State of Alaska Department of Administration Division of Retirement and Benefits	**AlaskaCare Retiree Health Plan Amendment**	**Number:** 2014-1 **Effective Date:** January 1, 2014
	Repeals/Amends: **Repeals:** (1) Benefit Summary, Plan Booklet, pp. 1-3 (2) Pre-certification addendum to Page 26, Plan Booklet, p. ii (3) Recognized Charge, Plan Booklet, pp. 13-15 (4) Certification, Plan Booklet, pp. 26-27, 29-34 (5) Dental Plan, Plan Booklet, pp. 66-75 (6) Usual, Customary and Reasonable, Plan Booklet, pp. 82-83 (7) Appeals, Plan Booklet, pp. 93-95 **Amends:** (1) Benefit Summary (2) Precertification (3) Transplant Services (4) Hospice Services (5) Experimental or Investigational Treatment (6) Medically Necessary Services and Supplies (7) Recognized Charge (8) Dental Services (9) Appeals	**Review Date:** **Distribution:** Deputy Commissioner Division Director Retirement/Benefits Manager Strategic Health Coordinator Appeals Supervisor Communications Supervisor Legal Counsel TPA File

The State of Alaska provides, by means of self-insurance, health benefits covering individuals entitled to coverage under AS 14.25, AS 22.25, AS 39.35or former AS 39.37, and their dependents. Such benefits are set forth in the ***Retiree Insurance Information Booklet*** (the "Plan"). Under authority of AS 39.30.090-098, the Commissioner of Administration hereby amends the Plan as follows:

Section 1: Repealed Provisions

The following provisions of the Plan are hereby repealed:

(1) Benefit Summary, Plan Booklet, pp. 1-3
(2) Pre-certification addendum to Page 26, Plan Booklet, p. ii
(3) Recognized Charge, Plan Booklet, pp. 13-15
(4) Certification, Plan Booklet, pp. 26-27, 29-34
(5) Dental Plan, Plan Booklet, pp. 66-75
(6) Usual, Customary and Reasonable, Plan Booklet, pp. 82-83
(7) Appeals, Plan Booklet, pp. 93-95

Section 2: Amended Provisions

(1) Benefit Summary

The following summary of benefits is inserted at p. 1 of the Plan Booklet:

a. Medical Benefit Schedule

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

Transplant services at a non-Institute of Excellence™ (IOE) facility or when out-of-network provider is used	60%
Out-of-Pocket Limit	
Annual individual out-of-pocket limit • Applies after the deductible is satisfied • Expenses paid at a coinsurance rate different than 80% do not apply against the out-of-pocket limit	$800
Benefit Maximums	
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	$2,000,000
Individual limit per benefit year on substance abuse treatment without precertification. *Subject to change every three years.*	$12,715
Individual lifetime maximum on substance abuse treatment without precertification. *Subject to change every three years.*	$25,430
Limit on travel for transplant services	$10,000 per transplant occurrence
Travel benefits without precertification	No benefits will be paid
Visit Limits	
Home health care	120 visits per benefit year Up to 4 hours = 1 visit
Outpatient hospice expenses	Up to 8 hours per day
Cognitive therapy, physical therapy, occupational therapy, and speech therapy rehabilitation benefits	No more than 2 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 • Surgical procedure	one visit per benefit year
Travel Limitations	
Non-overnight stay traveling expenses	$31/day
Overnight lodging	$80/night
Overnight lodging (Transplants)	$50/person/night $100/night maximum
Companion expenses	$31/night
Precertification Penalties	
A $400 benefit reduction applies if you fail to obtain precertification for certain medical services.	

b. Prescription Drug Schedule

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

c. Dental Benefit Schedule (if elected)

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

Benefit Maximums	
Annual individual maximum	$2,000

d. Vision Benefit Schedule (if elected)

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

e. Audio Benefit Schedule (if elected)

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

(2) Precertification

Insert at p. 26, Plan Booklet:

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 plan. It also allows Aetna to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

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

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

When you receive services from an out-of-network provider, you are responsible for obtaining the necessary precertification from Aetna for any services or supplies that require precertification as described in section 3, *Services Requiring Precertification*. If you do not precertify, your benefits may be reduced or the medical plan may not pay any benefits.

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 Aetna to precertify the admission or medical services and expenses prior to receiving any of the services or supplies that require precertification under the medical plan. To obtain precertification, call Aetna at the telephone number listed on your ID card in accordance with the following timelines:

For non-emergency admissions:	You, your physician or the facility must to call and request precertification at least 14 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 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

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

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

day. Aetna will review and process the request for an extended stay. You and your physician will receive a notification of an approval or denial.

