STATE OF ALASKA

AlaskaCare Employee Health Plan

JANUARY 1, 2018

Contact Information

AlaskaCare Plan Administrator

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WEB SITES

AlaskaCare 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.

AlaskaCare Claims Administrators

MEDICAL CLAIMS ADMINISTRATOR

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

Customer Service/Provider Locator .....(855) 784-8646
TDD *for hearing impaired* .....(800) 628-3323

24-Hour Nurse Line .....(800) 556-1555

Employee Assistance Plan .....(855) 417-2493

PRESCRIPTION DRUG CLAIMS ADMINISTRATOR

Paper Claims:
Aetna Pharmacy
P.O. Box 52444
Phoenix, AZ 85072-2444

Mail Order:
Aetna Rx Home Delivery
P.O. Box 417019
Kansas City, MO 64179-7019

Specialty:
Aetna Specialty Pharmacy
503 Sunport Lane
Orlando, FL 32809

Customer Service/Provider Locator .....(855) 784-8646
TDD *for hearing impaired* .....(800) 823-6373

Aetna Mail Order Pharmacy .....(888) 792-3862
TDD *for hearing impaired* .....(800) 823-6373

Aetna Specialty Pharmacy .....(866) 782-2779
TDD *for hearing impaired* .....(877) 833-2779

DENTAL CLAIMS ADMINISTRATOR

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

Customer Service .....(855) 718-1768

Customer Service-Spanish .....(877) 299-9063

VISION CLAIMS ADMINISTRATOR

Vision Services Plan (VSP)
P.O. Box 997105
Sacramento, CA 95899-7105
www.vsp.com

Customer Service .....(800) 877-7195

HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS ADMINISTRATOR

PayFlex Systems USA, Inc.
P.O. Box 4000
Richmond, KY 40476-4000
www.alaskacare.payflexdirect.com

Customer Service .....(888) 678-8242

COBRA ADMINISTRATOR

PayFlex Systems USA, Inc.
P.O. Box 4000
Richmond, KY 40476-4000
www.alaskacare.payflexdirect.com

Customer Service .....(888) 678-8242

Adoption Order

Leslie Ridle, Commissioner of the Department of Administration, hereby adopts, pursuant to authority under AS 39.30.090-098, the AlaskaCare Employee Health Plan dated January 1, 2018 ("**plan**"), as the official plan document governing the benefits contained therein. The **plan** is effective January 1, 2018 and applies to claims submitted for payment with dates of service on or after the effective date. All prior **plan** booklets, documents and related amendments are hereby repealed in their entirety.

Dated: _ January 1, 2018_ _

Leslie Ridle, Commissioner
Department of Administration

Table of Contents

1. *Introduction to Plan*

1.1. PLAN BENEFITS

You receive substantial value from the benefits the State of Alaska ("**State**") makes available to you. The **plan** gives you an opportunity to select the **benefit options** and levels of coverage that reflect your own personal needs, lifestyle, and situation. The **State** provides comprehensive benefits under the **plan** for you and your family. Your coverage under the **plan** is good worldwide.

With the **plan**, you can choose the benefits that best fit your needs. The **plan** offers a range of choices for each **benefit option**. Each **benefit option** has a monthly employee contribution or premium based on the cost of providing that coverage. Unless you have timely waived coverage in the **plan**, you are required to participate in both the **medical plan** and the **dental plan**. You may also voluntarily elect coverage under the **vision plan**. Additionally, you may choose to make pre-tax contributions to a health flexible spending account (HFSA) to pay for health care expenses that are not covered by the **plan**. These **benefit options** are described in detail in this **plan**.

This **plan** may be updated from time to time to reflect changes in benefits. You should make sure that you are referencing the most current edition, which is available from the Division of Retirement and Benefits ("**Division**"), or www.AlaskaCare.gov.

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

1.2. DEFINED TERMS

Bolded words in the **plan** are defined in section 15, *Definitions*.

1.3. ELIGIBILITY FOR COVERAGE

1.3.1. Eligible Employees

Benefit options under the **plan** are available to **eligible employees**. **Eligible employees** are permanent and long-term nonpermanent **employees** of the **State** whose bargaining unit or employee group participates in the **plan** and who are either:

- Full-time employees (including seasonal) who are scheduled to work 30 or more hours a week on a regular basis; or

- Part-time employees (including seasonal) who are scheduled to work at least 15 but less than 30 hours a week on a regular basis.

In addition to the above, **benefit options** may be offered to:

- Employees of the **State** whose bargaining unit or employee group participates in the **plan**, if the employee otherwise meets the criteria as outlined under the employer shared responsibility provisions in 26 U.S. Code § 4980H.

- Surviving dependents of peace officer and firefighters of the **State** whose bargaining unit or employee group participates in the **plan**, if the employee otherwise met the criteria as outlined under Alaska Statute 39.60.040, *Peace Officer and Firefighter Survivors' Fund*.

Coverage under the **medical plan** and **dental plan** for **eligible employees** who are full-time **employees** is mandatory unless the employee timely waives coverage at the time benefit coverage is offered upon entry into the plan, or during an annual open enrollment. Coverage under the **medical plan** and **dental plan** is optional for **eligible employees** who are part-time **employees**.

The following bargaining units and employee groups participate in the **plan**:

- 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
- Correctional Officers
- Employees not covered by a collective bargaining agreement

1.3.2. Eligible Dependents

You may enroll the following **dependents** in coverage under any or all of the **benefit options**:

- Your **spouse**.
- Your **children** until they attain age 26.

- Your **child** age 26 and older who is permanently and totally disabled. Permanent and total disability means the inability to engage in any substantial gainful activity due to a 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 continuous period of not less than 12 months. The permanent and total disability must have existed before the **child** attains age 26 and the **child** must be (i) unmarried, (ii) provide less than one-half of his or her own support, and (iii) share your principal place of residence for more than one-half of the year (unless the **child** is your natural or adopted **child** and is living with your ex-**spouse**). You must provide proof to the **claims administrator** of the permanent and total disability, proof that it existed before age 26, and proof of financial dependency, no later than 60 days after the **child's** 26th birthday. You must provide periodic proof of continued permanent and total disability as reasonably requested by the **claims administrator**.

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

When you enroll in the **plan**, you must also enroll each of your **dependents** in order for their claims to be paid. If your **dependents** subsequently change, you must notify the **Division** within 30 days, as provided under section 1.8.2, *Changes in Status or Other Applicable Events*.

1.3.3. Waiver of Coverage

If you or your family maintain coverage under another medical plan, you may voluntarily waive your **medical plan**, **dental plan** and/or **vision plan** coverage under the **plan**. Your election to waive your own medical, or dental coverage, or if chose not to elect coverage under the **vision plan,** also waives coverage for your **spouse** and **child**(ren). However, you may elect to waive the medical, dental and/or vision coverage for your **spouse** and **child**(ren) while maintaining your individual coverage.

- To elect to waive coverage under the **medical plan**, and/or **dental plan** for yourself, or to waive coverage for your dependents under the **medical plan**, **dental plan** and/or **vision plan** you must elect to *Opt Out* through the myRnB electronic enrollment system found at www.myrnb.alaska.gov. To elect to waive coverage you must elect to waive each component of the group health benefit plan coverage being waived and do so each **benefit year** during the annual open enrollment period. A waiver of coverage made during an annual open enrollment period is effective on the first day of the **benefit year** immediately following the open enrollment.

- You may elect to waive coverage during the 30-day period after you initially become eligible for coverage and before the date on which coverage becomes effective under the **plan**. Such waiver shall be effective as of the 31st consecutive day after you begin employment in a position eligible for coverage.

- If you change positions from a position in a bargaining unit that does not participate in the **plan** to a position covered by the **plan** you may elect to waive coverage within 30 days of the effective date of the change. The waiver shall be effective on the first day of the month following the change of position. If the change of position occurs on the first day of a month, the waiver shall be effective on such first day of the month.

During the term of a **benefit year** you may, based upon qualified changes in status or other applicable events that are allowed under section 1.8.2, *Changes in Status and other Applicable Events*, elect to:

- waive coverage previously elected for the **benefit year**; or

- enroll in coverage that was previously waived for the **benefit year**.

Elections under this subsection may be made on behalf of the **employee**, a **spouse** and **child**(ren) consistent with the change in status or other applicable event; provided that **spouses** and **child**(ren) may not be covered under any component of the **plan** if the **employee** is not also covered. Such elections shall be made no later than 30 days after the date of the change in status or other applicable event, unless federal law requires a lengthier election period, and shall be effective as of the date of the change in status or other applicable event.

1.3.4. Dual Coverage

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

1.4. MONTHLY EMPLOYEE CONTRIBUTION

The **State** contributes towards the cost of **benefit options** under the **plan**. The amount the **State** contributes is determined by your bargaining unit contract, or in the case of **eligible employees** not covered by a bargaining unit, by the **State**. However, in most instances you are also required to pay a portion of the health costs through a monthly employee contribution.

Unless otherwise stated in the collective bargaining agreement, the **State** contribution for part-time employees is ½ of the contribution for full-time employee, and the part-time employee must pay 1/2 of the full premium cost for any **benefit options** elected.

You can elect which options under the **medical plan** and **dental plan** you want. You can also elect whether or not to participate in the **vision plan**. In addition, you can elect if you want one or all of these coverages to extend to your eligible **dependents**, including your **spouse**. Each option under the **medical plan** and **dental plan**, as well as the **vision plan**, has a premium, or employee contribution. The current **employee monthly contribution** amounts are available from your human resources office, the **Division**, or www.AlaskaCare.gov.

- Your monthly employee contribution, will be deducted on a pre-tax basis in equal installments from your paychecks in the month coverage is provided. For example, premiums for July are withheld from paychecks issued in July. If your paycheck is insufficient to pay the premium, you should contact your human resources office or the **Division** for information on paying your premiums directly on an after-tax basis.

You may also decide to make additional pre-tax contributions to a health flexible spending account (HFSA). See section 6, *Health Flexible Spending Account (HFSA)*.

1.5. INITIAL COVERAGE ELECTIONS

1.5.1. New Employees

You must elect your **benefit options** and enroll your eligible dependents under the **plan** within 30 days of the date you are first hired.

- If you are an **eligible employee** who is a full-time **employee** and you do not timely elect your **benefit options**, you will be enrolled in the default option for the **medical plan** and for the **dental plan**. See section 1.6, *Default Options*.

- If you are an **eligible employee** who is a part-time **employee** and you do not timely elect your **benefit options**, neither you nor your **dependents** will be enrolled in the **plan**.

1.5.2. Rehired Employees

Employees who terminate employment and are rehired in a *new* **benefit year** will be enrolled in the **plan** as new **employees**.

Employees who terminate employment and are rehired in the *same* **benefit year** will be re-enrolled in the same **benefit options** they had during their prior employment.

1.5.3. Employees Moving from a Nonparticipating Bargaining Unit

Employees who move from a bargaining unit that does not participate in the **plan** to a bargaining unit that participates in the **plan** have 30 days from the date of the bargaining unit change to elect coverage and enroll their eligible dependents under the **plan**. If timely elected, coverage is effective as provided in section 1.7.4, *Employees Moving from a Nonparticipating Bargaining Unit*. If you do not timely elect coverage, you will be enrolled in the default option for the **medical plan** and the **dental plan**. See section 1.6, *Default Options*.

1.5.4. Dependents

You must elect coverage for your **dependents** at the same time you enroll in the **plan**. If you do not timely enroll your **dependents** in the **plan**, they will not be covered under the **plan** until you enroll them during the next open enrollment or, if sooner, due to a change in status or other applicable event. See section 1.8.2, *Changes in Status or Other Applicable Events*.

1.6. DEFAULT OPTIONS

The default options for the **medical plan** and **dental plan** for **eligible employees** who are full-time **employees** are established each **benefit year**. The default options are subject to change, generally effective the next **benefit year**. If you are enrolled in a default option and do not enroll in the **plan** during the following open enrollment, your defaults will be changed to the options established as the defaults for that **benefit year**. The default option for the **benefit year** beginning January 1, 2018 is the economy **medical plan** and economy **dental plan** for you and your eligible **dependents.** If you enroll no **dependents** under the **plan** within 30 days of the date you are first hired, the default option will be for employee-only economy **medical plan** and economy **dental plan**.

1.7. WHEN COVERAGE BEGINS

1.7.1. New Employees

If you are an **eligible employee** who is a full-time **employee**, you and your **dependents** are covered on the 31st consecutive day you are at work in pay status, unless coverage is waived in accordance with Section 1.3.3, *Waiver of Coverage*. For example, if you begin work on October 1, you are covered on October 31, if you have no periods of leave without pay and are still employed on that date.

If you are an **eligible employee** who is a part-time **employee** and you elect coverage for yourself and your **dependents** under the **plan** during the first 30 days of employment, you and your **dependents** are covered on the 31st consecutive day you are at work in pay status. For example, if you begin work

on April 3, and you elect coverage by May 2, you are covered on May 3, if you have no periods of leave without pay and are still employed on that date.

If you have leave without pay (*except for a leave taken as a result of injury or illness*) during your first 30 days of employment, you are covered after you return to work and are in pay status for 31 consecutive days, unless coverage is waived in accordance with Section 1.3.3, *Waiver of Coverage*. 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, if you have no other periods of leave without pay and are still employed on that date.

Notwithstanding the above and, except if coverage is waived in accordance with Section 1.3.3, *Waiver of Coverage*, in no event will your waiting period be longer than 90 calendar days, if you are at work and in pay status on such date.

1.7.2. Rehired Employees

If you are covered under the **plan** as an actively working **employee**, terminate employment with the **State**, and:

- *are rehired within seven calendar days* of the date your coverage terminated, your coverage begins on the day you return to work. For example, if you terminate employment on July 5, your coverage ends July 31, and you return to work on or before August 7, you are covered under the **plan** the day you return to work; or

- *are rehired more than seven calendar days* after your coverage terminated, coverage begins as set forth under section 1.7.1, *New Employees*.

1.7.3. Employees Returning from Leave Without Pay or Layoff

If you were covered under the **plan** when you began leave without pay or layoff, when you return to work from leave without pay or layoff, you are covered under the **plan** starting the day you return to work. For example, if you return to work from leave without pay on July 15, coverage begins under the **plan** for you and your **dependents** on July 15. This paragraph applies to the extent you did not continue coverage under the **plan** during an unpaid FMLA leave, as permitted under section 14.9, *Family and Medical Leave Act (FMLA*).

1.7.4. Employees Moving from a Nonparticipating Bargaining Unit

Employees who move from a bargaining unit that does not participate in the **plan** to a bargaining unit that participates in the **plan** will be covered under the **plan** on the first day of the month after the date of the bargaining unit change unless coverage is waived in accordance with section 1.3.3, *Waiver of*

Coverage. For example, if your bargaining unit change is effective October 15, your coverage under the **plan** begins on November 1.

If the change is effective on the first day of the month, you will be covered under the **plan** on that day. For example, if your bargaining unit change is effective November 1, you will become covered under the **plan** on that day. If you are on leave without pay or on layoff at the time the change occurs, you will not be covered under the **plan** until the day you return to work.

1.7.5. Dependents

Dependents are covered under the **plan,** unless coverage is waived in accordance with section 1.3.3, *Waiver of Coverage*, on the same day that you are covered if they meet the eligibility requirements and you timely enroll them in the **plan.**

Newborns are automatically covered under the **plan** for the first 31 days after birth. To continue coverage after 31 days, you will need to enroll the **child** under the **plan**.

New **dependent children** will be covered under the **plan** if you have elected a level of coverage that covers the new **dependent** and you timely enroll the **child** in the **plan, in accordance with 1.8.2.a, *Changes in status*.**

1.7.6. Surviving Dependents of Peace Officer and Firefighters

In accordance with AS 39.60 and the corresponding regulations governing the Peace Officer and Firefighter Survivors' Fund, surviving dependents of a deceased peace officer or firefighter covered under the **plan** at the time of the occupational death will receive the same level of coverage under the **plan** beginning the first day of the month following acknowledgement from Department of Public Safety that the dependents have presumptive or determined eligibility for benefits from the Peace Officer and Firefighter Survivors' Fund.

1.8. CHANGING YOUR COVERAGE

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

1.8.1. Open Enrollment

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

- elect to begin coverage under one or more **benefit options**;
- waive coverage as outlined in section 1.3.3, *Waiver of Coverage*

- change your **benefit options**; or

- terminate coverage under one or more **benefit options** (except that coverage under the **medical plan** and **dental plan** is mandatory for **eligible employees** who are full-time **employees** and have not waived coverage).

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

If you do not make any elections during open enrollment:

- You will automatically be re-enrolled in the same **benefit options** you had in the prior year, except if you waived coverage under section 1.3.3, *Waiver of Coverage*.

- If you waived coverage under section 1.3.3, *Waiver of Coverage*, you must make an election during each open enrollment to continue to waive coverage or you will be placed in the default option for the **medical plan** and **dental plan.** See section 1.6, *Default Options*.

- If you were enrolled in a default option for the **medical plan** or **dental plan** and the default options have changed, you will automatically be enrolled in the new default options.

- You will not be re-enrolled in the health flexible spending account (HFSA).

If you want to participate in the health flexible spending account (HFSA), you must make an election during each open enrollment.

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 due to a change in status or other applicable event. See section 1.8.2, *Change in Status or Other Applicable Events*.

1.8.2. Changes in Status or Other Applicable Events

You may change your elections, make a new election or, if permitted by the **plan**, terminate 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 other applicable event.

a. Changes in Status

The following are changes in status:

- A change in your legal marital status, including divorce or marriage.
- A change in the number of your **dependents**, including the death of a **spouse** or **dependent** or the birth or adoption (or placement for adoption) of your **child**.
- A change in your, your **spouse's**, or your **dependent's** employment status, including:
  - the termination or commencement of employment;
  - a change from part-time to full-time or full-time to part-time employment;
  - a commencement of or return from an unpaid leave of absence;
  - a change in worksite that affects eligibility; or
  - a return from a strike or lockout.
- your **dependent** satisfying or ceasing to satisfy the definition of **dependent** under the **benefit option.**
- your, your **spouse's**, or your **dependent's** change in the place of residence that affects eligibility.

Changes in coverage under the **medical plan**, **dental plan**, **vision plan**, and health flexible spending account (HFSA) 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 **benefit option**.

b. Other Applicable Events

There are other situations in which you can change your elections during the **benefit year**, referred to as other applicable events. These do not apply to the health flexible spending account (HFSA) unless specifically provided. Other applicable events include:

- **Significant Change in Cost or Coverage**

  If you elect to participate in the **plan** and your cost for a **benefit option** 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 option** providing similar coverage (if available), or if not available, drop coverage entirely (provided that you may not drop medical coverage unless you maintain medical coverage under another plan); or
  - if there is a significant cost decrease, begin participation in the **plan** and elect the coverage that significantly decreased in cost.

- **Cost Increase or Decrease**

  If you elect to participate in the **plan** and your cost for a **benefit option** 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.

- **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 option** providing similar coverage (if available), or drop such coverage if no other **benefit option** providing similar coverage is available under the **plan** (provided that you may not drop medical or dental coverage if it is mandatory). A "loss of coverage" means:

  - an elimination of a **benefit option**; or
  - a substantial decrease in medical care providers under a **benefit option** (such as a hospital ceasing to be a member of a preferred provider network or a substantial decrease in physicians in a preferred provider network).

- **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 **benefit 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 Benefit Option Providing Similar Coverage**

  If the **plan** adds a new **benefit 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**

  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's**, former **spouse's**, or **dependent's** employer if the other plan permits participants to make an election change or this **plan** permits you 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 coverage under the **medical plan** unless you maintain medical coverage under another plan.

- **Loss of Coverage Under Governmental/Educational Group Health Plan**

  You may make an election to add coverage under the **medical plan** or **dental plan** 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**

  If you or your **spouse** or **dependent** are entitled to HIPAA special enrollment under the **plan**, including the health flexible

spending account (HFSA), 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.

You, your **spouse** or **dependent** may also be enrolled in the **plan** during special enrollment periods if (i) you, your **spouse** or **dependent** 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 (ii) coverage under such plan is lost due to a loss of eligibility for such coverage. In addition, you, your **spouse** or **dependent** may be enrolled under the **plan** if you, your **spouse** or **dependent** become 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. *A 60 day enrollment period applies to this other applicable event.*

- **Entitlement to Medicare or Medicaid**

  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. 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**

  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 benefits under the **plan**, including the health flexible spending account (HFSA), to either: (i) cover the **child** or (ii) cancel coverage of the **child**, as applicable.

1.9. WHEN COVERAGE ENDS

1.9.1. For Employees

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

- The date that the **plan** or any **benefit option** under the **plan** is terminated.
- The date that the **plan** or any **benefit option** under the **plan** is voluntarily waived in accordance with section 1.3.3, *Waiver of Coverage.*
- The last day of the month in which you cease to be an **eligible employee**.
- The date you die.
- The last day of the month in which you were last in pay status (whether actively at work or on paid leave).
- The last day of the month in which you terminate employment.
- The last day of the month in which you are laid off or reduce your hours of employment such that you are no longer an **eligible employee**. Except, if leave without pay is for a furlough under 2 AAC 07.407, the furlough shall be treated as if the employee were in pay status in its effects on health benefit eligibility.
- The last day of the month in which you move from a position that participates in the **plan** to a position that does not.
- The last day of the month during which you fail to pay any required premium.
- The date you become a full-time member of the armed forces of any country.
- Notwithstanding the foregoing, if the state budget is not funded by July 1, necessitating a government shutdown, health benefits for noticed employees will stop on July 31 at 11:59 pm regardless of the start date of the government shutdown. A noticed employee is an employee who has been directed not to report to work due to the government shutdown and has not been recalled to work. Nothing in this provision waives the obligation of the noticed employee to pay the applicable employee contribution as outlined in section 1.4, *Monthly Employee Contribution.*

1.9.2. For Dependents

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

- The date that the **plan** or any **benefit option** under the **plan** is terminated.
- The date that **dependent** coverage under the **plan** or the **plan** is terminated.
- The date that **dependent** coverage under the **plan** is waived in accordance with section 1.3.3, *Waiver of Coverage.*
- The date a spouse ceases to be a **dependent** due to a divorce.
- The last day of the month in which a **dependent child** ceases to satisfy the eligibility requirements for a **dependent** under the **plan**.
- The date a **dependent** dies.
- The date that your coverage terminates, or for a **dependent** in the event of your death, the last day of the month in which you die.
- The last day of the month during which you fail to pay any required premium on behalf of your **dependents**.
- The date that you terminate coverage for your **dependents**.

1.9.3. Continued Coverage

You and/or your **dependents** may be eligible for continued health benefits when coverage ends under the **plan.** See section 9, *Consolidated Omnibus Budget Reconciliation Act* (*COBRA) and Extended Health Coverage,* section 14.8, *Continuation of Coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994* (*USERRA),* and section *14.9, Family and Medical Leave Act (FMLA).*

1.9.4. Surviving Dependents of Peace Officer and Firefighters

In accordance with AS 39.60, Peace Officer and Firefighters Survivors' Fund, for the surviving dependent of a peace officer or firefighter who is killed in the line of duty, coverage ends when the earliest event occurs:

- The date that the **plan** or any **benefit option** under the **plan** is terminated.

- The date that **dependent** coverage under the **plan** or the **plan** is terminated.

- The last day of the month in which the surviving **dependent** ceases to be eligible for benefits from the Peace Officer and Firefighter Survivors' Fund.

1.10. RECEIPT OF DOCUMENTS

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

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

1.11. FUTURE OF THE PLAN

Although the **State** intends to maintain the **plan** indefinitely, the **State** reserves the right, in its sole discretion, to alter, amend, delete, cancel, or otherwise change the **benefit options** or terms 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 **eligible employee**, **dependent**, or **covered person** will have any vested interest in the **plan** or the **benefit options** under the **plan**.

1.12. ADMINISTRATION OF THE PLAN

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

Except as may be otherwise specifically provided in the **plan**, the **Commissioner** has full, discretionary authority to enable it to carry out its duties under the **plan**, including, but not limited to, the authority to determine eligibility under the **plan** and to construe the terms of the **plan** and to determine all questions of fact or law arising hereunder. The **Commissioner** has all power necessary or convenient to enable it to exercise such authority. All such determinations and interpretations will be final, conclusive, and binding on all persons affected thereby. The **Commissioner** has full, discretionary authority to

correct any defect, supply any omission or reconcile any inconsistency and resolve ambiguities in the **plan** in such manner and to such extent as it may deem expedient, and the **Commissioner** will be the sole and final judge of such expediency.

2. *Benefit Schedules*

2.1. MEDICAL AND PRESCRIPTION DRUG BENEFITS

2.1.1. Medical Benefit Schedule

	Standard Plan	Economy Plan	Consumer Choice Plan
Deductibles			
Annual individual **deductible**	$400	$600	$2,500
Annual family **deductible**	$800	$1,200	$5,000
Coinsurance			
Most medical expenses • $100 penalty if seek non-**emergency care** at emergency room of a **hospital**	80%	70%	70%
Most medical expenses after **out-of-pocket limit** is satisfied	100%	100%	100%
Medical expenses for your **spouse** or **dependent children** if they are eligible to be covered by a **State** employee health trust and that coverage (i) has been waived, (ii) pays less than 70% of the **covered expenses**, or (iii) has an individual **deductible**, of at least $5,000.	30%	30%	30%
Facility services with a **network provider**	80%	70%	70%

Facility services with an out-of-**network hospital**, **surgery center**, **rehabilitative facility,** or free-standing imaging center in other 49 states or non-preferred provider **hospital**, **surgery center**, **rehabilitative facility,** or free standing imaging center in Anchorage	60%	50%	50%
Transplant services if an Institute of Excellence™ (IOE) facility is used	80%	70%	70%
Transplant services if a non-Institute of Excellence™ (IOE) facility is used	60%	50%	50%
Preventive care with a **network provider** or when use of an out-of-**network provider** has been **precertified.**	100%	100%	100%
Preventive care with an out-of-**network provider**	80%	70%	70%
Hearing benefit	80%	80%	80%
Inpatient **mental disorder** treatment with a **network provider**	80%	70%	70%
Inpatient **mental disorder** treatment with an out-of-**network provider**	60%	50%	50%
Inpatient **substance abuse** disorder treatment with a **network provider**	80%	70%	70%
Inpatient **substance abuse** disorder treatment with an out-of-**network provider**	60%	50%	50%

	Standard Plan	Economy Plan	Consumer Choice Plan
Out-of-Pocket Limit			
Annual individual **out-of-pocket limit** • The following expenses do not apply toward the **out-of-pocket limit**: • charges over the **recognized charge**; • non-**covered expenses**; • premiums; • **precertification** benefit reductions; • $100 penalty if seek non-**emergency care** at emergency room of a **hospital;** and • **Prescription drug** expenses	$1,850 $3,700 if use out-of-**network hospital**, **surgery center**, **rehabilitative facility,** or free-standing imaging center for **facility** services outside Alaska, or non-preferred provider **hospital**, **surgery center**, **rehabilitative facility,** or free-standing imaging center in Anchorage	$2,850 $5,700 if use out-of-**network hospital**, **surgery center**, **rehabilitative facility,** or free-standing imaging center for **facility** services outside Alaska, or non-preferred provider **hospital**, **surgery center**, **rehabilitative facility,** or free-standing imaging center in Anchorage	$5,500 $11,000 if use out-of-**network hospital**, **surgery center**, **rehabilitative facility,** or free-standing imaging center for **facility** services outside Alaska, or non-preferred provider **hospital**, **surgery center**, **rehabilitative facility,** or free-standing imaging center in Anchorage
Annual family **out-of-pocket limit** • The following expenses do not apply toward the **out-of-pocket limit**: • charges over the **recognized charge**; • non-**covered expenses**; • premiums; • **precertification** benefit reductions; • $100 penalty if seek non-**emergency care** at emergency room of a **hospital;** and • **Prescription drug** expenses	$3,700 $7,400 if use out-of-**network provider** for **hospital**, **surgery center**, **rehabilitative facility,** or free-standing imaging center services outside Alaska, or non-preferred provider **hospital**, **surgery center**, **rehabilitative facility,** or free standing imaging center in Anchorage	$5,700 $11,400 if use out-of-**network provider** for **hospital**, **surgery center**, **rehabilitative facility,** or free-standing imaging center services outside Alaska, or non-preferred provider **hospital**, **surgery center**, **rehabilitative facility,** or free standing imaging center in Anchorage	$11,000 $22,000 if use out-of-**network provider** for **hospital**, **surgery center**, **rehabilitative facility,** or free-standing imaging center services outside Alaska, or non-preferred provider **hospital**, **surgery center**, **rehabilitative facility,** or free standing imaging center in Anchorage

Benefit Maximums	
Individual limit on hearing aids • Maximum applies to a rolling 36 month period	$3,000
Visit/Service Limits	
Spinal manipulations including medical massage therapy when done in conjunction with spinal manipulations	20 visits per **benefit year**
Hearing exams	One per rolling 24 month period
Home health care. See section 3.5.8, *Home Health Care*, for exceptions.	120 visits per **benefit year** Up to 4 hours = 1 visit
Outpatient hospice expenses	Up to 8 hours per day
Cognitive therapy, physical therapy, occupational therapy, and speech therapy rehabilitation benefits	No more than 2 therapy visits in a 24 hour period Up to 1 hour = 1 visit
Employee assistance program	8 visits per problem per **benefit year**
Travel Benefits: Therapeutic treatments	➢ One visit and one follow-up per **benefit year**
Travel Benefits: • Prenatal/postnatal maternity care • Maternity delivery • Presurgical or postsurgical or second surgical opinion • Surgical procedure • Allergic condition	➢ One visit per **benefit year** ➢ One visit per **benefit year** ➢ One visit per **benefit year** ➢ One visit per **benefit year** ➢ One visit per **benefit year** for each allergic condition
Travel Per Diems/Limitations	
Travel per diem without overnight lodging. See section 3.5.23, *Travel*, for applicable criteria.	$51/day

Travel per diem with overnight lodging. See section 3.5.23, *Travel*, for applicable criteria.	$89/day
Companion per diem for **children** under age 18. See section 3.5.23, *Travel*, for applicable criteria.	$31/day
Overnight lodging for transplant services, in lieu of other travel per diems. See section 3.5.24, *Transplant Services*, for other applicable criteria.	$50 per person/night, up to $100/night
Limit on travel for transplant services	$10,000 per transplant occurrence
Travel benefits without **precertification**	No benefits will be paid
Precertification Penalties	
A $400 benefit reduction applies if you fail to obtain **precertification** for certain medical services. See section 3.4.3, *Services Requiring Precertification*.	

2.1.2. Prescription Drug Schedule

Prescription Tier	**Coinsurance**	**Minimum Covered Person Payment**	**Maximum Covered Person Payment**
Retail 30 Day at Network Pharmacy			
Generic prescription drug	80%	$10	$50
Preferred brand-name prescription drug	75%	$25	$75
Non-preferred brand-name prescription drug	65%	$80	$150
Mail Order 31-90 Day at Network Pharmacy			
Prescription Tier		**Copayment**	
Generic prescription drug		$20	
Preferred brand-name prescription drug		$50	
Non-preferred brand-name prescription drug		$100	

Out-of-Network Pharmacy	
Coinsurance for all **prescription drugs**	60%
Out-of-Pocket Limit	
Annual individual **out-of-pocket limit**	$1,000
Annual family **out-of-pocket limit**	$2,000

2.2. DENTAL BENEFIT SCHEDULE

	Standard Plan	Economy Plan
Annual individual **deductible**	$25 (waived for Class I services)	$25
Annual family **deductible**	$75 (waived for Class I services)	$75
Coinsurance		
Class I (preventive) services	100%	100%
Class II (restorative) services	80%	10%
Class III (prosthetic) services	50%	10%
	Standard Plan	**Economy Plan**
Orthodontia	50%	Not covered
Benefit Maximums		
Annual individual maximum	$1,500	$500
Orthodontia lifetime individual maximum • This maximum is not included in the annual individual maximum	$1,000	Not covered

2.3. VISION BENEFIT SCHEDULE

	Network Provider	Out-of-Network Provider
Exam	One per calendar year $10 **copayment** 100% after **copayment**	One per calendar year $10 **copayment** Maximum reimbursement limit of $100
Lenses • Single vision • Lined bifocal • Lined trifocal • Lenticular • Progressive	One pair per calendar year $25 **copayment** 100% after **copayment**	One pair per calendar year Maximum reimbursement limit of: Single vision: $75 Lined bifocal: $115 Lined trifocal: $130 Progressive: $115
Lens options • Anti-reflecting coating • Polycarbonate • Scratch resistant coating	Once per calendar year 100%	Not covered
Frames	One every two calendar years $25 **copayment** 100% after **copayment** up to $130 allowance (or $70 allowance at Costco) 20% off amount over allowance	One every two calendar years Maximum reimbursement limit of $70
Contact lenses (necessary)	$60 **copayment** 100% after **copayment** 15% off usual and customary professional fees for evaluation and fitting	Not covered

	Network Provider	Out-of-Network Provider
Contact lenses (elective and in lieu of lenses and frame)	Once per calendar year $130 allowance for contacts	Once per calendar year Maximum reimbursement limit of $105
Additional pairs of glasses	30% off unlimited additional pairs of **prescription** glasses or non-**prescription** sunglasses from the same **VSP doctor** on the same day as eye exam 20% off unlimited additional pairs of **prescription** glasses or non-**prescription** sunglasses from any **VSP doctor** within 12 months of your last eye exam	Not covered
Laser VisionCare Program	Average of 15% discounts off or 5% off promotional offer for laser surgery, including PRK, LASIK and Custom Lasik from a **VSP doctor**	Not covered
Low vision supplemental testing (includes evaluation, diagnosis and **prescription** of vision aids where indicated) Low vision supplemental aids	Two tests every two calendar years Allowance up to $125 75% **coinsurance** $1,000 maximum benefit to all low vision services, testing and materials, every two calendar years	Not covered
Extra savings and discounts	Guaranteed pricing on retinal screening as an enhancement to eye exam, allowance up to $39	Not covered

3. *Medical Plan*

3.1. ABOUT YOUR MEDICAL PLAN

The **medical plan** provides coverage for a wide range of medical expenses for the treatment of **illness** or **injury**. The **medical plan** also provides coverage for certain preventive and wellness benefits. With the **medical plan**, you can directly access any **network provider** or out-of-**network provider** for services and supplies covered under the **medical plan**. The **medical plan** pays benefits differently when services and supplies are obtained through **network providers** and out-of-**network providers**.

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

Coverage is subject to all the terms, policies and procedures outlined in the **medical plan**. Not all medical expenses are covered under the **medical plan**. Exclusions and limitations apply to certain medical services, supplies, and expenses. See section 3.5, *Covered Medical Expenses*, section 3.6.13, *Pharmacy Benefit Limitations*, section 3.6.14, *Pharmacy Benefit Exclusions*, and section 3.7, *Medical Benefit Exclusions*, to determine if medical services are covered, excluded or limited.

The **medical plan** provides access to covered benefits through a network of health care **providers** and **facilities**. The **medical plan** is designed to lower your out-of-pocket costs when you use **network providers** for **covered expenses**. Your **coinsurance** will generally be lower when you use **network providers** and **facilities**.

You also have the choice to access licensed **providers**, **hospitals** and other **facilities** outside the network for **covered expenses**. Your out-of-pocket costs will generally be higher when you use out-of-**network providers** because the **coinsurance** that you are required to pay is usually higher when you use out-of-**network providers**. Out-of-**network providers** have not agreed to accept the **negotiated charge** and may balance bill you for charges over the amount the **medical plan** pays. Additionally, when receiving services at an out-of-**network hospital** or other **facility** in the Municipality of Anchorage or outside of Alaska, the **recognized charge** is reduced to a percentage of Medicare that most closely reflects the aggregate contracted rate at the preferred **hospital** or other **facility** in the Anchorage area. See section 3.3.3, *Accessing Out-of-Network Provider and Benefits* and section 3.3.4, *Cost Sharing for Out-of-Network Benefits*, for additional information.

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

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

3.2. MEDICAL PLAN OPTIONS

There are three options available under the **medical plan**: consumer choice, economy, and standard. You elect which option under the **medical plan** that you want for you and your **dependents**. These options are identical in what is covered and how benefits are paid. However, the **deductibles**, **coinsurance**, and **out-of-pocket limits** are different with each option. See section 2.1.1, *Medical Benefit Schedule*, for details about how these items differ between the options. Additionally, the consumer choice plan offers a Health Reimbursement Arrangement (HRA) account not available under the remaining plans. See section 7 for details.

3.3. HOW THE MEDICAL PLAN WORKS

3.3.1. Accessing Network Providers and Benefits

You may select any **network provider** from **Aetna's provider** directory. You can access **Aetna's** online **provider** directory, DocFind®, at www.aetna.com/docfind/custom/alaskacare, for the names and locations of **physicians, hospitals** and other health care **providers** and facilities. Due to AlaskaCare having a custom provider network it is important that you use the AlaskaCare specific DocFind® tool rather than Aetna's public DocFind® tool in order to get accurate results. You can change your health care **provider** at any time.

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

Some health care services, such as hospitalization, outpatient surgery and certain other outpatient services, require **precertification** with **Aetna** to verify coverage for these services. You do not need to **precertify** services provided by a **network provider**. **Network providers** will be responsible for obtaining the necessary **precertification** for you. Since **precertification** is the **provider's** responsibility, there is no additional out-of-pocket cost to you as a result of a **network provider's** failure to **precertify** services. See section 3.4, *Understanding Precertification*, for more information.

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

You will receive notification of what the **medical plan** has paid toward your **covered expenses**. It will indicate any amounts you owe toward any **deductible**, **copayment**, **coinsurance**, or other non-**covered expenses** you

have incurred. You may elect to receive this notification by e-mail or through the mail. Contact **Aetna** if you have questions regarding this notification.

3.3.2. Cost Sharing For Network Benefits

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

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

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

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

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

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

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

3.3.3. Accessing Out-of-Network Providers and Benefits

You have the choice to directly access out-of-**network providers**. You will still be covered when you access out-of-**network providers** for covered benefits. When your medical service is provided by an out-of-**network provider,** the level of reimbursement from the **medical plan** for some **covered expenses** will usually be lower. This means your out-of-pocket costs will generally be higher.

Some health care services, such as hospitalization, outpatient surgery and certain other outpatient services, require **precertification** with **Aetna** to verify

coverage for these services. When you receive services from an out-of-**network provider**, you are responsible for obtaining the necessary **precertification** from **Aetna**. Your **provider** may **precertify** your treatment for you. However, you should verify with **Aetna** prior to receiving the services that the **provider** has obtained **precertification**. If the service is not **precertified**, the benefit payable may be significantly reduced or may not be covered. This means you will be responsible for the unpaid balance of any bills. You must call **Aetna** to **precertify** services. See section 3.4, *Understanding Precertification*, for more information on the **precertification** process and what to do if your request for **precertification** is denied.

When you use out-of-**network providers**, you may have to pay for services at the time they are rendered. You may be required to pay the charges and submit a claim form for reimbursement. When you pay an out-of-**network provider** directly, you will be responsible for completing a claim form to receive reimbursement of **covered expenses** under the **medical plan**. You must submit a completed claim form and proof of payment to **Aetna**. See section 8, *How to File a Claim*, for a complete description of how to file a claim under the **medical plan**.

