contraceptives paid under your medical benefit for female contraceptive prescription drugs and devices (including any related services and supplies) when they are provided, administered or removed, by a physician during an office visit.

10. Drugs with active ingredients that do not have a valid NDC identifier number, or drugs prescribed and obtained outside the United States that do not have the same active ingredient as a drug with a valid NDC identifier number.

11. **Cosmetic** drugs, medications or preparations used for **cosmetic** purposes or to promote hair growth, including but not limited to:

    - health and beauty aids
    - chemical peels
    - dermabrasion treatments
    - bleaching creams
    - ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin.

12. Drugs given or entirely consumed at the time and place they are prescribed or dispensed.

13. Drugs or supplies used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy, in oral, injectable and topical forms or any other form used internally or externally (including but not limited to gels, creams, ointments and patches). Any **prescription drug** in oral, topical or any other form that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes, including but not limited to:

    - Sildenafil citrate
    - Phentolamine
    - Apomorphine
    - Alprostadil

14. Any other **prescription drug** that is in a similar or identical class, or has a similar or identical mode of action or exhibits similar or identical outcomes.

15. Drugs which do not, by federal or state law, need a **prescription** order (i.e. over-the-counter drugs), even if a **prescription** is written.

16. Drugs given by, or while the person is an inpatient in, any health care **facility**, or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it.

17. Drugs used primarily for the treatment of **infertility**, or for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures.

18. Drugs used for the purpose of weight gain or reduction, including but not limited to:

    - stimulants
    - preparations
    - foods or diet supplements
    - dietary regimens and supplements
    - food or food supplements
    - appetite suppressants
    - other medications

19. Drugs used for the treatment of obesity.

20. All drugs or medications in a therapeutic drug class if one of the drugs in that therapeutic drug class is not a **prescription drug**.

21. **Durable medical equipment**, monitors or other equipment.

22. **Experimental or investigational** drugs or devices. This exclusion will not apply with respect to drugs that:

    - have been granted treatment investigational new drug (IND), or group c/treatment IND, status; or
    - are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and
    - The **pharmacy benefit manager** determines, based on available scientific evidence, are effective or show promise of being effective for the **illness**.

23. Any treatment, device, drug, or supply to alter the body's genes, genetic make-up, or the expression of the body's genes, except for the correction of congenital birth defects.

24. Implantable drugs and associated devices.

25. Injectables:
    - Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by the medical benefit portion of the **medical plan**.
    - Needles and syringes, except for needles and syringes for injectable insulin and other injectable drugs covered by the **medical plan**.

26. Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps.

27. **Prescription drugs** for which there is an over-the-counter product which has the same active ingredient and strength, even if a **prescription** is written.

28. **Prescription drugs**, medications, injectables or supplies provided through a third party vendor contract.

29. **Prescription** orders filled prior to the effective date or after the termination date of coverage under the **medical plan**.

30. Prophylactic drugs for travel.

31. Refills in excess of the amount specified by the **prescription** order. Before recognizing charges, the **pharmacy benefit manager** may require a new **prescription** or evidence as to need, if a **prescription** or refill appears excessive under accepted medical practice standards.

32. Refills dispensed more than one year from the date the latest **prescription** order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.

33. Replacement of lost or stolen **prescriptions**.

34. Drugs, services and supplies provided in connection with treatment of an occupational **injury** or occupational **illness**.

35. Drugs or preparations, devices and supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.

36. Any treatment, drug or supply related to changing sex or sexual characteristics, with the exception of hormones and hormone therapy.

37. Any drug or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or change the shape or appearance of a sex organ. This exclusion does not limit coverage of medically necessary gender dysphoria.

38. Supplies, devices or equipment of any type.

39. Test agents except diabetic test agents.

40. Products that meet all the following criteria are considered medical treatments and are not covered through the prescription drug benefit:
    - designated as an orphan drug or exhibits Gene Therapy technology; and
    - annual drug cost is over $500,000; and
    - is not self-administered; and
    - the first dose may be administered in an inpatient setting

3.7 MEDICAL BENEFIT EXCLUSIONS

Not every medical service or supply is covered by the **medical plan**, even if prescribed, recommended, or approved by your **provider**. The **medical plan** covers only those services and supplies that are **medically necessary** and included under section 3.5, *Covered Medical Expenses*, or section 3.6, *Your Prescription Drug Benefits*. The exclusions listed below apply to all coverage under the **medical plan**. Additional exclusions apply to specific **prescription drug** coverage under section 3.6.158, *Pharmacy Benefit Limitations* and section 3.6.21, *Pharmacy Benefit Exclusions*.

The **medical plan** does not cover any condition, ailment, or **injury** for which you receive benefits available under any Federal or state act (except services received from Alaska Native Health), even though you waive rights to those benefits.

Except as provided in section 3.5, *Covered Medical Expenses*, charges made for the following are not covered under the **medical plan**:

1. Abortion
2. Acupuncture, acupressure and acupuncture therapy.
3. Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine autoinjections.
4. Any charges in excess of the benefit, dollar, day, visit or supply limits stated in the **medical plan**.
5. Any non-**emergency** charges incurred outside of the United States if you traveled to such location to obtain medical services, **prescription drugs**, or supplies, even if otherwise covered under the **medical plan**. This also includes **prescription drugs** or supplies if:
    - such **prescription drugs** or supplies are unavailable or illegal in the United States; or
    - the purchase of such **prescription drugs** or supplies outside the United States is considered illegal.
6. Behavioral health services:
    - Treatment of a covered health care **provider** who specializes in the mental health care field and who receives treatment as a part of their training in that field.
    - Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.
    - Treatment of antisocial personality disorder.
    - Treatment in wilderness programs or other similar programs.
    - Treatment of intellectual disability, defects, and deficiencies.
    - Alcoholism or **substance abuse** rehabilitation treatment on an inpatient or outpatient basis.
7. Charges for a service or supply furnished by a **network provider** in excess of the **negotiated charge**.
8. Charges for a service or supply furnished to a **benefit recipient** who is not yet Medicare age eligible by an out-of-**network provider**, non-**preferred hospital** or **facility** or for **other health care** in excess of the **recognized charge**.
9. Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the **medical plan**.

10. Charges submitted for services by an unlicensed **hospital**, **physician** or other **provider** or not within the scope of the **provider**'s license.
11. **Cosmetic** services and plastic surgery: any treatment, surgery (**cosmetic** or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:
    - Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, **cosmetic** eyelid surgery, and other surgical procedures.
    - Procedures to remove healthy cartilage or bone from the nose (or other part of the body).
    - Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin.
    - Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when **medically necessary**.
    - Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy).
    - Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices.
    - Surgery to correct Gynecomastia.
    - Breast augmentation.
    - Otoplasty.
12. Counseling services and treatment by a marriage, religious, family, career, social adjustment, pastoral, or financial counselor.
13. Court ordered services, including those required as a condition of parole or release.
14. **Custodial care.**
15. Dental services covered under the **dental plan**.
16. Drugs, medications and supplies:
    - Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a **prescription** including vitamins.
    - Any services related to the dispensing, injection or application of a drug.
    - Any **prescription drug** purchased illegally outside the United States, even if otherwise covered under the **medical plan** within the United States.
    - Immunizations that are not considered preventive care such as those required due to your employment or travel.
    - Needles, syringes and other injectable aids, except as covered for diabetic supplies.
    - Drugs related to the treatment of non-**covered expenses**.
    - Performance enhancing steroids.
    - Injectable drugs if an alternative oral drug is available.
    - Outpatient prescription drugs.
    - Self-injectable drugs and medications.
    - Any expenses for **prescription drugs** and supplies covered under the **pharmacy** benefit portion of the **medical plan**.

- Charges for any **prescription drug** for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

17. Educational services:
    - Education, training and **room and board** while confined to an institution which is primarily a school or other institution for training.
    - Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs.
    - Services, treatment, and educational testing and training related to behavioral (conduct) problems.
    - Services or supplies which any school system is legally required to provide.
18. LEAP, TEACCH, Denver and Rutgers programs.
19. Habilitative services provided in an educational or training setting or to teach sign language
20. Any health examinations required:
    - By a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement or by any law of a government.
    - For securing insurance, school admissions or professional or other licenses, to travel, or to attend a school, camp, or sporting event or participate in a sport or other recreational activity.
21. Any special medical reports not directly related to treatment except when provided as part of a covered service.
22. **Experimental or investigational** drugs, devices, treatments or procedures.
23. **Facility** charges for care services or supplies provided in:
    - Rest homes
    - Assisted living facilities
    - Similar institutions serving as an individual's primary residence or providing primarily **custodial care** or rest care
    - Health resorts
    - Spas, sanitariums
    - Infirmaries at schools, colleges, or camps
24. Any food item, including infant formulas, nutritional supplements, vitamins, including **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.
25. Any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:
    - Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes.
    - Shoes (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an **illness** or **injury**.

26. Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
27. Hearing services covered under the **audio plan**.
28. Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:
    - Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds, and swimming pools.
    - Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices.
    - Equipment or supplies to aid sleeping or sitting, including non-**hospital** electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs.
    - Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature.
    - Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring.
    - Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your **illness** or **injury**.
    - Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or **illness**.
    - Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.
29. Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.
30. Any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:
    - Drugs related to the treatment of non-covered benefits.
    - Injectable **infertility** medications including but not limited to, menotropins, hCG, GnRH agonists, and IVIG.
    - Artificial insemination.
    - Any advanced reproductive technology (ART) procedures or services related to such procedures including but not limited to, in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), and intra-cytoplasmic sperm injection (ICSI).
    - **Infertility** services for couples in which one of the partners has had a previous sterilization procedure, with or without surgical reversal.
    - Procedures, services and supplies to reverse voluntary sterilization.
    - **Infertility** services for females with FSH levels 19 or greater mIU/ml on day three of the menstrual cycle.

- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to, fees for laboratory tests.
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (*e.g*., office, **hospital**, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges.
- Home ovulation prediction kits or home pregnancy tests.
- Any charges associated with care required to obtain ART Services (*e.g*., office, **hospital**, ultrasounds, laboratory tests), and any charges associated with obtaining sperm for any ART procedures.
- Ovulation induction and intrauterine insemination services if you are not **infertile**.

31. Maintenance care.
32. Payment for that portion of the charge for which Medicare or another party is the primary payer.
33. Miscellaneous charges for services or supplies including:
    - Annual or other charges to be in a **physician's** practice.
    - Charges to have preferred access to a **physician's** services such as boutique or concierge **physician** practices.
    - Cancelled or missed appointment charges or charges to complete claim forms.
    - Charges the recipient has no legal obligation to pay.
    - Charges that would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
        - Care in charitable institutions
        - Care for conditions related to current or previous military service
        - Care while in the custody of a governmental authority
        - Any care a public **hospital** or other **facility** is required to provide
        - Any care in a **hospital** or other **facility** owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.
34. Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities).
35. Non-**medically necessary** services, including but not limited to, those treatments, services, **prescription drugs** and supplies which are not **medically necessary**, as determined by the **claims administrator**, for the diagnosis and treatment of **illness**, **injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

36. Any service or supply primarily for your convenience and personal comfort or that of a third party, including: telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.
37. Private duty nursing during your **stay** in a **hospital**, and outpatient private duty nursing services.
38. Services provided by a **spouse**, parent, **child**, brother, sister, in-law, or any household member.
39. Services of a resident **physician** or intern rendered in that capacity.
40. Services provided where there is no evidence of pathology, dysfunction, or disease, except as specifically provided in connection with covered routine care and cancer screenings.
41. Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
    - Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ.
    - Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.
42. Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under section 12, Consolidated Omnibus Budget Reconciliation Act (COBRA) and Extended Health Coverage.
43. Services that are not covered under the **medical plan**.
44. Services and supplies provided in connection with treatment or care that is not covered under the **medical plan**.
45. Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:
    - Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching.
    - Drugs or preparations to enhance strength, performance, or endurance.
    - Treatments, services and supplies to treat **illnesses**, **injuries** or disabilities related to the use of performance-enhancing drugs or preparations.
46. Any of the following treatments or procedures:
    - Aromatherapy
    - Bio-feedback and bioenergetic therapy
    - Carbon dioxide therapy
    - Chelation therapy (except for heavy metal poisoning)
    - Educational therapy
    - Gastric irrigation
    - Hair analysis
    - Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds
    - Hypnosis, and hypnotherapy, except when performed by a **physician** as a form of anesthesia in connection with covered surgery
    - Lovaas therapy
    - Massage therapy
    - Megavitamin therapy
    - Primal therapy

- Psychodrama
- Purging
- Recreational therapy
- Rolfing
- Sensory or auditory integration therapy
- Sleep therapy
- Thermograms and thermography

47. Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum.
48. The following charges related to transplant coverage:
    - Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence.
    - Services and supplies furnished to a donor when recipient is not a **covered person**.
    - Home infusion therapy after the transplant occurrence.
    - Harvesting and/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 **precertified** by the **claims administrator**.
49. Transportation costs, including **ambulance** services, for routine transportation to receive outpatient or inpatient services.
50. Unauthorized services, including any services obtained by or on behalf of a person without **precertification** when required by the **plan**. This exclusion does not apply to a medical emergency or urgent care situation.
51. Vision services covered under the **vision plan**.
52. Any **illness** or **injury** related to employment or self-employment including any **illness** or **injury** that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational **illness** or similar program under local, state or Federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular **illness** or **injury** under such law, that **illness** or **injury** will be considered "non-occupational" regardless of cause.
53. Spinal disorders, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine, including manipulation of the spine treatment.
54. Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of co-morbid conditions, including but not limited to:

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical procedures, medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including morbid obesity.
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications.
- Counseling, coaching, training, hypnosis or other forms of therapy.
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.
-

55. Illegal acts, riot or rebellion, including services and supplies for treatment of an injury or condition caused by or arising out of active **covered person's** voluntary participation in a riot, armed invasion or aggression or rebellion or arising directly from an illegal act.

3.8 INDIVIDUAL CASE MANAGEMENT

If you have an **injury** or **illness** for which care or treatment may be necessary 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 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 that 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, procedures or suggestions for cost-effective use of existing **medical plan** provisions such as home health care and **skilled nursing facilities**.

Examples of conditions that may qualify for ICM include:

a) Spinal cord **injuries** with paralysis
b) High-risk infants undergoing neonatal care
c) Traumatic brain **injury** resulting from an **accident**
d) Severe burns
e) Multiple fractures
f) Stroke
g) Any confinement exceeding 30 days
h) **Illness** or **injury** 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.

4 HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

4.1 INTRODUCTION

The Health Reimbursement Arrangement (HRA) is an employer funded medical expense reimbursement account that **benefit recipients** may use to pay eligible medical expenses. Eligible medical expenses are health, dental, and vision expenses as defined under 26 U.S.C. Section 213(d) that are not otherwise reimbursable by the **health plan** or any other health plan. Eligible medical expenses must be expenses incurred by you, your **spouse**, or your **dependent children**. A complete list of eligible medical expenses is available in IRS Publication 502. Your monthly **health plan** premiums are eligible medical expenses that can be reimbursed by the HRA.

4.2 HOW THE HRA WORKS

You do not have to participate in the **health plan** in order to participate in your HRA.

A **member** is eligible for reimbursement under the HRA if they

a) have at least 25 years of **membership service** as a peace officer or firefighter,
b) for any other employee, have at least 30 years of **membership service**, or
c) have at least 10 years of **membership service** and reaches Medicare age.

You may request reimbursement from the HRA account for eligible medical expenses you have incurred. You will be reimbursed up to the amount of your balance in the HRA or the amount of the claim, whichever is less.

4.3 CARRYOVER OF UNUSED AMOUNTS IN HRA

The HRA is yours to use until the balance is exhausted. If you have a balance remaining in your HRA at the end of the **benefit year**, the remaining balance will be carried over to the following **benefit year**.

4.4 ELIGIBLE MEDICAL EXPENSES

Eligible medical expenses are health, dental and vision expenses as defined under 26 U.S.C. Section 213(d) that are not otherwise reimbursable by the **plan** or any other health plan. In addition, expenses reimbursed out of your HRA must be expenses incurred by you, your **spouse**, and your **dependent children**. The HRA claims administrator will make the final determination as to whether an expense may be reimbursed from the HRA.

A complete list of qualified medical expenses is available in IRS Publication No. 502. You will find it online at irs.gov/publications.

Examples of eligible medical expenses include:

a) your monthly **health plan** premiums
b) your monthly Medicare premiums
c) **custodial care** expenses

d) hearing aids
e) **deductibles**
f) **copayments**
g) **coinsurance**
h) amounts in excess of the maximums allowed by the **medical plan**, **dental plan**, or **vision plan**
i) insulin (whether or not prescribed)
j) **prescription drugs**
k) over-the-counter drugs, but only if you have a **prescription**

Examples of expenses that cannot be reimbursed include, but are not limited to:

a) certain **cosmetic** surgery and procedures
b) travel expenses
c) fees for health club
d) vitamins
e) qualified long-term care services

4.5 SUBMITTING CLAIMS FOR REIMBURSEMENT

You should submit a claim for medical expenses to the **plan** and any other health plan in which you participate first. You will receive an Explanation of Benefits (EOB) showing your out-of-pocket costs.

To be reimbursed for unpaid eligible medical expenses, claims for reimbursement to the HRA may be submitted in one of the following ways:

a) Direct claims submission – you submit your claims to the HRA claims administrator on the Request for Reimbursement form after receiving your EOB from the plan or any other health plan in which you participate. This form is available at AlaskaCare.gov. If you have more than one health plan, you must submit the claim with copies of the EOB from all plans.
b) Over-the-counter (OTC) claims submission- you must submit each claim with itemized statements or receipts, an EOB from your health plan, and a prescription.

Reimbursements are issued daily. Checks are payable to you, not to your **provider**. Your claim will be accepted if you file as soon as possible, but not later than 12 months after the date you incurred the expenses.

You can also submit for reimbursement of premium payments, including the **medical plan, DVA plan,** Medicare or other plans such as a Medicare Supplement plan. You can submit to the HRA claims administrator to have your monthly premium reimbursed to you from your HRA, or paid from the HRA directly to the entity from which you are purchasing coverage on a recurring basis. You can submit for reimbursement of future premium payments for the full plan year, when funds exist in the HRA, and sufficient proof is provided showing the applicable health insurance premiums were paid.

Additional information on this option is available at AlaskaCare.gov.

5 DENTAL, VISION, AUDIO (DVA) PLAN

5.1 INTRODUCTION

The State of Alaska is pleased to be able to offer this voluntary **DVA plan** for benefit recipients and their eligible dependents. These benefits may change from time to time. You should make sure that you are referencing the most current edition of the *AlaskaCare DCR Benefit Plan* booklet, which is available from the Division of Retirement and Benefits ("**Division**") or AlaskaCare.gov.

The **State**, through appropriate action of the Commissioner of Administration, is offering two (2) dental plan options under the voluntary Dental-Vision-Audio Plan ("Plan"): the Standard Dental Plan and the Legacy Dental Plan. Continued provision of two dental plan options is not guaranteed. The **State**, through appropriate action of the Commissioner of Administration, reserves the right in its sole discretion to amend the Plan, the schedule of benefits or any underlying benefit, as applicable, at any time and from time to time and to any extent that it may deem advisable.

5.2 ELIGIBILITY FOR DVA COVERAGE

5.2.1 Eligibility for coverage under the DVA plan

A **member** is eligible to elect coverage under the **DVA plan** if he or she retires directly from the **DCR Plan**, was an active member in the **DCR Plan** for at least 12 months immediately before their application for retirement, and

a) has at least 25 years of **membership service** as a peace officer or firefighter,

b) for any other employee, has at least 30 years of **membership service**, or

c) has at least 10 years of **membership service** and reaches Medicare age.

A disabled **member** receiving an occupational disability benefit at the time of conversion to a normal retirement benefit under the **DCR Plan** is considered to have retired directly from the **DCR Plan**, and the period of disability constitutes **membership service** for purposes of determining the **member's** eligibility to elect coverage under the **DVA plan**.

A disabled **member** who dies while receiving an occupational disability benefit or a deceased **member** whose **surviving spouse** receives an occupational death benefit is considered to have retired directly from the **DCR Plan** on the date that the **member** would have been eligible for normal retirement if he or she had lived. The period of disability and the period during which a **surviving spouse** receives an occupational death benefit each constitute **membership service** for purposes of determining the **surviving spouse's** eligibility to elect coverage under the **DVA plan**.

