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 dental 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 **dental plan's** Oral Health, Total Health program (see section 4.4, *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.

4.3.2. Class II Restorative Services

Covered expenses are paid at 80% of the **recognized charge** for the standard plan and 10% of the **recognized charge** for the preventive plan.

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 4.3.3, *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 for 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 a covered surgical procedures performed in a dental office).
- General anesthesia or IV sedation when necessary due to concurrent medical conditions.

4.3.3. Class III Prosthetic Services

Covered expenses are paid at 50% of the **recognized charge** for the standard plan and 10% of the **recognized charge** for the preventive plan.

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 seven 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 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.

- 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 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.

- 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.

- 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 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.

- 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.

4.3.4. 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.

4.4. 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 4.3, *Covered Dental Services*.

The following **covered persons** should consider enrolling in 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.

4.5. ORTHODONTIC BENEFITS AND LIMITS

Orthodontic services are defined as the procedures of treatment for correcting malocclusioned teeth.

The standard plan will pay 50% of the **recognized charge** for orthodontic services, up to the orthodontic lifetime maximum. See section 2.2, *Dental Benefit Schedule*. This lifetime maximum is not included in the **dental plan's** annual individual maximum. The **deductible** does not apply to orthodontic services.

The **dental plan's** obligation to make payments for treatment will end when treatment stops for any reason prior to completion, or upon termination of eligibility or of the **dental plan**.

If treatment began before the **covered person** was eligible under the **dental plan**, payment will be based on the balance of the dentist's normal payment pattern. The orthodontic lifetime maximum will apply to this amount.

Repair or replacement of an appliance furnished under the **dental plan** is not covered.

4.6. DENTAL PLAN EXCLUSIONS

In addition to the limitations and exclusions described elsewhere in the **dental plan**, the following services, procedures and conditions are not covered, even if otherwise **dentally**

necessary, if they relate to a condition that is otherwise covered by the **dental plan**, or if recommended, referred, or provided by a **dentist** or **dental care provider**.

1. Services covered under the **medical plan**.

2. General anesthesia and/or IV sedation, except as stated in section 4.3, *Covered Dental Services*.

3. Anesthetics, analgesics, hypnosis, and medications, including nitrous oxide, local anesthetics or any other prescribed drugs.

4. Services or supplies not specifically described in the dental plan as covered dental services.

5. Claims submitted more than 12 months after the date of service.

6. Congenital or developmental malformations, including, but not limited to treatment of cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia, and fluorosis (discoloration of teeth).

7. **Cosmetic** services.

8. **Experimental or investigational** procedures, including expenses incidental to or incurred as a direct consequence of such procedures.

9. Facility fees, including additional fees charged by the dentist for hospital, extended care facility or home care treatment.

10. Gnathologic recordings.

11. 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.

12. Instructions or training, including plaque control and oral hygiene or dietary instruction.

13. Localized delivery of antimicrobial agents.

14. Missed appointment charges.

15. Services and supplies related to never events, which are events that should never happen while receiving services in a dental office, including but not limited to removing a non-diseased tooth structure or performing a procedure on the wrong patient or wrong tooth.

16. Periodontal charting.

17. Precision attachments.

18. Rebuilding or maintaining chewing surface and stabilizing teeth, including services only to prevent wear or protect worn or cracked teeth. Such services include increasing vertical dimension, equilibration, periodontal splinting, and nightguards (occlusal guard).

19. Services on tongue, lip or cheek.

20. Services otherwise available, including:

- Those compensable under workers' compensation or employer's liability laws.
- Those provided by any city, county, state or Federal law, except for Medicaid coverage.
- Those provided, without cost to the **covered person**, by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under the **dental plan**.
- Any condition, disease, ailment, **injury** or diagnostic service to the extent that benefits are provided or would have been provided had the **covered person** enrolled, applied or maintained eligibility for such benefits under Title XVIII of the Social Security Act, as amended.
- Those provided under separate contracts that are used to provide coordinated coverage for **covered persons** and are considered parts of the same plan.

21. Services provided by a relative, which includes a **covered person**, a **spouse**, **same-sex partner**, child, sibling, or parent of a **covered person** or his or her **spouse** or **same-sex partner**.

22. Services and supplies for treatment of **illness** or **injury** for which a third party is or may be responsible to the extent of any recovery received from or on behalf of the third party. Includes benefits payable under any automobile medical, personal injury protection (PIP), automobile no fault, underinsured or uninsured, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to, or makes benefits available to, a **covered person**, whether or not such benefits are requested. See section 11, *Subrogation and Reimbursement Rights*.

23. Treatment of any disturbance of the temporomandibular joint (TMJ).

24. Treatment after coverage terminates, except for Class III services that were ordered and fitted while still eligible, and then only if such items are cemented

within 31 days after a **covered person's** eligibility ends. This provision is not applicable if the **Division** transfers the **dental plan** to another **claims administrator**.

25. Treatment before coverage begins under the **dental plan**.

26. Treatment that is not **dentally necessary**, including services not established as necessary for the treatment or prevention of a dental **injury** or disease otherwise covered under the **dental plan**; that are inappropriate with regard to standards of good dental practice; with poor prognosis.

4.7. 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 **Delta Dental**. **Delta Dental** 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, **Delta Dental**, at its expense, has the right to require you to obtain an oral examination. You must furnish to **Delta Dental** all diagnostic and evaluative material required to establish your right to benefits. Evaluative material includes dental X-rays, models, charts, and written reports.

5. *Vision Plan*

5.1. INTRODUCTION

The **vision plan** will pay for covered expenses up to the limits and maximums shown in section 2.3, *Vision Benefit Schedule.*

5.2. HOW VISION BENEFITS ARE PAID

5.2.1. Deductible

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

5.2.2. Copayment

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

5.2.3. Coinsurance

The **vision plan** pays 100% of the **recognized charges** for covered vision and optical services, less any applicable **copayment**.

5.2.4. Annual Allowances

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

5.2.5. 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, *Vision Benefit Schedule*. **VSP doctors** are located in retail, neighborhood, medical and professional settings, and include Costco Optical, Visionworks, Cohen's Fashion Optical, Wisconsin Vision, and RX Optical. You have the freedom to choose any **provider**, national retailer, or local retail chain.

For a list of **VSP doctors**, call **VSP** at the number listed in the front of this **plan** or visit www.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.

5.3. COVERED VISION SERVICES

The following services and supplies are covered under the **vision plan**.

5.3.1. 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. Subsequent regular eye examinations are covered once every calendar year.

5.3.2. Vision Supplies

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

- **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 with a **VSP doctor** at no additional cost to the **covered person**:

  - Progressive lenses
  - Anti-reflective coating
  - Scratch resistant coating
  - Polycarbonate lenses

- **Frames**

  Covered expenses include a frame every two calendar years up to the allowance set forth in section 2.3, *Vision Benefit Schedule*. 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 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**.

- **Additional Services**

  The following professional services are included in lens and frame coverage:

  - Prescribing and ordering proper lenses
  - Assisting in the selection of frames
  - Verifying the accuracy of the finished lenses
  - Proper fitting and adjustment of frames
  - Subsequent adjustments to frames to maintain comfort and efficiency
  - Progress or follow-up work as necessary

- **Contact Lenses**

  Elective contact lenses are available once every calendar year 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 necessary contact lenses.

- **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. The low vision benefit is subject to the maximums set forth in section 2.3, *Vision Benefit Schedule*.

5.4. VISION PLAN EXCLUSIONS

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:

- Optional **cosmetic** processes
- Color coating
- Mirror coating

- Blended lenses
- Cosmetic lenses
- Laminated lenses
- Oversized lenses
- UV (ultraviolet) protected lenses
- Certain limitations on low vision care
- A frame that costs more than the **vision plan** allowance
- Contact lenses, except as provided in section 5.3, *Covered Vision Services*.

The following services, procedures and conditions are not covered under the **vision plan**, even if they relate to a condition that is otherwise covered by the **vision plan** or if recommended, referred or provided by a **VSP doctor**.

1. 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.

2. Replacement of lenses and frames furnished under the **vision plan** which are lost or broken, except at the normal intervals when services are otherwise available.

3. Medical or surgical treatment of the eyes.

4. Corrective vision treatment that is **experimental or investigational**.

5. Costs for services and/or materials above the **vision plan** allowance.

6. Services and/or materials not listed as covered services in section 5.3, *Covered Vision Services*.

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**.

6. *Health Flexible Spending Account (HFSA)*

6.1. INTRODUCTION

The **health plan** is designed to cover most, but not all, of your health expenses. You can elect to reduce your salary on a pre-tax basis by a specified amount and contribute that money to a health flexible spending account (HFSA) to reimburse some of your unpaid medical expenses. Since your contributions are not subject to federal or state taxes, you pay less in taxes each year.

6.2. HOW THE HFSA WORKS

The health flexible spending account (HFSA) works similar to a personal checking account, except that accounts are maintained for bookkeeping purposes only, with no interest or earnings credited.

Coverage begins and ends as specified in section 1.7, *When Coverage Begins,* and section 1.9, *When Coverage Ends*. You decide how much you want to contribute to the HFSA each month, up to a maximum of $208 per month. Your contribution must be:

- in whole dollars;
- at least $20 per month ($240 per **benefit year**); and
- no more than $208 per month ($2,496 per **benefit year**).

The amount of contribution you elect will be deducted from your paycheck in equal amounts throughout the **benefit year**. Federal income taxes are not withheld on the amount you contribute. If you are on leave without pay or do not have enough payroll in a month, a contribution will not be taken that month.

Your contributions are deposited into your individual reimbursement account under the HFSA. Throughout the **benefit year**, you may request reimbursement from the HFSA for eligible medical expenses you have incurred. You will be reimbursed up to the amount that you elected for your annual contribution or the amount of the claim, whichever is less.