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

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

3.3.4. Cost Sharing for Out-of-Network Benefits

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

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

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

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

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

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

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

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

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

3.3.5. Availability of Providers

Aetna cannot guarantee the availability or continued network participation of a particular **provider** (*e.g.* **physician** or **hospital**). Either **Aetna** or any **network provider** may terminate the **provider** contract. To identify **network providers**, visit www.aetna.com/docfind/custom/alaskacare for **Aetna's** online **provider** directory.

3.3.6. Recognized Charge

The **recognized charge** is the charge contained in an agreement **Aetna** has with a **network provider**. If you use an out-of-**network provider**, the **covered expense** is the part of a charge which is the **recognized charge** as described in section 16, *Definitions – "Recognized Charge"*. If you use an out-of-**network provider** and the charge exceeds the **recognized charge**, the amount above the

recognized charge is not covered by the **medical plan**, and is your responsibility to pay. You are not responsible for charges exceeding the **recognized charge** when you use a **network provider**.

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

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

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

3.3.7. Common Accident Deductible Limit

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

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

3.3.8. Lifetime Maximum

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

3.4. UNDERSTANDING PRECERTIFICATION

3.4.1. Precertification

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

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

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

When you receive services from an out-of-**network provider**, you are responsible for obtaining the necessary **precertification** from **Aetna** for any services or supplies that require **precertification** as described in section 3.4.3, *Services Requiring Precertification*. If you do not **precertify**, your benefits may be reduced or the **medical plan** may not pay any benefits.

3.4.2. The Precertification Process

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

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

For non-**emergency** admissions:	You, your **physician** or the facility must call and request **precertification** at least 14 days before the date you are scheduled to be admitted.
For an **emergency** outpatient medical condition:	You or your **physician** must call prior to the outpatient care, treatment or procedure, if possible, or as soon as reasonably possible.

For an **emergency** admission:	You, your **physician** or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
For an **urgent admission**:	You, your **physician** or the facility must call before you are scheduled to be admitted.
For outpatient non-**emergency** medical services requiring **precertification**:	You or your **physician** must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

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

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

If **Aetna** determines that the **stay** or services and supplies are not **covered expenses**, the notification will explain why and how **Aetna's** decision can be appealed. You or your **provider** may request a review of the **precertification** decision in accordance with section 8, *How to File a Claim*.

3.4.3. Services Requiring Precertification

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

Precertification is required for the following types of medical expenses:

- **Stays** in a **hospital**
- **Stays** in a **skilled nursing facility**
- **Stays** in a **rehabilitation facility**
- **Stays** in a **hospice facility**

- Outpatient **hospice care**
- **Stays** in a **residential treatment facility** for treatment of **mental disorders** and **substance abuse**
- Partial hospitalization for treatment of **mental disorders** and **substance abuse**
- Home health care
- Private duty nursing care
- Transportation (non-emergent) by fixed wing aircraft (plane)
- Autologous chondrocyte implantation, Carticel (injection into the knee of cartilage cells grown from tissue cultures)
- Cochlear implant (surgical implant of a device into the ear to try to improve hearing)
- Dental **implants** and oral appliances
- Dialysis visits
- Dorsal column (lumbar) neurostimulators: trial or implantation (for relief of severe pain)
- Electric or motorized wheelchairs and scooters
- Gastrointestinal tract imaging through capsule endoscopy
- Hip surgery to repair impingement syndrome
- Hyperbaric oxygen therapy
- Lower Limb prosthetics
- Oncotype DX (a method for testing for genes that are in cancer cells)
- Organ transplants
- Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (reconstructive surgeries to attempt to correct structural abnormalities of the jaw bones)
- Osseointegrated implant
- Osteochondral allograft/knee (grafting of cartilage and bone from a cadaver to the knee joint)

- Power morcellation with uterine myomectomy, with hysterectomy or for removal of uterine fibroids
- Proton beam radiotherapy
- Reconstruction or other procedures that may be considered **cosmetic**
- Surgical spinal procedures
- Uvulopalatopharyngoplasty, including laser-assisted procedures (surgery to reconfigure the soft palate to try to help with sleep apnea)
- Ventricular assist devices
- MRI‑knee
- MRI‑spine
- Intensive outpatient programs for treatment of **mental disorders** and **substance abuse**, including:
  - Psychological testing
  - Neuropsychological testing
  - Outpatient detoxification
  - Psychiatric home care services
- Travel
- Use of an out-of-**network provider** for preventive care services.

3.4.4. How Failure to Precertify Affects your Benefits

A **precertification** benefit reduction of $400 will be applied to the benefits paid if you fail to obtain a required **precertification** prior to incurring medical expenses. This means that **Aetna** will reduce the amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

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

If **precertification** of travel expenses is not requested, the $400 benefit reduction will not apply; however, no travel benefits will be paid.

If **precertification** for the use of an out-of-**network provider** for preventive care services is not requested, the $400 benefit reduction will not apply; however, all charges incurred for preventive care services will be subject to payment under the **medical plan** provisions governing non-preventive care services.

3.5. COVERED MEDICAL EXPENSES

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

- Be included as a **covered expense** under the **medical plan**.
- Not be an excluded expense under the **medical plan**. See section 3.7, *Medical Benefit Exclusions*, for a list of services and supplies that are excluded, and section 3.6.14, *Pharmacy Benefit Exclusions*, for additional exclusions that apply with respect to the **prescription drug** benefit under the **medical plan**.
- Not exceed the maximums and limitations outlined in the **medical plan**. See section 2.1, *Medical and Prescription Drug Benefits*, and section 3.3, *How the Medical Plan Works*, for information about certain maximums and limits.
- Be obtained in accordance with all the terms, policies and procedures outlined in the **medical plan**.
- Be provided while coverage is in effect. See section 1.37, *When Coverage Begins*, and section 1.9, *When Coverage Ends*, for details on when coverage begins and ends.

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

3.5.1. Medically Necessary Services and Supplies

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

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

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

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease;
- not mostly for the convenience of the patient or **physician** or other health care **provider**; and
- no more costly than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease. This provision does not require the use of generic drugs.

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

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

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

- Those that do not require the technical skills of a medical professional who is acting within the scope of his or her license.
- Those furnished mainly for the comfort or convenience of the person, the person's family, anyone who cares for him or her, a health care **provider** or health care facility.

- Those furnished only because the person is in the **hospital** on a day when the person could safely and adequately be diagnosed or treated while not in the **hospital**.

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

3.5.2. Physician Services

a. Physician Visits

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

b. Surgery

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

- performing your surgical procedure;

- pre-operative and post-operative visits; and

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

c. Providers

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

- Dentistry (D.D.S. or D.M.D.)

- Medicine and surgery (M.D.)

- Osteopathy and surgery (D.O.)

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

- Acupuncturists

- Advanced nurse practitioners

- Audiologists

- Chiropractors

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

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

3.5.3. Nurse Advice Line

A registered nurse is available to you by phone 24 hours a day, free of charge by calling **Aetna's** number listed in the front of the **medical plan**. The nurse can be a resource in considering options for care or helping you decide whether

you or your **dependent** needs to visit your doctor, an urgent care facility or the emergency room. The nurse can also provide information on how you can care for yourself or your **dependent**. Information is available on **prescription drugs**, tests, surgery, or any other health-related topic. This service is confidential.

3.5.4. Preventive Care and Screening Services

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

The recommendations and guidelines referenced in this Section 3.5.4, *Preventive Care and Screening Services* will be updated periodically. This plan is subject to updated recommendations or guidelines that are issued by the following organizations beginning on the first day of the benefit year, one year after the recommendation or guideline is issued:

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

a. Scope of Preventive Care Services

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

- ➢ 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).

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

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

- 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.

b. Coverage

Unless otherwise specified, preventive care services are not subject to a **copayment** or **deductible**, and will be paid at 100% of the **provider's** rate, if the **provider** is a **network provider**. Preventive care services provided by an out-of-**network provider** are subject to payment under **medical plan** provisions governing non-preventive care services.

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

Unless otherwise specified, preventive care services under this section 3.5.4, *Preventive Care and Screening Services*, are limited to once per **benefit year**.

c. Routine Physical Exams

Covered expenses include charges made by your primary care **physician** (PCP) for routine physical exams. This includes routine

vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.

- Services as recommended in the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.

- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include, but are not limited to:

  - Screening and counseling services, such as:
    - Interpersonal and domestic violence;
    - Sexually transmitted diseases; and
    - Human Immune Deficiency Virus (HIV) infections.

  - Screening for gestational diabetes for women.

  - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older.

- X-rays, lab and other tests given in connection with the exam.

- For covered newborns, an initial hospital checkup.

d. Preventive Care Immunizations

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

- The materials for administration of immunizations.

e. Well Woman Preventive Visits

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

- A routine well woman preventive exam office visit, including Pap smears. A routine well woman preventive exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**.

- Routine preventive care breast cancer genetic counseling and breast cancer (BRCA) gene blood testing. **Covered expenses** include charges made by a **physician** and lab for the BRCA gene blood test and charges made by a genetic counselor to interpret the test results and evaluate treatment.

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

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and

- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

f. Routine Cancer Screenings

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

- Colonoscopies (removal of polyps performed during a screening procedure is a covered expense);

- Digital rectal exams;

- Double contrast barium enemas (DCBE)

- Fecal occult blood tests;

- Lung cancer screening

- Mammograms;

- Prostate specific antigen (PSA) tests; and

- Sigmoidoscopies.

These benefits will be subject guidelines on the basis of age, family history, and frequency that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and

- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration

g. Screening and Counseling Services

Covered expenses include charges made by your **physician** in an individual or group setting for the following:

- **Obesity and/or Healthy Diet**

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

  - Preventive counseling visits and /or risk factor reduction intervention;

  - Nutrition counseling; and

  - Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related disease.

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

- **Misuse of Alcohol and/or Drugs**

  Screening and counseling services to aid in prevention or reduction of the use of an alcohol agent or controlled substance.

Covered expenses includes preventive counseling visits, risk factor reduction intervention and a structured assessment.

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

- **Use of Tobacco Products**

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

  - Preventive counseling visits;
  - Treatment visits; and
  - Class visits.

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

- **Sexually Transmitted Infections**

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

- **Genetic Risks for Breast and Ovarian Cancer**

  Covered expenses include counseling and evaluation services to help you assess your breast and ovarian cancer susceptibility.

- **Prenatal Care**

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

- **Comprehensive Lactation Support and Counseling Services**

- **Lactation Support**

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

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

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

  Visits in excess of the lactation counseling maximum as shown above, are subject to the cost sharing provisions outlined in section 3.3.2, *Cost Sharing for Network Benefits* or section 3.3.4, *Cost Sharing for Out-of-Network Benefits*.

- **Breast Feeding Durable Medical Equipment**

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

- **Breast Pump**

  Covered expenses include the following:

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

  - If an electric breast pump was purchased within the previous three year period, the purchase of

another breast pump will not be covered until a three year period has elapsed from the last purchase.

- **Breast Pump Supplies**

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

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

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

h. Family Planning Services – Female Contraceptives

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

Coverage includes counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist. Such counseling services are covered expenses when provided in either a group or individual setting. Contraceptive counseling services are subject to a two visit maximum in a 12 consecutive month period. Visits in excess of this maximum are subject to the cost sharing provisions outlined in section 3.3.2, *Cost Sharing for Network Benefits* or section 3.3.4, *Cost Sharing for Out-of-Network Benefits*.

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

- **Voluntary Sterilization**

  Covered expenses include charges billed separately by the provider for female and male voluntary sterilization procedures

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

- **Contraceptives**

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

i. Limitations

Unless specified above, preventive care services do not include:

- Diagnostic lab, diagnostic tests, diagnostic procedures, or other labs, tests or procedures ordered, or given, in connection with any of the preventive care benefits described above;
- Exams given during your stay for medical care;
- Services not given by a **physician** or under his or her direction;
- Immunizations that are not considered preventive care such as those required due to your employment or travel;
- Pregnancy expenses (other than prenatal care as described above);
- Services and supplies incurred for an abortion;
- Services as a result of complications resulting from voluntary sterilization procedure and related follow-up care;
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;
- Male contraceptive methods, sterilization procedures or devices;

- The reversal of voluntary sterilization procedures, including any related follow-up care; or

- Charges incurred for family planning services while confined as an inpatient in a hospital or other facility for medical care.

3.5.5. Immunizations

In addition to the immunizations covered under section 3.5.4, *Preventive Care and Screening Services*, **covered expenses** include other immunizations for communicable diseases, including serums administered by a nurse or **physician**. Charges for office visits in connection with the immunizations are not covered.

3.5.6. Hospital Expenses

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

a. Room and Board

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

Room and board charges also include:

- Services of the **hospital's** nursing staff
- Admission and other fees
- General and special diets
- Sundries and supplies

b. Other Hospital Services and Supplies

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

- **Ambulance** services
- **Physicians** and surgeons

- Operating and recovery rooms
- Intensive or special care facilities
- Administration of blood and blood products, but not the cost of the blood or blood products
- Radiation therapy
- Speech therapy, physical therapy and occupational therapy
- Oxygen and oxygen therapy
- Radiological services, laboratory testing and diagnostic services
- Medications
- Intravenous (IV) preparations
- Discharge planning

c. Outpatient Hospital Expenses

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

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

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

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

d. Coverage for Emergency Medical Conditions

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

- Use of emergency room facilities
- Emergency room **physician** services
- **Hospital** nursing staff services

- Radiologists and pathologists services

With the exception of urgent care described below, if you visit a **hospital** emergency room for a non-**emergency** medical condition, the **medical plan** will pay a reduced benefit, as shown in section 2.1.1, *Medical Benefit Schedule*. No other **plan** benefits will pay for non-**emergency care** in the emergency room.

e. Coverage for Urgent Conditions

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

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

f. Facility-Only Preferred Provider Agreement

The **medical plan** has a **facility**-only preferred provider agreement for **facility** services in the municipality of Anchorage. The preferred facilities in the municipality of Anchorage are Alaska Regional Hospital, and their affiliated **surgery center** Surgery Center of Anchorage.

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

When receiving services at an out-of-**network hospital** or other type of **facility**, the **recognized charge** for the out-of-**network facility** services is reduced to the percentage of Medicare that most closely reflects the

aggregate contracted rate at the preferred **hospital** or **facility** in the Municipality of Anchorage.

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

- services that cannot be performed at a preferred provider hospital or **facility**; and
- **emergency** services.

3.5.7. Alternatives to Hospital Stays

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

a. Surgery Centers

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

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

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

b. Birthing Centers

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

- prenatal care;
- delivery; and
- postpartum care within 48 hours after a vaginal delivery and 96 hours after a cesarean delivery.

3.5.8. Home Health Care

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

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

Home health care expenses include charges for:

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

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

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

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

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

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

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

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

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

3.5.9. Private Duty Nursing

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

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

- A change in your medication.
- Treatment of an urgent or **emergency** medical condition by a **physician**.

- The onset of symptoms indicating a need for **emergency** treatment.
- Surgery.
- An inpatient **stay**.

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

- Nursing care that does not require the education, training and technical skills of a registered nurse or licensed practical nurse.
- Nursing care assistance for daily life activities, such as:
  - transportation
  - meal preparation
  - vital sign charting
  - companionship activities
  - bathing
  - feeding
  - personal grooming
  - dressing
  - toileting
  - getting in/out of bed or a chair.
- Nursing care provided for skilled observation.
- Nursing care provided while you are an inpatient in a **hospital** or health care facility.
- A service provided solely to administer oral medicine, except where law requires a registered nurse or licensed practical nurse to administer medicines.

3.5.10. Skilled Nursing Facility

IMPORTANT NOTE: The medical plan will reduce benefits by 20% if a covered person receives services from a non-preferred hospital, surgery center, rehabilitative facility, or free-standing imaging center in the Municipality of Anchorage or from an out-of-network hospital, surgery center, rehabilitative facility, or free standing imaging center provider in the other 49 states. In

addition, when receiving services at an out-of-network hospital or other type of facility, the recognized charge for the out-of-network facility services is reduced to the percentage of Medicare that most closely reflects the aggregate contracted rate at the preferred hospital or facility in the Municipality of Anchorage.

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

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

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

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

3.5.11. Hospice Care

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

a. Facility Expenses

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

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

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

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

b. Outpatient Hospice Expenses

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

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

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

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

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

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

3.5.12. Second Surgical Opinions

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

Charges for complex imaging services, radiological services and diagnostic tests required in connection with the second opinion are covered by the **medical**

plan. However, to avoid duplication, the attending **physician** is encouraged to share X-ray and test results with the consulting **physician(s).**

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

- 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, **Aetna** can provide you with a list of names of qualified **physicians**.

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

3.5.13. Diagnostic and Preoperative Testing

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

a. Diagnostic Complex Imaging Expenses

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

- Computed Tomography (CAT or CT) scans.
- Magnetic Resonance Imaging (MRI).
- Positron Emission Tomography (PET) scans.
- Any other outpatient diagnostic imaging service costing over $500.

- Complex imaging expenses for preoperative testing.

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

b. Outpatient Diagnostic Lab Work and Radiological Services

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

c. Outpatient Preoperative Testing

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

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

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

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

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

3.5.14. Cognitive Therapy, Physical Therapy, Occupational Therapy, and Speech Therapy Rehabilitation Benefits

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

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

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

- Speech therapy is covered for non-chronic conditions and acute **illnesses** and **injuries** and expected to restore the speech function or correct a speech impairment resulting from **illness** or **injury**; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.

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

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

The therapy should follow a specific treatment plan that:

- details the treatment, and specifies frequency and duration; and

- provides for ongoing reviews and is renewed only if continued therapy is appropriate.

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

- Therapies for the treatment of delays in development, unless resulting from acute **illness** or **injury**, or congenital defects amenable to surgical repair (such as cleft lip/palate). Examples of non-covered diagnoses include Down's syndrome and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

- Any services which are **covered expenses** in whole or in part under any other group plan sponsored by an employer.

- Any services unless provided in accordance with a specific treatment plan.

- Services for the treatment of delays in speech development, unless resulting from **illness**, **injury**, or congenital defect.

- Services provided during a **stay** in a **hospital**, **skilled nursing facility**, or hospice facility except as stated above.

- Services not performed by a **physician** or under the direct supervision of a **physician**.

- Treatment covered as part of spinal manipulation treatment. This applies whether or not benefits have been paid under that section.

- Services provided by a **physician** or physical, occupational or speech therapist who resides in your home or who is a member of your family, or a member of your **spouse**'s family.

- Special education to instruct a person whose speech has been lost or impaired to function without that ability. This includes lessons in sign language.

3.5.15 Massage Therapy

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

- Massage therapy is covered in conjunction with and for the purpose of making the body more receptive of spinal manipulation provided under section **3.5.27**, *Treatment of Spinal Disorders*.

- Medically necessary massage therapy is a **covered expense** if it is limited to the initial or acute phase of an injury or illness and is part of a specific treatment plan for physical or occupational rehabilitative therapy as outlined in 3.5.14, *Cognitive Therapy, Physical Therapy, Occupational Therapy, and Speech Therapy Rehabilitation Benefits.*

3.5.16. Anesthetic

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

3.5.17. Pregnancy Related Expenses

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

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

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

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

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

If you are **totally disabled** as a result of a problem with your pregnancy and your coverage under the **medical plan** ends, you may be eligible for extended benefits. See section 9, *Consolidated Omnibus Budget Reconciliation Act (COBRA) and Extended Health Coverage*.

3.5.18. Newborn Care

Covered expenses include newborn care provided within the first 31 days after birth. Newborn services provided after 31 days are not covered, unless you enroll your **child** under the **medical plan** within 30 days of birth. See section 1.7.5, *Dependents*.

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

3.5.19. Durable Medical and Surgical Equipment

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

- Bandages and surgical dressings.
- Rental or purchase 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.
- Oxygen or rental of equipment for the administration of oxygen.
- Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps.

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

- The initial purchase of such equipment and accessories to operate the equipment is covered only if **Aetna** is shown that:
  - long-term use is planned and the equipment cannot be rented; or
  - it is likely to cost less to buy the equipment than to rent it.
- Maintenance and repair of purchased equipment is covered unless needed due to misuse or abuse of the equipment.
- Replacement of purchased equipment and accessories is covered only if **Aetna** is shown that:
  - it is needed due to a change in the person's physical condition; or
  - it is likely to cost less to buy a replacement than to repair the existing equipment or to rent similar equipment.

The **medical plan** does not cover charges for more than one item of equipment for the same or similar purpose. The **medical plan** may limit the payment of

charges to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided.

3.5.20. Experimental or Investigational Treatment

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

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

3.5.21. Prosthetic Devices

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

The **medical plan** covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of

illness or **injury** or congenital defects, as described in the list of covered devices below, for an:

- internal body part or organ; or
- external body part.

Covered expenses also include replacement of a prosthetic device if:

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

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

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

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

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless the orthopedic shoe is an integral part of a covered leg brace.
- Trusses, corsets, and other support items.
- Any item listed in section 3.7, *Medical Benefit Exclusions*.

3.5.22. Ambulance Services

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

- Ground **Ambulance**. **Covered expenses** include charges for transportation:
  - To the first **hospital** where treatment is given in a medical **emergency**.
  - From one **hospital** to another **hospital** in a medical **emergency** when the first **hospital** does not have the required services or facilities to treat your condition.
  - From **hospital** to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
  - From home to **hospital** for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles.
  - When during a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, an **ambulance** is required to safely and adequately transport you to or from inpatient or outpatient **medically necessary** treatment.
- Air or Water **Ambulance.** **Covered expenses** include charges for transportation to a **hospital** by air or water **ambulance** when:
  - ground **ambulance** transportation is not available;
  - your condition is unstable, and requires medical supervision and rapid transport; and
  - in a medical **emergency**, transportation from one **hospital** to another **hospital**, when the first **hospital** does not have the required services or facilities to treat your condition and you need to be transported to another **hospital**, and the two conditions above are met.

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

- if an **ambulance** service is not required for your physical condition;

- if the type of **ambulance** service provided is not required for your physical condition; or

- by any form of transportation other than a professional **ambulance** service.

3.5.23. Travel

Travel is a **covered expense** only in the circumstances set forth in this section. Travel for transplant services is set forth in section 3.5.24, *Transplant Services*.

a. Treatment Not Available Locally

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

If you require treatment that is not available locally, **covered expenses** include round-trip transportation, not exceeding the cost of coach class commercial air transportation, from the site of the **illness** or **injury** to the nearest professional treatment. If you use ground transportation and the most direct one-way distance exceeds 100 miles, the **medical plan** pays the per diem set forth below.

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

- 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.

- Second surgical opinions which cannot be obtained locally (this will count as a presurgical trip).

- One visit for each allergic condition.

b. Surgery or Diagnostic Procedures in Other Locations

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

If the actual cost of surgery or diagnostic procedure, and all associated costs related to the surgery or diagnostic procedure, including travel, is

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

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

Contact **Aetna** for assistance with identifying less expensive options for surgery or diagnostic procedures.

c. Limitations

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

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

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

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

d. Per Diem

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

3.5.24. Transplant Services

a. Covered Expenses

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

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

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

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

- More than one transplant when not performed as part of a planned tandem or sequential transplant, (*e.g.*, a liver transplant with subsequent heart transplant).

b. Network Level of Benefits

The network level of benefits is paid only for a treatment received at a facility designated by the **medical plan** as an Institute of Excellence™ (IOE) for the type of transplant being performed. Each IOE facility has been selected to perform only certain types of transplants.

Services obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as out-of-**network services and supplies**, even if the facility is a **network provider** or IOE for other types of services.

The **medical plan** covers:

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

c. Levels of Transplant Care

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

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

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.

2. Pre-transplant/candidacy screening: Includes Human Leukocyte Antigent (HLA) typing/compatibility testing of prospective organ donors who are immediate family members.

3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; **prescription drugs** provided during your inpatient **stay** or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient **stay** or outpatient visit(s); cadaveric and live donor organ procurement.

4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

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

d. Limitations

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

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence.

- Services that are covered under any other benefit under this **medical plan**.

- Services and supplies furnished to a donor when the recipient is not covered under the **medical plan**.

- Home infusion therapy after the transplant occurrence.

- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing **illness**.

- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing **illness**.

- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by **Aetna**.

e. Network of Transplant Specialist Facilities

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

f. Travel Expenses

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

Covered expenses include the following:

- Transportation Expense

  - Expenses incurred by an Institute of Excellence™ (IOE) patient, and approved in advance by **Aetna**, for transportation between the patient's home and the Institute of Excellence™ (IOE) to receive services in connection with any listed procedure or treatment.

  - Expenses incurred by a companion and approved in advance by **Aetna** for transportation when traveling with

an Institute of Excellence™ (IOE) patient between the patient's home and the Institute of Excellence™ (IOE) to receive such services.

- Lodging Expenses

  - Expenses incurred by an Institute of Excellence™ (IOE) patient, and approved in advance by **Aetna**, for lodging away from home:

    - while traveling between the patient's home and the Institute of Excellence™ (IOE) to receive services in connection with any listed procedure or treatment; or

    - to receive outpatient services from the Institute of Excellence™ (IOE) in connection any listed procedure or treatment.

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

    - while traveling with an Institute of Excellence™ (IOE) patient between the patient's home and the Institute of Excellence™ (IOE) to receive services in connection with any listed procedure or treatment; or

    - when the companion's presence is required to enable an Institute of Excellence™ (IOE) patient to receive such services from the Institute of Excellence™ (IOE) on an inpatient or outpatient basis.

  - The **medical plan** will pay $50 per night per person for overnight lodging, up to a $100 maximum.

  - For purposes of determining travel expenses or lodging expenses, a **hospital** or other temporary residence from which an Institute of Excellence™ (IOE) patient travels in order to begin a period of treatment at the Institute of Excellence™ (IOE), or to which the patient travels after dismissal from the Institute of Excellence™ (IOE) at the end of a period of treatment, will be considered to be the patient's home.

- Travel and Lodging Benefit Maximum

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

3.5.25. Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) is a confidential counseling service, free of charge to you and your **dependents**, administered by **Aetna**. This service provides assessment, treatment and referral services, and covers up to eight counseling sessions per problem. 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 **plan** for the EAP counselor. EAP staff is available 24 hours a day, 7 days a week, 365 days a year. When you call, you may be able to work through your problem on the phone with an EAP staff member. In most cases, however, 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 counselor 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 counselor 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 unless required by law.

Additional services may be available through the EAP program. Visit www.AlaskaCare.com for more information.

3.5.26. Mental Disorder and Substance Abuse Treatment

a. Mental Disorders

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

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

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

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

b. Substance Abuse

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

- Inpatient Treatment: **Covered expenses** include charges for **room and board** at the semi-private room rate, and other services and supplies provided during your **stay** in a **psychiatric hospital** or **residential treatment facility**, appropriately licensed by the state department of health or its equivalent. Inpatient benefits include treatment in a **hospital** for the medical complications of **substance abuse**. Medical complications include **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis. Treatment

in a **hospital** is covered only when the **hospital** does not have a separate treatment facility section.

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

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

3.5.27. Treatment of Spinal Disorders

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

Benefits are subject to the maximum shown in section 2.1.1, *Medical Benefit Schedule*. However, this maximum does not apply to expenses incurred:

- during your **hospital stay**; or

- for surgery, including pre- and post-surgical care provided or ordered by the operating **physician**.

3.5.28. Medical Treatment of Mouth, Jaws, and Teeth

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

- 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 an underlying medical condition, **accident** or disease, other than periodontal disease, 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 **medical plan**. Treatment must begin during the year the **accident** occurred or the year following. The teeth must have been damaged or lost other than in the course of biting or chewing and must have been free of decay or in good repair.

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

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

3.5.29. Medical Treatment of Obesity

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

- An initial medical history and physical exam

- Diagnostics tests given or ordered during the first exam

- **Prescription drugs**

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

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

- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regiments and supplements, food or food supplements, appetite suppressants and other medications.

- Exercise programs, exercise or other equipment.

- Other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

3.5.30. Reconstructive or Cosmetic Surgery and Supplies

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

- Surgery needed to improve a significant functional impairment of a body part.

- Surgery to correct the result of an accidental **injury**, including subsequent related or staged surgery.

- Surgery to correct the result of an **injury** that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original **injury**.

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

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

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

3.5.31. Audio Services

Covered expenses include the following audio services:

- An otological (ear) examination by a **physician** or surgeon every 24 consecutive months.

- An audiological (hearing) examination and evaluation by a certified or licensed audiologist, including a follow up consultation. This includes claims for evaluation and management services.

- An electronic 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 consultation within 30 days following delivery of the hearing aid. Hearing aids are limited to one in a rolling 36 month period, and are subject to the maximums set forth in section 2.1.1, *Medical Benefit Schedule*.

- Repairs, servicing or alteration of hearing aid equipment.

You must provide **Aetna** 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.

Expenses incurred for a hearing aid within 30 days of termination of the **covered person's** coverage under the **medical plan** will be **covered expenses** under the **medical plan** if during the 30 days before the date coverage terminates:

- the **prescription** for the hearing aid was written; and
- the hearing aid was ordered.

3.6. YOUR PRESCRIPTION DRUG BENEFITS

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

3.6.1. Accessing Pharmacies and Benefits

The **medical plan** provides access to covered benefits through a network of **pharmacies**, vendors and suppliers. **Aetna** has contracted for these **network pharmacies** to provide **prescription drugs** and other supplies to you. You also have the choice to access state licensed **pharmacies** outside of the network for covered services.

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

3.6.2. Accessing Network Pharmacies and Benefits

You may select any **network pharmacy** from the **Aetna** Network Pharmacy Directory. You can access **Aetna's** online **provider** directory, DocFind® at www.aetna.com/docfind for the names and locations of **network pharmacies**. If you cannot locate a **network pharmacy** in your area, call **Aetna**.

You must present your ID card to the **network pharmacy** every time you get a **prescription** filled to be eligible for network benefits. The **network pharmacy**

will calculate your claim online. You will pay the **deductible**, **copayment** or **coinsurance**, if any, directly to the **network pharmacy**.

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

3.6.3. Emergency Prescriptions

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

3.6.4. Availability of Providers

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

3.6.5. Cost Sharing for Prescription Drug Tiers

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

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

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

If you have a medical need for a non-preferred brand-name drug, your doctor can ask for a medical exception. If the exception is granted, the drug will be

subject to preferred brand-name drug cost sharing. Exceptions granted as a result of a medical exception shall be based on individual case by case medical necessity determinations and do not apply or extend to other covered persons.

Drugs may be added or removed from the **Preferred Drug Guide** by the **claims administrator** for certain reasons. A **prescription drug** may also be moved from one tier to another. Here are some reasons why:

- As **brand-name prescription drugs** lose their patents and generic versions become available, the **brand-name prescription drug** may be covered at a higher out-of-pocket cost while the **generic prescription drug** may be covered at a lower out-of-pocket cost.
- The Food and Drug Administration (FDA) approves many new **prescription drugs** throughout the year.
- Drugs can be withdrawn from the market or may become available without a **prescription**.

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

3.6.6. Cost Sharing for Network Benefits

You share in the cost of your benefits. Cost sharing amounts and provisions are described in section 2.1.2, *Prescription Drug Schedule*. All cost sharing is payable directly to the **network pharmacy** at the time the **prescription** is dispensed.

3.6.7. When You Use an Out-of-Network Pharmacy

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

3.6.8. Cost Sharing for Out-of-Network Pharmacy Benefits

You share in the cost of your benefits. Cost sharing amounts and provisions are described in section 2.1.2, *Prescription Drug Schedule*. You will be responsible for any applicable **copayment** or **coinsurance** for **covered expenses** that you incur. Your **coinsurance** is based on the **recognized charge,** see section 16, *Definitions – "Recognized Charge"*. If the out-of-**network**

pharmacy charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**.

3.6.9. Pharmacy Benefit

The **medical plan** covers charges for outpatient **prescription drugs** for the treatment of an **illness** or **injury**, subject to the limitations and maximums set forth in section 2.1.2, *Prescription Drug Schedule* and the exclusions set forth in section 3.6.13, *Pharmacy Benefit Limitations*, section 3.6.14, *Pharmacy Benefit Exclusions*, and section 3.7, *Medical Benefit Exclusions*. **Prescriptions** must be written by a **provider** licensed to prescribe federal legend **prescription** drugs.

Generic prescription drugs may be substituted by your pharmacist for **brand name prescription drugs**. You may minimize your out-of-pocket costs by selecting a **generic prescription drug** when available.

Your **prescription drugs** benefit features an open preferred drug list, from which certain drugs (or services) are excluded. See www.AlaskaCare.gov for a list of drugs that are not covered under the plan. For each drug on the exclusion drug list there are preferred alternatives that are covered by the plan.

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

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

3.6.10. Retail Pharmacy Benefits

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

3.6.11. Mail Order Pharmacy

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

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

3.6.12. Other Covered Expenses

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

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

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

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

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

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

- **Diabetic Supplies.** The following diabetic supplies upon **prescription** by a **physician**:

  - Diabetic needles and syringes

  - Test strips for glucose monitoring and/or visual reading

  - Diabetic test agents

  - Lancets/lancing devices

  - Alcohol swabs

- **Preventive Care Drugs and Supplements**

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

  - prescribed by a **physician**;

  - obtained at a **network pharmacy**; and

- submitted to a pharmacist for processing.

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

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

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

- **Contraceptives**

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

  - Female oral and injectable contraceptives that are **generic prescription drugs** and **brand-name prescription drugs.**
  - Female contraceptive devices.

- FDA-approved brand-name emergency contraceptives (for women) when obtained at a network pharmacy.

- FDA-approved female generic over-the-counter (OTC) contraceptives.

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

Cost Sharing Waiver for Prescription Drug Contraceptives

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

- Female generic contraceptive **prescription drugs** or devices;

- FDA-approved female generic emergency contraceptives, when obtained at a **network pharmacy**.

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

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

- **brand-name prescription drugs** and brand-name devices; or

- FDA-approved female brand-name emergency contraceptives when obtained at a **network pharmacy**.

3.6.13. Pharmacy Benefit Limitations

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

- The **medical plan** will not cover expenses for any **prescription drug** for which the actual charge to you is less than the required **copayment** or **deductible**, or for any **prescription drug** for which no charge is made to you.

- You will be charged the out-of-network **prescription drug** cost sharing for **prescription drugs** recently approved by the FDA, but which have not yet been reviewed by the **Aetna** Health Pharmacy Management Department and Therapeutics Committee.

- **Aetna** has the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to section 8.14, *If a Claim Is Denied*.

- The number of **copayments** and/or **deductibles** you are responsible for per vial of Depo-Provera, an injectable contraceptive, or similar type contraceptive dispensed for more than a 30 day supply, will be based on the 90 day supply level. Coverage is limited to a maximum of 5 vials per **benefit year**.

3.6.14. Pharmacy Benefit Exclusions

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

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

1. Administration or injection of any drug.

2. Allergy sera and extracts.

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

4. Any drugs or medications, listed on the Aetna current year *Exclusion Drug List.*

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

6. Over-the-counter contraceptive supplies except as provided under section 3.6.12, *Other Covered Expenses - Preventive Care Drugs and Supplements*, including but not limited to:

    - condoms

- contraceptive foams
- jellies
- ointments
- services associated with the prescribing, monitoring and/or administration of contraceptives.

7. Compounded medications that do not contain at least one prescription ingredient that is FDA approved for medical use in the United States. This includes compounded medications formulated from any drug coded as over-the-counter, and any drugs coded as a pharmaceutical aid, such as bulk chemical.

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

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

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

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

    - Sildenafil citrate
    - Phentolamine
    - Apomorphine

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

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

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

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

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

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

15. Drugs used for the treatment of obesity.

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

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

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

    - have been granted treatment investigational new drug (IND), or group c/treatment IND status; or
    - are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and

Aetna determines, based on available scientific evidence, are effective or show promise of being effective for the **illness**.

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

20. Implantable drugs and associated devices.

21. Injectables:

- Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by the medical benefit portion of the **medical plan**.

- Needles and syringes, except for needles and syringes for injectable insulin and other injectable drugs covered by the **medical plan**.

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

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

24. Prescription drug or medication that is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product.

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

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

27. Prophylactic drugs for travel.

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

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

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

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

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

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

34. Any drug or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or change the shape or appearance of a sex organ.

35. Supplies, devices or equipment of any type.

36. Test agents except diabetic test agents.

3.7. MEDICAL BENEFIT EXCLUSIONS

Not every medical service or supply is covered by the **medical plan**, even if prescribed, recommended, or approved by your **provider**. The **medical plan** covers only those services and supplies that are **medically necessary** and included under section 3.5, *Covered Medical Expenses*, or section 3.6, *Your Prescription Drug Benefits*. The exclusions listed below apply to all coverage under the **medical plan**. Additional exclusions apply to specific **prescription drug** coverage under section 3.6.13, *Pharmacy Benefit Limitations* and section 3.6.14, *Pharmacy Benefit 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.

Charges made for the following are not covered except to the extent listed under section 3.5, *Covered Medical Expenses.*

1. Acupuncture, acupressure and acupuncture therapy.

2. Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.

3. Any charges in excess of the benefit, dollar, day, visit or supply limits stated in the **medical plan**.

4. Any non-**emergency** charges incurred outside of the United States if you traveled to such location to obtain medical services, **prescription drugs**, or supplies, even if otherwise covered under the **medical plan**. This also includes **prescription drugs** or supplies if:

   - such **prescription drugs** or supplies are unavailable or illegal in the United States; or

   - the purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

5. Applied Behavioral Analysis, the LEAP, TEACCH, Denver and Rutgers programs.

6. Behavioral health services:

   - Treatment of a covered health care **provider** who specializes in the mental health care field and who receives treatment as a part of their training in that field.

   - Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.

   - Treatment of antisocial personality disorder.

   - Treatment in wilderness programs or other similar programs.

   - Treatment of mental retardation, defects, and deficiencies.

   - Alcoholism or **substance abuse** rehabilitation treatment on an inpatient or outpatient basis.

7. Charges for a service or supply furnished by a **network provider** in excess of the **negotiated charge**.

8. Charges for a service of supply furnished by an out-of-**network provider** or for **other health care** in excess of the **recognized charge**.

9. Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the **medical plan**.

10. Charges submitted for services by an unlicensed **hospital**, **physician** or other **provider** or not within the scope of the **provider's** license.

11. **Cosmetic** services and plastic surgery except as may be provided under section 14.10, *Statement of Rights Under the Women's Health and Cancer Rights Act of*

1998; any treatment, surgery (**cosmetic** or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:

- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, **cosmetic** eyelid surgery, and other surgical procedures.

- Procedures to remove healthy cartilage or bone from the nose (or other part of the body).

- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin.

- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when **medically necessary**.

- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy).

- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices.

- Surgery to correct Gynecomastia.

- Breast augmentation.

- Otoplasty.

12. Counseling services and treatment by a marriage, religious, family, career, social adjustment, pastoral, or financial counselor.

13. Court ordered services, including those required as a condition of parole or release.

14. Custodial care.

15. Dental services covered under the **dental plan**.

16. Drugs, medications and supplies:

- Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a **prescription,** including vitamins.

- Any services related to the dispensing, injection or application of a drug.

- Any **prescription drug** purchased illegally outside the United States, even if otherwise covered under the **medical plan** within the United States.
- Immunizations related to work.
- Needles, syringes and other injectable aids, except as covered for diabetic supplies.
- Drugs related to the treatment of non-**covered expenses**.
- Performance enhancing steroids.
- Injectable drugs if an alternative oral drug is available.
- Outpatient **prescription drugs**.
- **Self-injectable drugs** and medications.
- Any expenses for **prescription drugs**, and supplies covered under the pharmacy benefit portion of the **medical plan**.
- Charges for any **prescription drug** for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

17. Educational services:

- Education, training and **room and board** while confined to an institution which is primarily a school or other institution for training.
- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs.
- Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause.
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.
- Services or supplies which any school system is legally required to provide.