5.2.2 Eligible Dependents

You may enroll the following **dependents** in coverage under the **DVA plan**:

a) Your **spouse**. You may be legally separated but not divorced.

b) Your **children** up to age 19 if they (i) are unmarried, (ii) provide less than one-half of their own support, and (iii) share your principal place of residence for more than one-half of the year (unless the **child** is your natural or adopted **child** and is living with your ex-**spouse**).

c) Your **children** up to age 23 if they meet the criteria listed above and are registered at and attending on a full-time basis an accredited educational or technical institution recognized by the Department of Education and Early Development.

d) 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 past age 23 who are incapable of employment because of a mental or physical incapacity can still be covered. The incapacity must have existed before age 23 and the children must continue to meet all other eligibility criteria, except for age. You must furnish the Division evidence of the incapacity and proof that the incapacity existed before age 23. 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. Incapacitated children remain covered as long as the incapacity exists, and you continue to provide periodic proof of the continued incapacity as required.

Your **dependent children's** spouse or **children** are not eligible for coverage under the **DVA plan.**

When you enroll in the **DVA plan**, you must also enroll each of your **dependents** in order for their claims to be paid. If your **dependents** subsequently change, you must notify the Division within 30 days, as provided under section 5.5, *Changing Your DVA Coverage.*

5.2.3 Qualified Domestic Relations Order DVA Coverage Requirements

If an **alternate payee** becomes a **benefit recipient** due to a **qualified domestic relations order**, then the **alternate payee** may enroll in coverage in accordance with the order, subject to the provisions of the **DVA plan**. The **alternate payee** must present the order to the **Division**, enroll in coverage within 60 days of the order, and pay the required premium. These requirements apply regardless of the retirement plan to which the order applies.

5.2.4 Dual DVA Coverage

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

5.3 INITIAL DVA COVERAGE ELECTIONS

5.3.1 Electing DVA Coverage

Benefit recipients who are eligible to be covered under the **DVA plan**, as described in Section 5.2.1, *Eligibility for coverage under the DVA plan*, may voluntarily elect coverage under the **DVA plan**. The plan requires monthly premium payments.

Benefit recipients who voluntarily choose to elect coverage under the **DVA plan**, may only elect coverage during the following events:

a) prior to the effective date of their retirement benefit under the **DCR Plan**;
b) with their application for survivor benefits; or
c) during the annual open enrollment period, if also electing the same or increased level of medical **plan** coverage for the first time. For example, a **retiree** who has no **medical plan** or **DVA plan** coverage may elect **medical plan** coverage for self and **spouse** and **DVA plan** coverage for self only during the open enrollment.

5.3.2 DVA Coverage Level and Premiums

Coverage under the **DVA plan** may be elected for:

a) retiree or **surviving spouse** only,
b) retiree and spouse,
c) retiree and child/children or **surviving spouse** and child/children, or
d) retiree and family (spouse and child/children).

Premiums may be paid by deductions from your HRA as described in section 4, *Health Reimbursement Arrangement (HRA)*. You must pay the full monthly premium for the coverage elected under the **DVA plan**.

An **alternate payee** must pay the full monthly premium for coverage elected under the **DVA plan.**

If at any time your HRA is insufficient to pay the full monthly premium for the coverage that you have elected, you must pay the premium directly to the **direct bill administrator** to maintain coverage. Contact the **Division** for more information.

A benefit recipient with multiple retirement accounts may elect dental-vision-audio insurance under each retirement account. If a benefit recipient elects coverage under multiple retirement accounts, different coverage tiers may be elected for each separate account so long as the same plan option (Standard or Legacy) is elected for all accounts.

5.4 When DVA Coverage Begins

5.4.1 New Benefit Recipients

If you timely elect coverage, you will be covered under the **DVA plan** on the first day of the month of your retirement, disability, or survivor/death benefits.

5.4.2 Dependents

Dependents are covered under the **DVA plan** on the same day that you are covered if they meet the eligibility requirements and you elect coverage for them. To cover a newborn under the **DVA plan**, you will need to enroll the **child** under the **DVA plan** within 30 days after birth. New **dependent children** will be covered under the **plan** immediately if you have elected a level of coverage that covers the new **dependent** and you timely enroll the **child** in the **DVA plan.**

To enroll your eligible dependent(s), you must complete and return the Retiree Health Dependent Change form to the Division within 120 days of the qualifying event.

5.5 CHANGING YOUR DVA COVERAGE

You may elect, change, or terminate coverage under the **DVA plan** as described in this section.

5.5.1 Open Enrollment

Open enrollment will be held annually. During open enrollment you may:

a) elect to begin coverage under the **DVA plan** if you are also electing the same or increased level of **medical plan** coverage for the first time; or
b) enroll in the plan of your choice (Standard or Legacy)
c) terminate coverage under the **medical plan**.

During the open enrollment period of each benefit year, if you are already enrolled in a dental-vision-audio plan, you may elect an offered dental-vision-audio plan option and increase or decrease your coverage tier level. Coverage premiums for elected benefits are subject to change under 2 AAC 39.280.

5.5.2 Decreasing DVA Coverage

You may decrease your level of **DVA plan** 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, you must submit a written request to the **Division** electing the level of coverage you would like. Once you decrease your coverage, you cannot increase it except as described in section 5.5.3, *Increasing Dependent DVA Coverage*.

You are required to notify the **Division** within 30 days that your **dependent** is no longer eligible under the **DVA plan**. For example, if you divorce or your **child** ceases to meet the eligibility requirements, you must notify the **Division** so that coverage can be terminated. If you fail to timely notify the **Division**, you may be required to repay the benefits which you or your **dependent** were not eligible to receive, and you may also forfeit your right to ongoing and future coverage, at the **State's** discretion.

5.5.3 Increasing Dependent DVA Coverage

You may increase **dependent** coverage only:

a) upon marriage; or
b) upon birth or adoption of your **child**.
c) becoming the legal, court appointed guardian of a dependent child
d) a change in your dependent's eligibility status as noted in section 5.4.2 Dependents

If you want to increase coverage due to marriage, 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, and the date the event occurred.

If you increase your coverage to include dependents following a qualifying life event or a qualified change in family structure, 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.

5.6 WHEN DVA COVERAGE ENDS

5.6.1 For Retirees

Coverage under the **DVA plan** terminates for **retirees** as of the date that is the earliest of:

a) The date that your coverage terminates.
b) The date you die.
c) The last day of the month in which you last paid the required monthly premium.

You may submit a written request to the **Division** to terminate your coverage. Coverage will end on the last day of the month in which the last premium was paid or deducted.

5.6.2 For Dependents

Coverage under the **DVA plan** terminates for **dependents** as of the date that is the earliest of:

a) The date a **spouse** ceases to be a **dependent** due to a divorce.
b) The last day of the month in which a **dependent child** ceases to satisfy the eligibility requirements for a **dependent** under the **DVA plan**.
c) The date a **dependent** dies.
d) The date that your coverage terminates, or for a **dependent** in the event of your death, the last day of the month in which you die.
e) The last day of the month in which you last paid the required monthly premium on behalf of your **dependents**.
f) The date that you terminate coverage for your **dependents.**

You may submit a written request to the **Division** to terminate **DVA plan** coverage for your **dependents**. Premium reductions are effective only after your written request is received by the **Division.**

If the Division becomes aware that your dependent is not eligible for coverage, the Division will automatically decrease your coverage tier and corresponding premiums to appropriately reflect the recipient's family structure.

5.6.3 Continued Coverage

Your **dependents** may be eligible for continued health benefits when coverage ends under the **DVA plan**. See section 12, *Consolidated Omnibus Budget Reconciliation Act (COBRA) and Extended Health Coverage.*

5.7 COORDINATION OF BENEFITS FOR DVA CLAIMS

If you are entitled to **DVA plan** benefits from other sources, such as employer or government sponsored DVA plans, the retiree **DVA plan** has the right to offset against or recover from those other plans or persons so that you do not duplicate recovery of covered DVA expenses.

The **DVA plan** coordinates benefits with other group DVA 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:

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

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

Here's how benefits are coordinated when a claim is made:

a) The primary plan pays benefits first, without regard to any other DVA plan.
b) When the **DVA 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 **DVA plan** on that claim. The plan pays the difference between the amount the other plan paid and 100% of expenses the **DVA plan** would cover.
c) Neither plan pays more than it would without coordination of benefits. Benefits payable under another **DVA plan** include the benefits that would have been payable whether or not a claim was actually submitted to the plan.
d) 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 two **prophylaxis** (dental cleanings) in a **benefit year**, the plans do not pay for four **prophylaxis** in a **benefit year**.

The order of coordination will be the same as for the **medical plan** as outlined in section 13.4, *Which Plan Pays First*.

6 STANDARD PLAN DENTAL BENEFITS

6.1 INTRODUCTION

The **dental plan** reflects the dental benefits under the **DVA plan**. Section 2.1.3, *Dental Benefit Schedule*, reflects the limits and maximums that the **dental plan** will pay for **covered expenses**.

6.2 How Dental Benefits Are Paid

6.2.1 Deductible

Each **covered person** must meet the annual individual **deductible** before the **dental plan** begins to pay benefits for that **covered person**. The **deductible** is waived for Class I preventive services. See section 2.1.3, *Dental Benefit Schedule*.

6.2.2 Coinsurance

After you satisfy the annual individual **deductible**, the **dental plan** pays the **coinsurance** amount that applies to you for Class II restorative services and Class III prosthetic services for most **covered expenses**. See section 2.1.3, *Dental Benefit Schedule*.

6.2.3 Network and Out-of-Network Coverage

You can directly access any network or out-of-network **dentist** or **dental care provider** for covered services and supplies under the **dental plan**. The **dental plan** pays differently when services and supplies are obtained through **network providers** and out-of-**network providers**. **Network providers** have contracted with the **dental claims administrator** either directly or through a third party to provide services and supplies under the **dental plan**. **Network providers** are identified in the **dental claims administrator**'s directory, which can be found online at AlaskaCare.gov.

The **dental plan** provides access to covered benefits through a broad network of health care **providers** and facilities. The **dental plan** is designed to lower your out-of-pocket costs when you use **network providers** for **covered expenses**. **Network providers** have agreed to accept a **negotiated charge** from the **dental plan**. Your **coinsurance** under the **dental plan** will be based on a **negotiated charge** between the **dentist** or **dental care provider** and the **dental claims administrator**, and you will not have to pay any amount above the **negotiated charge**.

You also have the choice to access licensed **dentists** and **dental care providers** outside the network for covered services and supplies. Your out-of-pocket costs will generally be higher when you use out-of-**network providers** because the **coinsurance** that you are required to pay is usually higher when you utilize out-of-**network providers**. Out-of-**network providers** have not agreed to a **negotiated charge** with the **dental claims administrator** and may balance bill you for charges over the **recognized charge** that the **dental plan** pays.

6.2.4 Availability of Providers

The **dental claims administrator** cannot guarantee the availability or continued network participation of a particular **dentist** or **dental care provider**. Either the **dental claims administrator** or any **network provider** may terminate the **provider** contract.

6.2.5 Out-of-Network Recognized Charge

The **covered expense** is the part of a charge which is the **recognized charge**. If a charge exceeds the **recognized charge**, the amount above the **recognized charge** is not covered by the **dental plan** and is your responsibility to pay.

6.2.6 Annual Maximum

The **dental plan** pays **covered expenses** up to an annual **individual** maximum for each **covered person**. See section 2.1.3, *Dental Benefit Schedule.*

6.3 COVERED DENTAL SERVICES

The **dental 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**.

6.3.1 Class I Preventive Services

Covered expenses are paid at 100% of the recognized charge. The amount paid by the Plan for Class I Preventive Services does not count toward the annual maximum benefit.

6.3.1.1 Diagnostic Services and Limitations

Services:

a) Examination.
b) Intra-oral x-rays to assist in determining required dental treatment.

Limitations:

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

6.3.1.2 Preventive Services and Limitations

Services:

a) **Prophylaxis** (cleanings).
b) Periodontal maintenance.
c) Topical application of fluoride.
d) Sealants.
e) Space maintainers.

Limitations:

a) **Prophylaxis** (cleaning) or **periodontal maintenance** is covered up to two times in any **benefit year**. Additional cleaning benefits may be available if **medically necessary** or **dentally necessary** and when **precertified** by the **dental claims administrator**. Additional cleaning benefits are available for **covered persons** with diabetes and **covered persons** in their third trimester of

pregnancy under the **dental plan's** Oral Health, Total Health program (see section 6.4, *Oral Health, Total Health Program and Benefits*).

b) **Covered persons** diagnosed with periodontal disease are eligible for a total of up to four cleanings per **benefit year**.

c) Topical application of fluoride is covered up to two times in any **benefit year** for **covered persons** age 18 and under. For **covered persons** age 19 and over, topical application of fluoride is covered up to two times in any **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).

d) 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.

e) 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.

6.3.2 Class II Restorative Services

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

6.3.2.1 Restorative Services and Limitations

Services: Fillings on teeth for the treatment of decay.

Limitations:

a) Inlays are considered an optional service; an alternate benefit of a composite filling will be provided.

b) Crown buildups are considered to be included in the crown **restoration** cost. A buildup will be a benefit only if necessary, for tooth retention.

c) Additional limitations when teeth are restored with crowns or **cast restorations** are in section 6.3.3, *Class III Prosthetic Services.*

d) A separate charge for general anesthesia and/or IV sedation when in conjunction with non-surgical procedures is not covered.

6.3.2.2 Oral Surgery Services and Limitations

Services:

a) Extractions (including surgical).

b) Other minor surgical procedures.

Limitations:

a) A separate, additional charge for **alveoloplasty** done in conjunction with surgical removal of teeth is not covered.

b) Surgery on larger lesions or malignant lesions is not considered minor surgery.

c) Brush biopsy is covered up to two times in any **benefit year**. Benefits are limited to the sample collection and do not include coverage for pathology (lab) services.

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

6.3.2.3.1 Periodontic Services and Limitations

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

Limitations:

a) Periodontal scaling and root planing is limited to once per quadrant in any 24-month period.
b) Coverage for **periodontal maintenance** procedure under Class I, Preventive.
c) A separate charge for post-operative care done within 3 months following periodontal surgery is not covered.
d) 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.

6.3.2.4 Anesthesia Services

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

6.3.3 Class III Prosthetic Services

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

6.3.3.1.1 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 functional acceptability.

Limitations:

a) **Cast restorations** (including **pontics**) are covered once in a seven year period on any tooth.
b) 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.

6.3.3.1.2 Prosthodontic Services and Limitations

Services:

a) Bridges.
b) Partial and complete dentures.
c) Denture **reline**s.
d) Repair of an existing prosthetic device.
e) Implants.

Limitations:

a) A **bridge** or denture (full or partial denture) will be covered once in a seven year period and only if the tooth, tooth site, or teeth involved have not received a **cast restoration** benefit in the last seven years.
b) 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.
c) Partial dentures: A temporary (interim) partial denture is only a benefit when placed within two 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** teeth unless the tooth requires a **cast restoration** due to decayed or **broken** teeth.
d) Denture adjustments, repairs, and **relines**: A separate, additional charge for denture adjustments, repairs, and **relines** done within six 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 two adjustments per denture in a 12-month period.
e) Tissue conditioning is covered no more than twice per denture in a 36-month period.
f) Surgical placement and removal of **implants** are covered. **Implant** placement and **implant** removal are limited to once per lifetime per tooth space. The **dental 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 seven 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 seven 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 seven years.
g) Fixed **bridges** or removable cast partial dentures are not covered for **covered persons** under age 16.

h) 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 paying the difference.

6.3.3.2 Other Services and Limitations

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.

6.3.4 General Limitation – Optional Services

If a more expensive treatment than is functionally adequate is performed, the **dental 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.

6.4 Oral Health, Total Health Program and Benefits

The **dental 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 in section 6.3, *Covered Dental Services*.

The following **covered persons** should consider enrolling in this program:

6.4.1 Diabetics

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

6.4.2 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.

6.5 Orthodontic Benefits

Orthodontic services are not covered under the **dental plan**.

6.6 Advance Claim Review for Dental Claims

Before beginning expensive treatment, ask your **dentist** to file a description of the proposed course of treatment and expected charges with the **dental claims administrator**. The **dental claims administrator** will review the proposal and advise you and your **dentist** of the estimated benefits payable.

A course of treatment is a planned program of one or more services or supplies. It may be rendered by one or more **providers** for the treatment of a condition diagnosed by the attending **physician** or **dentist** as a result of an examination. It begins on the day the **provider** first renders the service to correct or treat such a condition. **Emergency** treatments, oral examinations, **prophylaxis**, and dental x-rays are considered part of a course of treatment.

By receiving an advance review, you will eliminate the possibility of unexpected claim **denials**.

As part of advance claim review and for any claim, the **dental claims administrator**, at its expense, has the right to require you to obtain an oral examination. You must furnish to the **dental claims administrator** all diagnostic and evaluative material required to establish your right to benefits. Evaluative material includes dental X-rays, models, charts, and written reports.

7 Legacy Plan Dental Benefits

7.1 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.

7.2 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.

7.3 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.

7.4 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.

7.5 Deductible

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

7.6 Recognized Charge

Payment is based on the recognized charge for covered services. Charges or fees in excess of the recognized charge, as determined by the claims administrator, are your responsibility to pay.

The recognized charge is the charge contained in an agreement the claims administrator has with the provider either directly or through a third party. If no agreement is in place, the recognized charge is the lowest of:

a) The provider's usual charge for furnishing the service.
b) The charge the claims administrator determines to be appropriate based on factors such as the cost for providing the same or similar service or supply and the manner in which charges for the service or supply are made.
c) The charge the claims administrator determines to be the recognized charge percentage made for that service or supply.

The recognized charge percentile is the charge determined by the claims administrator on a semiannual basis to be in the 90th percentile of the charges made for a service or supply by providers in the geographic area where it is furnished. The recognized charge is determined by collecting the claims submitted for each procedure, defined by the procedure code, in a specific geographic area. The highest and lowest charges are ignored and the charge that allows 90% of all the claims to be paid in full is set as the recognized charge for that procedure. The geographic area is determined by where the procedure is performed. For example, most procedures in Juneau are based on charges submitted from all of Southeast Alaska. Some types of procedures, such as surgery, are based on statewide claims data to ensure sufficient information to establish a recognized charge.

If data is insufficient to determine a recognized charge, the claims administrator may consider items such as the following:

a) The recognized charge in a greater geographic area.
b) The complexity of the service or supply.

c) The degree of skill needed.
d) The type or specialty of the provider.
e) The range of services or supplies provided by a facility.

If two or more surgical procedures are performed during the same operative session, payment will be calculated as follows:

- The claims administrator will determine which procedures are primary, secondary or tertiary, taking into account the billed amounts.

Payment for each procedure will be made at the lesser of the billed charge or the following percentage of the recognized charge:

- Primary: 100%
- Secondary: 50%
- All others: 25%

Incidental procedures, those that take little or no additional resources or time when performed at the same time as another procedure, are not covered by the plan.

Charges in excess of the recognized charge as determined by the claims administrator are not paid by the plan.

7.7 Advance Claim Review

Before beginning treatment for which charges are expected to exceed $1,000, ask your dentist to file a description of the proposed course of treatment and expected charges with the claims administrator. The claims administrator reviews the proposal and advises you and your dentist of the estimated benefits payable.

A course of treatment is a planned program of one or more services or supplies. It may be rendered by one or more providers for the treatment of a condition diagnosed by the attending physician or dentist as a result of an examination. It begins on the day the provider first renders the service to correct or treat such a condition. Emergency treatments, oral examinations, **prophylaxis**, and dental X-rays are considered part of a course of treatment; but you may seek these services without advance claim review.

The plan pays for the least expensive, professionally adequate service. **By receiving an advance review, you will eliminate the possibility of unexpected claim denials.**

As part of advance claim review and for any claim, the claims administrator, at its expense, has the right to require you to obtain an oral examination. You must furnish to the claims administrator all diagnostic and evaluative material required to establish your right to benefits. Evaluative material includes dental X-rays, models, charts, and written reports.