For example, if you timely elect to make monthly contributions of $100 to the HFSA, your annual contribution election is $1,200. By March, you have contributed $300 to your account. In April, you incur a $500 expense that is not covered by the **medical plan**. If you are covered by the HFSA in April, you will be reimbursed $500 for that expense, even though you have not yet contributed sufficient money to cover the request. During the rest of the **benefit year**, you can be reimbursed for additional expenses up to $700 ($1,200 - $500).

If you drop coverage under the HFSA during a **benefit year**, you will be entitled to reimbursements from your HFSA for eligible medical expenses that were incurred during the **benefit year** but before your coverage under the HFSA ended, subject to COBRA continuation coverage. In addition, you will not be entitled to reimbursement of eligible medical expenses for any **dependent** after the person is no longer a **dependent**.

6.3. USE IT OR LOSE IT

In exchange for the tax advantages of using the health flexible spending account (HFSA), the Internal Revenue Service (IRS) requires that you forfeit any money remaining in your reimbursement account after all eligible medical expenses for the **benefit year** have been reimbursed. You must request reimbursement for expenses incurred during the **benefit year** no later than 90 days following the end of the **benefit year** (by March 31). Because of this use it or lose it rule, it is important that you plan carefully when you participate in the HFSA.

6.4. ELIGIBLE MEDICAL EXPENSES

Eligible medical expenses are health, dental and vision expenses as defined under Code Section 213(d) that are not otherwise reimbursable by the **plan** or any other health plan. In addition, expenses reimbursed out of your HFSA must be expenses incurred by you, your **spouse**, your **dependent children**, and any other **dependent** you claim on your income tax return each year. **PayFlex** will make the final determination as to whether an expense may be reimbursed from the HFSA.

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

Examples of eligible medical expenses include:

- **custodial care** expenses
- hearing aids
- **deductibles**
- **copayments**
- **coinsurance**
- amounts in excess of the maximums allowed by the **medical plan**, **dental plan**, or **vision plan**
- insulin (whether or not prescribed)

- **prescription drugs**
- over-the-counter drugs, but only if you have a **prescription**

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

- certain **cosmetic** surgery and procedures
- premiums for the **health plan**, **dental plan**, **vision plan** or other health care coverage
- travel expenses
- fees for health club
- vitamins
- qualified long-term care services

6.5. HFSA VS. TAX DEDUCTIONS

If you use the health flexible spending account (HFSA) to pay for eligible medical expenses, you cannot take a tax deduction on your income tax for the same medical expenses. You are allowed a deduction on your tax return for expenses that total more than 7.5% of your adjusted gross income. You must choose which is more advantageous for you. Since tax laws are complicated and subject to change, you should re-examine your tax situation every year, and discuss it with your tax specialist.

6.6. HOW MUCH TO CONTRIBUTE

The health flexible spending account (HFSA) can save you money if you budget your expenses carefully. Keep in mind that you must forfeit any money remaining in your reimbursement account at the end of the **benefit year** after all eligible medical expenses have been paid. Most **employees** find, however, that they can avoid the risk of forfeiture by planning ahead.

When considering how much to contribute, remember your annual contribution will be deducted from your paycheck over the entire **benefit year**, not just for a few months at a time. For example, if you expect to incur $600 in eligible medical expenses, you could contribute $50 per month ($600 for the **benefit year** or 12 x $50). Information that might be helpful for you to consider in determining how much to contribute to your HFSA includes:

- What expenses you may have that are not covered by the **plan** but are reimbursable from the HFSA;

- How much your **deductibles** are expected to be for the **benefit year;**
- An estimate of the total out-of-pocket costs you could pay under the **plan**;
- An estimate of what your **coinsurance** and **copayments** will total; and
- How much you paid for health care costs during the last **benefit year**. For example, if your out-of-pocket health care costs were $500 during the last **benefit year**, they may run close to that this year.

Remember, the law requires that what you do not use by the end of the **benefit year**, you lose.

6.7. 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 *EOB* showing your out-of-pocket costs.

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

- *Streamlined claims submission* – With this option, claims are sent to the **claims administrator** by you or your **provider** as normal. Any amounts that are unpaid by the **plan**, such as **deductibles**, **copayments**, or non-**covered medical expenses**, are electronically transferred to **PayFlex**. You cannot elect this option if you have any health coverage in addition to the **plan.** This includes a second **State** plan (such as coverage through your **spouse**) or any other health insurance plan. For example, a husband and wife who are covered by each other's health plans may not elect streamlined claims submission.
- *Direct claims submission* – With this option, you submit your claims to **PayFlex** 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 from your human resources office, the **Division**, **PayFlex**, or www.AlaskaCare.gov. If you have more than one health plan, you must submit the claim with copies of the *EOB* from all plans. This is the only option available if you have more than one health plan.
- *Over-the-counter (OTC) claims submission*— With this option, you submit claims to **PayFlex** on the *HFSA OTC Claims* form regardless of whether you have elected streamlined or direct 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**. Claims for services incurred during the **benefit year** will be accepted any time during

that year. You have 90 days after the end of the **benefit year** (generally until March 31) to file all unpaid claims for that **benefit year**.

7. *How To File A Claim*

7.1. REQUIRED CLAIM FORM SUBMISSION

You must submit a signed **State** claim form each **benefit year** for you, your **spouse** or **same-sex partner**, and your **dependent children** to the **Division**. Failure to submit a completed claim form when you submit your first claim for you, your **spouse** or **same-sex partner**, or your **dependent children** may result in benefits for your expenses being held until the form is received. You must complete the *Patient Information* section of the claim form, including the section pertaining to other group medical coverage, in its entirety. This requirement applies regardless of whether a **provider** submits billing directly to the **claims administrator** on your behalf. Any claims submitted directly by a **provider** will be pended until the **Division** receives a completed **State** claim form.

You may obtain claims forms from your human resources office, the **claims administrator**, the **Division**, or www.AlaskaCare.gov.

7.2. 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.

7.3. 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 **Aetna** directly. **Aetna** will send you an *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, **Aetna** will send the benefits check to you, along with the *EOB* form.

7.4. PHYSICIAN AND OTHER PROVIDER SERVICES

The fastest way to process bills is to ask your **provider** to bill **Aetna** directly on a medical claim form. The claim forms are available from your human resources office, the **Division**, **Aetna**, or www.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.

The itemized bill must include:

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

7.5. DENTAL SERVICES

You can get a *Dental Benefits Claim* form from your **provide**r, your human resources office, the **Division**, **Delta Dental**, or www.AlaskaCare.gov. Follow the instructions under section 7.4, *Physician and Other Provider Services*, for completing the form.

7.6. VISION SERVICES

You can get a *Vision Benefits Claim* form from your **provider**, your human resources office, the **Division**, **VSP**, or www.vsp.com/. Follow the instructions under section 7.4, *Physician and Other Provider Services*, for completing the form.

7.7. 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 **Aetna**. You can get these forms from your human resources office, the **Division**, **Aetna**, or www.AlaskaCare.gov.

The receipt must include the:

- Patient's name
- Date of purchase
- Prescription number
- Itemized purchase price for each drug

- Quantity
- Name of drug
- 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 **Aetna**, your claim will be held pending your submission of receipts.

7.8. MEDICAL BENEFITS

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

- Nursing care. If you need special nursing services at home or in the **hospital**, your claim must include the date, hours worked and the name of the referring **physician**.
- Blood and blood derivatives. You are encouraged to replace blood or blood derivatives that you use. If you do not, you must get a bill from the blood bank which includes the date of service, location where the blood was transported, and the total charge.
- Appliances (braces, crutches, wheelchairs, etc.). The bill must include a description of the item, indicate whether it was purchased or rented, list the name of the **physician** who prescribed the item, and show the total charge.
- **Ambulance**. The bill must include the date of the service, where you were transported to and from, and the total charge.

7.9. OTHER CLAIM FILING TIPS

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

If you have other health coverage in addition to the **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 10, *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 identification card or *EOB* available. Include your participant account number from your identification

card on any letter you write. The **claims administrator** needs this information to identify your particular coverage.

7.10. 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*.

7.11. BEFORE FILING A CLAIM

When you file a claim:

- Submit your bills with a claim form for each family member.
- Always check to make sure your **physician** or **dentist** has not already submitted your claim. If you give the **physician** 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 **plan**, include a copy of that plan's explanation of benefits showing the amount it paid for the services.

7.12. RECORDKEEPING

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

- Names of **physician**s and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

You should also keep all *EOBs* sent to you.

7.13. 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.

7.14. TIME FRAMES FOR PROCESSING CLAIMS

An *EOB* will be issued to you within 30 days after the **claims administrator** receives your claim. If the **claims administrator** needs additional time to process your claim, the **claims administrator** will send a notice of delay to you explaining the reasons within 30 days of receiving the claim, and will complete its processing and send the *EOB* no more than 45 days after receiving the claim. If additional information is needed to complete the processing of a claim, the notice of delay will describe the additional information needed and the party responsible for providing the additional information will have 45 days to submit it. Once the additional information is received, processing of the claim will be completed within 15 days.

7.15. IF A CLAIM IS DENIED

If a claim or **precertification** is denied, in whole or in part, your *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 **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 **plan**, you can take the following steps to file an **appeal**.

7.15.1. Initial Claim for Plan Benefits

Any claim to receive benefits under the **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 **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 **plan** will be followed in resolving any such dispute.

7.15.2. Initial Review of Plan Claims

When a claim for health benefits has been properly filed, you will be notified of the approval or **denial** within the time period set forth in section 7.15.9, *Chart of Time Limits for Plan 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.

7.15.3. Initial Denial of Plan Claims

If any claim for **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 **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** and **dental 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.
- 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.

7.15.4. First Level Appeal of 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 section 7.15.9, *Chart of Time Limits for Plan Claims*, 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 **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.