18. Any health examinations required:

- By a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement or by any law of a government.

- For securing insurance, school admissions or professional or other licenses, to travel, or to attend a school, camp, or sporting event or participate in a sport or other recreational activity.

19. Any special medical reports not directly related to treatment except when provided as part of a covered service.

20. Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies.

21. **Experimental or investigational** drugs, devices, treatments or procedures.

22. Facility charges for care services or supplies provided in:

    - Rest homes
    - Assisted living facilities
    - Similar institutions serving as an individual's primary residence or providing primarily **custodial care** or rest care
    - Health resorts
    - Spas, sanitariums
    - Infirmaries at schools, colleges, or camps

23. Any food item, including infant formulas, nutritional supplements, vitamins, including **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

24. Any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:

    - Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes.
    - Shoes (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an **illness** or **injury**.

25. Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

26. Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:

    - Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds, and swimming pools.

    - Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices.

    - Equipment or supplies to aid sleeping or sitting, including non-**hospital** electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs.

    - Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature.

    - Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring.

    - Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your **illness** or **injury**.

    - Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or illness.

    - Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

27. Hearing services that do not meet professional standards; hearing exams given during a **stay** in a **hospital** or other facility; replacement parts or repairs for a hearing aid; and any tests, appliances and devices for the improvement of hearing (including hearing aids and amplifiers); or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech.

28. Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

29. Any services, treatments, procedures, or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:

    - Drugs related to the treatment of non-covered benefits.

- Injectable **infertility** medications including but not limited to, menotropins, hCG, GnRH agonists, and IVIG.

- Artificial insemination.

- Any advanced reproductive technology (ART) procedures or services related to such procedures including but not limited to, in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), and intra-cytoplasmic sperm injection (ICSI).

- Artificial insemination for covered females attempting to become pregnant who are not **infertile**.

- **Infertility** services for couples in which one of the partners has had a previous sterilization procedure, with or without surgical reversal.

- Procedures, services and supplies to reverse voluntary sterilization.

- **Infertility** services for females with FSH levels 19 or greater mIU/ml on day three of the menstrual cycle.

- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to, fees for laboratory tests.

- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (*e.g.*, office, **hospital**, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges.

- Home ovulation prediction kits or home pregnancy tests.

- Any charges associated with care required to obtain ART Services (*e.g.*, office, **hospital**, ultrasounds, laboratory tests), and any charges associated with obtaining sperm for any ART procedures.

- Ovulation induction and intrauterine insemination services if you are not **infertile**.

30. Maintenance care.

31. Payment for that portion of the charge for which Medicare or another party is the primary payer.

32. Miscellaneous charges for services or supplies including:

- Annual or other charges to be in a **physician's** practice.
- Charges to have preferred access to a **physician's** services such as boutique or concierge **physician** practices.
- Cancelled or missed appointment charges or charges to complete claim forms.
- Charges the recipient has no legal obligation to pay.
- Charges that would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions
  - Care for conditions related to current or previous military service
  - Care while in the custody of a governmental authority
  - Any care a public **hospital** or other facility is required to provide
  - Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

33. Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities).

34. Non-**medically necessary** services, including but not limited to, those treatments, services, **prescription drugs** and supplies which are not **medically necessary**, as determined by **Aetna**, for the diagnosis and treatment of **illness**, **injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

35. Any service or supply primarily for your convenience and personal comfort or that of a third party, including: telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

36. Private duty nursing during your **stay** in a **hospital**, and outpatient private duty nursing services.

37. Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:
    - Surgical procedures to alter the appearance or function of the body.
    - Prosthetic devices.

38. Services provided by a **spouse**, parent, **child**, brother, sister, in-law, or any household member.

39. Services of a resident **physician** or intern rendered in that capacity.

40. Services provided where there is no evidence of pathology, dysfunction, or disease, except as specifically provided in connection with covered routine care and cancer screenings.

41. Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

    - Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ.

    - Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

42. Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under section 9, *Consolidated Omnibus Budget Reconciliation Act* (*COBRA) and Extended Health Coverage*.

43. Services that are not covered under the **medical plan**.

44. Services and supplies provided in connection with treatment or care that is not covered under the **medical plan**.

45. Speech therapy for treatment of delays in speech development. For example, the **medical plan** does not cover therapy when it is used to improve speech skills that have not fully developed.

46. Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:

    - Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching.

    - Drugs or preparations to enhance strength, performance, or endurance.

    - Treatments, services and supplies to treat **illnesses**, **injuries** or disabilities related to the use of performance-enhancing drugs or preparations.

47. Therapies for the treatment of delays in development, unless resulting from acute **illness** or **injury.** Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

48. Any of the following treatments or procedures:

- Aromatherapy
- Bio-feedback and bioenergetic therapy
- Carbon dioxide therapy
- Chelation therapy (except for heavy metal poisoning)
- Educational therapy
- Gastric irrigation
- Hair analysis
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds
- Hypnosis, and hypnotherapy, except when performed by a **physician** as a form of anesthesia in connection with covered surgery
- Lovaas therapy
- Massage therapy
- Megavitamin therapy
- Primal therapy
- Psychodrama
- Purging
- Recreational therapy
- Rolfing
- Sensory or auditory integration therapy
- Sleep therapy
- Thermograms and thermography

49. Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum.

50. The following charges related to transplant coverage:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence.
- Services and supplies furnished to a donor when recipient is not a **covered person**.
- Home infusion therapy after the transplant occurrence.
- Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing **illness**.
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing **illness**.
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise **precertified** by **Aetna**.

51. Transportation costs, including **ambulance** services, for routine transportation to receive outpatient or inpatient services.

52. Vision services covered under the **vision plan**.

53. Any **illness** or **injury** related to employment or self-employment including any **illness** or **injury** that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or Federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular **illness** or **injury** under such law, that **illness** or **injury** will be considered "non-occupational" regardless of cause.

54. Spinal disorders, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine, including manipulation of the spine treatment.

55. Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of co-morbid conditions, including but not limited to:

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical procedures, medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including morbid obesity.

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

- Counseling, coaching, training, hypnosis or other forms of therapy.

- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

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

3.8. INDIVIDUAL CASE MANAGEMENT

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

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

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

Examples of conditions that may qualify for ICM include:

- 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
- **Illness** or **injury** requiring substantial medical resources over a long period of time or those where another cost-effective alternative may be implemented.

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

4. *Dental Plan*

4.1. INTRODUCTION

There are two options available under the **dental plan**: preventive and standard. The **coinsurance** amount is different with each option. See section 2.2, *Dental Benefit Schedule*, for details about how these items differ between the options. You elect which option under the **dental plan** you want for you and your **dependents**.

4.2. HOW DENTAL BENEFITS ARE PAID

4.2.1. Deductible

Each **covered person** must meet the annual individual **deductible** before the **dental plan** begins to pay benefits for that **covered person**. The **deductible** is waived for Class I preventive services under the standard plan. See section 2.2, *Dental Benefit Schedule*.

4.2.2. Coinsurance

After you satisfy the annual individual **deductible**, the **dental plan** pays the **coinsurance** amount that applies to you for Class II restorative services and Class III prosthetic services depending on the dental option in which you are enrolled for most **covered expenses**. See section 2.2, *Dental Benefit Schedule*.

4.2.3. Network and Out-of-Network Coverage

You can directly access any network or out-of-network **dentist** or **dental care provider** for covered services and supplies under the **dental plan**. The **dental plan** pays differently when services and supplies are obtained through **network providers** and out-of-**network providers**. **Network providers** have contracted with **Delta Dental** either directly or through a third party to provide

services and supplies under the **dental plan**. **Network providers** are identified in **Delta Dental's** directory, which can be found online at www.deltadentalak.com.

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

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

4.2.4. Availability of Providers

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

4.2.5. Recognized Charge

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

4.2.6. Annual Maximum

The **dental plan** pays **covered expenses** up to an annual individual maximum for each **covered person**. See section 2.2, *Dental Benefit Schedule.*

4.3. COVERED DENTAL SERVICES

The preventive plan covers Class I preventive, Class II restorative, and Class III prosthetic services. The standard plan covers Class I preventive, Class II restorative, and Class III prosthetic services, as well as orthodontic services. This section describes the services covered in each class when performed by a **dentist** or **dental care provider** and when determined to be **dentally necessary**.

4.3.1. Class I Preventive Services

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

a. Diagnostic Services and Limitations

Services:

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

Limitations:

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

b. Preventive Services and Limitations

Services:

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

Limitations:

- **Prophylaxis** (cleaning) or **periodontal maintenance** is covered up to two times in any benefit year. Additional cleaning benefits

may be available if **medically necessary** or **dentally necessary** and when precertified by **Delta Dental.** Additional cleaning benefits are available for **covered persons** with diabetes and covered **persons** in their third trimester of pregnancy under the **dental plan's** Oral Health, Total Health program (see section 4.4, *Oral Health, Total Health Program and Benefits*).

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

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

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

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

4.3.2. Class II Restorative Services

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

a. Restorative Services and Limitations

Services: Fillings on teeth for the treatment of decay.

Limitations:

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

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

- Additional limitations when teeth are restored with crowns or **cast restorations** are in section 4.3.3, *Class III Prosthetic Services.*

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

b. Oral Surgery Services and Limitations

Services:

- Extractions (including surgical).
- Other minor surgical procedures.

Limitations:

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

c. Endodontic Services and Limitations

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

Limitations:

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

d. Periodontic Services and Limitations

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

Limitations:

- Periodontal scaling and root planing is limited to once per quadrant in any 24-month period.

- Coverage for **periodontal maintenance** procedure under Class I, Preventive.

- A separate charge for post-operative care done within 3 months following periodontal surgery is not covered.

- Full mouth **debridement** is limited to once in a 2-year period for members under age 19. For members age 19 and over, full mouth debridement is limited to once in a 2-year period only if there has been no cleaning (**prophylaxis**, **periodontal maintenance**) within 24 months.

e. Anesthesia Services

- General anesthesia or IV sedation in conjunction with a covered surgical procedure performed in a dental office.

- General anesthesia or IV sedation when necessary due to concurrent medical conditions.

4.3.3. Class III Prosthetic Services

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

a. Restorative Services and Limitations

Services: **Cast restorations**, such as crowns, onlays or lab **veneers**, necessary to restore decayed or **broken** teeth to a state of functional acceptability.

Limitations:

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

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

b. Prosthodontic Services and Limitations

Services:

- **Bridges.**

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

Limitations:

- A **bridge** or denture (full or partial denture) will be covered once in a seven year period and only if the tooth, tooth site, or teeth involved have not received a **cast restoration** benefit in the last seven years.
- Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
- Partial dentures: A temporary (interim) partial denture is only a benefit when placed within two months of the extraction of an **anterior** tooth or for missing **anterior** permanent teeth of **covered persons** age 16 or under. If a specialized or precision device is used, **covered expense** will be limited to the cost of a standard cast partial denture. No payment is provided for **cast restorations** for partial denture **retainer** teeth unless the tooth requires a **cast restoration** due to decayed or **broken** teeth.
- Denture adjustments, repairs, and **relines**: A separate, additional charge for denture adjustments, repairs, and **relines** done within six months after the initial placement is not covered. Subsequent **relines** will be covered once per denture in a 12-month period. Subsequent adjustments are limited to two adjustments per denture in a 12-month period.
- Tissue conditioning is covered no more than twice per denture in a 36-month period.
- Surgical placement and removal of **implants** are covered. **Implant** placement and **implant** removal are limited to once per lifetime per tooth space. The **dental plan** will also cover:
  - The final crown and **implant abutment** over a single **implant**. This benefit is limited to once per tooth or tooth space over the lifetime of the **implant**; or

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

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

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

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

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

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

c. Other Services and Limitations

Services: Athletic mouthguard.

Limitations:

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

4.3.4. General Limitation – Optional Services

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

4.4. ORAL HEALTH, TOTAL HEALTH PROGRAM AND BENEFITS

The **dental plan** covers additional cleanings (**prophylaxis** or **periodontal maintenance**) for certain **covered persons**. This benefit is for the cleaning only. Coverage for a routine exam and other services is subject to the frequency limitations outlined in section 4.3, *Covered Dental Services*. Please contact Delta Dental for enrollment instructions.

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

- **Diabetics**

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

- **Pregnant Persons**

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

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

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

4.5. ORTHODONTIC BENEFITS AND LIMITS

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

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

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

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

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

4.6. DENTAL PLAN EXCLUSIONS

In addition to the limitations and exclusions described elsewhere in the **dental plan**, the following services, procedures and conditions are not covered, even if: (1) otherwise **dentally necessary**; (2) they relate to a condition that is otherwise covered by the **dental plan**; or (3) recommended, referred, or provided by a **dentist** or **dental care provider**.

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

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

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

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

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

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

7. **Cosmetic** services.

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

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

10. Gnathologic recordings.

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

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

13. Localized delivery of antimicrobial agents.

14. Missed appointment charges.

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

16. Periodontal charting.

17. Precision attachments.

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

19. Services on tongue, lip or cheek.

20. Services otherwise available, including:

    - Those compensable under workers' compensation or employer's liability laws.

    - Those provided by any city, county, state or Federal law, except for Medicaid coverage.

    - Those provided, without cost to the **covered person**, by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under the **dental plan**.

    - Any condition, disease, ailment, **injury** or diagnostic service to the extent that benefits are provided or would have been provided had the **covered person** enrolled, applied or maintained eligibility for such benefits under Title XVIII of the Social Security Act, as amended.

    - Those provided under separate contracts that are used to provide coordinated coverage for **covered persons** and are considered parts of the same plan.

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

22. Services and supplies for treatment of **illness** or **injury** for which a third party is or may be responsible to the extent of any recovery received from or on behalf of the third party. Includes benefits payable under any automobile medical, personal injury protection (PIP), automobile no fault, underinsured or uninsured, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to, or makes benefits available to, a **covered person**, whether or not such benefits are requested. See section 12, *Subrogation and Reimbursement Rights*.

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

24. Treatment after coverage terminates, except for Class III services that were ordered and fitted while still eligible, and then only if such items are cemented within 31 days after a **covered person's** eligibility ends. This provision is not applicable if the **Division** transfers the **dental plan** to another **claims administrator**.

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

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

4.7. ADVANCE CLAIM REVIEW FOR DENTAL CLAIMS

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

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

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

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

5. *Vision Plan*

5.1. INTRODUCTION

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

5.2. HOW VISION BENEFITS ARE PAID

5.2.1. Deductible

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

5.2.2. Copayment

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

5.2.3. Coinsurance

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

5.2.4. Annual Allowances

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

5.2.5. Network Providers

If you choose a **VSP doctor** or an **affiliated provider** under the **vision plan**, you will lower your out-of-pocket costs. See section 2.3, *Vision Benefit Schedule*. **VSP doctors** are located in retail, neighborhood, medical and professional settings, and include Costco Optical, Visionworks, Cohen's Fashion Optical, Wisconsin Vision, and RX Optical. You have the freedom to choose any **provider**, national retailer, or local retail chain.

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

5.3. COVERED VISION SERVICES

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

5.3.1. Vision Exam

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

5.3.2. Vision Supplies

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

- **Prescription Lenses**

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

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

- **Frames**

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

  Some brands of spectacle frames may be unavailable for purchase under the **vision plan**, or may be subject to additional limitations. **Covered persons** may obtain details regarding frame brand availability from their **VSP doctor** or by calling **VSP** at the number in the front of the **plan**.

- **Additional Services**

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

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

- **Contact Lenses**

  Elective contact lenses are available once every calendar year in lieu of all other lens and frame benefits under the **vision plan**. Prior approval by **VSP** is not required for **covered persons** to be eligible for contact lenses.

- **Low Vision Benefit**

  The low vision benefit is available to **covered persons** who have severe visual problems that are not correctable with regular lenses. The **vision plan** covers complete low vision analysis and diagnosis, which includes a comprehensive examination of visual functions, and the **prescription** of corrective eyewear or vision aids where indicated. Supplemental care aids are also covered.

5.4. VISION PLAN EXCLUSIONS

The **vision plan** is designed to cover visual needs rather than **cosmetic** materials. When the **covered person** selects any of the following extras, the **vision plan** will pay the basic cost of the allowed lenses or frames, and the **covered person** will pay the additional costs for the options:

- Optional **cosmetic** processes
- Color coating
- Mirror coating
- Blended lenses
- **Cosmetic** lenses

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

The following services, procedures and conditions are not covered under the **vision plan**, even if: (1) they relate to a condition that is otherwise covered by the **vision plan**; or (2) they are recommended, referred or provided by a **VSP doctor**.

1. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ± .50 diopter power); or two pair of glasses in lieu of bifocals.
2. Replacement of lenses and frames furnished under the **vision plan** which are lost or broken, except at the normal intervals when services are otherwise available.
3. Medical or surgical treatment of the eyes or services covered under the **medical plan**.
4. Corrective vision treatment that is **experimental or investigational**.
5. Costs for services and/or materials above the **vision plan** allowance.
6. Services and/or materials not listed as covered services in section 5.3, *Covered Vision Services.*
7. Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the **vision plan.**
8. Charges submitted for services by an unlicensed **provider** or not within the scope of the **provider's** license.
9. Services provided by a **spouse,** parent, **child,** brother, sister, in-law, or any household member.
10. Services rendered before the effective date or after the termination of coverage, unless coverage is continued under section 9, *Consolidated Omnibus Budget Reconciliation Act (COBRA) and Extended Health Coverage.*

VSP may, at its discretion, waive any of these limitations if, in the opinion of **VSP's** optometric consultants, it is necessary for the visual welfare of the **covered person**.

6. *Health Flexible Spending Account (HFSA)*

6.1. INTRODUCTION

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

6.2. HOW THE HFSA WORKS

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

Coverage begins and ends as specified in section 1.7, *When Coverage Begins*, and section 1.9, *When Coverage Ends*. The maximum amount that you may elect to have contributed to your HFSA is determined annually by the Internal Revenue Service (IRS). The amount of contribution you elect will be deducted from your paycheck in equal amounts throughout the **benefit year**. You decide how much you want to contribute to the HFSA, up to the maximum annual amount determined by the IRS. Your contribution must be:

- in whole dollars; and
- at least $20 per month ($240 per benefit year).

Federal income taxes are not withheld on the amount you contribute. If you are on leave without pay or do not have enough payroll in a month, a contribution will not be taken that month.

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

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

Expenses are considered to have been incurred when you (or your **dependents**) are provided with the care—not when you are billed, charged or pay for it.

You have until the last day of the **benefit year** to incur expenses for reimbursement in your HFSA.

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

6.3. CARRYOVER OF UNUSED AMOUNTS IN HFSA

If you have a balance remaining in your HFSA at the end of the **benefit year**, an amount will be carried over to the immediately following **benefit year** equal to the lesser of (1) $500 or (2) the amount remaining in your HFSA after all of your eligible medical expenses submitted during the **benefit year** or within the run-out period have been reimbursed. The run-out period is the 90 day period following the end of the **benefit year** (March 31). This amount is called the "available carryover amount." Any unused amount in excess of $500 will be forfeited as provided in Section 6.4.

The available carryover amount does not reduce the maximum amount that you may elect to contribute to your HFSA for a **benefit year.**

> **EXAMPLE:** You elect to have $2,592 contributed to your HFSA for the 2017 benefit year and $2,640 for the 2018 benefit year. On December 31, 2017, you have an unused HFSA balance of $800. On February 1, 2018, you submit a claim of $350 for eligible medical expenses incurred in 2017. On March 31, 2018 (the last day of the run-out period) you have an available carryover amount of $450 ($800 - $350). As a result, you have $3,090 for which you may submit claims for the remainder of 2018 ($450 carryover + $2,640 for the 2018 election). For the remainder of 2018 you submit claims in the amount of $2,700, leaving an unused balance of $390 on December 31, 2018. This amount may be carried forward to pay 2019 expenses, to the extent not depleted during the run-out period.
>
> **EXAMPLE:** Assume the same facts as above, except that you did not submit claims for eligible medical expenses incurred in 2017 during the run-out period. In that case, you would have an available carryover amount of $500 for 2018, which is the lesser of $500 and the amount remaining at the end of the run-out period ($800). The excess amount above $500 would be forfeited. You will then have $3,140 for which you may submit claims for the remainder of 2018 ($500 carryover + $2,640 for the 2018 election.) For the remainder of 2018, you submit claims in the amount of $2,700, leaving an unused balance of $440 on December 31, 2018. This amount may be carried forward to pay 2019 expenses, to the extent not depleted during the run-out period.

Your available carryover amount, if any, will generally carry forward year to year.

6.4. USE IT OR LOSE IT

In exchange for the tax advantages of using the health flexible spending account (HFSA), the Internal Revenue Service (IRS) requires that you forfeit any money in excess of $500 remaining in your reimbursement account after all eligible medical expenses for the **benefit year** have been reimbursed. You must request reimbursement for expenses incurred during the **benefit year** no later than 90 days following the end of the **benefit year** (by March 31). Because of this use it or lose it rule, it is important that you plan carefully when you participate in the HFSA.

6.5. ELIGIBLE MEDICAL EXPENSES

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

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

Examples of eligible medical expenses include:

- **custodial care** expenses
- hearing aids
- **deductibles**
- **copayments**
- **coinsurance**
- amounts in excess of the maximums allowed by the **medical plan**, **dental plan**, or **vision plan**
- insulin (whether or not prescribed)
- **prescription drugs**
- over-the-counter drugs, but only if you have a **prescription**

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

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

6.6. HFSA VS. TAX DEDUCTIONS

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

6.7. HOW MUCH TO CONTRIBUTE

The health flexible spending account (HFSA) can save you money if you budget your expenses carefully. Keep in mind that you must forfeit any money in excess of $500 remaining in your reimbursement account at the end of the **benefit year** after all eligible medical expenses have been paid. Most **employees** find, however, that they can avoid the risk of forfeiture by planning ahead.

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

- What expenses you may have that are not covered by the plan but are reimbursable from the HFSA;
- How much your deductibles are expected to be for the benefit year;
- An estimate of the total out-of-pocket costs you could pay under the plan;
- An estimate of what your coinsurance and copayments will total; and

- How much you paid for health care costs during the last benefit year. For example, if your out-of-pocket health care costs were $500 during the last benefit year, they may run close to that this year.

Remember, any amount remaining in your HFSA at the end of the year that exceeds $500 will be forfeited.

6.8. SUBMITTING CLAIMS FOR REIMBURSEMENT

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

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

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

Reimbursements are issued daily. Checks are payable to you, not to your **provider**. Claims for services incurred during the **benefit year** will be accepted any time during that year. You have 90 days after the end of the **benefit year** (generally until March 31) to file all unpaid claims for that **benefit year**.

7. *Health Reimbursement Arrangement (HRA)*

7.1. INTRODUCTION

The Health Reimbursement Arrangement (HRA) is an employer-funded medical expense reimbursement account that **eligible employees** enrolled in the consumer choice plan may use to pay eligible medical expenses. High-deductible health plans like the consumer choice plan require employees to meet higher deductibles than traditional plans, so these plans have more out-of-pocket costs due at the time health care services are rendered. For **eligible employees** enrolled in the consumer choice plan, the employer will apply your available HRA balance towards your annual deductible for covered medical expenses.

7.2. HOW THE HRA WORKS

You must be enrolled in the consumer choice plan in order to participate in your HRA.

When you, or your eligible dependent, receive medical services or supplies covered under the medical plan, the expense will be covered by your HRA in the amount of your balance in the HRA or the amount of the allowable claim, whichever is less. The expenses covered by the HRA will reduce your deductible by a corresponding amount for that benefit year. Once the HRA is exhausted, you will be responsible for any remaining deductible before any additional benefits are payable under the medical plan.

7.3. CARRYOVER OF UNUSED AMOUNTS IN HRA

If you have a balance remaining in your HRA at the end of the **benefit year**, that balance will be carried over to the immediately following **benefit year**. Unused amounts will not carry forward more than one year, and in no instance will the HRA balance be greater than the balance of current and preceding benefit year contribution.

> **EXAMPLE:** You enroll in the consumer choice plan for yourself and your family effective January 1, 2018. Your employer contributes $1,500 to your family HRA balance for the 2018 benefit year. You and your eligible dependents receive only preventive services in the 2018 benefit year, and as a result your HRA balance on December 31, 2018 is $1,500. As of January 1, 2019, you have an unused HRA balance of $3,000, including the 2018 rollover and a new employer contribution of $1,500 for the 2019 benefit year. In the 2019 benefit year, you and your family receive $500 in non-preventive covered medical expenses. Your HRA balance on December 31, 2019 is $2,500. Only $1,500 is eligible to be rolled over to the 2020 benefit year.

7.4. USE IT OR LOSE IT

Coverage begins as specified in section 1.7, *When Coverage Begins*. The current year HRA and the allowable carryover HRA balance is yours to use until the balance is exhausted, or until your coverage ends as specified in section 1.9, *When Coverage Ends*. In addition, should you change plans to a plan other than the consumer choice plan during an annual open enrollment, or mid-year due to a qualified status change or other applicable event, your unused HRA balance is forfeit on the day your coverage under the new plan takes effect.

8. *How to File a Claim*

8.1. FILING HEALTH CLAIMS

Under the Plan, you may file claims for Plan benefits and appeal adverse claim determinations. Any reference to "you" in this How to File a Claim section includes you and your Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative. You may obtain claims forms from the **claims administrator**, the **Division**, or www.AlaskaCare.gov.

8.2. CLAIM FILING DEADLINE

To receive benefits, you must submit a claim within 90 days after treatment began, or within 30 days after treatment ends, whichever is later. **Network providers** will submit claims on your behalf. If you are unable to meet the deadline for filing the claim, your claim will be accepted if you file as soon as possible, but not later than 12 months after the date you incurred the expenses.

8.3. HOSPITAL SERVICES

Your health care coverage is good worldwide. If you are hospitalized in a licensed, general **hospital** anywhere, even outside Alaska, you can use your **hospital** benefits.

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

8.4. PHYSICIAN AND OTHER PROVIDER SERVICES

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

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

The itemized bill must include:

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

8.5. DENTAL SERVICES

You can get a *Dental Benefits Claim* form from your **provide**r, the **Division**, **Delta Dental**, or www.AlaskaCare.gov. Follow the instructions under section 8.4, *Physician and Other Provider Services*, for completing the form.

8.6. VISION SERVICES

You can get a *Vision Benefits Claim* form from your **provider**, the **Division**, **VSP**, or www.vsp.com. Follow the instructions under section 8.4, *Physician and Other Provider Services*, for completing the form.

8.7. PRESCRIPTION DRUGS

No claim filing is necessary if you obtain your drugs from a **network pharmacy**.

If you do not use a **network pharmacy**, be sure to obtain a receipt from the pharmacist. Cash register receipts are not acceptable. Medicines that do not require a **prescription** are not covered. Send the receipt with a medical claim form to **Aetna**. You can get these forms from the **Division**, **Aetna**, or www.AlaskaCare.gov.

The receipt must include the:

- Patient's name

- Date of purchase
- Prescription number
- Itemized purchase price for each drug
- Quantity
- Day supply
- Name of drug
- Name of **pharmacy**

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

If your prescription drug is denied for coverage at the pharmacy (point of sale), you may either:

- Pay for the prescription drug and **appeal** the **denial** of coverage at the point of sale by filing a *Medical Benefits Request* form with **Aetna**. You can get this form from the **Division**, **Aetna**, or www.AlaskaCare.gov.
- Delay filling the prescription and **appeal** the **denial** of coverage at the point of sale by filing a *Member Complaint and Appeal* form. You can get this form from the **Division**, **Aetna**, or www.AlaskaCare.gov.

8.8. MEDICAL BENEFITS

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

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

8.9. OTHER CLAIM FILING TIPS

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

If you have other health coverage in addition to the health **plan**, you should submit your claims to the primary plan first. Then send a copy of the claim and the *EOB* form from the primary plan to the secondary plan so that benefits will be coordinated properly between plans. See section 11, *Coordination of Benefits,* for information on how to determine which plan is primary.

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

8.10. BENEFIT PAYMENTS

If you have not paid the **provider** and you include the **provider's** name, address and tax identification number, the **claims administrator** will pay the **provider** directly. If you have already paid the **provider** and this fact is clearly shown on the claim form, the **claims administrator** will send the benefit check to you along with the *EOB* form.

8.11. BEFORE FILING A CLAIM

When you file a claim:

- Submit your bills with a claim form for each family member.
- Always check to make sure your **physician** or **dentist** has not already submitted your claim. If you give the **physician** or **dentist** permission to submit a claim, do not submit one yourself.

Complete the claim form fully and include information on any other group health care programs covering you and your **dependents**. If you have other coverage which should pay first before this **plan**, include a copy of that plan's explanation of benefits showing the amount it paid for the services.

8.12. RECORDKEEPING

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

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

You should also keep all *EOB* forms sent to you.

8.13. PHYSICAL EXAMINATIONS

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

8.14. IF A CLAIM IS DENIED

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8.14.1. Initial Claim for Benefits

Any claim to receive benefits under the **plan** must be filed with the **claims administrator** on the designated form as soon as possible, but no later than 12 months after the date you incurred the expenses, and will be deemed filed upon receipt.

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

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

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

8.14.2. Initial Review of Claims

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

- orally (unless you request written notice) of the additional information needed to decide the initial claim, not later than 24 hours after the receipt of the incomplete claim by the **claims administrator** for **urgent care claims**;

- in writing no later than fifteen calendar days after the receipt of the incomplete claim by the **claims administrator** for **pre-service claims**; or

- in writing no later than thirty calendar days after the receipt of the incomplete claim by the **claims administrator** for **post-service claims**.

For **urgent care claims** you must submit the additional information not less than 48 hours after the receipt of the notice from the **claims administrator**. For pre-service or post-service incomplete claims, the **claims administrator** may or may not allow an extension to the claims filing deadline, of up to 45 calendar days from receipt of the written notice, for you to provide additional information.

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

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

- within 72 hours after receipt of claim by the **claims administrator** for **urgent care claims**;

- no later than 15 calendar days after receipt of claim by the **claims administrator** for **pre-service claims**; or

- no later than 30 calendar days after the receipt of claim by the **claims administrator** for **post-service claims**.

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

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

8.14.3. Initial Denial of Claims

If your claim for benefits is denied in whole or in part, you will be given notice from the **claims administrator** that explains the following items:

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

request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- the **denial** code and its corresponding meaning, as well as a description of the **claims administrator's** standard, if any, that was used in the **denial** of the claim; and

- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist individuals with the internal claims and appeals and external review processes.

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

If you believe your claim should be covered under the terms of the **plan**, you should contact the **claims administrator** to discuss the reason for the **denial.** If you still feel the claim should be covered under the terms of the **plan,** you can take the following steps to file an **appeal**.

8.14.4. Ongoing Treatments

If the **claims administrator** has approved an ongoing course of treatment to be provided to you over a certain period of time or for a certain number of treatments, any reduction or termination by the **claims administrator** under such course of treatment before the approved period of time or number of treatments end will constitute a **denial**. You will be notified of the **denial**, in accordance with the timelines outlined in section 8.14.2, *Initial Review of Claims*, before the reduction or termination occurs, to allow you a reasonable time to file an **appeal** and obtain a determination on the **appeal**. Coverage for the ongoing course of treatment that is the subject of the **appeal** will continue pending the outcome of such **appeal**.

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

8.14.5. First Level Appeal of Initial Denial of Claim

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

claims, you may make a request for an expedited **appeal** orally or in writing, and all necessary information will be transmitted by telephone, facsimile, or other similarly expeditious method.

8.14.6. Decision on First Level of Appeal of Initial Denial of Claim

If appealing a **pre-service claim denial** that is not eligible for external review as outlined in section 8.14.9, *Application and Scope of External Review Process for Benefits Under the Medical Plan and Dental Plan*, you will receive notice of the **claims administrator's** decision on the first level of **appeal** within 15 calendar days of the claims administrator's receipt of your appeal. If appealing a **pre-service claim denial** that is eligible for external review, you will receive notice of the **claim administrator**'s decision on the first level of **appeal** within 30 calendar days of the **claim administrator**'s receipt of your **appeal**.

If appealing a **post-service claim denial** that is not eligible for external review as outlined in section 8.14.9, *Application and Scope of External Review Process for Benefits Under the Medical Plan and Dental Plan*, you will receive notice of the **claim administrator**'s decision on the first level of **appeal** within 30 calendar days after the **claims administrator**'s receipt of your **appeal**. If appealing a **post-service claim denial** that is eligible for external review, you will receive notice of the **claim administrator**'s decision on the first level of **appeal** within 60 calendar days after the **claims administrator**'s receipt of your **appeal**.

If the claim is denied on appeal, with respect to claims for benefits under the **plan,** the **claims administrator** will provide you with the following information free of charge as soon as possible and sufficiently in advance of the date on which the notice of **denial** is required to be provided to you that you have a reasonable opportunity to respond prior to that date:

- any new or additional evidence considered, relied upon, or generated by the **claims administrator** (or at the direction of the **claims administrator**) in connection with the claim; and

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

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

- The specific reasons for the **denial.**

- References to applicable **plan** provisions upon which the **denial** is based.

- A description of the review procedures and time limits, including information regarding how to initiate a second level **appeal**, and information on the external review process (with respect to benefits under the **medical plan** and **dental plan**).

- The specific internal rule, guideline, protocol, or other similar criterion, if any, relied upon in making the **denial**, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon, with a copy free of charge upon request.

- If the **denial** is based on a **medical necessity** or an **experimental or investigational** treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

- For **denials** of benefits under the **medical plan** and **dental plan**,

  - information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning),

  - the **denial** code and its corresponding meaning, as well as a description of the **claims administrator**'s standard, if any, that was used in the **denial** of the claim; and

  - the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist individuals with the internal claims and **appeals** and external review process.

- If the **denial** is a **final denial** under the plan, a discussion of the decision.

If a second level **appeal** is not available under Section 8.14.7, *Second Level Appeal of Denial of Claim*, the decision on the first level of **appeal** will be a **final denial,** that is final, conclusive, and binding on all persons, subject to external review under Section 8.14.9, *Application and Scope of External Review Process for Benefits Under the Medical Plan and Dental Plan.*

8.14.7. Second Level Appeal of Denial of Claim

You may initiate a second level of **appeal** of the **denial** of a claim, but only if the claim is not eligible for external review under section 8.14.9, *Application and Scope of External Review Process for Benefits Under the Medical Plan and*

Dental Plan, because it does not involve medical judgment or a **rescission** of coverage under the **medical plan** or the **dental plan**.

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

8.14.8. Decision on Second Level Appeal of Denial of Claim

The **claims administrator** will provide you with notice of its decision on the second level of **appeal** within 15 calendar days for **pre-service claim appeal**s or within 30 calendar days for **post-service claim appeal**s. If the claim is denied on the second level of **appeal**, the **claims administrator** will provide notice to you containing the information set forth in section 8.14.6, *Decision on First Level of Appeal of Claim Denial*. The decision on the second level of **appeal** will be a **final denial.**

8.14.9. Application and Scope of External Review Process for Benefits Under the Medical Plan and Dental Plan

Upon receipt of a **final denial** (including a deemed **final denial**) with respect to benefits under the **medical plan** or **dental plan**, you may apply for external review. Upon receipt of a **denial** with respect to benefits under the **medical plan** or **dental plan** that is not a **final denial**, you may only apply for external review as provided in section 8.14.11, *Expedited External Review Process for Medical Plan and Dental Plan.* The external review process will apply only to:

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

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

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

a. Timing of Request for External Review. You must file a request for external review of a benefit claim under the **medical plan** and **dental plan**

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

b. Preliminary Review. The **claims administrator** will complete a preliminary review of the request for external review within five business days to determine whether:

- you are or were covered under the applicable **medical plan** or **dental plan** at the time the covered service was requested or provided, as applicable;
- the type of claim is eligible for external review;
- you have exhausted (or are deemed to have exhausted) the **medical plan's** or **dental plan's** internal claims and **appeals** process; and
- you have provided all the information and forms required to process an external review.

The **claims administrator** will issue a notification to the claimant within one business day of completing the preliminary review. If the request is complete, but ineligible for external review, the notification will include the reasons for its ineligibility. If the request is not complete, the notification will describe the information or materials needed to make the request complete, and you will be allowed to perfect the request for external review by the later of the four month filing period described above, or within the 48 hour period following the receipt of the notification.

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

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

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

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

- Review all information and documents timely received under a *de novo* standard. This means the IRO will not be bound by any decisions or conclusions reached during the **claims administrator's** internal claims and **appeals** process. In addition to the information and documents provided, the IRO, to the extent the information and documents are available and the IRO considers them appropriate, will further consider the following in reaching a decision:

  - your medical records;

  - the attending **health care professional's** recommendation;

  - reports from appropriate **health care professionals** and other documents submitted by the **claims administrator**, you, or your **physician**;

  - the terms of the applicable **medical plan** or **dental plan** to ensure that the IRO's decision is not contrary to the terms of the **medical plan** or **dental plan**, unless the terms are inconsistent with applicable law;

  - appropriate practice guidelines, which must include applicable evidence-based standards and may include any

other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

- any applicable clinical review criteria developed and used by the **medical plan** or **dental plan**, unless the criteria are inconsistent with the terms of the **medical plan** or **dental plan** or with applicable law; and

- the opinion of the IRO's clinical reviewer(s) after considering the information described in this paragraph to the extent the information or documents are available and the clinical reviewer(s) consider appropriate.

d. Notice of Final External Review Decision. The IRO will provide written notice of its decision within 45 days after the IRO receives the request for external review. Such notice will be delivered to you and the **claims administrator** and will contain the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care **provider**, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous **denial**);

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

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

- a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied upon in making its decision;

- a statement that the determination is binding except to the extent that other remedies may be available under state or Federal law to the **medical plan**, **dental plan** or you;

- a statement that you may file an administrative **appeal** with the **Division**; and

- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

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

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

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

a. Application of Expedited External Review. You may make a request for expedited external review under the **medical plan** and **dental plan** at the time you receive either:

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

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

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

c. Referral to Independent Review Organization (IRO). Upon a determination that a request is eligible for expedited external review following the preliminary review, the **claims administrator** will assign an IRO pursuant to the requirements set forth above for standard external review. The **claims administrator** must provide or transmit all necessary documents and

information considered in making the **denial** or **final denial** determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard external review. In reaching a decision, the assigned IRO will review the claim *de novo,* meaning it is not bound by any decisions or conclusions reached during the **claims administrator's** internal claims and **appeals** process.

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

8.14.12. Third Level – Division of Retirement and Benefits Appeal

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

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

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

8.14.13. Fourth Level – Superior Court Appeal

If the claim is denied on the third level appeal, you will have the right to file an administrative appeal with the State of Alaska superior court. If you wish to appeal a decision under this section you must file a notice of appeal with the superior court within 30 days after the date that you receive notice of the denial on the third level appeal.

8.15. CLAIMS PROCEDURES APPLICABLE TO ALL CLAIMS

8.15.1. Authorized Representative

Your authorized representative may act on your behalf in pursuing a benefit claim or **appeal**, pursuant to reasonable procedures. In the case of an **urgent care claim**, a **health care professional** with knowledge of your medical condition will be permitted to act as your authorized representative.

8.15.2. Calculating Time Periods

The period of time within which an initial benefit determination or a determination on an **appeal** is required to be made will begin when a claim or **appeal** is filed regardless of whether the information necessary to make a determination accompanies the filing.