In many cases, alternative services or supplies may be used to treat a dental condition. If so, benefit coverage is limited to the services and supplies customarily employed to treat the disease or injury and recognized by the dental profession to be appropriate according to broadly accepted national standards of practice. The plan takes into account your total oral condition.

Following are examples of alternative services or supplies for restorative care:

a) Gold or baked porcelain restorations, crowns, and jackets. If a tooth can be restored with amalgam or like material and you and your dentist select another type of restoration, your benefits are limited to the appropriate charges for amalgam or similar material.
b) Reconstruction. Covered expenses only include charges for procedures necessary to eliminate oral disease and replace missing teeth. Appliances or restorations to increase vertical dimension or restore the occlusion are considered optional and not covered.

Following are examples of alternative services or supplies for prosthetic care:

a) Partial dentures. If cast chrome or acrylic partial dentures will restore a dental arch satisfactorily and you and your dentist choose a more elaborate precision appliance, covered expenses are limited to the appropriate charges for cast chrome or acrylic.
b) Complete dentures. If you and your dentist decide on personalized restorations or specialized techniques, as opposed to standard dentures, covered expenses are limited to appropriate charges for the standard dentures.
c) Replacement of existing dentures. Charges for existing denture replacements are covered only if the existing dentures are not or cannot be made serviceable; otherwise, covered expenses are limited to appropriate charges for services necessary to make appliances serviceable.

7.8 Covered Dental Services

7.8.1 Class I Preventive Services

The dental plan covers 100% of the recognized charge with no deductible for Class I preventive services rendered by a dentist (D.D.S. or D.M.D.).

Class I services include:

a) Oral examinations.
b) Dental X-rays required for the diagnosis of a specific condition.
c) Routine dental X-rays, but not more than one full mouth or series per year.
d) Topical fluoride application (painting the surface of the teeth with a fluoride solution).
e) **Prophylaxis**, including cleaning, scaling, and polishing.
f) Dental sealants for children through age 18.

7.8.2 Class II Restorative Services

Following the $50 annual deductible, the dental plan covers 80% of the recognized charge for Class II restorative services.

These include:

a) Fillings of silver amalgam, silicate, and plastic restoration.
b) Repair/relining of dentures and bridges.

c) Palliative (alleviation of pain) emergency treatment.
d) Extractions (removal of teeth).
e) Endodontics (treatment of disease of the tooth pulp) including pulpotomy, pulp capping, and root canal treatment.
f) Space maintainers.
g) Oral surgery, including surgical extractions.
h) Apicoectomy (surgical removal of a root tip).
i) Local and general anesthetic necessary for dental procedures.
j) Periodontic services (treatment of the supporting tooth structures), including periodontal prophylaxis.

7.8.3 Class III Prosthetic Services

Following the $50 annual deductible, the dental plan pays up to 50% of the recognized charge for Class III prosthetic services. These include:

a) Inlays and onlays.
b) Crowns.
c) Bridges, fixed and removable.
d) Dentures, full and partial.

Certain replacements or additions to existing dentures will be covered if proof, satisfactory to the claims administrator, is provided to show that one of the following conditions exist:

a) The replacement or addition of teeth on a bridge or denture is necessary to replace teeth extracted after the current denture was installed.
b) The present denture is at least 5 years old and cannot be made serviceable.
c) The present denture is an immediate temporary one and cannot be made permanent, replacement by a permanent denture is needed and replacement is made within 12 months from the date the immediate temporary one was first installed.

7.9 Dental Services Not Covered

The Retiree Legacy Dental Plan does not provide benefits for:

a) Services or supplies that are not necessary for diagnosis or treatment of dental condition as determined by the claims administrator even if prescribed, recommended, or approved by a dental professional.
b) Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.
c) Services that the dentist is not licensed to perform.
d) Charges that are higher than would have been charged if there were no Dental plan.
e) Services for dentures, bridges, crowns, or other devices started before the effective date of coverage.
f) Charges made after your coverage ends, unless they are for prosthetic devices fitted and ordered while you were covered and arriving within 90 days of the coverage end date.

g) Services rendered after the end of coverage, even if you are in the course of an approved treatment plan.
h) Charges of more than one dentist for the same services in the same visit.
i) Appliances or restorations necessary to increase vertical dimensions or restore occlusions.
j) Services for straightening teeth or correcting bite (orthodontics) except for tooth extractions necessary to proceed with orthodontic services.
k) A denture replacement made less than five years after the last one was obtained, whether or not it was covered by this plan, except as noted in section 4.2c, ***Class III Prosthetic Services.***
l) Replacement costs of a lost or stolen denture if this benefit has been used within the last five years.
m) Special techniques or personalized restoration for the construction of a denture beyond the standard procedure charges.
n) Myofunctional therapy, including in-mouth appliances to correct or control harmful habits.
o) Those charges that the claims administrator determines are not recognized charges as defined under the medical plan.
p) 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.
q) 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.
r) Services or supplies not specifically listed as a covered benefit under the health plan.
s) Services or supplies that are, as determined by the claims administrator, experimental or investigational as defined under the medical plan.

8 STANDARD PLAN VISION BENEFITS

8.1 INTRODUCTION

The **benefits** under this section reflect the vision benefits under the **Standard DVA Plan.** Section 2.3, *Standard Plan Vision Benefit Schedule*, reflects the limits and maximums that the **vision plan** will pay for **covered expenses**.

8.2 HOW VISION BENEFITS ARE PAID

8.2.1 Deductible

You pay no **deductible** under the **vision plan**.

8.2.2 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.

8.2.3 Copayment

Each covered person must pay any applicable copayment before the **vision plan** will pay any benefits for that covered person. See section 2.3, *Standard Plan Vision Benefit Schedule.*

8.2.4 Annual Allowances

The vision plan pays covered expenses up to an annual allowance for certain services. See section 2.3, *Standard Plan Vision Benefit Schedule.*

8.2.5 Network Providers

If you choose a VSP doctor or an affiliated provider under the vision plan, you will lower your out-of-pocket costs. See section 2.3, *Standard Plan Vision Benefit Schedule.*

For a list of VSP doctors, call VSP at the number listed in the front of this plan or visit *vsp.com*. Select a VSP doctor from the list and make an appointment. You must identify yourself as a covered person under the vision plan when you make the appointment. The VSP doctor will contact VSP to determine what benefits you are eligible for. If you do not identify yourself as a covered person, and the VSP doctor does not contact VSP, your benefits will be paid out-of-network.

8.2.6 Benefit Maximum

The **vision plan** pays **covered expenses** up to the maximums per **benefit year** shown in section 2.3, *Standard Plan Vision Benefit Schedule*.

8.3 COVERED VISION SERVICES

The following services and supplies are covered under the Standard Plan vision benefits.

8.3.1 Vision Exam

Covered expenses include a complete initial vision analysis including an appropriate examination of visual functions and the prescription of corrective eyewear where indicated by a legally qualified ophthalmologist or optometrist. Subsequent regular eye examinations are covered once every calendar year.

8.3.2 Vision Supplies

Covered expenses include charges for lenses and frames, or **prescription** contact lenses, when prescribed by a legally qualified ophthalmologist or optometrist.

8.3.3 Prescription Lenses

Covered expenses include one pair of prescription single vision, lined bifocal, lined trifocal, or lenticular lenses per calendar year. The following lens options are covered in full from a VSP doctor at no additional cost to the covered person:

a) Progressive lenses
b) Anti-reflective coating
c) Scratch resistant coating
d) Polycarbonate lenses

8.3.4 Frames

Covered expenses include a frame every two calendar years up to $200. There is a 20% discount for any out-of-pocket cost over the frame allowance. The frame allowance may be applied towards non-prescription sunglasses for post photorefractive keratectomy (PRK), Lasik, or Custom LASIK patients.

Some brands of spectacle frames may be unavailable for purchase under the vision plan or may be subject to additional limitations. Covered persons may obtain details regarding frame brand availability from their VSP doctor or by calling VSP at the number in the front of the plan.

8.3.5 Additional Services

The following professional services are included in lens and frame coverage:

a) Prescribing and ordering proper lenses
b) Assisting in the selection of frames
c) Verifying the accuracy of the finished lenses
d) Proper fitting and adjustment of frames
e) Subsequent adjustments to frames to maintain comfort and efficiency
f) Progress or follow-up work as necessary

8.3.6 Contact Lenses

Elective contact lenses are available once every calendar year up to $150 in lieu of all other lens and frame benefits under the vision plan. Prior approval by VSP is not required for covered persons to be eligible for elective contact lenses.

8.3.7 Low Vision Benefit

The low vision benefit is available to covered persons who have severe visual problems that are not correctable with regular lenses. The vision plan covers complete low vision analysis and diagnosis, which includes a comprehensive examination of visual functions, and the prescription of corrective eyewear or vision aids where indicated. Supplemental care aids are also covered.

8.4 Standard Plan Vision and Optical Services Not Covered

The vision plan is designed to cover visual needs rather than cosmetic materials. When the covered person selects any of the following extras, the vision plan will pay the basic cost of the allowed lenses or frames, and the covered person will pay the additional costs for the options:

a) Optional cosmetic processes
b) Color coating
c) Mirror coating
d) Blended lenses
e) Cosmetic lenses
f) Laminated lenses
g) Oversized lenses
h) UV (ultraviolet) protected lenses
i) Certain limitations on low vision care

j) A frame that costs more than the vision plan allowance

k) Contact lenses, except as provided in 8.3.6.

8.4.1 Vision Plan Exclusions

The following services, procedures and conditions are not covered under the vision plan, even if: (1) they relate to a condition that is otherwise covered by the vision plan; or (2) they are recommended, referred or provided by a VSP doctor:

a) Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a + .50 diopter power); or two pair of glasses in lieu of bifocals.

b) Replacement of lenses and frames furnished under the vision plan, regardless of the reason, except at the normal intervals when services are otherwise available.

c) Medical or surgical treatment of the eyes or services covered under the medical plan.

d) Corrective vision treatment, or other vision services or supplies that are experimental or investigational.

e) Costs for services and/or materials above the vision plan allowance.

f) Prescription sunglasses or light-sensitive lenses in excess of the amount which would be covered for non-tinted lenses.

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

h) Charges for special procedures such as orthoptics or vision training.

i) 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.

j) 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.

k) 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.

l) Services and/or materials not listed as covered services in section 10.2, Covered Vision Services.

m) Charges submitted for services that are not rendered or rendered to a person not eligible for coverage under the vision plan.

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

o) 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 such injury or illness. 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.

p) 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.

q) Charges submitted for services by an unlicensed provider or not within the scope of the provider's license.

r) Services provided by a spouse, parent, child, brother, sister, in-law, or any household member.

VSP may, at its discretion, waive any of these limitations if, in the opinion of VSP's optometric consultants, it is necessary for the visual welfare of the covered person.

8.5 Benefits for Vision Care Supplies After Your Coverage Terminates

If your coverage under the **DVA plan** terminates, the **vision plan** will cover expenses you incur for eyeglasses and contact lenses within 30 days after your coverage ends if:

a) A complete eye exam was performed in the 30 days before your coverage ended, and the exam included refraction; and

b) The exam resulted in lenses being prescribed for the first time, or new lenses ordered due to a change in prescription.

Coverage is subject to the benefit maximums described above and in section 2.3, *Vision Benefit Schedule.*

9 Legacy Plan Vision Benefits

9.1 Introduction

The **benefits** under this section reflect the vision benefits under the **Legacy DVA Plan.** Section 2.3, *Legacy Plan Vision Benefit Schedule*, reflects the limits and maximums that the Legacy Vision Plan will pay for **covered expenses**.

9.2 How Vision Benefits Are Paid

9.2.1 Deductible

You pay no **deductible** under the **vision plan**.

9.2.2 Coinsurance

The **vision plan** pays the **coinsurance** amount shown in section 2.3, *Legacy Plan Vision Benefit Schedule* for most **covered expenses**.

9.2.3 Accessing Coverage

You can directly access a **physician** or other vision care **provider** of your choice for covered vision services and supplies under the **vision plan**.

You may have to pay the **provider** or **facility** full charges and submit a claim to receive reimbursement from the **vision plan**. You will be responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to the **provider**. The **claims administrator** will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required by you.

9.2.4 Recognized Charge

The **covered expense** is the part of a charge which is the **recognized charge**. If a charge exceeds the **recognized charge**, the amount above the **recognized charge** is not covered by the **vision plan** and is your responsibility to pay.

9.2.5 Benefit Maximum

The **vision plan** pays **covered expenses** up to the maximums per **benefit year** show in section 2.3, *Legacy Plan Vision Benefit Schedule*.

9.3 COVERED VISION SERVICES

The following services and supplies are covered under the **vision plan.**

9.3.1 Vision Exam

Covered expenses include charges made by a legally qualified ophthalmologist or optometrist for a complete routine eye exam that includes refraction.

9.3.2 Vision Supplies

Covered expenses include charges for lenses and frames, or **prescription** contact lenses, when prescribed by a legally qualified ophthalmologist or optometrist, as follows:

9.3.2.1 Prescription Lenses

Covered expenses include **prescription** single vision, bifocal, trifocal and lenticular lenses prescribed for the first time. Charges for **prescription** contact lenses purchased in lieu of single vision lenses will be covered in an amount equal to the amount that would be covered for single vision lenses. See section 2.3, *Legacy Plan Vision Benefit Schedule.*

Covered expenses also include:

a) Aphakic lenses prescribed after cataract surgery;
b) Contact lenses required to correct visual acuity to 20/70 or better in the better eye if such correction cannot be made with conventional lenses; and
c) Certain lens options, limited to scratch resistant coating, antireflective coating, and polycarbonate lenses.

9.3.2.2 Frames

Covered expenses include expenses for frames if the lenses are covered under this section.

Eyeglass frames are covered when purchased with prescription lenses up to the eyeglass frames maximum per **benefit year**. See section 2.3, *Legacy Plan Vision Benefit Schedule*.

9.4 VISION PLAN EXCLUSIONS

In addition to the limitations and exclusions discussed elsewhere in the **health plan**, the following services, procedures and conditions are not covered, even if they relate to a condition that is otherwise covered by the **health plan**, or if recommended, referred or provided by a doctor.

a) Any charges in excess of the benefit, dollar, or supply limits stated in the **vision plan**.
b) Any exams given during your **stay** in a hospital or other facility for medical care.
c) Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures.
d) Prescription sunglasses or light sensitive lenses in excess of the amount which would be covered for non-tinted lenses.
e) For an eye exam which:
   - is required by an employer as a condition of employment;
   - an employer is required to provide under a labor agreement; or
   - is required by a law of a government.
f) **Prescription** or over-the-counter drugs or medicines.
g) Special vision procedures, such as orthoptics, vision therapy or vision training.
h) Vision service or supply which does not meet professionally accepted standards.
i) Tinting of eyeglass lenses.
j) Duplicate or spare eyeglasses or lenses or frames for them.
k) Two pairs of eyeglasses in lieu of bifocals.
l) Services or supplies furnished or ordered because of an eye exam that was done before the date the person becomes covered.
m) Services or supplies not specifically listed as a covered benefit under the **vision plan**.
n) Services or supplies that are, as determined by the vision claims administrator, experimental or investigational.
o) Services covered under the **medical plan.**
p) Replacement of lost, stolen or broken prescription lenses or frames for any reason.
q) Special supplies such as non-prescription sunglasses and subnormal vision aids.
r) Vision services 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 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.
s) Vision services that are covered in whole or in part:
   - Under any other part of the **health plan**;
   - Under any other plan or group benefits provided by the **State**; or
   - Under any workers' compensation law or any other law of like purpose.
t) Charges submitted for services that are not rendered or rendered to a person not eligible for coverage under the **vision plan.**
u) Charges submitted for services by an unlicensed **provider** or not within the scope of the **provider's** license.
v) Services provided by a **spouse,** parent, **child,** brother, sister, in-law, or any household member.
w) Services rendered before the effective date or after the termination of coverage, unless coverage is continued under section 12, *Consolidated Omnibus Budget Reconciliation Act (COBRA) and Extended Health Coverage.*

9.5 Benefits for Vision Care Supplies After Your Coverage Terminates

If your coverage under the **DVA plan** terminates, the **vision plan** will cover expenses you incur for eyeglasses and contact lenses within 30 days after your coverage ends if:

c) A complete eye exam was performed in the 30 days before your coverage ended, and the exam included refraction; and
d) The exam resulted in lenses being prescribed for the first time, or new lenses ordered due to a change in prescription.

Coverage is subject to the benefit maximums described above and in section 2.3, *Vision Benefit Schedule.*

10 Audio Plan

10.1 Introduction

The **audio plan** reflects the audio benefits under the **DVA plan.** Section 2.5, *Audio Benefit Schedule*, reflects the limits and maximums that the **audio plan** will pay for **covered expenses**.

10.2 How Audio Benefits Are Paid

10.2.1 Deductible

You pay no **deductible** under the **audio plan**.

10.2.2 Coinsurance

The **audio plan** pays the **coinsurance** amount shown in section 2.5, *Audio Benefit Schedule*, for most **covered expenses**.

10.2.3 Recognized Charge

The **covered expense** is the part of a charge which is the **recognized charge**. If a charge exceeds the **recognized charge**, the amount above the **recognized charge** is not covered by the **audio plan** and is your responsibility to pay.

10.2.4 Maximum Benefit

The **audio plan** pays up to the benefit maximum for each **covered person** shown in section 2.5, *Audio Benefit Schedule*.

10.3 Covered Audio Services

The following services and supplies are covered under the **audio plan.**

a) An otological (ear) examination by a **physician** or surgeon.
b) An audiological (hearing) examination and evaluation by a certified or licensed audiologist, including a follow-up consultation.
c) 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 aid.

d) Repairs, servicing, or alteration of hearing aid equipment.

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

10.4 AUDIO PLAN EXCLUSIONS

In addition to the limitations and exclusions discussed elsewhere in the **health plan**, the following services, procedures and conditions are not covered, even if they relate to a condition that is otherwise covered by the **health plan,** or if recommended, referred or provided by a doctor.

a) Replacement of a hearing aid, for any reason, more than once in a rolling 36-month period.
b) Batteries or other supplementary equipment other than those obtained upon purchase of the hearing aid.
c) A hearing aid exceeding the specifications prescribed for correction of hearing loss.
d) Expenses incurred after coverage ends, unless you order a hearing aid before the termination and receive it within 90 days of the end date.
e) Services or supplies that are not necessary for diagnosis or treatment of an audio condition as determined by the **audio claims administrator**, even if prescribed, recommended, or approved by an audio professional.
f) Those charges that the **audio claims administrator** determines exceed the **recognized charge**.
g) 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.
h) 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.
i) Medical or surgical treatment of the ears.
j) 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.
k) Audio examinations required as a condition of employment, under a labor agreement, or government law.
l) Services or supplies not specifically listed as a covered benefit under the **audio plan**.
m) Services or supplies that are, as determined by the **audio claims administrator**, **experimental or investigational.**
n) Services covered under the **medical plan.**

11 How To File A Health Plan Claim

11.1 Claim Filing Deadline

To receive benefits, you must submit a claim within 90 days after treatment began, or within 30 days after treatment ends, whichever is later. **Network providers** will submit claims on your behalf. If you are unable to meet the deadline for filing the claim, your claim will be accepted if you file as soon as possible, but not later than 12 months after the date you incurred the expenses.

11.2 Hospital Services

Your health care coverage is good worldwide. If you are hospitalized in a licensed, general **hospital** anywhere, even outside Alaska, you can use your **hospital** benefits.

When you are admitted to the **hospital**, give your health ID card to the admitting clerk. The **hospital** may bill the **claims administrator** directly. The **claims administrator** will send you an explanation of benefits (**EOB)** 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 **EOB** form.

11.3 Physician and Other Provider Services

The fastest way to process your claim is to ask your **provider** to bill the **claims administrator** directly on a medical claim form. The claim forms are available from the **Division**, the **claims administrator**, or AlaskaCare.gov.

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

If you submit an incomplete claim, you will be notified of additional information required in writing no later than thirty calendar days after the receipt of the incomplete claim by the claim administrator.

11.4 Dental Services

You can get a dental claim form from your **provider**, the **Division**, the **dental claims administrator**, or AlaskaCare.gov. Follow the instructions under section 11.3, *Physician and Other Provider Services*, for completing the form.

