SELECT BENEFITS

Insurance Information Booklet

State of Alaska

July 1, 2013

STATE OF ALASKA

SELECT BENEFITS

Insurance Information Booklet

July 1, 2013

Contact Information

AlaskaCare Plan Administrator

Telephone Numbers

State of Alaska, Division of Retirement and Benefits

Toll-free . . . . . .(800) 821-2251
In Juneau . . . . . (907) 465-4460
TDD *for hearing impaired* . . . . . (907) 465-2805

Mailing Address

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

Physical Address

333 Willoughby Avenue, 6th Floor
Juneau, AK 99801

Email Address

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

Web Sites

AlaskaCare Health Plans . . . . . ***AlaskaCare.gov***
Division of Retirement and Benefits. . . . . ***.Alaska.gov/drb***

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

Contact Information

AlaskaCare Claim Administrator

Claims Mailing Addresses

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

HealthSmart
P.O. Box 99004
Anchorage, AK 99509-9004

Pharmacy
Mail Order & Specialty:
Costco Mail Order Pharmacy
215 Deininger Circle
Corona, CA 92880-9911

Vision Services Plan (VSP) – Managed Care Plan
P.O. Box 997100
Sacramento, CA 95824

Telephone Numbers

Customer Service/Provider Locator . . . . . (877) 517-6370
TDD *for hearing impaired* . . . . . (877) 517-6416
International. . . . . (304) 340-0253

24-Hour Nurse Line. . . . . (800) 807-2997

24-Hour Pharmacy Help Desk/Locator. . . . . (800) 361-4542

Costco Mail Order Pharmacy Customer Service . . . . . (800) 607-6861

Costco Specialty Pharmacy. . . . . (866) 443-0060

Magellan – Employee Assistance Plan (EAP) . . . . . (800) 478-2812
TDD *for hearing impaired* . . . . . (800) 456-4006

Vision Services Plan (VSP) . . . . . (800) 877-7195

Physical Addresses

HealthSmart – Claims Administrator

In Anchorage
1500 W. Benson Blvd., 2nd Floor
Anchorage, AK 99509-9004

In Juneau
400 Willoughby Avenue, Suite 202
Juneau, AK 99801

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Adoption Order

Pursuant to authority under AS 39.30.090-098, the Commissioner of the State of Alaska, Department of Administration ("Commissioner"), hereby adopts the Select Benefits Insurance Booklet dated July 1, 2013 (the "Plan") as the official plan document governing the benefits contained therein. The Plan is effective upon adoption by the Commissioner and applies to claims submitted for payment with dates of service on or after the date indicated below. All prior Select Benefit plan documents and related amendments are hereby repealed in their entirety.

Dated: July 1, 2013

Becky Hultberg, Commissioner
Department of Administration

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1. Introduction to Select Benefits

Select Benefits Highlights

- Select Benefits insurance options may be purchased with benefit credits and, if necessary, through pre-tax payroll deductions.
- Employees covered by the health plan must elect a medical and dental plan; vision coverage is optional (see section 1.6, *Default Plan*).
- Other available benefits include life, accidental death and dismemberment, survivor, and disability insurance.
- Reimbursement accounts are available to help you pay for uncovered health expenses or day care expenses from pre-tax contributions.

1.1. The Select Benefits Plan

Besides receiving your paycheck, you get substantial value from the benefits the State makes available to you. Select Benefits is a flexible benefits program for eligible employees. Select Benefits gives you an opportunity to select the options and levels of coverage that reflect your own personal needs, lifestyle, and situation.

With Select Benefits, you see the full price of each benefit option and, using your benefit credits, choose to buy the benefits you need. If you need additional dollars to pay for the benefits you choose, or if you have out-of-pocket health care or dependent care expenses, Select Benefits offers significant tax advantages.

Select Benefits offers a range of options for each benefit. Each option has a price tag based on the cost of providing that coverage. If you are covered by the health plan, you receive a benefit credit and you must elect a medical and dental option. You may also choose vision coverage, life insurance, accidental death and dismemberment insurance, survivor benefits, and short-term or long-term disability insurance. You may also choose to contribute to a health flexible spending account and/or a dependent care assistance plan. These benefits are described in detail in this document.

This booklet may be updated from time to time to reflect changes in the plans. Be sure you are using the most current edition, which is available from your human resources office or the Division of Retirement and Benefits (the Division).

This booklet summarizes the Select Benefits plan, and it is not possible to address every individual circumstance. If you have any questions about how the Select

Benefits program pertains specifically to your situation, please contact the Division.

In case of conflict between this booklet and official plan documents, the documents will determine benefits.

1.2. Benefit Year

There is a short benefit year from July 1, 2013 through December 31, 2013. Effective January 1, 2014, and thereafter, the benefit year is January 1 through December 31.

1.3. Who is Covered

a. Employees

Benefits in this booklet are available to permanent and long-term nonpermanent employees of the State of Alaska whose bargaining unit/employee group participates in the Select Benefits plan and who meet the criteria shown below:

- Full-time or full-time seasonal employees (scheduled to work 30 or more hours a week on a regular basis).
- Part-time employees (scheduled to work at least 15 but less than 30 hours a week on a regular basis) who elect to participate in the plan.

  If you are a part-time employee and want to participate in the State's health plan, you must elect coverage within the first 30 consecutive calendar days of employment, following a qualified employment/family status change or during an open enrollment period. You receive one-half of the benefit credit **only** if you elect health coverage.

'Employees' are those persons actively working for the State and receiving earnings.

As of January 1, 2000, the following employee groups participate in Select Benefits:

- Confidential Employees Unit
- Supervisory Unit
- Unlicensed Vessel Personnel Unit (Inland Boatman's Union)
- Licensed Marine Engineers (Marine Engineers Beneficial Association)
- Alaska Vocational Technical Teachers Unit
- Mount Edgecumbe Teachers Unit

- Employees not covered by collective bargaining
- Correctional Officers

b. Dependents

Your eligible dependents for health insurance benefits include:

- Your spouse. You may be legally separated but not divorced.
- Same-sex partner as defined and documented by 2 AAC 38.010-2 AAC 38.100.
- Your children, including children of same-sex partner (as defined and documented by 2 AAC 38.010-2 AAC 38.100) from birth up to the date that the child attains age 26, who are not eligible to enroll in another employer-sponsored health plan through their own employment or the employment of their spouse. A "child" is your natural child; stepchild; legally adopted child; child lawfully placed with you for legal adoption; or child placed with you by an authorized placement agency or by judgment, decree, or other court order of any court of competent jurisdiction.
- Your children age 26 and older who are permanently and totally disabled. Permanent and total disability means the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continued period of not less than 12 months. The permanent and total disability must have existed before age 19 and the children must meet the definition of "child" in the preceding paragraph and be unmarried and chiefly dependent upon you for support. You must provide the claims administrator with evidence that the permanent and total disability exists, including proof that it existed before age 19 and proof of financial dependency. Children over age 26 are covered as long as they are permanently and totally disabled. Periodic proof of continued disability may be required.

Children that have access to their own employer group plan must enroll in that plan rather than their parent's plan.

You must notify the plan administrator in writing within 60 days of the date your child no longer meets the eligibility criteria.

If you and your spouse/partner both work for the State, you may both be eligible for coverage as employees. You may also be covered as a dependent under these plans. Similarly, a child can be covered as a dependent of more than one employee.

1.4. Benefit Credits/Premiums

The State contributes a benefit credit towards the cost of your health insurance. The benefit credit amount is determined by your bargaining unit contract, or in the case of employees not covered by collective bargaining, by the State. Current benefit credit amounts are available from your human resources office, the Division, or its Web site.

If you are a permanent full-time or permanent seasonal employee, you receive the full benefit credit amount. If you are a permanent part-time or permanent part-time seasonal employee, you receive one-half the benefit credit amount **only** if you elect health coverage.

You select the health benefits you wish to purchase and decide whether to purchase other optional insurance benefits. Each benefit has a price tag. Your total price tag will be deducted from the benefit credit. If your price tags are:

- Less than your benefit credit, the remaining benefit credit will be placed in your Health Flexible Spending Account (HFSA) (see section 9, *Health Flexible Spending Account*).
- More than your benefit credit, the difference will be deducted from your paycheck each month. Premiums are split in half and are deducted from your salary before taxes are calculated. They are withheld in the month coverage is provided. For example, premiums for July are withheld from checks issued in July. If your check is insufficient to pay the premium, you should contact your human resources office or the Division for information on paying health premiums directly.

1.5. Electing Coverage

a. New Employees

You must elect coverage within 30 days of the date you were first hired. If you do not elect coverage within 30 days, you will be enrolled in the default plan (see section 1.6, *Default Plan*).

b. Rehired Employees

Employees who are terminated and rehired in a *new* benefit year must enroll as described for new employees above.

Employees who are rehired in the same benefit year in which they terminated are re-enrolled in the same benefits they had during their previous employment.

c. Employees Moving from a Nonparticipating Unit

Employees who move from a bargaining unit that does not participate in Select Benefits have 30 days from the date of the bargaining unit change to elect coverage. If you do not elect coverage within 30 days, you will be enrolled in the default plan (see section 1.6, *Default Plan*).

1.6. Default Plan

The default plan for full-time employees is established each year and includes a medical and dental option but generally includes no other coverage. For part-time employees, the default plan is no coverage of any kind. The default plan is subject to change, generally effective the next benefit year. If you are enrolled in a default plan and do not enroll during the following open enrollment, your default plan will be changed to the plan established as the default plan for that benefit year.

1.7. Changing Coverage

You may elect, change, or delete any coverage during one of the opportunities described below. However, dental and vision coverage may be added, changed, or deleted during one of these opportunities only after you have been enrolled in your current election for at least two benefit years.

a. Open Enrollment

For the short benefit year, open enrollment will be held in May or June 2013. Changes made during this open enrollment are effective for the short benefit year starting July 1, 2013, and ending December 31, 2013. There will be another open enrollment in November or December 2013, and changes made during this open enrollment will be effective for the benefit year starting January 1, 2014, and ending December 31, 2014. Thereafter, open enrollment will be held annually each November or December. Changes made during open enrollment are effective for the next benefit year (see Section 1.2, *Benefit Year*).

If you are on leave without pay or layoff on the date the open enrollment or benefit year begins, you may elect coverage either during open enrollment or within 30 days of the date you return to work.

If you do not change your benefits during the open enrollment, you will automatically be re-enrolled in the same benefits you had in the prior year unless you were in a default plan and the default plan is changed. In addition, participation in the reimbursement accounts **is not** automatically renewed. If you want to be in the reimbursement accounts, you **must** submit an enrollment during each open enrollment. The enrollment must be for **all** the benefits you

want. If you are enrolled in one benefit year, including in the reimbursement accounts, and you don't submit an enrollment during open enrollment, you automatically will be re-enrolled for any insurance you have, but you will be dropped from the reimbursement accounts.

Elections made during open enrollment will remain in effect until the end of the benefit year unless you terminate your employment or change your elections following a qualified change in your family or employment status (see section 1.7(b), *Change in Status or Other Applicable Event*). The short benefit year runs from July 1, 2013 through December 31, 2013. Effective January 1, 2014, each benefit year runs from January 1 through December 31 (see section 1.2, *Benefit Year*).

b. Change in Status or Other Applicable Event

You may change your elections, make a new election or, if otherwise permitted by the plan, end your elections during the benefit year if you submit your request for a change within 30 days (60 days if noted below) of a change in status or other applicable event. The election change will be effective the date of the change in status or applicable event.

The following are changes in status:

- You gain or lose a dependent through birth, adoption, marriage, divorce, or death.
- Your dependent child is no longer eligible under the terms of the plan.
- Your spouse or your dependent child terminates employment.
- You, your spouse or your dependent child begins or returns from an extended period of leave without pay or layoff.
- Your spouse or your dependent child begins employment.
- You, your spouse or your dependent child change employment status from full-time to part-time or vice versa.
- You, your spouse or your dependent child has a change in worksite that affects eligibility.
- You, your spouse or your dependent child return from a strike or lockout.
- Your spouse has a significant involuntary change in health coverage caused by his or her employment.
- You, your spouse or your dependent child has a change in the place of residence that affects eligibility.

Life insurance, accidental death and dismemberment insurance, survivor benefits, and short term and long-term disability insurance may always be changed following a change in status. Changes in medical, dental, vision and HFSA and DCAP benefits must be on account of the change in status, necessary or appropriate as a result of the change in status, and consistent with the terms and conditions of the qualified benefit. Note that if you are required to elect a medical and dental option, you may not end your medical or dental coverage because of the change in status.

There are other situations in which you can change your election mid benefit year. These other applicable events include:

- **Significant Change in Cost or Coverage**
  *(Does **not** apply to HFSA.)* If you elect to participate in the plan and your cost for qualified benefits, including DCAP, significantly increases or decreases during the benefit year, you may:

  ~ Make a corresponding increase or decrease in your payments

  ~ If there is a significant cost increase, revoke your existing election and elect to receive coverage, on a prospective basis, under another benefit package option providing similar coverage (if available), or if not available, drop coverage entirely (provided that you may not drop medical or dental coverage if it is required coverage); or

  ~ If there is a significant cost decrease, begin participation in the plan and elect the coverage that significantly decreased in cost.

  These changes will be allowed under the DCAP only if the cost change is required by a dependent care provider who is not your relative.

- **Cost Increase or Decrease**
  If you elect to participate in the plan and your cost for qualified benefits or DCAP coverage increases or decreases during the benefit year, and you are required to make a corresponding change in your premium payments, the plan may make a prospective increase or decrease, as appropriate, in premium payments. These changes will be allowed under the DCAP only if the cost change is required by a dependent care provider who is **not** your relative.

- **Coverage is Significantly Reduced (with a Loss of Coverage)**
  If you, your spouse, or dependent have a significant reduction in coverage that results in a "loss of coverage," then you may cancel your election for coverage and elect to receive coverage, on a prospective basis, under another benefit package option providing similar coverage (if available), or drop such coverage if no other benefit package option providing similar coverage

is available under the plan (provided that you may not drop medical or dental coverage if it is required coverage).

- **Coverage is Significantly Reduced (without a Loss of Coverage)**
  If you, your spouse, or dependent have a significant reduction in coverage but not a "loss of coverage" (for example, a significant increase in deductible, copayment, or out-of-pocket limit), then you may cancel your election for coverage and elect to receive coverage, on a prospective basis, under another coverage option providing similar coverage. Coverage under the plan is "significantly reduced" only if there is an overall reduction in coverage provided under the plan.

- **Addition or Significant Improvement of Qualified Benefit Providing Similar Coverage**
  *(Does **not** apply to HFSA.)* If the plan adds a new benefit plan option or other coverage option (or significantly improves an existing benefit option or other coverage option), you may cancel your existing option and elect the newly-added option or the significantly improved option providing similar coverage, on a prospective basis.

- **Change in or Loss of Coverage Under Other Employer's Plan or Other Group Health Plan**
  *(Does **not** apply to HFSA.)* You may make an election change that is on account of and corresponds with a change made under the group health plan of your spouse, former spouse, or dependent's employer if the other plan permits participants to make an election change or this plan permits participants to make an election for a period of coverage that is different from the period of coverage under the other plan. However, you may not drop medical or dental coverage if it is required coverage.

- **Loss of Coverage Under Governmental/Educational Group Health Plan**
  *(Does **not** apply to HFSA.)* You may make an election to add medical, dental or vision coverage for you, your spouse or dependent if any of you lose coverage under any group health plan sponsored by a governmental or educational institution (including a state children's health insurance program, medical program of an Indian Tribal government, a state health benefits risk pool or a foreign government group health plan).

- **Special Enrollment**
  (*60 day enrollment period applies. Does **not** apply to DCAP.)* If you or your spouse or dependent are entitled to HIPAA special enrollment under the plan – due to the addition of a new dependent by adoption, placement for adoption, birth, or marriage – you may make a mid-year change to your election consistent with your change in enrollment. Eligible individuals may also be enrolled in the plan during special enrollment periods if (1) the eligible individual is covered under a Medicaid plan under Title XIX of the Social Security Act or a state children's health plan under Title XXI of the Social Security Act, and (2) coverage under such plans is lost due to a loss of eligibility for such coverage. In addition, an eligible individual may be enrolled under the plan if the eligible individual becomes eligible for premium assistance under such Medicaid plan or a state children's health plan (including any waiver or demonstration project conducted under or in relation to such plan), to the extent required under HIPAA.

- **Entitlement to Medicare or Medicaid**
  *(Does **not** apply to HFSA.)* If you, your spouse, or your dependent are covered under the plan and become entitled to coverage under Medicare or Medicaid (other than coverage solely under the program for distribution of pediatric vaccines), you may change your election to cancel or reduce coverage under the plan for the entitled person (provided that you may not drop medical or dental coverage if it is required coverage). If there is a loss of coverage under Medicare or Medicaid, you may elect to begin or increase coverage under the plan for the affected person.

- **Court Order/Medical Child Support Order**
  *(Does **not** apply to DCAP.)* If you are subject to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order), you may make a consistent change in your qualified benefits under the plan to either: (1) cover the child or (2) cancel coverage of the child, as applicable.

1.8. When Coverage Begins

Health coverage begins and ends as described in section 2.3, *When Health Coverage Begins,* and section 2.4, *When Health Coverage Ends*. If you elect benefits other than health coverage, coverage begins on the dates described below assuming you have sufficient salary to pay the premiums.

a. New/Rehired Employees

Coverage begins on the first of the month following 30 days of employment. For example, if you begin work on March 15, you are covered on May 1.

b. Employees Returning from Leave Without Pay or Layoff

When you return from leave without pay or layoff, you are covered on the first of the month following your return to work. For example, if you return to work from leave without pay on July 15, coverage begins on August 1.

1.9. When Coverage Ends

Coverage under Select Benefits, including health coverage, ends at the earliest time that one of the following occurs:

a. Employees on Leave Without Pay or Layoff

Coverage ends on the last day of the month in which you were last in pay status. For example, if you worked or were on paid leave status on January 15 and then placed on leave without pay or layoff, coverage ends on January 31.

b. Employees Who Terminate Employment

Coverage ends on the last day of the month in which you last worked. For example, if you last worked on January 15 and terminated your employment, coverage ends on January 31.

c. Dependents

Coverage for a dependent (under benefit options that cover dependents) ends on the same day as the employee's coverage, unless:

- You divorce. Coverage for your spouse ends on the date the divorce is final; or
- Your child no longer meets **all** eligibility requirements (see section 1.3(b), *Dependents*). Coverage ends on the last day of the month in which the child first fails to meet any of these requirements.

d. Employees Moving to a Nonparticipating Unit

Health coverage ends on the last day of the month in which you move from a position which participates in Select Benefits to a position that does not. Other benefits are unaffected by this change.

e. Failure to Pay the Required Premium

Coverage terminates at the end of the month for which the last required premium was paid.

1.10. Submitting Claims

Claims for all benefits should be submitted on the appropriate forms as soon as possible, preferably within 90 days after the services or event occurs. Some plans have restrictions on how long you have to file claims. See each benefit plan section for information on obtaining forms and filing claims.

No action at law or equity may be brought to recover on any group policy after three years from the time written proof of the claim is required to be furnished.

1.11. Receipt of Documents

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

All Division documents should be sent directly to the Division, or in the case of a claim, to the address in the front of this book. The Division will not be bound to any action due to receipt of a document at a location other than the Division or proper claim office.

1.12. Future of the Plan

Although the State of Alaska intends to maintain the Select Benefits plan indefinitely, the State reserves the right, in its sole discretion, to alter, amend, delete, cancel, or otherwise change the plans or components of the plan or any premium payments for the plan at any time and from time to time, and to any extent that it deems advisable. No covered person will have any vested interest in the plan or its components.

1.13. Flexible Benefits Plan

As outlined in section 1.1, *The Select Benefits Plan,* Select Benefits gives you the opportunity to select the options and levels of coverage that meet your needs. The ability to make a selection between receiving taxable income or non-taxable benefits is governed by section 125 of the Internal Revenue Code. The Flexible Benefits plan described in this section 1.13 explains the rules that apply when making selections under the Select Benefits plan in order that your benefits are tax-free to you.

Specifically, the Flexible Benefits plan allows you to:

- Direct your employer to pay for your cost of qualified benefits with pre-tax dollars; and
- Save additional taxes through a Health Flexible Spending Account (HFSA) and/or a Dependent Care Assistance Plan (DCAP).

"Qualified benefits" means the benefits under the Select Benefits plan for medical, dental, vision, life insurance, accidental death and dismemberment insurance, survivor benefits, and/or short-term or long-term disability insurance coverage.

The cost for medical and dental coverage is paid in whole or part with benefit

credits (see section 1.4, *Benefit Credits/Premiums*). Benefit credits that exceed the cost of medical and dental coverage may be used to pay the cost of other qualified benefits. The remaining cost of all other qualified benefits is paid by reducing your salary, on a pre-tax basis per pay period, by an amount equal to your cost for such qualified benefits. If you participate in the Flexible Benefits plan, you will not pay federal, state, local, or Social Security and Medicare taxes on these pre-tax amounts. Please be aware that this may reduce your future Social Security benefits.

You will become a participant under the Flexible Benefits plan effective as of the date you are an eligible employee and become covered under any qualified benefit, provided you properly elect coverage. Section 1.3(a), *Who Is Covered,* describes who is an eligible employee. Section 1.8, *When Coverage Begins,* and section 2.3, *When Health Coverage Begins,* describe when coverage under a qualified benefit begins.

Coverage under the Flexible Benefits plan ends at the same time as your other benefits, as specified in section 1.9, *When Coverage Ends.* In addition to these events, coverage under the Flexible Benefits plan will also end on the earlier of:

- The date you are no longer an eligible employee (except as otherwise required by USERRA or the FMLA (see section 8.20, *Other Mandated Coverage*));
- The date you revoke your election to participate when such a change is permitted under the Flexible Benefits plan pursuant to this section and section 1.7, *Changing Coverage*;
- With respect to benefit credits and pre-tax premium deductions for qualified benefits, the end of the month in which coverage under the underlying qualified benefit ends; or
- With respect to your HFSA and/or DCAP, as set forth in section 9.3, *How the Plan Works* and section 14.2, *How the Plan Works,* respectively.