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

3. Services Requiring Precertification

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

Precertification is required for the following types of medical expenses:

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

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

4. How Failure to Precertify Affects your Benefits

A precertification benefit reduction will be applied to the benefits paid if you fail to obtain a required precertification prior to incurring medical expenses. This means that Aetna will reduce the amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

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

- Except as otherwise provided below, Aetna will apply a $400 benefit reduction for failure to obtain precertification for the medical services listed in section 3 above, *Services Requiring Precertification*.

- If precertification of inpatient treatment for a mental disorder was not requested, your coinsurance for mental disorder benefits will be 50%.

- If precertification of travel expenses was not requested, no travel benefits will be paid.

(3) **Transplant Services**

Transplant services are covered as follows:

a. Covered Expenses

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

- Heart
- Lung
- Heart/lung
- Simultaneous pancreas kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine
- Bone marrow/stem cell
- Multiple organs replaced during one transplant surgery
- Tandem transplants (stem cell)
- Sequential transplants
- Re-transplant of same organ type within 180 days of the first transplant
- Any other single organ transplant, unless otherwise excluded under the medical plan.

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

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant)
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant)

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

b. Network Level of Benefits

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

The medical plan covers:

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

c. 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:

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

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

d. Limitations

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

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence
- Services that are covered under any other benefit under this medical plan
- Services and supplies furnished to a donor when the recipient is not covered under the medical plan
- Home infusion therapy after the transplant occurrence
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness

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

e. Network of Transplant Specialist Facilities

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

(4) Hospice Services

Hospice services are covered as follows:

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

a. Facility Expenses

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

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

b. Outpatient Hospice Expenses

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

- Part-time or intermittent nursing care by a registered nurse or licensed practical nurse for up to eight hours a day
- Part-time or intermittent home health aide services to care for you up to eight hours a day
- Medical social services under the direction of a physician. These include but are not limited to:

        - Assessment of your social, emotional and medical needs, and your home and family situation
        - Identification of available community resources
        - Assistance provided to you to obtain resources to meet your assessed needs.
    - Physical and occupational therapy
    - Consultation or case management services by a physician
    - Medical supplies
    - Prescription drugs
    - Dietary counseling
    - Psychological counseling

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

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

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

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

(5) Experimental or Investigational Treatment

Experimental or investigational treatment is covered as follows:

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

- You have been diagnosed with cancer or you are terminally ill
- Standard therapies have not been effective or are inappropriate
- Aetna determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment
- There is an ongoing clinical trial. You are enrolled in a clinical trial that meets these criteria:
    - The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or group c/treatment IND status
    - The clinical trial has passed independent scientific scrutiny and has been approved by an institutional review board that will oversee the investigation
    - The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food and Drug Administration or the Department of Defense) and conforms to the NCI standards
    - 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.

(6) Medically Necessary Services and Supplies

The medical plan pays only for medically necessary services and supplies. The medical plan will utilize Aetna's current Medical and Pharmacy Clinical Policy Bulletins for purposes of determining medical necessity. You may access Aetna's Clinical Policy Bulletins at:

www.aetna.com/healthcare-professionals/policies-guidelines/clinical_policy_bulletins.html

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

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

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

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

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

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

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

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

(7) Recognized Charge

Note: All uses of the term “usual, customary and reasonable” in the Plan Booklet are deleted and replaced with the term “recognized charge.”

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

- Medical, Vision, and Audio Expenses

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

  - What the provider bills or submits for that service or supply; or
  - the 90th percentile of the prevailing charge rate for the geographic area where the service is furnished as determined by Aetna in accordance with Aetna reimbursement policies.

- Prescription Drug Expenses

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

  - What the provider bills or submits for that service or supply; or
  - 110% of the average wholesale price or other similar resource.

- Dental Expenses

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

  - 100% of the covered expense;
  - 100% of the dentist's accepted filed fee with Delta Dental; or
  - 100% of the dentist's billed charge.

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

- what the dentist bills or submits for that service or supply; or
- 75% of the 80th percentile of the prevailing charge rate as determined by Delta Dental in accordance with its reimbursement policies.

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

- what the dentist bills or submits for that service or supply; or
- the prevailing charge rate as determined by Delta Dental in accordance with its reimbursement policies.

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

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

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

  - What the provider bills or submits for that service or supply; and
  - For professional services: the 80th percentile of the prevailing charge rate; for the geographic area where the service is furnished as determined by Aetna in accordance with Aetna reimbursement policies.