11.5 Vision Services

You can get a vision claim form from your **provider**, the **Division**, the **vision claims administrator**, or AlaskaCare.gov. Follow the instructions under section 11.3, *Physician and Other Provider Services*, for completing the form.

11.6 Audio Services

You can get an audio claim form from your **provider**, the **Division**, the **audio claims administrator**, or AlaskaCare.gov. Follow the instructions under section 11.3, *Physician and Other Provider Services*, for completing the form.

11.7 Prescription Drugs

No claim filing is necessary if you obtain your drugs from a **network pharmacy**.

If you do not use a **network pharmacy**, 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 medical claim form to the **claims administrator**. You can get these forms from the **Division**, the **claims administrator**, or AlaskaCare.gov.

The receipt must include the:

a) Patient's name
b) Date of purchase
c) **Prescription** number
d) Itemized purchase price for each drug
e) Quantity
f) Day supply
g) Name of drug
h) Name of **pharmacy**

The **medical 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 held pending your submission of receipts.

If your **prescription drug** is denied for coverage at the pharmacy (point of sale), you may either:

a) Pay for the **prescription drug** and **appeal** the **denial** of coverage at the point of sale by filing a Medical Benefits Request form with **Aetna**. You can get this form from your human resources office, the **Division**, **Aetna**, or AlaskaCare.gov.
b) Delay filling the prescription and **appeal** the **denial** of coverage at the point of sale by filing a Member Complaint and **Appeal** form. You can get this form from your human resource office, the **Division**, the **claims administrator**, or AlaskaCare.gov.

11.8 Medical Benefits

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

a) Nursing care. If you need special nursing services at home or in the **hospital**, your claim must include the date, hours worked and the name of the referring **physician**.

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

11.9 Other Claim Filing Tips

You must list your participant account number on all bills or correspondence. The number is listed on your health ID card. Send all bills to the **claims administrator's** address listed in the front of this **health plan**. This address is on your health ID card.

If you have other health coverage in addition to the **health plan**, you should submit your claims to the primary plan first. Then send a copy of the claim and the **EOB** from the primary plan to the secondary plan so that benefits will be coordinated properly between plans. See section 13, *Coordination of Benefits,* for information on how to determine which plan is primary.

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 health ID card or **EOB** form available. Include your participant account number from your health ID card on any letter you write. The **claims administrator** needs this information to identify your particular coverage.

11.10 Benefit Payments

If you have not paid the **provider** and you include the **provider's** name, address and tax identification number, the **claims administrator** will pay the **provider** directly. If you have already paid the **provider** and this fact is clearly shown on the claim form, the **claims administrator** will send the benefit check to you along with the **EOB** form

11.11 Before Filing a Claim

When you file a claim:

a) Submit your bills with a claim form for each family member.

b) Always check to make sure your **physician** or **dentist** has not already submitted your claim. If you give the **physician** or **dentist** permission to submit a claim, do not submit one yourself.

Complete the claim form fully and include information on any other group health care programs covering you and your **dependents**. If you have other coverage which should pay first before this **health plan**, include a copy of that plan's explanation of benefits showing the amount it paid for the services.

11.12 RECORDKEEPING

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

a) Names of **physicians** and others who furnish services
b) Dates expenses are incurred
c) Copies of all bills and receipts

You should also keep all **EOBs** sent to you.

11.13 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 **precertification** or benefits have been requested. This will be done at all reasonable times while **precertification** or a claim for benefits is pending or under review. This will be done at no cost to you.

11.14 IF A CLAIM IS DENIED

11.14.1 Initial Claim for Benefits

Any claim to receive benefits under the **plan** must be filed 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 **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:

a) are received by the person or unit customarily responsible for handling benefit matters; and

b) 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 **plan** will be followed in resolving any such dispute.

11.14.2 Initial Review of Claim

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

a) 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**;

b) in writing no later than fifteen calendar days after the receipt of the incomplete claim by the **claims administrator** for **pre-service claims**; or

c) in writing no later than thirty calendar days after the receipt of the incomplete claim by the **claims administrator** for **post-service 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 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:**

a) within 72 hours after receipt of claim by the **claims administrator** for **urgent care claims**;

b) no later than 15 calendar days after receipt of claim by the **claims administrator** for **pre-service claims**; or

c) 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.

11.14.3 Initial Denial of Claim

If your claim for benefits is denied in whole or in part, you will be given notice from the **claims administrator** that explains the following items:

a) The specific reasons for the **denial**.
b) References to **plan** provisions upon which the **denial** is based.
c) A description of any additional material or information needed and an explanation of why such material or information is necessary.
d) A description of the **plan's** 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 **medical plan** and **dental plan**).

e) 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.
f) 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.
g) For **urgent care claims**, a description of the expedited review process applicable to such claims.
h) For **denials** of benefits under the **medical plan** or **dental plan**:

- 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);

- 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

- 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 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.

If you believe your claim should be covered under the terms of the **plan**, you should contact the **claims administrator** to discuss the reason for the **denial.** If you still feel the claim should be covered under the terms of the **plan,** you can take the following steps to file an **appeal**.

11.14.4 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 in section 10.14.2, *Initial Review of Claims*, before the reduction or termination occurs, to allow you a reasonable time to file an **appeal** and obtain a determination on the **appeal**. 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.

11.14.5 First Level Appeal of Initial Denial of Claim

You may initiate a first level of **appeal** of the **denial** of a claim by filing a written **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 filed, the initial decision of the **claims administrator** will be the final decision under the **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 transmitted by telephone, facsimile, or other similarly expeditious method.

11.14.6 Decision on First Level of Appeal of Initial Denial of Claim

If appealing a **pre-service claim denial** that is not eligible for external review as outlined in section 10.14.9, *Application and Scope of External Review Process for Benefits Under the Medical Plan and Dental Plan*, you will receive notice of the **claims administrator's** decision on the first level of **appeal** within 15 calendar days of the claims administrator's receipt of your appeal. If appealing a **pre-service claim 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 in section 10.14.9, *Application and Scope of External Review Process for Benefits Under the Medical Plan and Dental Plan*, you will receive notice of the **claim administrator**'s decision on the first level of **appeal** within 30 calendar days after the **claims administrator**'s receipt of your **appeal**. If appealing a **post-service claim denial** that is eligible for external review, you will receive notice of the **claim administrator**'s decision on the first level of **appeal** within 60 calendar days after the **claims administrator**'s receipt of your **appeal**.

If the claim is denied on appeal, with respect to claims for benefits under the **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 **denial** is required to be provided to you 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) any new or additional rationale that forms the basis of the **claims administrator**'s denial, if any.

Additionally, if the claim 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, reasonable access to and copies of all documents, records, and other information that apply to the claim. The notice will also contain:

a) The specific reasons for the **denial.**
b) References to applicable **plan** provisions upon which the **denial** is based.
c) A description of the review procedures and time limits, including information regarding how to initiate a second level **appeal**, and information on the external review process (with respect to benefits under the **medical plan** and **dental plan**).
d) 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.

e) 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.

f) For **denials** of benefits under the **medical plan** and **dental plan**,

- 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),
- 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
- 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.

g) If the **denial** is a **final denial** under the plan, a discussion of the decision.

If a second level **appeal** is not available under Section 10.14.7, *Second Level Appeal of Denial of Claim*, the decision on the first level of **appeal** will be a **final denial,** that is final, conclusive, and binding on all persons, subject to external review under Section 10.14.9, *Application and Scope of External Review Process for Benefits Under the Medical Plan and Dental Plan.*

11.14.7 Second Level Appeal of Denial of Claim

You may initiate a second level of **appeal** of the **denial** of a claim, but only if the claim is not eligible for external review under section 10.14.9, *Application and Scope of External Review Process for Benefits Under the Medical Plan and Dental Plan*, because it does not involve medical judgment or a **rescission** of coverage under the **medical plan** or the **dental 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.

11.14.8 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 **pre-service claim appeal**s or within 30 calendar days for **post-service claim appeal**s. If the claim is denied on the second level of **appeal**, the **claims administrator** will provide notice to you containing the information set forth in section 10.14.6, *Decision on First Level of Appeal of Claim Denial*. The decision on the second level of **appeal** will be a **final denial.**

11.14.9 Application and Scope of External Review Process for Benefits Under the Medical Plan

Upon receipt of a **final denial** (including a deemed **final denial**) with respect to benefits under the **medical plan** or **dental plan**, you may apply for external review. Upon receipt of a **denial** with respect to benefits

under the **medical plan** or **dental plan** that is not a **final denial**, you may only apply for external review as provided in section 10.14.11, *Expedited External Review Process for Medical Plan and Dental Plan.* The external review process will apply only to:

a) a **final denial** with respect to benefits under the **medical plan** or **dental plan** that involves medical judgment, including but not limited to, those based on the **medical plan's** or **dental 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

b) a **rescission** of coverage under the **medical plan** or **dental plan** (whether or not the **rescission** has any effect on any particular benefit at that time).

11.14.10 Standard External Review Process for Claims under the Medical Plan

11.14.10.1 Timing of Request for External Review.

You must file a request for external review of a benefit claim under the **medical plan** and **dental 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.

11.14.10.2 Preliminary Review.

The **claims administrator** will 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 applicable **medical plan** or **dental 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 **medical plan's** or **dental plan's** internal claims and **appeals** process; and
d) you have provided all the information and forms required to process an external review.

The **claims administrator** will 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 will include the reasons for its ineligibility. If the request is not complete, the notification will 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.

11.14.10.3 Referral to Independent Review Organization (IRO).

The claims administrator will 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:

a) 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.
b) Review all documents and any information considered in making a **final denial** received by the **claims administrator**. The **claims administrator** will provide the IRO with such 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 will 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 will notify you and the **claims administrator** of its decision within one business day.
c) 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 will then terminate the external review.
d) Review all information and documents timely received under a *de novo* standard. This means the IRO will 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, will further consider the following in reaching a decision:
    - your medical records;
    - the attending health care professional's recommendation;
    - reports from appropriate health care professionals and other documents submitted by the claims administrator, you, or your physician;
    - the terms of the applicable medical plan or dental plan to ensure that the IRO's decision is not contrary to the terms of the medical plan or dental plan, unless the terms are inconsistent with applicable law;
    - appropriate practice 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;
    - any applicable clinical review criteria developed and used by the medical plan or dental plan, unless the criteria are inconsistent with the terms of the medical plan or dental plan or with applicable law; and
    - 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.

11.14.10.4 Notice of Final External Review Decision.

The IRO will provide written notice of its decision within 45 days after the IRO receives the request for external review. Such notice will be delivered to you and the **claims administrator** and will 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 the **medical plan**, **dental plan** or you;

f) a statement that you may file an administrative **appeal** with the **Division**; and

g) current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

11.14.10.5 Reversal of Plan's Decision.

If the **final denial** of the **claims administrator** is reversed by the decision, the **medical plan** or **dental plan** will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for a claim, upon receipt of notice of such reversal.

11.14.10.6 Maintenance of Records.

An IRO will 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.

11.14.11 Expedited External Review Process for Medical Plan

11.14.11.1 Application of Expedited External Review.

You may make a request for expedited external review under the **medical plan** and **dental plan** at the time you receive either:

a) a **denial** with respect to benefits under the **medical plan**, if the **denial** involves a medical condition 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

b) a **final denial** with respect to benefits under the **medical plan** or **dental 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.

11.14.11.2 Preliminary Review.

Immediately upon receipt of a request for expedited external review, the **claims administrator** must determine whether the request meets the reviewability requirements set forth above. The **claims administrator** will immediately send a notice that meets the requirements set forth for standard external review of claims, as well as its eligibility determination.

11.14.11.3 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 will 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, will consider the information or documents described above under the procedures for standard external review. In reaching a decision, the assigned IRO will review the claim *de novo,* meaning it is not bound by any decisions or conclusions reached during the claims administrator's internal claims and appeals process.

11.14.11.4 Notice of Final External Review Decision.

The IRO will 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 will provide written confirmation of the decision to you and the claims administrator.

11.14.12 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**. If you 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 second level appeal or external review 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 **medical plan** or **dental 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**.

11.14.13 Fourth Level - Appeal to Office of Administrator Hearings

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.

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:

a) AlaskaCare Retiree Health Plan Notice of Appeal

b) 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).

11.15 Claims Procedures Applicable to All Claims

11.15.1 Authorized Representative

Your authorized representative may act on your behalf in pursuing a benefit claim or **appeal**, pursuant to reasonable procedures. In the case of an **urgent care claim**, a **health care professional** with knowledge of your medical condition will be permitted to act as your authorized representative.

11.15.2 Calculating Time Periods

The period of time within which an initial benefit determination or a determination on an **appeal** is required to be made will begin when a claim or **appeal** is filed regardless of whether the information necessary to make a determination accompanies the filing.

Solely for purposes of initial **pre-service claims** and **post-service claims**, if the time period for making the initial benefit determination is extended (in the **claims administrator**'**s** discretion) because you failed to submit information necessary to decide the claim, the time period for making the determination will be suspended from the date notification of the extension is sent to you until the earlier of (1) the date on which response from you is received, or (2) the end of the time period given to you to provide the additional information, as set forth in the applicable section under 10.14, *If a Claim is Denied*.

11.15.3 Full and Fair Review

Upon request, and free of charge, you or your duly authorized representative will be given reasonable access to, and copies of, all documents, records, and other information relevant to your claim, or may submit to the appropriate person or entity written comments, documents, records, and other information relating to the claim. If timely requested, review of a denied claim will take into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim without regard to whether such information was submitted or considered in the initial benefit determination.

Appeals for health claims will be reviewed by an appropriate named fiduciary of the **health plan** who is neither the individual nor subordinate of the individual who made the initial determination. The **claims administrator** will not give any weight to the initial determination, and, if the **appeal** is based, in whole or in part, on a medical judgment, the **claims administrator** will consult with an appropriate **health care professional** who is neither the individual nor subordinate of the individual who was consulted in connection with the initial determination. The **claims administrator** will identify any medical or vocational experts whose advice was obtained without regard to whether the advice was relied upon in making the benefit determination. In the case of two levels of **appeal**, the second level reviewer will not afford deference to the first level reviewer, nor will the second level reviewer be the same individual or the subordinate of the first level reviewer.

11.15.4 Exhaustion of Remedies

If you fail to file a request for review of a **denial**, in whole or in part, including a request for external review, in accordance with the procedures herein outlined, you will have no right to review and no right to bring an administrative appeal with the State of Alaska, Department of Administration, Office of Administrative Hearings (OAH) or an action in Alaska Superior Court, and the **denial** of the claim will become final and binding on all persons for all purposes.

With respect to claims under the **medical plan**, except as provided below, if the **claims administrator** fails to strictly adhere to all the requirements with respect to a claim under section 11.14, *If a Claim Is Denied*, and section 11.15, *Claims Procedures Applicable to All Claims*, you are deemed to have exhausted the internal claims and **appeals** process with respect to such claims. Accordingly, you may initiate an external review with respect to such claims as outlined in section 11.14, *If a Claim Is Denied*. You are also entitled to pursue any available remedies under **State** law, as applicable, with respect to such claims.

Notwithstanding the above, the internal claims and **appeals** process with respect to claims under the **health plan** will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you, so long as the **claims administrator** demonstrates that the violation was for good cause or due to matters beyond the control of the **claims administrator** and that

the violation occurred in the context of an ongoing, good faith exchange of information between the **claims administrator** and you. This exception is not available if the violation is part of a pattern of violations by the **claims administrator**. You may request a written explanation of the violation from the **claims administrator**, and the **claims administrator** will provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the process outlined in section 11.14, *If a Claim Is Denied*, and section 11.15, *Claims Procedures Applicable to All Claims,* to be deemed exhausted. If the IRO or a court rejects your request for immediate review due to deemed exhaustion on the basis that the **claims administrator** met the standards for the exception described in this subsection, you will have the right to resubmit and pursue the internal **appeal** of the **medical plan** claim. In such case, within a reasonable time after the IRO or court rejects the claim for immediate review (not to exceed 10 days), the **claims administrator** will provide you with notice of the opportunity to resubmit and pursue the internal **appeal** of the **medical plan** claim. Time periods for re-filing the **medical plan** claim will begin to run upon your receipt of such notice.

12 CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) AND EXTENDED HEALTH COVERAGE

12.1 INTRODUCTION

If your **dependents** lose coverage due to a qualifying event, your **dependents** may continue coverage under the **health plan** by electing COBRA coverage and paying the required premium as described in this section. When you lose coverage under the **health plan**, there is no continuation coverage available to you.

Your **dependents** may elect COBRA continuation coverage:

a) under the **medical plan** only;
b) under the **DVA plan** only; or
c) under the **medical plan** and under the **DVA plan**.

12.2 RIGHT TO CONTINUATION COVERAGE

If your **dependent** is a qualified beneficiary, he/she may elect to continue coverage under the **health plan** after a qualifying event. Only those persons who are covered under the **health plan** on the day before the event which triggered termination of coverage are eligible to elect COBRA continuation coverage.

A qualified beneficiary is a person who is covered under the **health plan** on the day before a qualifying event who is:

a) a **spouse**; or
b) a **dependent child**.

The right to continued coverage is triggered by a qualifying event, which, but for the continued coverage, would result in a loss of coverage under the **health plan.** A “loss of coverage” includes ceasing to be

covered under the same terms and conditions as in effect immediately before the qualifying event or an increase in the premium or contribution that must be paid by a **covered person**. Qualifying events include:

a) Your death.
b) Your divorce or legal separation from your **spouse**.
c) Your **child** ceasing to be a **dependent child** under the eligibility requirements of the **health plan**.

If a qualifying event occurs to a qualified beneficiary, then that qualified beneficiary may elect to continue coverage under the **medical plan,** or **DVA plan**.

12.3 Election of Continuation Coverage

Continuation coverage does not begin unless it is elected by a qualified beneficiary. Each qualified beneficiary who loses coverage as a result of a qualifying event has an independent right to elect continuation coverage, regardless of whether any other qualified beneficiary with respect to the same qualifying event elects continuation coverage.

The election period begins on or before the date the qualified beneficiary would lose coverage under the **health plan** due to the qualifying event, and ends on or before the date that is 60 days after the later of:

a) the date the qualified beneficiary would lose coverage due to the qualifying event or
b) the date on which notice of the right to continued coverage is sent by the **COBRA administrator**.

The election of continuation coverage must be made on a form provided by the **COBRA administrator** and payment for coverage, as described in the notice, must be made when due. An election is considered to be made on the date it is sent to the **COBRA administrator.**

12.4 Period of Continuation Coverage

In the case of any qualifying event discussed in section 12.2, *Right to Continuation Coverage*, a qualified beneficiary may elect to extend coverage for a period of up to 36 months from the date of the qualifying event, unless coverage ends earlier as described in section 12.5, *End of Continuation Coverage*.

12.5 End of Continuation Coverage

Continuation coverage will end upon the dates of the following occurrences, even if earlier than the periods specified under section 12.4, *Period of Continuation Coverage:*

a) Timely payment of premiums for the continuation coverage is not made (including any grace periods).
b) The qualified beneficiary first becomes covered under any other group health plan, after the date on which continuation coverage is elected, as an employee or otherwise, unless such other plan contains a limitation (other than a limitation which does not apply by virtue of HIPAA with respect to any pre-existing condition).
c) The **State** ceases to provide any group health plan to any employee or **retiree**.

Notwithstanding the foregoing, the **health plan** may also terminate the continuation coverage of a qualified beneficiary for cause on the same basis that it could terminate the coverage of a similarly

situated non-COBRA beneficiary for cause (*e.g.*, in the case of submitting fraudulent claims to the **Division**).

12.6 COST OF CONTINUATION COVERAGE

The qualified beneficiary who elects to continue coverage is responsible for paying the cost of continuation coverage. The premiums are payable on a monthly basis. By law, premiums cannot exceed 102% of the full cost for such coverage. After a qualifying event, **COBRA administrator** will provide a notice with the amount of the premium, to whom the premium is to be paid, and the date of each month that payment is due. Failure to pay premiums on a timely basis will result in termination of coverage as of the date the premium is due. Payment of any premium will only be considered to be timely if made within 30 days after the date due.

A premium must be paid for the cost of continuation coverage for the time period between the date of the event which triggered continuation coverage and the date continued coverage is elected. This payment must be made within 45 days after the date of election. **COBRA administrator** will provide you notice specifying the amount of the premium, to whom the premium is to be paid, and the date payment is due. Failure to pay this premium on the date due will result in cancellation of coverage back to the initial date coverage would have terminated.