To make an election for the benefit year in which you first become a participant, you must make an election before the first day of the month in which participation begins (see section 1.5, *Electing Coverage*).

If, in your initial year of eligibility, you are a full-time employee and do not make an election on or before the specified due date, you will be deemed to have elected:

- To participate in the default plan (see section 1.6, *Default Plan*) and receive only medical and dental benefits on a pre-tax basis;
- Not to receive any other qualified benefits on a pre-tax basis, including, vision coverage, life insurance coverage, accidental death and dismemberment insurance coverage, survivor benefits, and/or short-term or long-term disability insurance coverage; and

- Not to have your salary reduced to participate in the HFSA and/or DCAP.

For each benefit year after you become a participant, you may make an election to: (i) change your current coverage, (ii) stop your coverage (except with respect to medical and dental benefits if you are a full-time employee), or (iii) begin coverage, on or before the last day of the open enrollment period prior to the next benefit year (see section 1.7, *Changing Coverage*).

An election, once made, will generally remain in effect until the earliest of:

- The date you are no longer a participant,
- The effective date of a new election,
- The date the Flexible Benefits plan or a qualified benefit ends, or
- The end of the benefit year, except as provided in this section and section 1.5, *Electing Coverage.*

Except as provided under this section and section 1.7, *Changing Coverage*, or as otherwise required by law, an election may be changed only as of the beginning of the benefit year after the election is made.

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2. Health Plan

Health Plan Highlights

- Coverage begins for new employees on the 31st consecutive day of work (no leave without pay can occur during the 31-day eligibility period except as to leave related to a health status factor).
- Coverage ends on the last day of the month in which pay status ends for employees who are on leave without pay or on layoff (except for federal family leave).
- Coverage ends on the last day of the month for terminating employees.
- Provides for continued coverage after termination.

2.1. Benefit Summary

This information is only intended to be a summary of coverages provided. Other provisions of this booklet contain additional information or exclusions. You may also refer to the Summary of Benefits and Coverage.

a. Medical Benefits

Deductibles	Premium Plan	Standard Plan	Economy Plan
Annual Individual Deductible	$150*	$150*	$250*
Annual Family Deductible Limit	$300*	$300*	$500*
Coinsurance	**Premium Plan**	**Standard Plan**	**Economy Plan**
Most Medical Expenses	90%	80%	70%
Most Medical Expenses after Out-of-Pocket Limit	100%	100%	100%
Chemical Dependency Treatment	90%	80%	70%
Mental/Nervous Treatment without Certification	50%	50%	50%

**For the short benefit year July 1, 2013 through December 31, 2013.*

i. Out-of-Pocket Limit

After the deductible, the plan pays the coinsurance shown above for most medical expenses until your portion reaches the out-of-pocket limit shown below. After that, the plan pays 100% of most covered services for the remainder of the benefit year for that person. Expenses that are paid at a coinsurance rate different than your normal coinsurance, such as mental/nervous disorder treatment without certification, are not credited to this out-of-pocket limit.

	Premium Plan	Standard Plan	Economy Plan
Out-of-pocket limit in addition to the deductible	$175*	$600*	$1,000*

**For the short benefit year July 1, 2013 through December 31, 2013.*

ii. Prescription Drug Copayments

You pay the amounts listed below for each prescription up to a 30-day or 90-day supply.

Prescription Drugs		
	Up to 30-Day Supply	31 to 90-Day Supply
Participating Pharmacy All Drugs Minimum Maximum	 20% copay $13 copay $61 copay	 20% copay $21 copay $122 copay
Mail Order Generic Brand Name		 $8 copay $20 copay
Annual Copay Maximum	$500* Individual $1,000* Family	

**For the short benefit year July 1, 2013 through December 31, 2013.*

Prescriptions filled at a nonparticipating pharmacy are subject to the medical plan deductible and paid at 60%.

Prescription drug mail order forms are available from the web, the claims administrator, or the Division.

iii. Benefit Maximum

Mental and Nervous Disorders Treatment Without Certification or Plan Referral	30 outpatient visits per year 50% copay
Chemical Dependency Treatment Without Certification or Plan Referral	30 outpatient visits per year
Spinal Treatment Annual Limit	$750 per person

b. Dental Benefits

Deductibles	Premium Plan	Standard Plan	Preventive Plan
Annual Individual – Class I services	None	None	$12.50*
Annual Individual – Class II and III (combined services)	$12.50*	$12.50*	Not Covered
Annual Family Maximum	$37.50*	$37.50*	$37.50*
Coinsurance	**Premium Plan**	**Standard Plan**	**Preventive Plan**
Class I (preventive) services	100%	100%	100%
Class II (restorative) services	85%	85%	Not Covered
Class III (prosthetic) services	75%	50%	Not Covered
Orthodontia	50%	Not Covered	Not Covered
Benefit Maximums	**Premium Plan**	**Standard Plan**	**Preventive Plan**
Annual Individual Maximum	$2,500	$1,500	$500
Orthodontia Individual Lifetime Maximum	$2,000	Not Covered	Not Covered

**For the short benefit year July 1, 2013 through December 31, 2013.*

c. Vision Benefits

	Managed Care Plan (Member Doctor)	Managed Care Plan (Non-Member Doctor)	Standard Plan
Co-payment	Exam: $10 Lenses and frames: $25 (combined)	Not applicable	Not applicable
Exams	One per benefit year Covered in full less any applicable copayment	One per benefit year up to a maximum benefit limit of $45	One per benefit year 90% covered
Lenses	One pair per benefit year Single vision: 100%* Bifocal: 100%* Trifocal: 100%* Lenticular: 100%* **Less any applicable copayment*	One pair per benefit year subject to the following reimbursement limits: Single vision: $45 Bifocal: $65 Trifocal: $85 Lenticular: $125	One pair per benefit year Single vision: 100% Bifocal: 100% Trifocal: 100% Lenticular: 100%
Lens Options	Every benefit year Anti-reflective coating: 100% Scratch resistant coating: 100% Polycarbonate lenses: 100% All other in-network lens options at discounted price controlled pricing	Every benefit year Anti-reflective coating: not covered Scratch resistant coating: not covered Polycarbonate lenses: not covered Progressive lenses: up to $85	Every benefit year Anti-reflective coating: not covered Scratch resistant coating: not covered Polycarbonate lenses: not covered Progressive lenses: covered if bundled into the lens charge. If Progressive is billed as a lens option, then it is not covered
Frames	One pair every other benefit year $130 allowance for a wide selection of frames 20% off amount over allowance $70 allowance at Costco	One pair every other benefit year up to $47	One pair every other benefit year $90 maximum
Contact Lenses (instead of glasses)	$105 allowance for contacts and contact lens exam (fitting and evaluation)	$105 allowance for contacts and contact lens exam (fitting and evaluation)	$170 maximum for contact lenses
Annual Individual Maximum	Not applicable	Not applicable	$350/covered person

**For the short benefit year July 1, 2013 through December 31, 2013.*

Note: Under the Managed Care Plan, benefits at affiliate providers may differ.

d. Audio Benefits

Coinsurance	
All Services	80%
Benefit Maximums	
Individual Maximum/3 consecutive years	$800

2.2. Introduction

The State of Alaska provides comprehensive benefits for you and your family, including hospitalization, medical, surgical, maternity care, and other services necessary for the diagnosis and treatment of a nonoccupational injury or disease.

These benefits are subject to change. You should ensure that you have the current booklet and any addendum by contacting the Division or visiting its Web site.

2.3. When Health Coverage Begins

a. New Employees

If you are a permanent or long-term nonpermanent full-time or full-time seasonal employee, you and your eligible dependents are covered on the 31st consecutive day you are at work in pay status.

Example

If you begin work on October 1, you are covered on October 31, assuming you have no periods of leave without pay or do not terminate your employment during that time.

If you are a permanent or long-term nonpermanent part-time or part-time seasonal employee who elects coverage during the first 30 days of employment, you and your eligible dependents are covered on the 31st consecutive day you are at work in pay status.

If you have leave without pay (except for a leave related to a health factor) during your first 30 days of employment, you are covered after you return to work and are in pay status for 31 consecutive days. For example, if you start work on October 1, but have leave without pay and return to work October 15, coverage begins on November 14.

b. Rehired Employees

If you were previously insured under this health plan as an actively working employee and you are rehired **within** seven calendar days of the date your insurance terminated, your coverage begins on the day you return. For example, if your coverage ends July 31 and you return to work on or before August 7, you are covered the day you return to work. If you were previously insured and you are rehired **more than** seven calendar days after your insurance terminated, you are considered a new employee and coverage for you and your dependents begins on the 31st consecutive day as specified for new employees.

c. Employees Returning from Leave Without Pay or Layoff

If you were covered when you began leave without pay or layoff, when you return to work from leave without pay or layoff, you are covered starting the day you begin work. For example, if you return to work from leave without pay on July 15, coverage begins that day. Your dependents are eligible at the same time.

d. New Dependents

If you add new dependents, they are eligible for benefits immediately.

e. Employees Moving from a Nonparticipating Unit

Employees who move from a bargaining unit which does not participate in the State Health plan to a bargaining unit that participates in Select Benefits will be covered on the first day of the month after the bargaining unit change occurs. For example, if your bargaining unit change is effective October 15, your health benefits change on November 1. If the change is effective on the first of the month, health benefits also change on that day. For example, if your bargaining unit change is effective November 1, your health benefits change on that day. If you are not in pay status at the time the change occurs, you will not be covered until the day you return to pay status.

2.4. When Health Coverage Ends

Coverage under the Group Health plan ends at the same time as your other benefits, as specified in section 1.9, *When Coverage Ends*.

There are several options available for continuing health benefits when coverage ends. Options are described in section 7, *COBRA and Extended Health Coverage*.

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3. Medical Benefits

Medical Plan Highlights

- Requires an annual deductible for each person, with a maximum annual deductible per family.
- Pays the coinsurance amount you select after the deductible for most covered expenses each year until your out-of-pocket expenses reach your out-of-pocket limit, then pays 100% of most covered expenses for that person for the remainder of the benefit year.
- Requires certification from the claims administrator for all inpatient stays, outpatient chemical dependency and mental disorder treatment, home health care, skilled nursing services, and certain outpatient procedures.
- Provides participating pharmacy card and mail-order programs for prescription drugs.
- Has an unlimited lifetime maximum benefit.

3.1. About the Medical Plans

There are three plans available; Economy, Standard, and Premium. The plans are identical in what is covered and how benefits are paid with the only difference being in the deductible, coinsurance, and out-of-pocket limits. Please refer to section 2.1, *Benefit Summary,* for details about how these items differ between the plans.

You choose which plan you want during the times described in the preceding sections. All plans cover you and your eligible dependents as described in the preceding sections. If you choose the Premium plan, you may choose it to cover yourself only or yourself and your family. If you choose Premium coverage for yourself only, you receive the higher coinsurance on your claims or out-of-pocket limit. Your dependents will be covered by the provisions of the Standard plan, with its lower coinsurance and higher out-of-pocket limit. If you choose the Standard or Economy plans, you and your dependents are covered by the same provisions. See the section 3.2(b), *Deductibles,* and section 3.2(c), *Coinsurance,* below for a description of how those provisions are applied.

3.2. How Medical Benefits Are Paid

a. Benefit Year

The short benefit year for this plan begins July 1, 2013 and ends December 31, 2013. Effective January 1, 2014, each benefit year runs from January 1 through December 31. Thereafter, all benefit limits in a benefit year are reset on January 1 each year.

b. Deductibles

The deductible amount is based on the plan you are enrolled in, Economy, Standard, or Premium, as shown in section 2.1, *Benefit Summary*.

Each covered person must first meet the annual deductible, until your family reaches the family deductible limit, before the medical plan begins to pay benefits. In the event of a common accident involving two or more family members, only one deductible is required.

c. Coinsurance

After you meet the annual deductible, the medical plan pays the coinsurance amount, based on the plan you are enrolled in, for most covered expenses. Your out-of-pocket expense, the amount you must pay in addition to the deductible, is the difference between the coinsurance amount paid by the plan, and 100% of covered expenses. When your out-of-pocket expense equals the out-of-pocket limit for the plan you are enrolled in for any one person, the medical plan pays 100% of most covered medical expenses for that person for the rest of the benefit year. This out-of-pocket limit does not apply to expenses paid at a rate other than the normal coinsurance, to expenses applied against deductibles or copayments, or to benefits not payable because of failure to precertify or follow plan referrals.

For example, if you enrolled in the Standard plan, you must first satisfy a deductible of $250. Then the plan pays 80% of most of your covered expenses. When your 20% payments total $1,000, most claims for you for the rest of the benefit year would be paid at 100%.

d. Maximum Allowed Charges

Claims payment is limited to the maximum allowed charge for eligible services. If a charge exceeds the maximum allowed charge, the amount above the maximum allowed charge is not covered by the Plan, and is your responsibility to pay.

The maximum allowed charge is the charge contained in an agreement the claims administrator has with the provider either directly or through a third party. If no agreement is in place, the maximum allowed charge is determined in accordance with the provisions of this section 3.2(d).

To determine the maximum allowed charge, the Plan utilizes the benchmark data on healthcare charges compiled by and licensed from FAIR Health, Inc. The benchmarks are based on 12 months of charges and are arranged in percentiles by procedure codes and geozips.

Procedure codes are codes (alpha/numeric) assigned to services and procedures performed for patients by medical and dental practitioners. Each code number is unique and refers to a specific medical service or procedure. For purposes of determining the maximum allowed charge, the procedure codes utilized are the Current Procedural Terminology, or CPT codes owned and licensed from the American Medical Association. For dental procedures, the Code on Dental Procedures and Nomenclature, or (CDT) codes, owned by and licensed from the American Dental Association, are used.

Geozips refer to geographical areas generally organized by the first three digits of the U.S. zip codes. For purposes of determining the maximum allowed charge, the State of Alaska is divided into three geozips:

Area #1 – Geozip 996	Area #2 – Geozip 995	Area #3 – Geozip 999
Zip Codes that begin with 996 or 998	Zip Codes that begin with 995 or 997	Zip Codes that begin with 999

Alaska data relate to services provided in Alaska. If a procedure is provided in a different state, FAIR Health data for the appropriate state will be used. Only Inpatient Facility data are not organized by geozip; nationally these data are organized by 18 regions defined as rural or urban. Inpatient Facility data for Alaska are organized into two regions, rural and urban.

i. Calculation Methodologies

For purposes of determining the maximum allowed charge, the Plan utilizes the following Fair Health Benchmark modules which provide charge values by percentile based on geozip and procedure code:

- FH Benchmarks Medical/Surgical
- FH Benchmarks Anesthesia
- FH Benchmarks Dental
- FH Benchmarks Healthcare Common Procedure Coding System (HCPCS)

Benchmark data are updated at least twice a year in the FAIR Health database. The cutoff date for benchmark data to be included in a module is approximately three months prior to the release of each module. FAIR Health® data are arranged by percentiles, and provide benchmark values from lowest to highest from the 50th to the 95th percentile. The Plan sets the maximum allowed charge at the 90th percentile benchmark which is either an actual or derived value as described below.

(a) **Actual Value:** Actual provider charges are utilized generally when there are nine or more occurrences of a procedure in a particular geozip. An occurrence is a single service or procedure. Occurrences may be by the same or different providers. Insurers and claims administrators who contribute data to FAIR Health must submit all their claims for all services and procedures for the particular time period. For example, if there were claims submitted by a contributor for 10 brain surgeries in a geozip for the period, there would be 10 "occurrences" of that procedure. These would be added to the "occurrences" reported for the geozip by other contributors. The total occurrences in a geozip indicate the number of times a procedure was reported as performed (or service as provided) in the geozip for a 12 – month period reflected in the module from the data submitted by all contributors.

To determine percentile values for actual charges, the provider charges are arrayed from lowest to highest and the percentile values are determined. The modules provide values for charge data from the 50th to the 95th percentiles. When an actual value is reported for the 70th percentile, for example, it indicates that 70 percent of the charges for the code and geozip are equal to or lower than the reported value and 30 percent of the charges are higher than the reported value; at the 80th percentile, 80 percent are lower and 20 percent are higher. The Plan uses the 90th percentile benchmark to determine the maximum allowed charge.

(b) **Derived Value:** When there are fewer than the number of occurrences required to calculate an "actual" value of a procedure (or no occurrences) in a geographic area, FAIR Health's relative value methodology is used to determine the benchmark values. This method utilizes a relative value scale and the actual charge data to determine conversion factors used to develop benchmark charges.

Explanation of Derivation Process

- *Geozip* – FAIR Health defines geographic areas for its data generally on the basis of the first three digits of a ZIP code. Referred to as a geozip, an area may contain one three-digit ZIP code or a grouping of three-digit ZIP codes.
- *Code Range* – FAIR Health groups related procedure codes into a series of ranges. Using a range of codes, Fair Health can model less frequently performed services using the billing patterns of frequently performed similar services in the same geographic area and time period. All charge data for the codes within a range are used to derive the percentile values for each of the codes under this methodology.
- *Relative Value* – Each code has a relative value. In a relative value system, healthcare services and procedures are each assigned a "relative value" based on the resources, time, risks and complexity of the particular service or procedure in comparison with other procedures.
- *Conversion Factor* – The conversion factor is determined by dividing each of the billed charges for every code in a range by its associated relative value.
- *Assigning Conversion Factors to Percentiles* – When the conversion factors for all the charges in the code range are determined, they are used to calculate the percentile values. First, the conversion factors for all codes in the range are arrayed from lowest to the highest then they are assigned to percentiles. For example, if there are 100 charge frequencies for a code group, each charge has a related conversion factor. The conversion factor that appears in the 80th place on the spectrum of lowest to highest is the 80th percentile conversion factor.
- *Calculating the Benchmark* – The conversion factor is multiplied by the relative value for each procedure code in the code range to produce the benchmark values.

All data in the Allowed Medical, Inpatient Facility and Outpatient Facility modules are derived.

ii. Claims Administrator Adjustments

If two or more surgical procedures are performed through the same site or bilaterally (on two similar body parts, such as two feet) during a single operation, the Plan calculates payment as follows:

- The claims administrator will determine which procedures are primary, secondary and tertiary, taking into account the billed amounts;
- Payment for each procedure will be made at the lesser of the billed charge or the following percentage of the maximum allowed charge:
  - ~ Primary: 100%
  - ~ Secondary: 50%
  - ~ All others: 25%

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

Assistant surgeons are paid at 25% of the maximum allowed charge.

e. Lifetime Maximum

The plan provides an unlimited lifetime benefit for each covered person for all covered medical expenses, except that the audio benefit pays only up to the maximum benefit shown in Section 2.1(d), *Benefit Summary,* for each person in a covered three-year period consisting of the current and two previous benefit years.

3.3. Covered Medical Expenses

The medical plan provides coverage for you and your eligible dependents subject to the provisions of this section 3.

a. Medical Necessity

i. Medically Necessary Services or Supplies

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

- Care or treatment which is expected to improve or maintain your health or to relieve pain and suffering without aggravating the condition or causing additional health problems;
- A diagnostic procedure which is expected to provide information to determine the course of treatment; and
- No more costly than another service or supply which could fulfill these requirements.

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

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

ii. Medically Unnecessary Services or Supplies

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

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

b. Physician's Services

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

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

Also covered are:

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

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

c. Nurse Advice Line

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

d. Preventive Care Services

The purpose of providing preventive care benefits is to promote wellness, disease prevention and early detection by encouraging participants to have regular preventive examinations to identify potential health risks and provide the opportunity for early intervention.

i. Scope of Preventive Care Services

(a) Services are considered preventive care when a participant:

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

(b) If a health condition is diagnosed during a preventive care exam or screening, the preventive exam or screening still qualifies for preventive care coverage.

(c) Services are considered diagnostic care, and not preventive care, when:

- Abnormal results on a previous preventive or diagnostic screening test requires further diagnostic testing or services,
- Abnormal test results found on a previous preventive or diagnostic service requires the same test be repeated sooner than the normal age and gender guideline as recommended by the U.S. Preventive Services Task Force would require, or
- Services are ordered due to current symptom(s) that require further diagnosis.

ii. Coverage

(a) The plan will pay for preventive care services only if the service:

- Falls within the scope of a preventive care service in section 3.3(d)(i) *Scope of Preventive Care Services;* and
- Is identified as a covered preventive service in section 3.3(d)(iii), *Covered Preventive Care Services for Adults,* section 3.3(d)(iv), *Covered Preventive Care Services for Children,* and section 3.3(d)(v), *Prevention of Obesity.*

(b) Payment Rates:

- Unless otherwise specified, preventive care services identified in 3.3d-iii, *Covered Preventive Care Services for Adults,* section 3.3(d)(iv), *Covered Preventive Care Services for Children,* and section 3.3(d)(v), *Prevention of Obesity,* are not subject to co-payment or deductible, and will be paid at 100% of the provider's rate, if the provider is an in-network provider. Preventive care services provided by an out-of-network provider are subject to payment under plan provisions governing non-preventive care services.

(c) Unless otherwise specified, services identified in 3.3(d)(iii), *Covered Preventive Care Services for Adults,* section 3.3(d)(iv), *Covered Preventive Care Services for Children,* and section 3.3(d)(v), *Prevention of Obesity,* are limited for payment as a preventive care benefit at the frequency of once per benefit year.

iii. Covered Preventive Care Services for Adults

The preventive care benefit provides the following services at the frequencies indicated for adults age 19 and above.

(a) General Health Care

- Physical exams – once per benefit year for adults age 19 and older.
- Pelvic/breast exam by practitioner – once per benefit year.

(b) Screening Procedures

- Lipid panel – routine screening every five years beginning at age 20. More frequent testing of those at risk for cardiovascular disease as determined by physician.
- Fasting blood glucose – for high-risk patients screenings starting at age 45 at three-year intervals. Earlier screening as determined by physician for individuals with risk factors.
- Abdominal aortic aneurysm screening – one-time screening by ultrasonography for men between age 65 and 75 who previously smoked.
- Mammogram – starting at age 40, performed once each benefit year if recommended by physician.
- BRCA mutation – one-time genetic assessment for breast and ovarian cancer susceptibility as recommended by physician. One breast MRI per benefit year if BRCA positive or immediate family of BRCA carrier but untested.
- Pap test – test every 1-3 years as determined by physician.