Solely for purposes of initial **pre-service claims** and **post-service claims**, if the time period for making the initial benefit determination is extended (in the **claims administrator's** discretion) because you failed to submit information necessary to decide the claim, the time period for making the determination will be suspended from the date notification of the extension is sent to you until the earlier of (1) the date on which response from you is received, or (2) the end of the time period given to you to provide the additional information, as set forth in the applicable section under 8.14, *If a Claim is Denied*.

8.15.3. Full and Fair Review

Upon request, and free of charge, you or your duly authorized representative will be given reasonable access to, and copies of, all documents, records, and other information relevant to your claim, or may submit to the appropriate person or entity written comments, documents, records, and other information relating to the claim. If timely requested, review of a denied claim will take into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim without regard to whether such information was submitted or considered in the initial benefit determination.

Appeals for health claims will be reviewed by an appropriate named fiduciary of the **plan** who is neither the individual nor subordinate of the individual who made the initial determination. The **claims administrator** will not give any weight to the initial determination, and, if the **appeal** is based, in whole or in part, on a medical judgment, the **claims administrator** will consult with an appropriate **health care professional** who is neither the individual nor subordinate of the individual who was consulted in connection with the initial determination. The **claims administrator** will identify any medical or vocational experts whose advice was obtained without regard to whether the advice was relied upon in making the benefit determination. In the case of two levels of **appeal**, the second level reviewer will not afford deference to the first level reviewer, nor will the second level reviewer be the same individual or the subordinate of the first level reviewer.

8.15.4. Exhaustion of Remedies

If you fail to file a request for review of a **denial**, in whole or in part, of benefits in accordance with the procedures herein outlined, you will have no right to review and no right to bring an action, at law or in equity, in any court and the **denial** of the claim will become final and binding on all persons for all purposes.

With respect to claims under the **medical plan** and **dental plan**, except as provided below, if the **claims administrator** fails to strictly adhere to all the requirements with respect to a claim under section 8.14, *If a Claim Is Denied*, and section 8.15, *Claims Procedures Applicable to All Claims*, you are deemed to have exhausted the internal claims and **appeals** process with respect to such claims. Accordingly, you may initiate an external review with respect to such claims as outlined in section 8.14, *If a Claim Is Denied*. You are also entitled to pursue any available remedies under State law, as applicable, with respect to such claims.

Notwithstanding the above, the internal claims and **appeals** process with respect to claims under the **medical plan** or **dental plan** will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you, so long as the **claims administrator** demonstrates that the violation was for good cause or due to matters beyond the control of the **claims administrator** and that the violation occurred in the context of an ongoing, good faith exchange of information between the **claims administrator** and you. This exception is not available if the violation is part of a pattern of violations by the **claims administrator**. You may request a written explanation of the violation from the **claims administrator**, and the **claims administrator** will provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the process outlined in sections 8.14, *If a Claim Is Denied*, and section 8.15, *Claims Procedures Applicable to All Claims*, to be deemed exhausted. If the IRO or a court rejects your request for immediate review due to deemed

exhaustion on the basis that the **claims administrator** met the standards for the exception described in this subsection, you will have the right to resubmit and pursue the internal **appeal** of the **medical plan** or **dental plan** claim. In such case, within a reasonable time after the IRO or court rejects the claim for immediate review (not to exceed 10 days), the **claims administrator** will provide you with notice of the opportunity to resubmit and pursue the internal **appeal** of the **medical plan** or **dental plan** claim. Time periods for re-filing the **medical plan** or **dental plan** claim will begin to run upon your receipt of such notice.

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

9.1. INTRODUCTION

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

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

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

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

9.2. RIGHT TO CONTINUATION COVERAGE

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

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

- an eligible employee;
- surviving dependents of peace officer and firefighters of the **State** whose bargaining unit or employee group participates in the **plan**, if the employee otherwise met the criteria as outlined under Alaska Statute 39.60.040, *Peace Officer and Firefighter Survivors' Fund*;
- a spouse; or
- a dependent child.

The right to continued coverage is triggered by a qualifying event, which, but for the continued coverage, would result in a loss of coverage under the **plan**. A "loss of coverage" includes ceasing to be covered under the same terms and conditions as in effect immediately before the qualifying event or an increase in the premium or contribution that must be paid by a **covered person**. Qualifying events include:

- Your death.
- The termination (other than by reason of gross misconduct) of your employment or reduction of your hours that would result in a termination of coverage under the **plan**.
- Your divorce or legal separation from your **spouse.**
- The surviving dependents of peace officer and firefighters who no longer qualify for premium payments as outlined under Alaska Statute 39.60.040, *Peace Officer and Firefighter Survivors' Fund*;
- Your becoming entitled to Medicare benefits under Title XVIII of the Social Security Act (42 USC § 1395-1395ggg).
- Your **child** ceasing to be a **dependent child** under the eligibility requirements of the **plan**.

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

9.3. ELECTION OF CONTINUATION COVERAGE

Continuation coverage does not begin unless it is elected by a qualified beneficiary. Each qualified beneficiary who loses coverage as a result of a qualifying event has an independent right to elect continuation coverage, regardless of whether any other qualified beneficiary with respect to the same qualifying event elects continuation coverage.

The election period begins on or before the date the qualified beneficiary would lose coverage under the **plan** due to the qualifying event, and ends on or before the date that is 60 days after the later of:

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

The election of continuation coverage must be made on a form provided by **PayFlex** and payment for coverage, as described in the notice, must be made when due. An election is considered to be made on the date it is sent to **PayFlex**.

9.4. PERIOD OF CONTINUATION COVERAGE

9.4.1. Termination of Employment or Reduction in Hours

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

9.4.2. Second Qualifying Event

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

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

9.4.3. Disability

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

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

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

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

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

9.4.4. Other Qualifying Events

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

9.4.5. Health Flexible Spending Account (HFSA)

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

9.4.6. Health Reimbursement Arrangement (HRA)

You have a right to choose to continue you HRA benefit on COBRA when coverage is lost due to a qualifying event. Coverage is extended only to those individuals covered at the time of termination and may only continue the same coverage that was in effect prior to termination. Your HRA plan is considered a bundled or integrated HRA plan, meaning it must be offered in conjunction with the consumer choice plan and can't be offered as a standalone plan. This means that a former covered employee or dependent of the consumer choice plan can only enroll in HRA COBRA if they elect consumer choice COBRA coverage. Premiums for HRA COBRA coverage are incorporated in the COBRA cost for the consumer choice plan.

9.5. END OF CONTINUATION COVERAGE

Continuation coverage will end upon the dates of the following occurrences, even if earlier than the periods specified under section 9.4, *Period of Continuation Coverage*.

- Timely payment of premiums for the continuation coverage is not made (including any grace periods).
- You first become covered under any other group health plan, after the date on which continuation coverage is elected, as an employee or otherwise, unless such other plan contains a limitation (other than a limitation which does not apply by virtue of HIPAA with respect to any pre-existing condition).
- You first become entitled to benefits under Medicare, after the date on which continuation coverage is elected.
- The **State** ceases to provide any group health plan to any **employee**.
- You cease to be disabled, if continuation coverage is due to the disability.

Notwithstanding the foregoing, the **plan** may also terminate the continuation coverage of a qualified beneficiary for cause on the same basis that it could terminate the coverage of a similarly situated non-COBRA beneficiary for cause (*e.g.*, in the case of submitting fraudulent claims to the **Division)**.

9.6. COST OF CONTINUATION COVERAGE

You are responsible for paying the cost of continuation coverage. The premiums are payable on a monthly basis. By law, premiums cannot exceed 102% of the full premium cost for such coverage (or 150% for any extended period of coverage due to disability). After a qualifying event, **PayFlex** will provide a notice with the amount of the premium, to whom the premium is to be paid, and the date of each month that payment is due. Failure to pay premiums on a timely basis will result in termination of coverage as of the date the premium is due. Payment of any premium will only be considered to be timely if made within 30 days after the date due.

A premium must be paid for the cost of continuation coverage for the time period between the date of the event which triggered continuation coverage and the date continued coverage is elected. This payment must be made within 45 days after the date of election. **PayFlex** will provide you notice specifying the amount of the premium, to whom the premium is to be paid, and the date payment is due. Failure to pay this premium on the date due will result in cancellation of coverage back to the initial date coverage would have terminated.

9.7. NOTIFICATION REQUIREMENTS

9.7.1. General Notice to Covered Eligible Employee and Spouse

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

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

9.7.2. Employer Notice to Division

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

9.7.3. Covered Eligible Employee/Qualified Beneficiary Notice to Administrator

You must notify the **Division** of:

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

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

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

See section 9.3, *Election of Continuation Coverage*, for timing of notices applicable to disability determinations.

You or another qualified beneficiary, or a representative acting on behalf of you or another qualified beneficiary, may provide this notice. The provisions of notice by one individual satisfies any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the qualifying event. Failure to provide timely notice will result in your loss of any right to elect continuation coverage.

9.7.4. Division's Notice to Qualified Beneficiary

Upon receipt of a notice of qualifying event, **PayFlex** will provide to each qualified beneficiary notice of his or her right to elect continuation coverage, no later than 14 days after the date on which **PayFlex** received notice of the qualifying event. Any notification to a qualified beneficiary who is your **spouse** will be treated as a notification to all other qualified beneficiaries residing with such **spouse** at the time such notification is made.

9.7.5. Unavailability of Coverage

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

9.7.6. Notice of Termination of Coverage

PayFlex will provide notice to each qualified beneficiary of any termination of continuation coverage which is effective earlier than the end of the maximum period of continuation coverage applicable to such qualifying event, as soon as practicable following **PayFlex's** determination that continuation coverage should terminate.

9.7.7. Use of a Single Notice

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

- a single notice can be provided to you and your **spouse** if you both reside at your address; and
- a single notice can be provided to you or your **spouse** for a **dependent child**, if the **dependent child** resides with you or your **spouse**.

9.8. CONTINUATION HEALTH BENEFITS PROVIDED

The continuation coverage provided to a qualified beneficiary who elects continued coverage will be identical to the coverage provided to similarly situated persons covered under the **plan** with respect to whom a qualifying event has not occurred. If coverage is

modified under the **plan** for any group of similarly situated beneficiaries, the coverage will also be modified in the same manner for all individuals who are qualified beneficiaries under the **plan**. Continuation coverage will not be conditioned on evidence of good health.

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

9.9. BANKRUPTCY PROCEEDINGS

Special continuation coverage provisions apply in the event of bankruptcy of the **State**. Notwithstanding any of the preceding sections, in the event of a bankruptcy proceeding under Title XI of the United States Code, where a loss of coverage or substantial elimination of your coverage occurs on or before the date of the loss or substantial elimination of coverage and any other individual who, on the day before the bankruptcy proceeding, is a beneficiary (under the **plan** as a **spouse**, or **dependent child**) within one year before or after the date of the commencement of the bankruptcy proceeding, continuation coverage will be provided under the **plan** to the extent required under Code Section 4980(B).

9.10. EXTENDED COVERAGE FOR DISABLED EMPLOYEES OR DEPENDENTS

Eligible employees or **dependents** who are **totally disabled**, lose coverage under the **medical plan**, and waive their right to COBRA continuation coverage, are eligible for a limited extension of their coverage under the **medical plan**. This extended coverage is not available to an **employee** who is **totally disabled** and entitled to the protections under section 14.9, *Family and Medical Leave Act (FMLA)*.

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

You must be **totally disabled** due to **injury**, **illness**, or pregnancy when coverage under the **medical plan** terminates to be eligible for this benefit. Extended health benefits for **total disability** are provided for the number of months you have been covered under the **medical plan**, up to a maximum of 12 months. However, only the condition which caused the **total disability** is covered and coverage is provided only while you or your **dependent**, as applicable, is **totally disabled**.

To be eligible for extended health benefits, you or your **dependent**, as applicable, must be under a **physician**'s care and submit evidence of disability to the **claims administrator** within 90 days after you lose coverage under the **medical plan**. The **physician** must complete a *Statement of Disability* form available from the **Division** or the **claims administrator**. You must satisfy any unpaid portion of the **deductible** within three months of the date you lose coverage.

This extended coverage terminates when you or your **dependent**, as applicable, become covered under a group health plan with similar benefits.

10. *Coordination with Medicare*

10.1. PRIMARY COVERAGE TO MEDICARE

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

10.2. SECONDARY COVERAGE TO MEDICARE

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

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

10.3. MEDICARE COVERAGE ELECTION

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

10.4. ELIGIBILITY FOR MEDICARE

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

11. *Coordination of Benefits*

11.1. When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies to the **medical plan** and **dental plan** when you or your covered **dependent** has health coverage under more than one plan. The order of benefit determination rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

11.2. Defined Terms

When used in this provision, the following words and phrases have the meaning explained herein.

a. **Allowable Expense**. Allowable expense means a health care service or expense, including **coinsurance** and **copayments**, without reduction of any applicable **deductible**, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services (for example, an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a **covered person** is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

- If a **covered person** is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense. This does not apply if one of the plans provides coverage for a private room.

- If a person is covered by two or more plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.

- If a person is covered by two or more plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.

- The amount a benefit is reduced or not reimbursed by the primary plan because a **covered person** does not comply with the plan provisions is not an allowable

expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

If a person is covered by one plan that computes its benefit payments on the basis of reasonable or recognized charges, and another plan that provides its benefits or services on the basis of negotiated charges, the primary plan's payment arrangements will be the allowable expense for all the plans. However, if the secondary plan has a negotiated fee or payment amount different from the primary plan and if the provider contract permits, that negotiated fee will be the allowable expense used by the secondary plan to determine benefits.

b. **Closed Panel Plan(s)**. A plan that provides health benefits to **covered persons** primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

c. **Custodial Parent**. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the **child** resides more than one half of the calendar year without regard to any temporary visitation.

d. **Plan**. Any plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors.

- Other prepaid coverage under service plan contracts, or under group or individual practice.

- Uninsured arrangements of group or group-type coverage.

- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans.

- Medicare or other governmental benefits.

- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the plan includes medical, prescription drug, dental, and vision coverage, those coverages will be considered separate plans. For example, medical coverage will be

coordinated with other medical plans and dental coverage will be coordinated with other dental plans.

The health plan is any part of the plan that provides benefits for health care expenses.

e. **Primary Plan/Secondary Plan.** The order of benefit determination rules state whether the health plan is a primary plan or secondary plan as to another plan covering the person.

- When the health plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.
- When the health plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.
- When there are more than two plans covering the person, the health plan may be a primary plan as to one or more other plans, and may be a secondary plan as to a different plan or plans.

11.3. WHICH PLAN PAYS FIRST

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

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage will be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
- The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

    1. Non-**Dependent** or **Dependent**. The plan that covers the person other than as a **dependent**, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a **dependent** is secondary. However, if the person is a Medicare beneficiary and, as a result of Federal law, Medicare is secondary to the plan covering the person as a **dependent**;

and primary to the plan covering the person as other than a **dependent** (*e.g.* a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

2. **Child** Covered Under More than One Plan. The order of benefits when a **child** is covered by more than one plan is:

   A. The primary plan is the plan of the parent whose birthday is earlier in the year if:

      i. The parents are married or living together whether or not married.

      ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

   B. If the specific terms of a court decree state that one of the parents is responsible for the **child**'s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the **dependent child**'s health care expenses, but that parent's spouse does, the plan of the parent's spouse is the primary plan.

   C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:

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

      For a **dependent child** covered under more than one plan of individuals who are not the parents of the **child**, the order of benefits should be determined as outlined above as if the individuals were the parents.

3. Active Employee or Retired or Laid off Employee. The plan that covers a person as an employee who is neither laid off nor retired from the employer who sponsors the plan or as a **dependent** of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a **dependent** of a retired or laid off employee is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the non-**dependent** or **dependent** rules above determine the order of benefits.

4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's **dependent**) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the non-**dependent** or **dependent** rules above determine the order of benefits.

5. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, subscriber longer is primary.

If the preceding rules do not determine the primary plan, the allowable expenses will be shared equally between the plans meeting the definition of plan under this provision. In addition, the **plan** will not pay more than it would have paid had it been primary.

11.4. HOW COORDINATION OF BENEFITS WORKS

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

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

Under the COB provision of the **medical plan** and **dental plan**, the amount normally reimbursed for covered benefits or expenses under the **medical plan** and **dental plan** is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under the **medical plan** and **dental plan** for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of the **medical plan** and **dental plan** and another plan both agree that the **medical plan** and **dental plan** determines its benefits before such other plan, the benefits

of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a **covered person** is enrolled in two or more closed panel plans, COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans.

11.5. RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under the **medical plan** and **dental plan** and other plans. The **claims administrator** has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

11.6. FACILITY OF PAYMENT

Any payment made under another plan may include an amount which should have been paid under the **medical plan** and **dental plan**. If so, the **claims administrator** may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under the **medical plan** and **dental plan**. The **claims administrator** will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

11.7. RIGHT OF RECOVERY

If the amount of the payments made by the **claims administrator** is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the **covered person**. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

12. *Subrogation and Reimbursement Rights*

12.1. RIGHT OF SUBROGATION AND REIMBURSEMENT

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

12.2. FUNDS TO WHICH SUBROGATION AND REIMBURSEMENT RIGHTS APPLY

The **plan's** subrogation and reimbursement rights apply if the **covered person** receives, or has the right to receive, any sum of money, regardless of whether it is characterized as amounts paid for medical expenses or otherwise, paid or payable from any person, plan, or legal entity that is legally obligated to make payments as a result of a judgment, settlement, or otherwise, arising out of any act or omission of any third party (whether a third party or another **covered person** under the **plan**):

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

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

12.3. AGREEMENT TO HOLD RECOVERY IN TRUST

If a payment is made under the **plan**, and the person to or for whom it is made recovers monies from a third party as a result of settlement, judgment, or otherwise, that person will hold in trust for the **plan** the proceeds of such recovery and reimburse the **plan** to the extent of its payments.

12.4. DISCLAIMER OF MAKE WHOLE DOCTRINE

The **plan** has the right to be paid first and in full from any settlement or judgment, regardless of whether the **covered person** has been "made whole." The **plan's** right is a first priority lien. The **plan's** rights will continue until the **covered person's** obligations hereunder to the **plan** are fully discharged, even though the **covered person** does not receive full compensation or recovery for his or her injuries, damages, loss or debt. This right to subrogation *pro tanto* will exist in all cases.

12.5. DISCLAIMER OF COMMON FUND DOCTRINE

The **covered person** will be responsible for all expenses of recovery from such third parties or other persons, including but not limited to, all attorneys' fees incurred in collection of such third-party payments, or payments by other persons. Any attorneys' fees and/or expenses owed by the **covered person** will not reduce the amount of reimbursement due to the **plan**.

12.6. OBLIGATIONS OF THE COVERED PERSON

The **covered person** will furnish any and all information and assistance requested by the **claims administrator**. If requested, the **covered person** will execute and deliver to the **claims administrator** a subrogation and reimbursement agreement before or after any payment of benefits by the **plan**. The **covered person** will not discharge or release any party from any alleged obligation to the **covered person** or take any other action that could impair the **plan's** rights to subrogation and reimbursement without the written authorization of the **claims administrator**.

12.7. PLAN'S RIGHT TO SUBROGATION

If the **covered person** or anyone acting on his or her behalf has not taken action to pursue his or her rights against a third party described in section 12.2, *Funds to Which Subrogation and Reimbursement Rights Apply*, or any other persons to obtain a judgment, settlement or other recovery, the **claims administrator** or its designee, upon giving 30 days' written notice to the **covered person**, will have the right to take such action in the name of the **covered person** to recover that amount of benefits paid under the **plan**; provided, however, that any such action taken without the consent of the **covered person** will be without prejudice to such **covered person**.

12.8. ENFORCEMENT OF PLAN'S RIGHT TO REIMBURSEMENT

If a **covered person** fails or refuses to comply with these provisions by reimbursing the **plan** as required herein, the **plan** has the right to impose a constructive trust over any and all funds received by the **covered person**, or as to which the **covered person** has the right to receive. The **plan** has the authority to pursue any and all legal and equitable relief available to enforce the rights contained in this section, against any and all appropriate parties who may be in possession of the funds described herein. The **plan** also has the right to terminate coverage for the **covered person** under the **plan**.

12.9. FAILURE TO COMPLY

If a **covered person** fails to comply with the requirements under this section, the **covered person** will not be eligible to receive any benefits, services or payments under the **plan** for

any **illness** or **injury** until there is compliance, regardless of whether such benefits are related to the act or omission of such third party or other persons.

12.10. DISCRETIONARY AUTHORITY OF ADMINISTRATOR

The **State** will have full discretionary authority to interpret the provisions of this section 12, *Subrogation and Reimbursement Rights*, and to administer and pursue the **health plan's** subrogation and reimbursement rights. It will be within the discretionary authority of the **State** to resolve, settle, or otherwise compromise its subrogation and reimbursement rights when appropriate. The **State** is under no legal obligation to reduce its lien or reimbursement rights unless, in its sole discretion, it determines that doing so is appropriate.

13. *Protected Health Information Under the Health Insurance Portability and Accountability Act (HIPAA)*

13.1. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The **plan** will use and disclose **protected health information** to the extent of and in accordance with the uses and disclosures permitted by HIPAA, as set forth in the **Privacy Regulations**. Specifically, the **plan** will use and disclose **protected health information** for purposes related to health care treatment, **payment** for health care and **health care operations**.

13.2. PLAN DOCUMENTS

In order for the **plan** to disclose **protected health information** to the **State** or to provide for or permit the disclosure of **protected health information** to the **State** by a health insurance issuer or HMO with respect to the **plan**, the **plan** must ensure that the **plan** documents restrict uses and disclosures of such information by the **State** consistent with the requirements of HIPAA.

13.3. DISCLOSURES BY THE PLAN TO THE STATE

The **plan** may:

- Disclose summary health information to the **State**, if the **State** requests the summary health information for the purpose of:
    - obtaining premium bids from health plans for providing health insurance coverage under the **plan**; or
    - modifying, amending, or terminating the **plan**.
- Disclose to the **State** information on whether an **individual** is participating in the **plan**, or is enrolled in or has disenrolled from a health insurance issuer offered by the **plan**.
- Disclose **protected health information** to the **State** to carry out plan administration functions that the **State** performs, consistent with the provisions of this section.
- With an authorization from the **covered person**, disclose **protected health information** to the **State** for purposes related to the administration of other employee benefit plans and fringe benefits sponsored by the **State**.

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

- Not disclose (and may not permit a health insurance issuer to disclose) **protected health information** to the **State** as otherwise permitted by this section unless a statement is included in the **plan's** notice of privacy practices that the **plan** (or a health insurance issuer with respect to the **plan**) may disclose **protected health information** to the **State**.

- Not disclose **protected health information** to the **State** for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the **State**.

- Not disclose (and may not permit a health insurance issuer to disclose) **protected health information** that is genetic information about an individual for underwriting purposes as defined in Section 1180(b)(4) of the Social Security Act and underlying regulations.

13.4. USES AND DISCLOSURES BY STATE

The **State** may only use and disclose **protected health information** as permitted and required by the **plan**, as set forth within this section. Such permitted and required uses and disclosures may not be inconsistent with the provisions of HIPAA. The **State** may use and disclose **protected health information** without an authorization from a **covered person** for plan administrative functions including **payment** activities and **health care operations**. In addition, the **State** may also use and disclose **protected health information** to accomplish the purpose for which any disclosure is properly made pursuant to section 13.3, *Disclosures by the Plan to the State*.

13.5. CERTIFICATION

The **plan** may disclose **protected health information** to the **State** only upon receipt of a certification from the **State** that the **plan** documents have been amended to incorporate the provisions provided for in this section and that the **State** so agrees to the provisions set forth therein.

13.6. CONDITIONS AGREED TO BY THE STATE

The **State** agrees to:

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

- Ensure that any agents, including a subcontractor, to whom the **State** provides **protected health information** received from the **plan** agree to the same restrictions

and conditions that apply to the **State** with respect to such **protected health information**, and that any such agents or subcontractors agree to implement reasonable and appropriate security measures to protect any **electronic protected health information** belonging to the **plan** that is provided by the **State**.

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

- Not use or disclose **protected health information** in connection with any other benefit or employee benefit plan of the **State** unless authorized by an **individual**.

- Report to the **plan** any **protected health information** use or disclosure that is inconsistent with the uses or disclosures provided for by this section, or any **security incident** of which it becomes aware.

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

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

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

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

- If feasible, return or destroy all **protected health information** received from the **plan** that the **State** still maintains in any form, and retain no copies of such **protected health information** when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the **electronic protected health information** that it creates receives, maintains, or transmits on behalf of the **plan**.

- Ensure that the separation and requirements of sections 13.3, *Disclosures by the Plan to the State*, section 13.4, *Uses and Disclosures by State,* and section 13.5, *Certification* of the **plan** are supported by reasonable and appropriate security measures.

13.7. ADEQUATE SEPARATION BETWEEN THE PLAN AND THE STATE

In accordance with HIPAA, only the persons identified in the **State**'s HIPAA policies and procedures may be given access to **protected health information**.

13.8. LIMITATIONS OF ACCESS AND DISCLOSURE

The persons described in section 13.3, *Disclosures by the Plan to the State*, may only have access to and use and disclose **protected health information** for **plan** administration functions that the **State** performs for the **plan**.

13.9. NONCOMPLIANCE

If the persons or classes of persons described in section 13.3, *Disclosures by the Plan to the State*, do not comply with this **plan** document, the **plan** and the **State** will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

14. *Other Mandated Coverages*

14.1. GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

The **plan** will comply with GINA, as amended, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any Federal law or regulations governing the **plan**. As part of such compliance, the **plan** will not:

- Adjust plan contribution amounts or premiums on the basis of genetic information.
- Request or require a **covered person** or any of the **covered person**'s family members to undergo a genetic test.
- Request, require, or purchase genetic information for underwriting purposes during coverage or with respect to any **covered person**, prior to such individual's enrollment in the **plan**.

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

14.2. STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of **stay** in connection with childbirth for the mother or newborn **child** to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending **provider** (*e.g.*, your **physician**, nurse midwife, or **physician** assistant), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a **provider** obtain authorization from the **plan** for prescribing a length of **stay** that is 48 hours (or 96 hours) or less. However, to use certain **providers** or facilities, or to reduce your out-of-pocket costs, you may be required to obtain **precertification**. For information on **precertification**, contact **Aetna**.

Under Federal law, the **plan** may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) **stay** is treated in a manner less favorable to the mother or newborn than any earlier portion of the **stay**.

14.3. ELIGIBILITY FOR MEDICAID BENEFITS

Benefits will be paid in accordance with any assignment of rights made by or on behalf of any **eligible employee** or **dependent** as required by a state plan for medical assistance approved under Title XIX, Section 1912(a)(1)(A) of the Social Security Act. For purposes

of enrollment and entitlement to benefits, an **eligible employee's** or **dependent's** eligibility for or receipt of medical benefits under a state plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account. The **State** will have a right to any payment made under a state plan for medical assistance approved under Title XIX of the Social Security Act when the **plan** has a legal liability to make such payment.

14.4. PROHIBITION ON RESCISSIONS

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

14.5. DEPENDENT STUDENTS ON MEDICALLY NECESSARY LEAVE OF ABSENCE

The **plan** will comply with Michelle's Law of 2008, as amended from time to time, and any regulations issued thereunder, to the extent required thereunder and not otherwise inconsistent with any federal law or regulations governing the **plan**. As part of such compliance, the health **plan** will extend coverage for up to one year when a full-time student otherwise would lose eligibility if the full-time student takes a medically necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless **dependent child** coverage ends earlier under another **plan** provision, such as the parent's termination of employment or the **dependent child's** age exceeding the **plan's** limit. A medically necessary leave of absence for purposes of full-time student medical leave occurs when a **child** who is a **dependent** and a full-time student (but who would not be a **dependent** if he or she were not a full-time student) takes a leave of absence from his or her educational institution or otherwise changes his or her enrollment status from full-time to part-time due to a serious illness or injury. The **plan** must receive written certification from the full-time student's **physician** confirming the serious illness or injury and the medical necessity of the leave or change in status. **Dependent** coverage will continue during the leave as if the **dependent child** had

maintained full-time student status. This requirement applies even if the **plan** changes during the extended period of coverage.

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

The **State** surrendered grandfather status of the **plan** effective January 1, 2017. The **plan** will comply with the 2010 federal health care reform law, called the PPACA. If Congress, federal or state regulators, or the courts make further changes or clarifications regarding the Affordable Care Act and its implementing regulations, the **plan** will comply with them even if they are not stated in this booklet or if they conflict with statements made in this booklet.

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

The **plan** will comply with HIPAA, as amended from time to time, and any regulations issued thereunder to the extent required thereunder and to the extent not otherwise inconsistent with any federal law or regulations governing the health plan. Such compliance will include (i) providing **eligible employees** certification of their coverage under the **plan** to the extent required by HIPAA and (ii) permitting eligible individuals to enroll in the **plan** during special enrollment periods upon the loss of other coverage or upon the acquisition of a new **dependent** to the extent required under HIPAA, or (iii) discrimination against any person in terms of eligibility, continued eligibility or level of required employee contribution based upon health status, medical condition (including both physical and mental illnesses, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

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

a. Generally

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

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

b. Continuation of Coverage

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

c. Election of USERRA Continuation Coverage

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

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

If the **eligible employee** is unable to give advance notice of **uniformed service**, the **eligible employee** may still be able to elect continuation coverage under this section if the failure to give advance notice was because giving such notice was impossible, unreasonable, or precluded by military necessity. In such a case, the election period will begin on the date the **eligible employee** leaves for **uniformed service** and will end on the earlier of: (i) the 24 month period beginning on the date on which the **eligible employee's** absence for the **uniformed service** begins; or (ii) the date on which the **eligible employee** fails to return from **uniformed service** or apply for a position of employment. For these purposes, "military necessity" occurs only when deemed to be so by a designated military authority as described in 20 CFR § 1002.86 and may include situations where a mission, operation, exercise or requirement is classified, or could be compromised or otherwise adversely affected by public knowledge. It may be impossible or unreasonable to give advance notice under

certain circumstances such as when the employer is unavailable or the **eligible employee** is required to report for **uniformed service** in an extremely short period of time.

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

d. Cost of USERRA Continuation Coverage

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

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

e. Coordination with COBRA

An **eligible employee** who is absent from work by reason of **service in the uniformed services** may be eligible for continuation coverage under section 9, *Consolidated Omnibus Budget Reconciliation Act* (*COBRA) and Extended Health Coverage*. The continuation coverage provided in this section will not limit or otherwise interfere with those continuation coverage rights; provided, however, any continuation coverage provided under this section will run concurrently with any continuation coverage available under section 9, *Consolidated Omnibus Budget Reconciliation Act* (*COBRA) and Extended Health Coverage*.

f. USERRA Continuation Health Benefits Provided

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

g. Waiting Period and Exclusions Upon Reemployment

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

h. Reinstatement of Coverage Upon Reemployment

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

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

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

services will be permitted to apply any accrued paid vacation, annual or similar leave while on such leave by reason of **service in the uniformed services**.

14.9. FAMILY AND MEDICAL LEAVE ACT (FMLA)

a. Generally

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

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

In addition, any spouse, son, daughter, parent, or nearest blood relative ("next of kin") of a "covered servicemember" will be granted leave not to exceed a total of 26 work weeks during a single 12 month period to care for the "covered servicemember." During the single 12 month period described above, an employee may be granted a combined total of 26 work weeks of leave for any combination of leaves under the FMLA. For purposes of this policy, the phrase "covered servicemember" means a member of the Armed Forces, including a member of the National Guard or Reserves, who:

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

b. Continuation Coverage

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

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

c. Termination of FMLA Continuation Coverage

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

- The **eligible employee** informs the **State** of his or her intent not to return from FMLA leave.
- The **eligible employee** fails to return from the FMLA leave.
- The **eligible employee** exhausts his or her FMLA leave.
- The employment relationship would have been terminated if the **eligible employee** had not taken FMLA leave.

After the last day of FMLA leave, an **eligible employee** may be eligible for continuation of health coverage at the **eligible employee's** own expense under Federal law as described in section 9, *Consolidated Omnibus Budget Reconciliation Act* (*COBRA) and Extended Health Coverage*.

d. Employee Contributions

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

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

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

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

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

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

15. *Other Plan Provisions*

15.1. ACCESS TO RECORDS

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

15.2. PLAN LIABILITY

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

15.3. FREE CHOICE OF HOSPITAL AND PROVIDER

You may select any **hospital** that meets the criteria in section 3.5.6, *Hospital Expenses.* You may select any **provider** who meets the definition of **provider** in section 16, *Definitions*.

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

Under the **plan**, payments may be made, at the discretion of the **claims administrator**, to the **provider** furnishing the service or making the payment, or to the **eligible employee**, or to such **provider** and the **eligible employee** jointly.

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

15.4. PLAN MUST BE EFFECTIVE

Health coverage is expense-incurred coverage only and not coverage for the **illness** or **injury** itself. This means that the **plan** will pay benefits only for expenses incurred while this coverage is in force. Except as described in section 9, *Consolidated Omnibus Budget Reconciliation Act* (*COBRA) and Extended Health Coverage*, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated, even if the expenses were incurred as a result of an **accident**, **injury**, or **illness** which occurred, commenced or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

15.5. MEDICAL OUTCOMES

Neither the **State** nor the **claims administrator** makes any express or implied warranties nor assumes any responsibility for the outcome of any covered services or supplies.

15.6. EPIDEMICS AND PUBLIC DISASTERS

The services this **plan** provides are subject to the availability of **hospital** facilities and the ability of **hospitals**, **hospital** employees, **physicians** and surgeons, and other **providers** to furnish services. The **plan** does not assume liability for epidemics, public disasters, or other conditions beyond its control which make it impossible to obtain the services that the **plan** provides.

15.7. VESTED RIGHTS

Except as cited in section 9, *Consolidated Omnibus Budget Reconciliation Act* (*COBRA) and Extended Health Coverage*, the **plan** does not confer rights beyond the date that coverage is terminated or the effective date of any change to the plan provisions, including benefits and eligibility provisions. For this reason, no rights from the **plan** can be considered vested rights. You are not eligible for benefits or payments from the **plan** for any services, treatment, medical attention, or care rendered after the date your coverage terminates.

15.8. AMENDMENT OR TERMINATION PROCEDURE

The following provisions will apply to the amendment and termination of the **plan**. To the extent that a benefit does not address amendment or termination of the benefit, the following provisions will also apply to such benefit. The **State**, through appropriate action of the **Commissioner** to take such action, will have the right in its sole discretion to amend the **plan**, the schedule of benefits or any underlying benefit, as applicable, at any time and from time to time and to any extent that it may deem advisable. Such modification or amendment will be duly incorporated in writing. The **State**, through appropriate action of the **Commissioner** to take such action, will have the right in its sole discretion to terminate the **plan** or any underlying benefit at any time and to the extent that it may deem advisable. Any amendment or termination of the **plan**, the schedule of benefits or underlying benefit will be effective as of the date the **State**, through the **Commissioner**, may determine in connection therewith. To the extent allowed by Internal Revenue Code and applicable **State** law, any such amendment may be effective retroactively.

15.9. CANCELLATION

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

15.10. RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

15.11. NONALIENATION

Except as otherwise required pursuant to a qualified medical child support, no benefit under the **plan** and underlying benefit prior to actual receipt thereof by any **eligible employee**, **spouse**, or his or her beneficiary will be subject to any debt, liability, contract, engagement, or tort of any **eligible employee**, **spouse**, or his or her beneficiary, nor subject to anticipation, sale, assignment (except in the case of medical benefits), transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation, or any other voluntary or involuntary alienation or other legal or equitable process, nor transferable by operation of law except as may be provided in the benefit.

15.12. ADDITIONAL TAXES OR PENALTIES

If there are any taxes or penalties payable by the **State** on behalf of any **covered person**, such taxes or penalties will be payable by the **covered person** to the employer to the extent such taxes would have been originally payable by the **covered person** had this **plan** not been in existence.

15.13. NO GUARANTEE OF TAX CONSEQUENCES

Neither the **claims administrators** nor the **State** makes any commitment or guarantee that any amounts paid to or for the benefit of a **covered person** under the **plan** will be excludable from the **covered person's** gross income for federal, state, or local income tax purposes or for Social Security tax purposes, or that any other federal or state tax treatment will apply to or be available to any **covered person**. It will be the obligation of each **covered person** to determine whether payment under the **plan** is excludable from the **covered person** gross income for federal, state, and local income tax purposes, and Social Security tax purposes, and to notify the **State** if the **covered person** has reason to believe that any such payment is not excludable.

15.14. EMPLOYMENT OF CONSULTANTS

The **State**, or a fiduciary named by the **State** pursuant to the **plan**, may employ one or more persons to render advice with regard to their respective responsibilities under the **plan**.

15.15. DESIGNATION OF FIDUCIARIES

The **State** may designate another person or persons to carry out any fiduciary responsibility of the **State** under the **plan**. The administrator will not be liable for any act or omission of such person in carrying out such responsibility, except as may be otherwise provided under applicable law.

15.16. FIDUCIARY RESPONSIBILITIES

To the extent permitted under applicable law, no fiduciary of the **plan** will be liable for any act or omission in carrying out the fiduciary's responsibilities under the **plan**.

15.17. ALLOCATION OF FIDUCIARY RESPONSIBILITIES

To the extent permitted under applicable law, each fiduciary under the **plan** will be responsible only for the specific duties assigned under the **plan** and will not be directly or indirectly responsible for the duties assigned to another fiduciary.

15.18. LIMITATION OF RIGHTS AND OBLIGATIONS

Neither the establishment nor maintenance of the **plan** nor any amendment thereof, nor the purchase of any benefit, including any benefit **plan** or insurance policy, nor any act or omission under the **plan** or resulting from the operation of the **plan** will be construed:

- as conferring upon any **covered person**, beneficiary, or any other person any right or claim against the **State**, or **claims administrator**, except to the extent that such right or claim will be specifically expressed and provided in the **plan** or provided under applicable law;
- as creating any responsibility or liability of the **State** or the **claims administrator** for the validity or effect of the **plan**; or
- as a contract or agreement between the **State** and any **covered person** or other person.

15.19. NOTICE

Any notice given under the **plan** will be sufficient if given to the **State** as administrator, when addressed to its office; if given to the **claims administrator**, when addressed to its office; or if given to a **covered person**, when addressed to the **covered person**, at his or her address as it appears in the records of the administrator or the **claims administrator**.

15.20. DISCLAIMER OF LIABILITY

Nothing contained herein will confer upon a **covered person** any claim, right, or cause of action, either at law or at equity, against the **plan**, the **State** or the **claims administrator** for the acts or omissions of any **provider** of services or supplies for any benefits provided under the **plan**.

15.21. RIGHT OF RECOVERY

If the **State** or the **claims administrator** makes any payment that according to the terms of the **plan** and the benefits provided hereunder should not have been made, the **State** or the administrator may recover that incorrect payment, whether or not it was made due to the **State's** or the **claims administrator's** own error, from the person to whom it was made, or from any other appropriate party. If any such incorrect payment is made directly to a **covered person**, then the **State** or the **claims administrator** may deduct it when making future payments directly to that **covered person**.

15.22. LEGAL COUNSEL

The **State** may from time to time consult with counsel, who may be counsel for the **State**, and will be fully protected in acting upon the advice of such counsel.

15.23. EVIDENCE OF ACTION

All orders, requests, and instructions to the **State** or the **claims administrator** by the **State** or by any duly authorized representative, will be in writing and the administrator will act and will be fully protected in acting in accordance with such orders, requests, and instructions.