7.15.5. Decision on First Level of Appeal of Plan Claim Denial

You will receive notice of the **claims administrator's** decision on the first level of **appeal** within the time period set forth in section 7.15.9, *Chart of Time Limits for Plan Claims*. If the claim for benefits under the **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** and **dental 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:

- 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

- 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 **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 **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** and **dental 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** and **dental 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.

- For **denials** of benefits under the **medical plan** and **dental 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, except as provided in section 7.15.6, *Second Level Appeal of Plan Claim Denial*.

7.15.6. Second Level Appeal of Plan Claim Denial

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 7.15.10, *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 claim **appeal** with the

claims administrator within the time period set forth in section 7.15.9, *Chart of Time Limits for Plan Claims*, which will be deemed filed upon receipt. If you do not file a timely second level of **appeal** with respect to a claim that is eligible for a second level of **appeal**, the decision on the first level of **appeal** will be final, conclusive, and binding on all persons.

7.15.7. Decision on Second Level of Appeal of Plan Claim Denial

The **claims administrator** will provide you with notice of its decision on the second level of **appeal** within the time period set forth in section 7.15.9, *Chart of Time Limits for Plan Claims*. 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 7.15.5, *Decision on First Level of Appeal of Plan Claim Denial*. The decision on the second level of **appeal** will be final, conclusive and binding on all persons.

7.15.8. 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** within the time period set forth in section 7.15.9, *Chart of Time Limits for Plan Claims*, before the reduction or termination occurs, to allow you a reasonable time to file an **appeal** and obtain a determination on the **appeal**. With respect to **appeals** for benefits under the **medical plan** and **dental 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.

7.15.9. Chart of Time Limits for Plan 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 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 **denia**l by claimant.	One level **appeal**: 30 days after **claims administrator's** receipt of **appeal** from claimant. Two level **appea**l: *First level* - 15 days after **claims administrator's** receipt of claimant's first level **appeal** request. *Second level* – 15 days after **claims administrator's** receipt of claimant's second level **appeal** request.

	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**
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.	One level **appeal**: 60 days after **claims administrator's** receipt of **appeal** from claimant. Two level **appeal**: *First level* - 30 days after **claims administrator's** receipt of claimant's first level **appeal** request. *Second level* – 30 days after **claims administrator's** receipt of claimant's second level **appeal** request.

7.15.10. Application and Scope of External Review Process for Benefits Under the Medical Plan and Dental 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 only apply for external review as provided below regarding expedited external review for **urgent care claims**.

The external review process will apply only to:

- a **final denial** with respect to benefits under the **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

- 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).

7.15.11. Standard External Review Process for Claims for Benefits under the Medical Plan and Dental Plan

a. 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, 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** will complete a preliminary review of the request for external review within five business days to determine whether:

- 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;

- the type of claim is eligible for external review;

- you have exhausted (or are deemed to have exhausted) the **medical plan's** or **dental plan's** internal claims and appeals process; and

- 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.

c. 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:

- 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** 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.

- 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.

- Review all information and documents timely received under a *de novo* standard. 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.

d. 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 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**);

- the date the IRO received the assignment to conduct external review and the date of the decision;

- references to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching the decision;

- 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;

- 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;

- a statement that judicial review may be available to you; and

- 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** 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.

f. 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.

7.15.12. Expedited External Review Process for Medical Plan or Dental Plan

a. 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 **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** 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.

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** will 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** 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* 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 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**.

7.16. CLAIMS PROCEDURES APPLICABLE TO ALL CLAIMS

7.16.1. 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.

7.16.2. 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 (at least 45 days).

7.16.3. 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 **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.

7.16.4. Exhaustion of Remedies

If you fail to file a request for review of a **denial**, in whole or in part, of benefits in accordance with the procedures herein outlined, you will have no right to review and no right to bring action, at law or in equity, in any 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** and **dental plan**, except as provided below, if the **claims administrator** fails to strictly adhere to all the requirements with respect to a claim under section 7.15, *If a Claim Is Denied*, and section 7.16, *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 7.15, *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 **medical plan** or **dental 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 sections 7.15, *If a Claim Is Denied*, and section 7.16, *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** or **dental 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** or **dental plan** claim. Time periods for re-filing the **medical plan** or **dental plan** claim will begin to run upon your receipt of such notice.

8. *Consolidated Omnibus Budget Reconciliation Act (COBRA) and Extended Health Coverage*

8.1. INTRODUCTION

If you and/or your **dependents** lose coverage due to a qualifying event, you and/or your **dependents** may continue coverage under the **plan** by electing COBRA coverage and paying the required premium as described in this section.

You may elect coverage under the **plan** that is the same or less than the level of coverage that you or your **dependents** had at the time your coverage terminates under the **plan**. For example, if you are covered under the **medical plan** and have elected the standard plan, you may elect COBRA continuation coverage under either the standard plan or the economy plan, but not the premium plan. Additionally, you may elect COBRA continuation coverage:

- under the **medical plan** only; or
- under the **medical plan** and under the **dental plan** and/or the **vision plan**.

You may not elect COBRA continuation coverage under the **dental plan** or the **vision plan** without also electing COBRA continuation coverage under the **medical plan**.

8.2. RIGHT TO CONTINUATION COVERAGE

If you are a qualified beneficiary, you may elect to continue coverage under the **plan** after a qualifying event. Only those persons who are covered under the **plan** on the day before the event which triggered termination of coverage are eligible to elect COBRA continuation coverage, except that **dependent children** born to or placed for adoption with you while you are on continuation coverage may be added to your coverage if the **child** is otherwise eligible under the **plan**.

A qualified beneficiary is a person who is covered under the **plan** on the day before a qualifying event (but also including **dependent children** born to or placed for adoption with you during the continuation coverage) who is:

- an **eligible employee**;
- a **spouse** or **same-sex partner**; or
- 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 **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:

- Your death.
- The termination (other than by reason of gross misconduct) of your employment or reduction of your hours that would result in a termination of coverage under the **plan**.
- Your divorce or legal separation from your **spouse** or dissolution of your same-sex partnership with your **same-sex partner.**
- Your becoming entitled to Medicare benefits under Title XVIII of the Social Security Act (42 USC § 1395-1395ggg).
- Your child ceasing to be a **dependent child** under the eligibility requirements of the **plan**.

If a qualifying event occurs to a qualified beneficiary, then that qualified beneficiary may elect to continue coverage under the **medical plan**, **dental plan** and/or **vision plan**.

8.3. 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 **plan** due to the qualifying event, and ends on or before the date that is 60 days after the later of:

- the date the qualified beneficiary would lose coverage due to the qualifying event; or
- the date on which notice of the right to continued coverage is sent by **PayFlex**.

The election of continuation coverage must be made on a form provided by **PayFlex** 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 **PayFlex**.

8.4. PERIOD OF CONTINUATION COVERAGE

8.4.1. Termination of Employment or Reduction in Hours

In the case of a qualifying event caused by termination of employment or reduction in hours, the qualified beneficiary may elect to extend coverage for a period of up to 18 months from the date of the qualifying event.

8.4.2. Second Qualifying Event

If a second or additional qualifying event occurs during the initial 18 month continuation coverage period (or during a 29 month maximum coverage period in the case of a disability), the qualified beneficiary may elect to extend the continuation coverage period for a period of up to 36 months from the date of the earlier qualifying event.

If you became entitled to Medicare within 18 months prior to a qualifying event caused by termination of employment or reduction in hours, qualified beneficiaries (other than you) may elect to extend coverage for a period of 36 months from the date of your entitlement to Medicare benefits.

8.4.3. Disability

If a qualified beneficiary is determined under Title II or XVI of the Social Security Act to be disabled within 60 days of the initial continuation coverage period due to termination of employment or reduction of hours (even if the disability commenced or was determined to be a disability before the first 60 days of the initial 18 month continuation coverage period), coverage may be continued for all qualified beneficiaries for a period of up to 29 months from the date of the qualifying event.

You must provide notice of a disability determination to **PayFlex** within 18 months of the qualifying event and within 60 days after the latest of:

- the date of the disability determination by the Social Security Administration;
- the date the qualifying event occurs;
- the date you lose or would lose coverage due to the qualifying event; or
- the date on which you are informed, via the **plan** or the general COBRA notice, of your obligation to provide such notice and procedures for providing such notice.

You are also responsible for notifying the **Division** within 30 days of the later of:

- the date of the final determination by the Social Security Administration that you are no longer disabled; or
- on the date which you are informed, via the **plan** or the general COBRA notice, of your obligation to provide such notice and procedures for providing such notice.

8.4.4. Other Qualifying Events

In the case of any qualifying event not otherwise described above, the qualified beneficiary may elect to extend coverage for a period of up to 36 months from the date of the qualifying event.

8.4.5. Health Flexible Spending Account (HFSA)

Notwithstanding the above, continuation coverage under the health flexible spending account (HFSA) will extend only until the end of the **benefit year** in which the qualifying event occurs.

8.5. END OF CONTINUATION COVERAGE

Continuation coverage will end upon the dates of the following occurrences, even if earlier than the periods specified under section 8.4, *Period of Continuation Coverage*.

- Timely payment of premiums for the continuation coverage is not made (including any grace periods).
- You first become 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).
- You first become entitled to benefits under Medicare, after the date on which continuation coverage is elected.
- The **State** ceases to provide any group health plan to any **employee**.
- You cease to be disabled, if continuation coverage is due to the disability.

Notwithstanding the foregoing, the **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)**.

8.6. COST OF CONTINUATION COVERAGE

You are 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 premium cost for such coverage (or 150% for any extended period of coverage due to disability). After a qualifying event, **PayFlex** will provide a notice with 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. **PayFlex** 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.