- Chlamydia, gonorrhea, HIV and syphilis screening – all sexually active male and females, as recommended by physician.
- Bone mineral density screening – once every two benefit years for women 65 years and older or men 70 years and older. Or, younger postmenopausal women who have had a fracture or have one or more risk factors for osteoporosis as determined by physician.
- Colorectal cancer screening – all men and women beginning at age 50, one Fecal Occult Blood Test (FOBT) screening each benefit year, or screening with flexible sigmoidoscopy every five years with or without annual FOBT, or double contrast barium enema every five years or colonoscopy every 10 years. High-risk: earlier or more frequently as recommended by physician.
- Prostate cancer screening: discussion of risks/benefits of prostate cancer screening. Testing may include annual Prostate Specific Antigen (PSA) and/or exam.

(c) Immunizations:

- Diphtheria, Tetanus (Td/Tdap) – one-time Tdap. Td booster every 10 years for all adults.
- Measles, Mumps, Rubella (MMR) – one to two doses as recommended by physician for all adults.
- Pneumococcal – high-risk or at age 65; one to two doses as recommended by physician for all adults.
- Influenza – once per benefit year for all adults.
- Chicken Pox (Varicella) – one series of two doses at least one month apart for adults with no history of chicken pox.
- Hepatitis A – based on individual risk or physician recommendation: one two-dose series.
- Hepatitis B – based on individual risk or physician recommendation: one three-dose series.
- Meningococcal – based on individual risk or physician recommendation: one or two doses per lifetime.
- Human Papillomavirus (HPV) – for individuals 9-26, one three-dose series. Dose 2 at 2 months from Dose 1. Dose 3 at 6 months from Dose 1.
- Shingles (Zoster) – one dose age 60 years of age and older for all adults.

iv. Covered Preventive Care Services for Children

The preventive care benefit provides the following services at the frequencies indicated for children from birth to age 18.

(a) General Health Care

- Wellness exam[1] – at birth; at age 1, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months; and every year from age 3 through 18.
- Blood pressure – every year from age 3 through 18.
- Visual screening[2,3] – every year from age 3 through 6; and at age 8, 10, 12, 15, and 18.
- Hearing screening[2] – at birth; every year from age 4 through 6; and at age 8, 10, 12, and 15.

(b) Screenings

- Hereditary/Metabolic Screening
  ~ At birth
- Lead Screening
  ~ At age 9 months
  ~ When indicated
- Hematocrit or Hemoglobin
  ~ At age 12 months
  ~ Annually for females during adolescence and when indicated

(c) Immunizations[4]

- Hepatitis A[5]
  ~ Dose 1 at age 12 months
  ~ Dose 2 at age 18 months
- Hepatitis B[5]
  ~ Dose 1 at birth
  ~ Dose 2 at age 2 months
  ~ Dose 3 ate age 6 to 18 months
- Diphtheria/Tetanus/Pertussis (DTaP)[6]
  ~ Dose 1 at age 2 months
  ~ Dose 2 at age 4 months
  ~ Dose 3 at age 6 months
  ~ Dose 4 at age 15 to 18 months
  ~ Dose 5 at age 4 to 6
  ~ After age 7: One dose of Tdap if five doses were not received previously

- H. Influenza Type B (Hib)
  ~ Dose 1 at age 2 months
  ~ Dose 2 at age 4 months
  ~ Dose 3 at age 6 months[6]
  ~ Dose 4 at age 12 to 15 months
- Polio (IPV)[6]
  ~ Dose 1 at age 2 months
  ~ Dose 2 at age 4 months
  ~ Dose 3 at age 6 to 18 months
  ~ Dose 4 at age 4 to 6
- Pneumococcal Conjugate (PCV)[6,7]
  ~ Dose 1 at age 2 months
  ~ Dose 2 at age 4 months
  ~ Dose 3 at age 6 months
  ~ Dose 4 at age 12 to 15 months
- Measles/Mumps/Rubella (MMR)[5]
  ~ Dose 1 at age 12 to 15 months
  ~ The second dose of MMR is routinely recommended at age 4 to 6, but may be administered during any visit, provided at least one month has elapsed since the receipt of the first dose and that both doses are administered at or after age 12 months.
- Chicken Pox[5]
  ~ Dose 1 at age 12 to 15 months
  ~ Dose 2 at age 4 to 6
  ~ Children not receiving the vaccine prior to 18 months can receive the vaccine at any time. Children 13 years or older who haven't been vaccinated and haven't had chicken pox should receive two doses of the vaccine at least four weeks apart. Second dose catch-up is recommended for those who previously received only one dose.
- Influenza[5]
  ~ One or two doses annually for all children from age 6 months through age 18.
- Meninogococcal[6]
  ~ Dose 1 at age 11 to 12
  ~ One-time booster at age 16

- Rotavirus
  - ~ Dose 1 at age 2 months
  - ~ Dose 2 at age 4 months
  - ~ Dose 3 at age 6 months
- Human Papillomavirus (HPV)
  - ~ One three-dose series for individuals between ages 9 and 26. Dose 2 at two months from Dose 1. Dose 3 at six months from Dose 1.

(d) Care for Patients with Risk Factors

- Tuberculin Test
  - ~ Testing should be done upon recognition of high-risk factors. Frequency should be determined by community and personal risk factors.
- Cholesterol Screening
  - ~ Screening will be done at the doctor's discretion, based on the child's family history and risk factors.
- Chlamydia, Gonorrhea, HIV, and Syphilis Screening[8,9]
  - ~ As recommended by doctor
- Pelvic Exam and Pap Test[9,10]
  - ~ As recommended by doctor

[1] This includes, at appropriate ages, height, weight, and Body Mass Index (BMI) measurement, developmental and behavioral assessment, including autism screening, and other care as determined by doctor.

[2] As shown and when conditions indicate. If patient is uncooperative, rescreen within six months.

[3] Optometric exams require and optional vision benefit.

[4] Additional immunizations and expanded age ranges may be eligible based on the Alaska state mandate for childhood immunizations.

[5] Children can get this vaccine at any age if not previously vaccinated.

[6] Or other series/schedule as recommended by doctor.

[7] Previously unvaccinated older infants and children who are beyond the age of the routine infant schedule should follow the dosing guidelines recommended by their doctor.

[8] Routine screening for all sexually active females and males.

[9] Strongly recommended for females who have been sexually active.

[10] Pap tests should begin approximately three years after the onset of sexual activity.

v. Prevention of Obesity

The Preventive Care Benefit provides the following obesity prevention services at the frequencies indicated:

(a) Benefits for Children (birth through age 18)

Children with a body mass index (BMI) in the 85th and 95th percentile are eligible for:

- Four additional preventive office visits per benefit year specifically for obesity.
- One set of recommended laboratory studies per benefit year as follows:
  - ~ Lipid Profile
  - ~ Hemoglobin A1c
  - ~ Aspartate Aminotransferase (AST)
  - ~ Alanine Aminotransferase (ALT)
  - ~ Fasting Glucose (FBS)

(b) Benefits for Adults (age 19 and above)

Adults with BMI over 30 are eligible for:

- Two additional preventive office visits per benefit year specifically for obesity and blood pressure measurement.
- One set of laboratory studies per benefit year as follows:
  - ~ Lipid Profile
  - ~ Hemoglobin A1c
  - ~ Aspartate Aminotransferase (AST)
  - ~ Alanine Aminotransferase (ALT)
  - ~ Fasting Glucose (FBS)

e. Emergency Room Visits

Visits to the emergency room of a hospital are paid at normal plan benefits. However, if the visit is for nonemergency services, a penalty of $100 will be applied to the claim before benefits are calculated.

An emergency is defined as a sudden and unexpected change in a person's condition which, if immediate care is not provided, could be expected to result in loss of life or limb, significant impairment to bodily function or permanent dysfunction of a body part. A nonemergency is anything that does not meet this criteria.

Services received in a physician's office or an urgent care facility are not subject to this penalty.

f. Hospitalization

Important: Certification is required for all hospital stays. If certification is not obtained, a $400 penalty will be assessed before any benefits may be paid. Please refer to section 3.3(l), *Certification.*

i. Hospital Coverage

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

- Be accredited by the Joint Commission on Accreditation of Hospitals, be a 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.

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

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

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

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

ii. Hospital-Only Preferred Provider Agreement

There is a hospital-only preferred provider agreement in effect for hospital services in the municipality of Anchorage, and in the remaining 49 states. This preferred provider agreement does not include services provided by hospitals outside of Anchorage while still in Alaska. The preferred provider in Anchorage is Alaska Regional Hospital.

The plan will reduce benefits by 20 percent if a member receives services from a nonpreferred hospital. In addition, the out-of-pocket maximum that otherwise applies under your plan will be doubled. All services provided by a hospital, including testing or outpatient surgery, are subject to this provision except for:

- Services received when following a referral from the managed behavioral health administrator for mental health/chemical dependency treatment,
- Services that cannot be performed at the preferred Anchorage area hospital, or
- Services received for emergency treatment defined by the plan as follows: A medical emergency is the sudden and unexpected onset of a condition or an injury—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 serious jeopardy in the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child. There are many conditions that may determine medical emergencies – what they all have in common is the need for quick action.
- Services that are provided by a hospital with respect to which the Select Benefits plan receives a discount because of the relationship of that hospital with the preferred provider, provided that the hospital is located outside of the municipality of Anchorage or in one of the other 49 states.

Coordination of benefits will be provided without penalty for dependents whose primary insurance participates with a nonpreferred provider.

g. Home Health Care

Important: Certification is required before any home health care is received. If certification is not obtained, a $200 penalty will be assessed before any benefits may be paid. Please refer to section 3.3(l), *Certification.*

The medical plan pays for the charges of a home health care agency for services and supplies furnished to you at home for care in accordance with a home health care plan.

A home health care agency is an organization:

- Providing skilled nursing and other therapeutic services in the patient's home;
- Associated with a professional policy-making group of at least one physician and one full-time supervising registered nurse;
- Keeping complete medical records on each patient;
- Staffed by a full-time administrator; and
- Meeting licensing standards.

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

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

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

- A visit by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) to provide skilled nursing care;
- A visit from therapists to provide physical, occupational, or speech therapy; and
- Up to four hours of assistance by a home health aide.

Skilled nursing care:

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

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

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

- Services or supplies not included in the home health care plan;
- Services of a person who ordinarily resides in your home or is a member of your family or the family of your spouse;
- Services of any social worker; and
- Transportation services.

h. Skilled Nursing Care

Important: Certification is required before any skilled nursing care is received. If certification is not obtained, a $200 penalty will be assessed before any benefits may be paid. Please refer to section 3.3(l), *Certification.*

The medical plan pays for charges by a registered nurse (R.N.), licensed practical nurse (L.P.N.), or nursing agency for skilled care. Services must be certified for you to receive full plan benefits.

Covered services include:

- Visiting nursing care of an R.N. or L.P.N. of not more than two hours to perform specific skilled nursing tasks; and
- Private duty nursing by an R.N. or L.P.N. if your condition requires skilled nursing services and visiting nursing care is inadequate.

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

- Nursing care that does not require the education, training and technical skills of an R.N. or L.P.N., such as transportation, meal preparation, charting of vital signs, and companionship activities;
- Private duty nursing care given while the person is an inpatient in a hospital or other health care facility;
- Care provided to help a person in the activities of daily life, such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting;
- Care provided solely for skilled observation except as follows for no more than 4 hours per day for a period of no more than 10 consecutive days following the occurrence of:

~ Change in patient medication;

~ Need for urgent or emergency medical services provided by a physician, or the onset of symptoms indicating the likely need for such services;

~ Surgery;

~ Release from inpatient confinement; or

- Any service provided solely to administer oral medicines, except where applicable law requires that such medicines be administered by an R.N. or L.P.N.

i. Skilled Nursing Facility

Important: Certification is required before any skilled nursing facility care is received. If certification is not obtained, a $200 penalty will be assessed before any benefits may be paid. Please refer to section 3.3(l), *Certification*.

The medical plan pays for charges of a skilled nursing facility while you are confined for recovery from a disease or injury.

The following services at a skilled nursing facility are covered:

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

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

- 24-hour professional nursing care by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), if directed by a full-time R.N.;
- Physical restoration services to help a patient meet a goal of self-care in daily living activities;
- Full-time supervision by a physician or R.N.;
- A complete medical record on each patient; and

- A utilization review plan.

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

j. Outpatient Procedures and Plan-Required Second Opinions

Important: Certification is required before having any of the following procedures. If certification is not obtained, a $200 penalty will be assessed before any benefits may be paid. Please refer to section 3.3(l), *Certification*.

- MRI-knee: study of the knee using magnetic resonance imaging technology. If the necessity for this procedure cannot be readily determined, you may be required to have an independent medical exam by a physician certified by the appropriate specialty board and not in practice with the physician recommending the procedure or treatment. The results of this exam will be used as a second opinion to determine the necessity of the procedure or treatment.
- MRI-spine: study of the spine using magnetic resonance imaging technology

k. Employee-Elected Second Opinions

The plan pays for obtaining a second surgical opinion when the first surgeon has recommended nonemergency (see section 3.3(e), *Emergency Room Visits,* for definition of emergency) surgery.

Charges for X-rays and diagnostic tests required in connection with the second opinions are included. However, to avoid duplication, the attending physician is encouraged to share X-ray and test results with the consulting physician(s).

To qualify for second opinion benefits, the proposed surgery:

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

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

An emergency is defined as a sudden and unexpected change in a person's physical condition with acute symptoms which are widely accepted professionally in the United States as severe enough to require immediate care. A nonemergency is anything that would not meet these conditions for immediate care.

l. Certification

To receive full benefits, certification is required for:

- Confinement in a hospital, treatment facility or skilled nursing facility;
- Home health care or skilled nursing care services;
- Outpatient psychiatric and chemical dependency treatment; and
- Any of the procedures or treatments listed under in section 3.3(j), *Outpatient Procedures and Plan-Required Second Opinions.*

Call the claims administrator for certification of all services except for psychiatric or chemical dependency treatment. To request certification for inpatient or outpatient psychiatric or chemical dependency treatment, call the managed mental health administrator. (See section 3.3(l)(iv), *Mental Health Benefits Without Certification,* for more information on certification for mental disorders or chemical dependency.) Phone numbers for these administrators are shown in the front of this booklet. You, your physician, or the facility may call. Initial and ongoing certifications are made following a medical review by the claims administrator.

i. When To Call

You should call:

- At least 14 days in advance of a prescheduled admission, or as soon as the admission is scheduled (you must call **before** the confinement or service begins);
- 60 days before the expected delivery date for maternity; or
- Within two working days following an emergency admission, or as soon as reasonably possible.

An emergency admission is an admission where the physician admits the person to the hospital right after the sudden and unexpected change in a person's physical or mental condition which:

- Requires immediate confinement as a full-time hospital inpatient; and
- If immediate inpatient care was not given could, as determined by the claims administrator, reasonably be expected to result in:
  - ~ Loss of life or limb;
  - ~ Significant impairment to bodily function; or
  - ~ Permanent dysfunction of a body part.

You will receive prompt written notice of the days and/or services approved. If you are to be confined in a hospital or other facility, the claims administrator sends notice to the hospital or the facility as well as to you and your physician.

ii. Certification of Additional Days

If your physician is considering lengthening a stay, you, your physician, or the hospital or facility must call the claims administrator to request certification for additional days. Call no later than the last day previously certified. Also call if the physician sees a need for additional home health care, skilled nursing services, or supplies.

If there has been no prior contact, the claims administrator will contact the facility on the last scheduled date of confinement to check your condition. If medically necessary, additional days of confinement may be certified at that time.

When the claims administrator certifies any confinement, procedure, service, or supply, it is only for the purpose of reviewing whether the service is necessary to the care or treatment of the illness or injury. Certification does not guarantee that all charges are covered under the plan. All charges submitted for payment are subject to all other terms and conditions of the plan, regardless of certification by the claims administrator.

iii. Benefits Without Certification

If the claims administrator does not certify as medically necessary a confinement (or any day of it), listed procedure or treatment, home health care, skilled nursing service or supply, either specifically or as a part of a planned program of care, benefits are paid as follows:

- **If certification has been requested and denied**, no benefits are paid for the hospital or facility room and board, the home health care, the skilled nursing care or supply, the procedure, or the treatment.
- **If certification has not been requested and the confinement is not medically necessary,** no benefits will be paid for the facility room and board. In addition, the first $400 ($200 of skilled nursing facility) of other medically necessary facility charges, if any, are not covered.
- **If certification has not been requested and the procedure, treatment, home health care, skilled nursing care or supply is not medically necessary,** no benefits will be paid.

- **If certification has not been requested and the confinement, procedure, treatment, service or supply is medically necessary**, a penalty will be assessed:
  - ~ For hospital or treatment facilities, the first $400 of expenses will not be paid; and
  - ~ For home health care, skilled nursing facilities, skilled nursing care or supply, or any of the treatments or procedures listed in section 3.3(j), *Outpatient Procedures and Plan-Required Second Opinions,* the first $200 of expenses will not be paid.

iv. Mental Health Benefits Without Certification

Failure to obtain certification and/or follow plan referrals for treatment of mental disorders or chemical dependency will result in reduced benefits as shown below:

- Mental Disorders
  - ~ If **certification is not requested or plan referrals are not followed and the confinement or outpatient service is medically necessary,** the plan will pay 50% of covered expenses following the deductible. Outpatient benefits will be limited to 30 visits per benefit year.
  - ~ If **certification is not requested and the confinement is not medically necessary,** no benefits will be payable for hospital or treatment facility room and board expenses incurred during the stay. Other covered expenses related to the confinement, if any, will be paid at 50% following the deductible.
  - ~ If **certification is not requested and the outpatient services are not medically necessary,** no benefits will be payable.
  - ~ If **certification is requested and denied,** no benefits will be paid for outpatient services or for hospital or treatment facility room and board expenses during that stay.
- Chemical Dependency
  - ~ If **certification is not requested or plan referrals are not followed and the confinement or outpatient services are medically necessary,** a penalty will be assessed:
    - o For hospital or treatment facilities, the first $400 of expenses will not be paid; and
    - o For outpatient services, the first $200 of expenses will not be paid.

Benefits will be limited to the annual and lifetime amounts shown in section 2.1, *Benefit Summary,*. These limits are subject to change. Please check with the claims administrator or the Division for the current amounts.

- ~ If **certification is not requested and the confinement is not medically necessary,** no benefits will be paid for facility room and board. In addition, the first $400 of other medically necessary facility charges, if any, are not covered.
- ~ If **certification is not requested and the outpatient services are not medically necessary,** no benefits will be paid.
- ~ If **certification is requested and denied,** no benefits will be paid for outpatient services or for hospital or treatment facility room and board expenses during that stay.

m. Prescription Drugs

The plan pays for prescription drugs for the treatment of an illness, disease, or injury if dispensed upon prescription of a provider who is licensed to prescribe drugs and is acting within the scope of his or her license. This includes needles and syringes purchased simultaneously with insulin, as well as other diabetic supplies.

For any drug provided while you are a registered bed-patient in a hospital, skilled nursing facility, psychiatric facility or any similar institution, the medical plan pays normal plan benefits for covered expenses after the annual deductible is satisfied.

For drugs purchased on an outpatient basis, you may obtain your medication from a participating pharmacy, the mail order program or any other provider. For prescription drug benefits, a provider is defined as a pharmacy, physician, dentist, or other legally authorized dispenser of drugs. **To receive the best benefit,** you must obtain your prescription drugs from a participating pharmacy or from the mail order pharmacy.

If you do not obtain your prescription drugs from a participating pharmacy as described below, benefits for prescription drugs will be subject to the medical plan deductible and paid at the normal pharmacy coinsurance rate shown in Section 2.1, *Benefit Summary.*

i. Participating Pharmacies

If you obtain your prescriptions at participating pharmacies, you will only need to pay your pharmacy co-payment (see section 2.1, *Benefit Summary*)

for each prescription. The pharmacy will file a claim for you so that you do not have to pay for the prescription and file a claim for reimbursement.

A list of participating pharmacies is available from the claims administrator, the AlaskaCare Web site, or the Division.

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

ii. Mail Order Program

If you take maintenance medication, you can take advantage of this optional program. See the first page of this booklet for the mail order pharmacy provider.

For brand name drugs, you pay a low co-payment (see section 2.1, *Benefit Summary*) per prescription or refill. The remainder of the cost is paid by the plan. There is no cost to you for generic drugs.

To use this program, obtain an order form from your human resources office, the mail order pharmacy, the claims administrator, or the Division. Send it to the mail order pharmacy along with your physician's prescription. Unless indicated by the physician, you receive the generic equivalent when available and permissible by law.

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

iii. Definitions

Prescription drugs are medical substances which must bear a label that states, "Caution: Federal law prohibits dispensing without a prescription." Diabetic supplies are defined as sugar test tablets, sugar test tape, acetone test tablets and Benedict's solution or the equivalent. A generic drug is:

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

iv. Exclusions

Benefits are not payable under any prescription drug benefit for:

- A device of any type;
- Any drug entirely consumed at the time and place it is prescribed;
- The administration or injection of any drug;
- More than the number of refills specified by the prescriber. The claims administrator, before paying the claim, may require a new prescription or evidence as to need. For example, the need may be questioned if the prescriber did not specify the number of refills, or if the frequency or number of prescriptions or refills appears excessive under accepted medical practice standards; and
- Any refill of a drug dispensed more than one year after the latest prescription for it.

n. Radiation, X-Rays, and Laboratory Tests

The medical plan pays normal benefits for X-rays, radium treatments, and radioactive isotope treatments if you have specific symptoms. This includes diagnostic X-rays, lab tests, TENS therapy, and analyses performed while you are an inpatient.

o. Physical Examinations

In addition to covered preventive care services, the plan covers physical examinations resulting from illness or accident subject to plan deductible and coinsurance provisions.

p. Immunizations

In addition to the immunizations covered under preventive care services, the plan covers other immunizations for communicable diseases, including serums administered by a nurse or doctor, subject to plan deductible and coinsurance provisions. Charges for office visits in connection with the immunizations are not covered.

q. Rehabilitative Care

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

Rehabilitative care includes:

- Physical therapy and occupational therapy;
- Speech therapy if existing speech function (the ability to express thoughts, speak words, and form sentences) has been lost and the speech therapy is expected to restore the level of speech the individual had attained before the onset of the disease or injury; and
- Rehabilitative counseling or other help needed to return the patient to activities of daily living but excluding maintenance care or educational, vocational or social adjustment services.