12.7 NOTIFICATION REQUIREMENTS

12.7.1 General Notice to Covered Retiree and Spouse

The **health plan** will provide, at the time of commencement of coverage, written notice to you and your **spouse** of your **dependent's** rights to continuation coverage. The **health plan** may satisfy this obligation by furnishing a single notice addressed to both you and your **spouse** if you both reside at your address, and the **spouse's** coverage commences on or after the date on which your coverage commences. No separate notice is required to be sent to **dependent children** who share a residence with you or your **spouse.** This general notice will be provided no later than the earlier of:

a) 90 days after your coverage commencement date under the **health plan**; or
b) the date on which the **Division** is required to furnish a COBRA election notice.

12.7.2 Covered Eligible Retiree/Qualified Beneficiary Notice to Administrator

You or the qualified beneficiary must notify the **Division** of:

a) your divorce or legal separation from your **spouse** ; or
b) a **child** ceasing to be a **dependent child** under the eligibility requirements of the **health plan**.

You or the qualified beneficiary must give notice as soon as possible, but no later than 60 days after the later of:

a) the date of such qualifying event;
b) the date that the qualified beneficiary loses or would lose coverage due to such qualifying event; or

c) the date on which you are informed, via the **health plan** or the general COBRA notice, of your obligation to provide such notice and the **health plan** procedures for providing such notice.

You or the qualified beneficiary, or a representative acting on behalf of you or the qualified beneficiary, may provide this notice. The provision of notice by one individual satisfies any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the qualifying event. Failure to provide timely notice will result in the qualified beneficiary's loss of any right to elect continuation coverage.

12.7.3 Division's Notice to Qualified Beneficiary

Upon receipt of a notice of a qualifying event, the **COBRA administrator** will provide to each qualified beneficiary notice of their right to elect continuation coverage, no later than 14 days after the date on which the **COBRA administrator** received notice of the qualifying event. Any notification to a qualified beneficiary who is your **spouse** will be treated as a notification to all other qualified beneficiaries residing with such **spouse** at the time such notification is made.

12.7.4 Unavailability of Coverage

If the **COBRA administrator** receives a notice of a qualifying event or disability determination and determines that the person is not entitled to continuation coverage, the **COBRA administrator** will notify the person with an explanation as to why such coverage is not available.

12.7.5 Notice of Termination of Coverage

The **COBRA administrator** will provide notice to each qualified beneficiary of any termination of continuation coverage which is effective earlier than the end of the maximum period of continuation coverage applicable to such qualifying event, as soon as practicable following the **COBRA administrator** determination that continuation coverage should terminate.

12.7.6 Use of a Single Notice

Required notices must be provided to each qualified beneficiary or individual; however:

a) a single notice can be provided to you and your **spouse** if you both reside at your address; and
b) a single notice can be provided to you or your **spouse** for a **dependent child**, if the **dependent child** resides with you or your **spouse**.

12.8 CONTINUATION HEALTH BENEFITS PROVIDED

The continuation coverage provided to a qualified beneficiary who elects continued coverage will be identical to the coverage provided to similarly situated persons covered under the **health plan** with respect to whom a qualifying event has not occurred. If coverage is modified under the **health plan** for any group of similarly situated beneficiaries, the coverage will also be modified in the same manner for all individuals who are qualified beneficiaries under the **health plan**. Continuation coverage will not be conditioned on evidence of good health.

A qualified beneficiary may change their elections during open enrollment for the **health plan**.

12.9 Extended Coverage for Disabled Retirees or Dependents

Retirees or **dependents** who are **totally disabled**, lose coverage under the **medical plan** and waive their right to COBRA continuation coverage are eligible for a limited extension of their coverage under the **medical plan**.

Extended coverage under the **medical plan** is at no cost to the **totally disabled retiree** or **totally disabled dependent**.

You must be **totally disabled** due to **injury**, **illness**, or pregnancy when coverage under the **medical plan** terminates to be eligible for this benefit. Extended health benefits for **total disability** are provided for the number of months you have been covered under the **medical plan**, up to a maximum of 12 months. However, only the condition which caused the **total disability** is covered and coverage is provided only while you or your **dependent**, as applicable, is **totally disabled**.

To be eligible for extended health benefits, you or your **dependent**, as applicable, must be under a **physician**'s care and submit evidence of disability to the **claims administrator** within 90 days after you lose coverage under the **medical plan**. The **physician** must complete a *Statement of Disability* form available from the **Division** or the **claims administrator**. You must satisfy any unpaid portion of the **deductible** within three months of the date you lose coverage.

This extended coverage terminates when you or your **dependent**, as applicable, become covered under a group health plan with similar benefits.

13 Coordination of Benefits

13.1 When Coordination of Benefits Applies to the Medical Plan

This coordination of benefits (COB) provision applies to the **medical plan** when you or your covered **dependent** has health coverage under more than one plan. The order of benefit determination rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and depending on the coordination of benefits provisions of the plan may reduce the benefits it pays to not exceed 100% of the total allowable expense. When the **medical plan** is secondary, the combined payment calculated after coordination of benefits, may be less than 100% of the total allowable expense.

13.2 How Coordination of Benefits Works

In determining the amount to be paid when the **medical plan** is secondary on a claim, the secondary plan allowable expenses will be reduced by any benefits payable under the primary plan for those expenses. This will be done before the benefits under the **medical plan** are determined.

In addition, when the **medical plan** is the secondary plan, the **medical plan** shall apply the allowable expense, reduced by the amount paid by the primary plan for those expenses. The balance remaining will be applied to the **medical plan**'s deductible until met.

Any rule for coordinating other plan benefits with those under the **medical plan** will be applied after the **medical plan** benefits have been determined under the above rules. Allowable expenses will be reduced by any primary plan benefits available for those expenses.

Under the COB provision of the **medical plan**, the amount normally reimbursed for covered benefits or expenses under the **medical plan** is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under the **medical plan** for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses.

When the COB rules of the **medical plan** and another plan both agree that the **medical plan** determines their benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

Example:

This example assumes that the retiree has Medicare so Medicare pays first and assumes neither deductible has been met.

Claim satisfies the Medicare and AlaskaCare individual deductibles		
Recognized Charge:		
Medicare Allowed:	$	2,000.00
Medicare Deductible:	$	226.00[1]
Remaining Charge:	$	1,774.00
Medicare Payment (80%):	$	1,419.20
Medicare Allowed:	$	2,000.00
Retiree Plan Deductible:	$	300.00
Remaining Charge:	$	1,700.00
Retiree Plan Maximum Payment (80%):	$	1,360.00
Excess of Medicare Payment:	$	(779.20)
Medicare Allowed:	$	2,000.00
Medicare Paid:	$	1,419.20
Retiree Plan Paid:	$	580.80
Member Responsibility:	$	-

[1] Medicare deductible amount is governed by, and may change based on, federal statutes and regulations. This is an example only and based on the 2023 Medicare deductible.

If a **covered person** is enrolled in two or more closed panel plans, COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans.

13.3 DEFINED TERMS

When used in this provision, the following words and phrases have the meaning explained herein.

a) Allowable Expense

Allowable expense means a health care service or expense, including **coinsurance** and **copayment**s, without reduction of any applicable **deductible**, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services (for example, an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a **covered person** is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

- If a **covered person** is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense. This does not apply if one of the plans provides coverage for a private room.
- If a person is covered by two or more plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.
- If a person is covered by two or more plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.
- The amount a benefit is reduced or not reimbursed by the primary plan because a **covered person** does not comply with the plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, **precertification** of admissions, and preferred provider arrangements.

If a person is covered by one plan that computes its benefit payments on the basis of reasonable or recognized charges, and another plan that provides its benefits or services on the basis of negotiated charges, the primary plan's payment arrangements will be the allowable expense for all the plans. However, if the secondary plan has a negotiated fee or payment amount different from the primary plan and if the provider contract permits, that negotiated fee will be the allowable expense used by the secondary plan to determine benefits.

b) Closed Panel Plan(s)

A plan that provides health benefits to **covered persons** primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

c) Custodial Parent

A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the **child** resides more than one half of the calendar year without regard to any temporary visitation.

d) Plan

Any plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors.
- Other prepaid coverage under service plan contracts, or under group or individual practice.
- Uninsured arrangements of group or group-type coverage.
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans.
- Medicare or other governmental benefits.
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the plan includes medical, **prescription drug**, dental, vision and audio coverage, those coverages will be considered separate plans. For example, medical coverage will be coordinated with other medical plans, and dental coverage will be coordinated with other dental plans.

The health plan is any part of the plan that provides benefits for health care expenses.

e) Primary Plan/Secondary Plan

The order of benefit determination rules state whether a health plan is a primary plan or secondary plan as to another plan covering the person.

- When a health plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.
- When a health plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.
- When there are more than two plans covering the person, a health plan may be a primary plan as to one or more other plans and may be a secondary plan as to a different plan or plans.

13.4 Which Plan Pays First

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

a) The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

b) A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage will be excess to any other parts of the plan provided

by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

c) A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

d) The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

1. Non-**Dependent** or **Dependent**. The plan that covers the person other than as a **dependent**, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a **dependent** is secondary. However, if the person is a Medicare beneficiary and, as a result of Federal law, Medicare is secondary to the plan covering the person as a **dependent**; and primary to the plan covering the person as other than a **dependent** (*e.g.* a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

2. **Child** Covered Under More than One Plan. The order of benefits when a **child** is covered by more than one plan is:

A. The primary plan is the plan of the parent whose birthday is earlier in the year if:

i. The parents are married or living together whether or not married.

ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

B. If the specific terms of a court decree state that one of the parents is responsible for the **child**'s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the **dependent child**'s health care expenses, but that parent's spouse does, the plan of the parent's spouse is the primary plan.

C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:

i. The plan of the custodial parent;
ii. The plan of the spouse of the custodial parent;
iii. The plan of the noncustodial parent; and then
iv. The plan of the spouse of the noncustodial parent.

For a dependent **child** covered under more than one plan of individuals who are not the parents of the **child**, the order of benefits should be determined as outlined above as if the individuals were the parents.

3. Active Employee or Retired or Laid off Employee. The plan that covers a person as an employee who is neither laid off nor retired from the employer who sponsors the plan or as a **dependent** of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a **dependent** of a retired or laid off employee is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the non-**dependent** or **dependent** rules above determine the order of benefits.

4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's **dependent**) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the non-**dependent** or **dependent** rules above determine the order of benefits.

5. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, subscriber longer is primary.

A. If the preceding rules do not determine the primary plan, the allowable expenses will be shared equally between the plans meeting the definition of plan under this provision. In addition, the **health plan** will not pay more than it would have paid had it been primary.

13.5 Right to Receive and Release Necessary Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under the **medical plan** and **DVA plan** and other plans. The **claims administrator** has the right to release or obtain any information and make or recover any **payments** it considers necessary in order to administer this provision.

13.6 Facility of Payment

Any payment made under another plan may include an amount which should have been paid under the **medical plan**. If so, the **claims administrator** may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under the **medical plan**. The **claims administrator** will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

13.7 Right of Recovery

If the amount of the payments made by the **claims administrator** is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided

for the **covered person**. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

14 SUBROGATION AND REIMBURSEMENT RIGHTS

14.1 RIGHT OF SUBROGATION AND REIMBURSEMENT

The **health plan** has the right to full subrogation and reimbursement of any and all amounts paid by the **health plan** to, or on behalf of, a **covered person**, for which a third party is allegedly responsible. The **health plan** will have a lien against such funds, and the right to impose a constructive trust upon such funds, and will be reimbursed therefrom.

14.2 FUNDS TO WHICH SUBROGATION AND REIMBURSEMENT RIGHTS APPLY

The **health plan's** subrogation and reimbursement rights apply if the **covered person** receives, or has the right to receive, any sum of money, regardless of whether it is characterized as amounts paid for medical expenses or otherwise, paid or payable from any person, plan, or legal entity that is legally obligated to make payments as a result of a judgment, settlement, or otherwise, arising out of any act or omission of any third party, (whether a third party or another **covered person** under the **health plan**):

a) who is allegedly wholly or partially liable for costs or expenses incurred by the **covered person**, in connection for which the **health plan** provided benefits to, or on behalf of, such **covered person**; or
b) whose act or omission allegedly caused **injury** or **illness** to the **covered person**, in connection for which the **health plan** provided benefits to, or on behalf of, such **covered person**.

14.3 AGREEMENT TO HOLD RECOVERY IN TRUST

If a payment is made under the **health plan**, and the person to or for whom it is made recovers monies from a third party as a result of settlement, judgment, or otherwise, that person will hold in trust for the **health plan** the proceeds of such recovery and reimburse the **health plan** to the extent of its payments.

14.4 DISCLAIMER OF MAKE WHOLE DOCTRINE

The **health plan** has the right to be paid first and in full from any settlement or judgment, regardless of whether the **covered person** has been "made whole." The **health plan's** right is a first priority lien. The **health plan's** rights will continue until the **covered person's** obligations hereunder to the **health plan** are fully discharged, even though the **covered person** does not receive full compensation or recovery for their injuries, damages, loss or debt. This right to subrogation *pro tanto* will exist in all cases.

14.5 DISCLAIMER OF COMMON FUND DOCTRINE

The **covered person** will be responsible for all expenses of recovery from such third parties or other persons, including but not limited to, all attorneys' fees incurred in collection of such third-party

payments, or payments by other persons. Any attorneys' fees and/or expenses owed by the **covered person** will not reduce the amount of reimbursement due to the **health plan**.

14.6 Obligations of the Covered Person

The **covered person** will furnish any and all information and assistance requested by the **claims administrator**. If requested, the **covered person** will execute and deliver to the **claims administrator** a subrogation and reimbursement agreement before or after any **payment** of benefits by the **health plan**. The **covered person** will not discharge or release any party from any alleged obligation to the **covered person** or take any other action that could impair the **health plan's** rights to subrogation and reimbursement without the written authorization of the **claims administrator**.

14.7 Plan's Right to Subrogation

If the **covered person** or anyone acting on their behalf has not taken action to pursue their rights against a third party described in section 14.2, *Funds to Which Subrogation and Reimbursement Rights Apply*, or any other persons to obtain a judgment, settlement or other recovery, the **claims administrator** or its designee, upon giving 30 days' written notice to the **covered person**, will have the right to take such action in the name of the **covered person** to recover that amount of benefits paid under the **health plan**; provided, however, that any such action taken without the consent of the **covered person** will be without prejudice to such **covered person**.

14.8 Enforcement of Plan's Right to Reimbursement

If a **covered person** fails or refuses to comply with these provisions by reimbursing the **health plan** as required herein, the **health plan** has the right to impose a constructive trust over any and all funds received by the **covered person**, or as to which the **covered person** has the right to receive. The **health plan** has the authority to pursue any and all legal and equitable relief available to enforce the rights contained in this section, against any and all appropriate parties who may be in possession of the funds described herein. The **health plan** also has the right to terminate coverage for the **covered person** under the **health plan**.

14.9 Failure to Comply

If a **covered person** fails to comply with the requirements under this section, the **covered person** will not be eligible to receive any benefits, services or payments under the **health plan** for any **illness** or **injury** until there is compliance, regardless of whether such benefits are related to the act or omission of such third party or other persons.

14.10 Discretionary Authority of Administrator

The **State** will have full discretionary authority to interpret the provisions of this section 14, *Subrogation and Reimbursement Rights,* and to administer and pursue the **health plan's** subrogation and reimbursement rights. It will be within the discretionary authority of the **State** to resolve, settle, or otherwise compromise its subrogation and reimbursement rights when appropriate. The **State** is under

no legal obligation to reduce its lien or reimbursement rights unless, in its sole discretion, it determines that doing so is appropriate.

15 PROTECTED HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

15.1 USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The **health plan** will use and disclose **protected health information** to the extent of and in accordance with the uses and disclosures permitted by HIPAA, as set forth in the **Privacy Regulations**. Specifically, the **health plan** will use and disclose **protected health information** for purposes related to health care treatment, **payment** for health care, and **health care operations**.

15.2 PLAN DOCUMENTS

In order for the **health plan** to disclose **protected health information** to the **State** or to provide for or permit the disclosure of **protected health information** to the **State** by a health insurance issuer or HMO with respect to the **health plan**, the **health plan** must ensure that the **health plan** documents restrict uses and disclosures of such information by the **State** consistent with the requirements of HIPAA.

15.3 DISCLOSURES BY THE PLAN TO THE STATE

The **health plan** may:

a) Disclose summary health information to the State, if the State requests the summary health information for the purpose of:

- obtaining premium bids from health plans for providing health insurance coverage under the health plan; or
- modifying, amending, or terminating the health plan.

b) Disclose to the **State** information on whether an individual is participating in the health plan, or is enrolled in or has disenrolled from a health insurance issuer offered by the health plan.

c) Disclose **protected health information** to the **State** to carry out plan administration functions that the **State** performs, consistent with the provisions of this section.

d) With an authorization from the covered person, disclose **protected health information** to the **State** for purposes related to the administration of other employee benefit plans and fringe benefits sponsored by the State.

e) Not permit a health insurance issuer with respect to the health plan to disclose **protected health information** to the **State** except as permitted by this section.

f) Not disclose (and may not permit a health insurance issuer to disclose) **protected health information** to the **State** as otherwise permitted by this section unless a statement is included in the health plan's notice of privacy practices that the health plan (or a health insurance issuer with respect to the health plan) may disclose protected health information to the **State**.

g) Not disclose **protected health information** to the **State** for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the **State**.

h) Not disclose (and may not permit a health insurance issuer to disclose) **protected health information** that is genetic information about an individual for underwriting purposes as defined in Section 1180(b)(4) of the Social Security Act and underlying regulations.

15.4 Uses and Disclosures by State

The **State** may only use and disclose **protected health information** as permitted and required by the **health plan**, as set forth within this section. Such permitted and required uses and disclosures may not be inconsistent with the provisions of HIPAA. The **State** may use and disclose **protected health information** without an authorization from a **covered person** for plan administrative functions including **payment** activities and **health care operations**. In addition, the **State** may also use and disclose **protected health information** to accomplish the purpose for which any disclosure is properly made pursuant to section 15.3, *Disclosures by the Plan to the State*.

15.5 Certification

The **health plan** may disclose **protected health information** to the **State** only upon receipt of a certification from the **State** that the **health plan** documents have been amended to incorporate the provisions provided for in this section and that the **State** so agrees to the provisions set forth therein.

15.6 Conditions Agreed to by the State

The **State** agrees to:

a) Not use or further disclose **protected health information** other than as permitted or required by the **health plan** document or as required by law.
b) Ensure that any agents, including a subcontractor, to whom the **State** provides **protected health information** received from the **health plan** agree to the same restrictions and conditions that apply to the **State** with respect to such **protected health information**, and that any such agents or subcontractors agree to implement reasonable and appropriate security measures to protect any **electronic protected health information** belonging to the **health plan** that is provided by the **State**.
c) Not use or disclose **protected health information** for employment-related actions and decisions unless authorized by an **individual**.
d) Not use or disclose **protected health information** in connection with any other benefit or employee benefit plan of the **State** unless authorized by an **individual**.

e) Report to the **health plan** any **protected health information** use or disclosure that is inconsistent with the uses or disclosures provided for by this section, or any **security incident** of which it becomes aware.
f) Make **protected health information** available to an **individual** in accordance with HIPAA's access requirements pursuant to 45 CFR § 164.524.
g) Make **protected health information** available for amendment and incorporate any amendments to **protected health information** in accordance with 45 CFR § 164.526.
h) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528.
i) Make internal practices, books and records relating to the use and disclosure of **protected health information** received from the **health plan** available to the Secretary of the Department of Health and Human Services for the purposes of determining the **health plan's** compliance with HIPAA.
j) If feasible, return or destroy all **protected health information** received from the **health plan** that the **State** still maintains in any form, and retain no copies of such **protected health information** when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).
k) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the **electronic protected health information** that it creates receives, maintains, or transmits on behalf of the **health plan**.
l) Ensure that the separation and requirements of section 15.3, *Disclosures by the Plan to the State*, section 15.4, *Uses and Disclosures by State*, and section 15.5, *Certification* of the **health plan** are supported by reasonable and appropriate security measures.