8.7. NOTIFICATION REQUIREMENTS

8.7.1. General Notice to Covered Eligible Employee and Spouse/Same-Sex Partner

The **plan** will provide, at the time of commencement of coverage, written notice to you and your **spouse** or **same-sex partner** of your rights to continuation coverage. This general notice will be provided no later than the earlier of:

- 90 days after your coverage commencement date under the **plan**; or
- the date on which the **Division** is required to furnish a COBRA election notice.

8.7.2. Employer Notice to Division

Your employer will notify the **Division** in the event of your death, termination of employment (other than gross misconduct), reduction in hours, layoff, or entitlement to Medicare benefits within 30 days after the date of the qualifying event.

8.7.3. Covered Eligible Employee/Qualified Beneficiary Notice to Administrator

You must notify the **Division** of:

- your divorce or legal separation from your **spouse** or dissolution of same-sex partnership from your **same-sex partner**;
- a **child** ceasing to be a **dependent child** under the eligibility requirements of the **plan**;
- a second qualifying event; or
- notice of disability entitlement or cessation of disability.

You must give notice as soon as possible, but no later than 60 days after the later of:

- the date of such qualifying event;
- the date that you lose or would lose coverage due to such qualifying event; or
- the date on which you are informed, via the **plan** or the general COBRA notice, of your obligation to provide such notice and the plan procedures for providing such notice.

See section 8.3, *Election of Continuation Coverage*, for timing of notices applicable to disability determinations.

You or another qualified beneficiary, or a representative acting on behalf of you or another qualified beneficiary, may provide this notice. The provisions 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 your loss of any right to elect continuation coverage.

8.7.4. Division's Notice to Qualified Beneficiary

Upon receipt of a notice of qualifying event, **PayFlex** will provide to each qualified beneficiary notice of their right to elect continuation coverage, no later than 14 days after the date on which **PayFlex** 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.

8.7.5. Unavailability of Coverage

If **PayFlex** receives a notice of a qualifying event or disability determination and determines that the person is not entitled to continuation coverage, **PayFlex** will notify the person with an explanation as to why such coverage is not available.

8.7.6. Notice of Termination of Coverage

PayFlex 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 **PayFlex's** determination that continuation coverage should terminate.

8.7.7. Use of a Single Notice

Required notices must be provided to each qualified beneficiary or individual; however:

- a single notice can be provided to you and your **spouse** or **same-sex partner** if you both reside at your address; and
- 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**.

8.8. 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 **plan** with respect to whom a qualifying event has not occurred. If coverage is modified under the **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 **plan**. Continuation coverage will not be conditioned on evidence of good health.

You may change your elections during open enrollment for the **plan**.

8.9. BANKRUPTCY PROCEEDINGS

Special continuation coverage provisions apply in the event of bankruptcy of the **State**. Notwithstanding any of the preceding sections, in the event of a bankruptcy proceeding under Title XI of the United States Code, where a loss of coverage or substantial elimination of your coverage occurs on or before the date of the loss or substantial elimination of coverage and any other individual who, on the day before the bankruptcy proceeding, is a beneficiary (under the **plan** as a **spouse**, **same-sex partner** or

dependent child) within one year before or after the date of the commencement of the bankruptcy proceeding, continuation coverage will be provided under the **plan** to the extent required under Code Section 4980(B).

8.10. EXTENDED COVERAGE FOR DISABLED EMPLOYEES OR DEPENDENTS

Eligible employees 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**. This extended coverage is not available to an **employee** who is **totally disabled** and entitled to the protections under section 13.9, *Family and Medical Leave Act (FMLA)*.

Extended coverage under the **medical plan** is at no cost to the **totally disabled eligible employee** 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** is 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 **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.

9. *Coordination with Medicare*

9.1. PRIMARY COVERAGE TO MEDICARE

If coverage under the **medical plan** is primary to Medicare and you and/or your **dependents** who are eligible to be covered by Medicare incur a claim, the **medical plan** will pay for **covered expenses** subject to any applicable **deductible**, **copayment**, **coinsurance**, and any applicable **out-of-pocket limit**, exclusions or any other limits.

9.2. 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. The benefit payable under the **medical plan** will be reduced by the greater of:

- the amount actually paid by Medicare part A, Part B, Part C or Part D; or
- the amount Medicare would pay if you or your **dependents** were enrolled in Medicare Part A and Part B.

9.3. MEDICARE COVERAGE ELECTION

If you and your **dependents** choose not 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.

9.4. 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.

10. *Coordination of Benefits*

10.1. WHEN COORDINATION OF BENEFITS APPLIES

This coordination of benefits (COB) provision applies to the **medical plan** and **dental 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 may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

10.2. 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 copayments, 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 all plans covering a person are high deductible plans and the person intends to contribute to a health savings account established in accordance with Code Section 223, the primary high deductible plan's deductible is not an allowable expense, except as to any health expense that may not be subject to the deductible as described in Code Section 223(c)(2)(C).

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, and vision 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 the health plan is a primary plan or secondary plan as to another plan covering the person.

- When the 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 the 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, the 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.

10.3. WHICH PLAN PAYS FIRST

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

- 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.

- 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.

- 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:

        - The plan of the custodial parent;
        - The plan of the spouse of the custodial parent;
        - The plan of the noncustodial parent; and then
        - 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.

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 **plan** will not pay more than it would have paid had it been primary.

10.4. HOW COORDINATION OF BENEFITS WORKS

In determining the amount to be paid when the **medical plan** and **dental plan** is secondary on a claim, the secondary plan will calculate the benefits that it would have paid on the claim in the absence of other health insurance coverage and apply that amount to any allowable expense under the **medical plan** and **dental plan** that was unpaid by the primary plan. The amount will be reduced so that when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense.

In addition, a secondary plan will credit to its plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of the **medical plan** and **dental plan**, the amount normally reimbursed for covered benefits or expenses under the **medical plan** and **dental 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** and **dental 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 **dental plan** and another plan both agree that the **medical plan** and **dental plan** determines its 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.

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.

10.5. 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 **dental 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.

10.6. FACILITY OF PAYMENT

Any payment made under another plan may include an amount which should have been paid under the **medical plan** and **dental 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** and **dental 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.

10.7. 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.

11. *Subrogation and Reimbursement Rights*

11.1. RIGHT OF SUBROGATION AND REIMBURSEMENT

The **plan** has the right to full subrogation and reimbursement of any and all amounts paid by the **plan** to, or on behalf of, a **covered person**, for which a third party is allegedly responsible. The **plan** will have a lien against such funds, and the right to impose a constructive trust upon such funds, and will be reimbursed therefrom.

11.2. FUNDS TO WHICH SUBROGATION AND REIMBURSEMENT RIGHTS APPLY

The **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 **plan**):

- who is allegedly wholly or partially liable for costs or expenses incurred by the **covered person**, in connection for which the **plan** provided benefits to, or on behalf of, such **covered person**; or

- whose act or omission allegedly caused **injur**y or **illness** to the **covered person**, in connection for which the **plan** provided benefits to, or on behalf of, such **covered person**.

11.3. AGREEMENT TO HOLD RECOVERY IN TRUST

If a payment is made under the **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 **plan** the proceeds of such recovery and reimburse the **plan** to the extent of its payments.

11.4. DISCLAIMER OF MAKE WHOLE DOCTRINE

The **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 **plan's** right is a first priority lien. The **plan's** rights will continue until the **covered person's** obligations hereunder to the **plan** are fully discharged, even though the **covered person** does not receive full compensation or recovery for his or her injuries, damages, loss or debt. This right to subrogation *pro tanto* will exist in all cases.

11.5. 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 **plan**.

11.6. 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 **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 **plan's** rights to subrogation and reimbursement without the written authorization of the **claims** administrator.

11.7. PLAN'S RIGHT TO SUBROGATION

If the **covered person** or anyone acting on his or her behalf has not taken action to pursue his or her rights against a third party described in section 11.2, *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 **plan**; provided, however, that any such action taken without the consent of the **covered person** will be without prejudice to such **covered person**.

11.8. ENFORCEMENT OF PLAN'S RIGHT TO REIMBURSEMENT

If a **covered person** fails or refuses to comply with these provisions by reimbursing the **plan** as required herein, the **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 **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 **plan** also has the right to terminate coverage for the **covered person** under the **plan**.

11.9. 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 **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.

11.10. DISCRETIONARY AUTHORITY OF ADMINISTRATOR

The **State** will have full discretionary authority to interpret the provisions of this section 11, *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.

12. *Protected Health Information Under the Health Insurance Portability and Accounting Act (HIPAA)*

12.1. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The **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 **plan** will use and disclose **protected health information** for purposes related to health care treatment, **payment** for health care and **health care operations**.

12.2. PLAN DOCUMENTS

In order for the **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 **plan**, the **plan** must ensure that the **plan** documents restrict uses and disclosures of such information by the **State** consistent with the requirements of HIPAA.

12.3. DISCLOSURES BY THE PLAN TO THE STATE

The **plan** may:

- 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 **plan**; or
  - modifying, amending, or terminating the **plan**.
- Disclose to the **State** information on whether an **individual** is participating in the **plan**, or is enrolled in or has disenrolled from a health insurance issuer offered by the **plan**.
- Disclose **protected health information** to the **State** to carry out plan administration functions that the **State** performs, consistent with the provisions of this section.
- 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**.

- Not permit a health insurance issuer with respect to the **plan** to disclose **protected health information** to the **State** except as permitted by this section.

- 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 **plan's** notice of privacy practices that the **plan** (or a health insurance issuer with respect to the **plan**) may disclose **protected health information** to the **State**.

- 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**.

- 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.

12.4. USES AND DISCLOSURES BY STATE

The **State** may only use and disclose **protected health information** as permitted and required by the **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 12.3, *Disclosures by the Plan to the State*.