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

r. Anesthetic

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

s. Pregnancy

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

Coverage is provided for a hospital stay for childbirth for at least 48 hours following a normal delivery or 96 hours following a cesarean delivery.

Pregnant women may get screening for high-risk pregnancy factors and receive special counseling about those risks. If you are pregnant, call the claims administrator as soon as possible for advice and counseling on having a healthy pregnancy. A nurse consultant will assess the risk factors in your pregnancy and discuss ways to reduce them with you, as well as provide ongoing monitoring and evaluation. The nurse can also provide educational materials, nutritional analysis and ongoing support.

If you are totally disabled as a result of a pregnancy problem and your coverage ends, you may be eligible for extended benefits. (See section 7, *COBRA and Extended Health Coverage*.) Totally disabled means the complete inability of an individual to perform everyday duties appropriate for your employment, age or sex. The inability may be due to disease, illness, injury, or pregnancy. The plan reserves the right of determination of total disability based upon the report of a duly qualified physician or physicians chosen by the plan.

t. Newborn Care

Newborn care provided within the first 72 hours after birth is covered. This includes nursery charges, physician's services and other routine care for a newborn child and is limited to 72 hours following the birth. Newborn services provided after 72 hours are not covered.

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

u. Well Baby Care

The plan covers outpatient routine examinations and screenings, including immunizations, for dependents from birth through 24 months of age according to the current American Association of Pediatrics (AAP) published guidelines in effect on the date of service. Coverage is 100% of the recognized charge, without deductible being assessed for these services.

v. Durable Medical Equipment/Supplies

When medically necessary, the medical plan covers supplies prescribed by a physician, including:

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

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

- The initial purchase of such equipment and accessories to operate the equipment is covered only if the claims administrator is shown that:
  - ~ Long-term use is planned; and

~ The equipment cannot be rented; or

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

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

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

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

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

Durable medical and surgical equipment is equipment that is:

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

w. Travel

Travel must be preauthorized to receive reimbursement under the medical plan. Contact the claims administrator for preauthorization before you or your dependent travel.

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

- Transportation to the nearest hospital by professional ambulance. A professional ambulance is a land or air vehicle specially equipped to transport injured or sick people to a destination capable of caring for them upon arrival. Specially equipped means that the vehicle contains the appropriate stretcher, oxygen, and other medical equipment necessary for patient care en route. A medical technician trained in life-saving services accompanies the transported patient;
- Round-trip transportation, not exceeding the cost of coach class commercial air transportation, from the site of the illness or injury to the **nearest** professional treatment. If you use ground transportation and the most direct one-way distance exceeds 100 miles, the medical plan pays your documented travel expenses while en route for fares, mileage, food and lodging for the most direct route. Only eligible persons are reimbursed.

Travel does not include reimbursement of airline miles used to obtain tickets, the cost of lodging (except as specified for preoperative testing below), food, or local ground transportation such as airport shuttles, cabs or car rental.

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

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

Travel, as described above, is covered **only** in the circumstances set forth in the sections below.

i. Emergencies

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

An emergency is defined as a sudden and unexpected change in a person's condition which, if immediate transfer is not made, could be expected to result in loss of life or limb, significant impairment to bodily function or permanent dysfunction of a body part.

ii. Treatment Not Available Locally

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

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

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

If you need transportation for a nonemergency condition which cannot be treated locally, you must receive preauthorization. Obtain a *Travel Preauthorization* form from your human resources office, the claims administrator, the Division, or its Web site. Complete the top portion and have your physician complete the bottom portion. Submit the form to the claims administrator **before** you travel. The claims administrator will provide you with written preauthorization.

If you do not have time to obtain the form or you have not received written preauthorization from the claims administrator, you **must** call the claims administrator **before** you travel.

iii. Second Surgical Opinions

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

If you require transportation for a second surgical opinion which cannot be obtained locally, you must receive preauthorization. Obtain a *Travel Preauthorization* form from your human resources office, the claims administrator, the Division, or its Web site. Complete the top portion and have your physician complete the bottom portion. Submit the form to the claims administrator **before** you travel.

If you do not have time to obtain the form or you have not received written preauthorization, you **must** call the claims administrator **before** you travel.

iv. Surgery In Other Locations

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

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

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

v. Lodging

If you require **preoperative testing and surgery** more than 100 miles from your home, food and lodging expenses outside of the hospital are covered only for the day(s) on which you actually receive preoperative testing. Preoperative testing is testing performed within 7 days prior to surgery. **Food and lodging is covered only in this situation.**

The plan will pay $31 per day without overnight lodging, or $80 per day if overnight lodging is required. If a parent or legal guardian accompanies a child under age 18, the plan pays up to an additional $31 per day. Submit your receipts for actual expenses to the claims administrator for reimbursement.

x. Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) is a confidential counseling service, free of charge to you and your dependents, administered by the managed mental health administrator (see the front of this booklet for phone numbers). This service provides assessment, treatment and referral services. The program is geared to provide assistance with difficulties that you may encounter at work, emotional problems, stress, family or relationship problems, and drug and alcohol abuse.

Call the number shown on in the front of the booklet for the EAP provider. Staff is available 24 hours a day, 7 days a week. When you call, you may be able to work through your problem on the phone with an EAP counselor. In most cases though, the staff will try to schedule an appointment with a local counselor. The counselor will then assess your situation in person. Based upon this assessment, he or she will either counsel you or refer you to another professional for specialized care. In an emergency, the EAP staff will provide crisis counseling by phone or will direct you immediately to appropriate medical or psychiatric facilities in your area.

Your call or visit to the EAP staff is completely confidential. Unless you choose to tell others, no one needs to know about your EAP counseling sessions. EAP counseling offices are located away from your work site. Discussions with an EAP counselor will not be revealed to anyone without your written permission. However, in cases involving child abuse or threatened harm to yourself or others, EAP counselors may be required by law to suspend confidentiality to protect the persons involved.

y. Mental Disorder and Chemical Dependency Treatment

Important: Certification and plan referral are required for all treatment in order to receive maximum plan benefits. If certification is not obtained or plan referral is not followed, benefits will be reduced. Please refer to section 3.3(l), *Certification.*

The medical plan pays for treatment of chemical dependency and mental disorders. Inpatient expenses for room and board and other necessary services and supplies are covered. Also covered are physician's charges for inpatient or outpatient treatment.

i. Mental Disorders

Treatment of a mental disorder received through a plan referral is paid at normal plan benefits following the deductible. Treatment received without a plan referral is paid at 50%. There is a maximum number of visits that applies to outpatient treatment received without a plan referral. See section 2.1, *Benefit Summary* for details. Any benefits received with a plan referral will apply to this maximum.

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

- Schizophrenia
- Bipolar disorder (manic/depressive)
- Pervasive Mental Development Disorder (Autism)
- Panic disorder
- Major depressive disorder
- Psychotic depression
- Obsessive compulsive disorder

ii. Chemical Dependency

Treatment of chemical dependency is paid at normal plan benefits following the deductible. If treatment is received without a plan referral, the first $400 of inpatient treatment expenses and the first $200 of outpatient treatment expenses will not be covered.

Benefits for chemical dependency treatment received **without a plan referral** are limited to the amounts shown in section 2.1, *Benefit Summary*). The amount is subject to change. Please check with the claims administrator or the Division for the most current maximum. Any benefits received with a plan referral will apply to these maximums.

z. Treatment of Spinal Disorders

An annual limit as shown in section 2.1, *Benefit Summary,* applies to specific services to diagnose and treat:

- Misalignment or dislocation of the spine; and
- Strained muscles or ligaments related to the spinal disorder.

The services subject to this limit are:

- Office visits;
- Examinations;
- Consultations; and
- Regional manipulations.

This limit applies regardless of whether services are performed by a physician, chiropractor, osteopath, or other covered provider.

The limit does not apply if you are confined as a full-time inpatient in a hospital.

aa. Medical Treatment of Mouth, Jaws, and Teeth

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

- Inpatient hospital care to perform dental services if required due to an underlying medical condition;
- Surgery needed to treat wounds, cysts or tumors or to alter the jaw, joint or bite relationships when appliance therapy alone cannot provide functional improvement;
- Nonsurgical treatment of infections or diseases not related to the teeth, supporting bones or gums;
- Dental implants if necessary due to disease or accident but only if dentures or bridges are inappropriate or ineffective. (False teeth for use with the implants are covered only under the dental plan as a Class III service.);

- Services needed to treat accidental fractures or dislocations of the jaw or injury to natural teeth if the accident occurs while the individual is covered by the plan. Treatment must begin during the year the accident occurred or the year following. The teeth must have been damaged or lost other than in the course of biting or chewing and must have been free of decay or in good repair; and
- Diagnosis, appliance therapy (excluding braces), nonsurgical treatment, and surgery by a cutting procedure which alters the jaw joints or bite relationship for temporomandibular joint disorder or similar disorder of the joint.

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

ab. Medical Treatment of Obesity

i. Weight-Reduction Program

Medically necessary expenses for medical supervision of weight-reduction programs will be covered as any other medical condition when the following criteria are met:

- Body Mass Index (BMI) greater than or equal to 30kg/m2, or
- BMI greater than or equal to 27kg/m2 with underlying comorbidities, including but not limited to, cardiopulmonary complications, diabetes, hypertension and obstructive sleep apnea.

ii. Surgical Treatment of Obesity

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

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

Covered surgical obesity procedures are limited to:

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

ac. Plastic, Cosmetic, and Reconstructive Surgery

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

- Improve the function of a part of the body (excluding teeth or any structure that supports the teeth) and that is malformed as a result of:
  - ~ A severe birth defect, including harelip or webbed fingers or toes; or
  - ~ Disease, or surgery performed to treat a disease or injury; and
- Repair an injury sustained in an accident which occurs while you are covered under the plan, provided such treatment is started within 90 days of the accident.

ad. Taxes

Any portion of a claim which is itemized as sales, excise, or other taxes, and relates to an otherwise covered expense, is reimbursable.

ae. Audio Services

The plan covers the following audio services:

- An otological (ear) examination by a physician or surgeon.
- An audiological (hearing) examination and evaluation by a certified or licensed audiologist, including a follow-up consultation.

- A hearing aid (monaural or binaural) prescribed as a result of the examination. This includes ear mold(s), hearing aid instrument, initial batteries, cords, and other necessary supplementary equipment as well as warranty, and follow-up consultant within 30 days following delivery of the hearing aid.
- Repairs, servicing or alteration of hearing aid equipment.

You must provide the claims administrator with written certification from the examining physician explaining that you are suffering a hearing loss that may be lessened by the use of a hearing aid.

3.4. Plan Exclusions

a. Limitations and Exclusions

The medical plan does not cover any condition, ailment, or injury for which you receive:

- Benefits from your employer's liability plan, federal or state workers' compensation, or similar law; or
- Benefits available under any federal or state act (except services received from Alaska Native Health), even though you waive rights to those benefits.

The following services and supplies are **not covered** and are excluded when determining benefits:

- Charges in connection with an occupational injury or illness. An occupational injury or illness is one that arises out of or in the course of any work for pay or profit, or in any way results from any injury or illness which does. However, if proof is furnished that an individual is covered under workers' compensation or similar law, but is not covered for a particular illness under such law, that illness will not be considered occupational regardless of cause.
- Charges for plastic, cosmetic, and reconstructive surgery; services or supplies which improve, alter or enhance appearance **are not** covered, even if they are for psychological or emotional reasons, except as listed in section 3.3(ac), *Plastic, Cosmetic, and Reconstructive Surgery.*
- Services provided in an institution which is primarily a rest home, for the aged, or a nursing home.
- Custodial care regardless of where services are provided, or any portion of a hospital stay which is primarily custodial. Custodial care is comprised of services and supplies, including room and board and other institutional services, whether or not the individual is disabled, primarily to assist in the activities of daily living. These services and supplies are designated as custodial care without regard to the prescription, recommendation or performance of the practitioner or provider.
- Education, training, and room and board while confined in an institution which is primarily a school or other institution for training.
- Hospitalization primarily for physiotherapy or diagnostic studies.
- Artificial insemination, in vitro fertilization or embryo transfer procedures.
- Reversal of a sterilization procedure.
- Charges for services or supplies that the claims administrator determines are not the maximum allowed charge.
- X-ray, laboratory, pathological services and machine diagnostic tests, unless related to a specific illness, injury or a definitive set of symptoms, except as provided in section 3.3(n), *Radiation, X-Rays, and Laboratory Tests.*
- Services or supplies that are not medically necessary as determined by a medical review by the claims administrator, even if prescribed, recommended or approved by a physician for the diagnosis or treatment of a physical or mental condition.
- Marriage, child, career, social adjustment, pastoral, financial, sexual, or family counseling, except as provided through the Employee Assistance Program described in section 3.3(x), *Employee Assistance Program (EAP).*
- Treatment of mental, neuropsychiatric and personality disorders, except as described in section 3.3(y), *Mental Disorder and Chemical Dependency Treatment.*
- Services, therapy, drugs, or supplies for sex transformations or related to sex change surgery or any treatment of gender identity disorders.
- Services, therapy, drugs, or supplies for sexual dysfunctions or inadequacies, including services or supplies for a prosthesis in connection with impotency.
- Visual analysis, therapy or training relating to muscular imbalance of the eye (orthoptics).
- Routine foot care procedures, such as:
  - ~ The trimming of nails, corns, or calluses;
  - ~ Fallen arches;

~ Other symptomatic complaints of the feet;

~ Routine hygienic care.

- Treatment designed primarily to provide a change in environment or a controlled environment (milieu therapy).
- Care furnished mainly to provide surroundings free from exposure that can worsen the person's disease or injury.
- Those charges you would not pay if you did not have health care coverage, except those for covered services furnished, paid for or reimbursed under the Maternal/Child Health Unit and Handicapped Children's Program Section, Division of Public Health, Department of Health and Social Services of the State of Alaska.
- Any services or supplies for which no charge is made or would not be made if this medical plan were not in effect, nor for services or supplies for which you would not be legally liable if this plan were not in effect.
- Services or supplies that are, as determined by the claims administrator, experimental, or investigational. A drug, device, procedure, or treatment **will be** determined to be experimental or investigational if:

  ~ There is insufficient data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;

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

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

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

  However, this exclusion **will not apply** to services or supplies (other than drugs) received in connection with a disease if the claims administrator determines that:

  ~ The disease can be expected to cause death within one year in the absence of effective treatment; and

  ~ The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, the claims administrator will take into account the results of a review by a panel of independent medical professionals selected by the claims administrator. This panel will include professionals who treat the type of disease involved.

  Also, this exclusion **will not apply** to drugs under the following situations:

  ~ Drugs that have been granted treatment investigational new drug (IND) or Group c/treatment IND status;

  ~ Drugs that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or

  ~ If the claims administrator determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

- Injury or other loss sustained as a result of war, or an act of war, or any international armed conflict, whether declared or not.
- Services, treatment, education, testing, or training related to learning disabilities or developmental delay.
- Services of a resident physician or intern rendered in that capacity.
- Wigs and mastectomy bras.
- Orthopedic shoes.
- Primal therapy, rolfing, psychodrama, megavitamin therapy, or carbon dioxide therapy.
- Acupuncture therapy, unless performed by a physician as a form of anesthesia in connection with surgery covered under the plan.
- Eye refractions or hearing aids, or the fitting of eye glasses or hearing aids, except as described under section 5, *Vision Plan* and section 3.3(ae), *Audio Services*.
- Services or supplies which any school system is required to provide under the law.
- Services or supplies not specifically listed as a covered benefit under the medical plan (see section 3.3, *Covered Medical Expenses*).
- Services or supplies for education, special education, or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Charges you incur during a hospital confinement beginning prior to the date you became covered under the medical plan.

- Charges for treatment of employees who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- Special diet supplements, vitamin injections, hospital confinement for weight reduction programs, exercise club membership fees, exercise equipment, whole body calorimeter studies, biofeedback and hypnosis.
- Charges for physical examinations required for purposes of employment or to obtain insurance.
- Replacement of a hearing aid, for any reason, more than once in a three benefit year period.
- Batteries or other supplementary equipment other than those obtained upon purchase of the hearing aid.
- A hearing aid exceeding the specifications prescribed for correction of hearing loss.
- Expenses incurred after coverage ends, unless you order a hearing aid before the termination and receive it within 90 days of the end date.

3.5. Individual Case Management

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

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

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

Examples of conditions that may qualify for ICM include:

- Spinal cord injuries with paralysis;
- High-risk infants undergoing neonatal care;
- Traumatic brain injury resulting from an accident;
- Severe burns;
- Multiple fractures;
- Stroke;
- Any confinement exceeding 30 days; and
- Conditions or injuries requiring substantial medical resources over a long period of time or those where another cost-effective alternative may be implemented.

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

3.6. Patient Auditor Program

Under the Patient Auditor Program, if you find an error on a hospital or any health care provider's bill, you can share in the savings.

Always request an **itemized** bill when you leave the hospital, physician's office or clinic. Review it carefully, checking to see that you are charged only for treatment and services you received. Look for duplicate entries of the same service. If you were hospitalized, check the admission and discharge dates for accuracy.

If you find an overcharge, discuss it with the hospital or physician and obtain a corrected itemized bill. Submit the original bill with the overcharges circled, the adjusted bill, and an *Award Request Form* available from your human resources office or the Division to the claims administrator.

After verification of overcharges of at least $100 and recovery of any overpayments, the claims administrator will issue you a check for 50% of the savings. You may be awarded up to a maximum of $400 per year. All awards are considered taxable income.

Billing errors for noncovered items are not eligible for awards. The program only applies when this plan is the primary insurer.

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4. Dental Benefits

Dental Plan Highlights

- May select from three different plans; Preventive, Standard, or Premium.
- All plans cover 100% of the maximum allowed charge for most preventive services (X-rays, exams, cleaning, etc.).
- Standard and Premium Plans cover most restorative (fillings, extractions, etc.) and prosthetic (crowns, dentures, etc.) services after the annual deductible is met.
- Premium Plan covers most orthodontic services after the annual deductible is met.

4.1. About the Dental Plans

There are three plans available; Preventive, Standard, and Premium. The plans cover different types of dental services and have different coinsurance amounts and deductibles. Please refer to section 2.1, *Benefit Summary,* for details about how these items differ between the plans.

You choose which plan you want during the times described in section 1.7, *Changing Coverage*. All plans cover you and your eligible dependents as described in those sections.

a. Benefit Year

The short benefit year for all plans begins July 1, 2013 and ends December 31, 2013. Effective January 1, 2014, each benefit year runs from January 1 through December 31. Thereafter, all benefit limits in a benefit year are reset on January 1 each year.

b. Maximum Allowed Charge

Payment under all plans is based on the maximum allowed charge for covered services. Charges or fees in excess of the maximum allowed charge level, as determined by the claims administrator, are your responsibility to pay.

Maximum allowed charge means the charge the claims administrator determines to be the prevailing rate charged in the geographic area where the service is provided or the provider's usual charge, whichever is less.

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

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

- The prevailing charges in a greater geographic area;
- The complexity of the service or supply;
- The degree of skill needed;
- The type or specialty of the provider; and
- The range of services or supplies provided by a facility.

4.2. Covered Dental Services

The Preventive plan covers only Class I preventive services while the Standard and Premium plans both cover Class I preventive, Class II restorative, and Class III prosthetic services. The Premium plan covers orthodontic services. Following is a description of the services covered in each class.

a. Class I Preventive Services

Covered by all plans:

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

b. Class II Restorative Services

Covered by the Standard and Premium plans:

- Fillings of silver amalgam, silicate, and plastic restoration
- Repair of dentures and bridges
- Palliative (alleviation of pain) emergency treatment
- Extractions (removal of teeth)
- Endodontics (treatment of disease of the tooth pulp) including pulpotomy, pulp capping, and root canal treatment
- Space maintainers
- Oral surgery, including surgical extractions
- Apicoectomy (surgical removal of a root tip)
- Periodontic services (treatment of the supporting tooth structures), including periodontal prophylaxis

c. Class III Prosthetic Services

Covered by the Standard and Premium plans:

- Inlays and onlays
- Crowns
- Fixed and removable bridges, initial placement
- Full and partial dentures, initial placement

d. Orthodontic Services

The Premium plan is the only plan that covers the orthodontic services for diagnosis and correction of a misalignment of the teeth, the bite or the jaw or jaw joint relationship. This includes:

- Consultations and office visits;
- Removable or fixed appliance therapy;
- Ongoing active treatment, including all active retention appliances.

Not included is any surgical procedure to correct malocclusion.

4.3. Preventive Plan

a. Annual Maximum Benefit

The Preventive plan pays up to the annual limit shown in the Benefits Summary for all covered dental services for each eligible person during the benefit year.

b. Deductible

You pay the annual deductible amount shown in section 2.1, *Benefit Summary,* for each person, up to a maximum family deductible amount.

c. Coinsurance

The Preventive plan covers Class I preventive services at the coinsurance amount shown in section 2.1, *Benefit Summary,* of the maximum allowed charge after the deductible. Class II restorative, Class III prosthetic, and orthodontia services are not covered.

4.4. Standard Plan

a. Annual Maximum Benefit

The Standard plan pays up to the annual maximum shown in section 2.1, *Benefit Summary,* for all covered dental services for each eligible person during the benefit year.

b. Deductible

You pay the annual deductible shown in section 2.1, *Benefit Summary,* for each person for Class II and III services, combined. The maximum annual family deductible is shown in section 2.1, *Benefit Summary*.

c. Coinsurance

The Standard plan covers Class I preventive, Class II restorative, and Class III prosthetic services at the coinsurance amounts shown in section 2.1, *Benefit Summary,* for each eligible person.