15.7 Adequate Separation Between the Plan and the State

In accordance with HIPAA, only the persons identified in the **State's** HIPAA policies and procedures may be given access to **protected health information**.

15.8 Limitations of Access and Disclosure

The persons described in section 15.3, *Disclosures by the Plan to the State*, may only have access to and use and disclose **protected health information** for plan administration functions that the **State** performs for the **health plan**.

15.9 Noncompliance

If the persons or classes of persons described in section 15.3*, Disclosures by the Plan to the State,* do not comply with this **health plan** document, the **health plan** and the **State** will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

16 OTHER MANDATED COVERAGES

16.1 GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

The **health plan** will comply with GINA, as amended, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any Federal law or regulations governing the **health plan**. As part of such compliance, the **health plan** will not:

a) Adjust plan contribution amounts or premiums on the basis of genetic information.

b) Request or require a **covered person** or any of the **covered person's** family members to undergo a genetic test.

c) Request, require, or purchase genetic information for underwriting purposes during coverage or with respect to any **covered person**, prior to such individual's enrollment in the **health plan**.

Under this section, "genetic information" includes your genetic tests, the genetic tests of your family members, and your family medical history.

16.2 STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any **hospital** length of **stay** in connection with childbirth for the mother or newborn **child** to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending **provider** (*e.g.*, your **physician**, nurse midwife, or physician assistant), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a **provider** obtain authorization from the **health plan** for prescribing a length of **stay** that is 48 hours (or 96 hours) or less. However, to use certain **providers** or facilities, or to reduce your out-of-pocket costs, you may be required to obtain **precertification**. For information on **precertification**, contact the **claims administrator**.

Under Federal law, the **health plan** may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) **stay** is treated in a manner less favorable to the mother or newborn than any earlier portion of the **stay**.

16.3 ELIGIBILITY FOR MEDICAID BENEFITS

Benefits will be paid in accordance with any assignment of rights made by or on behalf of any **retiree** or **dependent** as required by a state plan for medical assistance approved under Title XIX, Section 1912(a)(1)(A) of the Social Security Act. For purposes of enrollment and entitlement to benefits, a **retiree's** or **dependent's** eligibility for or receipt of medical benefits under a state plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account. The **State** will have a

right to any **payment** made under a state plan for medical assistance approved under Title XIX of the Social Security Act when the **health plan** has a legal liability to make such payment.

16.4 Dependent Students on Medically Necessary Leave of Absence

The **health plan** will comply with Michelle's Law of 2008, as amended from time to time, and any regulations issued thereunder, to the extent required thereunder and not otherwise inconsistent with any federal law or regulations governing the **health plan**. As part of such compliance, the **health plan** will extend coverage for up to one year when a full-time student otherwise would lose eligibility if the full-time student takes a **medically necessary** leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless **dependent child** coverage ends earlier under another **health plan** provision, such as the parent's termination of employment or the **dependent child's** age exceeding the **health plan's** limit. A **medically necessary** leave of absence for purposes of full-time student medical leave occurs when a **child** who is a **dependent** and a full-time student (but who would not be a **dependent** if he or she were not a full-time student) takes a leave of absence from their educational institution or otherwise changes their enrollment status from full-time to part-time due to a serious **illness** or **injury**. The **health plan** must receive written certification from the full-time student's **physician** confirming the serious **illness** or **injury** and the **medical necessity** of the leave or change in status. **Dependent** coverage will continue during the leave as if the **dependent child** had maintained full-time student status. This requirement applies even if the **health plan** changes during the extended period of coverage.

17 Other Plan Provisions

17.1 Access to Records

All **covered persons** under the **health plan** consent to and authorize all **providers** to examine and copy any portions of the **hospital** or medical records requested by the **health plan** when processing a claim, **precertification**, or **claim appeal**.

17.2 Health Plan Liability

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

17.3 Free Choice of Hospital and Provider

You may select any **hospital** that meets the criteria in section 3.5.4, *Hospital Expenses*. You may select any **provider** who meets the definition of **provider** in section 19, *Definitions*.

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

Under the **health 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 **covered persons** do so as independent contractors. The **health plan** is not liable for any claim or demand from damages arising from or in any way connected with any **injuries** that **covered persons** suffer while receiving care in any **hospital** or services from any **provider**.

17.4 Plan Must Be Effective

Health coverage is expense-incurred coverage only and not coverage for the **illness** or **injury** itself. This means that the **health plan** will pay benefits only for expenses incurred while this coverage is in force. Except as described in section 12, *Consolidated Omnibus Budget Reconciliation Act (COBRA) and Extended Health Coverage*, 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 **illness** 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.

17.5 Medical Outcomes

Neither the **State** nor the **claims administrator** makes any express or implied warranties nor assumes any responsibility for the outcome of any covered services or supplies.

17.6 Epidemics and Public Disasters

The services this **health plan** provides are subject to the availability of **hospital** facilities and the ability of **hospitals**, **hospital** employees, **physicians** and surgeons, and other **providers** to furnish services. The **health plan** does not assume liability for epidemics, public disasters, or other conditions beyond its control which make it impossible to obtain the services that the **health plan** provides.

17.7 Vested Rights

Except as cited in section 12, *Consolidated Omnibus Budget Reconciliation Act (COBRA) and Extended Health Coverage*, the **health plan** does not confer rights beyond the date that coverage is terminated or the effective date of any change to the **health plan** provisions, including benefits and eligibility provisions. For this reason, no rights from the **health plan** can be considered vested rights. You are not eligible for benefits or payments from the **health plan** for any services, treatment, medical attention, or care rendered after the date your coverage terminates.

18 General Provisions

18.1 Amendment or Termination Procedure

The following provisions will apply to the amendment of the **plan**. To the extent that a benefit does not address amendment or termination of the benefit, the following provisions will also apply to such benefit. The **State**, through appropriate action of the **Commissioner** to take such action, will have the right in its sole discretion to amend the **plan**, the schedule of benefits or any underlying benefit, as applicable, at any time, and from time to time, and to any extent that it may deem advisable. Such modification or amendment will be duly incorporated in writing. The **State**, through appropriate action of the **Commissioner** to take such action, will have the right in its sole discretion to terminate any benefit at any time and to the extent that it may deem advisable. Any amendment of the **plan** or the schedule of benefits, or any amendment or termination of an underlying benefit, will be effective as of the date the **State**, through the **Commissioner**, may determine in connection therewith. To the extent allowed by Internal Revenue Code and applicable **State** law, any such amendment may be effective retroactively.

18.2 Cancellation

The **State** may cancel any portion of the contract with the **claims administrator** without the consent of the **covered persons**.

18.3 Right to Receive and Release Necessary Information

The **plan** may release or obtain information from any other 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** provisions.

18.4 Nonalienation

Except as otherwise required pursuant to a qualified medical **child** support, no benefit under the **plan** and underlying benefit prior to actual receipt thereof by any **retiree**, **spouse**, or their beneficiary will be subject to any debt, liability, contract, engagement, or tort of any **retiree**, **spouse**, or their beneficiary, nor subject to anticipation, sale, assignment (except in the case of medical benefits), transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation, or any other voluntary or involuntary alienation or other legal or equitable process, nor transferable by operation of law except as may be provided in the benefit.

18.5 Additional Taxes or Penalties

If there are any taxes or penalties payable by the **State** on behalf of any **covered person**, such taxes or penalties will be payable by the **covered person** to the employer to the extent such taxes would have been originally payable by the **covered person** had this **plan** not been in existence.

18.6 No Guarantee of Tax Consequences

Neither the **claims administrators** nor the **State** makes any commitment or guarantee that any amounts paid to or for the benefit of a **covered person** under the **plan** will be excludable from the **covered person's** gross income for federal, state, or local income tax purposes or for Social Security tax purposes, or that any other federal or state tax treatment will apply to or be available to any **covered person**. It will be the obligation of each **covered person** to determine whether payment under the **plan** is excludable from the **covered person** gross income for federal, state, and local income tax purposes, and Social Security tax purposes, and to notify the **State** if the **covered person** has reason to believe that any such payment is not excludable.

18.7 Employment of Consultants

The **State**, or a fiduciary named by the **State** pursuant to the **plan**, may employ one or more persons to render advice with regard to their respective responsibilities under the **plan**.

18.8 Designation of Fiduciaries

The **State** may designate another person or persons to carry out any fiduciary responsibility of the **State** under the **plan**. The administrator will not be liable for any act or omission of such person in carrying out such responsibility, except as may be otherwise provided under applicable law.

18.9 Fiduciary Responsibilities

To the extent permitted under applicable law, no fiduciary of the **plan** will be liable for any act or omission in carrying out the fiduciary's responsibilities under the **plan**.

18.10 Allocation of Fiduciary Responsibilities

To the extent permitted under applicable law, each fiduciary under the **plan** will be responsible only for the specific duties assigned under the **plan** and will not be directly or indirectly responsible for the duties assigned to another fiduciary.

18.11 Limitation of Rights and Obligations

Neither the establishment nor maintenance of the **plan** nor any amendment thereof, nor the purchase of any benefit, including any benefit plan or insurance policy, nor any act or omission under the **plan** or resulting from the operation of the **plan** will be construed:

a) as conferring upon any **covered person**, beneficiary, or any other person any right or claim against the **State**, or **claims administrator**, except to the extent that such right or claim will be specifically expressed and provided in the **plan** or provided under applicable law;
b) as creating any responsibility or liability of the **State** or the **claims administrator** for the validity or effect of the **plan**; or
c) as a contract or agreement between the **State** and any **covered person** or other person.

18.12 NOTICE

Any notice given under the **plan** will be sufficient if given to the **State** as administrator, when addressed to its office; if given to the **claims administrator**, when addressed to its office; or if given to a **covered person**, when addressed to the **covered person**, at their address as it appears in the records of the administrator or the **claims administrator**.

18.13 DISCLAIMER OF LIABILITY

Nothing contained herein will confer upon a **covered person** any claim, right, or cause of action, either at law or at equity, against the **plan**, the **State** or the **claims administrator** for the acts or omissions of any **provider** of services or supplies for any benefits provided under the **plan**.

18.14 RIGHT OF RECOVERY

If the **State** or the **claims administrator** makes any payment that according to the terms of the **plan** and the benefits provided hereunder should not have been made, the **State** or the administrator may recover that incorrect payment, whether or not it was made due to the **State's** or the **claims administrator's** own error, from the person to whom it was made, or from any other appropriate party. If any such incorrect payment is made directly to a **covered person**, then the **State** or the **claims administrator** may deduct it when making future payments directly to that **covered person**.

18.15 LEGAL COUNSEL

The **State** may from time to time consult with counsel, who may be counsel for the **State**, and will be fully protected in acting upon the advice of such counsel.

18.16 EVIDENCE OF ACTION

All orders, requests, and instructions to the **State** or the **claims administrator** by the **State** or by any duly authorized representative, will be in writing and the administrator will act and will be fully protected in acting in accordance with such orders, requests, and instructions.

18.17 PROTECTIVE CLAUSE

Neither the **State** nor the **claims administrator** will be responsible for the validity of any contract of insurance or other benefit contract or policy by any benefit **provider** issued to the **State** or for the failure on the part of any insurance company or other benefit **provider** to make payments thereunder.

18.18 RECEIPT AND RELEASE

Any payments to any **covered person** will, to the extent thereof, be in full satisfaction of the claim of such **covered person** being paid thereby, and the **State** may condition payment thereof on the delivery by the **covered person** of the duly executed receipt and release in such form as may be determined by the **State**.

18.19 Legal Actions

If the **State** is made a party to any legal action regarding the **plan**, except for a breach of fiduciary responsibility of such person or persons, any and all costs and expenses, including reasonable attorneys' fees, incurred by the **State** in connection with such proceeding will be paid from the assets of the **plan** unless paid by the **State**.

No legal action can be brought to recover under any benefits after three years from the deadline for filing claims.

18.20 Reliance

The **State** will not incur any liability in acting upon any notice, request, signed letter, telegram, or other paper or document believed by the **State** to be genuine or to be executed or sent by an authorized person.

18.21 Misrepresentation

Any material misrepresentation on the part of the **covered person** making application for coverage or receipt of benefits, will render the coverage null and void. Each **covered person** is required to notify the **State** or **claims administrator** of any change in status or other applicable events as required under this **plan** or the applicable benefit. Any failure to notify the **State** or c**laims administrator** of any change in status or other applicable events will be deemed by the **State** to be an act that constitutes fraud and an intentional misrepresentation of material fact prohibited by the **plan** that may result in a retroactive termination of coverage.

18.22 Entire Plan

The **plan** document and the documents, if any, incorporated by reference herein will constitute the only legally governing documents for the **plan**. No oral statement or other communication will amend or modify any provision of the **plan** as set forth herein.

18.23 Applicable Law and Venue

This **plan** is established and administered in the **State**, and is governed by the laws of the **State**. Any and all suits or legal proceedings of any kind that are brought against the **State** must be filed in one of the Judicial Districts in the State of Alaska.

18.24 Changes to the 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 **Commissioner**.

18.25 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 such payments, this **plan** is fully discharged from liability.

18.26 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 **plan**.

19 DEFINITIONS

The following words have the defined meanings when used in the **plan**:

Word	Definition
Accident	**Accident** means a sudden, unexpected, and unforeseen, identifiable occurrence or event producing, at the time, objective symptoms of a bodily **injury**. The **accident** must occur while the person is covered under the **plan**. The occurrence or event must be definite as to time and place. It must not be due to, or contributed by, an **illness** or disease of any kind.
Aetna	**Aetna** means Aetna Life Insurance Company, an affiliate of **Aetna**, or a third-party vendor under contract with **Aetna**. **Aetna** is the third-party administrator and Claims Administrator of the **medical plan**.
Aggregate contract rate	**Aggregate contract rate** means the average of all discounts in the fee schedule negotiated with the preferred facility in Anchorage.
Alternate Payee	**Alternate Payee** means the person who receives a portion of a retiree's retirement or disability benefit pursuant to a qualified domestic relations order.
Alveoloplasty	**Alveoloplasty** is the surgical shaping of the bone of the upper or the lower jaw. It is performed most commonly in conjunction with the removal of a tooth or multiple teeth to have the gums heal smoothly for the placement of partial denture or denture.
Ambulance	**Ambulance** means a professional land, water or air vehicle staffed with medical personnel and specially equipped to transport **injured** or sick people to a destination capable of caring for them upon arrival. Specially equipped means that the vehicle contains the appropriate stretcher, oxygen, and other medical equipment necessary for patient care enroute.
Anterior	**Anterior** means teeth located at the front of the mouth.
Appeal	**Appeal** means review by the **claims administrator**, or Division of Retirement and Benefits of a **denial**.
Audio Plan	**Audio plan** means audio benefits under the **DVA plan** as set forth in section 10, *Audio Plan*.
Average wholesale price (AWP)	**Average wholesale price (AWP)** means the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons weekly price updates (or any other similar publication designated by the **claims administrator**) on the day that a **pharmacy** claim is submitted for adjudication.
Behavioral health provider	**Behavioral health provider** means a licensed organization or professional providing diagnostic, therapeutic, or psychological services for behavioral health conditions.

Word	Definition
Benefit option	**Benefit option** means the **medical plan**, **dental plan**, **vision plan**, and health flexible spending account (HFSA).
Benefit recipient	**Benefit recipient** means a **retiree** or **surviving spouse** who is eligible for benefits under the **plan** in accordance with section 1.3.1, *Eligibility for coverage under the health plan*.
Benefit year	**Benefit year** means January 1 through December 31.
Birthing center	**Birthing center** means a freestanding facility that meets all of the following requirements: 1. Meets licensing standards. 2. Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care. 3. Charges for its services. 4. Is directed by at least one **physician** who is a specialist in obstetrics and gynecology. 5. Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period. 6. Extends staff privileges to **physicians** who practice obstetrics and gynecology in an area **hospital**. 7. Has at least two beds or two birthing rooms for use by patients while in labor and during delivery. 8. Provides, during labor, delivery and the immediate postpartum period, full-time **skilled nursing care** directed by a registered nurse or certified nurse midwife. 9. Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and **child**. 10. Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear. 11. Is equipped and has trained staff to handle **emergency** medical conditions and provide immediate support measures to sustain life if complications arise during labor or a **child** is born with an abnormality which impairs function or threatens life. 12. Accepts only patients with low-risk pregnancies. 13. Has a written agreement with a **hospital** in the area for **emergency** transfer of a patient or a **child**. Written procedures for such a transfer must be displayed and the staff must be aware of them. 14. Provides an ongoing quality assurance program. This includes reviews by **physicians** who do not own or direct the facility. 15. Keeps a medical record on each patient and **child**.
Body mass index	**Body mass index** or **"BMI"** is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared
Brand name prescription drug	**Brand name prescription drug** is a **prescription drug** with a proprietary name assigned to it by the manufacturer or distributor and so indicated by Medi-Span or any other similar publication designated by **Aetna**.
Bridge	**Bridge** means a fixed partial denture. A **bridge** replaces one or more missing teeth using a **pontic** (false tooth or teeth) permanently attached to the adjacent teeth.

Word	Definition
	Retainer crowns (crowns placed on adjacent teeth) are considered part of the **bridge**.
Broken	**Broken** is the description of a tooth that has a piece or pieces that have been completely separated from the rest of the tooth. Note that cracks are not the same as **broken**.
Cast restoration	**Cast restoration** means crowns, inlays, onlays, and any other **restoration** to fit a specific **covered person's** tooth that is made at a laboratory and cemented into the tooth.
Child	**Child** or **children** means the **eligible employee's**, **spouse's** (i) natural child, (ii) stepchild, (iii) legally adopted child, (iv) child who is in the physical custody of the **eligible employee**, **spouse** and for whom bona fide adoption proceedings are underway, or (v) child who is placed with the **eligible employee**, **spouse** by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.
Claims administrator	**Claims administrator** means a person, firm, or company which has agreed to provide technical or administrative services and advice in connection with the operation of all or a part of a benefit provided for under the **plan**, and perform such other functions, including processing and payment of claims, as may be delegated to it under such contract. The **claims administrator** may review claims **appeals** and, if applicable, coordinate external reviews, as provided by the **plan**.
COBRA Administrator	**COBRA administrator** means a person, firm, or company which has agreed to administer continuation coverage under COBRA in connection with the operation of all or a part of a benefit provided for under the **plan**, and perform such other functions, as may be delegated to it under such contract.
Coinsurance	**Coinsurance** means the percentage of **covered expenses** which the **plan** pays after application of any applicable **deductible**.
Commissioner	**Commissioner** means the Commissioner of the State of Alaska Department of Administration.
Copay (ment)	**Copayment** or **copay** means the specific dollar amount required to be paid by you or on your behalf under the **plan**.
Cosmetic	**Cosmetic** means services or supplies that alter, improve or enhance appearance.
Covered expense	**Covered expense** means the medical, **prescription drug**, dental, or vision services and supplies shown as covered under the **plan**, including any applicable sales, excise, or other taxes.
Covered person	**Covered person** means each **eligible employee** and **dependent** who is covered under the **plan**.
Custodial care	**Custodial care** means services and supplies, including **room and board** and other institutional services, that are primarily intended to help you meet personal needs. **Custodial care** can be prescribed by a **physician** or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of **custodial care** include: 1. Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications. 2. Care of a stable tracheostomy (including intermittent suctioning). 3. Care of a stable colostomy/ileostomy.