12.5. CERTIFICATION

The **plan** may disclose **protected health information** to the **State** only upon receipt of a certification from the **State** that the **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.

12.6. CONDITIONS AGREED TO BY THE STATE

The **State** agrees to:

- Not use or further disclose **protected health information** other than as permitted or required by the **plan** document or as required by law.

- Ensure that any agents, including a subcontractor, to whom the **State** provides **protected health information** received from the **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 **plan** that is provided by the **State**.

- Not use or disclose **protected health information** for employment-related actions and decisions unless authorized by an **individual**.

- 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**.

- Report to the **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.

- Make **protected health information** available to an **individual** in accordance with HIPAA's access requirements pursuant to 45 CFR § 164.524.

- Make **protected health information** available for amendment and incorporate any amendments to **protected health information** in accordance with 45 CFR § 164.526.

- Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528.

- Make internal practices, books and records relating to the use and disclosure of **protected health information** received from the **plan** available to the Secretary of the Department of Health and Human Services for the purposes of determining the **plan's** compliance with HIPAA.

- If feasible, return or destroy all **protected health information** received from the **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).

- 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 **plan**.

- Ensure that the separation and requirements of sections 12.3, *Disclosures by the Plan to the State,* section 12.4, *Uses and Disclosures by State,* and section 12.5, *Certification* of the **plan** are supported by reasonable and appropriate security measures.

12.7. 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**.

12.8. LIMITATIONS OF ACCESS AND DISCLOSURE

The persons described in section 12.3, *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 **plan**.

12.9. NONCOMPLIANCE

If the persons or classes of persons described in section 12.3, *Disclosures by the Plan to the State*, do not comply with this **plan** document, the **plan** and the **State** will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

13. *Other Mandated Coverages*

13.1. GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

The **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 **plan**. As part of such compliance, the **plan** will not:

- Adjust plan contribution amounts or premiums on the basis of genetic information.
- Request or require a **covered person** or any of the **covered person**'s family members to undergo a genetic test.
- 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 **plan**.

Under this section, "genetic information" includes your genetic tests, the genetic tests of your family members, and your family medical history.

13.2. 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 **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 **Aetna**.

Under Federal law, the **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**.

13.3. ELIGIBILITY FOR MEDICAID BENEFITS

Benefits will be paid in accordance with any assignment of rights made by or on behalf of any **eligible employee** 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, an **eligible employee'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 **plan** has a legal liability to make such payment.

13.4. PROHIBITION ON RESCISSIONS

The **plan** will comply with Section 2712 of the Public Health Service Act, as added by Section 1001 of the PPACA and incorporated into Section 9815 of the Internal Revenue Code, 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 **plan**. As part of such compliance, the **plan** will not **rescind** your coverage or your **dependents**' coverage, except in the case where you or your **dependent** has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact, as prohibited by the terms of the **plan**. Failure to notify the **plan** of any change in status or other applicable events as required under the **plan** will be deemed by the plan 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. The **plan** will provide 30 days advance written notice to you or your **dependent**, as applicable, before rescinding your coverage. Notwithstanding the foregoing, the **plan** may still cancel or discontinue coverage effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. Nothing in this section will prohibit the **plan** from cancelling or discontinuing such coverage prospectively for any reason provided under the **plan**.

13.5. DEPENDENT STUDENTS ON MEDICALLY NECESSARY LEAVE OF ABSENCE

The **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 **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 plan provision, such as the parent's termination of employment or the **dependent child's** age exceeding the **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 his or her educational institution or otherwise changes his or her enrollment status from full-time to part-time due to a serious illness or injury. The **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 **plan** changes during the extended period of coverage.

13.6. PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 (PPACA)

The **plan** will comply with required provisions PPACA. The **State** believes the **plan** is a grandfathered health plan under PPACA. As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the **plan** may not include certain consumer protections of PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in PPACA, for example, the elimination of lifetime limits on benefits.

You may contact the U.S. Department of Health and Human Services at www.healthreform.gov for information on which protections do and do not apply to grandfathered health plans.

13.7. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

The **plan** will comply with HIPAA, as amended from time to time, 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. Such compliance will include (i) providing **eligible employees** certification of their coverage under the **plan** to the extent required by HIPAA and (ii) permitting eligible individuals to enroll in the **plan** during special enrollment periods upon the loss of other coverage or upon the acquisition of a new **dependent** to the extent required under HIPAA, or (iii) discrimination against any person in terms of eligibility, continued eligibility or level of required employee contribution based upon health status, medical condition (including both physical and mental illnesses, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

13.8. CONTINUATION OF COVERAGE UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

a. Generally

An **eligible employee** may be entitled to reemployment and other rights during and after a period of **service in the uniformed services** under USERRA. The **plan** will be administered in compliance with the requirements of USERRA to the extent applicable.

To be eligible for such USERRA benefits, before leaving for military service, the **eligible employee** is generally required to give the employer advance notice that such **eligible employee** is leaving the job for **service in the uniformed services**. When such **eligible employee** returns from military service, he or she must timely submit an application for reemployment with the employer and request information regarding such **eligible employee's** reemployment rights. Time limits for returning to work will depend on the length of time of such military service.

b. Continuation of Coverage

If an **eligible employee** is absent from a position of employment with the employer by reason of **service in the uniformed services** (whether voluntary or involuntary) and was covered under the **plan** immediately prior to his or her absence due to **service in the uniformed services**, such **eligible employee** will then be entitled to elect to continue health care coverage under the **plan** for the **eligible employee** and his or her covered **dependents** for the time period allowed under the **plan**. Thereafter, coverage will continue for a period equal to the lesser of (i) the 24 month period beginning on the date on which such **eligible employee** is absent from employment with the employer by reason of **service in the uniformed services** or (ii) the day following the date on which the **eligible employee** fails to apply for or return to a position of employment with the employer as determined pursuant to USERRA Section 4312(e). **Eligible employees** may elect to discontinue coverage under the **plan** during **service in the uniformed services** by submitting the applicable forms to the **Division.**

c. Election of USERRA Continuation Coverage

Continuation coverage does not begin unless it is elected by the **eligible employee.**

The **eligible employee** may elect to continue coverage described in section 1.3.1, *Eligible Employees* by reason of **service in the uniformed services** for himself or herself and his or her covered **dependents**. **Dependents** do not have an independent right to elect USERRA continuation coverage. The election period for continued coverage will begin on the date the **eligible employee** gives the employer advance notice that he or she is required to report for **uniformed service** (whether such service is voluntary or involuntary) and will end 60 days after the date the **eligible employee** would otherwise lose coverage under the applicable **plan**.

If the **eligible employee** is unable to give advance notice of **uniformed service**, the **eligible employee** may still be able to elect continuation coverage under this section if the failure to give advance notice was because giving such notice was impossible, unreasonable, or precluded by military necessity. In such a case, the election period will begin on the date the **eligible employee**

leaves for **uniformed service** and will end on the earlier of: (i) the 24 month period beginning on the date on which the **eligible employee's** absence for the **uniformed service** begins; or (ii) the date on which the **eligible employee** fails to return from **uniformed service** or apply for a position of employment. For these purposes, "military necessity" occurs only when deemed to be so by a designated military authority as described in 20 CFR § 1002.86 and may include situations where a mission, operation, exercise or requirement is classified, or could be compromised or otherwise adversely affected by public knowledge. It may be impossible or unreasonable to give advance notice under certain circumstances such as when the employer is unavailable or the **eligible employee** is required to report for **uniformed service** in an extremely short period of time.

The election of USERRA continuation coverage must be made on a form provided by the **claims administrator** and made within the sixty (60) day period described herein. An election is considered to be made on the date it is sent to the **claims administrator**. If timely elected pursuant to this section, coverage will be reinstated as of the date the **eligible employee** lost coverage due to absence for **service in the uniformed service** and will last for the period set forth in paragraph b; provided that the **eligible employee** pays all unpaid costs for the coverage pursuant to paragraph d.

d. Cost of USERRA Continuation Coverage

If an **eligible employee** elects USERRA continuation coverage for himself or herself and, if applicable, his or her eligible covered **dependent(s),** such **eligible employee** will be required to pay 102% of the full premium cost for such coverage; provided, however, with respect to such **eligible employee's** initial 31 days of **service in the uniformed services**, he or she will not be required to pay more for such coverage than is otherwise required for eligible persons.

Premiums are due on the first day of each month for which continuation coverage is desired. 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, other than that referred to below, will only be considered to be timely if made within 30 days after the date due. A premium must also be paid for the cost of continuation coverage for the time period between the date that continuation coverage commences and the date continuation coverage is elected. This payment must be made within 45 days after the date of election. Failure to pay this premium on the date due will result in cancellation of coverage back to the initial date coverage would have terminated.

e. Coordination with COBRA

An **eligible employee** who is absent from work by reason of **service in the uniformed services** may be eligible for continuation coverage under section

8, *Consolidated Omnibus Budget Reconciliation Act* (*COBRA) and Extended Health Coverage*. The continuation coverage provided in this section will not limit or otherwise interfere with those continuation coverage rights; provided, however, any continuation coverage provided under this section will run concurrently with any continuation coverage available under section 8, *Consolidated Omnibus Budget Reconciliation Act* (*COBRA) and Extended Health Coverage*.

f. USERRA Continuation Health Benefits Provided

The continuation coverage provided to an **eligible employee** serving in the **uniformed services** who elects continued coverage (and his or her covered **dependents**) will be identical to the coverage provided under the group health coverage to similarly situated persons covered by the group health coverage who are active. If coverage is modified under the group health coverage for any group of similarly situated beneficiaries, such coverage will also be modified in the same manner for all individuals who are covered under USERRA continuation coverage. Continuation coverage may not be conditioned on evidence of good health. If the group health plan coverage under the **health plan** provides an open enrollment period during which similarly situated active employees may choose to be covered under another group health plan or under another benefit package within the group health plan coverage under the **health plan**, or to add or eliminate coverage of family members, the group health plan coverage under the **health plan** will provide the same opportunity to individuals who have elected USERRA continuation coverage.