4.5. Premium Plan

a. Annual Maximum Benefit

The Premium plan pays up to the annual and lifetime maximum benefits shown in section 2.1, *Benefit Summary,* for each eligible person.

b. Deductible

You pay the annual deductible shown in section 2.1, *Benefit Summary,* for each person for Class II and III services combined. The maximum annual family deductible is shown in section 2.1, *Benefit Summary*.

c. Coinsurance

The Premium plan pays coinsurance amounts shown in section 2.1, *Benefit Summary,* for all services.

4.6. Dental Services Not Covered

The Dental plans do not provide benefits for:

- Services for congenital deformities (these are covered by the medical plan) or for purposes of improving personal appearance.
- Services that the dentist is not licensed to perform.
- Charges that are higher than would have been charged if there were no Dental plan.
- Services for dentures, bridges, crowns, or other devices started before the effective date of coverage.
- Charges made after your coverage ends, unless they are for prosthetic devices fitted and ordered while you were covered and arriving within 90 days of the date coverage ends.
- Services rendered after the end of coverage, even if you are in the course of an approved treatment plan.
- Charges of more than one dentist for the same services in the same visit.
- Appliances or restorations necessary to increase vertical dimensions or restore occlusions except as specified under the Premium plan.
- Services for straightening teeth or correcting bite (orthodontics) except tooth extractions necessary to proceed with orthodontic services or as specified under the Premium plan.
- A denture replacement made less than five years after the last one was obtained, whether or not it was covered by this plan.
- Replacement costs of a lost or stolen denture if this benefit has been used within the last five years.

- Special techniques or personalized restoration for the construction of a denture beyond the standard procedure charges.
- Myofunctional therapy including in-mouth appliances to correct or control harmful habits.

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

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

a. Advance Claim Review

Before beginning treatment for which charges are expected to exceed $1,000, ask your dentist to file a description of the proposed course of treatment and expected charges with the claims administrator. The claims administrator will then 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 commences on the day the provider first renders the service to correct or treat such a condition. Emergency treatments, oral examinations, cleanings, and dental X-rays are considered part of a course of treatment, but you may seek these services without advance claim review.

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

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

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

Examples of alternative services or supplies for restorative care are:

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

Examples of alternative services or supplies for prosthodontic care are:

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

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5. Vision Plan

Vision Plan Highlights

- May choose between two vision plans.
- Covers eye examination, lenses, and frames at specified intervals.
- Standard Plan allows use of any qualified provider.
- Managed Care Plan requires use of a member doctor to receive the best benefit.

5.1. About the Vision Plans

There are two plans available: Standard and Managed Care. The plans cover the same services but at different time intervals and provide different reimbursements.

The Managed Care plan requires the use of a member doctor to receive the best benefit. Please refer to section 2.1, *Benefit Summary,* for information about differences in coverage between these two plans.

You choose which plan you want during the times described starting in section 1.7, *Changing Coverage*. All plans cover you and your eligible dependents as described in those sections.

5.2. Standard Plan

The Standard plan allows the use of any licensed optometrist or ophthalmologist. You do not have to receive certification for these services. Claims are filed with the claims administrator listed in the front of this booklet. Your provider may file for you or may require you to pay for the services and file for reimbursement.

a. Benefit Year

There is a short benefit year from July 1, 2013 through December 31, 2013. Effective January 1, 2014, and thereafter, the benefit year is January 1 through December 31.

b. Annual Maximum Benefit

The Standard plan pays up to the annual maximum shown in section 2.1, *Benefit Summary,* for all covered vision services for each eligible participant during the benefit year.

c. Deductible

You pay no deductible under this plan.

d. Coinsurance

The plan pays the coinsurance amount shown in section 2.1, *Benefit Summary,* of the maximum allowed charge for vision and optical services.

e. Maximum Allowed Charge

Payment is based on the maximum allowed charge for covered services. Charges or fees in excess of the maximum allowed charge level, as determined by the claims administrator, are your responsibility to pay. The maximum allowed charge for the Standard plan are calculated in accordance with the procedures set forth in Section 3.2(d), *How Medical Benefits Are Paid, Maximum Allowed Charge*.

f. Covered Vision and Optical Services

The following services and supplies are covered:

- One complete vision examination including required refraction, by a legally qualified ophthalmologist or optometrist, each benefit year.
- Up to two single vision, bifocal, trifocal, or lenticular lenses per benefit year.
- One set of frames every two benefit years, up to the limit shown in section 2.1, *Benefit Summary*.
- Prescribed contact lenses each benefit year, up to the annual limit shown in section 2.1, *Benefit Summary.*

g. Vision and Optical Services Not Covered

Benefits are not payable under the Standard plan for the following services:

- Tinting
- Anti-reflective coating for lenses
- Scratch coating for lenses
- Polycarbonate lenses
- Two pairs of glasses in lieu of bifocals
- Nonprescription glasses or special purpose visual aids, even if prescribed.
- Prescription sunglasses or light-sensitive lenses in excess of the amount which would be covered for non-tinted lenses.
- Medical or surgical treatment of the eyes

- Eye examination which a labor agreement requires the employer to provide, which are required as a condition of employment, or which are required by any government law.
- Replaced or duplicate lenses if this benefit has been utilized in the current benefit period, regardless of the reason.
- Replacement or duplicate frames if this benefit has been utilized in the current or prior benefit period, regardless of the reason.
- Charges for special procedures such as orthoptics or vision training.
- Services or supplies provided under other provisions of this plan.
- Services or supplies which are covered in whole or in part under any workers' compensation law or any other law of similar purpose.
- Services or supplies you received prior to becoming eligible for coverage, including lenses and frames ordered as part of a prior examination, even if you receive the lenses and frames after becoming eligible for this plan.
- Services and/or materials not identified as a covered service or plan benefit.

5.3. Managed Care Vision Plan

The Managed Care plan has a panel of member doctors who provide vision services and supplies. By using a member doctor, you obtain a better benefit than if you used a doctor who is not a member. If you see a nonmember doctor, you receive the benefits listed in section 2.1(c), *Vision Benefits.*

For a list of member doctors, call the Managed Care plan administrator at the number listed in the front of this booklet or visit their Web site. Select a doctor from the list and make an appointment. You must identify yourself as a Managed Care VSP member when you make the appointment. The doctor will contact VSP to determine what benefits you are eligible for.

The benefits described in this section 5.3 is a summary of the services and materials available under the Managed Care Vision plan. In the event of a conflict between the information provided in this section 5.3 and the contract between the State of Alaska and its managed care vision provider, the terms of the contract shall control.

a. Benefit Year

There is a short benefit year from July 1, 2013 through December 31, 2013. Effective January 1, 2014, and thereafter, the benefit year is January 1 through December 31.

b. Deductible

You pay no deductible under this plan.

c. Copayment

There shall be a copayment of $10.00 for the examination payable by the participant to the member doctor at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional $25.00 copayment payable at the time the materials are ordered. However, the copayment for materials shall not apply to elective contact lenses. The plan pays 100% of the member doctor's charges for covered vision and optical services, less any applicable copayment.

d. Covered Vision and Optical Services

The following services and supplies are covered under the plan subject to the limits set forth in Section 2.1, *Benefit Summary:*

- One complete initial vision analysis including an appropriate examination of visual functions and the prescription of corrective eyewear where indicated. Subsequent regular eye examinations once every benefit year.
- One pair of single vision, bifocal, trifocal, or lenticular lenses per benefit year. The following lens options are covered in full with a member doctor at no additional cost to the participant.
  - ~ Progressive lenses
  - ~ Anti-reflective coating
  - ~ Scratch resistant coating
  - ~ Polycarbonate lenses
- A frame is available every 2 benefit years. The in-network frame allowance is $130. 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.
- 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.

- Necessary and elective contact lenses are available once every benefit year in lieu of all other lens and frame benefits available under this plan. The in-network contact lens allowance is $105 and there is a 15% discount on the contact lens fitting and evaluation.
- Professional services for severe visual problems not corrected with regular lenses (low vision), including supplemental testing and supplemental aids.

e. Vision and Optical Services Not Covered

The Managed Care plan is designed to cover visual needs rather than cosmetic materials. When the participant selects any of the following options, the plan will pay the basic cost of the allowed lenses or frames, and the participant will pay the additional cost for the options:

- Optional cosmetic processes
- Color coating
- Mirror coating
- Blended lenses
- Cosmetic lenses
- Laminated lenses
- Oversize lenses
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2
- UV (ultraviolet) protected lenses
- Certain limitations on low vision care
- A frame that costs more than the plan allowance
- Contact lenses (except as noted elsewhere herein).

There is no benefit for professional services connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a +/- .50 diopter power); or two pairs of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this plan which are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.

- Corrective vision treatment of an Experimental Nature. For purposes of this plan, Experimental Nature means a procedure or lens that is not used universally or accepted by the vision care profession as determined by the vision claims administrator.
- Costs for services and/or materials above the plan benefit allowances.
- Services and/or materials not identified as a covered service or plan benefit.

6. How to File a Claim

6.1. Required Claim Form Submission

So that the plan can pay benefits, you must submit a signed, State of Alaska claim form each benefit year for you, your spouse, and your eligible dependent children. Failure to submit a completed claim form when you submit your first claim for you, your spouse 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.

These requirements apply even if a provider submits a computerized or other billing directly to the claims administrator for you. In that case, if you do not already have a claim form on file for the patient for that year, you must submit a claim form, including the completed *Patient Information* section, or benefits may be held pending the arrival of the form.

Claim forms are included in the welcome kit sent to you after you are eligible for benefits or you may obtain them from your human resources office, the claims administrator, the AlaskaCare Web site, or the Division.

6.2. Claim Filing Deadline

To receive benefits, you should submit a claim within 90 days after treatment began, or within 30 days after treatment ends, whichever is later. If, through no fault of your own, 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.

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

6.4. Physician and Other Provider Services

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

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

The itemized bill must include:

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

6.5. Dental Services

You can get a *Dental Benefits Claim* form from your provider, your human resources office, the Division, the claims administrator, or the AlaskaCare Web site. Follow the instructions under physician services for completing the form.

6.6. Vision Services

You can get a *Vision Benefits Claim* form from your provider, human resources office, the Division, the claims administrator, or the AlaskaCare Web site. Follow the instructions under physician services for completing the form.

6.7. Audio Services

You can get a *Medical/Audio/Nonparticipating Pharmacy Claim* form from your provider, the human resources office, the Division, the claims administrator, or the AlaskaCare Web site. Follow the instructions under physician services for completing the form.

6.8. Prescription Drugs

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

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

If you do not use a participating pharmacy or the mail-order program, be sure to obtain a receipt from the pharmacist. Cash register receipts are not acceptable. Medicines that do not require a prescription are not covered. Send the receipt with a *Medical/Audio/Nonparticipating Pharmacy Claim* form to the claims administrator. You can get these forms from your human resources office, the claims administrator, the AlaskaCare Web site, or the Division.

The receipt must include the:

- Patient's name;
- Date of purchase;
- Prescription number;
- Itemized purchase price for each drug;
- Quantity;
- Name of drug; and
- Name of pharmacy.

6.9. 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.

6.10. 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 book. This address is also in your welcome kit and on your identification card.

If you have other health coverage in addition to this plan, you should submit your claims to the primary plan first. Then send a copy of the claim and the explanation of benefits from the primary plan to the secondary plan so that benefits will be coordinated properly between plans. See section 8.1, *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 *Explanation of Benefits* form available. Also, include your participant account number from your identification card on any letter you write. The claims administrator needs this information to identify your particular coverage.

6.11. 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 *Explanation of Benefits* form.

6.12. Before Filing a Claim

Before you file a claim:

- Check that your deductible has been paid. The deductible is the amount of covered expenses you must pay in a benefit year before your plan starts paying benefits.
- Once you meet your deductible, submit your bills with a claim form for each family member.

- Always check to make sure your doctor or dentist has not already submitted 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 they paid for the services.

6.13. Recordkeeping

Keep complete records of expenses for each of your dependents.

Important records are:

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

You should also keep **all** Explanation of Benefits forms sent to you as it is not possible for the claims administrator to provide duplicate copies.

6.14. Physical Examinations

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

6.15. If a Claim is Denied

If a claim or precertification is denied, in whole or in part, your Explanation of Benefits (EOB) or letter from the claims administrator will explain the reason for the denial. If you believe your claim or precertification should be covered under the terms of this 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.

a. Claims Administrator Appeals

i. Level I Appeal

Submit your request in writing, explaining the nature of your appeal,

including copies of EOB's, correspondence, and pertinent medical records. Your appeal must be received by the claims administrator within 180 days of the date the EOB or precertification denial letter was issued. You will receive a written decision from the claims administrator within 30 days after their receipt of your appeal. If you are not satisfied with the Level I decision, you can submit a Level II appeal review.

ii. Level II Appeal

The claims administrator must receive your written request for a Level II appeal within 60 days of the date the Level I decision letter was issued. Your appeal will be reviewed by a panel who did not participate in the Level I review. You will receive a written decision from the claims administrator within 60 days after their receipt of all relevant information in your appeal. If you are not satisfied with their final decision, you can request a review by the plan administrator.

b. Plan Administrator Appeals

If you disagree with the final claims administrator's decision, you can send a written request for review to the plan administrator. Your appeal must be postmarked or received within 45 days from the date the claims administrator's final decision letter was issued. The plan administrator will request a copy of your claims administrator appeal file, including any documentation from your provider for their records and review of your appeal. You may submit additional relevant material with your written appeal. The plan administrator will issue a decision within 90 days after receiving all the relevant material in your appeal.

Your appeal may be sent to an Independent Review Organization (IRO). IRO is an organization of medical experts qualified to review your appeal. If your appeal is forwarded to the IRO, the plan administrator will issue a decision in writing within 30 days after receiving the IRO's recommendation. If you are not satisfied with the decision, you may appeal to the Superior Court.

URGENT Appeals

If your doctor or provider advises the claims administrator or plan administrator that a delay in your appeal process could harm your health, an emergency review and decision will be made within 72 hours after receipt of your appeal.

7. COBRA and Extended Health Coverage

COBRA Coverage Highlights

- Available to employees who lose coverage due to leave without pay, layoff, move to a position that does not participate in the Select Benefits plan, or termination of employment.
- Available to dependents who lose coverage due to the employee's death or due to divorce or because a dependent child is no longer eligible.
- Provides for no break in coverage.

7.1. Introduction

You and/or your dependents will lose coverage if one of the situations in section 1.9, *When Coverage Ends,* occurs. You and/or your dependents may continue coverage under the plan by electing COBRA coverage and paying the required premium, except if you lost coverage under the plan because you did not timely pay the required premium. Newborns and children placed for adoption with you while you are on COBRA coverage may be added to your coverage if the child is otherwise eligible under the plan.

The coverage that may be continued may be the same or less than the level of coverage that you or your dependents had at the time coverage terminates. For example, if you are covered by the Standard medical plan when your coverage terminates, you may elect to continue either Standard or Economy medical, but may not elect Premium medical. You may elect medical only or include dental and vision coverage with the medical. You may not elect dental or vision coverage without medical coverage. You may change your elections during the next open enrollment under the Select Benefits plan.

7.2. Length of Continued Coverage

If you lose coverage because you have begun leave without pay, been laid off, or terminate your employment (for other than gross misconduct), you may continue coverage for up to 18 months. If your dependents have more than one qualifying event, they may be eligible for an additional period of coverage but the combined periods cannot exceed 36 months.

If your dependents lose coverage due to divorce, your death or they no longer meet the eligibility criteria, they may continue coverage for up to 36 months.

If you or your dependents are disabled within 60 days of the initial qualifying event for continuation coverage due to termination of employment, lay off, or leave without pay, you may continue coverage for you and your dependents up to an additional 11 months. To elect this additional coverage, you must notify the Division of your status before the end of your 18-month coverage period and within 60 days of your Social Security disability determination. The premium may increase for the additional 11 months of coverage. Coverage may be terminated if Social Security determines you are no longer disabled. In this case, you must notify the Division within 30 days of the final Social Security determination.

7.3. Electing COBRA Coverage

If your employment terminates, you have a leave without pay, you are laid off,or you die, the claims administrator will notify you or your family of the right to COBRA continued coverage and provide you with the necessary forms and information within 44 days of the occurrence of the qualifying event. If you are divorced or your child loses coverage, you or your family must notify the Division within 60 days of the qualifying event and the claims administrator will notify you and your family of the right to COBRA continued coverage and provide you with the necessary forms and information within 14 days thereafter.

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

7.4. Premium Payment

If you, your spouse, or dependents elect COBRA continuation coverage, the full premium cost of coverage must be paid each month. The claims administrator will bill you for the premium due. You have 45 days from the date you elect coverage to pay the initial required premium. Premiums are due retroactive to the date your coverage would have ended. Premiums are due monthly. The current premium rate is available from the Division or its Web site.

7.5. When Continuation Ends

Your COBRA continuation coverage ends:

- When the required premium is not paid on time;
- When the person continuing coverage becomes covered under another group health plan unless that plan contains any exclusion or limitation which relates to a pre-existing condition of the person ;
- When the person continuing coverage first becomes entitled to Medicare benefits;
- When the State ceases to maintain any group health plan;
- If you are disabled under the Social Security Act and have continued coverage for 18 months AND you are determined to be no longer disabled by Social Security.

7.6. Extended Coverage for Disabled Employees or Dependents

Disabled employees or dependents who lose coverage under the Select Benefits plan and who waive their individual right to COBRA continuation coverage under section 7.2, *Length of Continued Coverage,* through section 7.5, *When Continuation Ends,* are eligible for a limited extension of their health coverage, as described in this section; provided, however, that a disabled employee who is on FMLA leave and entitled to the protections under section 8.20(c), *Family and Medical Leave Act (FMLA),* is not eligible for extended health coverage under this section 7.6. Extended health coverage under this section 7.6 is at no cost to the disabled employee.

You or your dependents are entitled to a limited extension of health benefits if you are totally disabled due to injury, illness, or pregnancy when coverage terminates. Extended health benefits for total disability are provided for the number of months you have been covered under the health plan, up to a maximum of 12 months. However, only the condition which caused the 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 must be under a physician's care and submit evidence of disability to the claims administrator within 90 days after you lose coverage. 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.

Totally disabled for purposes of this section 7.6 means the complete inability of an individual to perform everyday duties appropriate for their occupation, employment, age or sex. The inability may be due to disease, illness, injury, or pregnancy. The Select Benefits plan reserves the right of determination of total disability based upon the report of a duly qualified physician or physicians chosen by the plan.

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8. *General Provisions – Health Benefits*

8.1. Coordination of Benefits

If you are entitled to benefits from other sources, such as employer or government sponsored health plans, the State of Alaska may have the right to offset against or recover from those other plans or persons so that you do not duplicate recovery of medical expenses.

The State of Alaska plan coordinates benefits with other group health care plans to which you or your covered dependents belong. Other group plans are defined as benefit sources recognized for coordination of benefits and are listed below:

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

You may be covered both as a employee and as a dependent of another covered employee. If that occurs, you will receive benefits from both plans. However, the benefits received will be subject to the coordination of benefits provisions as indicated in this section.

a. How Benefits Are Coordinated

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

- The primary plan pays benefits first, without regard to any other plan.
- When the State of Alaska plan is secondary, the amount it will pay will be figured by subtracting the benefits payable by the other plan from 100% of expenses **covered** by the State plan on that claim. The plan pays the difference between the amount the other plan paid and 100% of expenses the State plan would cover.

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

EXAMPLE

	First Plan	Second Plan
Covered expenses	$1,000	$1,000
Less deductible	- 100	- 250
	= 900	= 750
Plan coinsurance	x 80%	x 80%
Plan payment without coordination	= 720	= 600
Plan payment with coordination	= 720	= 280

- AlaskaCare will only pay 30% of covered charges for your dependents if your spouse or children are covered by a state employee health trust and that coverage:
  - ~ Has been waived,
  - ~ Pays less than 70% of covered expenses, or
  - ~ Has an individual out-of-pocket maximum, including deductible, of more than $3,500.

b. Determining Order of Payment

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

- The plan covering the employee directly, rather than as a dependent, is the primary plan.
- A plan covering a person as a laid-off or retired employee is secondary to a plan that covers the person as an active employee.
- Any active plan, whether it covers you as the employee or a dependent, is primary to Medicare.
- If a child is covered under both parents' plans, the plan of the parent whose birthday falls earlier in the year is the primary plan. If both parents have the same birthday, the plan that has covered a parent longer is the primary plan.

Following are exceptions to this birthday rule:

- ~ If the other plan does not have this birthday rule, the other plan's rule is used to decide which plan is primary.
- ~ If you are separated or divorced, the plans pay in the following order:
  - First, the plan of the parent whom the court has established as financially responsible for the child's health care. The claims administrator must be informed of the court decree. However, even though you are divorced and required to pay for medical coverage, your dependents are not automatically eligible for this plan. (For more information on eligibility and continuing coverage, see section 1.3(b), *Dependents,* and section 7.1, *COBRA and Extended Health Coverage Introduction*);
  - Second, the plan of the parent with custody of the child;
  - Third, the plan of the spouse of the parent with custody of the child; and
  - Fourth, the plan of the parent who does not have custody of the child.

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

It is your responsibility to report the existence of any plan, or the benefits payable to you under any plan, in the interests of computing services or benefits due under this plan.

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

8.2. REIMBURSEMENT PROVISION

If you or a dependent suffers a loss or an injury caused by the act or omission of a third party (such as a car accident), the claims administrator can recover any benefits paid. Medical benefits for the loss or injury will be paid only if that person suffering the loss or injury, or the legally authorized representative, agrees in writing:

- To pay the plan up to the amount of the benefits received under the plan subject to applicable law if damages are collected. Damages may be collected by action at law, settlement, or otherwise.