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

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

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

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

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

- Additional Information

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

(8) Dental Services

Dental Services are covered as follows:

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

1. Class I Preventive Services

Covered expenses are paid at 100% of the recognized charge.

a. Diagnostic Services and Limitations

Services:

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

Limitations:

- Periodic (routine) or comprehensive examinations or consultations are covered once in any 6-month period
- Complete series x-rays or a panoramic film is covered once in any 5-year period
- Supplementary bitewing x-rays are covered once in any 12-month period
- Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered
- Only the following x-rays are covered by the DVA plan: complete series or panoramic, periapical, occlusal, and bitewing

b. Preventive Services and Limitations

Services:

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

Limitations:

- Prophylaxis (cleaning) or periodontal maintenance is covered once in any 6-month period. Additional cleaning benefit is available for covered persons with diabetes, covered persons in their third trimester of pregnancy, and covered persons with periodontal disease under the DVA plan's Oral Health, Total Health program (see below, *Oral Health, Total Health Program and Benefits*).

- Topical application of fluoride is covered once in any 6-month period for covered persons age 18 and under. For covered persons age 19 and over, topical application of fluoride is covered once in any 6-month period if there is recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment (poor diet or oral hygiene does not constitute a medical disease).

- Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant per tooth, during any 5-year period.

- Space maintainers are limited to once per space. Space maintainers for primary anterior teeth, missing permanent teeth or for covered persons age 14 or over are not covered.

2. Class II Restorative Services

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

a. Restorative Services and Limitations

Services: Fillings on teeth for the treatment of decay.

Limitations:

- Inlays are considered an optional service; an alternate benefit of a composite filling will be provided.
- Crown buildups are considered to be included in the crown restoration cost. A buildup will be a benefit only if necessary for tooth retention.
- Additional limitations when teeth are restored with crowns or cast restorations are in section 3, *Class III Prosthetic Services.*
- A separate charge for general anesthesia and/or IV sedation when in conjunction with non-surgical procedures is not covered.

b. Oral Surgery Services and Limitations

Services:

- Extractions (including surgical)
- Other minor surgical procedures

Limitations:

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

c. Endodontic Services and Limitations

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

Limitations:

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

d. Periodontic Services and Limitations

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

Limitations:

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

e. Anesthesia Services

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

3. Class III Prosthetic Services

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

a. 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:

- Cast restorations (including pontics) are covered once in a 7-year period on any tooth.

- Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and the covered person is responsible for paying the difference.

b. Prosthodontic Services and Limitations

Services:

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

Limitations:

- A bridge or denture (full or partial denture) will be covered once in a 7-year period and only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the last 7 years.

- Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.

- Partial dentures: A temporary (interim) partial denture is only a benefit when placed within 2 months of the extraction of an anterior tooth or for missing anterior permanent teeth of covered persons age 16 or under. If a specialized or precision device is used, covered expense will be limited to the cost of a standard cast partial denture. No payment is provided for cast restorations for partial denture retainer teeth unless the tooth requires a cast restoration due to decayed or broken teeth.

- Denture adjustments, repairs, and relines: A separate, additional charge for denture adjustments, repairs, and relines done within 6 months after the initial placement is not covered. Subsequent relines will be covered once per denture in a 12-month period. Subsequent adjustments are limited to 2 adjustments per denture in a 12-month period.

- Tissue conditioning is covered no more than twice per denture in a 36-month period.

- Surgical placement and removal of implants are covered. Implant placement and implant removal are limited to once per lifetime per tooth space. The DVA plan will also cover:

    - The final crown and implant abutment over a single implant. This benefit is limited to once per tooth or tooth space over the lifetime of the implant; or

    - Provide an alternate benefit per arch of a full or partial denture for the final implant-supported prosthetic when the implant is placed to support a prosthetic device. The frequency limitation for prosthetic devices will apply to this alternate benefit (once in any 7-year period); or

    - The final implant-supported prosthetic bridge retainer and implant abutment, or pontic. The benefit is limited to once per tooth or tooth space in any 7-year period.

    - Implant-supported prosthetic bridges are not covered if one or more of the retainers is supported by a natural tooth.

- These benefits or alternate benefits are not provided if the tooth, implant, or tooth space received a cast restoration or prosthodontic benefit, including a pontic, within the previous 7 years.

- Fixed bridges or removable cast partial dentures are not covered for covered persons under age 16.