g. Waiting Period and Exclusions Upon Reemployment

Notwithstanding any other provision herein, an **eligible employee** and his or her eligible covered **dependent**s whose benefit coverage is terminated by reason of **service in the uniformed services** will not be subject to any exclusion or waiting period upon reinstatement of such coverage under the group health coverage under the **health plan** following **service in the uniformed services**; provided, however, the above will not apply to any condition determined by the Secretary of Veterans Affairs to have been incurred in or aggravated during the performance of **service in the uniformed services**.

h. Reinstatement of Coverage Upon Reemployment

The **Division** will promptly reinstate the coverage under the **plan** at reemployment upon request.

i. Rights, Benefits, and Obligations of Employees Absent from Employment by Reason of Service in the Uniformed Services

An **eligible employee** who is absent from employment with the **State** by reason of **service in the uniformed services** will be considered on furlough or leave of absence while performing such service and will be entitled to such other rights and benefits as are generally provided by the **State** to **eligible employees** having similar status and pay who are on furlough or leave of absence; provided, however, an **eligible employee** who knowingly provides written notice of intent not to return to employment with the **State** will cease to be entitled to such rights and benefits. Furthermore, an **eligible employee** who is absent from employment with the **State** by reason of **service in the uniformed services** will be permitted to apply any accrued paid vacation, annual or similar leave while on such leave by reason of **service in the uniformed services**.

13.9. FAMILY AND MEDICAL LEAVE ACT (FMLA)

a. Generally

The FMLA generally allows certain employees who worked at least 1,250 hours during the preceding 12 months the right to take an unpaid leave (or a paid leave if it has been earned) for a period of up to 12 work weeks during a 12 month period because of:

- The birth of a child and to care for such child.
- The placement of a child for adoption or foster care, and to care for such child.
- The need to care for a family member (child, spouse, or parent) with a "serious health condition" as defined under the FMLA.
- An employee's own "serious health condition" that makes the employee unable to do his or her job.
- Any "qualifying exigency" (as defined under the FMLA) arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation.

In addition, any spouse, son, daughter, parent, or nearest blood relative ("next of kin") of a "covered servicemember" will be granted leave not to exceed a total of 26 work weeks during a single 12 month period to care for the "covered servicemember." During the single 12 month period described above, an employee may be granted a combined total of 26 work weeks of

leave for any combination of leaves under the FMLA. For purposes of this policy, the phrase "covered servicemember" means a member of the Armed Forces, including a member of the National Guard or Reserves, who:

- is undergoing medical treatment, recuperation, or therapy;
- is otherwise in an "outpatient status" (as defined by regulations); or
- is otherwise on the temporary disability retired list, for a "serious injury or illness" (as defined by regulations).

b. Continuation Coverage

Notwithstanding any other provisions in the **plan**, under the FMLA, an **eligible employee** who is covered under the **plan** is entitled to continue health benefit coverage under the **plan** during the period the **eligible employee** is on a FMLA leave. If paid leave runs concurrently with FMLA leave, employee contributions must be made by payroll deduction under the HFSA or by whatever alternative method is normally utilized for making such contributions when the **eligible employee** is on paid leave.

If the FMLA leave is unpaid leave, employee contributions must be paid at the same time as the contribution would be made if by payroll deduction, or as otherwise agreed to in writing between the **State** and the **eligible employee**. Failure of an **eligible employee** to pay his or her share of contributions within 30 days after the due date will result in termination of coverage, subject to this section. The **plan** coverage provided pursuant to the FMLA is the same as would be provided if the **eligible employee** had been employed during the leave period. The **eligible employee** may choose not to continue **plan** coverage during the FMLA leave. If the **eligible employee** chooses to discontinue coverage during the FMLA leave (or if coverage ends due to the failure to make timely contributions), the **eligible employee** will be immediately reinstated to **plan** coverage when the **eligible employee** returns from the FMLA leave without regard to any waiting period. The **eligible employee's** right to continue coverage for non-health benefits will be governed by the right to continue such coverages during non-FMLA type leaves. The **eligible employee** will be notified of such right, if any, to continue other benefit coverage during a FMLA leave.

c. Termination of FMLA Continuation Coverage

Except as provided under this section, FMLA benefit coverage will terminate when:

- The **eligible employee** informs the **State** of his or her intent not to return from FMLA leave.
- The **eligible employee** fails to return from the FMLA leave.

- The **eligible employee** exhausts his or her FMLA leave.
- The employment relationship would have been terminated if the **eligible employee** had not taken FMLA leave.

After the last day of FMLA leave, an **eligible employee** may be eligible for continuation of health coverage at the **eligible employee's** own expense under Federal law as described in section 8, *Consolidated Omnibus Budget Reconciliation Act* (*COBRA) and Extended Health Coverage*.

d. Employee Contributions

Eligible employees will pay any applicable employee contributions under the **health plan**.

The **State** may recover from the **eligible employee**: (i) contributions made by the **State** during a period of unpaid FMLA leave for maintaining the **eligible employee's** health benefit coverage if the **eligible employee** fails to return to work after the FMLA leave has been exhausted, unless the failure to return to work is due to a serious health condition of the **eligible employee** or a family member, or a serious injury or illness of a covered servicemen which would otherwise entitle the **eligible employee** to FMLA leave, or other circumstances beyond the **eligible employee's** control; or (ii) the **eligible employee's** share of contributions the **eligible employee** was obligated to make but which the **State** elected to make on the **eligible employee's** behalf in order to maintain the **eligible employee's** health benefit coverage (or non-health benefit coverage, as appropriate), regardless of whether the **eligible employee** returns from such leave.

13.10. STATEMENT OF RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending **physician** and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same **deductibles** and **coinsurance** applicable to other medical and surgical benefits provided under the **plan**. See section 2.1.1, *Medical Benefit Schedule*.

14. *Other Plan Provisions*

14.1. ACCESS TO RECORDS

All **covered persons** under the **plan** consent to and authorize all **providers** to examine and copy any portions of the **hospital** or medical records requested by the **plan** when processing a claim, **precertification**, or claim **appeal**.

14.2. PLAN LIABILITY

The full extent of liability under the **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."

14.3. FREE CHOICE OF HOSPITAL AND PROVIDER

You may select any **hospital** that meets the criteria in section 3.5.6, *Hospital Expenses*. You may select any **provider** who meets the definition of **provider** in section 15, *Definitions*.

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

Under the **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 **eligible employee**, or to such **provider** and the **eligible employee** jointly.

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

14.4. PLAN MUST BE EFFECTIVE

Health coverage is expense-incurred coverage only and not coverage for the **illness** or **injury** itself. This means that the **plan** will pay benefits only for expenses incurred while this coverage is in force. Except as described in section 8, *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.

14.5. 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.

14.6. EPIDEMICS AND PUBLIC DISASTERS

The services this **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 **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 **plan** provides.

14.7. VESTED RIGHTS

Except as cited in section 8, *Consolidated Omnibus Budget Reconciliation Act* (*COBRA) and Extended Health Coverage*, the **plan** does not confer rights beyond the date that coverage is terminated or the effective date of any change to the plan provisions, including benefits and eligibility provisions. For this reason, no rights from the **plan** can be considered vested rights. You are not eligible for benefits or payments from the **plan** for any services, treatment, medical attention, or care rendered after the date your coverage terminates.

14.8. AMENDMENT OR TERMINATION PROCEDURE

The following provisions will apply to the amendment and termination 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 the **plan** or any underlying benefit at any time and to the extent that it may deem advisable. Any amendment or termination of the **plan**, the schedule of benefits or 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.

14.9. CANCELLATION

The **State** may cancel any portion of the contract with the **claims administrator** without the consent of the **covered persons.**

14.10. 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.

14.11. 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 **eligible employee**, **spouse**, **same-sex partner,** or his or her beneficiary will be subject to any debt, liability, contract, engagement, or tort of any **eligible employee**, **spouse**, **same-sex partner**, or his or her 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.

14.12. 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.

14.13. 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.

14.14. 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**.

14.15. 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.

14.16. 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**.

14.17. 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.

14.18. 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:

- 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;
- as creating any responsibility or liability of the **State** or the **claims administrator** for the validity or effect of the **plan**; or
- as a contract or agreement between the **State** and any **covered person** or other person.

14.19. 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 his or her address as it appears in the records of the administrator or the **claims administrator**.

14.20. 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**.

14.21. 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**.

14.22. 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.

14.23. 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.

14.24. 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.

14.25. 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**.

14.26. 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.

14.27. 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.

14.28. 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.

14.29. 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.

14.30. 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 the First Judicial District, Juneau, Alaska.

14.31. 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**.

14.32. 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.

14.33. 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**.

15. *Definitions*

The following words have the defined meanings when used in the **plan**:

- "**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**" means Aetna Life Insurance Company, an affiliate of **Aetna**, or a third party vendor under contract with **Aetna**. **Aetna** is the third party administrator of the **medical plan**.

- **"Affiliate providers"** means **providers** of covered services and materials who are not contracted as **VSP doctors** but who have agreed to bill **VSP** directly for vision services under the **vision plan**. Some affiliate providers may be unable to provide all vision services under the **vision plan**. **Covered persons** should discuss requested services with their **provider** or contact **VSP** for more information.

- "**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**" 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 en route.

- "**Anterior**" means teeth located at the front of the mouth.

- "**Appeal**" means review by the **claims administrator** of a **denial**.

- **"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**" means a licensed organization or professional providing diagnostic, therapeutic, or psychological services for behavioral health conditions.

- "**Benefit credits**" mean the amount that the **State** contributes toward the cost of **benefit options** under the **plan**.