- To provide the claims administrator a lien in the amount of the benefit paid. This lien may be filed with the third party, his or her agent, or a court which has jurisdiction in the matter.

8.3. Access to Records

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

8.4. Applicable Law and Venue

The Select Benefits plan is established and administered in the State of Alaska, and is governed by the laws of the State of Alaska. Any and all suits or legal proceedings of any kind that are brought against the State must be filed in the First Judicial District, Juneau, Alaska.

8.5. Cancellation

The State of Alaska may cancel any portion of the contract with the claims administrator without the consent of the members by written notice delivered to the other party not less than 60 days before the cancellation is effective.

8.6. 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 of the Department of Administration..

8.7. Contract Liability

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

8.8. 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 this plan provides.

8.9. Evidence of Medical Necessity

The claims administrator may require that any person who receives services under this plan submit a certificate of medical necessity within a reasonable time from people or organizations considered appropriate. If evidence of medical necessity is requested, members cannot continue to receive benefits under this plan unless they provide a requested certificate, subject to a medical review board, that substantiates the medical necessity for continued care. The claims administrator will not request such a certificate more frequently than every 10 days.

8.10. 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 under this contract.

8.11. Free Choice of Hospital and Physician

You may select any hospital who meets the criteria in section 3.3(f), *Hospitalization*. You may select any physician or surgeon who meets the definition of provider in section 3.3(b), *Physician's Services*.

The payments made under this plan for services that a physician or surgeon renders are not construed as regulating in any way the fees that the physician or surgeon charges.

Under this plan, payments may be made, at the discretion of the claims administrator, to the physician or other person or organization furnishing the service or making the payment, or to the employee, or to such person or organization and the employee jointly.

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

8.12. Adequate Notice

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

8.13. Plan Must Be Effective

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

8.14. Medical Outcomes

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

8.15. Premiums

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

8.16. Right of Recovery

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

- To require the return of the overpayment on request; or

- To reduce by the amount of the overpayment any future benefit payment made to or on behalf of that person or another person in his or her family.

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

8.17. Right to Receive and Release Necessary Information

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

8.18. Transfer of Benefits, Assignment, Garnishment and Attachment

All rights to benefits under this plan are personal and available only to you. They may not be transferred to anyone else.

Benefits or other rights of members of this plan are not assignable or subject to garnishment or attachment by creditors. Also, this plan is not obligated by any attempted or purported assignment, garnishment, or attachment. The plan may pay for services or supplies to a member by remitting funds to you, the provider of services or supplies, the group, other carrier, or jointly to any of these. The plan's good faith remittance discharges its obligation to the extent of the remittance amount, and it is not liable to anyone because of the selection of the payee.

8.19. Vested Rights

Except as cited under in section 7, *COBRA and Extended Health Coverage,* this plan does not confer rights beyond the date that coverage is terminated. For this reason, no rights from this plan can be considered vested rights. You are not eligible for benefits or payments from this plan for any services, treatment, medical attention, or care rendered after the date your coverage terminates.

8.20. Other Mandated Coverage

a. Patient Protection and Affordable Care Act of 2010 ("PPACA")

The health plan will comply with required provisions of the Patient Protection and Affordable Care Act of 2010 ("PPACA"). However, the State of Alaska believes the health 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 health 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.

i. Prohibition on Rescissions

The health 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 health plan. As part of such compliance, the health 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 health plan. Failure to notify the plan of any change in status or other applicable events as required under the plan or the qualified benefits 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 health plan will provide 30 days advance written notice to you or your dependent, as applicable. Notwithstanding the foregoing, the health 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 health plan from cancelling or discontinuing such coverage prospectively for any reason provided under the health plan.

Rescission or rescind means a cancellation or discontinuance of coverage that has retroactive effect. A rescission does not include the cancellation or discontinuance of coverage that (1) has only a prospective effect, or (2) is effective retroactively, to the extent it is attributable to a failure to timely pay required premiums or contributions toward the rest of coverage.

b. Continuation Coverage Under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")

Right to USERRA Continuation Coverage. You may be entitled to reemployment and other rights after a period of service in the uniformed services under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). You also may be entitled to continue group health coverage for yourself and your dependents for up to 24 months beginning on the date on which you are absent from employment by reason of service in the uniformed services. "Uniformed services" includes the:

- Armed Forces
- Certain types of service by members of the National Disaster Medical System
- Public Health Service Commission Corps
- Training or duty in the Army National Guard or the Air National Guard
- Other categories of persons designated by the President in time of war or emergency

"Service in the uniformed services" means:

- the performance of a duty on a voluntary or involuntary basis in a uniformed Service under competent authority and includes active duty, active and inactive duty for training, National Guard duty under Federal law;
- a period for which you are absent from a position of employment for the purpose of an examination to determine your fitness to perform any such duty;
- a period for which you are absent from employment to perform funeral honors duty as authorized by law; and
- service as an intermittent disaster-response appointee upon activation of the National Disaster Medical System or as a participant in an authorized training program.

Notice Requirements

To be eligible for these USERRA benefits, you are generally required to give your employer advance notice that you are leaving your job for service in the uniformed services. When you return from military service, you must timely submit an application for reemployment with your employer and request information regarding your reemployment rights. Time limits for returning to work will depend on the length of time of your military service. Please contact your human resources officer for more information.

Length and Cost of USERRA Continuation Coverage. If you are on a leave from your employment because of service in the uniformed services and you were covered under the health plan immediately before your leave, you can elect to continue health care coverage for yourself and your dependents who were also covered under the health plan (your dependents do not have an independent right to elect USERRA continuation coverage). USERRA continuation coverage will last for up to the lesser of:

- 24 months beginning on the date your leave begins; or
- the day following the date allowed under USERRA for you to apply for or return to employment and you fail to do so.

You will be required to pay for this coverage at 102% of the full premium cost; provided, however, that if your service in the uniformed services is fewer than 31 days, you will not be required to pay more for this coverage than actively-employed covered persons.

To elect continued health coverage while in the uniformed services, you must elect such coverage on a form provided by the plan administrator. Coverage must be elected during an election period that begins on the date you give your employer advance notice that you are required to report for uniformed service and that ends 60 days after you would otherwise lose your health coverage. If you are unable to provide this advance notice because giving the notice would be impossible, unreasonable, or is precluded by military necessity, your election period begins on the date you leave for uniformed service and shall end on the earlier of: (a) the 24 month period beginning on the date on which your absence for the uniformed service begins; or (b) the date allowed under USERRA for you to return from uniformed service or apply for a position of employment and you fail to do so. If you elect coverage in a timely manner, it will be retroactive to the day you lost coverage as a result of your military leave.

Your initial premium for USERRA continuation coverage is due within 45 days after you elect the coverage. In addition, future premiums for USERRA continuation coverage are due on the first day of each month of coverage and will be considered late if not received within 30 days of that date. Late payment will result in loss of coverage for you and any covered dependents. USERRA coverage runs concurrently with continued health coverage provided under this health plan (see Section 7, *COBRA and Extended Health Coverage*). You may discontinue coverage under the health plan during your service by submitting the applicable forms to the plan administrator.

During your service, you will be entitled to the same health plan coverage

that is available to employees with similar status and pay who are actively working for the employer.

Waiting Periods and Exclusions Upon Reemployment

When you return to employment from uniformed service, you may request that your coverage under the health plan be reinstated. Your request should be made within 30 days of your reemployment after uniformed service. If you are reinstated, you will not be subject to any exclusion or waiting periods. However, this does not apply to conditions that were incurred or aggravated during your service in uniformed services.

c. Family and Medical Leave Act (FMLA)

If the employer is subject to the requirements of the Family and Medical Leave Act ("FMLA") as amended, any employee entitled to FMLA leave may continue their benefits, and any dependents' benefits, under the health plan as if continuously employed during the entire FMLA leave period. Certain limitations stated below may apply. No new conditions or waiting periods will apply to the benefits upon your return to work.

You may be entitled to FMLA leave for the following reasons:

- Birth of a child, and to care for such child;
- Placement of a child with you for adoption or foster care, and to care for such child;
- To care for your seriously ill spouse, child, or parent;
- A serious health condition that makes you unable to perform your job functions;
- Any "qualifying exigency" as defined under the FMLA arising out of the fact that the employee's spouse, child, 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; or
- To care for a "covered servicemember" with a "serious injury or illness," if the employee is the spouse, child, parent, or "next of kin" of the covered servicemember, as these terms are defined under the FMLA.

The employer shall be responsible for determination of your eligibility, rights, or length of leave period for FMLA for purposes of continuing your benefits under the health plan.

Unless provided otherwise, leave for the reasons set forth above can be for a period of up to twelve (12) work weeks in a rolling twelve (12) month period.

Leave to care for a "covered servicemember" with a "serious injury or illness" can be for up to a total of twenty-six (26) work weeks during a single twelve (12) month period which begins on the first day of the FMLA leave; provided, however that an employee who takes such a leave may be granted a combined total of twenty-six (26) work weeks of leave for any combination of leaves under the FMLA during the single twelve (12) month period, but is not entitled to more than twelve (12) weeks of leave for any reason set forth above, other than caring for a covered servicemember.

The employer may recover from the employee contributions made by the employer during a period of unpaid FMLA leave for maintaining the employee's health plan coverage if the employee fails to return to work after the FMLA leave has been exhausted, unless the failure to return to work is due to the continuation, reoccurrence or onset of either a serious health condition of the employee or a family member, or a serious injury or illness of a covered servicemember which would otherwise entitle the employee to FMLA leave, or other circumstances beyond the employee's control.

d. Genetic Information Nondiscrimination Act of 2008

The health plan will comply with the Genetic Information Nondiscrimination Act of 2008, as amended, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing the health plan. As part of such compliance, the health plan will not:

- 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; or
- Request, require, or purchase genetic information for underwriting purposes during coverage or with respect to any covered person, prior to such individual's enrollment in the health plan.

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

e. Dependent Students on Medically Necessary Leave of Absence

The health plan will comply with Michelle's Law of 2008, as amended from time to time, and any regulations issued thereunder, to the extent required thereunder and not otherwise inconsistent with any federal law or regulations governing the health plan. As part of such compliance, the health plan will extend coverage for up to one year when a full-time student otherwise would

lose eligibility if the full-time student takes a medically necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless dependent child coverage ends earlier under another 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.

f. Statement of Rights Under the Newborns' and Mother's 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 or the insurance issuer 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 pre-certification. For information on pre-certification, contact your Administrator.

Also, under federal law, plans 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.

g. Statement of Rights Under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("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 this plan (see Section 2.1, *Benefit Summary*).

If you would like more information on WHCRA benefits, call your plan administrator.

8.21. Protected Health Information Under HIPAA

This section is intended as good faith compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and is to be construed in accordance with HIPAA and guidance issued thereunder. This section is limited to benefits under the Select Benefits plan that are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR 160 and 164, as amended) ("Privacy Regulations") and that are uninsured and provide Protected Health Information to the State.

The Select Benefits plan will use 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," as those terms are defined in the Privacy Regulations.

In order for the plan to disclose Protected Health Information to an employer or to provide for or permit the disclosure of Protected Health Information to an employer by a health insurance issuer or HMO with respect to the plan, the Select Benefits plan must ensure that the plan documents restrict uses and disclosures of such information by the employer consistent with the requirements of HIPAA.

The Select Benefits plan may:

- Disclose Summary Health Information to the employer, if the employer 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.

  "Summary Health Information" is 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 a group 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.
- Disclose to the employer information on whether an individual is participating in the Select Benefits plan, or is enrolled in, or has disenrolled from a health insurance issuer or HMO offered by the plan.
- Disclose Protected Health Information to the employer to carry out plan administration functions that the employer performs, consistent with these provisions.
- With an authorization from the covered employee, disclose Protected Health Information to the employer for purposes related to the administration of other employee plans and fringe benefits sponsored by the employer.
- Not permit a health insurance issuer or HMO with respect to the Plan to disclose Protected Health Information to the employer except as permitted here.
- Not disclose (and may not permit a health insurance issuer or HMO to disclose) Protected Health Information to the employer as otherwise permitted unless a statement is included in the plan's notice of privacy practices that the plan (or a health insurance issuer or HMO with respect to the plan) may disclose Protected Health Information to the employer.
- Not disclose Protected Health Information to the employer for the purpose of employment-related actions or decisions or in connection with any other benefit or employee plan of the employer.

The employer may only use and disclose Protected Health Information as permitted and required by the plan, as set forth here. Such permitted and required uses and disclosures may not be inconsistent with the provisions of HIPAA. The

employer may use and disclose Protected Health Information without an authorization from a covered employee for plan administrative functions including Payment activities and Health Care Operations, as defined in the regulations. In addition, the employer may also use and disclose Protected Health Information to accomplish the purpose for which any disclosure is properly made.

The plan may disclose Protected Health Information to the employer only upon receipt of a certification from the State that the plan documents have been amended to incorporate the provisions provided for here and that the State so agrees to the provisions set forth therein.

The employer 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 employer provides Protected Health Information received from the plan agree to the same restrictions and conditions that apply to the employer 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 employer;
- 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 plan of the employer 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 here, 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; and
- If feasible, return or destroy all Protected Health Information received from the plan that the employer 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; and
- Ensure that these separations and requirements are supported by reasonable and appropriate security measures.

In accordance with HIPAA, only the employees or classes of employees set forth in the Notice of Privacy Practices may be given access to Protected Health Information:

These persons may only have access to and use and disclose Protected Health Information for plan administration functions related to the Health Care Operations that the State performs for the plan.

If the persons or classes of persons described above do not comply with this plan document, the plan and the State will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

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9. Health Flexible Spending Account (HFSA)

Health Flexible Spending Account Highlights

- Reimburses you for many expenses not otherwise covered by the health plan.
- Contributions are not subject to federal taxes.
- May contribute up to $208 each benefit month.
- Use it or lose it. Any balance remaining in your account at the end of the benefit year is forfeited.

9.1. 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 pre-tax money to a Health Flexible Spending Account (HFSA) to reimburse some of your unpaid health expenses. Since your contributions are not subject to federal taxes, you pay less in taxes each year.

9.2. Who May Participate

Employees participating in the Select Benefits plan who are eligible for group health coverage as described in section 1.3(a), *Employees*, are eligible to participate in the Health Flexible Spending Account.

Part-time employees are eligible to participate **only** if they elect to participate in both medical coverage and basic life insurance as described in section 15.1, *Basic Life and AD&D*.

9.3. How the Plan Works

The Health Flexible Spending Account works similar to a personal checking account.

Coverage begins and ends as specified in section 1.8, *When Coverage Begins,* and section 1.9, *When Coverage Ends*. You decide how much you want to contribute

each month, up to a maximum of $208 per benefit month. Your contribution must be:

- In whole dollars,
- At least $20 per month ($240 per year), and
- No more than $208 per month.

Your contribution will be split and deducted from your paycheck twice per month for each month that you are in pay status. Federal income taxes are not withheld on the amount you contribute. If you are on leave without pay or don't have enough payroll in a month, a contribution will not be taken that month. Your coverage will be suspended for that month.

Your contributions are deposited into your individual plan account. Claims for unpaid health care expenses are filed and you are reimbursed up to the amount of your annual contribution or the amount of the claim, whichever is less.

For example, if, prior to the benefit year beginning January 1, 2014, you elect to make monthly contributions of $100, your annual 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 your health plan. If you are covered by the Health Flexible Spending Account for 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 year, you can be reimbursed for additional expenses up to $700 ($1,200 - $500).

If you stop being a participant during a benefit year, you will be entitled to reimbursements from your Health Flexible Spending Account for qualifying health care expenses that were incurred during the benefit year but before you stopped being a participant, subject to COBRA continuation coverage. In addition, you will not be entitled to reimbursement of qualifying health care expenses for any dependent after the person is no longer a dependent.

9.4. Use It or Lose It

In exchange for tax advantages of using the Health Flexible Spending Account, the Internal Revenue Service (IRS) requires that you forfeit any money left in your reimbursement account after all qualified claims for the benefit year have been paid. 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 use this account.

9.5. Qualified Health Care Expenses

Eligible expenses must meet the Internal Revenue Service definition under Section 213(d) for medical expenses and must not be covered or paid in full by your health plan(s). The final determination for eligibility is made by the plan.

A complete list of tax deductible medical expenses is available in IRS publication #502. You will find it online at www.irs.gov/publications.

Most eligible services or supplies must be prescribed and/or performed by a licensed provider. Only those expenses which are not paid by any of your health plans are eligible to be reimbursed.

In addition, expenses reimbursed out of your Health Flexible Spending Account must be expenses you or your dependent incurred. For these purposes, eligible dependents include your spouse and children who meet the eligibility requirements shown in section 1.3(b), *Dependents,* and any other dependent you claim on your income tax return each year.

Over-the-Counter Drugs

Effective January 1, 2011, over-the-counter (OTC) drugs and medicines may be reimbursed from your HFSA only if the claim is accompanied by a written prescription from a healthcare provider who is licensed to prescribe drugs.

Certain items are exempt from this requirement including:

- Insulin
- Co-pays and deductibles
- Items that are not drugs or medicines
- Medical equipment such as crutches
- Medical supplies such as bandages
- Diagnostic devices such as blood sugar test kits

Please note that certain items such as homeopathic medicines or vitamins require a certificate of need or similar documentation. A list of these items, and those covered under the OTC provision, is included on the HFSA OTC claim form.

Note: Cosmetic surgery or procedures (such as tooth bleaching) and insurance premiums are not eligible expenses.

9.6. HFSA vs. Tax Deductions

If you use the Health Flexible Spending Account to pay for eligible expenses, you cannot take a tax deduction on your income tax for the same 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.

9.7. How Much to Contribute

Here are some things to think about to help you decide how much to contribute to your Health Flexible Spending Account:

- What expenses you may have that are not covered by a health plan but are reimbursable from this account.
- How much your deductibles are expected to be for the benefit year.
- An estimate of the total out-of-pocket maximum you could pay.
- An estimate of what your coinsurance and copayments will total.
- 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 don't use, you lose.

9.8. Claiming Your Reimbursements

To be reimbursed for eligible expenses, you should submit the claim to all health plans first. You will receive an Explanation of Benefits showing your out-of-pocket expenses.

Claims to the Health Flexible Spending Account (HFSA) may be submitted in one of two ways:

- *Streamlined claims submission* – With this option, claims are sent to the claims office by you or your provider as normal. Any amounts that are unpaid by the health plan, such as deductibles, copayments, or uncovered expenses, are electronically transferred to the HFSA administrator.

  You cannot elect this option if you have any other health coverage. This includes a second State of Alaska 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 the HFSA administrator after receiving your Explanation of Benefits (EOB) from your group health plan(s). If you have more than one health plan, you must submit the claim with copies of the EOBs from **all plans. This is the only option available if you have more than one health plan.**

Reimbursements are issued twice per month. 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 a 90-day grace period after the end of the benefit year (generally until March 31) to file all unpaid claims for that benefit year.

The minimum reimbursement is $25. If you submit a claim for less than $25, you will be reimbursed only after your accumulated claims exceed $25. Final claims submitted after the end of the benefit year will be reimbursed, regardless of the amount, up to your annual election.

Over-the-counter (OTC) claims submission— with this option, you submit claims to the HFSA claims administrator regardless of whether you have selected streamlined or direct claims submission. You must submit each claim with itemized statements or receipts, an explanation of benefits (EOB) form from all health plans, and the prescription or certificate of need.

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10. Life Insurance

Life Insurance Highlights

- Employee coverage only.
- Payments made at death regardless of the cause.
- Amounts available:
  - ~ $10,000
  - ~ $20,000
  - ~ $30,000
  - ~ $40,000
  - ~ $48,000
- Conversion privileges available.
- Waiver of premium available if you become disabled before age 60.
- Payroll deductions for coverage are not taxed by the federal government as income.

Note: No more than $10,000 may be selected if you also select Survivor Benefits.

10.1. Introduction

If you die from any cause while covered under this plan, the Life Insurance plan will pay benefits to your designated beneficiary or beneficiaries. This plan is available to employees only.

If you enroll in Survivor Benefits, you cannot enroll for more than $10,000 of this life insurance. If you want to enroll in the AD&D plan, you must enroll for at least $10,000 of this life insurance coverage.

10.2. Amount of Coverage

You may enroll for one of the following amounts of life insurance:

- $10,000
- $20,000
- $30,000
- $40,000
- $48,000

10.3. Your Beneficiary

To name a beneficiary, you must complete a Beneficiary Designation form, available from your human resources office, the Division, or its Web site. You may name one or more beneficiaries. If you name more than one beneficiary, you must designate the percentage to be paid to each person. Also, you should name a contingent beneficiary in case your primary beneficiary dies before receiving benefits. To change your beneficiary at any time, submit a revised Beneficiary Designation form to the Division. The change will become effective on the date that the Division receives your form.

10.4. Waiver of Premium With Disability

If you become totally disabled before age 60 and cannot work or engage in any occupation for wage or profit for nine months, you may apply for a premium waiver. If approved, your life insurance will remain in force at no cost to you as long as you remain disabled. Proof of your continuing disability must be furnished as required.

10.5. Assignment of Policy

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

10.6. Conversion Privilege

If coverage ends because you terminate employment or become disabled, you may convert to any form of individual policy of life insurance customarily issued by the carrier, except term insurance. No evidence of your good health is required.

You must apply for conversion and pay the premium within 31 days after termination of coverage. The amount of the premium will be based on your age and the amount of insurance you have elected. If you die during this 31-day period, the amount of insurance you were entitled to convert will be paid to your beneficiary, whether or not you applied for conversion. For more information and application forms, please contact your human resources office or the Division.

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11. Accidental Death and Dismemberment (AD&D) Plan

Accidental Death and Dismemberment (AD&D) Highlights

- "Employee only" or "employee and family" coverage.
- Employee benefit amount for accidental death is $100,000.
- Dependent benefit amounts are based on family composition at time of loss.
- Accidental dismemberment benefit amounts are based on the type of dismemberment.
- Payroll deductions for coverage are not taxed by the federal government as income.

Note: To select AD&D coverage, you must also enroll for at least $10,000 of Life Insurance.