Word	Definition
	4. Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings. 5. Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing). 6. Watching or protecting you. 7. Respite care, adult (or child) day care, or convalescent care. 8. Institutional care, including **room and board** for rest cures, adult day care and convalescent care. 9. Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods. 10. Any service that can be performed by a person without any medical or paramedical training.
Day care treatment	**Day care treatment** means a **partial confinement treatment** program to provide treatment for you during the day. The **hospital**, **psychiatric hospital** or **residential treatment facility** does not make a room charge for **day care treatment.** Such treatment must be available for at least four hours, but not more than 12 hours in any 24-hour period.
DCR Plan	**DCR Plan** means the PERS/TRS Defined Contribution Retirement Plan, as amended from time to time.
Debridement	**Debridement** means the removal of excess plaque. A periodontal pre-cleaning procedure done when there is too much plaque for the **dentist** to perform an exam.
Deductible	**Deductible** means the amount of **covered expenses** for which you are responsible each **benefit year** before any benefits are payable under the **plan**.
Delta Dental	**Delta Dental** means Delta Dental of Alaska. Delta Dental of Alaska is a business name used by Oregon Dental Service, which is a not-for-profit health insurer licensed in Alaska. **Delta Dental** is the **claims administrator** of the **dental plan**.
Denial	**Denial** means any of the following: a denial, reduction, termination, or failure to provide or make payment (in whole or in part) for a benefit, including determinations based on eligibility, and, with respect to benefits under the **plan,** a denial, reduction, termination or failure to provide or make payment for a benefit based on utilization review or a failure to cover a benefit because it is determined to be **experimental or investigational** or not **medically necessary**. With respect to the **medical plan** and **dental plan**, it also means a **rescission** of coverage whether or not, in connection with the **rescission**, there is an adverse effect on any particular health benefit at the time.
Dental care provider	**Dental care provider** means a **dentist**, registered hygienist or certified dental therapist who is operating within the scope of their license, certification or registration.
Dental plan	**Dental plan** means dental benefits under the **plan**, as set forth in section 5, *Dental Plan*.
Dentally necessary	**Dentally necessary** means services that: 1. are established as necessary for the treatment or prevention of a dental **injury** or disease otherwise covered under the **dental plan**; 2. are appropriate with regard to standards of good dental practice in the **service area**;

Word	Definition
	3. have a good prognosis; and/or 4. are the least costly of the alternative supplies or levels of service that can be safely provided. For example, coverage would not be allowed for a crown when a filling would be adequate to restore the tooth appropriately. The fact that a **dentist** may recommend or approve a service or supply does not make the charge **dentally necessary.**
Dentist	**Dentist** means a licensed **dentist,** or a **physician** licensed to do the dental work he or she performs, who is operating within the scope of their license as required under law within the state of practice.
Dependent	**Dependent** means a **retiree's spouse**, or **child**.
Detoxification	**Detoxification** means the process by which an alcohol-intoxicated or drug-intoxicated, or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the: • intoxicating alcohol or drug; • alcohol or drug-dependent factors; or • alcohol in combination with drugs; as determined by a **physician**. The process must keep the physiological risk to the patient at a minimum and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.
Direct bill administrator	**Direct bill administrator** means a person, firm, or company which has agreed to provide billing services in connection with the operation of all or a part of a benefit provided for under the **plan**, and perform such other functions, as may be delegated to it under such contract.
Division	**Division** means the State of Alaska, Division of Retirement and Benefits.
Durable medical equipment	**Durable medical equipment** means equipment and the accessories needed to operate it that is: • made for and mainly used in the treatment of an **illness** or **injury**; • suited for use in the home; • not normally of use to persons who do not have an **illness** or **injury**; • not for use in altering air quality or temperature; and • not for exercise or training. **Durable medical equipment** does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids, and telephone alert systems.
DVA Plan	**DVA plan**" means the **dental plan**, the **vision plan** and the **audio plan** under the **health plan**.
Electronic protected health information	**Electronic protected health information** means electronic **protected health information** as defined at 45 CFR § 160.103, which generally means **protected health information** that is transmitted by, or maintained in, electronic media. For these purposes, electronic media means: (i) electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or (ii) transmission media used to exchange information already in electronic storage media (*e.g.*, the internet, extranet, leased lines, dial up lines,

Word	Definition
	private networks, and the physical movement of removable/transportable electronic storage media).
Emergency	**Emergency** means a sudden and unexpected change in a person's condition, including severe pain, such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in loss of life or limb, significant impairment to bodily function or permanent dysfunction of a body part, or with respect to a pregnant woman, the health of the woman and her unborn child.
Emergency care	**Emergency care** means the treatment given in a **hospital**'s emergency room to evaluate and treat an **emergency** medical condition.
Enhanced EGWP	**Enhanced EGWP** means a Medicare **prescription drug** plan with additional coverage from AlaskaCare that enhances, or provide supplemental wrap benefits, to the Medicare **prescription drug** plan. When combined, the enhanced wrap and the EGWP are designed to provide the same benefits as those provided to non-Medicare eligible **benefit recipients** and **dependents**.
EOB	**EOB** means an *Explanation of Benefits* form.
Experimental or investigational	**Experimental or investigational** means, except as provided for under any clinical trials benefit provision, a drug, a device, a procedure, or treatment where: 1. there is not enough outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved; 2. approval required by the FDA has not been granted for marketing; 3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational** or for research purposes; 4. it is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of phases indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or 5. 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 or investigational**, or for research purposes.
Facility	**Facility** means a freestanding **birthing center**, dialysis clinic, free standing imaging center, **hospital, hospice facility, psychiatric hospital, rehabilitation facility, surgery center, residential treatment facility, skilled nursing facility** or **urgent care provider.**
Final denial	**Final denial** means a **denial** of benefits under the **medical plan** or **dental plan** that has been upheld by the **claims administrator** at the completion of the internal **appeals** process or a **denial** of benefits under the **medical plan** or **dental plan** with respect to which the internal **appeals** process has been deemed exhausted (a deemed **final denial**).
Formulary	**Formulary** means a listing of **prescription drugs** (both **generic prescription drugs** and **brand-name prescription drugs**) established by the **plan** administrator. The **formulary** will tell you if a drug is covered and tell you what **plan** payment tier it is in. You can also see if there are alternatives that cost less. The **Formulary** also includes an Exclusion List of drugs that are identified as excluded under the plan,

Word	Definition
	subject to periodic review and modification. A copy of the **Formulary** will be made available upon request or may be accessed at AlaskaCare.gov.
Generic alternative prescription drug	**Generic alternative prescription drug** means a **prescription drug** used for the same purpose as the **brand-name prescription drug but** can have different ingredients or different amounts of ingredients as the **brand-name prescription drug**.
Generic equivalent prescription drug	**Generic equivalent prescription drug** means a **prescription drug** used for the same purpose as the **brand-name prescription drug** and contains the identical amounts of the same active ingredients as the **brand-name prescription drug**.
Generic prescription drug	**Generic prescription drug** means a **prescription drug**, whether identified by its chemical, proprietary, or nonproprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medispan or any other publication designated by **Aetna**.
Geographic area	**Geographic area** means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three-digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three-digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three-digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three-digit zip codes, the grouping never crosses state lines.
Health care operations	**Health care operations** means health care operations as defined by 45 CFR § 164.501, as amended. Generally, **health care operations** include, but are not limited to, the following activities taken by or on behalf of the **plan**: 1. Quality assessment. 2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care **providers** and patients with information about treatment alternatives and related functions. 3. Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities. 4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance). 5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs. 6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the **plan**, including **formulary** development and administration, development or improvement of **payment** methods or coverage policies. 7. Business management and general administrative activities of the **plan**, including, but not limited to: • Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements. • Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers.

Word	Definition
	• Resolution of internal grievances. • Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity under HIPAA or, following completion of the sale or transfer, will become a covered entity. • Any other activity considered to be a health care operation activity pursuant to 45 CFR § 164.501.
Health care professional	**Health care professional** means a **physician** or other health care professional licensed, accredited, or certified to perform health services consistent with state law.
Home delivery pharmacy	**Home delivery pharmacy** means an establishment where **prescription drugs** are legally given out by mail or another carrier.
Health plan	**Health plan** means the **medical plan** and **DVA plan**.
Home health care agency	**Home health care agency** means an organization that meets all of the following requirements: 1. provides **skilled nursing services** and other therapeutic services in the patient's home; 2. is associated with a professional policy-making group (of at least one **physician** and one full-time supervising registered nurse) which makes policy; 3. has full time supervision by a **physician** or registered nurse; 4. keeps complete medical records on each patient; 5. is staffed by an administrator; and 6. meets licensing standards.
Home health care plan	**Home health care plan** means a plan that provides for continued care and treatment of an **illness** or **injury** in a place of confinement other than a **hospital** or **skilled nursing facility**. The attending **physician** must prescribe care treatment in writing.
Homebound	**Homebound** means that you are confined to your place of residence: 1. due to an **illness** or **injury** which makes leaving the home medically contraindicated; or 2. because the act of transport would be a serious risk to your life or health. Situations where you would not be considered **homebound** include, but are not limited to, the following: 1. you do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or 2. you are wheelchair bound but could safely be transported via wheelchair accessible transport.
Hospice care	**Hospice care** means care given to a **terminally ill** person by or under arrangements with a **hospice care agency**. The care must be part of a **hospice care program**.
Hospice care agency	**Hospice care agency** means an agency or organization that meets all of the following requirements: 1. Has **hospice care** available 24 hours a day. 2. Meets any licensing or certification standards established by the jurisdiction where it is located. 3. Provides: • Skilled nursing services;

Word	Definition
	• Medical social services; and • Psychological and dietary counseling. 4. Provides, or arranges for, other services which include: • Physician services; • Physical and occupational therapy; • Part time home health aide services which mainly consist of caring for terminally ill people; and • Inpatient care in a facility when needed for pain control and acute and chronic symptom management. 5. Has at least the following personnel: • One physician; • One registered nurse; and • One licensed or certified social worker employed by the agency. 6. Establishes policies about how hospice care is provided. 7. Assesses the patient's medical and social needs. 8. Develops a hospice care program to meet those needs. 9. Provides an ongoing quality assurance program. This includes reviews by physicians, other than those who own or direct the agency. 10. Permits all area medical personnel to utilize its services for their patients. 11. Keeps a medical record on each patient. 12. Uses volunteers trained in providing services for non-medical needs. 13. Has a full-time administrator.
Hospice care program	Hospice care program is a written plan of hospice care which meets all of the following requirements: 1. Is established by and reviewed from time to time by a physician attending the person, and appropriate personnel of a hospice care agency. 2. Is designed to provide palliative and supportive care to terminally ill persons, and supportive care to their families. 3. Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.
Hospice facility	Hospice facility means a facility, or distinct part of one, that meets all of the following requirements: 1. Mainly provides inpatient hospice care to terminally ill persons. 2. Charges patients for its services. 3. Meets any licensing or certification standards established by the jurisdiction where it is located. 4. Keeps a medical record on each patient. 5. Provides an ongoing quality assurance program including reviews by physicians other than those who own or direct the facility. 6. Is run by a staff of physicians. At least one staff physician must be on call at all times. 7. Provides 24-hour-a-day nursing services under the direction of a registered nurse. 8. Has a full-time administrator.
Hospital	Hospital means an institution providing inpatient medical care and treatment of sick and injured people. It must:

Word	Definition
	1. be accredited by the Joint Commission on the Accreditation of Healthcare Organizations; be a medical care, 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 2. 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. In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative hospital, or facility primarily for rehabilitative or custodial services.
Illness	**Illness** means a pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.
Implant	**Implant** is an artificial, permanent tooth root replacement used to replace a missing tooth or teeth. It is surgically placed into the upper or lower jaw bone and supports a single crown, fixed **bridge**, or partial or full denture.
Implant abutment	**Implant abutment** is an attachment used to connect an **implant** and an **implant supported prosthetic** device.
Implant supported prosthetic	**Implant supported prosthetic** means a crown, **bridge**, or removable partial or full denture that is supported by or attached to an **implant**.
Individual	**Individual** means any person who is the subject of **protected health information**.
Infertility	**Infertility** or **infertile** means the condition of a presumably healthy **covered person** who is unable to conceive or produce conception after: 1. *for a woman who is under 35 years of age*: one year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or 2. *for a woman who is 35 years of age or older*: six months or more of timed, unprotected coitus, or 6 cycles of artificial insemination.
Injury	**Injury** means an accidental bodily injury that is the sole and direct result of an unexpected or reasonably unforeseen occurrence or event, or the reasonable unforeseeable consequences of a voluntary act by the person.
Maintenance care	**Maintenance care** means care made up of services and supplies that: 1. are given mainly to maintain, rather than to improve, a level of physical, or mental function; and 2. give a surrounding free from exposures that can worsen the person's physical or mental condition.
Medical plan	**Medical plan** means medical, **prescription drug**, and employee assistance benefits under the **plan**, as set forth in section 3**Error! Reference source not found.**, *Medical Plan*.

Word	Definition
Medically necessary	**Medically necessary** or **medical necessity** has the meaning set forth in section 3.5.1, *Medically Necessary Services and Supplies*.
Member	**Member** means a person who is eligible to participate in the **DCR Plan** and who is covered by the **DCR Plan**.
Membership service	**Membership service** means full-time or part-time employment with the **State** or a political subdivision or public organization of the **State** that participates in the **DCR Plan.**
Mental disorder	**Mental disorder** means an **illness** commonly understood to be a **mental disorder**, whether or not it has a physiological or organic basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a **psychiatric physician**, a psychologist or a psychiatric social worker. A **mental disorder** includes but is not limited to: 1. Schizophrenia 2. Bipolar disorder (manic/depressive) 3. Pervasive Mental Development Disorder (Autism) 4. Panic disorder 5. Major depressive disorder 6. Psychotic depression 7. Obsessive compulsive disorder 8. Anorexia/bulimia nervosa 9. Psychotic disorders/delusional disorder 10. Schizo-affective disorder
Negotiated charge	**Negotiated charge** means the maximum charge that a **network provider** has agreed to make as to any service or supply for the purpose of benefits under the **plan**.
Network pharmacy	**Network pharmacy** means a **pharmacy** that has contracted with **the pharmacy benefit manager** to furnish services or supplies for the **plan**.
Network provider	**Network provider** means a health care **provider** or **pharmacy** that has contracted with a **claims administrator** to furnish services or supplies for the **plan**, but only if the **provider** is a **network provider** for the service or supply involved
Network service or supply	**Network service(s) or supply(ies)** means health care service(s) or supply(ies) that is/are furnished by a **network provider**.
Night care treatment	**Night care treatment** means a **partial confinement treatment** program provided when you need to be confined during the night. A room charge is made by the **hospital**, **psychiatric hospital**, or **residential treatment facility**. Such treatment must be available at least eight hours in a row at a night and five nights per week.
Non-preferred brand-name drug (non-formulary)	**Non-preferred brand-name drug (non-formulary)** means a **brand-name prescription drug** that does not appear on the **Formulary.**
OptumRx	**OptumRx** is the pharmacy benefit manager (claims administrator) of the **prescription drug** benefits.
Other health care	**Other health care** means a health care service or supply that is neither **network service(s) or supply(ies)** nor out-of-**network service(s) and supply(ies). Other health care** can include care given by a **provider** who does not fall into any of the

Word	Definition
	categories in your **provider** directory or in DocFind® at aetna.com/docfind/custom/alaskacare.
Out-of-pocket limit	**Out-of-pocket limit** means the maximum amount you are responsible to pay for benefits under the **plan** each **benefit year**, including **deductible** and **coinsurance** not paid by the **plan**. Premiums, charges over the **recognized charge**, **precertification** benefit reductions, and non-**covered expenses** do not accrue toward the **out-of-pocket limit**. A separate **out-of-pocket limit** applies with respect to the medical benefit portion and **prescription** benefit portion of the **medical plan.**
Partial confinement treatment	**Partial confinement treatment** means a plan of medical, psychiatric, nursing, counseling or therapeutic services to treat **substance abuse** or **mental disorders** which meets all of the following requirements: 1. It is carried out in a **hospital**, **psychiatric hospital**, or **residential treatment facility** on less than a full-time inpatient basis. 2. It is in accord with accepted medical practice for the condition of the person. 3. It does not require full-time confinement. 4. It is supervised by a **psychiatric physician** who weekly reviews and evaluates its effect. **Day care treatment** and **night care treatment** are considered **partial confinement treatment**.
PayFlex	**PayFlex** means PayFlex Systems USA, Inc., the flexible spending account and COBRA **claims administrator** under the **plan**.
Payment	**Payment** means payment as defined by 45 § CFR 164.501, as amended. Generally, **payment** activities include, but are not limited to, activities undertaken by the **plan** to obtain premiums or determine or fulfill its responsibility for coverage and provision of **plan** benefits that relate to an **individual** to whom health care is provided. These activities include, but are not limited to, the following: 1. Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and **copayments** as determined for an **individual's** claim). 2. Coordination of benefits. 3. Adjudication of health benefit claims (including **appeals** and other payment disputes). 4. Subrogation of health benefit claims. 5. Establishing **eligible employee** contributions. 6. Risk adjusting amounts due based on an **eligible employee's** health status and demographic characteristics. 7. Billing, collection activities and related health care data processing. 8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to an **eligible employee's** inquiries about payments. 9. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance). 10. **Medical necessity** reviews or reviews of appropriateness of care or justification of charges. 11. Utilization review, including **precertification**, preauthorization, concurrent review and retrospective review.

Word	Definition
	12. Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following **protected health information** may be disclosed for **payment** purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or **plan**). 13. Reimbursement to the **plan.** 14. Any other activity considered to be a **payment** activity pursuant to 45 CFR § 164.501.
Periodontal maintenance	**Periodontal maintenance** is a periodontal procedure for **covered persons** who have previously been treated for periodontal disease. In addition to cleaning the visible surfaces of the teeth (as in **prophylaxis**), surfaces below the gum line are also cleaned. This is a more comprehensive service than a regular cleaning (**prophylaxis**).
Pharmacy	**Pharmacy** means an establishment where **prescription drugs** are legally dispensed. **Pharmacy** includes a retail **pharmacy**, **home delivery pharmacy** and **specialty pharmacy network pharmacy**.
Pharmacy benefit manager	**Pharmacy benefit manager** means a person, firm, or company which has agreed to provide technical or administrative services and advice in connection with the operation of all or a part of a pharmacy benefit provided for under the **plan**, and perform such other functions, including processing and payment of claims, as may be delegated to it under such contract. The **pharmacy benefit manager** may review pharmacy claims **appeals** and, if applicable, coordinate external reviews, as provided by the **plan**.
Physician	**Physician** means a duly licensed member of a medical profession who: 1. has an M.D. or D.O. degree; 2. is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and 3. provides medical services which are within the scope of their license or certificate. A **physician** also includes a health professional who: 1. is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices; 2. provides medical services which are within the scope of their license or certificate; 3. under applicable insurance law is considered a **physician** for purposes of this coverage; 4. has the medical training and clinical expertise suitable to treat your condition; 5. specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, **substance abuse** or a **mental disorder**; and 6. is not you or related to you.
Plan	**Plan** means the AlaskaCare Employee Health Plan, the terms of which are set forth in this document, as may be amended from time to time.
Plan Administrator	**Plan Administrator shall mean the Commissioner of the Department of Administration, State of Alaska, or their designee.**
Pontic	**Pontic** is an artificial tooth that replaces a missing tooth and is part of a **bridge**.

Word	Definition
Post-service claim	**Post-service claim** means any claim for a medical benefit that is not an **urgent care claim** or a **pre-service claim.**
Pre-service claim	**Pre-service claim** means any claim for a medical benefit the **health plan** conditions receipt of such benefit, in whole or in part, on approval of the benefit prior to obtaining medical care.
Precertification	**Precertification** or **precertify** means a process where the **claims administrator** is contacted before certain services are provided. It is not a guarantee that benefits will be payable.
Preferred brand-name drug	**Preferred brand-name drug** means a **brand-name prescription drug** that appears on the **Formulary.**
Prescription	**Prescription** means an order for the dispensing of a **prescription drug** by a **physician** or **dentist,** acting within the scope of their license, who has the legal authority to write an order for a **prescription drug**. If it is an oral order, it must be promptly put in writing by the **pharmacy**.
Prescription drug	**Prescription drug** means a drug, biological, or compounded **prescription** which, by state and Federal law, may be dispensed only by **prescription** and which is required to be labeled Caution: Federal law prohibits dispensing without prescription. This includes a **self-injectable drug** prescribed to be self-administered or administered by any other person except one who is acting within their capacity as a paid **health care professional**. Covered **self-injectable drugs** include injectable insulin.
Prevailing charge rate	**Prevailing charge rate** means rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. **Aetna** updates its systems with these changes within 180 days after receiving them from FAIR Health.
Primary Care Provider	**Primary care provider** means a health care practitioner who sees people that have common medical problems. This person is most often a doctor. However, a primary care provider may be a physician assistant or a nurse practitioner.
Privacy Regulations	**Privacy Regulations** mean the regulations under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164, as amended).
Prophylaxis	**Prophylaxis** is cleaning and polishing of all teeth.
Protected health information	**Protected health information** means protected health information as defined at 45 CFR § 164.501 which, generally, means information (including demographic information) that (i) identifies an **individual** (or with respect to which there is a reasonable basis to believe the information can be used to identify an **individual**), (ii) is created or received by a health care **provider**, a health plan, or a health care clearinghouse, and (iii) relates to the past, present, or future physical or mental health or condition of an **individual**; the provision of health care to an **individual**; or the past, present, or future **payment** for the provision of health care to an **individua**l.
Provider	**Provider** means any recognized **health care professional**, **pharmacy** or **facility** providing services within the scope of its license.
Psychiatric hospital	**Psychiatric hospital** means an institution that meets all of the following requirements: 1. Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, **substance abuse** or **mental disorders**.