- "**Benefit option**" means the **medical plan**, **dental plan**, **vision plan**, and health flexible spending account (HFSA).

- "**Benefit year**" means January 1 through December 31.

- "**Birthing center**" means a freestanding facility that meets all of the following requirements:
  - Meets licensing standards.
  - Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
  - Charges for its services.
  - Is directed by at least one **physician** who is a specialist in obstetrics and gynecology.
  - Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period.
  - Extends staff privileges to **physicians** who practice obstetrics and gynecology in an area **hospital**.
  - Has at least two beds or two birthing rooms for use by patients while in labor and during delivery.
  - Provides, during labor, delivery and the immediate postpartum period, full-time **skilled nursing care** directed by a registered nurse or certified nurse midwife.
  - Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and **child**.
  - Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
  - 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.
  - Accepts only patients with low-risk pregnancies.
  - 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.
  - Provides an ongoing quality assurance program. This includes reviews by **physicians** who do not own or direct the facility.
  - Keeps a medical record on each patient and **child**.

- **"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**" 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**" 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. **Retainer** crowns (crowns placed on adjacent teeth) are considered part of the **bridge**.

- "**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**" 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**" or **"children"** means the **eligible employee's**, **spouse's**, or **same-sex partner's** (i) natural child, (ii) stepchild, (iii) legally adopted child, (iv) child who is in the physical custody of the **eligible employee**, **spouse** or **same-sex partner** and for whom bona fide adoption proceedings are underway, or (v) child who is placed with the **eligible employee**, **spouse** or **same-sex partner** by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

- "**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**.

- "**Coinsurance**" means the percentage of **covered expenses** which the **plan** pays after application of any applicable **deductible**.

- "**Commissioner**" means the Commissioner of the State of Alaska Department of Administration.

- "**Copayment**" means the specific dollar amount required to be paid by you or on your behalf under the **plan**.

- "**Cosmetic**" means services or supplies that alter, improve or enhance appearance.

- "**Covered expense**" means the medical, prescription drug, dental, or vision services and supplies shown as covered under the **plan**.

- "**Covered person**" means each **eligible employee** and **dependent** who is covered under the **plan**.

- "**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:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications.
- Care of a stable tracheostomy (including intermittent suctioning).
- Care of a stable colostomy/ileostomy.
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings.
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing).
- Watching or protecting you.
- Respite care, adult (or child) day care, or convalescent care.
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care.
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods.
- Any service that can be performed by a person without any medical or paramedical training.

- "**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.

- "**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**" means the amount of **covered expenses** for which you are responsible each **benefit year** before any benefits are payable under the **plan**.

- "**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**" 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**" means a dentist, registered hygienist or certified dental therapist who is operating within the scope of his or her license, certification or registration.

- **"Dental plan"** means dental benefits under the **plan**, as set forth in section 4, *Dental Plan*.

- "**Dentally necessary**" means services that:
  - are established as necessary for the treatment or prevention of a dental **injury** or disease otherwise covered under the **dental plan**;
  - are appropriate with regard to standards of good dental practice in the **service area**;
  - have a good prognosis; and/or
  - 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**" means a licensed **dentist** or a **physician** licensed to do the dental work he or she performs, who is operating within the scope of his or her license as required under law within the state of practice.

- "**Dependent**" means an **eligible employee's spouse, same-sex partner**, or **child**.

- **"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.

- "**Division**" means the State of Alaska, Division of Retirement and Benefits.

- "**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 <u>not</u> include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids, and telephone alert systems.

- "**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, private networks, and the physical movement of removable/transportable electronic storage media).

- "**Eligible employee**" means a permanent or long-term nonpermanent **employee** of the **State** whose bargaining unit or employee group participates in the **plan** and who meets the criteria set forth in section 1.3.1, *Eligible Employees*. An **eligible employee** does not include temporary employees, leased employees, or employees who are scheduled to work less than 15 hours per week.

- "**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"** means the treatment given in a **hospital'**s emergency room to evaluate and treat an **emergency** medical condition.

- "**Employee**" means a common law employee of the **State** who is actively at work and receiving earnings.

- "**EOB**" means an *Explanation of Benefits* form.

- "**Experimental or investigational**" means, except as provided for under any clinical trials benefit provision, a drug, a device, a procedure, or treatment where:
  - 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;
  - approval required by the FDA has not been granted for marketing;
  - a recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational** or for research purposes;
  - 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
  - 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.

- "**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**").

- "**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**" 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**" 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**:
  - Quality assessment.
  - 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.
  - Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities.
  - 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).
  - Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs.
  - 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.
  - 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.

- 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**" means a **physician** or other health care professional licensed, accredited, or certified to perform health services consistent with state law.

- "**Home health care agency**" means an organization that meets all of the following requirements:
  - provides **skilled nursing services** and other therapeutic services in the patient's home;
  - is associated with a professional policy-making group (of at least one **physician** and one full-time supervising registered nurse) which makes policy;
  - has full time supervision by a **physician** or registered nurse;
  - keeps complete medical records on each patient;
  - is staffed by an administrator; and
  - meets licensing standards.

- "**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**" means that you are confined to your place of residence:
  - due to an **illness** or **injury** which makes leaving the home medically contraindicated; or
  - 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:
  - you do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
  - you are wheelchair bound but could safely be transported via wheelchair accessible transport.

- "**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**" means an agency or organization that meets all of the following requirements:
  - Has **hospice care** available 24 hours a day.
  - Meets any licensing or certification standards established by the jurisdiction where it is located.

- Provides:
  - Skilled nursing services;
  - Medical social services; and
  - Psychological and dietary counseling.
- 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.
- Has at least the following personnel:
  - One **physician**;
  - One registered nurse; and
  - One licensed or certified social worker employed by the agency.
- Establishes policies about how **hospice care** is provided.
- Assesses the patient's medical and social needs.
- Develops a **hospice care program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full time administrator.

- "**Hospice care program**" is a written plan of **hospice care** which meets all of the following requirements:
  - Is established by and reviewed from time to time by a **physician** attending the person, and appropriate personnel of a **hospice care agency**.
  - Is designed to provide palliative and supportive care to **terminally ill** persons, and supportive care to their families.
  - 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**" means a facility, or distinct part of one, that meets all of the following requirements:
  - Mainly provides inpatient hospice care to **terminally ill** persons.
  - Charges patients for its services.
  - Meets any licensing or certification standards established by the jurisdiction where it is located.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program including reviews by physicians other than those who own or direct the facility.
  - Is run by a staff of **physicians**. At least one staff **physician** must be on call at all times.
  - Provides 24-hour-a-day nursing services under the direction of a registered nurse.

- Has a full-time administrator.

- "**Hospital**" means an institution providing inpatient medical care and treatment of sick and **injured** people. It must:
  - 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
  - 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**" 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**" 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**" is an attachment used to connect an **implant** and an **implant supported prosthetic** device.

- "**Implant supported prosthetic**" means a crown, **bridge**, or removable partial or full denture that is supported by or attached to an **implant**.

- "**Individual**" means any person who is the subject of **protected health information**.

- "**Infertility**" or **"infertile"** means the condition of a presumably healthy **covered person** who is unable to conceive or produce conception after:
  - *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
  - *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**" 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.

- "**Mail order pharmacy**" means an establishment where **prescription drugs** are legally given out by mail or other carrier.

- "**Maintenance care**" means care made up of services and supplies that:
  - are given mainly to maintain, rather than to improve, a level of physical, or mental function; and
  - give a surrounding free from exposures that can worsen the person's physical or mental condition.

- "**Medical plan**" means medical, prescription drug, and employee assistance benefits under the **plan**, as set forth in section 3, *Medical Plan*.

- "**Medically necessary**" or "**medical necessity**" has the meaning set forth in section 3.5.1, *Medically Necessary Services and Supplies*.

- "**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:
  - Schizophrenia
  - Bipolar disorder (manic/depressive)
  - Pervasive Mental Development Disorder (Autism)
  - Panic disorder
  - Major depressive disorder
  - Psychotic depression
  - Obsessive compulsive disorder
  - Anorexia/bulimia nervosa
  - Psychotic disorders/delusional disorder
  - Schizo-affective disorder

- "**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**" means a p**harmacy** that has contracted with **Aetna** to furnish services or supplies for the **plan**.

- "**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(s) or supply(ies)"** means health care service(s) or supply(ies) that is/are furnished by a **network provider**.

- "**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.

- "**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 categories in your **provider** directory or in DocFind® at www.aetna.com/docfind/custom/alaskacare.

- "**Out-of-pocket limit**" means the maximum amount you are responsible to pay for benefits under the **plan** each **benefit year**, including **coinsurance** not paid by the **plan**. Expenses applied towards a **deductible**, 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**" 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:
  - It is carried out in a **hospital**, **psychiatric hospital**, or **residential treatment facility** on less than a full-time inpatient basis.
  - It is in accord with accepted medical practice for the condition of the person.
  - It does not require full-time confinement.
  - 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**" means PayFlex Systems USA, Inc., the flexible spending account and COBRA **claims administrator** under the **plan**.

- "**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:
  - 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).
  - Coordination of benefits.
  - Adjudication of health benefit claims (including **appeals** and other payment disputes).
  - Subrogation of health benefit claims.
  - Establishing **eligible employee** contributions.
  - Risk adjusting amounts due based on an **eligible employee's** health status and demographic characteristics.
  - Billing, collection activities and related health care data processing.
  - 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.

- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance).
- **Medical necessity** reviews or reviews of appropriateness of care or justification of charges.
- Utilization review, including **precertification**, preauthorization, concurrent review and retrospective review.
- 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**).
- Reimbursement to the **plan.**
- Any other activity considered to be a "**payment**" activity pursuant to 45 CFR § 164.501.