15.24. PROTECTIVE CLAUSE

Neither the **State** nor the **claims administrator** will be responsible for the validity of any contract of insurance or other benefit contract or policy by any benefit **provider** issued to the **State** or for the failure on the part of any insurance company or other benefit **provider** to make payments thereunder.

15.25. RECEIPT AND RELEASE

Any payments to any **covered person** will, to the extent thereof, be in full satisfaction of the claim of such **covered person** being paid thereby, and the **State** may condition payment thereof on the delivery by the **covered person** of the duly executed receipt and release in such form as may be determined by the **State**.

15.26. LEGAL ACTIONS

If the **State** is made a party to any legal action regarding the **plan**, except for a breach of fiduciary responsibility of such person or persons, any and all costs and expenses, including reasonable attorneys' fees, incurred by the **State** in connection with such proceeding will be paid from the assets of the **plan** unless paid by the **State**.

No legal action can be brought to recover under any benefits after three years from the deadline for filing claims.

15.27. RELIANCE

The **State** will not incur any liability in acting upon any notice, request, signed letter, telegram, or other paper or document believed by the **State** to be genuine or to be executed or sent by an authorized person.

15.28. MISREPRESENTATION

Any material misrepresentation on the part of the **covered person** making application for coverage or receipt of benefits, will render the coverage null and void. Each **covered person** is required to notify the **State** or **claims administrator** of any change in status or other applicable events as required under this **plan** or the applicable benefit. Any failure to notify the **State** or c**laims administrator** of any change in status or other applicable events will be deemed by the **State** to be an act that constitutes fraud and an intentional misrepresentation of material fact prohibited by the **plan** that may result in a retroactive termination of coverage.

15.29. ENTIRE PLAN

The **plan** document and the documents, if any, incorporated by reference herein will constitute the only legally governing documents for the **plan**. No oral statement or other communication will amend or modify any provision of the **plan** as set forth herein.

15.30. APPLICABLE LAW AND VENUE

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

15.31. CHANGES TO THE PLAN

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

15.32. FACILITY OF PAYMENT

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

15.33. PREMIUMS

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

16. *Definitions*

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

- "**Accident**" means a sudden, unexpected, and unforeseen, identifiable occurrence or event producing, at the time, objective symptoms of a bodily **injury**. The **accident** must occur while the person is covered under the **plan**. The occurrence or event must be definite as to time and place. It must not be due to, or contributed by, an **illness** or disease of any kind.

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

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

- "A**ggregate contract rate**" means the average of all discounts in the fee schedule negotiated with the preferred facility in Anchorage.

- "**Alveoloplasty**" is the surgical shaping of the bone of the upper or the lower jaw. It is performed most commonly in conjunction with the removal of a tooth or multiple teeth to have the gums heal smoothly for the placement of partial denture or denture.

- "**Ambulance**" means a professional land, water or air vehicle staffed with medical personnel and specially equipped to transport **injured** or sick people to a destination capable of caring for them upon arrival. Specially equipped means that the vehicle contains the appropriate stretcher, oxygen, and other medical equipment necessary for patient care en route.

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

- "**Appeal**" means review by the **claims administrator**, or Division of Retirement and Benefits of a **denial**.

- **"Average wholesale price (AWP)"** means the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons weekly price updates (or any other similar publication designated by the **claims administrator**) on the day that a **pharmacy** claim is submitted for adjudication.

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

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

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

- "**Birthing center**" means a freestanding facility that meets all of the following requirements:
  - Meets licensing standards.
  - Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
  - Charges for its services.
  - Is directed by at least one **physician** who is a specialist in obstetrics and gynecology.
  - Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period.
  - Extends staff privileges to **physicians** who practice obstetrics and gynecology in an area **hospital**.
  - Has at least two beds or two birthing rooms for use by patients while in labor and during delivery.
  - Provides, during labor, delivery and the immediate postpartum period, full-time **skilled nursing care** directed by a registered nurse or certified nurse midwife.
  - Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and **child**.
  - Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
  - Is equipped and has trained staff to handle **emergency** medical conditions and provide immediate support measures to sustain life if complications arise during labor or a **child** is born with an abnormality which impairs function or threatens life.
  - Accepts only patients with low-risk pregnancies.
  - Has a written agreement with a **hospital** in the area for **emergency** transfer of a patient or a **child**. Written procedures for such a transfer must be displayed and the staff must be aware of them.
  - Provides an ongoing quality assurance program. This includes reviews by **physicians** who do not own or direct the facility.

- Keeps a medical record on each patient and **child**.

- **"Body mass index"** or **"BMI"** is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

- "**Brand name prescription drug**" is a **prescription drug** with a proprietary name assigned to it by the manufacturer or distributor and so indicated by Medi-Span or any other similar publication designated by **Aetna**.

- "**Bridge**" means a fixed partial denture. A **bridge** replaces one or more missing teeth using a **pontic** (false tooth or teeth) permanently attached to the adjacent teeth. **Retainer** crowns (crowns placed on adjacent teeth) are considered part of the **bridge**.

- "**Broken**" is the description of a tooth that has a piece or pieces that have been completely separated from the rest of the tooth. Note that cracks are not the same as **broken**.

- "**Cast restoration**" means crowns, inlays, onlays, and any other **restoration** to fit a specific **covered person's** tooth that is made at a laboratory and cemented into the tooth.

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

- "**Claims administrator**" means a person, firm, or company which has agreed to provide technical or administrative services and advice in connection with the operation of all or a part of a benefit provided for under the **plan**, and perform such other functions, including processing and payment of claims, as may be delegated to it under such contract. The **claims administrator** may review claims **appeals** and, if applicable, coordinate external reviews, as provided by the **plan**.

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

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

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

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

- "**Covered expense**" means the medical, prescription drug, dental, or vision services and supplies shown as covered under the **plan**, including any applicable sales, excise, or other taxes.

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

- "**Custodial care**" means services and supplies, including **room and board** and other institutional services, that are primarily intended to help you meet personal needs. **Custodial care** can be prescribed by a **physician** or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of **custodial care** include:
  - Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications.
  - Care of a stable tracheostomy (including intermittent suctioning).
  - Care of a stable colostomy/ileostomy.
  - Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings.
  - Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing).
  - Watching or protecting you.
  - Respite care, adult (or child) day care, or convalescent care.
  - Institutional care, including **room and board** for rest cures, adult day care and convalescent care.
  - Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods.
  - Any service that can be performed by a person without any medical or paramedical training.

- "**Day care treatment**" means a **partial confinement treatment** program to provide treatment for you during the day. The **hospital**, **psychiatric hospital** or **residential treatment facility** does not make a room charge for **day care treatment.** Such treatment must be available for at least four hours, but not more than 12 hours in any 24-hour period.

- "**Debridement**" means the removal of excess plaque. A periodontal "pre-cleaning" procedure done when there is too much plaque for the **dentist** to perform an exam.

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

- "**Delta Dental**" means Delta Dental of Alaska. Delta Dental of Alaska is a business name used by Oregon Dental Service, which is a not-for-profit health insurer licensed in Alaska. **Delta Dental** is the **claims administrator** of the **dental plan**.

- "**Denial**" means any of the following: a denial, reduction, termination, or failure to provide or make payment (in whole or in part) for a benefit, including determinations based on eligibility, and, with respect to benefits under the **plan,** a denial, reduction, termination or failure to provide or make payment for a benefit based on utilization review or a failure to cover a benefit because it is determined to be **experimental or investigational** or not **medically necessary**. With respect to the **medical plan** and **dental plan**, it also means a **rescission** of coverage whether or not, in connection with the **rescission**, there is an adverse effect on any particular health benefit at the time.

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

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

- "**Dentally necessary**" means services that:
  - are established as necessary for the treatment or prevention of a dental **injury** or disease otherwise covered under the **dental plan**;
  - are appropriate with regard to standards of good dental practice in the **service area**;
  - have a good prognosis; and/or
  - are the least costly of the alternative supplies or levels of service that can be safely provided. For example, coverage would not be allowed for a crown when a filling would be adequate to restore the tooth appropriately.

  The fact that a **dentist** may recommend or approve a service or supply does not make the charge **dentally necessary.**

- "**Dentist**" means a licensed **dentist** or a **physician** licensed to do the dental work he or she performs, who is operating within the scope of his or her license as required under law within the state of practice.

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

- **"Detoxification"** means the process by which an alcohol-intoxicated or drug-intoxicated, or an alcohol-dependent or drug-dependent person is medically

managed through the period of time necessary to eliminate, by metabolic or other means, the:

- intoxicating alcohol or drug;
- alcohol or drug-dependent factors; or
- alcohol in combination with drugs;

as determined by a **physician**. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

- "**Division**" means the State of Alaska, Division of Retirement and Benefits.
- "**Durable medical equipment**" means equipment and the accessories needed to operate it that is:
  - made for and mainly used in the treatment of an **illness** or **injury**;
  - suited for use in the home;
  - not normally of use to persons who do not have an **illness** or **injury**;
  - not for use in altering air quality or temperature; and
  - not for exercise or training.

  Durable medical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids, and telephone alert systems.
- "**Electronic protected health information**" means "electronic protected health information" as defined at 45 CFR § 160.103, which generally means **protected health information** that is transmitted by, or maintained in, electronic media. For these purposes, "electronic media" means: (i) electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or (ii) transmission media used to exchange information already in electronic storage media (*e.g.*, the internet, extranet, leased lines, dial up lines, private networks, and the physical movement of removable/transportable electronic storage media).
- "**Eligible employee**" means a permanent or long-term nonpermanent **employee** of the **State** whose bargaining unit or employee group participates in the **plan** and who meets the criteria set forth in section 1.3.1, *Eligible Employees*. An **eligible employee** does not include temporary employees, leased employees, or employees who are scheduled to work less than 15 hours per week, except if the employee otherwise meets the criteria outlined under the employer shared responsibility provisions in section 26 U.S. Code § 4980H.

- "**Emergency"** means a sudden and unexpected change in a person's condition, including severe pain, such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in loss of life or limb, significant impairment to bodily function or permanent dysfunction of a body part, or with respect to a pregnant woman, the health of the woman and her unborn child.

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

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

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

- "**Experimental or investigational**" means, except as provided for under any clinical trials benefit provision, a drug, a device, a procedure, or treatment where:
  - there is not enough outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved;
  - approval required by the FDA has not been granted for marketing;
  - a recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational** or for research purposes;
  - it is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
  - the written protocols or informed consent used by the treating facility or any other facility studying substantially the same drug, device, procedure or treatment, states that it is **experimental or investigational**, or for research purposes.

- "**Facility**" means a freestanding **birthing center**, dialysis clinic, free standing imaging center, **hospital, hospice facility, psychiatric hospital, rehabilitation facility, surgery center, residential treatment facility, skilled nursing facility** or **urgent care provider.**

- "**Final denial**" means a **denial** of benefits under the **medical plan** or **dental plan** that has been upheld by the **claims administrator** at the completion of the internal **appeals** process or a **denial** of benefits under the **medical plan** or **dental plan** with respect to which the internal **appeals** process has been deemed exhausted (a "deemed **final denial**").

- "**Formulary**" means a listing of **prescription drugs** (both **generic prescription drugs** and **brand-name prescription drugs**) established by the plan administrator. The **formulary** will tell you if a drug is covered and tell you what plan payment tier it is in. You can also see if there are alternatives that cost less. The list is subject to periodic review and modification. This list is outlined in the **Preferred Drug Guide.** The **Preferred Drug Guide** also includes an Exclusion List of drugs that are identified as excluded under the plan, subject to periodic review and modification.

- "**Generic alternative prescription drug"** means a **prescription drug** used for the same purpose as the **brand-name prescription drug,** but can have different ingredients or different amounts of ingredients as the **brand-name prescription drug**.

- "**Generic prescription drug**" means a **prescription drug**, whether identified by its chemical, proprietary, or nonproprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medispan or any other publication designated by **Aetna**.

- "**Geographic area**" means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.

- "**Health care operations**" means "health care operations" as defined by 45 CFR § 164.501, as amended. Generally, **health care operations** include, but are not limited to, the following activities taken by or on behalf of the **plan**:
  - Quality assessment.

  - Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care **providers** and patients with information about treatment alternatives and related functions.

  - Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities.

  - Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance).

  - Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs.

- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the **plan**, including **formulary** development and administration, development or improvement of **payment** methods or coverage policies.

- Business management and general administrative activities of the **plan**, including, but not limited to:

    - Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements.

    - Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers.

    - Resolution of internal grievances.

    - Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

    - Any other activity considered to be a "health care operation" activity pursuant to 45 CFR § 164.501.

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

- "**Home health care agency**" means an organization that meets all of the following requirements:
    - provides **skilled nursing services** and other therapeutic services in the patient's home;

    - is associated with a professional policy-making group (of at least one **physician** and one full-time supervising registered nurse) which makes policy;

    - has full time supervision by a **physician** or registered nurse;

    - keeps complete medical records on each patient;

    - is staffed by an administrator; and

    - meets licensing standards.

- "**Home health care plan**" means a plan that provides for continued care and treatment of an **illness** or **injury** in a place of confinement other than a **hospital** or **skilled nursing facility**. The attending **physician** must prescribe care treatment in writing.

- "**Homebound**" means that you are confined to your place of residence:

- due to an **illness** or **injury** which makes leaving the home medically contraindicated; or

- because the act of transport would be a serious risk to your life or health.

Situations where you would not be considered **homebound** include, but are not limited to, the following:

- you do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or

- you are wheelchair bound but could safely be transported via wheelchair accessible transport.

- "**Hospice care**" means care given to a **terminally ill** person by or under arrangements with a **hospice care agency**. The care must be part of a **hospice care program**.

- "**Hospice care agency**" means an agency or organization that meets all of the following requirements:
  - Has **hospice care** available 24 hours a day.

  - Meets any licensing or certification standards established by the jurisdiction where it is located.

  - Provides:

    - Skilled nursing services;

    - Medical social services; and

    - Psychological and dietary counseling.

  - Provides, or arranges for, other services which include:

    - **Physician** services;

    - Physical and occupational therapy;

    - Part time home health aide services which mainly consist of caring for **terminally ill** people; and

    - Inpatient care in a **facility** when needed for pain control and acute and chronic symptom management.

  - Has at least the following personnel:

    - One physician;

    - One registered nurse; and

- One licensed or certified social worker employed by the agency.

- Establishes policies about how **hospice care** is provided.
- Assesses the patient's medical and social needs.
- Develops a **hospice care program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full time administrator.

- "**Hospice care program**" is a written plan of **hospice care** which meets all of the following requirements:
  - Is established by and reviewed from time to time by a **physician** attending the person, and appropriate personnel of a **hospice care agency**.
  - Is designed to provide palliative and supportive care to **terminally ill** persons, and supportive care to their families.
  - Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.

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

- Has a full-time administrator.

- "**Hospital**" means an institution providing inpatient medical care and treatment of sick and **injured** people. It must:
  - be accredited by the Joint Commission on the Accreditation of Healthcare Organizations; be a medical care, psychiatric, or tuberculosis hospital as defined by Medicare; or have a staff of qualified **physicians** treating or supervising treatment of the sick and **injured**; and

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

  In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative hospital, or facility primarily for rehabilitative or custodial services.

- "**Illness**" means a pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

- "**Implant**" is an artificial, permanent tooth root replacement used to replace a missing tooth or teeth. It is surgically placed into the upper or lower jaw bone and supports a single crown, fixed **bridge**, or partial or full denture.

- "**Implant abutment**" is an attachment used to connect an **implant** and an **implant supported prosthetic** device.

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

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

- "**Infertility**" or **"infertile"** means the condition of a presumably healthy **covered person** who is unable to conceive or produce conception after:
  - *for a woman who is under 35 years of age*: one year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or

  - *for a woman who is 35 years of age or older*: six months or more of timed, unprotected coitus, or 6 cycles of artificial insemination.

- "**Injury**" means an accidental bodily injury that is the sole and direct result of an unexpected or reasonably unforeseen occurrence or event, or the reasonable unforeseeable consequences of a voluntary act by the person.

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

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

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

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

- "**Mental disorder**" means an **illness** commonly understood to be a **mental disorder**, whether or not it has a physiological or organic basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a **psychiatric physician**, a psychologist or a psychiatric social worker. A **mental disorder** includes but is not limited to:
  - Schizophrenia
  - Bipolar disorder (manic/depressive)
  - Pervasive Mental Development Disorder (Autism)
  - Panic disorder
  - Major depressive disorder
  - Psychotic depression
  - Obsessive compulsive disorder
  - Anorexia/bulimia nervosa
  - Psychotic disorders/delusional disorder
  - Schizo-affective disorder

- "**Negotiated charge**" means the maximum charge that a **network provider** has agreed to make as to any service or supply for the purpose of benefits under the **plan**.

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

- "**Network provider**" means a health care **provider** or **pharmacy** that has contracted with a **claims administrator** to furnish services or supplies for the **plan**, but only if the **provider** is a **network provider** for the service or supply involved.

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

- "**Night care treatment**" means a **partial confinement treatment** program provided when you need to be confined during the night. A room charge is made by the **hospital**, **psychiatric hospital**, or **residential treatment facility**. Such treatment must be available at least eight hours in a row at a night and five nights per week.

- "**Non-preferred brand-name drug (non-formulary)**" means a **brand-name prescription drug** that does not appear on the **Preferred Drug Guide.**

- "**Other health care**" means a health care service or supply that is neither **network service(s) or supply(ies)** nor out-of-**network service(s) and supply(ies). Other health care** can include care given by a **provider** who does not fall into any of the categories in your **provider** directory or in DocFind® at www.aetna.com/docfind/custom/alaskacare.

- "**Out-of-pocket limit**" means the maximum amount you are responsible to pay for benefits under the **plan** each **benefit year**, including **deductible** and **coinsurance** not paid by the **plan**. Premiums, charges over the **recognized charge**, **precertification** benefit reductions, and non-**covered expenses** do not accrue toward the **out-of-pocket limit**. A separate **out-of-pocket limit** applies with respect to the medical benefit portion and **prescription** benefit portion of the **medical plan.**

- "**Partial confinement treatment**" means a plan of medical, psychiatric, nursing, counseling or therapeutic services to treat **substance abuse** or **mental disorders** which meets all of the following requirements:
  - It is carried out in a **hospital**, **psychiatric hospital**, or **residential treatment facility** on less than a full-time inpatient basis.
  - It is in accord with accepted medical practice for the condition of the person.
  - It does not require full-time confinement.
  - It is supervised by a **psychiatric physician** who weekly reviews and evaluates its effect.

  Day care treatment and **night care treatment** are considered **partial confinement treatment**.

- "**PayFlex**" means PayFlex Systems USA, Inc., the flexible spending account and COBRA **claims administrator** under the **plan**.

- "**Payment**" means "payment" as defined by 45 § CFR 164.501, as amended. Generally, **payment** activities include, but are not limited to, activities undertaken by the **plan** to obtain premiums or determine or fulfill its responsibility for coverage and provision of **plan** benefits that relate to an **individual** to whom health care is provided. These activities include, but are not limited to, the following:
    - Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and **copayments** as determined for an **individual's** claim).
    - Coordination of benefits.
    - Adjudication of health benefit claims (including **appeals** and other payment disputes).
    - Subrogation of health benefit claims.
    - Establishing **eligible employee** contributions.
    - Risk adjusting amounts due based on an **eligible employee's** health status and demographic characteristics.
    - Billing, collection activities and related health care data processing.
    - Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to an **eligible employee's** inquiries about payments.
    - Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance).
    - **Medical necessity** reviews or reviews of appropriateness of care or justification of charges.
    - Utilization review, including **precertification**, preauthorization, concurrent review and retrospective review.
    - Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following **protected health information** may be disclosed for **payment** purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or **plan**).
    - Reimbursement to the **plan.**
    - Any other activity considered to be a "**payment**" activity pursuant to 45 CFR § 164.501.

- "**Periodontal maintenance**" is a periodontal procedure for **covered persons** who have previously been treated for periodontal disease. In addition to cleaning the visible surfaces of the teeth (as in **prophylaxis**), surfaces below the gum line are also cleaned. This is a more comprehensive service than a regular cleaning (**prophylaxis**).

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

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

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

- "**Plan**" means the AlaskaCare Employee Health Plan, the terms of which are set forth in this document, as may be amended from time to time.

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

- "**Post-service claim**" means any claim for a medical benefit that is not an **urgent care claim** or a **pre-service claim.**

- "**Pre-service claim**" means any claim for a medical benefit the **health plan** conditions receipt of such benefit, in whole or in part, on approval of the benefit prior to obtaining medical care.

- "**Precertification**" or "**precertify**" means a process where the **claims administrator** is contacted before certain services are provided. It is not a guarantee that benefits will be payable.

- "**Preferred brand-name drug**" means a **brand-name prescription drug** that appears on the **Preferred Drug Guide.**

- "**Preferred Drug Guide**" is a listing of **prescription drugs** established by the **claims administrator** or an affiliate, which includes **brand-name prescription drugs.** This list is subject to periodic review and modification by the **claims administrator.** A copy of the **Preferred Drug Guide** will be made available upon request or may be accessed at www.AlaskaCare.gov.

- "**Prescription**" means an order for the dispensing of a **prescription drug** by a **physician** or **dentist,** acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**. If it is an oral order, it must be promptly put in writing by the **pharmacy**.

- "**Prescription drug**" means a drug, biological, or compounded **prescription** which, by state and Federal law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal law prohibits dispensing without prescription." This includes a **self-injectable drug** prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid **health care professional**. Covered **self-injectable drugs** include injectable insulin.

- "**Prevailing charge rate**" means rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. **Aetna** updates its systems with these changes within 180 days after receiving them from FAIR Health.

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

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

- "**Protected health information**" means "protected health information" as defined at 45 CFR § 164.501 which, generally, means information (including demographic information) that (i) identifies an **individual** (or with respect to which there is a reasonable basis to believe the information can be used to identify an **individual**), (ii) is created or received by a health care **provider**, a health plan, or a health care clearinghouse, and (iii) relates to the past, present, or future physical or mental health or condition of an **individual**; the provision of health care to an **individual**; or the past, present, or future **payment** for the provision of health care to an **individua**l.

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

- "**Psychiatric hospital**" means an institution that meets all of the following requirements:
  - Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, **substance abuse** or **mental disorders**.
  - Is not mainly a school or a custodial, recreational or training institution.
  - Provides infirmary-level medical services.
  - Provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
  - Is supervised full-time by a **psychiatric physician** who is responsible for patient care and is there regularly.
  - Is staffed by **psychiatric physicians** involved in care and treatment.
  - Has a **psychiatric physician** present during the whole treatment day.
  - Provides, at all times, psychiatric social work and nursing services.
  - Provides, at all times, **skilled nursing care** by licensed nurses who are supervised by a full-time registered nurse.
  - Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatric physician**.
  - Makes charges.
  - Meets licensing standards.
- "**Psychiatric physician**" means a **physician** who:
  - Specializes in psychiatry; or
  - Has the training or experience to do the required evaluation and treatment of alcoholism, **substance abuse** or **mental disorders**.
- "**Recognized charge**" means the **negotiated charge** contained in an agreement the **claims administrator** has with the **provider** either directly or through a third party. If there is no such agreement, the **recognized charge** is determined in accordance with the provisions of this section. An out-of-**network provider** has the right to bill the difference between the **recognized charge** and the actual charge. This difference will be the **covered person's** responsibility.
  - **<u>Medical Expenses</u>**

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

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

➢ **Facility Expenses in Anchorage and outside of Alaska**

As to out-of-network **facility** services or supplies received in the Municipality of Anchorage or outside of Alaska, the **recognized charge** for each service or supply is the lesser of:

- what the **facility** bills or submits for that service or supply; or
- 185% of the Medicare allowed rate for those services.

➢ **Free standing imaging centers**

As to out-of-network **facility** expenses at a free standing imaging center, the **recognized charge** for a service or supply is 50% of the amount billed by the **provider**.

➢ **Prescription Drug Expenses**

As to **prescription drug** expenses, the **recognized charge** for each service or supply is the lesser of:

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

➢ **Dental Expenses**

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

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

For out-of-network **dentists** or **dental care providers** in the **State**, the **recognized charge** is the lesser of:

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

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

For out-of-network **dentists** or **dental care providers** outside the **State**, the **recognized charge** is the lesser of:

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

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

➢ **Vision Expenses**

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

➢ **Medical/Dental/Vision/Prescription Drug Expenses**

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

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

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

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

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

- the duration and complexity of a service;

- whether multiple procedures are billed at the same time, but no additional overhead is required (excluding physical therapy);

- whether an assistant surgeon is involved and necessary for the service;

- if follow up care is included;

- whether there are any other characteristics that may modify or make a particular service unique; and

- when a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

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

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

➢ **Additional Information**

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

- "**Rehabilitation facility**" means a facility, or a distinct part of a facility which provides **rehabilitative care**, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

- "**Rehabilitative care**" means the combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by **illness** or **injury**.

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

- "**Rescission**" or "**rescind**" means a cancellation or discontinuance of coverage under the **medical plan** or **dental plan** that has retroactive effect. A rescission does not include the cancellation or discontinuance of coverage that has only a prospective effect or is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the rest of coverage.

- "**Residential treatment facility (mental disorders)**" means an institution that meets all of the following requirements:
  - On-site licensed **behavioral health provider** 24 hours per day/7 days a week.
  - Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
  - Patient is admitted by a **physician**.
  - Patient has access to necessary medical services 24 hours per day/7 days a week.
  - Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
  - Offers group therapy sessions with at least a registered nurse or Masters-Level Health Professional.
  - Has the ability to involve family/support systems in therapy (required for **children** and adolescents; encouraged for adults).
  - Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy.
  - Has peer oriented activities.
  - Services are managed by a licensed **behavioral health provider** who, while not needing to be individually contracted, needs to (1) meet **Aetna's** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
  - Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
  - Provides a level of skilled intervention consistent with patient risk.
  - Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
  - Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

- "**Residential treatment facility (substance abuse)**" means an institution that meets all of the following requirements:
  - On-site licensed **behavioral health provider** 24 hours per day/7 days a week.
  - Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
  - Patient is admitted by a **physician**.
  - Patient has access to necessary medical services 24 hours per day/7 days a week.
  - If the **covered person** requires **detoxification** services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending **physician**.
  - Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
  - Offers group therapy sessions with at least a registered nurse or Masters-Level Health Professional.
  - Has the ability to involve family/support systems in therapy (required for **children** and adolescents; encouraged for adults).
  - Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy.
  - Has peer oriented activities.
  - Services are managed by a licensed **behavioral health provider** who, while not needing to be individually contracted, needs to (1) meet **Aetna's** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
  - Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
  - Provides a level of skilled intervention consistent with patient risk.
  - Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
  - Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.
  - Has the ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.

- 24-hours per day/7 days a week supervision by a **physician** with evidence of close and frequent observation.

- On-site, licensed **behavioral health provider**, medical or **substance abuse** professionals 24 hours per day/7 days a week.

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

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

- "**Room and board**" means charges made by an institution for **room and board** and other **medically necessary** services and supplies. The charges must be regularly made at a daily or weekly rate.

- "**Security incident**" means "security incident" as defined at 45 CFR § 164.304, which, generally, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

- "**Security Regulations**" mean the regulations under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Parts 160 and 164, as amended).

- "**Self-injectable drugs**" mean **prescription drugs** that are intended to be self-administered by injection to a specific part of the body to treat certain chronic medical conditions.

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

- "**Service in the uniformed services**" means (i) the performance of a duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, and National Guard duty under Federal law, (ii) a period for which an **eligible employee** is absent from a position of employment for the purpose of an examination to determine the fitness of the **eligible employee** to perform any such duty, (iii) a period for which the **eligible employee** is absent from employment to perform funeral honors duty as authorized by law, and (iv) service as an intermittent disaster-response appointee upon activation of the National Disaster Medical System ("NDMS") or as a participant in an authorized training program.

- "**Skilled nursing care**" means:
  - Those services provided by a visiting registered nurse or licensed practical nurse for the purpose of performing specific skilled nursing tasks; and

- Private duty nursing services provided by a registered nurse or licensed practical nurse if the patient's condition requires **skilled nursing care** and visiting nursing care is not adequate.

- "**Skilled nursing facility**" means an institution that meets all of the following requirements:
  - Licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **illness** or **injury**:
    - professional nursing care by a registered nurse or a licensed practical nurse directed by a full-time registered nurse; and
    - physical restoration services to help patients to meet a goal of self-care in daily living activities.
  - Provides 24 hour a day nursing care by licensed nurses directed by a full-time registered nurse.
  - Is supervised full-time by a **physician** or a registered nurse.
  - Keeps a complete medical record on each patient.
  - Has a utilization review plan.
  - Is not an institution for rest or care of the aged, drug addicts, alcoholics, people who are mentally incapacitated, or people with **mental disorders**.
  - Charges patients for its services.
  - An institution or a distinct part of an institution that meets all of the following requirements:
    - It is licensed or approved under state or local law.
    - Is primarily engaged in providing **skilled nursing care** and related services for residents who require medical or nursing care, or **rehabilitation services** for the rehabilitation of injured, disabled, or sick persons.
  - Qualifies as a **skilled nursing facility** under Medicare or as an institution accredited by:
    - The Joint Commission on Accreditation of Health Care Organizations;
    - The Bureau of Hospitals of the American Osteopathic Association; or
    - The Commission on the Accreditation of Rehabilitative Facilities.

Skilled nursing facilities also include rehabilitation **hospitals** (all levels of care, *e.g.* acute) and portions of a **hospital** designated for skilled or **rehabilitation services**. **Skilled nursing facilities** do not include institutions which provide only (i) minimal care, (ii) c**ustodial care** or educational care, (iii) ambulatory services, or (iv) part-time care services, or institutions which primarily provide for the care and treatment of alcoholism, **substance abuse** or **mental disorders**.

- "**Skilled nursing services**" means services that meet all of the following requirements:
  - The services require medical or paramedical training.
  - The services are rendered by a registered nurse or licensed practical nurse. within the scope of his or her license.
  - The services are not custodial.
- "**Specialty care drugs**" means **prescription drugs** that include injectable, infusion, and oral drugs prescribed to address complex, chronic disease with associated co-morbidities such as cancer, rheumatoid arthritis, hemophilia, and multiple sclerosis, which are listed in the specialty care drug list.
- "**Specialty pharmacy network**" means a network of pharmacies designated to fill **specialty care drugs.**
- "**Spouse**" means the person to whom the **eligible employee** is legally married under state law. A **spouse** includes a person to whom the **eligible employee** is legally separated, but not divorced.
- "**State**" means the State of Alaska.
- "**Stay**" means a full-time inpatient confinement for which a **room and board** charge is made.
- "**Substance abuse**" means a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered **dependents**.) This term does not include conditions not attributable to a **mental disorder** that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.
- **"Summary health information"** means "summary health information" as defined by 45 CFR § 164.504(a), as amended, which generally is information that may be individually identifiable health information, and:
  - that summarizes the claims history, claims expenses, or type of claims experienced by **individuals** for whom the **State** has provided health benefits under the **health plan**; and

- from which the information described at § 164.514(b)(2)(i) of the **Privacy Regulations** has been deleted, except that the geographic information described in § 164.514(b)(2)(i)(B) of the **Privacy Regulations** need only be aggregated to the level of a five digit zip code.

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

- Written procedures for such a transfer must be displayed and the staff must be aware of them.

- Provides an ongoing quality assurance program. The program must include reviews by **physicians** who do not own or direct the **facility**.

- Keeps a medical record on each patient.

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

- **"Totally disabled"** or "**total disability**" means, for purposes of extended coverage under the **medical plan**, your complete inability to perform everyday duties appropriate for your employment, age or sex. The inability may be due to disease, **illness**, **injury**, or pregnancy. The **State** reserves the right to determine **total disability** based upon the report of a duly qualified **physician** or **physicians** chosen by the **claims administrator**.

- "**Uniformed Service"** means the Armed Forces, the Army National Guard, the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commission corps of the Public Health Service, and any other category of persons designated by the President of the United States of America in time of war or emergency. For purposes of USERRA coverage only, services as an intermittent disaster response appointee of the NDMS when federally activated or attending authorized training in support of their Federal mission is deemed service in the uniformed services, although such appointee is not a member of the "uniformed services" as defined by USERRA.

- "**Urgent admission**" means a **hospital** admission by a **physician** due to:
  - The onset of or change in an **illness**, the diagnosis of an **illness**, or an **injury**; and

  - The condition, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a **hospital** within two weeks from the date the need for the confinement becomes apparent.

- "**Urgent care claim**" means any claim for medical care or treatment where the failure to make a non-urgent care determination quickly (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or (ii) in the opinion of a **physician** with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

- "**Urgent care provider**" means:
  - A freestanding medical facility that meets all of the following requirements.

    - Provides unscheduled medical services to treat an **urgent condition** if the person's **physician** is not reasonably available.

- Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
- Makes charges.
- Is licensed and certified as required by any state or Federal law or regulation.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.
- Is run by a staff of **physicians**. At least one **physician** must be on call at all times.
- Has a full time administrator who is a licensed **physician**.

➢ A **physician's** office, but only one that:

- Has contracted with **Aetna** to provide urgent care; and
- Is, with **Aetna's** consent, included in the **directory** as a network **urgent care provider.**

➢ It is not the emergency room or outpatient department of a **hospital**.

- "**Urgent condition**" means a sudden **illness**, **injury,** or condition that:
  - ➢ is severe enough to require prompt medical attention to avoid serious deterioration of your health;
  - ➢ includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
  - ➢ does not require the level of care provided in the emergency room of a **hospital**; and
  - ➢ requires immediate outpatient medical care that cannot be postponed until your **physician** becomes reasonably available.
- "**Veneer**" means a layer of tooth-colored material attached to the surface of an **anterior** tooth to repair chips or cracks, fix gaps and change the shape and size of teeth. A chairside **veneer** is a **restoration** created in the **dentist's** office. A laboratory **veneer** is a **restoration** that is created (cast) at a laboratory. Chairside and laboratory **veneers** may be paid at different benefit levels.
- **"Vision plan"** means vision benefits under the **plan**, as set forth in section 5, *Vision Plan*.

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

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

STATE OF ALASKA

AlaskaCare Employee Health Plan

JANUARY 1, 2017

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 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.

AlaskaCare Claims Administrators

MEDICAL CLAIMS ADMINISTRATOR

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

Customer Service/Provider Locator .....(855) 784-8646
TDD *for hearing impaired* .....(800) 628-3323

24-Hour Nurse Line .....(800) 556-1555

Employee Assistance Plan .....(855) 417-2493

PRESCRIPTION DRUG CLAIMS ADMINISTRATOR

Paper Claims:
Aetna Pharmacy
P.O. Box 52444
Phoenix, AZ 85072-2444

Mail Order:
Aetna Rx Home Delivery
P.O. Box 417019
Kansas City, MO 64179-7019

Specialty:
Aetna Specialty Pharmacy
503 Sunport Lane
Orlando, FL 32809

Customer Service/Provider Locator .....(855) 784-8646
TDD *for hearing impaired* .....(800) 823-6373

Aetna Mail Order Pharmacy .....(888) 792-3862
TDD *for hearing impaired* .....(800) 823-6373

Aetna Specialty Pharmacy .....(866) 782-2779
TDD *for hearing impaired* .....(877) 833-2779

DENTAL CLAIMS ADMINISTRATOR

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

Customer Service .....(855) 718-1768

Customer Service-Spanish .....(877) 299-9063

VISION CLAIMS ADMINISTRATOR

Vision Services Plan (VSP)
P.O. Box 997105
Sacramento, CA 95899-7105
www.vsp.com

Customer Service .....(800) 877-7195

HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS ADMINISTRATOR

PayFlex Systems USA, Inc.
P.O. Box 4000
Richmond, KY 40476-4000
www.alaskacare.payflexdirect.com

Customer Service .....(888) 678-8242

COBRA ADMINISTRATOR

PayFlex Systems USA, Inc.
P.O. Box 4000
Richmond, KY 40476-4000
www.alaskacare.payflexdirect.com

Customer Service .....(888) 678-8242

Adoption Order

Sheldon Fisher, Commissioner of the Department of Administration, hereby adopts, pursuant to authority under AS 39.30-090-098, the AlaskaCare Employee Health Plan dated January 1, 2017 ("**plan**"), as the official plan document governing the benefits contained therein. The **plan** is effective upon adoption and applies to claims submitted for payment with dates of service on or after the date indicated below. All prior **plan** booklets, documents and related amendments are hereby repealed in their entirety.

Dated: 1/1/17

Sheldon Fisher, Commissioner
Department of Administration

Table of Contents

1. *Introduction to Plan*

1.1. PLAN BENEFITS

You receive substantial value from the benefits the State of Alaska ("**State**") makes available to you. The **plan** gives you an opportunity to select the **benefit options** and levels of coverage that reflect your own personal needs, lifestyle, and situation. The **State** provides comprehensive benefits under the **plan** for you and your family. Your coverage under the **plan** is good worldwide.

With the **plan**, you can choose the benefits that best fit your needs. The **plan** offers a range of choices for each **benefit option**. Each **benefit option** has a monthly employee contribution or premium based on the cost of providing that coverage. Unless you have timely waived coverage in the **plan**, you are required to participate in both the **medical plan** and the **dental plan**. You may also voluntarily elect coverage under the **vision plan**. Additionally, you may choose to make pre-tax contributions to a health flexible spending account (HFSA) to pay for health care expenses that are not covered by the **plan**. These **benefit options** are described in detail in this **plan**.

This **plan** may be updated from time to time to reflect changes in benefits. You should make sure that you are referencing the most current edition, which is available from the Division of Retirement and Benefits ("**Division**"), or www.AlaskaCare.gov.

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

1.2. DEFINED TERMS

Bolded words in the **plan** are defined in section 15, *Definitions*.

1.3. ELIGIBILITY FOR COVERAGE

1.3.1. Eligible Employees

Benefit options under the **plan** are available to **eligible employees**. **Eligible employees** are permanent and long-term nonpermanent **employees** of the **State** whose bargaining unit or employee group participates in the **plan** and who are either:

- Full-time employees (including seasonal) who are scheduled to work 30 or more hours a week on a regular basis; or

- Part-time employees (including seasonal) who are scheduled to work at least 15 but less than 30 hours a week on a regular basis.

In addition to the above, **benefit options** may be offered to employees of the **State** whose bargaining unit or employee group participates in the **plan**, if the employee otherwise meets the criteria as outlined under the employer shared responsibility provisions in 26 U.S. Code § 4980H.

Coverage under the **medical plan** and **dental plan** for **eligible employees** who are full-time **employees** is mandatory unless the employee timely waives coverage at the time benefit coverage is offered upon entry into the plan, or during an annual open enrollment. Coverage under the **medical plan** and **dental plan** is optional for **eligible employees** who are part-time **employees**.

The following bargaining units and employee groups participate in the **plan**:

- 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
- Correctional Officers
- Employees not covered by a collective bargaining agreement

1.3.2. Eligible Dependents

You may enroll the following **dependents** in coverage under any or all of the **benefit options**:

- Your **spouse**.
- Your **children** until they attain age 26.
- Your **child** age 26 and older who is permanently and totally disabled. Permanent and total disability means the inability to engage in any substantial gainful activity due to a 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 continuous period of not less than 12 months. The permanent and total disability must have existed before the **child** attains age 26 and the **child** must be (i) unmarried,

(ii) provide less than one-half of his or her own support, and (iii) share your principal place of residence for more than one-half of the year (unless the **child** is your natural or adopted **child** and is living with your ex-**spouse**). You must provide proof to the **claims administrator** of the permanent and total disability, proof that it existed before age 26, and proof of financial dependency, no later than 60 days after the **child's** 26th birthday. You must provide periodic proof of continued permanent and total disability as reasonably requested by the **claims administrator**.