Word	Definition
	2. Is not mainly a school or a custodial, recreational or training institution. 3. Provides infirmary-level medical services. 4. Provides, or arranges with a **hospital** in the area for, any other medical service that may be required. 5. Is supervised full-time by a **psychiatric physician** who is responsible for patient care and is there regularly. 6. Is staffed by **psychiatric physicians** involved in care and treatment. 7. Has a **psychiatric physician** present during the whole treatment day. 8. Provides, at all times, psychiatric social work and nursing services. 9. Provides, at all times, **skilled nursing care** by licensed nurses who are supervised by a full-time registered nurse. 10. Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatric physician**. 11. Makes charges. 12. Meets licensing standards.
Psychiatric physician	**Psychiatric physician** means a **physician** who: 1. Specializes in psychiatry; or 2. Has the training or experience to do the required evaluation and treatment of alcoholism, **substance abuse** or **mental disorders**.
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. An out-of-**network provider** or out-of- **network pharmacy** has the right to bill the difference between the **recognized charge** and the actual charge. This difference will be the **covered person's** responsibility. ➢ <u>Medical, Vision, and Audio Expenses</u> As to medical, vision and audio services or supplies, the **recognized charge** for each service or supply is the <u>lesser of</u>: • what the **provider** bills or submits for that service or supply; <u>or</u> • the 90th percentile of the **prevailing charge rate** for the **geographic area** where the service is furnished as determined by the **claims administrator** in accordance with the **claims administrator** reimbursement policies.

	➢ Facility Expenses in Anchorage and outside of Alaska for non-Medicare age eligible benefit recipients and dependents. As to out-of-network **facility** services or supplies received in the Municipality of Anchorage or outside of Alaska, the **recognized charge** for each service or supply is the lesser of: • what the **facility** bills or submits for that service or supply; or • 185% of the Medicare allowed rate for those services. ➢ Free standing imaging centers for non-Medicare age eligible benefit recipients and dependents. As to out-of-network **facility** expenses at a free-standing imaging center, the **recognized charge** for a service or supply is 50% of the amount billed by the **provider**. ➢ Prescription Drug Expenses As to **prescription drug** expenses, **recognized charge** means the negotiated charge contained in an agreement the **pharmacy benefit manager** has with the **pharmacy** either directly or through a third party. If there is no such agreement, the **prescription drug** expense the **recognized charge** for each service or supply is the lesser of: • what the **provider** bills or submits for that service or supply; • 110% of the **average wholesale price** or other similar resource; or • For Medicare eligible **benefit recipients** and **dependents** covered under the **enhanced EGWP**, the Medicare approved amount. ➢ Dental Expenses Standard Plan Recognized Charge- 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 the dental claims administrator; 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** for the geographic area where the services is furnished 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**

Word	Definition
	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 • 75% of the 80th percentile of the prevailing charge rate for the geographic area where the service is furnished as determined by Delta Dental in accordance with its reimbursement policies. Legacy Plan Recognized Charge- The recognized charge is the charge contained in an agreement the claims administrator has with the provider either directly or through a third party. If no agreement is in place, the recognized charge is the lowest of: • The provider's usual charge for furnishing the service. • The charge the claims administrator determines to be appropriate based on factors such as the cost for providing the same or similar service or supply and the manner in which charges for the service or supply are made. • The charge the claims administrator determines to be the recognized charge percentage made for that service or supply. The recognized charge percentile is the charge determined by the claims administrator on a semiannual basis to be in the 90th percentile of the charges made for a service or supply by providers in the geographic area where it is furnished. The recognized charge is determined by collecting the claims submitted for each procedure, defined by the procedure code, in a specific geographic area. The highest and lowest charges are ignored and the charge that allows 90% of all the claims to be paid in full is set as the recognized charge for that procedure. The geographic area is determined by where the procedure is performed. For example, most procedures in Juneau are based on charges submitted from all of Southeast Alaska. Some types of procedures, such as surgery, are based on statewide claims data to ensure sufficient information to establish a recognized charge. If data is insufficient to determine a recognized charge, the claims administrator may consider items such as the following: • The recognized charge in a greater geographic area. • The complexity of the service or supply. • The degree of skill needed. • The type or specialty of the provider. • The range of services or supplies provided by a facility.

Word	Definition
	• If two or more surgical procedures are performed during the same operative session, payment will be calculated as follows: • The claims administrator will determine which procedures are primary, secondary or tertiary, taking into account the billed amounts. Payment for each procedure will be made at the lesser of the billed charge or the following percentage of the recognized charge: - Primary: 100% - Secondary: 50% - All others: 25% Incidental procedures, those that take little or no additional resources or time when performed at the same time as another procedure, are not covered by the plan. Charges in excess of the recognized charge as determined by the claims administrator are not paid by the plan. ➢ Calculation of Medical/ Vision/Audio 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 the **claims administrator** determines that a **network provider** or **network pharmacy** is not available to provide the service or supply. This includes situations in which you are admitted to a network **hospital** and non-**network physicians**, 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 the claims administrator in accordance with the claims administrator reimbursement policies. If the **claims administrator** has an agreement with a **provider** (directly, or indirectly through a third party) which sets the rate that the **claims administrator** will pay for a service or supply, then the **recognized charge** is the rate established in such agreement. The **claims administrator** may also reduce the **recognized charge** by applying the **claims administrator** reimbursement policies. The **claims administrator** reimbursement policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

Word	Definition
	• the duration and complexity of a service; • 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; and • 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. The **claims administrator** reimbursement policies are based on the **claims administrator**'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. The **claims administrator** uses a commercial software package to administer some of these policies. The **claims administrator** 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 the **claims administrator** on the date that the service or supply was provided. ➢ Additional Information **Aetna's** website 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.
Rehabilitation facility	**Rehabilitation facility** means a facility, or a distinct part of a facility which provides **rehabilitative care**, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.
Rehabilitative care	**Rehabilitative care** means the combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by **illness** or **injury**.
Reline	**Reline** means the process of resurfacing the tissue side of a denture with new base material.
Rescission	**Rescission** or **rescind** means a cancellation or discontinuance of coverage under the **medical plan** or **dental plan** that has retroactive effect. A **rescission** does not include the cancellation or discontinuance of coverage that has only a prospective

Word	Definition
	effect or is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the rest of coverage.
Residential treatment facility (mental disorders)	**Residential treatment facility (mental disorders)** means an institution that meets all of the following requirements: 1. On-site licensed **behavioral health provider** 24 hours per day/7 days a week. 2. Provides a comprehensive patient assessment (preferably before admission, but at least upon admission). 3. Patient is admitted by a **physician**. 4. Patient has access to necessary medical services 24 hours per day/7 days a week. 5. Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs. 6. Offers group therapy sessions with at least a registered nurse or Masters-Level Health Professional. 7. Has the ability to involve family/support systems in therapy (required for **children** and adolescents; encouraged for adults). 8. Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy. 9. Has peer-oriented activities. 10. Services are managed by a licensed **behavioral health provider** who, while not needing to be individually contracted, needs to (1) meet **Aetna's** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director). 11. Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission. 12. Provides a level of skilled intervention consistent with patient risk. 13. Meets any and all applicable licensing standards established by the jurisdiction in which it is located. 14. Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.
Residential treatment facility (substance abuse)	**Residential treatment facility (substance abuse)** means an institution that meets all of the following requirements: 1. On-site licensed **behavioral health provider** 24 hours per day/7 days a week. 2. Provides a comprehensive patient assessment (preferably before admission, but at least upon admission). 3. Patient is admitted by a **physician**. 4. Patient has access to necessary medical services 24 hours per day/7 days a week. 5. If the **covered person** requires **detoxification** services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending **physician**. 6. Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs. 7. Offers group therapy sessions with at least a registered nurse or Masters-Level Health Professional.

Word	Definition
	8. Has the ability to involve family/support systems in therapy (required for **children** and adolescents; encouraged for adults). 9. Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy. 10. Has peer-oriented activities. 11. Services are managed by a licensed **behavioral health provider** who, while not needing to be individually contracted, needs to (1) meet **Aetna's** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director). 12. Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission. 13. Provides a level of skilled intervention consistent with patient risk. 14. Meets any and all applicable licensing standards established by the jurisdiction in which it is located. 15. Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service. 16. Has the ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally. 17. 24-hours per day/7 days a week supervision by a **physician** with evidence of close and frequent observation. 18. On-site, licensed **behavioral health provider**, medical or **substance abuse** professionals 24 hours per day/7 days a week.
Restoration	**Restoration** means the treatment that repairs a **broken** or decayed tooth. **Restorations** include, but are not limited to, fillings and crowns.
Retainer	**Retainer** means a tooth used to support a prosthetic device (**bridges**, partial dentures or overdentures).
Retiree	**Retiree** means a **member** who has elected to receive benefits under this **health plan**.
Room and board	**Room and board** means charges made by an institution for **room and board** and other **medically necessary** services and supplies. The charges must be regularly made at a daily or weekly rate.
Security incident	**Security incident** means security incident as defined at 45 CFR § 164.304, which, generally, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
Security Regulations	**Security Regulations** mean the regulations under the Security Standards for the Protection of Electronic **Protected Health Information** (45 CFR Parts 160 and 164, as amended).
Self-injectable drugs	**Self-injectable drugs** mean **prescription drugs** that are intended to be self-administered by injection to a specific part of the body to treat certain chronic medical conditions.
Service area	**Service area** means the **geographic area**, as determined by **Delta Dental**, in which **network providers** for the dental coverage portion under the **dental plan** are located.

Word	Definition
Skilled nursing care	**Skilled nursing care** means: • Those services provided by a visiting registered nurse or licensed practical nurse for the purpose of performing specific skilled nursing tasks; and • Private duty nursing services provided by a registered nurse or licensed practical nurse if the patient's condition requires **skilled nursing care** and visiting nursing care is not adequate.
Skilled nursing facility	**Skilled nursing facility** means an institution that meets all of the following requirements: 1. Licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **illness** or **injury**: • professional nursing care by a registered nurse or a licensed practical nurse directed by a full-time registered nurse; and • physical restoration services to help patients to meet a goal of self-care in daily living activities. 2. Provides 24 hour a day nursing care by licensed nurses directed by a full-time registered nurse. 3. Is supervised full-time by a **physician** or a registered nurse. 4. Keeps a complete medical record on each patient. 5. Has a utilization review plan. 6. Is not an institution for rest or care of the aged, drug addicts, alcoholics, people who are mentally incapacitated, or people with **mental disorders**. 7. Charges patients for its services. 8. An institution or a distinct part of an institution that meets all of the following requirements: • It is licensed or approved under state or local law. • Is primarily engaged in providing **skilled nursing care** and related services for residents who require medical or nursing care, or **rehabilitation services** for the rehabilitation of injured, disabled, or sick persons. 9. Qualifies as a **skilled nursing facility** under Medicare or as an institution accredited by: • The Joint Commission on Accreditation of Health Care Organizations; • The Bureau of Hospitals of the American Osteopathic Association; or • The Commission on the Accreditation of Rehabilitative Facilities. **Skilled nursing facilities** also include rehabilitation **hospitals** (all levels of care, *e.g.* acute) and portions of a **hospital** designated for skilled or **rehabilitation services**. **Skilled nursing facilities** do not include institutions which provide only (i) minimal care, (ii) c**ustodial care** or educational care, (iii) ambulatory services, or (iv) part-time care services, or institutions which primarily provide for the care and treatment of alcoholism, **substance abuse** or **mental disorders**.
Skilled nursing services	**Skilled nursing services** means services that meet all of the following requirements: • The services require medical or paramedical training. • The services are rendered by a registered nurse or licensed practical nurse. within the scope of their license. • The services are not custodial.

Word	Definition
Specialty care drugs	**Specialty care drugs** means **prescription drugs** that include injectable, infusion, and oral drugs prescribed to address complex, chronic disease with associated co-morbidities such as cancer, rheumatoid arthritis, hemophilia, and multiple sclerosis, which are listed in the specialty care drug list.
Specialty pharmacy network	**Specialty pharmacy network** means a network of pharmacies designated to fill **specialty care drugs.**
Spouse	**Spouse** means the person to whom the **eligible employee** is legally married under state law. A **spouse** includes a person to whom the **eligible employee** is legally separated, but not divorced.
State	**State** means the State of Alaska.
Stay	**Stay** means a full-time inpatient confinement for which a **room and board** charge is made.
Substance abuse	**Substance abuse** means a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered **dependents**.) This term does not include conditions not attributable to a **mental disorder** that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.
Summary health information	**Summary health information** means **summary health information** as defined by 45 CFR § 164.504(a), as amended, which generally is information that may be individually identifiable health information, and: • that summarizes the claims history, claims expenses, or type of claims experienced by **individuals** for whom the **State** has provided health benefits under the **health plan**; and • from which the information described at § 164.514(b)(2)(i) of the **Privacy Regulations** has been deleted, except that the geographic information described in § 164.514(b)(2)(i)(B) of the **Privacy Regulations** need only be aggregated to the level of a five digit zip code.
Summary Plan Description	**Summary Plan Description (SPD)** is an important document that tells participants what the plan provides and how it operates. The SPD for the AlaskaCare plan is also referred to as the Insurance Information Booklet.
Surgery center	**Surgery center** means a freestanding ambulatory surgical facility that meets all of the following requirements: 1. Meets licensing standards. 2. Is set up, equipped and run to provide general surgery. 3. Charges for its services. 4. Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period. 5. Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period. 6. Extends surgical staff privileges to: o **Physicians** who practice surgery in an area **hospital**; and o **Dentists** who perform oral surgery.

Word	Definition
	7. Has at least two operating rooms and one recovery room. 8. Provides, or arranges with a medical **facility** in the area for, diagnostic x-ray and lab services needed in connection with surgery. 9. Does not have a place for patients to **stay** overnight. 10. Provides, in the operating and recovery rooms, full-time **skilled nursing services** directed by a registered nurse. 11. Is equipped and has trained staff to handle **emergency** medical conditions. 12. Must have all of the following: o a **physician** trained in cardiopulmonary resuscitation; o a defibrillator; o a tracheotomy set; and o a blood volume expander. 13. Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients. 14. Written procedures for such a transfer must be displayed and the staff must be aware of them. 15. Provides an ongoing quality assurance program. The program must include reviews by **physicians** who do not own or direct the **facility**. 16. Keeps a medical record on each patient.
Surviving Spouse	**Surviving Spouse** means the **spouse** of a **retiree** who has been married to the **retiree** for at least one year at the time of the **retiree's** death.
Terminally ill	**Terminally ill** means a medical prognosis of 12 months or less to live.
Totally disabled	**Totally disabled** or **total disability** means, for purposes of extended coverage under the **medical plan**, your complete inability to perform everyday duties appropriate for your employment, age or sex. The inability may be due to disease, **illness**, **injury**, or pregnancy. The **State** reserves the right to determine **total disability** based upon the report of a duly qualified **physician** or **physicians** chosen by the **claims administrator**.
Urgent admission	**Urgent admission** means a **hospital** admission by a **physician** due to: 1. The onset of or change in an **illness**, the diagnosis of an **illness**, or an **injury**; and 2. The condition, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a **hospital** within two weeks from the date the need for the confinement becomes apparent.
Urgent care claim	**Urgent care claim** means any claim for medical care or treatment where the failure to make a non-urgent care determination quickly (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or (ii) in the opinion of a **physician** with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
Urgent care provider	**Urgent care provider** means: 1. A freestanding medical facility that meets all of the following requirements. • Provides unscheduled medical services to treat an **urgent condition** if the person's **physician** is not reasonably available. • Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.

Word	Definition
	• Makes charges. • Is licensed and certified as required by any state or Federal law or regulation. • Keeps a medical record on each patient. • Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility. • Is run by a staff of **physicians**. At least one **physician** must be on call at all times. • Has a full-time administrator who is a licensed **physician**. 2. A **physician's** office, but only one that: • Has contracted with **Aetna** to provide urgent care; and • Is, with **Aetna's** consent, included in the **directory** as a network **urgent care provider.** • It is not the emergency room or outpatient department of a **hospital**.
Urgent condition	**Urgent condition** means a sudden **illness**, **injury,** or condition that: 1. is severe enough to require prompt medical attention to avoid serious deterioration of your health; 2. includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment; 3. does not require the level of care provided in the emergency room of a **hospital**; and 4. requires immediate outpatient medical care that cannot be postponed until your **physician** becomes reasonably available.
Veneer	**Veneer** means a layer of tooth-colored material attached to the surface of an **anterior** tooth to repair chips or cracks, fix gaps and change the shape and size of teeth. A chairside **veneer** is a **restoration** created in the **dentist's** office. A laboratory **veneer** is a **restoration** that is created (cast) at a laboratory. Chairside and laboratory **veneers** may be paid at different benefit levels.
Vision plan	**Vision plan** means vision benefits under the elected vision **plan**, as set forth in *Section 8. Standard Plan Vision Benefits,* or *Section 9. Legacy Plan Vision Benefits*.
Year of service	**Year of service** means the equivalent of 52 weeks of permanent full-time employment, which may consist of a combination of permanent full-time or permanent part-time **membership service**.

20 VERSION HISTORY

Date	Version	Description
01/01/2021	2021	Formatting of document was updated. Section 3.5.16, 3.6.16, updated per CARES Act. Section 5.6.1, 5.6.2, 5.5.2, 5.5.3, updated per DVA Regulation changes 2 AAC 39.210, 2 AAC 39.240, 2 AAC 39.260, 2 AAC 39.265, 2 AAC 39.290, 2 AAC 36.265
01/01/2022	2022	Section 3.5.13.3, 13.5.13.4, 3.5.13.5, 3.5.13.6, 5.1, 3.5.13.8, 3.5.15 Section 3.5.29 updated to reflect new standard of care.
01/01/2023	2023	2.1.1 Medical Benefit Schedule 3.4.2 The Precertification Process 3.4.3 Services Requiring Precertification 3.4.4 How Failure to Precertify Affects your Benefits 3.5.13 Preventive Care and Screening Services 3.5.26 Gene Based, Cellular and other Innovative Therapies 3.6.15 Medicare Prescription Drug Plan 3.6.17 Medicare Part D Premium Surcharge 3.6.20 Pharmacy Benefit Exclusions 3.7 Medical Benefit Exclusions 4.5 Submitting Claims for Reimbursement 6.3.2.4 Class II Restorative Services 17.23 Applicable Law and Venue 18 Definitions
01/01/2024	2024	1.3.2 Eligibility for Coverage 1.5 When Coverage Begins 1.6 Changing your Coverage 1.7 When Coverage Ends 2.1 Medical and Prescription Drug Benefits 3.4 Understanding Precertification 3.5.5 Facility-Owned Preferred Provider Agreement 3.5.15 COVID-19 Testing and Vaccination 3.5.22 Prosthetic Devices 3.5.23 Ambulance Services 3.6.11 Home Delivery Pharmacy 3.6.17 Medicare Part D Premium Surcharge 3.7 Medical Benefit Exclusions 5.4 When DVA Coverage Begins 5.5.3 Increasing Dependent DVA Coverage 10.3 Physician and Other Provider Services 12.2 How Coordination of Benefits Works 18. Definitions
01/01/2025	2025	2.2 Dental Benefit Schedule 2.3 Standard Plan Vision Benefit Schedule 2.4 Legacy Plan Vision Benefit Schedule 3.5.32 Supplemental Surgery and Travel 3.5.33 Virtual Physical Therapy 6. Standard Plan Dental Benefits

		8. Standard Plan Vision Benefits 9. Legacy Plan Vision Benefits