- "**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**" means an establishment where **prescription drugs** are legally dispensed. **Pharmacy** includes a retail **pharmacy**, **mail order pharmacy** and **specialty pharmacy network pharmacy**.

- "**Physician**" means a duly licensed member of a medical profession who:
  - has an M.D. or D.O. degree;
  - is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
  - provides medical services which are within the scope of his or her license or certificate.

  A **physician** also includes a health professional who:
  - is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
  - provides medical services which are within the scope of his or her license or certificate;
  - under applicable insurance law is considered a **physician** for purposes of this coverage;
  - has the medical training and clinical expertise suitable to treat your condition;
  - specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, **substance abuse** or a **mental disorder**; and
  - is not you or related to you.

- "**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.

- "**Pontic**" is an artificial tooth that replaces a missing tooth and is part of a **bridge**.

- "**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**" 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**" 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.

- "**Prescription**" means an order for the dispensing of a **prescription drug** by a **physician** or **dentist,** acting within the scope of his or her 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**" 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 his or her capacity as a paid **health care professional**. Covered **self-injectable drugs** include injectable insulin.

- "**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.

- "**Privacy Regulations**" mean the regulations under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164, as amended).

- "**Prophylaxis**" is cleaning and polishing of all teeth.

- "**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**" means any recognized **health care professional**, **pharmacy** or facility providing services within the scope of its license.

- "**Psychiatric hospital**" means an institution that meets all of the following requirements:
  - Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, **substance abuse** or **mental disorders**.
  - Is not mainly a school or a custodial, recreational or training institution.
  - Provides infirmary-level medical services.
  - Provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
  - Is supervised full-time by a **psychiatric physician** who is responsible for patient care and is there regularly.
  - Is staffed by **psychiatric physicians** involved in care and treatment.
  - Has a **psychiatric physician** present during the whole treatment day.
  - Provides, at all times, psychiatric social work and nursing services.
  - Provides, at all times, **skilled nursing care** by licensed nurses who are supervised by a full-time registered nurse.
  - 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**.
  - Makes charges.
  - Meets licensing standards.

- "**Psychiatric physician**" means a **physician** who:
  - Specializes in psychiatry; or
  - Has the training or experience to do the required evaluation and treatment of alcoholism, **substance abuse** or **mental disorders**.

- "**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** has the right to bill the difference between the **recognized charge** and the actual charge. This difference will be the **covered person's** responsibility.

  - **Medical Expenses**

    As to medical services or supplies, the **recognized charge** for each service or supply is the lesser of:

    - what the **provider** bills or submits for that service or supply; or

    - 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.

- **Vision Expenses**

  As to vision expenses, the **recognized charge** for a service or supply is the amount billed by the **provider**.

- **Medical/Dental/Vision/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 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 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; 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.

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.

- "**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**" 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**" means the process of resurfacing the tissue side of a denture with new base material.

- "**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 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)**" means an institution that meets all of the following requirements:
  - On-site licensed **behavioral health provider** 24 hours per day/7 days a week.
  - Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
  - Patient is admitted by a **physician**.
  - Patient has access to necessary medical services 24 hours per day/7 days a week.
  - Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
  - Offers group therapy sessions with at least a registered nurse or Masters-Level Health Professional.
  - Has the ability to involve family/support systems in therapy (required for **children** and adolescents; encouraged for adults).
  - Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy.
  - Has peer oriented activities.
  - 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).
  - Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
  - Provides a level of skilled intervention consistent with patient risk.
  - Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
  - Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

- "**Residential treatment facility (substance abuse)**" means an institution that meets all of the following requirements:
  - On-site licensed **behavioral health provider** 24 hours per day/7 days a week.
  - Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
  - Patient is admitted by a **physician**.
  - Patient has access to necessary medical services 24 hours per day/7 days a week.
  - 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**.
  - Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
  - Offers group therapy sessions with at least a registered nurse or Masters-Level Health Professional.
  - Has the ability to involve family/support systems in therapy (required for **children** and adolescents; encouraged for adults).
  - Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy.
  - Has peer oriented activities.
  - 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).
  - Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
  - Provides a level of skilled intervention consistent with patient risk.
  - Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
  - Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.
  - 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.
  - 24-hours per day/7 days a week supervision by a **physician** with evidence of close and frequent observation.
  - On-site, licensed **behavioral health provider**, medical or **substance abuse** professionals 24 hours per day/7 days a week.

- "**Restoration**" means the treatment that repairs a **broken** or decayed tooth. **Restorations** include, but are not limited to, fillings and crowns.

- "**Retainer**" means a tooth used to support a prosthetic device (**bridges**, partial dentures or overdentures).

- "**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.

- "**Same-sex partner**" means an individual (other than a **spouse**) where the individual and an **eligible employee** together satisfy all of the following requirements:
  - Are the same gender.
  - Are at least 18 years old and competent to enter into a contract.
  - Have been in an exclusive, committed, and intimate relationship for the last consecutive 12 months and intend to continue that relationship indefinitely.
  - Have resided together at a common primary residence for the last 12 consecutive months and intend to reside together indefinitely.
  - Consider themselves to be members of each other's immediate family.
  - Are not related to each other to a degree of closeness that would preclude them from marrying each other in the **State** if they were of the opposite sex from each other.
  - Are not legally married to anyone else.
  - Have not executed an affidavit affirming same-sex partner status with anyone else within the last 12 months.
  - Are each other's sole same-sex partner and are each responsible for the common welfare of the other.
  - Share financial obligations, including joint responsibility for basic living expenses and health care costs.
  - Have completed and filed with the **Division** a Statement of Domestic Partnership as provided by the **Division**.
  - Have satisfied any other requirements required by law or the **Division**.

- "**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**" 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**" 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**" means the **geographic area**, as determined by **Delta Dental**, in which **network providers** for the dental coverage portion under the **dental plan** are located.

- "**Service in the uniformed services**" means (i) the performance of a duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, and National Guard duty under Federal law, (ii) a period for which an

eligible employee is absent from a position of employment for the purpose of an examination to determine the fitness of the **eligible employee** to perform any such duty, (iii) a period for which the **eligible employee** is absent from employment to perform funeral honors duty as authorized by law, and (iv) service as an intermittent disaster-response appointee upon activation of the National Disaster Medical System ("NDMS") or as a participant in an authorized training program.

- "**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**" means an institution that meets all of the following requirements:
  - Licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **illness** or **injury**:
    - professional nursing care by an 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.
  - Provides 24 hour a day nursing care by licensed nurses directed by a full-time registered nurse.
  - Is supervised full-time by a **physician** or a registered nurse.
  - Keeps a complete medical record on each patient.
  - Has a utilization review plan.
  - Is not an institution for rest or care of the aged, drug addicts, alcoholics, people who are mentally incapacitated, or people with **mental disorders**.
  - Charges patients for its services.
  - 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.
  - 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) **custodial 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**" 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 his or her license.
  - The services are not custodial.

- "**Specialty pharmacy network**" means a network of pharmacies designated to fill **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.

- "**Spouse**" means the person to whom the **eligible employee** is married where the marriage was validly entered into in a state whose laws authorize the marriage, even if the **eligible employee** is domiciled in a state that does not recognize the validity of the marriage. A **spouse** includes a person to whom the **eligible employee** is legally separated, but not divorced.

- "**State**" means the State of Alaska.

- "**Stay**" means a full-time inpatient confinement for which a **room and board** charge is made.

- "**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"** 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.

- "**Surgery center**" means a freestanding ambulatory surgical facility that meets all of the following requirements:
  - Meets licensing standards.
  - Is set up, equipped and run to provide general surgery.
  - Charges for its services.
  - 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.
  - Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
  - Extends surgical staff privileges to:
    - **Physicians** who practice surgery in an area **hospital**; and
    - **Dentists** who perform oral surgery.
  - Has at least two operating rooms and one recovery room.
  - Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
  - Does not have a place for patients to stay overnight.
  - Provides, in the operating and recovery rooms, full-time **skilled nursing services** directed by a registered nurse.
  - Is equipped and has trained staff to handle **emergency** medical conditions.
  - Must have all of the following:
    - a **physician** trained in cardiopulmonary resuscitation;
    - a defibrillator;
    - a tracheotomy set; and
    - a blood volume expander.
  - Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients.
  - Written procedures for such a transfer must be displayed and the staff must be aware of them.
  - Provides an ongoing quality assurance program. The program must include reviews by **physicians** who do not own or direct the facility.
  - Keeps a medical record on each patient.

- **"Terminally ill"** means a medical prognosis of 12 months or less to live.

- **"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**.

- "**Uniformed Service"** means the Armed Forces, the Army National Guard, the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commission corps of the Public Health Service, and any other category of persons designated by the President of the United States of America in time of war or emergency. For purposes of USERRA coverage only, services as an intermittent disaster response appointee of the NDMS when federally

activated or attending authorized training in support of their Federal mission is deemed service in the uniformed services, although such appointee is not a member of the "uniformed services" as defined by USERRA.

- "**Urgent admission**" means a **hospital** admission by a **physician** due to:
  - The onset of or change in an **illness**, the diagnosis of an **illness**, or an **injury**; and
  - 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**" 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**" means:
  - 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.
    - 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**.
  - 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**" means a sudden **illness**, **injury,** or condition that:
  - is severe enough to require prompt medical attention to avoid serious deterioration of your health;
  - includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
  - does not require the level of care provided in the emergency room of a **hospital**; and

- requires immediate outpatient medical care that cannot be postponed until your **physician** becomes reasonably available.

- "**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"** means vision benefits under the **plan**, as set forth in section 5, *Vision Plan*.

- "**VSP**" means Alaska Vision Services, Inc., the **claims administrator** for the **vision plan**.

- **"VSP doctor"** means an optometrist or opthalmologist licensed and otherwise qualified to practice vision care or provide vision care materials who has contracted with **VSP** to provide such services for the **plan**.