11.1. Introduction

The Accidental Death and Dismemberment (AD&D) plan will pay benefits for death or serious injury resulting from a covered accident. ***To enroll in the AD&D plan, you must be enrolled for at least $10,000 of Life Insurance benefits.***

11.2. Who May Be Covered

This plan is available for yourself only or yourself and your family. If you elect to cover your family, your eligible dependents include:

- Your spouse. You may be legally separated but not divorced.
- Your children from 14 days old up to 23 years of age ***only*** if they are:
  - ~ Your natural children, stepchildren, foster children placed through a State foster child program, legally adopted children, children in your physical custody and for whom bona fide adoption proceedings are underway, or children for whom you are the legal, court-appointed guardian;
  - ~ Unmarried and chiefly dependent upon you for support; and

~ Living with you in a normal parent-child relationship;

- This provision is waived for natural/adopted children of the employee who are living with a divorced spouse, assuming all other criteria is met.
- Only stepchildren living with the employee more than 50% of the time are covered under this plan.

Children incapable of employment because of a mental or physical incapacity are covered even if they are past the maximum age. However, the incapacity must have existed before age 19 and the children must continue to rely chiefly on you for support. You must furnish the carrier with evidence of the incapacities, proof that they existed before age 19 and proof of financial dependency. Children are covered as long as the incapacity exists and they meet the definition of children, except for age. Periodic proof of the continued incapacity may be required.

If the AD&D plan covers more than one family member, each eligible family member may be covered both as an employee and as a dependent, or as the dependent of more than one employee.

11.3. Amount of Coverage

The full benefit amount for employees who enroll in this plan is $100,000. If you enroll your family, the benefits payable for a loss incurred by a family member will be based on the composition of your family at the time of the loss. This is shown in the following table:

Family Composition at Time of Loss	Full Benefit Amount
Employee, Spouse and Dependent Children	
• Employee	$100,000
• Spouse	40,000
• Each Child	5,000
Employee and Spouse	
• Employee	$100,000
• Spouse	50,000
Employee and Dependent Children	
• Employee	$100,000
• Each Child	10,000

The plan will pay benefits if a covered individual dies or suffers a covered loss within 365 days after, and as the result of, an accidental injury, independent of all other causes. Benefits will be paid as follows:

For the Loss of…	Benefit Payable
Life	Full benefit amount
Both eyes, feet or hands or any combination thereof	Full benefit amount
One eye, one foot or one hand	1/2 of full benefit amount
Thumb and index finger of same hand	1/4 of full benefit amount

11.4. Your Beneficiary

If you die while covered, this plan will pay benefits to the surviving beneficiary or beneficiaries named on your Beneficiary Designation form. If you name more than one beneficiary, you must designate the percentage to be paid to each person. You may also name a contingent beneficiary in case your primary beneficiary dies before receiving benefits. To change your beneficiary at any time, submit a revised form to the Division. The change will become effective on the date the Division receives your form.

If you are dismembered or a covered family member dies or is dismembered, benefits will be paid to you.

Your AD&D insurance cannot be assigned; it is not subject to the claims of creditors.

11.5. Exclusions

The AD&D plan will not pay benefits for a loss resulting from any of the following:

- Suicide or suicide attempt by the covered person while sane or insane.
- Disease or bacterial infections, except pyogenic infections which occur through an accidental cut or wound.
- Injury sustained while serving as a pilot or crew member of any aircraft, **except** when traveling on State business.
- Declared or undeclared war or any act thereof.
- Service in the military, naval or air service of any country.

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12. Survivor Benefits

Survivor Benefits Highlights

- Coverage for employee only.
- Payments made at death regardless of the cause.
- You select the payment duration.
- Present value of coverage is $38,000.
- Waiver of premium available if you become disabled before age 60.
- Conversion privileges available.
- Payroll deductions for coverage are not taxed by the federal government as income.

Note: Survivor Benefits are not available if you have selected more than $10,000 in Life Insurance.

12.1. Introduction

If you die from any cause while covered under this plan, the Survivor Benefits will pay benefits to your designated beneficiary or beneficiaries. This plan is available to employees only.

If you enroll in Survivor Benefits, you cannot enroll for more than $10,000 of Life Insurance.

12.2. Amount of Coverage

The present value of coverage provided by this plan is $38,000. If you die while covered, your designated beneficiary will receive the benefit amount, paid in monthly payments over a specified period of years. You select the payout period. The monthly amount payable to your beneficiary will be based on your elected period as follows:

Available Payout Period	Monthly Benefits
5 years	$765
10 years	$455
15 years	$360
20 years	$315
25 years	$290
30 years	$275

12.3. Your Beneficiary

To name a beneficiary, you must complete a Beneficiary Designation form, available from your human resources office or the Division. If you name more than one beneficiary, you must designate the percentage to be paid to each person. You may also designate a contingent beneficiary to receive the benefit in case your primary beneficiary dies before you.

Once payments begin to your beneficiaries, they must designate their own beneficiary to receive any remaining unpaid monthly benefits in the event of their death.

To change your beneficiary, submit a revised Beneficiary Designation form to the Division. The change will become effective on the date the Division receives your form.

This coverage may not be assigned; it is not subject to the claims of creditors.

12.4. Waiver of Premium With Disability

If you become totally disabled before age 60 and are unable to work or engage in any occupation for wage or profit for nine months, you may apply for a premium waiver. If approved, your Survivor Benefits will remain in force at no cost to you as long as you are disabled. Proof of your continuing disability must be furnished upon request.

12.5. Conversion Privilege

If your Survivor Benefits end because you terminate employment or become disabled, you may convert to any form of individual policy of life insurance customarily issued by the carrier except a policy of term insurance. No evidence of your good health is required.

You must apply for conversion and pay the premium within 31 days after termination of coverage. The premium will be based on your age. If you die during the 31-day period, the amount of insurance you were entitled to convert will be paid to your beneficiary, whether or not you had applied for conversion.

For more information and application forms, please contact your human resources office or the Division.

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13. Disability Benefits

Short-Term Disability Highlights

- Pays $210 per calendar week of disability minus other disability and retirement benefits.
- Benefits begin on the 31st day of your absence due to total disability or when all accrued paid leave has been exhausted, whichever is later.
- Benefits may continue for up to 180 days from the date of disability.
- Benefits are reduced by income payable from other sources such as retirement benefits or workers' compensation.
- Pays benefits for a totally disabling pregnancy like any other illness.

Long-Term Disability Highlights

- Two coverage options are available:
  - ~ benefit equal to 50% of monthly base pay.
  - ~ benefit equal to 70% of monthly base pay.
- Benefits are reduced by income payable from other sources such as retirement benefits or workers' compensation.
- Maximum monthly benefit is $8,000; minimum is $100.
- 180-day waiting period.
- Pays benefits for a totally disabling pregnancy like any other illness.

13.1. Introduction

This section of your handbook describes the Short-Term Disability (STD) plan and the Long-Term Disability (LTD) plan. These plans are designed to replace a portion of your income if you become disabled and are unable to work due to illness or injury. You may enroll for the short-term plan separately or one of the long-term plans or a combination of the short-term plan with one long-term plan.

13.2. About the Plans

a. Pre-Existing Conditions

These plans will not cover a disability which occurs during the first 24 months of your current period of coverage if the disability is caused by, contributed to, or is a consequence of a "pre-existing condition." A pre-existing condition is a condition for which you received diagnosis, tests, or treatment or for which you took drugs or medicines prescribed or recommended by a physician, within 12 months before your current coverage under this plan began.

b. Other Income Benefits

Disability benefits will be reduced by any "other income benefits" paid to you or your family due to your disability or retirement as follows:

- Income received by you from any employer or from any occupation for compensation or profit (other than in connection with an approved rehabilitation program).
- Disability, retirement or unemployment benefits required or provided for by law, including:
  - ~ Disability retirement,
  - ~ Disability benefits under workers' compensation laws or similar laws, to compensate for:
    - o Loss of past and future wages,
    - o Impairment of earnings capacity or diminished ability to compete in the open labor market, or
    - o Any degree of permanent impairment or loss of bodily function or capacity,
  - ~ Benefits paid under the Jones Act,
  - ~ Retirement benefits based on length of service,
  - ~ Unemployment compensation benefits,
  - ~ No-fault wage replacement benefits,
  - ~ Statutory disability benefits,
  - ~ Disability and retirement benefits under the Federal Social Security Act, the Canada Pension plan, and the Quebec Pension plan, or
  - ~ Disability, retirement or unemployment benefits provided under any group insurance or pension plan or any other arrangement of coverage for individuals in a group (whether on an insured or uninsured basis), including sick leave and disability benefits from any State-sponsored or funded retirement system.

If you receive "other income" in a single lump sum, that payment will be subtracted from your disability benefit over 60 months. The disability carrier will have the right to make retroactive adjustments for any lump sum payments received from a retroactive award.

If there is an increase in your government benefits during a period of total disability, the increase will not be considered as "other income benefits" unless it results from a change in the number of your family members, or it results from a correction in the calculation of the benefit level originally established for your disability.

Payments from defined contribution plans, such as the State of Alaska Supplemental Annuity plan and Deferred Compensation plan, and Social Security benefits paid to your dependent children 18 years or older, are not considered "other income benefits."

c. Benefits Payments Are Taxable

Since these disability plans are part of the Select Benefits program, you have the advantage of paying for coverage with earnings deducted from your salary *before* federal income taxes are withheld. That reduces the cost of your coverage. Due to these tax advantages, however, **disability benefit payments you receive from the plans are subject to federal income tax.**

d. Filing Claims

You must apply for disability benefits under these plans within one year after the date you become totally disabled.

The carrier, at its own expense, has the right to examine you if you have filed a claim. Examinations may be made as often as they are reasonably required during the period for which you claim benefits.

The carrier also has the right to recover any overpayment of disability benefits either directly from you or by deduction from your future monthly benefit payments.

e. Limitations

The Disability plans will not pay benefits when any of the following occur:

- You are no longer totally disabled or under the care of a legally-qualified physician. You must be personally seen and treated by a physician to be considered under the physician's care.
- You begin work at a reasonable occupation, receive compensation or profit, or are paid leave.
- You fail to furnish required proof of the continuance of total disability or refuse to be examined when required.
- Your disability benefit period ends, as shown in the *Duration of Payments* sections.
- You die. If you have a surviving spouse or children, they will be eligible for a three-month survivor benefit as described in the LTD section, *Survivor Income Benefit.*

If the plans terminate while you are receiving disability benefits, your benefits will not be affected.

f. Exclusions

The Disability plans will not cover any disability which results from the following:

- Intentionally self-inflicted injuries.
- Your commission of, or your attempt to commit, an assault, battery, or felony.
- War, or any act of war (whether war is declared or not), insurrection, rebellion, or participation in a riot or civil commotion.

13.3. Short-Term Disability Plan

a. When Benefits are Payable

If you become disabled while enrolled in the Short-Term Disability (STD) plan, benefits will begin the 31st day of a disability absence or when all paid leave has been exhausted, **whichever is later.** A "disability absence" is any absence from work caused by an injury or a disease. To receive benefits, you must first submit medical certification of your disability from your physician.

b. Benefit Amount

Your weekly benefit will be $210, minus any other disability or retirement benefits you receive as described in the section, *Other Income Benefits*. Partial weeks of disability will be prorated at $30 per day.

c. Duration of Payments

Benefits may be paid for a period of disability of up to 180 days which begin on the date you are first disabled or until Long-Term Disability benefits commence, regardless of whether full benefits have been realized.

d. Recurring Periods of Disability

One "period of disability" may include more than one disability absence. Disability absences due to the same or related causes and separated by less than two consecutive weeks of full-time work will be considered to be the same period of disability. A new disability absence due to a cause different from that of any prior disability must be separated from the prior disability by at least one day of full-time active work for you to become eligible for a new maximum period of payment.

13.4. Long-Term Disability Plan

The Long-Term Disability (LTD) plan is designed to pay benefits for a total disability which lasts an extensive period of time. This plan offers a choice of two benefit options. If you enroll, you may elect a benefit equal to:

- 50% of your base monthly pay; or
- 70% of your base monthly pay.

These percentages reflect combined payment from this plan and payments for disability or retirement as described in the section *Other Income Benefits.* Your monthly costs will depend on the option you choose and the amount of your monthly base pay.

a. When Benefits Are Payable

To receive benefits from this plan, you must be totally disabled. That is, you are unable to work at any reasonable occupation due to sickness or injury, and are under the care of a physician. Medical certification is required.

Benefits will begin after you have completed a 180-day waiting period of total disability. This waiting period begins on the day you are both totally disabled and under the care of a physician. You will be considered disabled no earlier than 31 days before the date you are first seen and treated by a qualified physician for the cause of your disability.

b. Benefit Amount

Depending upon which LTD plan you are enrolled in at the time of your disability, your monthly benefit will equal either 50% or 70% of your monthly base pay, reduced by any "other income." "Monthly base pay" is your pay of record on April 1 for the benefit year beginning on the first day of the following July. It excludes bonuses, overtime, and other compensation. Adjustments may be made for part-time, seasonal or newly-hired employees.

For both options, the maximum monthly benefit payable is $8,000, and the minimum benefit is $100 per month. Appropriate adjustments will be made for partial months.

c. Duration of Payments

If you are disabled at age 60 or younger, benefits may be paid to you until you reach age 65. If you are disabled at age 61 or over, the following table shows how long payments may be made.

Disability Benefit Period	
Age at Disability	**Duration of Benefit Payments**
60 or younger	To age 65
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	24 months
67	18 months
68	18 months
69	18 months
70 or over	12 months

d. Recurring Periods of Disability

Once a period of total disability has ended, any new period of disability will be treated separately. Two or more separate periods of total disability that occur while you are covered under this plan and resulting from the same or related causes will be considered as one period if they are separated by less than three months.

e. Limitations on Benefit Period

No more than 24 months of benefits will be paid if a total disability is caused by one of the following:

- Mental or nervous conditions.
- Conditions caused by or contributed to by chemical dependency, or hallucinogenic substances.

If, after the first 24 months of benefits, you are confined as an inpatient in a hospital for more than 30 days for treatment of one of these conditions, benefits will continue until you have been free of confinement for that condition for a total of 90 days during any 12-month period. The section *Recurring Period of Disability* will not apply.

f. Survivor Income Benefit

If you die while receiving LTD benefits, a survivor benefit equal to three months of benefits will be paid to your surviving spouse or dependent children. This amount will not be reduced by "other income benefits."

g. Pregnancy Coverage

Benefits for a totally disabling pregnancy-related condition are paid to female employees on the same basis as for any other condition. As with any disability, a physician must certify that the employee is totally disabled, and additional evidence may be required before a determination is made whether benefits will be paid.

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14. Dependent Care Assistance Plan (DCAP)

Dependent Care Assistance Plan Highlights

- The plan can help pay costs of dependent care while you work.
- You may contribute up to $5,000 of annual earnings to your individual plan account; further IRS limitations may apply.
- You may request reimbursement from the plan for eligible dependent care costs, up to the balance in your account.
- Careful budgeting is important because the IRS requires you to forfeit any balance remaining in your account after all eligible expenses have been paid. In other words, use it or lose it.
- Your eligible contributions are not subject to federal income tax.

14.1. Introduction

If you pay someone to take care of your children, elderly relatives, or other dependents while you work, the Dependent Care Assistance plan can help ease the financial strain.

You do not pay federal income taxes on the portion of eligible earnings you contribute to the plan. As a result, if you participate, you may save money on your day care costs.

14.2. How the Plan Works

If you choose to participate in the Dependent Care Assistance plan, you complete a Select Benefit enrollment for the *monthly amount* you want to contribute. Your contribution must be in whole dollars. The minimum amount you may contribute is $25 per month ($150 for the short benefit year beginning July 1, 2013 and ending December 31, 2013, and $300 for benefit years thereafter); the maximum amount allowed by the IRS is $5,000 per taxable year.

The amount of contributions you elect will be deducted from your paycheck in equal amounts throughout the benefit year. If you are on leave without pay or don't have enough payroll in a month, a contribution will not be taken that month and will not be made up from any future payroll. Your contributions are automatically stopped when the $5,000 limit is reached for a taxable year.

Your contributions are deposited into your individual plan account. Federal income taxes are not withheld on the amount you contribute. Throughout the benefit year, you may request reimbursement from the plan for eligible costs you have incurred. You will be reimbursed up to the balance in your individual account. If you terminate, services must be provided before or on the last day of the month in which you terminated your employment.

If you stop being a participant during a benefit year, you will be entitled to reimbursement from your Dependent Care Assistance plan for eligible dependent care expenses that are incurred before you stopped being a participant but not to exceed the credit balance of the Dependent Care Assistance plan at the time you stopped being a participant.

14.3. Use It or Lose It

A word of caution: Due to the tax advantages, the Dependent Care Assistance plan is strictly regulated. According to the IRS, you must forfeit any money remaining in your plan account after all your eligible expenses for the year have been reimbursed. In other words, if you don't use it, you lose it. Most employees find, however, that they can take full advantage of the plan by carefully budgeting for upcoming expenses.

14.4. Eligible Dependents

To be reimbursed by the plan, expenses must be for the care of your dependents, which include:

- Children under age 13 for whom you or your spouse can claim federal income tax exemptions.
- Your spouse or other individuals who live in your home, rely on you for more than half their financial support, and are mentally or physically unable to take care of themselves.

14.5. Eligible Expenses

Eligible dependent care expenses are those which would otherwise qualify for a tax credit under Internal Revenue Service regulations. To qualify as dependent care expenses, the expenses must allow you and your spouse to be gainfully employed or to search for gainful employment. For instance, you may use the plan to pay for child care expenses while you work, but you may not use the plan for a babysitter while you go to a movie.

Your dependent care expenses must also be for the care of a "qualifying individual." "Qualifying individual" means: (1) your "qualifying child" as defined in Code Section 152(a)(1) who is under age 13 or (ii) your dependent (under Code Section 152 but not subsections (b)(1), (b)(2) and (d)(1)(B)) or spouse who is physically or mentally incapable of caring for himself or herself and who shares a household with you for more than ½ of the year. A child of divorced or separated parents is a qualifying individual of the custodial parent if (1) the child is in the custody of one or both parents more than ½ of the year, (2) the child receives over ½ of his or her support from his or her parents, and (3) the parents are legally divorced or separated.

Note: Your child who is under age 13 or is physically or mentally incapable of caring for himself or herself may be deemed to be a qualifying individual even if the former spouse, and not you, may be entitled to claim a personal exemption deduction with respect to the child.

Additionally, you will not be entitled to reimbursement unless both you and your spouse work or your spouse (i) is a full-time student or (ii) is mentally or physically unable to care for himself or herself and shares your household. In these two cases, the IRS will assume that your spouse has an income of $250 per month if you have one qualifying individual, or $500 per month if you have two or more qualifying individuals. The maximum amount you may be reimbursed is based on your spouse's "assumed" income. If he or she works part-time, the maximum amount you may be reimbursed is your spouse's assumed income or actual earned income, whichever is greater.

Example

Jerry and his wife Ruth have two children. Since Ruth is a full-time student for nine months each year, her assumed income is $500 for each month she is a student, or $4,500 a year (9 x $500). Consequently, Jerry can receive up to $4,500 a year in nontaxable reimbursement from his Dependent Care Assistance Plan.

You cannot be reimbursed for expenses which have been paid from other sources such as another employer's plan. If you receive a duplicate reimbursement, you must declare the second payment as taxable income.

The short benefit year is from July 1, 2013 to December 31, 2013. Effective January 1, 2014, each benefit year runs from January 1 through December 31. If you are hired after the first day of the benefit year, services must be provided on or after the first of the month in which your first dependent care deduction was taken from your paycheck.

Eligible dependent care costs are reimbursable whether services are provided inside or outside your home. If services are provided outside your home, however, the following restrictions apply:

- Day care center expenses are reimbursable only if the center complies with state and local laws. In most cases, that means the facility must be licensed.
- Services provided in someone's home are reimbursable. If seven or more people are cared for, however, the home would probably be considered a day care center, and state and local laws would apply.
- Services provided outside your home for anyone other than your child under age 13 are reimbursable only if the dependent spends at least eight hours each day in your home.

For more information about eligible expenses, please refer to the tax instructions for filing *Federal Income Tax Form 1040* and IRS Publication *#503 Dependent Care Expenses*. These publications are available from your local Internal Revenue Service office, or the public library.

14.6. Limitations and Exclusions

Examples of expenses that are not considered qualified dependent care expenses include, but are not limited to:

- Services provided by someone you claim as a dependent on your federal income tax form,
- Services provided by any of your children younger than age 19 on December 31 of the year in which the expenses are incurred;
- Services not required by your employment, such as babysitters for leisure activity;
- Amounts paid for food, clothing, or education;
- Transportation expense for a dependent care provider
- Care when you are on vacation, holiday or sick leave
- Custodial care; or
- Overnight camp.

When the expense incurred includes expenses for other benefits that are incident to and an inseparable part of the care, the full amount of the expense is considered to be for such care.

14.7. IRS Reimbursement Limitations

When deciding how much to contribute to the plan, you should consider the following limits, set by the IRS, on the amount of nontaxable reimbursement you may receive each year:

- If you are single, the most you may receive from this plan and any other plan combined is $5,000 in nontaxable reimbursement per year.
- If you are married and filing jointly, the maximum amount your household may receive is $5,000 per year. If you are married and filing separately, the most you as an individual may receive is $2,500.
- If you are single, your total nontaxable reimbursement for dependent care from this plan and any other plan cannot exceed your annual earned income. Earned income means wages, salaries, tips, and other employee compensation, plus net earnings from self-employment. If you are married, your total nontaxable reimbursement cannot exceed your or your spouse's earned income for the year, whichever is less.

14.8. Benefits Can Be Taxable

It's important to consider limits set by the IRS because you will be required to pay taxes on reimbursements that exceed the limits. That might happen, for example, if your spouse's income is unexpectedly reduced, and your reimbursement exceeds his or her annual earnings.

You will have to report the excess as taxable income when filing your federal income tax.