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

When you enroll in the **plan**, you must also enroll each of your **dependents** in order for their claims to be paid. If your **dependents** subsequently change, you must notify the **Division** within 30 days, as provided under section 1.8.2, *Changes in Status or Other Applicable Events*.

1.3.3. Waiver of Coverage

If you or your family maintain coverage under another medical plan, you may voluntarily waive your **medical plan**, **dental plan** and/or **vision plan** coverage under the **plan**. Your election to waive your own medical, or dental coverage, or if chose not to elect coverage under the **vision plan,** also waives coverage for your **spouse** and **child**(ren). However, you may elect to waive the medical, dental and/or vision coverage for your **spouse** and **child**(ren) while maintaining your individual coverage.

- To elect to waive coverage under the **medical plan**, and/or **dental plan** for yourself, or to waive coverage for your dependents under the **medical plan**, **dental plan** and/or **vision plan** you must elect to *Opt Out* through the myRnB electronic enrollment system found at www.myrnb.alaska.gov. To elect to waive coverage you must elect to waive each component of the group health benefit plan coverage being waived and do so each **benefit year** during the annual open enrollment period. A waiver of coverage made during an annual open enrollment period is effective on the first day of the **benefit year** immediately following the open enrollment.

- You may elect to waive coverage during the 30-day period after you initially become eligible for coverage and before the date on which coverage becomes effective under the **plan**. Such waiver shall be effective as of the 31st consecutive day after you begin employment in a position eligible for coverage.

- If you change positions from a position in a bargaining unit that does not participate in the **plan** to a position covered by the **plan** you may

elect to waive coverage within 30 days of the effective date of the change. The waiver shall be effective on the first day of the month following the change of position. If the change of position occurs on the first day of a month, the waiver shall be effective on such first day of the month.

During the term of a **benefit year**, you may elect to:

- waive coverage previously elected for the **benefit year**; or
- enroll in coverage that was previously waived for the **benefit year**, based upon qualified changes in status or other applicable events that are allowed under section 1.8.2, *Changes in Status and other Applicable Events*.

Elections under this subsection may be made on behalf of the **employee**, a **spouse** and **child**(ren) consistent with the change in status or other applicable event; provided that **spouses** and **child**(ren) may not be covered under any component of the **plan** if the **employee** is not also covered. Such elections shall be made no later than 30 days after the date of the change in status or other applicable event, unless federal law requires a lengthier election period, and shall be effective as of the date of the change in status or other applicable event.

1.3.4. Dual Coverage

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

1.4. MONTHLY EMPLOYEE CONTRIBUTION

The **State** contributes towards the cost of **benefit options** under the **plan**. The amount the **State** contributes is determined by your bargaining unit contract, or in the case of **eligible employees** not covered by a bargaining unit, by the **State**. However, in most instances you are also required to pay a portion of the health costs through a monthly employee contribution.

Unless otherwise stated in the collective bargaining agreement, the **State** contribution for part-time employees is ½ of the contribution for full-time employee, and the part-time employee must pay the difference in addition to the normal monthly employee contribution for any **benefit options** elected.

You can elect which options under the **medical plan** and **dental plan** you want. You can also elect whether or not to participate in the **vision plan**. In addition you can elect if you want one or all of these coverages to extend to your eligible **dependents**, including your

spouse. Each option under the **medical plan** and **dental plan**, as well as the **vision plan**, has a premium, or employee contribution. The current **employee monthly contribution** amounts are available from your human resources office, the **Division**, or www.AlaskaCare.gov.

- Your monthly employee contribution, will be deducted on a pre-tax basis in equal installments from your paychecks in the month coverage is provided. For example, premiums for July are withheld from paychecks issued in July. If your paycheck is insufficient to pay the premium, you should contact your human resources office or the **Division** for information on paying your premiums directly on an after-tax basis.

You may also decide to make additional pre-tax contributions to a health flexible spending account (HFSA). See section 6, *Health Flexible Spending Account (HFSA)*.

1.5. INITIAL COVERAGE ELECTIONS

1.5.1. New Employees

You must elect your **benefit options** under the **plan** within 30 days of the date you are first hired.

- If you are an **eligible employee** who is a full-time **employee** and you do not timely elect your **benefit options**, you will be enrolled in the default option for the **medical plan** and for the **dental plan**. See section 1.6, *Default Options*.

- If you are an **eligible employee** who is a part-time **employee** and you do not timely elect your **benefit options**, neither you nor your **dependents** will be enrolled in the **plan**.

1.5.2. Rehired Employees

Employees who terminate employment and are rehired in a *new* **benefit year** will be enrolled in the **plan** as new **employees**.

Employees who terminate employment and are rehired in the *same* **benefit year** will be re-enrolled in the same **benefit options** they had during their prior employment.

1.5.3. Employees Moving from a Nonparticipating Bargaining Unit

Employees who move from a bargaining unit that does not participate in the **plan** to a bargaining unit that participates in the **plan** have 30 days from the date of the bargaining unit change to elect coverage under the **plan**. If timely elected, coverage is effective as provided in section 1.7.4, *Employees Moving*

from a Nonparticipating Bargaining Unit. If you do not timely elect coverage, you will be enrolled in the default option for the **medical plan** and the **dental plan**. See section 1.6, *Default Options*.

1.5.4. Dependents

You must elect coverage for your **dependents** at the same time you enroll in the **plan**. If you do not timely enroll your **dependents** in the **plan**, they will not be covered under the **plan** until you enroll them during the next open enrollment or, if sooner, due to a change in status or other applicable event. See section 1.8.2, *Changes in Status or Other Applicable Events*.

1.6. DEFAULT OPTIONS

The default options for the **medical plan** and **dental plan** for **eligible employees** who are full-time **employees** are established each **benefit year**. The default options are subject to change, generally effective the next **benefit year**. If you are enrolled in a default option and do not enroll in the **plan** during the following open enrollment, your defaults will be changed to the options established as the defaults for that **benefit year**. The default option for the **benefit year** beginning January 1, 2017 is the economy **medical plan** and economy **dental plan** for you and your eligible **dependents.**

1.7. WHEN COVERAGE BEGINS

1.7.1. New Employees

If you are an **eligible employee** who is a full-time **employee**, you and your **dependents** are covered on the 31st consecutive day you are at work in pay status, unless coverage is waived in accordance with Section 1.3.3, *Waiver of Coverage*. For example, if you begin work on October 1, you are covered on October 31, if you have no periods of leave without pay and are still employed on that date.

If you are an **eligible employee** who is a part-time **employee** and you elect coverage for yourself and your **dependents** under the **plan** during the first 30 days of employment, you and your **dependents** are covered on the 31st consecutive day you are at work in pay status. For example, if you begin work on April 3, and you elect coverage by May 2, you are covered on May 3, if you have no periods of leave without pay and are still employed on that date.

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 , unless coverage is waived in accordance with Section 1.3.3, *Waiver of Coverage*. 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, if you have no other periods of leave without pay and are still employed on that date.

Notwithstanding the above and, except if coverage is waived in accordance with Section 1.3.3, *Waiver of Coverage*, in no event will your waiting period be longer than 90 calendar days, if you are at work and in pay status on such date.

1.7.2. Rehired Employees

If you are covered under the **plan** as an actively working **employee**, terminate employment with the **State**, and:

- *are rehired within seven calendar days* of the date your coverage terminated, your coverage begins on the day you return to work. For example, if you terminate employment on July 5, your coverage ends July 31, and you return to work on or before August 7, you are covered under the **plan** the day you return to work; or

- *are rehired more than seven calendar days* after your coverage terminated, coverage begins as set forth under section 1.7.1, *New Employees*.

1.7.3. Employees Returning from Leave Without Pay or Layoff

If you were covered under the **plan** when you began leave without pay or layoff, when you return to work from leave without pay or layoff, you are covered under the **plan** starting the day you return to work. For example, if you return to work from leave without pay on July 15, coverage begins under the **plan** for you and your **dependents** on July 15. This paragraph applies to the extent you did not continue coverage under the **plan** during an unpaid FMLA leave, as permitted under section 13.9, *Family and Medical Leave Act (FMLA*).

1.7.4. Employees Moving from a Nonparticipating Bargaining Unit

Employees who move from a bargaining unit that does not participate in the **plan** to a bargaining unit that participates in the **plan** will be covered under the **plan** on the first day of the month after the date of the bargaining unit change unless coverage is waived in accordance with section 1.3.3, *Waiver of Coverage*. For example, if your bargaining unit change is effective October 15, your coverage under the **plan** begins on November 1.

If the change is effective on the first day of the month, you will be covered under the **plan** on that day. For example, if your bargaining unit change is effective November 1, you will become covered under the **plan** on that day.

If you are on leave without pay or on layoff at the time the change occurs, you will not be covered under the **plan** until the day you return to work.

1.7.5. Dependents

Dependents are covered under the **plan,** unless coverage is waived in accordance with section 1.3.3, *Waiver of Coverage*, on the same day that you are covered if they meet the eligibility requirements and you timely enroll them in the **plan.**

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

1.8. CHANGING YOUR COVERAGE

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

1.8.1. Open Enrollment

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

- elect to begin coverage under one or more **benefit options**;
- waive coverage as outlined in section 1.3.3, *Waiver of Coverage*
- change your **benefit options**; or
- terminate coverage under one or more **benefit options** (except that coverage under the **medical plan** and **dental plan** is mandatory for **eligible employees** who are full-time **employees** and have not waived coverage).

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

If you do not make any elections during open enrollment:

- You will automatically be re-enrolled in the same **benefit options** you had in the prior year, except if you waived coverage under section 1.3.3, *Waiver of Coverage*.

- If you waived coverage under section 1.3.3, *Waiver of Coverage*, you must make an election during each open enrollment to continue to waive coverage or you will be placed in the default option for the **medical plan** and **dental plan.** See section 1.6, *Default Options*.

- If you were enrolled in a default option for the **medical plan** or **dental plan** and the default options have changed, you will automatically be enrolled in the new default options.

- You will not be re-enrolled in the health flexible spending account (HFSA).

If you want to participate in the health flexible spending account (HFSA), you must make an election during each open enrollment.

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 due to a change in status or other applicable event. See section 1.8.2, *Change in Status or Other Applicable Events*.

1.8.2. Changes in Status or Other Applicable Events

You may change your elections, make a new election or, if permitted by the **plan**, terminate 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 other applicable event.

a. Changes in Status

The following are changes in status:

- A change in your legal marital status, including divorce or marriage.

- A change in the number of your **dependents**, including the death of a **spouse** or **dependent** or the birth or adoption (or placement for adoption) of your **child**.

- A change in your, your **spouse's**, or your **dependent's** employment status, including:

  - the termination or commencement of employment;

  - a change from part-time to full-time or full-time to part-time employment;

- a commencement of or return from an unpaid leave of absence;
- a change in worksite that affects eligibility; or
- a return from a strike or lockout.

- your **dependent** satisfying or ceasing to satisfy the definition of **dependent** under the **benefit option.**
- your, your **spouse's**, or your **dependent's** change in the place of residence that affects eligibility.

Changes in coverage under the **medical plan**, **dental plan**, **vision plan**, and health flexible spending account (HFSA) 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 **benefit option**.

b. Other Applicable Events

There are other situations in which you can change your elections during the **benefit year**, referred to as other applicable events. These do not apply to the health flexible spending account (HFSA) unless specifically provided. Other applicable events include:

- **Significant Change in Cost or Coverage**

  If you elect to participate in the **plan** and your cost for a **benefit option** 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 option** providing similar coverage (if available), or if not available, drop coverage entirely (provided that you may not drop medical coverage unless you maintain medical coverage under another plan); or
  - if there is a significant cost decrease, begin participation in the **plan** and elect the coverage that significantly decreased in cost.

- **Cost Increase or Decrease**

  If you elect to participate in the **plan** and your cost for a **benefit option** 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.

- **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 option** providing similar coverage (if available), or drop such coverage if no other **benefit option** providing similar coverage is available under the **plan** (provided that you may not drop medical or dental coverage if it is mandatory). A "loss of coverage" means:

  - an elimination of a **benefit option**; or

  - a substantial decrease in medical care providers under a **benefit option** (such as a hospital ceasing to be a member of a preferred provider network or a substantial decrease in physicians in a preferred provider network).

- **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 **benefit 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 Benefit Option Providing Similar Coverage**

  If the **plan** adds a new **benefit 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**

  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's**, former **spouse's**, or **dependent's** employer if the other plan permits participants to make an election change or this **plan** permits you 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 coverage under the **medical plan** unless you maintain medical coverage under another plan.

- **Loss of Coverage Under Governmental/Educational Group Health Plan**

  You may make an election to add coverage under the **medical plan** or **dental plan** 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**

  If you or your **spouse** or **dependent** are entitled to HIPAA special enrollment under the **plan**, including the health flexible spending account (HFSA), 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.

  You, your **spouse** or **dependent** may also be enrolled in the **plan** during special enrollment periods if (i) you, your **spouse** or **dependent** 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 (ii) coverage under such plan is lost due to a loss of eligibility for such coverage. In addition, you, your **spouse** or **dependent** may be enrolled under the **plan** if you, your **spouse** or **dependent** become 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. *A 60 day enrollment period applies to this other applicable event.*

- **Entitlement to Medicare or Medicaid**

  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. 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**

  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 benefits under the **plan**, including the health flexible spending account (HFSA), to either: (i) cover the **child** or (ii) cancel coverage of the **child**, as applicable.

1.9. WHEN COVERAGE ENDS

1.9.1. For Employees

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

- The date that the **plan** or any **benefit option** under the **plan** is terminated.
- The date that the **plan** or any **benefit option** under the **plan** is voluntarily waived in accordance with section 1.3.3, *Waiver of Benefits.*
- The last day of the month in which you cease to be an **eligible employee**.
- The date you die.
- The last day of the month in which you were last in pay status (whether actively at work or on paid leave).
- The last day of the month in which you terminate employment.

- The last day of the month in which you are laid off or reduce your hours of employment such that you are no longer an **eligible employee**.

- The last day of the month in which you move from a position that participates in the **plan** to a position that does not.

- The last day of the month during which you fail to pay any required premium.

- The date you become a full-time member of the armed forces of any country.

1.9.2. For Dependents

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

- The date that the **plan** or any **benefit option** under the **plan** is terminated.

- The date that **dependent** coverage under the **plan** or the **plan** is terminated.

- The date that **dependent** coverage under the **plan** is waived in accordance with section 1.3.3, *Waiver of Coverage.*

- The date a spouse ceases to be a **dependent** due to a divorce.

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

- The date a **dependent** dies.

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

- The last day of the month during which you fail to pay any required premium on behalf of your **dependents**.

- The date that you terminate coverage for your **dependents**.

1.9.3. Continued Coverage

You and/or your **dependents** may be eligible for continued health benefits when coverage ends under the **plan.** See section 8, *Consolidated Omnibus Budget Reconciliation Act* (*COBRA) and Extended Health Coverage*, section 13.8, *Continuation of Coverage under the Uniformed Services Employment*

and Reemployment Rights Act of 1994 (*USERRA)*, and section *13.9*, *Family and Medical Leave Act (FMLA).*

1.10. RECEIPT OF DOCUMENTS

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

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

1.11. FUTURE OF THE PLAN

Although the **State** intends to maintain the **plan** indefinitely, the **State** reserves the right, in its sole discretion, to alter, amend, delete, cancel, or otherwise change the **benefit options** or terms 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 **eligible employee**, **dependent**, or **covered person** will have any vested interest in the **plan** or the **benefit options** under the **plan**.

1.12. ADMINISTRATION OF THE PLAN

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

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

2. *Benefit Schedules*

2.1. MEDICAL AND PRESCRIPTION DRUG BENEFITS

2.1.1. Medical Benefit Schedule

	Standard Plan	Economy Plan
Deductibles		
Annual individual **deductible**	$400	$600
Annual family **deductible**	$800	$1,200
Coinsurance		
Most medical expenses • $100 penalty if seek non-**emergency care** at emergency room of a **hospital**	80%	70%
Most medical expenses after **out-of-pocket limit** is satisfied	100%	100%
Medical expenses for your **spouse** or **dependent children** if they are eligible to be covered by a **State** employee health trust and that coverage (i) has been waived, (ii) pays less than 70% of the **covered expenses**, or (iii) has an individual out-of-pocket limit, including **deductible**, of more than $3,500.	30%	30%
Facility services with a **network provider**	80%	70%
Facility services with an out-of-**network hospital**, **surgery center**, **rehabilitative facility,** or free standing imaging center in other 49 states or non-preferred provider **hospital**, **surgery center**, **rehabilitative facility,** or free standing imaging center in Anchorage	60%	50%
Transplant services if an Institute of Excellence™ (IOE) facility is used	80%	70%
Transplant services if a non-Institute of Excellence™ (IOE) facility is used	60%	50%

Preventive care with a **network provider** or when use of an out-of-**network provider** has been **precertified.**	100%	100%
Preventive care with an out-of-**network provider**	80%	70%
Hearing benefit	80%	80%
Inpatient **mental disorder** treatment with a **network provider**	80%	70%
Inpatient **mental disorder** treatment with an out-of-**network provider**	60%	50%
Inpatient **substance abuse** disorder treatment with a **network provider**	80%	70%
Inpatient **substance abuse** disorder treatment with an out-of-**network provider**	60%	50%
	Standard Plan	**Economy Plan**
Out-of-Pocket Limit		
Annual individual **out-of-pocket limit** • The following expenses do not apply toward the **out-of-pocket limit**: • charges over the **recognized charge**; • non-**covered expenses**; • premiums; • **precertification** benefit reductions; • $100 penalty if seek non-**emergency care** at emergency room of a **hospital;** and • **Prescription drug** expenses	$1,850 $3,700 if use out-of-**network hospital**, **surgery center**, **rehabilitative facility,** or free standing imaging center for **facility** services outside Alaska, or non-preferred provider **hospital**, **surgery center**, **rehabilitative facility,** or free standing imaging center in Anchorage	$2,850 $5,700 if use out-of-**network hospital**, **surgery center**, **rehabilitative facility,** or free standing imaging center for **facility** services outside Alaska, or non-preferred provider **hospital**, **surgery center**, **rehabilitative facility,** or free standing imaging center in Anchorage

Annual family **out-of-pocket limit** • The following expenses do not apply toward the **out-of-pocket limit**: • charges over the **recognized charge**; • non-**covered expenses**; • premiums; • **precertification** benefit reductions; • $100 penalty if seek non-**emergency care** at emergency room of a **hospital;** and • • **Prescription drug** expenses	$3,700 $7,400 if use out-of-**network provider** for **hospital**, **surgery center**, **rehabilitative facility,** or free standing imaging center services outside Alaska, or non-preferred provider **hospital**, **surgery center**, **rehabilitative facility,** or free standing imaging center in Anchorage	$5,700 $11,400 if use out-of-**network provider** for **hospital**, **surgery center**, **rehabilitative facility,** or free standing imaging center services outside Alaska, or non-preferred provider **hospital**, **surgery center**, **rehabilitative facility,** or free standing imaging center in Anchorage
Benefit Maximums		
Individual limit on hearing aids • Maximum applies to a rolling 36 month period	$3,000	
Visit/Service Limits		
Spinal manipulations including medical massage therapy when done in conjunction with spinal manipulations	20 visits per **benefit year**	
Hearing exams	One per rolling 24 month period	
Home health care. See section 3.5.8, *Home Health Care*, for exceptions.	120 visits per **benefit year** Up to 4 hours = 1 visit	
Outpatient hospice expenses	Up to 8 hours per day	
Cognitive therapy, physical therapy, occupational therapy, and speech therapy rehabilitation benefits	No more than 2 therapy visits in a 24 hour period Up to 1 hour = 1 visit	
Employee assistance program	8 visits per problem per **benefit year**	
Travel Benefits: Therapeutic treatments	One visit and one follow-up per **benefit year**	

Travel Benefits: • Prenatal/postnatal maternity care • Maternity delivery • Presurgical or postsurgical or second surgical opinion • Surgical procedure • Allergic condition	One visit per **benefit year** ➢ One visit per **benefit year** One visit per **benefit year** ➢ One visit per **benefit year** One visit per **benefit year** for each allergic condition
Travel Per Diems/Limitations	
Travel per diem without overnight lodging. See section 3.5.22, *Travel*, for applicable criteria.	$51/day
Travel per diem with overnight lodging. See section 3.5.22, *Travel*, for applicable criteria.	$89/day
Companion per diem for **children** under age 18. See section 3.5.22, *Travel*, for applicable criteria.	$31/day
Overnight lodging for transplant services, in lieu of other travel per diems. See section 3.5.23, *Transplant Services*, for other applicable criteria.	$50 per person/night, up to $100/night
Limit on travel for transplant services	$10,000 per transplant occurrence
Travel benefits without **precertification**	No benefits will be paid
Precertification Penalties	
A $400 benefit reduction applies if you fail to obtain **precertification** for certain medical services. See section 3.4.3, *Services Requiring Precertification*.	

2.1.2. Prescription Drug Schedule

Prescription Tier	Coinsurance	Minimum Covered Person Payment	Maximum Covered Person Payment
Retail 30 Day at Network Pharmacy			
Generic prescription drug	80%	$10	$50
Preferred brand-name prescription drug	75%	$25	$75
Non-preferred brand-name prescription drug	65%	$80	$150

Mail Order 31-90 Day at Network Pharmacy	
Prescription Tier	**Copayment**
Generic prescription drug	$20
Preferred brand-name prescription drug	$50
Non-preferred brand-name prescription drug	$100

Out-of-Network Pharmacy	
Coinsurance for all **prescription drugs**	60%
Out-of-Pocket Limit	
Annual individual **out-of-pocket limit**	$1,000
Annual family **out-of-pocket limit**	$2,000

2.2. DENTAL BENEFIT SCHEDULE

	Standard Plan	Economy Plan
Annual individual **deductible**	$25 (waived for Class I services)	$25
Annual family **deductible**	$75 (waived for Class I services)	$75
Coinsurance		

Class I (preventive) services	100%	100%
Class II (restorative) services	80%	10%
Class III (prosthetic) services	50%	10%
	Standard Plan	**Economy Plan**
Orthodontia	50%	Not covered
Benefit Maximums		
Annual individual maximum	$1,500	$500
Orthodontia lifetime individual maximum • This maximum is not included in the annual individual maximum	$1,000	Not covered

2.3. VISION BENEFIT SCHEDULE

	Network Provider	**Out-of-Network Provider**
Exam	One per calendar year $10 **copayment** 100% after **copayment**	One per calendar year $10 **copayment** Maximum reimbursement limit of $100
Lenses • Single vision • Lined bifocal • Lined trifocal • Lenticular • Progressive	One pair per calendar year $25 **copayment** 100% after **copayment**	One pair per calendar year Maximum reimbursement limit of: Single vision: $75 Lined bifocal: $115 Lined trifocal: $130 Progressive: $115

	Network Provider	Out-of-Network Provider
Lens options • Anti-reflecting coating • Polycarbonate • Scratch resistant coating	Once per calendar year 100%	Not covered
Frames	One every two calendar years $25 **copayment** 100% after **copayment** up to $130 allowance (or $70 allowance at Costco) 20% off amount over allowance	One every two calendar years Maximum reimbursement limit of $70
Contact lenses (necessary)	$60 **copayment** 100% after **copayment** 15% off usual and customary professional fees for evaluation and fitting	Not covered
Contact lenses (elective and in lieu of lenses and frame)	Once per calendar year $130 allowance for contacts	Once per calendar year Maximum reimbursement limit of $105
Additional pairs of glasses	30% off unlimited additional pairs of **prescription** glasses or non-**prescription** sunglasses from the same **VSP doctor** on the same day as eye exam 20% off unlimited additional pairs of **prescription** glasses or non-**prescription** sunglasses from any **VSP doctor** within 12 months of your last eye exam	Not covered

	Network Provider	Out-of-Network Provider
Laser VisionCare Program	Average of 15% discounts off or 5% off promotional offer for laser surgery, including PRK, LASIK and Custom Lasik from a **VSP doctor**	Not covered
Low vision supplemental testing (includes evaluation, diagnosis and **prescription** of vision aids where indicated) Low vision supplemental aids	Two tests every two calendar years Allowance up to $125 75% **coinsurance** $1,000 maximum benefit to all low vision services, testing and materials, every two calendar years	Not covered
Extra savings and discounts	Guaranteed pricing on retinal screening as an enhancement to eye exam, allowance up to $39	Not covered

3. *Medical Plan*

3.1. ABOUT YOUR MEDICAL PLAN

The **medical plan** provides coverage for a wide range of medical expenses for the treatment of **illness** or **injury**. The **medical plan** also provides coverage for certain preventive and wellness benefits. With the **medical plan**, you can directly access any **network provider** or out-of-**network provider** for services and supplies covered under the **medical plan**. The **medical plan** pays benefits differently when services and supplies are obtained through **network providers** and out-of-**network providers**.

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

Coverage is subject to all the terms, policies and procedures outlined in the **medical plan**. Not all medical expenses are covered under the **medical plan**. Exclusions and limitations apply to certain medical services, supplies, and expenses. See section 3.5, *Covered Medical Expenses*, section 3.6.12, *Pharmacy Benefit Limitations*, section 3.6.13, *Pharmacy Benefit Exclusions*, and section 3.7, *Medical Benefit Exclusions*, to determine if medical services are covered, excluded or limited.

The **medical plan** provides access to covered benefits through a network of health care **providers** and **facilities**. The **medical plan** is designed to lower your out-of-pocket costs when you use **network providers** for **covered expenses**. Your **coinsurance** will generally be lower when you use **network providers** and **facilities**.

You also have the choice to access licensed **providers**, **hospitals** and other **facilities** outside the network for **covered expenses**. Your out-of-pocket costs will generally be higher when you use out-of-**network providers** because the **coinsurance** that you are required to pay is usually higher when you use out-of-**network providers**. Out-of-**network providers** have not agreed to accept the **negotiated charge** and may balance bill you for charges over the amount the **medical plan** pays. Additionally, when receiving services at an out-of-**network hospital** or other **facility** in the Municipality of Anchorage or outside of Alaska, the **recognized charge** is reduced to a percentage of Medicare that most closely reflects the aggregate contracted rate at the preferred **hospital** or other **facility** in the Anchorage area. See section 3.3.3, *Accessing Out-of-Network Provider and Benefits* and section 3.3.4, *Cost Sharing for Out-of-Network Benefits*, for additional information.

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

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

3.2. MEDICAL PLAN OPTIONS

There are two options available under the **medical plan**: economy, and standard. You elect which option under the **medical plan** that you want for you and your **dependents**. These options are identical in what is covered and how benefits are paid. However, the **deductibles**, **coinsurance**, and **out-of-pocket limits** are different with each option. See section 2.1.1, *Medical Benefit Schedule,* for details about how these items differ between the options.

3.3. HOW THE MEDICAL PLAN WORKS

3.3.1. Accessing Network Providers and Benefits

You may select any **network provider** from **Aetna's provider** directory. You can access **Aetna's** online **provider** directory, DocFind®, at www.aetna.com/docfind/custom/alaskacare, for the names and locations of **physicians, hospitals** and other health care **providers** and facilities. Due to AlaskaCare having a custom provider network it is important that you use the AlaskaCare specific DocFind® tool rather than Aetna's public DocFind® tool in order to get accurate results. You can change your health care **provider** at any time.

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

Some health care services, such as hospitalization, outpatient surgery and certain other outpatient services, require **precertification** with **Aetna** to verify coverage for these services. You do not need to **precertify** services provided by a **network provider**. **Network providers** will be responsible for obtaining the necessary **precertification** for you. Since **precertification** is the **provider's** responsibility, there is no additional out-of-pocket cost to you as a result of a **network provider's** failure to **precertify** services. See section 3.4, *Understanding Precertification,* for more information.

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

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

3.3.2. Cost Sharing For Network Benefits

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

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

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

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

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

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

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

3.3.3. Accessing Out-of-Network Providers and Benefits

You have the choice to directly access out-of-**network providers**. You will still be covered when you access out-of-**network providers** for covered benefits. When your medical service is provided by an out-of-**network provider,** the level of reimbursement from the **medical plan** for some **covered expenses** will usually be lower. This means your out-of-pocket costs will generally be higher.

Some health care services, such as hospitalization, outpatient surgery and certain other outpatient services, require **precertification** with **Aetna** to verify coverage for these services. When you receive services from an out-of-**network provider**, you are responsible for obtaining the necessary **precertification** from **Aetna**. Your **provider** may **precertify** your treatment

for you. However you should verify with **Aetna** prior to receiving the services that the **provider** has obtained **precertification**. If the service is not **precertified**, the benefit payable may be significantly reduced or may not be covered. This means you will be responsible for the unpaid balance of any bills. You must call **Aetna** to **precertify** services. See section 3.4, *Understanding Precertification*, for more information on the **precertification** process and what to do if your request for **precertification** is denied.

When you use out-of-**network providers**, you may have to pay for services at the time they are rendered. You may be required to pay the charges and submit a claim form for reimbursement. When you pay an out-of-**network provider** directly, you will be responsible for completing a claim form to receive reimbursement of **covered expenses** under the **medical plan**. You must submit a completed claim form and proof of payment to **Aetna**. See section 7, *How to File a Claim*, for a complete description of how to file a claim under the **medical plan**.

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

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

3.3.4. Cost Sharing for Out-of-Network Benefits

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

When receiving services at an out-of-**network hospital** or **facility** in the Municipality of Anchorage or outside of Alaska, the **recognized charge** for the out-of-**network hospital** or **facility** services is reduced to a percentage of

Medicare that most closely reflects the aggregate contracted rate at the preferred **hospital** or **facility** in the Anchorage area.

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

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

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

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

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

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

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

3.3.5. Availability of Providers

Aetna cannot guarantee the availability or continued network participation of a particular **provider** (*e.g.* **physician** or **hospital**). Either **Aetna** or any **network provider** may terminate the **provider** contract. To identify **network providers**, visit www.aetna.com/docfind/custom/alaskacare for **Aetna's** online **provider** directory.

3.3.6. Recognized Charge

The **recognized charge** is the charge contained in an agreement **Aetna** has with a **network provider**. If you use an out-of-**network provider**, the **covered expense** is the part of a charge which is the **recognized charge** as described in section 15, *Definitions – "Recognized Charge"*. If you use an out-of-**network provider** and the charge exceeds the **recognized charge**, the amount above the **recognized charge** is not covered by the **medical plan**, and is your responsibility to pay. You are not responsible for charges exceeding the **recognized charge** when you use a **network provider**.

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

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

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

3.3.7. Common Accident Deductible Limit

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

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

3.3.8. Lifetime Maximum

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

3.4. UNDERSTANDING PRECERTIFICATION

3.4.1. Precertification

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

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

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

When you receive services from an out-of-**network provider**, you are responsible for obtaining the necessary **precertification** from **Aetna** for any services or supplies that require **precertification** as described in section 3.4.3, *Services Requiring Precertification*. If you do not **precertify**, your benefits may be reduced or the **medical plan** may not pay any benefits.

3.4.2. The Precertification Process

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

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

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

Aetna will provide a written notification to you and your **physician** of the **precertification** decision. If **Aetna precertifies** your supplies or services, the

approval is good for 60 days as long as you remain enrolled in the **medical plan**.

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

If **Aetna** determines that the **stay** or services and supplies are not **covered expenses**, the notification will explain why and how **Aetna's** decision can be appealed. You or your **provider** may request a review of the **precertification** decision in accordance with section 7, *How to File a Claim*.

3.4.3. Services Requiring Precertification

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

Precertification is required for the following types of medical expenses:

- **Stays** in a **hospital**
- **Stays** in a **skilled nursing facility**
- **Stays** in a **rehabilitation facility**
- **Stays** in a **hospice facility**
- Outpatient **hospice care**
- **Stays** in a **residential treatment facility** for treatment of **mental disorders** and **substance abuse**
- Partial hospitalization for treatment of **mental disorders** and **substance abuse**
- Home health care
- Private duty nursing care
- Transportation (non-emergent) by fixed wing aircraft (plane)

- Autologous chondrocyte implantation, Carticel (injection into the knee of cartilage cells grown from tissue cultures)
- Cochlear implant (surgical implant of a device into the ear to try to improve hearing)
- Dental **implants** and oral appliances
- Dialysis visits
- Dorsal column (lumbar) neurostimulators: trial or implantation (for relief of severe pain)
- Electric or motorized wheelchairs and scooters
- Gastrointestinal tract imaging through capsule endoscopy
- Hip surgery to repair impingement syndrome
- Hyperbaric oxygen therapy
- Lower Limb prosthetics
- Oncotype DX (a method for testing for genes that are in cancer cells)
- Organ transplants
- Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (reconstructive surgeries to attempt to correct structural abnormalities of the jaw bones)
- Osseointegrated implant
- Osteochondral allograft/knee (grafting of cartilage and bone from a cadaver to the knee joint)
- Power morcellation with uterine myomectomy, with hysterectomy or for removal of uterine fibroids
- Proton beam radiotherapy
- Reconstruction or other procedures that may be considered **cosmetic**
- Surgical spinal procedures
- Uvulopalatopharyngoplasty, including laser-assisted procedures (surgery to reconfigure the soft palate to try to help with sleep apnea)

- Ventricular assist devices
- MRI - knee
- MRI - spine
- Intensive outpatient programs for treatment of **mental disorders** and **substance abuse**, including:
  - Psychological testing
  - Neuropsychological testing
  - Outpatient detoxification
  - Psychiatric home care services
- Travel
- Use of an out-of-**network provider** for preventive care services.

3.4.4. How Failure to Precertify Affects your Benefits

A **precertification** benefit reduction of $400 will be applied to the benefits paid if you fail to obtain a required **precertification** prior to incurring medical expenses. This means that **Aetna** will reduce the amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

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

If **precertification** of travel expenses is not requested, the $400 benefit reduction will not apply; however, no travel benefits will be paid.

If **precertification** for the use of an out-of-**network provider** for preventive care services is not requested, the $400 benefit reduction will not apply; however, all charges incurred for preventive care services will be subject to payment under the **medical plan** provisions governing non-preventive care services.

3.5. COVERED MEDICAL EXPENSES

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

- Be included as a **covered expense** under the **medical plan**.
- Not be an excluded expense under the **medical plan**. See section 3.7, *Medical Benefit Exclusions,* for a list of services and supplies that are excluded, and section 3.6.14, *Pharmacy Benefit Exclusions*, for additional exclusions that apply with respect to the **prescription drug** benefit under the **medical plan**.
- Not exceed the maximums and limitations outlined in the **medical plan**. See section 2.1, *Medical and Prescription Drug Benefits,* and section 3.3, *How the Medical Plan Works,* for information about certain maximums and limits.
- Be obtained in accordance with all the terms, policies and procedures outlined in the **medical plan**.
- Be provided while coverage is in effect. See section 1.3, *When Coverage Begins,* and section 1.9, *When Coverage Ends*, for details on when coverage begins and ends.

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

3.5.1. Medically Necessary Services and Supplies

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

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

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

- in accordance with generally accepted standards of medical practice;

- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease;

- not mostly for the convenience of the patient or **physician** or other health care **provider**; and

- no more costly than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease. This provision does not require the use of generic drugs.

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

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

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

- Those that do not require the technical skills of a medical professional who is acting within the scope of his or her license.

- Those furnished mainly for the comfort or convenience of the person, the person's family, anyone who cares for him or her, a health care **provider** or health care facility.

- Those furnished only because the person is in the **hospital** on a day when the person could safely and adequately be diagnosed or treated while not in the **hospital**.

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

3.5.2. Physician Services

a. Physician Visits

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

your home, in a **hospital** or other facility during your **stay**, or in an outpatient facility.

b. Surgery

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

- performing your surgical procedure;
- pre-operative and post-operative visits; and
- consultation with another **physician** to obtain a second opinion prior to the surgery.

c. Providers

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

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

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

- Acupuncturists
- Advanced nurse practitioners
- Audiologists
- Chiropractors
- Christian Science practitioners authorized by the Mother Church, First Church of Christ Scientist, Boston, Massachusetts
- Dieticians
- Licensed clinical social workers
- Licensed marital and family counselors
- Massage therapists
- Naturopaths
- Nutritionists

- Occupational therapists
- Ophthalmologists
- Optometrists
- Physical therapists
- Physician assistants
- Podiatrists
- Practitioners with a master's degree in psychology or social work, if supervised by a psychologist, medical doctor or licensed clinical social worker
- Psychological associates
- Psychologists
- State-certified nurse midwives or registered midwives

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

3.5.3. Nurse Advice Line

A registered nurse is available to you by phone 24 hours a day, free of charge by calling **Aetna's** number listed in the front of the **medical plan**. The nurse can be a resource in considering options for care or helping you decide whether you or your **dependent** needs to visit your doctor, an urgent care facility or the emergency room. The nurse can also provide information on how you can care for yourself or your **dependent**. Information is available on **prescription drugs**, tests, surgery, or any other health-related topic. This service is confidential.

3.5.4. Preventive Care and Screening Services

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

The recommendations and guidelines referenced in this Section 3.4.12, Preventive Care and Screening Services will be updated periodically. This plan is subject to updated recommendations or guidelines that are issued by the following organizations beginning on the first day of the benefit year, one year after the recommendation or guideline is issued:

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

a. Scope of Preventive Care Services

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

- 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).

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

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

- 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.

b. Coverage

Unless otherwise specified, preventive care services are not subject to a **copayment** or **deductible**, and will be paid at 100% of the **provider's** rate, if the **provider** is a **network provider**. Preventive care services provided by an out-of-**network provider** are subject to payment under **medical plan** provisions governing non-preventive care services.

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

Unless otherwise specified, preventive care services under this section 3.5.4, *Preventive Care and Screening Services*, are limited to once per **benefit year**.

c. Routine Physical Exams

- Covered expenses include charges made by your primary care physician (PCP) for routine physical exams. This includes routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.

- Services as recommended in the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.

- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include, but are not limited to:

  - Screening and counseling services, such as:
    - Interpersonal and domestic violence;
    - Sexually transmitted diseases; and
    - Human Immune Deficiency Virus (HIV) infections.

  - Screening for gestational diabetes for women.

  - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older.

- X-rays, lab and other tests given in connection with the exam.

- For covered newborns, an initial hospital check up.

d. Preventive Care Immunizations

- Covered expenses include charges made by your physician or a provider for the following that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention:Immunizations for infectious disease; and

- The materials for administration of immunizations.

e. Well Woman PreventiveVisits

- Covered expenses include charges made by your physician obstetrician, or gynecologist for:A routine well woman preventive exam office visit, including Pap smears. A routine well woman preventive exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**.

- Routine preventive care breast cancer genetic counseling and breast cancer (BRCA) gene blood testing. **Covered expenses** include charges made by a **physician** and lab for the BRCA gene blood test and charges made by a genetic counselor to interpret the test results and evaluate treatment.

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

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and

- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

f. Routine Cancer Screenings

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

- Colonoscopies (removal of polyps performed during a screening procedure is a covered expense);

- Digital rectal exams;

- Double contrast barium enemas (DCBE)

- Fecal occult blood tests;

- Lung cancer screening

- Mammograms;

- Prostate specific antigen (PSA) tests; and

- Sigmoidoscopies.