- Porcelain restorations are considered cosmetic if placed on the upper second or third molars or the lower first, second, or third molars. Coverage is limited to a corresponding metallic prosthetic. The covered person is responsible for paying the difference.

c. 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.

4. General Limitation – Optional Services

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

5. Oral Health, Total Health Program and Benefits

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

The following covered persons should consider enrolling this program:

Diabetics

For covered persons with diabetes, elevated blood sugar levels can have a negative effect on oral health. Diabetes increases the risk of cavities, gum disease, tooth loss, dry mouth and infection. Conversely, poor oral health can make diabetes more difficult to manage. Infections may cause blood sugar to rise and require more insulin to keep it under control. Research confirms that regular visits

to the dentist may help in the diagnosis and management of diabetes. Diabetic covered persons are eligible for a total of four cleanings per calendar year.

Pregnant Persons

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

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

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

(9) Appeals

1. If a Claim is Denied

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

a. Initial Claim for Health Plan Benefits

Any claim to receive benefits under the health plan must be filed with the claims administrator within the designated time period on the designated form, and will be deemed filed upon receipt. If you fail to follow the claims procedures under the health plan for filing an urgent care claim or a pre-service claim, you will be notified orally (unless you request written notice) of the proper procedures to follow, not later than 24 hours for urgent care claims and five days for pre-service claims. This special timing rule applies only to urgent care claims and pre-service claims that: (1) are received by the person or unit customarily responsible for handling benefit matters; and (2) specify a claimant, a medical condition or

symptom, and a specific treatment, service, or product for which approval is requested.

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

b. Initial Review of Health Plan Claims

When a claim for health benefits has been properly filed, you will be notified of the approval or denial within the time periods set forth in the chart below. 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.

c. Initial Denial of Health Plan Claims

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

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

meaning, and the treatment code and its corresponding meaning), (B) the denial code and its corresponding meaning, as well as a description of the claims administrator's standard, if any, that was used in the denial of the claim, and (C) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist 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.

d. First Level Appeal of Health Plan Claim Denial

You may initiate a first level of appeal of the denial of a claim by filing a written claim appeal with the claims administrator within the time period set forth in the chart below, which will be deemed filed upon receipt. If the request is not timely, the decision of the claims administrator will be the final decision under the health plan, and will be final, conclusive, and binding on all persons. For urgent care claims, you may make a request for an expedited appeal orally or in writing, and all necessary information will be transmitted by telephone, facsimile, or other similarly expeditious method.

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

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

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

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

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

The decision on review will be final, conclusive and binding on all persons.

f. 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 under of 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 chart below, before the reduction or termination occurs, to allow you a reasonable time to file an appeal and obtain a determination on the appeal. With respect to appeals for benefits under the medical plan, coverage for the ongoing course of treatment that is the subject of the appeal will continue pending the outcome of such appeal.

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

2. Chart of Time Limits for Health Benefit Claims

	MAXIMUM TIME LIMITS FOR:							
TYPE OF CLAIM	**Claims administrator to decide initial claim (if no additional information is needed) (whether adverse or not)**	**Extension of time by Plan for determining initial claim**	**Claims administrator to notify claimant of information needed from claimant to decide initial claim, if not provided by claimant**	**Claims administrator to notify claimant of claimant's failure to follow proper procedures**	**Claimant to then provide needed information (if extension allowed by Plan)**	**Claims administrator to decide claim after requesting additional information and notifying claimant (if applicable)**	**Claimant to file appeal**	**Claims administrator to decide appeal**
Urgent Care Claims	For claims for **medical plan** benefits, no later than 72 hours after receipt of the claim by the **claims administrator**	None	No later than 24 hours after receipt of incomplete claim by **claims administrator**	No later than 24 hours after receipt of improper claim by **claims administrator**	Not less than 48 hours after receipt of notice from **claims administrator**	No later than 48 hours after earlier of (i) **claims administrator's** receipt of additional information from claimant, or (ii) end of time period given to claimant to provide additional information (48 hours)	180 days after receipt of **denial** by claimant	All **appeals** must be decided within 72 hours after **claim**s **administrator's** receipt of **appeal** from claimant