14.9. Reimbursement Plan vs. Tax Credit

Currently, the IRS allows you to take a tax credit for dependent care on your tax return. The tax credit is subtracted from Federal income tax, whereas this plan reduces taxable income. Participation in this Flexible Benefits plan affects this credit because you cannot take the credit on your tax return for expense reimbursed by this plan. Furthermore, the tax credit available will be reduced dollar for dollar by the amount you are reimbursed by this plan. You will have to decide which is better for you financially—the tax credit or the Dependent Care Assistance plan.

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.

14.10. Budgeting For Your Plan

The Dependent Care Assistance plan can save you money if you budget your expenses carefully. Keep in mind that *you must forfeit any money remaining in your account at the end of the benefit year* after all eligible 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 contributions will be deducted from your paycheck for the entire benefit year, not just for a few months at a time. For example, say you expect to incur $600 in dependent care costs only during the summer, when your children are out of school. To budget for your anticipated summer expenses, you could contribute $100 per month ($600 for the benefit year or 6 x $100).

Here are some questions to consider when budgeting for the plan:

- Do you need child care throughout the year or only during your children's summer vacation?
- Is your spouse a full-time student or planning to return to school?
- Does your dependent care center qualify for reimbursement?
- Does your spouse participate in a dependent care reimbursement plan?
- Does your spouse work a rotating shift? How will this affect your dependent care needs?
- Do you and your spouse file separate or joint income tax returns?

14.11. Submitting Claims For Reimbursement

To be reimbursed for eligible expenses, you must file a claim for reimbursement. You may file a claim once a month. If you have more than one bill, file all the month's bills together. If you have more than one provider, you may submit more than one claim. You have 60 days after the end of the benefit year to file a claim for expenses incurred during the year.

To file a claim, complete and submit a *Request for Reimbursement* form to the Division, along with an itemized invoice from your provider. The invoice must contain the following information:

- Provider's name, address, and Tax Identification Number (TIN) or Social Security Number (SSN). The TIN or SSN is especially important because you will have to provide the information when you file your tax return. If you don't, the amount you were reimbursed for that provider's services will be taxable.
- Name of the dependent who received the care and his or her relationship to you.
- Period covered and charges.

The *Request for Reimbursement* form has a section which can be used in place of a separate invoice. The forms are available from your human resources office, the Division, or its Web site.

Claims over $25 will be reimbursed up to the amount of your request. If there isn't enough money in your account to pay the full amount, you'll be reimbursed up to your account balance. The remainder will be paid later, after there is a sufficient balance. If you submit a claim for $25 or less, you will be reimbursed only after your accumulated claims exceed $25. Final claims submitted after the end of the benefit year will be reimbursed, regardless of the amount, up to the balance in your account.

14.12. Future of the Plan

The State of Alaska has established this plan with the intention that it will be maintained indefinitely; however, the State reserves the right to alter, amend, delete, cancel, or otherwise change the Dependent Care Assistance plan or any of the provisions of the plan at any time.

If the plan is discontinued, your contributions will cease. You will, however, be able to use the balance remaining in your account for eligible expenses incurred until the end of the benefit year. Requests for reimbursement must be made within 60 days after the end of the year.

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15. Group Life Plans

Group Life Highlights

- Basic Life and Accidental Death and Dismemberment (AD&D) premium is paid by the State.
- Basic Life and AD&D covers employee, spouse and eligible children.
- Basic Life and AD&D pays $2,000 for employee's death ($10,000 for employee's death for supervisory, confidential, partially exempt, exempt, and general government employees); lesser amounts for dependent's death. Pays additional $5,000 if the employee's death is accidental.
- Optional Life and AD&D may be elected at hire.
- Optional Life and AD&D coverage is equal to employee's annual salary, double the amount if the death is accidental.

15.1. Basic Life and AD&D

a. Who is Covered

i. Employees

Basic Life and Accidental Death and Dismemberment (AD&D) coverage is provided free of charge to permanent and long-term nonpermanent employees of the State of Alaska as shown below:

- Full-time employees of the State of Alaska (those whose position is scheduled to work 30 or more hours a week on a regular basis).
- Full-time seasonal employees of the State of Alaska (subject to the guidelines outlined in section 1.8, *When Coverage Begins,* and section 1.9, *When Coverage Ends*.).
- Part-time employees of the State of Alaska who elect to participate in the plan (those whose positions are scheduled to work at least 15 but less than 30 hours a week on a regular basis).

If you are a part-time employee and want to participate in the State's Basic Life and AD&D plan, you must elect coverage within the first 31 consecutive calendar days of employment. You need to sign an enrollment card and enroll in the Group Health plan. You must pay one-half of the health and life premium cost. If you do not elect coverage within the first 31 days, you

must show evidence of good health if you want to participate at a later date. Contact your human resources office or the Division for more information.

ii. Dependents

Your eligible dependents include:

- Your spouse. You may be legally separated but not divorced.
- Your children from 14 days old up to 23 years of age ***only*** if they are:
  - ~ Your natural children, stepchildren, foster children placed through a State foster child program, legally adopted children, children in your physical custody and for whom bona fide adoption proceedings are underway, or children for whom you are the legal, court-appointed guardian;
  - ~ Unmarried and chiefly dependent upon you for support;
  - ~ Living with you in a normal parent-child relationship;
    - o This provision is waived for natural/adopted children of the employee who are living with a divorced spouse, assuming all other criteria is met.
    - o Only stepchildren living with the employee more than 50% of the time are covered under this plan.
  - ~ In addition, ***if they are between the ages of 19 and 23,*** they must be attending school regularly on a full- or half-time basis.

Children incapable of employment because of a mental or physical incapacity are covered even if they are past the maximum age. However, the incapacity must have existed before age 19 and the children must continue to rely chiefly on you for support. You must furnish the carrier with evidence of the incapacities, proof that they existed before age 19 and proof of financial dependency. Children are covered as long as the incapacity exists and they meet the definition of children, except for age. Periodic proof of the continued incapacity may be required.

If the State of Alaska Group Life plan covers more than one family member, each eligible family member may be covered both as an employee and as a dependent, or as the dependent of more than one employee. A member is defined as the employee or eligible dependent covered by the plan.

The plan is the agreement described in this Life plan, between the State of Alaska and the life carrier, and any endorsements not attached or later issued.

b. How To Enroll

Even though the State of Alaska pays the premium for the Basic Insurance, you must complete an enrollment card indicating your designated beneficiary or beneficiaries. Your beneficiaries would receive the benefit if you died. You are automatically the beneficiary for any accidental dismemberment benefit. The enrollment card also offers you the opportunity to select Optional Life Insurance (see section 15.2, *Optional Life and AD&D Coverage*).

c. When Coverage Begins

i. New Employees

You and your eligible dependents are covered by the State-paid Basic Insurance on the 31st consecutive calendar day of pay status. If you are disabled and not at work on the 31st consecutive calendar day, you are not covered for Basic Insurance benefits until you return and complete 31 consecutive calendar days of pay status. Your dependents are eligible on the same day you are eligible unless they are confined in a hospital or similar institution on the date coverage would normally begin. In that case, their coverage is delayed until they are released.

ii. Rehired Employees

If you were previously insured and are rehired within seven calendar days of the date your insurance terminated, your coverage begins on the day you return. If previously insured and rehired more than seven calendar days after the date your insurance terminated, you are considered a new employee and coverage begins on the 31st consecutive calendar day as specified for new employees.

iii. Employees Returning From Leave Without Pay or Layoff

If you are an employee returning to work from leave without pay or from layoff and you were covered prior to your leave/layoff, you and your dependents are covered on the day you return. Your dependents also are eligible for benefits on that day unless they are confined in a hospital or similar institution on the date coverage would normally begin. In that case, their coverage is delayed until they are released.

iv. Newborn Children

Coverage for a newborn child is effective from 14 days old. However, if your child is confined in a hospital or a similar institution on the effective date of coverage, benefits begin when the child is released.

v. New Dependents

If you add new dependents (other than a newborn child), they are covered immediately unless they are confined to a hospital or similar institution. Coverage then begins when they are released from the facility.

d. Amount of Basic Life and AD&D Coverage

i. Employees

If you die from any cause, your Basic Life Insurance pays your beneficiary a benefit of $2,000 ($10,000 for supervisory, confidential, partially exempt, exempt, and general government employees).

If you die from an accident, your Basic AD&D Insurance pays your beneficiary an additional benefit of $5,000, subject to the exclusions in section 15.2(e), *Optional AD&D Exclusions.*

ii. Dependents

If your spouse dies, your Basic Life Insurance pays you a benefit of $1,000.

If a child dies, your Basic Life Insurance pays you according to the following schedule:

Age of Child at Death	Benefit Amount
14 days but not more than 6 months	$100
6 months but not more than 2 years	$200
2 years but not more than 3 years	$400
3 years and over	$500

iii. Basic AD&D Coverage

Besides the full amount of the Basic Life, Basic AD&D benefits are payable for losses that occur within 100 days of an accident and as a result of accidental bodily injury, independent of all other causes, for loss of life, or loss of both hands, both feet, sight of both eyes or any such combination. One-half of the full amount is payable if you lose one hand, one foot, or the sight of one eye.

As used above, "loss" for hands and feet means complete severance through or above the wrist or ankle joint; for eyes, complete and irrevocable loss of sight. Loss of sight must be certified as being entire and irrecoverable by a licensed physician specializing in ophthalmology and certified by the American Board of Ophthalmology.

iv. Basic AD&D Exclusions

AD&D benefits are not payable if the loss directly or completely results:

- From suicide or any attempted self-destruction while sane or insane;
- From declared or undeclared war, or any act of war;
- Either directly or indirectly from illness or disease or bacterial infection other than infection that occurs simultaneously with and because of an accidental cut or wound; or
- From service in the armed forces of any country or international authority unless the service does not exceed 30 days.

15.2. Optional Life and AD&D Coverage

As an employee of the State of Alaska you may also choose to enroll in Optional Life Insurance. Optional Life Insurance, excluding Accidental Death and Dismemberment (AD&D), is payable as a result of death from any cause.

The amount of Optional Life Insurance available to you is equal to your annual income rounded to the next highest $1,000. The maximum available is $60,000. This coverage is not available for dependents.

a. How To Enroll

On the same form for designating your beneficiaries for Basic Life (see section 15.1, *Basic Life and AD&D*) you may select Optional Life Insurance.

If you enroll in Optional Life Insurance within 31 consecutive calendar days from the date you were hired as a permanent or long-term nonpermanent employee, you do not have to show evidence of your good health. If you do not enroll within that time, you must furnish the life carrier with satisfactory evidence of your good health to become covered. The life carrier may ask that you have a medical examination at your expense.

b. Premiums

The premiums for Optional Life Insurance are deducted from your paycheck. Premiums are calculated based on your age and salary at enrollment. A list of premiums may be obtained from your human resources office, the Division, or its Web site.

If your salary or age changes, the amount of your Optional Life Insurance and premium is recalculated annually to reflect those changes.

Premium rates are subject to change each year.

c. When Coverage Begins

Your Optional Life Insurance is effective on the first day of the month for which you pay the premium, but not earlier than the first day of the month following 30 days of employment. For example, if you are hired May 15 and sign up at that time, your first premium deduction is made in July so you are covered from July 1.

d. Amount of Optional Life and AD&D Coverage

If you die from any cause, your Optional Life pays your beneficiary the full amount of your insurance.

If you die from an accident, your Optional AD&D insurance pays your beneficiary an additional benefit equal to the value of your Optional Life Insurance benefit.

Besides the full amount of Optional Life Insurance, Optional AD&D benefits are payable for losses that occur within 100 days of an accident and as a result of accidental bodily injury, independent of all other causes, for loss of life, or loss of both hands, both feet, sight of both eyes or any such combination. One-half of the full amount is payable if you lose one hand, one foot, or the sight of one eye.

As used above, "loss" for hands and feet means complete severance through or above the wrist or ankle joint; for eyes, complete and irrevocable loss of sight. Loss of sight must be certified as being entire and irrecoverable by a licensed physician specializing in ophthalmology and certified by the American Board of Ophthalmology.

e. Optional AD&D Exclusions

AD&D benefits are not payable if the loss directly or completely results:

- From suicide or any attempted self-destruction while sane or insane;
- From declared or undeclared war, or any act of war;
- Either directly or indirectly from illness or disease or bacterial infection other than infection that occurs simultaneously with and because of an accidental cut or wound; or
- From service in the armed forces of any country or international authority unless the service does not exceed 30 days.

15.3. Payment Examples

The following examples show how payments are made under the Basic Insurance and Optional Insurance plans, assuming Optional Life Insurance of $20,000.

Life Insurance Payment With Basic Insurance Only:		**Example 1**	**Example 2**
Nonaccidental death	Basic Life	$ 2,000	$10,000*
Accidental death	Basic Life Basic AD&D Total	$ 2,000 5,000 $ 7,000	$10,000* 5,000 $15,000*
Life Insurance Payment With $20,000 of Optional Insurance:		**Example 1**	**Example 2**
Nonaccidental death	Basic Life Optional Life Total	$ 2,000 20,000 $22,000	$10,000* 20,000 $30,000*
Accidental death	Basic Life Optional Life Basic AD&D Optional AD&D Total	$ 2,000 20,000 5,000 20,000 $47,000	$10,000* 20,000 5,000* 20,000 $55,000
Dismemberment Payment With Basic Insurance Only:			
Loss of one eye, foot or hand	Basic AD&D	$ 2,500	
Loss of both eyes, feet or hands or any combination thereof	Basic AD&D	$ 5,000	
Dismemberment Payment With $20,000 of Optional Insurance:			
Loss of one eye, foot or hand	Basic AD&D Optional AD&D Total	$ 2,500 10,000 $12,500	
Loss of both eyes, feet or hands or any combination thereof	Basic AD&D Optional AD&D Total	$ 5,000 20,000 $25,000	

**For supervisory, confidential, partially exempt, exempt, and general government employees.*

15.4. When Coverage Ends

Coverage under the Basic and Optional Life and AD&D ends at the earliest time that one of the following occurs:

a. Employees on Leave Without Pay or Layoff

Coverage ends on the last day of the month in which you were last in pay status. For example, if you worked or were in paid leave status on January 15 and then placed on leave without pay or layoff, coverage ends on January 31.

If your leave without pay occurs while you are on federal family leave, your Basic Life coverage will be extended to the end of the month in which your federal family leave ends. Optional Life terminates at the end of the month in which you were last in pay status regardless of federal family leave.

b. Employees Who Terminate Employment

Coverage ends on the last day of the month in which you last worked. For example, if you last worked on January 15 and terminated your employment, coverage ends on January 31.

c. Dependents

Coverage for a dependent ends on the same day as the employee's coverage ends, unless:

- You are divorced. Coverage ends on the date the divorce is final; or
- Your child no longer meets all eligibility requirements. Coverage ends on the last day of the month in which the child first fails to meet these requirements.

15.5. How to Continue Coverage

a. Employees on Leave Without Pay or Layoff

You may continue your Basic and/or Optional Life coverage while on leave without pay or layoff by paying the monthly premium to the life carrier. You should make a check payable for the monthly premium(s), note your social security number and the policy number on it and send it to the life carrier. The policy number and carrier address are available from your human resources office or the Division.

b. Employees Who Terminate Employment

If your insurance ends because you terminate employment or transfer to a class of employees not eligible under this Life plan, you may convert your State Optional Life insurance. You may convert to any form of individual policy of insurance (without double indemnity or disability riders) that the life carrier customarily issues, except a policy of term insurance. This coverage amount may not exceed the amount for which you were eligible as an employee.

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

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

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

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16. Travel Accidental Death and Dismemberment

Travel AD&D Plan Highlights

- Provides coverage while traveling on State business.
- Pays $100,000 to your beneficiary if you die accidentally ($200,000 for supervisory, confidential, partially exempt, exempt, and general government employees).
- Provides coverage for accidental injury in varying amounts, not exceeding $100,000 ($200,000 for supervisory, confidential, partially exempt, exempt, and general government employees).

16.1. Who is Covered

- All employees while in travel status on the business of the State, including any members of the governing body of the State and any member of a board or commission of the State.
- All employees while on the business of the State, riding as a passenger, pilot operator or crew member in or on, boarding or alighting from, or struck down by an aircraft identified by the State and operated at the time with the consent of the State and piloted by an authorized pilot employed by the State of Alaska.

16.2. When Coverage Begins and Ends

Coverage begins on the first day of employment and ends on the last day of employment.

16.3. Amount of Coverage

The value of this policy is $100,000 ($200,000 for supervisory, confidential, partially exempt, exempt, and general government employees). It is payable to your beneficiary if you die accidentally while on the business of the State and during the course of any bona fide trip anywhere in the world. A trip is considered to have begun when you leave your home or regular place of employment and continues until you return to your home or regular place of employment, whichever occurs first.

In addition, if you suffer an accidental injury, directly and independently of any other cause, within one year from the date of an accident that this travel policy covers, and that injury results in any losses set forth below, the policy pays the specified sum. The total amount payable for all such losses, as a result of any one accident, will not exceed $100,000 ($200,000 for supervisory, confidential, partially exempt, exempt, and general government employees).

For the Loss of…	Benefit Payable
Life	$100,000 or $200,000*
Two limbs or sight of two eyes or one limb and sight of one eye	$100,000 or $200,000*
One limb or sight of one eye	$50,000

**For supervisory, confidential, partially exempt, exempt, and general government employees.*

Exclusions notwithstanding, this coverage applies to:

- Employees of the Department of Natural Resources while spraying or spreading chemicals or water on forest fires at the direction of the State;
- Employees of the State while performing activities or duties for which the employee receives special hazards pay; and
- Employees engaged in low-level flying during wolf control activities.

16.4. Travel Accident Exclusions

The Travel AD&D policy does not cover an individual for any loss caused by or resulting from:

- Commuter travel, vacations, or leaves of absence;
- Flying in an aircraft being used for or in connection with acrobatic or stunt flying, racing, or endurance tests, crop dusting, seeding or spraying, banner towing, or any test for experimental purposes, unless previously consented to in writing by the State;
- Suicide or any attempted self-destruction while sane or insane;
- Declared or undeclared war, or any act of war;
- Either directly or indirectly from illness, disease, or bacterial infection other than infection that occurs simultaneously with and because of an accidental cut or wound; or
- Service in the armed forces of any country or international authority unless the service does not exceed 30 days.

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17. General Provisions – Optional Benefits

17.1. Applicable Law and Venue

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

17.2. Assignment

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

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

17.3. Beneficiary

If you die, your life insurance benefits are paid to the beneficiary you designated on your enrollment form. If your covered spouse or children die, you receive any life insurance benefits.

If you want to change your beneficiary, you may do so without your beneficiary's consent by revising your enrollment card and submitting it to the Division. The change is not effective until it is filed with the State of Alaska.

The term beneficiary means only that person or persons whom you designate on your enrollment form and file with the Division.

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

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

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

17.4. Cancellation

Either the State of Alaska or the Life Carrier may cancel this Life plan without the consent of the insured by written notice delivered to the other party not less than 60 days before the cancellation is effective.

17.5. Clerical Error

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

17.6. Conversion

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

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

17.7. Entire Contract

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

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

17.8. Facility of Payment

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

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

17.9. Incontestability

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

17.10. Misstatement of Age

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

17.11. Notice of Death

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

17.12. Payment of Claims

All amounts payable for loss of life are paid to the designated beneficiary in accordance with and subject to the provisions of the Life plan. All other amounts payable under this provision are paid to you. Written notice of claim must be given to the Division, within 30 days after the occurrence or the beginning of any

loss that this provision covers, or as soon as is reasonably possible. Notice given by or on behalf of the claimant to any authorized life carrier agent, with sufficient information to identify the insured, is considered notice.

17.13. Right of Examination

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

17.14. Waiver of Premium with Permanent Total Disability

A waiver of premium is available only for your Optional Life Insurance.

If, before age 60, you become totally disabled and unable to perform any work or engage in any occupation for wage or profit for nine consecutive months, you may apply for a premium waiver. If the waiver is granted, your insurance remains in force without any premium payment as long as you remain disabled. After approval, you must furnish proof of disability during the three-month period immediately before each anniversary of the premium waiver to the life carrier. The life carrier has the right to have a designated physician examine you, but not more than once in any 12-month period after your disability insurance has been in force for two years.

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

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

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

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

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

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

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18. Special Officers and Search & Rescue Volunteers

Accidental Death and Dismemberment coverage is extended to all Special Officers appointed by the Alaska Department of Public Safety while performing the duties of a Special Officer under the direction of the State, including travel as a passenger under the direction of the State and travel as a passenger only in any aircraft owned or operated by the Alaska National Guard.

The coverage is also extended to individual volunteers who have been requested by the Department of Public Safety to assist search and rescue operations under the direction of the State.

The amount of coverage provided to Special Officers and search and rescue volunteers is $25,000. It is payable if a Special Officer dies accidentally while performing the duties of a Special Officer under the direction of the State or if a search and rescue volunteer dies accidentally while assisting in a search and rescue mission. The volunteer must have been requested to assist in the mission by the Alaska Department of Public Safety and be under the direction of the State.

If a Special Officer or search and rescue volunteer suffers accidental injury, directly and independently of any other cause within one year from the date of an accident covered by this policy, and that injury results in any of the losses set forth below, the State will pay the sum specified opposite such loss. The total amount payable for all such losses as a result of any one accident will not exceed $25,000.

For the Loss of…	Benefit Payable
Life	$25,000
Two limbs or sight of two eyes or one limb and sight of one eye	$25,000
One limb or sight of one eye	$12,500

A medical expense benefit of up to $15,000 is paid to Special Officers and search and rescue volunteers under the travel policy for the actual expense of ambulance to and from the hospital, treatment by a legally qualified physician or surgeon, confinement within a legally constituted hospital or employment of a trained nurse for any accidental injury sustained while performing an assignment under the direction of the Department of Public Safety.

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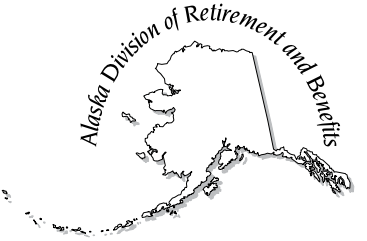

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