	MAXIMUM TIME LIMITS FOR:							
TYPE OF CLAIM	**Claims administrator to decide initial claim (if no additional information is needed) (whether adverse or not)**	**Extension of time by Plan for determining initial claim**	**Claims administrator to notify claimant of information needed from claimant to decide initial claim, if not provided by claimant**	**Claims administrator to notify claimant of claimant's failure to follow proper procedures**	**Claimant to then provide needed information (if extension allowed by Plan)**	**Claims administrator to decide claim after requesting additional information and notifying claimant (if applicable)**	**Claimant to file appeal**	**Claims administrator to decide appeal**
Pre-Service Claims	No later than 15 days after receipt of **claim** by the **claims administrator**	One time 15-day extension allowed if (i) due to matters beyond **claims administrator's** control and (ii) **claims administrator** notifies claimant before end of initial 15-day time period of the circumstances requiring such extension and the date claims administrator expects to render decision. If extension is due to claimant's failure to submit information, notice will describe required information. ***Note:*** **Claims administrator** may or may not allow extension due to claimant's failure to provide needed information.	N/A	No later than 5 days after receipt of improper claim by **claims administrator**	At least 45 days after receipt of notice from **claims administrator.** ***Note***: **Claims administrator** may or may not request needed information from claimant.	No later than 15 days after earlier of (i) **claims administrator 's** receipt of additional information from claimant, if requested, or (ii) end of time period given to claimant to provide additional information (45 days)	180 days after receipt of **denial** by claimant	30 days after **claims administrator's** receipt of **appeal** from claimant
Post-Service Claims	No later than 30 days after receipt of **claim** by the **claims administrator**	One time 15-day extension allowed if (i) due to matters beyond **claims administrator's** control and (ii) **claims administrator** notifies claimant before end of initial 30-day time period of the circumstances requiring such extension and the date claims administrator expects to render decision. If extension is due to claimant's failure to submit information, notice will describe required information. ***Note:*** **Claims administrator** may or may not allow extension due to claimant's failure to provide needed information.	N/A	N/A	At least 45 days after receipt of notice from **claims administrator**. ***Note:*** **Claims administrator** may or may not request needed information from claimant.	No later than 15 days after earlier of (i) **claims administrator 's** receipt of additional information from claimant, if requested, or (ii) end of time period given to claimant to provide additional information (45 days)	180 days after receipt of **denial** by claimant	60 days after **claims administrator's** receipt of **appeal** from claimant

3. 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, you may apply for external review as provided below. Upon receipt of a denial with respect to benefits under the medical plan that is not a final denial, you only apply for external review as provided below regarding expedited external review for urgent care claims.

A final denial with respect to benefits under the medical plan that involves medical judgment (including, but not limited to, those based on the medical plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational; and

A rescission of coverage under the medical plan (whether or not the rescission has any effect on any particular benefit at that time).

4. Standard External Review Process for Claims for Benefits under the Medical Plan**

a. Timing of Request for External Review. You must file a request for external review of a benefit claim under the medical 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, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

b. Preliminary Review. The claims administrator shall 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 medical 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 internal claims; and (D) you have provided all the information and forms required to process an external review. The claims administrator shall issue a notification to the claimant within one business day of completing the preliminary review. If the request is complete, but ineligible for external review, the notification shall include the reasons for its ineligibility. If the request is not complete, the notification shall describe the information or materials needed to make the request complete, and you will be allowed to perfect the request for external review by the later of the

four month filing period described above, or within the 48 hour period following the receipt of the notification.

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

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

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

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

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

you, or your physician; (iv) the terms of the applicable medical plan to ensure that the IRO's decision is not contrary to the terms of the medical plan, unless the terms are inconsistent with applicable law; (v) 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; (vi) any applicable clinical review criteria developed and used by the medical plan, unless the criteria are inconsistent with the terms of the medical plan or with applicable law; and (vii) the opinion of the IRO's clinical reviewer(s) after considering the information described in this paragraph to the extent the information or documents are available and the clinical reviewer(s) consider appropriate.

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

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

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

5. Expedited External Review Process for Medical Plan

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

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

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

b. Preliminary Review. Immediately upon receipt of a request for expedited external review, the claims administrator must determine whether the request meets the reviewability requirements set forth above. The claims administrator shall immediately send a notice that meets the requirements set forth for standard external review of you for its eligibility determination.

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

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

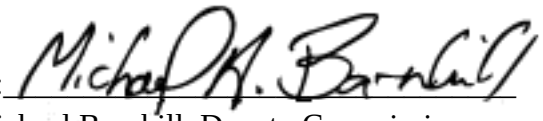
Section 3: Conflict

In the event of a conflict between the language contained in this Amendment and previously adopted language contained in the Plan, the provisions of this Amendment shall control.

Section 4: Effective Date

This amendment is effective for claims submitted for payment with dates of service on or after January 1, 2014.

Adopted this 31st day of December, 2013.

By: 
Michael Barnhill, Deputy Commissioner