These benefit will be subject guidelines on the basis of age, family history, and frequency that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and

- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration

g. Screening and Counseling Services

Covered expenses include charges made by your **physician** in an individual or group setting for the following:

- **Obesity and/or Healthy Diet**

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

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

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

- **Misuse of Alcohol and/or Drugs**

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

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

- **Use of Tobacco Products**

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

products that contain tobacco. Coverage includes the following to aid in the cessation of the use of tobacco products:

- Preventive counseling visits;
- Treatment visits; and
- Class visits.

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

- **Sexually Transmitted Infections**

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

- **Genetic Risks for Breast and Ovarian Cancer**

  Covered expenses include counseling and evaluation services to help you assess your breast and ovarian cancer susceptibility.

- **Prenatal Care**

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

- **Comprehensive Lactation Support and Counseling Services**

  - **Lactation Support**

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

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

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

Visits in excess of the lactation counseling maximum as shown above, are subject to the cost sharing provisions outlined in section 3.2.2, *Cost Sharing for Network Benefits* or section 3.2.4, *Cost Sharing for Out-of-Network Benefits*.

- **Breast Feeding Durable Medical Equipment**

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

- **Breast Pump**

Covered expenses include the following:

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

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

- **Breast Pump Supplies**

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

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

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

h. Family Planning Services – Female Contraceptives

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

Coverage includes counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist. Such counseling services are covered expenses when provided in either a group or individual setting. Contraceptive counseling services are subject to a two visit maximum in a 12 consecutive month period. Visits in excess of this maximum are subject to the cost sharing provisions outlined in section 3.2.2, *Cost Sharing for Network Benefits* or section 3.2.4, *Cost Sharing for Out-of-Network Benefits*.
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The following contraceptive methods are **covered expenses**:

- **Voluntary Sterilization**

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

- **Contraceptives**

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

i. Limitations

Unless specified above, preventive care services do not include:

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

3.5.5. Immunizations

In addition to the immunizations covered under section 3.5.4, *Preventive Care and Screening Services*, **covered expenses** include other immunizations for

communicable diseases, including serums administered by a nurse or **physician**. Charges for office visits in connection with the immunizations are not covered.

3.5.6. Hospital Expenses

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

a. Room and Board

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

Room and board charges also include:

- Services of the **hospital's** nursing staff
- Admission and other fees
- General and special diets
- Sundries and supplies

b. Other Hospital Services and Supplies

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

- **Ambulance** services
- **Physicians** and surgeons
- Operating and recovery rooms
- Intensive or special care facilities
- Administration of blood and blood products, but not the cost of the blood or blood products
- Radiation therapy
- Speech therapy, physical therapy and occupational therapy

- Oxygen and oxygen therapy
- Radiological services, laboratory testing and diagnostic services
- Medications
- Intravenous (IV) preparations
- Discharge planning

c. Outpatient Hospital Expenses

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

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

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

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

d. Coverage for Emergency Medical Conditions

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

- Use of emergency room facilities
- Emergency room **physician** services
- **Hospital** nursing staff services
- Radiologists and pathologists services

With the exception of urgent care described below, if you visit a **hospital** emergency room for a non-**emergency** medical condition, the **medical plan** will pay a reduced benefit, as shown in section 2.1.1, *Medical Benefit Schedule*. No other **plan** benefits will pay for non-**emergency care** in the emergency room.

e. Coverage for Urgent Conditions

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

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

f. Facility-Only Preferred Provider Agreement

The **medical plan** has a **facility**-only preferred provider agreement for **facility** services in the municipality of Anchorage. The preferred facilities in the municipality of Anchorage are Alaska Regional Hospital, and their affiliated **surgery center** Surgery Center of Anchorage.

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

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

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

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

- **emergency** services.

3.5.7. Alternatives to Hospital Stays

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

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

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

- Services and supplies provided by the **surgery center** on the day of the procedure.

- The operating **physician's** services for performing the procedure, related pre- and post-operative care, and administration of anesthesia.

- Services of another **physician** for related post-operative care and administration of anesthesia. This does not include a local anesthetic.

b. Birthing Centers

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

- prenatal care;

- delivery; and

- postpartum care within 48 hours after a vaginal delivery and 96 hours after a cesarean delivery.

3.5.8. Home Health Care

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

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

Home health care expenses include charges for:

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

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

- care is provided within 10 days of discharge from a **hospital** or **skilled nursing facility** as a full time inpatient; and
- care is needed to transition from the **hospital** or **skilled nursing facility** to home care.

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

Coverage for home health care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-

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

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

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

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

3.5.9. Private Duty Nursing

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

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

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

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

- Nursing care that does not require the education, training and technical skills of a registered nurse or licensed practical nurse.
- Nursing care assistance for daily life activities, such as:
  - transportation
  - meal preparation
  - vital sign charting
  - companionship activities
  - bathing
  - feeding
  - personal grooming
  - dressing
  - toileting
  - getting in/out of bed or a chair.
- Nursing care provided for skilled observation.
- Nursing care provided while you are an inpatient in a **hospital** or health care facility.
- A service provided solely to administer oral medicine, except where law requires a registered nurse or licensed practical nurse to administer medicines.

3.5.10. Skilled Nursing Facility

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

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

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

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

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

3.5.11. Hospice Care

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

a. Facility Expenses

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

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

- **Room and board** and other services and supplies furnished during a **stay** for pain control and other acute and chronic symptom management.

- Services and supplies furnished to you on an outpatient basis.

b. Outpatient Hospice Expenses

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

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

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

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

  - assessment of your social, emotional and medical needs, and your home and family situation;

  - identification of available community resources; and

  - assistance provided to you to obtain resources to meet your assessed needs.

- Physical and occupational therapy.

- Consultation or case management services by a **physician**.

- Medical supplies.

- **Prescription drugs**.

- Dietary counseling.

- Psychological counseling.

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

- A **physician** for a consultation or case management.

- A physical or occupational therapist.

- A **home health care agency** for:

- Physical and occupational therapy;
- Part-time or intermittent home health aide services for your care up to eight hours a day;
- Medical supplies;
- **Prescription drugs**;
- Psychological counseling; and
- Dietary counseling.

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

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

3.5.12. Second Surgical Opinions

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

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

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

- 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, **Aetna** can provide you with a list of names of qualified **physicians**.

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

3.5.13. Diagnostic and Preoperative Testing

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

a. Diagnostic Complex Imaging Expenses

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

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

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

b. Outpatient Diagnostic Lab Work and Radiological Services

Covered expenses include charges for radiological services (other than diagnostic complex imaging), lab services, and pathology and

other tests provided to diagnose an **illness** or **injury**. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a **physician**. The charges must be made by a **physician**, **hospital** or licensed radiological facility or lab.

c. Outpatient Preoperative Testing

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

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

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

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

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

3.5.14. Cognitive Therapy, Physical Therapy, Occupational Therapy, and Speech Therapy Rehabilitation Benefits

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

- Physical therapy is covered for non-chronic conditions and acute **illnesses** and **injurie**s, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness**, **injury** or surgical procedure. Physical

therapy does not include educational training or services designed to develop physical function.

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

- Speech therapy is covered for non-chronic conditions and acute **illnesses** and **injuries** and expected to restore the speech function or correct a speech impairment resulting from **illness** or **injury**; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.

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

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

The therapy should follow a specific treatment plan that:

- details the treatment, and specifies frequency and duration; and

- provides for ongoing reviews and is renewed only if continued therapy is appropriate.

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

- Therapies for the treatment of delays in development, unless resulting from acute **illness** or **injury**, or congenital defects amenable to surgical repair (such as cleft lip/palate). Examples of non-covered diagnoses include Down's syndrome and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

- Any services which are **covered expenses** in whole or in part under any other group plan sponsored by an employer.

- Any services unless provided in accordance with a specific treatment plan.

- Services for the treatment of delays in speech development, unless resulting from **illness**, **injury**, or congenital defect.

- Services provided during a **stay** in a **hospital**, **skilled nursing facility**, or hospice facility except as stated above.

- Services not performed by a **physician** or under the direct supervision of a **physician**.

- Treatment covered as part of spinal manipulation treatment. This applies whether or not benefits have been paid under that section.

- Services provided by a **physician** or physical, occupational or speech therapist who resides in your home or who is a member of your family, or a member of your **spouse**'s family.

- Special education to instruct a person whose speech has been lost or impaired to function without that ability. This includes lessons in sign language.

3.5.15 Massage Therapy

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

- Massage therapy is covered in conjunction with and for the purpose of making the body more receptive of spinal manipulation provided under section Error! Reference source not found.**7**, *Treatment of Spinal Disorders*.

- Medically necessary massage therapy is a **covered expense** if it is limited to the initial or acute phase of an injury or illness and is part of a specific treatment plan for physical or occupational rehabilitative therapy as outlined in 3.5.14, *Cognitive Therapy, Physical Therapy, Occupational Therapy, and Speech Therapy Rehabilitation Benefits.*

3.5.16. Anesthetic

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

3.5.17. Pregnancy Related Expenses

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

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

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

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

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

If you are **totally disabled** as a result of a problem with your pregnancy and your coverage under the **medical plan** ends, you may be eligible for extended benefits. See section 8, *Consolidated Omnibus Budget Reconciliation Act (COBRA) and Extended Health Coverage*.

3.5.18. Newborn Care

Covered expenses include newborn care provided within the first 31 days after birth. Newborn services provided after 31 days are not covered, unless you enroll your **child** under the **medical plan** within 30 days of birth. See section 1.7.5, *Dependents*.

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

3.5.19. Durable Medical and Surgical Equipment

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

- Bandages and surgical dressings.
- Rental or purchase 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.
- Oxygen or rental of equipment for the administration of oxygen.
- Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps.

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

- The initial purchase of such equipment and accessories to operate the equipment is covered only if **Aetna** is shown that:
  - long-term use is planned and the equipment cannot be rented; or
  - it is likely to cost less to buy the equipment than to rent it.
- Maintenance and repair of purchased equipment is covered unless needed due to misuse or abuse of the equipment.
- Replacement of purchased equipment and accessories is covered only if **Aetna** is shown that:
  - it is needed due to a change in the person's physical condition; or
  - it is likely to cost less to buy a replacement than to repair the existing equipment or to rent similar equipment.

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

3.5.20. Experimental or Investigational Treatment

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

- You have been diagnosed with cancer or you are **terminally ill**.
- Standard therapies have not been effective or are inappropriate.

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

- You are enrolled in an ongoing clinical trial that meets all of the following criteria:

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

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

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

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

  - You are treated in accordance with protocol.

3.5.21. Prosthetic Devices

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

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

- internal body part or organ; or

- external body part.

Covered expenses also include replacement of a prosthetic device if:

- the replacement is needed because of a change in your physical condition or normal growth or wear and tear;

- it is likely to cost less to buy a new prosthetic device than to repair the existing one; or
- the existing prosthetic device cannot be made serviceable.

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

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

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

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless the orthopedic shoe is an integral part of a covered leg brace.
- Trusses, corsets, and other support items.
- Any item listed in section 3.7, *Medical Benefit Exclusions*.

3.5.22. Ambulance Services

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

- Ground **Ambulance**. **Covered expenses** include charges for transportation:
  - To the first **hospital** where treatment is given in a medical **emergency**.

- From one **hospital** to another **hospital** in a medical **emergency** when the first **hospital** does not have the required services or facilities to treat your condition.

- From **hospital** to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.

- From home to **hospital** for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles.

- When during a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, an **ambulance** is required to safely and adequately transport you to or from inpatient or outpatient **medically necessary** treatment.

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

  - ground **ambulance** transportation is not available;

  - your condition is unstable, and requires medical supervision and rapid transport; and

  - in a medical **emergency**, transportation from one **hospital** to another **hospital**, when the first **hospital** does not have the required services or facilities to treat your condition and you need to be transported to another **hospital**, and the two conditions above are met.

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

- if an **ambulance** service is not required for your physical condition;

- if the type of **ambulance** service provided is not required for your physical condition; or

- by any form of transportation other than a professional **ambulance** service.

3.5.23. Travel

Travel is a **covered expense** only in the circumstances set forth in this section. Travel for transplant services is set forth in section 3.5.24, *Transplant Services*.

a. Treatment Not Available Locally

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

If you require treatment that is not available locally, **covered expenses** include round-trip transportation, not exceeding the cost of coach class commercial air transportation, from the site of the **illness** or **injury** to the nearest professional treatment. If you use ground transportation and the most direct one-way distance exceeds 100 miles, the **medical plan** pays the per diem set forth below.

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

- 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.
- Second surgical opinions which cannot be obtained locally (this will count as a presurgical trip).
- One visit for each allergic condition.

b. Surgery or Diagnostic Procedures In Other Locations

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

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

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

Preoperative testing is testing performed within seven days prior to surgery.

Contact **Aetna** for assistance with identifying less expensive options for surgery or diagnostic procedures.

c. Limitations

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

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

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

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

d. Per Diem

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

3.5.24. Transplant Services

a. Covered Expenses

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

- Heart
- Lung
- Heart/lung
- Simultaneous pancreas kidney (SPK)

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

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

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

b. Network Level of Benefits

The network level of benefits is paid only for a treatment received at a facility designated by the **medical plan** as an Institute of Excellence™

(IOE) for the type of transplant being performed. Each IOE facility has been selected to perform only certain types of transplants.

Services obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as out-of-**network services and supplies**, even if the facility is a **network provider** or IOE for other types of services.

The **medical plan** covers:

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

c. Levels of Transplant Care

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

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

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.

2. Pre-transplant/candidacy screening: Includes Human Leukocyte Antigent (HLA) typing/compatibility testing of prospective organ donors who are immediate family members.

3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; **prescription drugs** provided during your inpatient **stay** or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient **stay** or outpatient visit(s); cadaveric and live donor organ procurement.

4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

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

d. Limitations

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

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence.

- Services that are covered under any other benefit under this **medical plan**.

- Services and supplies furnished to a donor when the recipient is not covered under the **medical plan**.

- Home infusion therapy after the transplant occurrence.

- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing **illness**.

- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing **illness**.

- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by **Aetna**.

e. Network of Transplant Specialist Facilities

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

f. Travel Expenses

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

Covered expenses include the following:

- Transportation Expense

  - Expenses incurred by an Institute of Excellence™ (IOE) patient, and approved in advance by **Aetna**, for transportation between the patient's home and the Institute of Excellence™ (IOE) to receive services in connection with any listed procedure or treatment.

  - Expenses incurred by a companion and approved in advance by **Aetna** for transportation when traveling with an Institute of Excellence™ (IOE) patient between the patient's home and the Institute of Excellence™ (IOE) to receive such services.

- Lodging Expenses

- Expenses incurred by an Institute of Excellence™ (IOE) patient, and approved in advance by **Aetna**, for lodging away from home:
    - while traveling between the patient's home and the Institute of Excellence™ (IOE) to receive services in connection with any listed procedure or treatment; or
    - to receive outpatient services from the Institute of Excellence™ (IOE) in connection any listed procedure or treatment.
- Expenses incurred by a companion and approved in advance by **Aetna** for lodging away from home:
    - while traveling with an Institute of Excellence™ (IOE) patient between the patient's home and the Institute of Excellence™ (IOE) to receive services in connection with any listed procedure or treatment; or
    - when the companion's presence is required to enable an Institute of Excellence™ (IOE) patient to receive such services from the Institute of Excellence™ (IOE) on an inpatient or outpatient basis.
- The **medical plan** will pay $50 per night per person for overnight lodging, up to a $100 maximum.
- For purposes of determining travel expenses or lodging expenses, a **hospital** or other temporary residence from which an Institute of Excellence™ (IOE) patient travels in order to begin a period of treatment at the Institute of Excellence™ (IOE), or to which the patient travels after dismissal from the Institute of Excellence™ (IOE) at the end of a period of treatment, will be considered to be the patient's home.

- Travel and Lodging Benefit Maximum
    - For all travel expenses and lodging expenses incurred in connection with any one Institute of Excellence™ (IOE) procedure or treatment type:
        - The total benefit payable will not exceed $10,000 per transplant occurrence.

- Benefits will be payable only for such expenses incurred during a period which begins on the day a **covered person** becomes an Institute of Excellence™ (IOE) patient and ends on the earlier to occur of:

    - one year after the date the procedure is performed or;

    - the date the Institute of Excellence™ (IOE) patient ceases to receive any services from the Institute of Excellence™ (IOE) in connection with the procedure.

3.5.25. Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) is a confidential counseling service, free of charge to you and your **dependents**, administered by **Aetna**. This service provides assessment, treatment and referral services, and covers up to eight counseling sessions per problem. 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 **plan** for the EAP counselor. EAP staff is available 24 hours a day, 7 days a week, 365 days a year. When you call, you may be able to work through your problem on the phone with an EAP staff member. In most cases, however, 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 counselor 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 counselor 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 unless required by law.

Additional services may be available through the EAP program. Visit www.AlaskaCare.com for more information.

3.5.26. Mental Disorder and Substance Abuse Treatment

a. Mental Disorders

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

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

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

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

b. Substance Abuse

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

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

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

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

3.5.27. Treatment of Spinal Disorders

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

Benefits are subject to the maximum shown in section 2.1.1, *Medical Benefit Schedule*. However, this maximum does not apply to expenses incurred:

- during your **hospital stay**; or

- for surgery, including pre- and post-surgical care provided or ordered by the operating **physician**.

3.5.28. Medical Treatment of Mouth, Jaws, and Teeth

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

- 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 an underlying medical condition, **accident** or disease, other than periodontal disease, 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 **medical plan**. Treatment must begin during the year the **accident** occurred or the year following. The teeth must have been damaged or lost other than in the course of biting or chewing and must have been free of decay or in good repair.

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

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

3.5.29. Medical Treatment of Obesity

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

- An initial medical history and physical exam

- Diagnostics tests given or ordered during the first exam

- **Prescription drugs**

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

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

- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regiments and supplements, food or food supplements, appetite suppressants and other medications.

- Exercise programs, exercise or other equipment.

- Other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

3.5.30. Reconstructive or Cosmetic Surgery and Supplies

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

- Surgery needed to improve a significant functional impairment of a body part.

- Surgery to correct the result of an accidental **injury**, including subsequent related or staged surgery.

- Surgery to correct the result of an **injury** that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original **injury**.

Note: **Injuries** that occur as a result of a medical (non-surgical) treatment are not considered accidental **injuries**, even if unplanned or unexpected.

- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an **illness** or **injury**) when the defect results in severe facial disfigurement, or the defect results in significant functional impairment and the surgery is needed to improve function.

Covered expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.

3.5.31. Audio Services

Covered expenses include the following audio services:

- An otological (ear) examination by a **physician** or surgeon every 24 consecutive months.

- An audiological (hearing) examination and evaluation by a certified or licensed audiologist, including a follow up consultation. This includes claims for evaluation and management services.

- An electronic 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 consultation within 30 days following delivery of the hearing aid. Hearing aids are limited to one in a rolling 36 month period, and are subject to the maximums set forth in section 2.1.1, *Medical Benefit Schedule*.

- Repairs, servicing or alteration of hearing aid equipment.

You must provide **Aetna** 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.

Expenses incurred for a hearing aid within 30 days of termination of the **covered person's** coverage under the **medical plan** will be **covered expenses** under the **medical plan** if during the 30 days before the date coverage terminates:

- the **prescription** for the hearing aid was written; and
- the hearing aid was ordered.

3.6. YOUR PRESCRIPTION DRUG BENEFITS

Covered expenses do not include all **prescription drugs**, medications and supplies. The **medical plan** pays benefits only for **prescription drug** expenses that are **medically necessary**. **Covered expenses** are subject to cost sharing requirements as described in section 2.1.2, *Prescription Drug Schedule*.

3.6.1. Accessing Pharmacies and Benefits

The **medical plan** provides access to covered benefits through a network of **pharmacies**, vendors and suppliers. **Aetna** has contracted for these **network pharmacies** to provide **prescription drugs** and other supplies to you. You also have the choice to access state licensed **pharmacies** outside of the network for covered services.

Obtaining your benefits through **network pharmacies** has many advantages. Your out-of-pocket costs may vary between **network pharmacies** and out-of-**network pharmacies**. Benefits and cost sharing may also vary by the type of **network pharmacy** where you obtain your **prescription drug** and whether or not you purchase a **non-preferred brand-name drug**, **preferred brand–name drug** or **generic prescription drug**.

3.6.2. Accessing Network Pharmacies and Benefits

You may select any **network pharmacy** from the **Aetna** Network Pharmacy Directory. You can access **Aetna's** online **provider** directory, DocFind® at www.aetna.com/docfind for the names and locations of **network pharmacies**. If you cannot locate a **network pharmacy** in your area, call **Aetna**.

You must present your ID card to the **network pharmacy** every time you get a **prescription** filled to be eligible for network benefits. The **network**

pharmacy will calculate your claim online. You will pay the **deductible**, **copayment** or **coinsurance**, if any, directly to the **network pharmacy**.

You do not have to complete or submit claim forms. The **network pharmacy** will take care of claim submission.

3.6.3. Emergency Prescriptions

When you need a **prescription** filled in an **emergency** or urgent care situation, or when you are traveling, you can obtain network benefits by filling your **prescription** at any network retail **pharmacy**. The **network pharmacy** will fill your **prescription** and only charge you the **medical plan's** cost sharing amount. If you access an out-of-**network pharmacy** you will pay the full cost of the **prescription** and will need to file a claim for reimbursement. You will be reimbursed for your **covered expenses** up to the cost of the **prescription** less the pharmacy benefit's cost sharing for network benefits.

3.6.4. Availability of Providers

Aetna cannot guarantee the availability or continued network participation of a particular **pharmacy**. Either **Aetna** or any **network pharmacy** may terminate the **provider** contract.

3.6.5. Cost Sharing for Prescription Drug Tiers

The **medical plan** provides a three-tier **prescription drug** program. Cost sharing amounts and provisions are described in section 2.1.2, *Prescription Drug Schedule*. Your **copayment** is based on the tier under which your **prescription drug** is categorized:

- First Tier: **generic prescription drug** - You pay the lowest cost for **prescription drugs** in this level.
- Second Tier: **preferred brand-name drug** – You pay a slightly higher cost for **prescription drugs** in this level.
- Third Tier: **non-preferred brand-name drug** – You pay the highest cost for **prescription drugs** in this level.

You and your **physician** can search for a drug at www.AlaskaCare.gov, to verify that it is covered under the **plan,** and to determine what tier it is categorized under and if it is on the **Preferred Drug Guide**. You can also see if there are alternatives that cost less, or which drugs are excluded from coverage. Make sure your **physician** knows that you pay more for second or third tier drugs. He or she can consider this before writing a **prescription**.

If you have a medical need for a non-preferred brand-name drug, your doctor can ask for a medical exception. If the exception is granted, the drug will be

subject to preferred brand-name drug cost sharing. Exceptions granted as a result of a medical exception shall be based on individual case by case medical necessity determinations and do not apply or extend to other covered persons.

Drugs may be added or removed from the **Preferred Drug Guide** by the **claims administrator** for certain reasons. A **prescription drug** may also be moved from one tier to another. Here are some reasons why:

- As **brand-name prescription drugs** lose their patents and generic versions become available, the **brand-name prescription drug** may be covered at a higher out-of-pocket cost while the **generic prescription drug** may be covered at a lower out-of-pocket cost.

- The Food and Drug Administration (FDA) approves many new **prescription drugs** throughout the year.

- Drugs can be withdrawn from the market or may become available without a **prescription**.

The most up-to-date **formulary** information can be found at www. AlaskaCare.gov – so please visit it often.

3.6.6. Cost Sharing for Network Benefits

You share in the cost of your benefits. Cost sharing amounts and provisions are described in section 2.1.2, *Prescription Drug Schedule*. All cost sharing is payable directly to the **network pharmacy** at the time the **prescription** is dispensed.

3.6.7. When You Use an Out-of-Network Pharmacy

You can directly access an out-of-**network pharmacy** to obtain covered outpatient **prescription drugs**. You will pay the **pharmacy** for your **prescription drugs** at the time of purchase and submit a claim form to receive reimbursement from the **medical plan**. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to an out-of-**network pharmacy**. The **medical plan** will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required by you.

3.6.8. Cost Sharing for Out-of-Network Pharmacy Benefits

You share in the cost of your benefits. Cost sharing amounts and provisions are described in section 2.1.2, *Prescription Drug Schedule*. You will be responsible for any applicable **copayment** or **coinsurance** for **covered**

expenses that you incur. Your **coinsurance** is based on the **recognized charge,** see section 15, *Definitions – "Recognized Charge"*. If the out-of-**network pharmacy** charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**.

3.6.9. Pharmacy Benefit

The **medical plan** covers charges for outpatient **prescription drugs** for the treatment of an **illness** or **injury**, subject to the limitations and maximums set forth in section 2.1.2, *Prescription Drug Schedule* and the exclusions set forth in section 3.6.13, *Pharmacy Benefit Limitations*, section 3.6.14, *Pharmacy Benefit Exclusions*, and section 3.7, *Medical Benefit Exclusions*. **Prescriptions** must be written by a **provider** licensed to prescribe federal legend **prescription** drugs.

Generic prescription drugs may be substituted by your pharmacist for **brand name prescription drugs**. You may minimize your out-of-pocket costs by selecting a **generic prescription drug** when available.

Your **prescription drugs** benefit features an open preferred drug list, from which certain drugs (or services) are excluded. See www.AlaskaCare.gov for a list of drugs that are not covered under the plan. For each drug on the exclusion drug list there are preferred alternatives that are covered by the plan.

Coverage of **prescription drugs** may be subject to the **medical plan's** requirements or limitations. **Prescription drugs** covered by the **medical plan** are subject to drug utilization review by **Aetna** and/or your **provider** and/or your **network pharmacy**.

Coverage for **prescription drugs** and supplies is limited to the supply limits as described below.

3.6.10. Retail Pharmacy Benefits

3.6.11. Outpatient prescription drugs are covered when dispensed by a network retail pharmacy. Copay applies to each 30-day supply. Each prescription is limited to a maximum 90 day supply, as applicable, when filled at a network pharmacy. Mail Order Pharmacy

Outpatient **prescription drugs** are covered when dispensed by a network **mail order pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a network **mail order pharmacy**. **Prescriptions** for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a network **mail order pharmacy**.

The **medical plan** will not cover outpatient **prescription drugs** received through an out-of-network **mail order pharmacy**.

3.6.12. Other Covered Expenses

The following **prescription drugs**, medications and supplies are also **covered expenses** under the **medical plan**:

- **Self-injectable prescripton medications**. Injectable medication that can be self-administered by the patient, and are not administered during an inpatient stay, in a provider's office or by a **health care professional.**

- **Off-Label Use.** FDA approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be:

  - recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations or the American Hospital Formulary Service Drug Information); or

  - the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal.

  Coverage of off-label use of these drugs may be subject to the **medical plan's** requirements or limitations.

- **Diabetic Supplies.** The following diabetic supplies upon **prescription** by a **physician**:

  - Diabetic needles and syringes

  - Test strips for glucose monitoring and/or visual reading

  - Diabetic test agents

  - Lancets/lancing devices

  - Alcohol swabs

- **Preventive Care Drugs and Supplements**

  Covered expenses include preventive care drugs and supplements (including over-the-counter drugs and supplements) obtained at a **network pharmacy**. They will be covered at 100%, without a copayment **or coinsurance,** when they are:

- prescribed by a **physician**;
- obtained at a **network pharmacy**; and
- submitted to a pharmacist for processing.

The preventive care drugs and supplements covered under this **plan** include, but may not be limited to:

- Aspirin: Benefits are available to adults.
- Oral Fluoride Supplements: Benefits are available to children whose primary water source is deficient in fluoride.
- Folic Acid Supplements: Benefits are available to adult females planning to become pregnant or capable of pregnancy.
- Iron Supplements: Benefits are available to children without symptoms of iron deficiency. Coverage is limited to children who are at increased risk for iron deficiency anemia.
- Vitamin D Supplements: Benefits are available to adults to promote calcium absorption and bone growth in their bodies.
- Risk-Reducing Breast Cancer Prescription Drugs: **Covered expenses** include charges incurred for **generic prescription drugs** prescribed by a **physician** for a woman who is at increased risk for breast cancer and is at low risk for adverse medication side effects.
- FDA-approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products.

Coverage of preventive care drugs and supplements will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the U.S. Preventive Services Task Force.

- **Contraceptives**

  Covered expenses include charges made by a network **pharmacy** for the following contraceptive methods when prescribed by a **physician** and the **prescription** is submitted to the pharmacist for processing:

- Female oral and injectable contraceptives that are **generic prescription drugs** and **brand-name prescription drugs.**

- Female contraceptive devices.

- FDA-approved brand-name emergency emergency contraceptives (for women) when obtained at a network pharmacy.

- FDA-approved female generic over-the-counter (OTC) contraceptives.

The **plan** does not cover all contraceptives. A current listing of contraceptives that are covered under the **plan** is available from the **claims administrator** and can be found by calling the toll-free number on the back of your ID card or www.AlaskaCare.gov.

Cost Sharing Waiver for Prescription Drug Contraceptives

Contraceptives are covered at 100% without a **copayment** or **coinsurance** if they are:

- Female generic contraceptive **prescription drugs** or devices;

- FDA-approved female generic emergency contraceptives, when obtained at a **network pharmacy**.

With respect to **out-of-network pharmacy** contraceptive **prescription drugs** or devices, the per **coinsurance** will apply.

The **copayment** and **coinsurance** applies to contraceptive **prescription drugs** or devices that have a **generic equivalent prescription drug** or **generic alternative prescription drug** available within the same therapeutic drug class unless you are granted a medical exception, and the **prescription drugs** or devices are:

- **brand-name prescription drugs** and brand-name devices; or

- FDA-approved female brand-name emergency contraceptives when obtained at a **network pharmacy**.

3.6.13. Pharmacy Benefit Limitations

- A **network pharmacy** may refuse to fill a **prescription** order or refill when in the professional judgment of the pharmacist the **prescription** should not be filled.

- The **medical plan** will not cover expenses for any **prescription drug** for which the actual charge to you is less than the required **copayment** or **deductible**, or for any **prescription drug** for which no charge is made to you.

- You will be charged the out-of-network **prescription drug** cost sharing for **prescription drugs** recently approved by the FDA, but which have not yet been reviewed by the **Aetna** Health Pharmacy Management Department and Therapeutics Committee.

- **Aetna** has the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to section 7.14, *If a Claim Is Denied*.

- The number of **copayments** and/or **deductibles** you are responsible for per vial of Depo-Provera, an injectable contraceptive, or similar type contraceptive dispensed for more than a 30 day supply, will be based on the 90 day supply level. Coverage is limited to a maximum of 5 vials per **benefit year**.

3.6.14. Pharmacy Benefit Exclusions

Not every health care service or supply is covered by the **medical plan**, even if prescribed, recommended, or approved by your **provider**. The **medical plan** covers only those services and supplies that are **medically necessary** and included in section 3.5, *Covered Medical Expenses*, or section 3.6, *Your Prescription Drug Benefits*. Charges made for the following are not covered except to the extent listed under section 3.5, *Covered Medical Expenses*, section 3.6, *Your Prescription Drug Benefits.*

The following **prescription drug** exclusions are in addition to the exclusions listed under section 3.7, *Medical Benefit Exclusions*.

1. Administration or injection of any drug.

2. Allergy sera and extracts.

3. Any drugs or medications, services and supplies that are not **medically necessary** for the diagnosis, care or treatment of the **illness** or **injury** involved. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

4. Any drugs or medications, listed on the Aetna current year *Exclusion Drug List.*

5. Biological sera, blood, blood plasma, blood products or substitutes or any other blood products.

6. Over-the-counter contraceptive supplies except as provided under section 3.6.12, *Preventive Care Drugs and Supplements*, including but not limited to:

    - condoms
    - contraceptive foams
    - jellies
    - ointments
    - services associated with the prescribing, monitoring and/or administration of contraceptives.

7. **Cosmetic** drugs, medications or preparations used for **cosmetic** purposes or to promote hair growth, including but not limited to:

    - health and beauty aids
    - chemical peels
    - dermabrasion
    - treatments
    - bleaching
    - creams
    - ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin.

8. Drugs given or entirely consumed at the time and place they are prescribed or dispensed.

9. Drugs or supplies used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy, in oral, injectable and topical forms or any other form used internally or externally (including but not limited to gels, creams, ointments and patches). Any **prescription drug** in oral, topical or any other form that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes, including but not limited to:

- Sildenafil citrate
- Phentolamine
- Apomorphine
- Alprostadil
- Any other **prescription drug** that is in a similar or identical class, or has a similar or identical mode of action or exhibits similar or identical outcomes.

10. Drugs which do not, by federal or state law, need a **prescription** order (*i.e.* over-the-counter drugs), even if a **prescription** is written.

11. Drugs given by, or while the person is an inpatient in, any health care facility, or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it.

12. Drugs used primarily for the treatment of infertility, or for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures.

13. Drugs used for the purpose of weight gain or reduction, including but not limited to:

    - stimulants
    - preparations
    - foods or diet supplements
    - dietary regimens and supplements
    - food or food supplements
    - appetite suppressants
    - other medications

14. Drugs used for the treatment of obesity.

15. All drugs or medications in a therapeutic drug class if one of the drugs in that therapeutic drug class is not a **prescription drug**.

16. **Durable medical equipment**, monitors or other equipment.

17. **Experimental or investigational** drugs or devices. This exclusion will not apply with respect to drugs that:

- have been granted treatment investigational new drug (IND), or group c/treatment IND status; or

- are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and

Aetna determines, based on available scientific evidence, are effective or show promise of being effective for the **illness**.

18. Any treatment, device, drug, or supply to alter the body's genes, genetic make-up, or the expression of the body's genes, except for the correction of congenital birth defects.

19. Implantable drugs and associated devices.

20. Injectables:

    - Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by the medical benefit portion of the **medical plan**.

    - Needles and syringes, except for needles and syringes for injectable insulin and other injectable drugs covered by the the **medical plan**.

21. Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps.

22. **Prescription drugs** for which there is an over-the-counter product which has the same active ingredient and strength, even if a **prescription** is written.

23. **Prescription drugs**, medications, injectables or supplies provided through a third party vendor contract.

24. **Prescription** orders filled prior to the effective date or after the termination date of coverage under the **medical plan**.

25. Prophylactic drugs for travel.

26. Refills in excess of the amount specified by the **prescription** order. Before recognizing charges, **Aetna** may require a new **prescription** or evidence as to need, if a **prescription** or refill appears excessive under accepted medical practice standards.

27. Refills dispensed more than one year from the date the latest **prescription** order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.

28. Replacement of lost or stolen **prescriptions**.

29. Drugs, services and supplies provided in connection with treatment of an occupational **injury** or occupational **illness**.

30. Drugs or preparations, devices and supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.

31. Any treatment, drug or supply related to changing sex or sexual characteristics, including hormones and hormone therapy.

32. Any drug or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or change the shape or appearance of a sex organ.

33. Supplies, devices or equipment of any type.

34. Test agents except diabetic test agents.

3.7. MEDICAL BENEFIT EXCLUSIONS

Not every medical service or supply is covered by the **medical plan**, even if prescribed, recommended, or approved by your **provider**. The **medical plan** covers only those services and supplies that are **medically necessary** and included under section 3.5, *Covered Medical Expenses*, or section 3.6, *Your Prescription Drug Benefits.* The exclusions listed below apply to all coverage under the **medical plan**. Additional exclusions apply to specific **prescription drug** coverage under section 3.6.13, *Pharmacy Benefit Limitations* and section 3.6.14, *Pharmacy Benefit 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.

Charges made for the following are <u>not</u> covered except to the extent listed under section 3.5, *Covered Medical Expenses.*

1. Acupuncture, acupressure and acupuncture therapy.

2. Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.

3. Any charges in excess of the benefit, dollar, day, visit or supply limits stated in the **medical plan**.

4. Any non-**emergency** charges incurred outside of the United States if you traveled to such location to obtain medical services, **prescription drugs**, or supplies, even if otherwise covered under the **medical plan**. This also includes **prescription drugs** or supplies if:

   - such **prescription drugs** or supplies are unavailable or illegal in the United States; or

   - the purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

5. Applied Behavioral Analysis, the LEAP, TEACCH, Denver and Rutgers programs.

6. Behavioral health services:

   - Treatment of a covered health care **provider** who specializes in the mental health care field and who receives treatment as a part of their training in that field.

   - Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.

   - Treatment of antisocial personality disorder.

   - Treatment in wilderness programs or other similar programs.

   - Treatment of mental retardation, defects, and deficiencies.

   - Alcoholism or **substance abuse** rehabilitation treatment on an inpatient or outpatient basis.

7. Charges for a service or supply furnished by a **network provider** in excess of the **negotiated charge**.

8. Charges for a service of supply furnished by an out-of-**network provider** or for **other health care** in excess of the **recognized charge**.

9. Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the **medical plan**.

10. Charges submitted for services by an unlicensed **hospital**, **physician** or other **provider** or not within the scope of the **provider's** license.

11. **Cosmetic** services and plastic surgery except as may be provided under section 10, *Statement of Rights Under the Women's Health and Cancer Rights Act of 1998;* any treatment, surgery (**cosmetic** or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:

- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, **cosmetic** eyelid surgery, and other surgical procedures.

- Procedures to remove healthy cartilage or bone from the nose (or other part of the body).

- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin.

- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when **medically necessary**.

- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy).

- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices.

- Surgery to correct Gynecomastia.

- Breast augmentation.

- Otoplasty.

12. Counseling services and treatment by a marriage, religious, family, career, social adjustment, pastoral, or financial counselor.

13. Court ordered services, including those required as a condition of parole or release.

14. **Custodial care.**

15. Dental services covered under the **dental plan**.

16. Drugs, medications and supplies:

- Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a **prescription,** including vitamins.

- Any services related to the dispensing, injection or application of a drug.
- Any **prescription drug** purchased illegally outside the United States, even if otherwise covered under the **medical plan** within the United States.
- Immunizations related to work.
- Needles, syringes and other injectable aids, except as covered for diabetic supplies.
- Drugs related to the treatment of non-**covered expenses**.
- Performance enhancing steroids.
- Injectable drugs if an alternative oral drug is available.
- Outpatient **prescription drugs**.
- **Self-injectable drugs** and medications.
- Any expenses for **prescription drugs**, and supplies covered under the pharmacy benefit portion of the **medical plan**.
- Charges for any **prescription drug** for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

17. Educational services:

- Education, training and **room and board** while confined to an institution which is primarily a school or other institution for training.
- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs.
- Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause.
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.
- Services or supplies which any school system is legally required to provide.

18. Any health examinations required:

- By a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement or by any law of a government.

- For securing insurance, school admissions or professional or other licenses, to travel, or to attend a school, camp, or sporting event or participate in a sport or other recreational activity.

19. Any special medical reports not directly related to treatment except when provided as part of a covered service.

20. Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies.

21. **Experimental or investigational** drugs, devices, treatments or procedures.

22. Facility charges for care services or supplies provided in:

- Rest homes

- Assisted living facilities

- Similar institutions serving as an individual's primary residence or providing primarily **custodial care** or rest care

- Health resorts

- Spas, sanitariums

- Infirmaries at schools, colleges, or camps

23. Any food item, including infant formulas, nutritional supplements, vitamins, including **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

24. Any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:

- Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes.

- Shoes (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an **illness** or **injury**.

25. Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

26. Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:

- Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds, and swimming pools.

- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices.

- Equipment or supplies to aid sleeping or sitting, including non-**hospital** electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs.

- Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature.

- Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring.

- Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your **illness** or **injury**.

- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or illness.

- Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

27. Hearing services that do not meet professional standards; hearing exams given during a **stay** in a **hospital** or other facility; replacement parts or repairs for a hearing aid; and any tests, appliances and devices for the improvement of hearing (including hearing aids and amplifiers); or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech.

28. Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

29. Any services, treatments, procedures, or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:

- Drugs related to the treatment of non-covered benefits.
- Injectable **infertility** medications including but not limited to, menotropins, hCG, GnRH agonists, and IVIG.
- Artificial insemination.
- Any advanced reproductive technology (ART) procedures or services related to such procedures including but not limited to, in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), and intra-cytoplasmic sperm injection (ICSI).
- Artificial insemination for covered females attempting to become pregnant who are not **infertile**.
- **Infertility** services for couples in which one of the partners has had a previous sterilization procedure, with or without surgical reversal.
- Procedures, services and supplies to reverse voluntary sterilization.
- **Infertility** services for females with FSH levels 19 or greater mIU/ml on day three of the menstrual cycle.
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to, fees for laboratory tests.
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (*e.g.*, office, **hospital**, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges.
- Home ovulation prediction kits or home pregnancy tests.
- Any charges associated with care required to obtain ART Services (*e.g.*, office, **hospital**, ultrasounds, laboratory tests), and any charges associated with obtaining sperm for any ART procedures.
- Ovulation induction and intrauterine insemination services if you are not **infertile**.

30. **Maintenance care.**

31. Payment for that portion of the charge for which Medicare or another party is the primary payer.

32. Miscellaneous charges for services or supplies including:

- Annual or other charges to be in a **physician's** practice.
- Charges to have preferred access to a **physician's** services such as boutique or concierge **physician** practices.
- Cancelled or missed appointment charges or charges to complete claim forms.
- Charges the recipient has no legal obligation to pay.
- Charges that would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions
  - Care for conditions related to current or previous military service
  - Care while in the custody of a governmental authority
  - Any care a public **hospital** or other facility is required to provide
  - Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

33. Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities).

34. Non-**medically necessary** services, including but not limited to, those treatments, services, **prescription drugs** and supplies which are not **medically necessary**, as determined by **Aetna**, for the diagnosis and treatment of **illness**, **injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

35. Any service or supply primarily for your convenience and personal comfort or that of a third party, including: telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

36. Private duty nursing during your **stay** in a **hospital**, and outpatient private duty nursing services.

37. Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:

- Surgical procedures to alter the appearance or function of the body.
- Hormones and hormone therapy.
- Prosthetic devices.
- Medical or psychological counseling.

38. Services provided by a **spouse**, parent, **child**, brother, sister, in-law, or any household member.

39. Services of a resident **physician** or intern rendered in that capacity.

40. Services provided where there is no evidence of pathology, dysfunction, or disease, except as specifically provided in connection with covered routine care and cancer screenings.

41. Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ.
- Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

42. Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under section 8, *Consolidated Omnibus Budget Reconciliation Act* (*COBRA) and Extended Health Coverage*.

43. Services that are not covered under the **medical plan**.

44. Services and supplies provided in connection with treatment or care that is not covered under the **medical plan**.

45. Speech therapy for treatment of delays in speech development. For example, the **medical plan** does not cover therapy when it is used to improve speech skills that have not fully developed.

46. Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:

- Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching.
- Drugs or preparations to enhance strength, performance, or endurance.
- Treatments, services and supplies to treat **illnesses**, **injuries** or disabilities related to the use of performance-enhancing drugs or preparations.

47. Therapies for the treatment of delays in development, unless resulting from acute **illness** or **injury.** Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

48. Any of the following treatments or procedures:

- Aromatherapy
- Bio-feedback and bioenergetic therapy
- Carbon dioxide therapy
- Chelation therapy (except for heavy metal poisoning)
- Educational therapy
- Gastric irrigation
- Hair analysis
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds
- Hypnosis, and hypnotherapy, except when performed by a **physician** as a form of anesthesia in connection with covered surgery
- Lovaas therapy
- Massage therapy
- Megavitamin therapy
- Primal therapy
- Psychodrama

- Purging
- Recreational therapy
- Rolfing
- Sensory or auditory integration therapy
- Sleep therapy
- Thermograms and thermography

49. Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum.

50. The following charges related to transplant coverage:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence.
- Services and supplies furnished to a donor when recipient is not a **covered person**.
- Home infusion therapy after the transplant occurrence.
- Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing **illness**.
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing **illness**.
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise **precertified** by **Aetna**.

51. Transportation costs, including **ambulance** services, for routine transportation to receive outpatient or inpatient services.

52. Vision services covered under the **vision plan**.

53. Any **illness** or **injury** related to employment or self-employment including any **illness** or **injury** that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your

employer, workers' compensation, or an occupational illness or similar program under local, state or Federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular **illness** or **injury** under such law, that **illness** or **injury** will be considered "non-occupational" regardless of cause.

54. Spinal disorders, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine, including manipulation of the spine treatment.

55. Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of co-morbid conditions, including but not limited to:

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical procedures, medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including morbid obesity.

- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications.

- Counseling, coaching, training, hypnosis or other forms of therapy.

- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

56. Illegal acts, riot or rebellion, including services and supplies for treatment of an **injury** or condition caused by or arising out of active **covered person's** voluntary participation in a riot, armed invasion or aggression or rebellion or arising directly from an illegal act.

3.8. INDIVIDUAL CASE MANAGEMENT

If you have an **injury** or **illness** for which care or treatment may be necessary for some time, the **medical plan** provides for alternate means of care through individual case management (ICM). For example, if you are facing an extended period of care or treatment, this may be provided in a **skilled nursing facility** or in your home. These settings offer cost savings as well as other advantages to you and your family.

When reviewing claims for the ICM program, **Aetna** always works with you, your family, and your **physician** so that you receive close, personal attention. **Aetna** identifies and evaluates potential claims for ICM, always keeping in mind that alternative care must result in savings without detracting from the quality of care.

Through ICM, **Aetna** can consider recommendations involving expenses usually not covered for reimbursement. This includes suggestions to use alternative medical management techniques, procedures, or suggestions for cost-effective use of existing **medical plan** provisions such as home health care and **skilled nursing facilities**.

Examples of conditions that may qualify for ICM include:

- 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
- **Illness** or **injury** requiring substantial medical resources over a long period of time or those where another cost-effective alternative may be implemented.

If you have questions regarding ICM and its possible application to you, call **Aetna**. All parties must approve alternate care before it is provided.

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4. *Dental Plan*

4.1. INTRODUCTION

There are two options available under the **dental plan**: preventive and standard. The **coinsurance** amount is different with each option. See section 2.2, *Dental Benefit Schedule,* for details about how these items differ between the options. You elect which option under the **dental plan** you want for you and your **dependents**.

4.2. HOW DENTAL BENEFITS ARE PAID

4.2.1. Deductible

Each **covered person** must meet the annual individual **deductible** before the **dental plan** begins to pay benefits for that **covered person**. The **deductible** is waived for Class I preventive services under the standard plan. See section 2.2, *Dental Benefit Schedule*.

4.2.2. Coinsurance

After you satisfy the annual individual **deductible**, the **dental plan** pays the **coinsurance** amount that applies to you for Class II restorative services and Class III prosthetic services depending on the dental option in which you are enrolled for most **covered expenses**. See section 2.2, *Dental Benefit Schedule*.

4.2.3. Network and Out-of-Network Coverage

You can directly access any network or out-of-network **dentist** or **dental care provider** for covered services and supplies under the **dental plan**. The **dental plan** pays differently when services and supplies are obtained through **network providers** and out-of-**network providers**. **Network providers** have contracted with **Delta Dental** either directly or through a third party to provide services and supplies under the **dental plan**. **Network providers** are identified in **Delta Dental's** directory, which can be found online at www.deltadentalak.com.

The **dental plan** provides access to covered benefits through a broad network of health care **providers** and facilities. The **dental plan** is designed to lower your out-of-pocket costs when you use **network providers** for **covered expenses**. **Network providers** have agreed to accept a **negotiated charge** from the **dental plan**. Your **coinsurance** under the **dental plan** will be based on a **negotiated charge** between the **dentist** or **dental care provider** and **Delta Dental**, and you will not have to pay any amount above the **negotiated charge**.

You also have the choice to access licensed **dentists** and **dental care providers** outside the network for covered services and supplies. Your out-of-pocket costs will generally be higher when you use out-of-**network providers** because the **coinsurance** that you are required to pay is usually higher when you utilize out-of-**network providers**. Out-of-**network providers** have not agreed to a **negotiated charge** with **Delta Dental**, and may balance bill you for charges over the **recognized charge** that the **dental plan** pays.

4.2.4. Availability of Providers

Delta Dental cannot guarantee the availability or continued network participation of a particular **dentist** or **dental care provider**. Either **Delta Dental** or any **network provider** may terminate the **provider** contract.

4.2.5. Recognized Charge

The **covered expense** is the part of a charge which is the **recognized charge**. If a charge exceeds the **recognized charge**, the amount above the **recognized charge** is not covered by the **dental plan**, and is your responsibility to pay.

4.2.6. Annual Maximum

The **dental plan** pays **covered expenses** up to an annual individual maximum for each **covered person**. See section 2.2, *Dental Benefit Schedule.*

4.3. COVERED DENTAL SERVICES

The preventive plan covers Class I preventive, Class II restorative, and Class III prosthetic services. The standard plan covers Class I preventive, Class II restorative, and Class III prosthetic services, as well as orthodontic services. This section describes the services covered in each class when performed by a **dentist** or **dental care provider** and when determined to be **dentally necessary**.

4.3.1. Class I Preventive Services

Covered expenses are paid at 100% of the **recognized charge**.

a. Diagnostic Services and Limitations

Services:

- Examination.
- Intra-oral x-rays to assist in determining required dental treatment.

Limitations:

- Periodic (routine) or comprehensive examinations or consultations are covered up to two times in any **benefit year**.
- Complete series x-rays or a panoramic film is covered once in any 5-year period.
- Supplementary bitewing x-rays are covered once in any **benefit year**.
- Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered.
- Only the following x-rays are covered by the **dental plan**: complete series or panoramic, periapical, occlusal, and bitewing.

b. Preventive Services and Limitations

Services:

- **Prophylaxis** (cleanings).
- Periodontal maintenance.
- Topical application of fluoride.
- Sealants.
- Space maintainers.

Limitations:

- **Prophylaxis** (cleaning) or **periodontal maintenance** is covered up to two times in any benefit year. Additional cleaning benefits may be available if **medically necessary** or **dentally necessary** and when precertified by **Delta Dental.** Additional cleaning benefits are available for **covered persons** with diabetes and covered **persons** in their third trimester of pregnancy under the **dental plan's** Oral Health, Total Health program (see section 4.4, *Oral Health, Total Health Program and Benefits*).
- **Covered persons** diagnosed with periodontal disease are eligible for a total of up to four cleanings per **benefit year.**

- Topical application of fluoride is covered up to two times in any **benefit year** for **covered persons** age 18 and under. For **covered persons** age 19 and over, topical application of fluoride is covered up to two times in any **benefit year** if there is recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment (poor diet or oral hygiene does not constitute a medical disease).

- Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant per tooth, during any 5-year period.

- Space maintainers are limited to once per space. Space maintainers for primary **anterior** teeth, missing permanent teeth or for **covered persons** age 14 or over are not covered.

4.3.2. Class II Restorative Services

Covered expenses are paid at 80% of the **recognized charge** for the standard plan and 10% of the **recognized charge** for the economy plan option.

a. Restorative Services and Limitations

Services: Fillings on teeth for the treatment of decay.

Limitations:

- Inlays are considered an optional service; an alternate benefit of a composite filling will be provided.

- Crown buildups are considered to be included in the crown **restoration** cost. A buildup will be a benefit only if necessary for tooth retention.

- Additional limitations when teeth are restored with crowns or **cast restorations** are in section 4.3.3, *Class III Prosthetic Services.*

- A separate charge for general anesthesia and/or IV sedation when in conjunction with non-surgical procedures is not covered.

b. Oral Surgery Services and Limitations

Services:

- Extractions (including surgical).

- Other minor surgical procedures.

Limitations:

- A separate, additional charge for **alveoloplasty** done in conjunction with surgical removal of teeth is not covered.
- Surgery on larger lesions or malignant lesions is not considered minor surgery.
- Brush biopsy is covered up to two times in any **benefit year**. Benefits are limited to the sample collection and do not include coverage for pathology (lab) services.

c. Endodontic Services and Limitations

Services: Procedures for treatment of teeth with diseased or damaged nerves (for example, pulpal therapy and root canal filling).

Limitations:

- A separate charge for cultures is not covered.
- Pulp capping is covered only when there is exposure of the pulp.
- Cost of retreatment of the same tooth by the same **dentist** within 24 months of a root canal is not eligible for additional coverage.

d. Periodontic Services and Limitations

Services: Treatment of diseases of the gums and supporting structures of the teeth and/or **implants.**

Limitations:

- Periodontal scaling and root planing is limited to once per quadrant in any 24-month period.
- Coverage for **periodontal maintenance** procedure under Class I, Preventive.
- A separate charge for post-operative care done within 3 months following periodontal surgery is not covered.
- Full mouth **debridement** is limited to once in a 2-year period and only if there has been no cleaning (**prophylaxis**, **periodontal maintenance**) within 24 months.

e. Anesthesia Services

- General anesthesia or IV sedation in conjunction with a covered surgical procedures performed in a dental office).
- General anesthesia or IV sedation when necessary due to concurrent medical conditions.

4.3.3. Class III Prosthetic Services

Covered expenses are paid at 50% of the **recognized charge** for the standard plan and 10% of the **recognized charge** for the economy plan option.

a. Restorative Services and Limitations

Services: **Cast restorations**, such as crowns, onlays or lab **veneers**, necessary to restore decayed or **broken** teeth to a state of functional acceptability.

Limitations:

- **Cast restorations** (including **pontics**) are covered once in a seven year period on any tooth.
- Porcelain **restorations** are considered **cosmetic** dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and the **covered person** is responsible for paying the difference.

b. Prosthodontic Services and Limitations

Services:

- **Bridges.**
- Partial and complete dentures.
- Denture **relines.**
- Repair of an existing prosthetic device.
- **Implants.**

Limitations:

- A **bridge** or denture (full or partial denture) will be covered once in a seven year period and only if the tooth, tooth site, or

teeth involved have not received a **cast restoration** benefit in the last seven years.

- Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.

- Partial dentures: A temporary (interim) partial denture is only a benefit when placed within two months of the extraction of an **anterior** tooth or for missing **anterior** permanent teeth of **covered persons** age 16 or under. If a specialized or precision device is used, **covered expense** will be limited to the cost of a standard cast partial denture. No payment is provided for **cast restorations** for partial denture **retainer** teeth unless the tooth requires a **cast restoration** due to decayed or **broken** teeth.

- Denture adjustments, repairs, and **relines**: A separate, additional charge for denture adjustments, repairs, and **relines** done within six months after the initial placement is not covered. Subsequent **relines** will be covered once per denture in a 12-month period. Subsequent adjustments are limited to two adjustments per denture in a 12-month period.

- Tissue conditioning is covered no more than twice per denture in a 36-month period.

- Surgical placement and removal of **implants** are covered. **Implant** placement and **implant** removal are limited to once per lifetime per tooth space. The **dental plan** will also cover:

  - The final crown and **implant abutment** over a single **implant**. This benefit is limited to once per tooth or tooth space over the lifetime of the **implant**; or

  - Provide an alternate benefit per arch of a full or partial denture for the final **implant supported prosthetic** when the **implant** is placed to support a prosthetic device. The frequency limitation for prosthetic devices will apply to this alternate benefit (once in any seven year period); or

  - The final **implant supported prosthetic bridge retainer** and **implant abutment**, or **pontic**. The benefit is limited to once per tooth or tooth space in any seven year period.

  - **Implant supported prosthetic bridges** are not covered if one or more of the **retainers** is supported by a natural tooth.

- These benefits or alternate benefits are not provided if the tooth, **implant**, or tooth space received a **cast restoration** or prosthodontic benefit, including a **pontic**, within the previous seven years.

- Fixed **bridges** or removable cast partial dentures are not covered for **covered persons** under age 16.

- Porcelain **restorations** are considered **cosmetic** if placed on the upper second or third molars or the lower first, second, or third molars. Coverage is limited to a corresponding metallic prosthetic. The **covered person** is responsible for paying the difference.

c. Other Services and Limitations

Services: Athletic mouthguard.

Limitations:

- An athletic mouthguard is covered once in any 12 month period for **covered persons** age 15 and under and once in any 24-month period age 16 and over.

4.3.4. General Limitation – Optional Services

If a more expensive treatment than is functionally adequate is performed, the **dental plan** will pay the applicable percentage of the **recognized charge** for the least costly treatment. The **covered person** will be responsible for the remainder of the **dentist's** fee.

4.4. ORAL HEALTH, TOTAL HEALTH PROGRAM AND BENEFITS

The **dental plan** covers additional cleanings (**prophylaxis** or **periodontal maintenance**) for certain **covered persons**. This benefit is for the cleaning only. Coverage for a routine exam and other services is subject to the frequency limitations outlined in section 4.3, *Covered Dental Services*. Please contact Delta Dental for enrollment instructions.

The following **covered persons** should consider enrolling in this program:

- **Diabetics**

  For **covered persons** with diabetes, elevated blood sugar levels can have a negative effect on oral health. Diabetes increases the risk of cavities, gum disease, tooth loss, dry mouth and infection. Conversely, poor oral health can make diabetes more difficult to manage. Infections may cause blood sugar to rise and require more insulin to keep it under control. Research confirms that regular

visits to the **dentist** may help in the diagnosis and management of diabetes. Diabetic **covered persons** are eligible for a total of four cleanings per benefit year.

- **Pregnant Persons**

  Keeping the mouth healthy during a pregnancy is important for a **covered person** and the baby. According to the American Dental Association, pregnant women who have periodontal (gum) disease are more likely to have a baby that is born too early and too small.

  Research suggests that periodontal disease triggers increased levels of biological fluids that induce labor. Furthermore, data suggests that women whose periodontal condition worsens during pregnancy have an even higher risk of having a premature baby. Dental visits during a woman's third trimester of pregnancy may help prevent pre-term, low birth weight babies.

  Covered persons should talk to their **dentist** about scheduling a routine cleaning or **periodontal maintenance** during the third trimester of pregnancy. Pregnant **covered persons** are eligible for a cleaning in the third trimester of pregnancy regardless of normal plan frequency limits.

4.5. ORTHODONTIC BENEFITS AND LIMITS

Orthodontic services are defined as the procedures of treatment for correcting malocclusioned teeth.

The standard plan will pay 50% of the **recognized charge** for orthodontic services, up to the orthodontic lifetime maximum. See section 2.2, *Dental Benefit Schedule*. This lifetime maximum is not included in the **dental plan's** annual individual maximum. The **deductible** does not apply to orthodontic services.

The **dental plan's** obligation to make payments for treatment will end when treatment stops for any reason prior to completion, or upon termination of eligibility or of the **dental plan**.

If treatment began before the **covered person** was eligible under the **dental plan**, payment will be based on the balance of the **dentist's** normal payment pattern. The orthodontic lifetime maximum will apply to this amount.

Repair or replacement of an appliance furnished under the **dental plan** is not covered.

4.6. DENTAL PLAN EXCLUSIONS

In addition to the limitations and exclusions described elsewhere in the **dental plan**, the following services, procedures and conditions are not covered, even if: (1) otherwise

dentally necessary; (2) they relate to a condition that is otherwise covered by the **dental plan**; or (3) recommended, referred, or provided by a **dentist** or **dental care provider**.

1. Services covered under the **medical plan**.

2. General anesthesia and/or IV sedation, except as stated in section 4.3, *Covered Dental Services*.

3. Anesthetics, analgesics, hypnosis, and medications, local anesthetics or any other prescribed drugs.

4. Services or supplies not specifically described in the **dental plan** as covered dental services.

5. Claims submitted more than 12 months after the date of service.

6. Congenital or developmental malformations, including, but not limited to treatment of cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia, and fluorosis (discoloration of teeth).

7. **Cosmetic** services.

8. **Experimental or investigational** procedures, including expenses incidental to or incurred as a direct consequence of such procedures.

9. Facility fees, including additional fees charged by the **dentist** for hospital, extended care facility or home care treatment.

10. Gnathologic recordings.

11. Illegal acts, riot or rebellion, including services and supplies for treatment of an injury or condition caused by or arising out of a **covered person**'s voluntary participation in a riot, armed invasion or aggression or rebellion or arising directly from an illegal act.

12. Instructions or training, including plaque control and oral hygiene or dietary instruction.

13. Localized delivery of antimicrobial agents.

14. Missed appointment charges.

15. Services and supplies related to never events, which are events that should never happen while receiving services in a dental office, including but not limited to removing a non-diseased tooth structure or performing a procedure on the wrong patient or wrong tooth.

16. Periodontal charting.

17. Precision attachments.

18. Rebuilding or maintaining chewing surface and stabilizing teeth, including services only to prevent wear or protect worn or cracked teeth. Such services include increasing vertical dimension, equilibration, and periodontal splinting.

19. Services on tongue, lip or cheek.

20. Services otherwise available, including:

- Those compensable under workers' compensation or employer's liability laws.
- Those provided by any city, county, state or Federal law, except for Medicaid coverage.
- Those provided, without cost to the **covered person**, by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under the **dental plan**.
- Any condition, disease, ailment, **injury** or diagnostic service to the extent that benefits are provided or would have been provided had the **covered person** enrolled, applied or maintained eligibility for such benefits under Title XVIII of the Social Security Act, as amended.
- Those provided under separate contracts that are used to provide coordinated coverage for **covered persons** and are considered parts of the same plan.

21. Services provided by a relative, which includes a **covered person**, a **spouse**, **child,** sibling, or parent of a **covered person** or his or her **spouse**.

22. Services and supplies for treatment of **illness** or **injury** for which a third party is or may be responsible to the extent of any recovery received from or on behalf of the third party. Includes benefits payable under any automobile medical, personal injury protection (PIP), automobile no fault, underinsured or uninsured, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to, or makes benefits available to, a **covered person**, whether or not such benefits are requested. See section 11, *Subrogation and Reimbursement Rights*.

23. Treatment of any disturbance of the temporomandibular joint (TMJ).

24. Treatment after coverage terminates, except for Class III services that were ordered and fitted while still eligible, and then only if such items are cemented within 31 days after a **covered person's** eligibility ends. This provision is not

applicable if the **Division** transfers the **dental plan** to another **claims administrator**.

25. Treatment before coverage begins under the **dental plan**.

26. Treatment that is not **dentally necessary**, including services not established as necessary for the treatment or prevention of a dental **injury** or disease otherwise covered under the **dental plan**; that are inappropriate with regard to standards of good dental practice; with poor prognosis.

4.7. ADVANCE CLAIM REVIEW FOR DENTAL CLAIMS

Before beginning expensive treatment, ask your **dentist** to file a description of the proposed course of treatment and expected charges with **Delta Dental**. **Delta Dental** will review the proposal and advise you and your **dentist** of the estimated benefits payable.

A course of treatment is a planned program of one or more services or supplies. It may be rendered by one or more **providers** for the treatment of a condition diagnosed by the attending **physician** or **dentist** as a result of an examination. It begins on the day the **provider** first renders the service to correct or treat such a condition. **Emergency** treatments, oral examinations, **prophylaxis**, and dental x-rays are considered part of a course of treatment.

By receiving an advance review, you will eliminate the possibility of unexpected claim **denials**.

As part of advance claim review and for any claim, **Delta Dental**, at its expense, has the right to require you to obtain an oral examination. You must furnish to **Delta Dental** all diagnostic and evaluative material required to establish your right to benefits. Evaluative material includes dental X-rays, models, charts, and written reports.

5. *Vision Plan*

5.1. INTRODUCTION

The **vision plan** will pay for **covered expenses** up to the limits and maximums shown in section 2.3, *Vision Benefit Schedule.*

5.2. HOW VISION BENEFITS ARE PAID

5.2.1. Deductible

You pay no **deductible** under the **vision plan**.

5.2.2. Copayment

Each **covered person** must pay any applicable **copayment** before the **vision plan** will pay any benefits for that covered service. See section 2.3, *Vision Benefit Schedule*.

5.2.3. Coinsurance

The **vision plan** pays 100% of the **recognized charges** for covered vision and optical services, less any applicable **copayment**.

5.2.4. Annual Allowances

The **vision plan** pays **covered expenses** up to an annual allowance for certain services. See section 2.3, *Vision Benefit Schedule*.

5.2.5. Network Providers

If you choose a **VSP doctor** or an **affiliated provider** under the **vision plan**, you will lower your out-of-pocket costs. See section 2.3, *Vision Benefit Schedule*. **VSP doctors** are located in retail, neighborhood, medical and professional settings, and include Costco Optical, Visionworks, Cohen's Fashion Optical, Wisconsin Vision, and RX Optical. You have the freedom to choose any **provider**, national retailer, or local retail chain.

For a list of **VSP doctors**, call **VSP** at the number listed in the front of this **plan** or visit www.vsp.com. Select a **VSP doctor** from the list and make an appointment. You must identify yourself as a **covered person** under the **vision plan** when you make the appointment. The **VSP doctor** will contact **VSP** to determine what benefits you are eligible for. If you do not identify yourself as a **covered person**, and the **VSP doctor** does not contact **VSP**, your benefits will be paid out-of-network.

5.3. COVERED VISION SERVICES

The following services and supplies are covered under the **vision plan**.

5.3.1. Vision Exam

Covered expenses include a complete initial vision analysis including an appropriate examination of visual functions and the **prescription** of corrective eyewear where indicated by a legally qualified ophthalmologist. Subsequent regular eye examinations are covered once every calendar year.

5.3.2. Vision Supplies

Covered expenses include charges for lenses and frames, or prescription contact lenses, when prescribed by a legally qualified ophthalmologist or optometrist.

- **Prescription Lenses**

  Covered expenses include one pair of **prescription** single vision, lined bifocal, lined trifocal, or lenticular lenses per calendar year. The following lens options are covered in full with a **VSP doctor** at no additional cost to the **covered person**:

  - Progressive lenses
  - Anti-reflective coating
  - Scratch resistant coating
  - Polycarbonate lenses

- **Frames**

  Covered expenses include a frame every two calendar years. There is a 20% discount for any out-of-pocket cost over the frame allowance. The frame allowance may be applied towards non-**prescription** sunglasses for post PRK, Lasik, or Custom LASIK patients.

  Some brands of spectacle frames may be unavailable for purchase under the **vision plan**, or may be subject to additional limitations. **Covered persons** may obtain details regarding frame brand availability from their **VSP doctor** or by calling **VSP** at the number in the front of the **plan**.

- **Additional Services**

The following professional services are included in lens and frame coverage:

- Prescribing and ordering proper lenses
- Assisting in the selection of frames
- Verifying the accuracy of the finished lenses
- Proper fitting and adjustment of frames
- Subsequent adjustments to frames to maintain comfort and efficiency
- Progress or follow-up work as necessary

- **Contact Lenses**

  Elective contact lenses are available once every calendar year in lieu of all other lens and frame benefits under the **vision plan**. Prior approval by **VSP** is not required for **covered persons** to be eligible for contact lenses.

- **Low Vision Benefit**

  The low vision benefit is available to **covered persons** who have severe visual problems that are not correctable with regular lenses. The **vision plan** covers complete low vision analysis and diagnosis, which includes a comprehensive examination of visual functions, and the **prescription** of corrective eyewear or vision aids where indicated. Supplemental care aids are also covered. .

5.4. VISION PLAN EXCLUSIONS

The **vision plan** is designed to cover visual needs rather than **cosmetic** materials. When the **covered person** selects any of the following extras, the **vision plan** will pay the basic cost of the allowed lenses or frames, and the **covered person** will pay the additional costs for the options:

- Optional **cosmetic** processes
- Color coating
- Mirror coating
- Blended lenses
- **Cosmetic** lenses

- Laminated lenses
- Oversized lenses
- UV (ultraviolet) protected lenses
- Certain limitations on low vision care
- A frame that costs more than the **vision plan** allowance
- Contact lenses, except as provided in section 5.3, *Covered Vision Services*.

The following services, procedures and conditions are not covered under the **vision plan**, even if: (1) they relate to a condition that is otherwise covered by the **vision plan**; or (2) they are recommended, referred or provided by a **VSP doctor**.

1. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ± .50 diopter power); or two pair of glasses in lieu of bifocals.
2. Replacement of lenses and frames furnished under the **vision plan** which are lost or broken, except at the normal intervals when services are otherwise available.
3. Medical or surgical treatment of the eyes or services covered under the **medical plan**.
4. Corrective vision treatment that is **experimental or investigational**.
5. Costs for services and/or materials above the **vision plan** allowance.
6. Services and/or materials not listed as covered services in section 5.3, *Covered Vision Services*.
7. Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the **vision plan.**
8. Charges submitted for services by an unlicensed **provider** or not within the scope of the **provider's** license.
9. Services provided by a **spouse,** parent, **child,** brother, sister, in-law, or any household member.
10. Services rendered before the effective date or after the termination of coverage, unless coverage is continued under section 9, *Consolidated Omnibus Budget Reconciliation Act (COBRA) and Extended Health Coverage.*

VSP may, at its discretion, waive any of these limitations if, in the opinion of **VSP's** optometric consultants, it is necessary for the visual welfare of the **covered person**.

6. *Health Flexible Spending Account (HFSA)*

6.1. INTRODUCTION

The **health plan** is designed to cover most, but not all, of your health expenses. You can elect to reduce your salary on a pre-tax basis by a specified amount and contribute that money to a health flexible spending account (HFSA) to reimburse some of your unpaid medical expenses. Since your contributions are not subject to federal or state taxes, you pay less in taxes each year.

6.2. HOW THE HFSA WORKS

The health flexible spending account (HFSA) works similar to a personal checking account, except that accounts are maintained for bookkeeping purposes only, with no interest or earnings credited.

Coverage begins and ends as specified in section 1.7, *When Coverage Begins,* and section 1.9, *When Coverage Ends*. The maximum amount that you may elect to have contributed to your HFSA is determined annually by the Internal Revenue Service (IRS). The amount of contribution you elect will be deducted from your paycheck in equal amounts throughout the **benefit year**. You decide how much you want to contribute to the HFSA, up to the maximum annual amount determined by the IRS.Your contribution must be:

- in whole dollars; and
- at least $20 per month ($240 per benefit year).

Federal income taxes are not withheld on the amount you contribute. If you are on leave without pay or do not have enough payroll in a month, a contribution will not be taken that month.

Your contributions are deposited into your individual reimbursement account under the HFSA. Throughout the **benefit year**, you may request reimbursement from the HFSA for eligible medical expenses you have incurred. You will be reimbursed up to the amount that you elected for your annual contribution or the amount of the claim, whichever is less.

For example, if you timely elect to make monthly contributions of $100 to the HFSA, your annual contribution election is $1,200. By March, you have contributed $300 to your account. In April, you incur a $500 expense that is not covered by the **medical plan**. If you are covered by the HFSA in April, you will be reimbursed $500 for that expense, even though you have not yet contributed sufficient money to cover the request. During the rest of the **benefit year**, you can be reimbursed for additional expenses up to $700 ($1,200 - $500).

Expenses are considered to have been incurred when you (or your **dependents**) are provided with the care—not when you are billed, charged or pay for it.

You have until the last day of the **benefit year** to incur expenses for reimbursement in your HFSA.

If you drop coverage under the HFSA during a **benefit year**, you will be entitled to reimbursements from your HFSA for eligible medical expenses that were incurred during the **benefit year** but before your coverage under the HFSA ended, subject to COBRA continuation coverage. In addition, you will not be entitled to reimbursement of eligible medical expenses for any **dependent** after the person is no longer a **dependent**.

6.3. CARRYOVER OF UNUSED AMOUNTS IN HFSA

If you have a balance remaining in your HFSA at the end of the **benefit year**, an amount will be carried over to the immediately following **benefit year** equal to the lesser of (1) $500 or (2) the amount remaining in your HFSA after all of your eligible medical expenses submitted during the **benefit year** or within the run-out period have been reimbursed. The run-out period is the 90 day period following the end of the **benefit year** (March 31) . This amount is called the "available carryover amount." Any unused amount in excess of $500 will be forfeited as provided in Section 6.4.

The available carryover amount does not reduce the maximum amount that you may elect to contribute to your HFSA for a **benefit year.**

> **EXAMPLE:** You elect to have $2,544 contributed to your HFSA for the 2016 benefit year and$2,592 for the 2017 benefit year. On December 31, 2016, you have an unused HFSA balance of $800. On February 1, 2017, you submit a claim of $350 for eligible medical expenses incurred in 2016. On March 31, 2017 (the last day of the run-out period) you have an available carryover amount of $450 ($800 - $350). As a result, you have $3,042 for which you may submit claims for the remainder of 2017 ($450 carryover + $2,592 for the 2017 election). For the remainder of 2017 you submit claims in the amount of $2,700, leaving an unused balance of $342 on December 31, 2017. This amount may be carried forward to pay 2018 expenses, to the extent not depleted during the run-out period.
>
> **EXAMPLE:** Assume the same facts as above, except that you did not submit claims for eligible medical expenses incurred in 2016 during the run-out period. In that case, you would have an available carryover amount of $500 for 2017, which is the lesser of $500 and the amount remaining at the end of the run-out period ($800). The excess amount above $500 would be forfeited. You will then have $3,092 for which you may submit claims for the remainder of 2017 ($500 carryover + $2,592 for the 2017 election.) For the remainder of 2017, you submit claims in the amount of $2,700, leaving an unused balance of $392 on December 31, 2017. This amount may be carried forward to pay 2018 expenses, to the extent not depleted during the run-out period.

Your available carryover amount, if any, will generally carry forward year to year.

6.4. USE IT OR LOSE IT

In exchange for the tax advantages of using the health flexible spending account (HFSA), the Internal Revenue Service (IRS) requires that you forfeit any money in excess of $500 remaining in your reimbursement account after all eligible medical expenses for the **benefit year** have been reimbursed. You must request reimbursement for expenses incurred during the **benefit year** no later than 90 days following the end of the **benefit year** (by March 31). Because of this use it or lose it rule, it is important that you plan carefully when you participate in the HFSA.

6.5. ELIGIBLE MEDICAL EXPENSES

Eligible medical expenses are health, dental and vision expenses as defined under Code Section 213(d) that are not otherwise reimbursable by the **plan** or any other health plan. In addition, expenses reimbursed out of your HFSA must be expenses incurred by you, your **spouse**, your **dependent children**, and any other **dependent** you claim on your income tax return each year. **PayFlex** will make the final determination as to whether an expense may be reimbursed from the HFSA.

A complete list of tax deductible medical expenses is available in IRS Publication No. 502. You will find it online at www.irs.gov/publications.

Examples of eligible medical expenses include:

- **custodial care** expenses
- hearing aids
- **deductibles**
- **copayments**
- **coinsurance**
- amounts in excess of the maximums allowed by the **medical plan**, **dental plan**, or **vision plan**
- insulin (whether or not prescribed)
- **prescription drugs**
- over-the-counter drugs, but only if you have a **prescription**

Examples of expenses that cannot be reimbursed include, but are not limited to:

- certain **cosmetic** surgery and procedures
- premiums for the **health plan**, **dental plan**, **vision plan** or other health care coverage
- travel expenses
- fees for health club
- vitamins
- qualified long-term care services

6.6. HFSA VS. TAX DEDUCTIONS

If you use the health flexible spending account (HFSA) to pay for eligible medical expenses, you cannot take a tax deduction on your income tax for the same medical expenses. You are allowed a deduction on your tax return for expenses that total more than 7.5% of your adjusted gross income. You must choose which is more advantageous for you. Since tax laws are complicated and subject to change, you should re-examine your tax situation every year, and discuss it with your tax specialist.

6.7. HOW MUCH TO CONTRIBUTE

The health flexible spending account (HFSA) can save you money if you budget your expenses carefully. Keep in mind that you must forfeit any money in excess of $500 remaining in your reimbursement account at the end of the **benefit year** after all eligible medical expenses have been paid. Most **employees** find, however, that they can avoid the risk of forfeiture by planning ahead.

When considering how much to contribute, remember your annual contribution will be deducted from your paycheck over the entire **benefit year**, not just for a few months at a time. For example, if you expect to incur $600 in eligible medical expenses, you could contribute $50 per month ($600 for the **benefit year** or 12 x $50). Information that might be helpful for you to consider in determining how much to contribute to your HFSA includes:

- What expenses you may have that are not covered by the plan but are reimbursable from the HFSA;
- How much your deductibles are expected to be for the benefit year;
- An estimate of the total out-of-pocket costs you could pay under the plan;
- An estimate of what your coinsurance and copayments will total; and

- How much you paid for health care costs during the last benefit year. For example, if your out-of-pocket health care costs were $500 during the last benefit year, they may run close to that this year.

Remember, any amount remaining in your HFSA at the end of the year that exceeds $500 will be forfeited.

6.8. SUBMITTING CLAIMS FOR REIMBURSEMENT

You should submit a claim for medical expenses to the **plan** and any other health plan in which you participate first. You will receive an *EOB* showing your out-of-pocket costs.

To be reimbursed for unpaid eligible medical expenses, claims for reimbursement to the HFSA may be submitted in one of the following ways:

- Streamlined claims submission – With this option, claims are sent to the claims administrator by you or your provider as normal. Any amounts that are unpaid by the plan, such as deductibles, copayments, or non-covered medical expenses, are electronically transferred to PayFlex. You cannot elect this option if you have any health coverage in addition to the plan. This includes a second State plan (such as coverage through your spouse) or any other health insurance plan. For example, a husband and wife who are covered by each other's health plans may not elect streamlined claims submission.
- Direct claims submission – With this option, you submit your claims to PayFlex on the Request for Reimbursement form after receiving your EOB from the plan or any other health plan in which you participate. This form is available from your human resources office, the Division, PayFlex, or www.AlaskaCare.gov. If you have more than one health plan, you must submit the claim with copies of the EOB from all plans. This is the only option available if you have more than one health plan.
- Over-the-counter (OTC) claims submission— With this option, you submit claims to PayFlex on the HFSA OTC Claims form regardless of whether you have elected streamlined or direct claims submission. You must submit each claim with itemized statements or receipts, an EOB from your health plan, and a prescription.

Reimbursements are issued daily. Checks are payable to you, not to your **provider**. Claims for services incurred during the **benefit year** will be accepted any time during that year. You have 90 days after the end of the **benefit year** (generally until March 31) to file all unpaid claims for that **benefit year**.

7. *How To File A Claim*

7.1. FILING HEALTH CLAIMS

Under the Plan, you may file claims for Plan benefits and appeal adverse claim determinations. Any reference to "you" in this How To File A Claim section includes you and your Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.You may obtain claims forms from your human resources office, the **claims administrator**, the **Division**, or www.AlaskaCare.gov.

7.2. CLAIM FILING DEADLINE

To receive benefits, you must submit a claim within 90 days after treatment began, or within 30 days after treatment ends, whichever is later. **Network providers** will submit claims on your behalf. If you are unable to meet the deadline for filing the claim, your claim will be accepted if you file as soon as possible, but not later than 12 months after the date you incurred the expenses.

7.3. HOSPITAL SERVICES

Your health care coverage is good worldwide. If you are hospitalized in a licensed, general **hospital** anywhere, even outside Alaska, you can use your **hospital** benefits.

When you are admitted to the **hospital**, give your health ID card to the admitting clerk. The **hospital** may bill **Aetna** directly. **Aetna** will send you an *EOB* form that shows the amount charged and the amount paid to the **hospital**. If you already paid the **hospital** charges and this fact is shown clearly on the claim form, **Aetna** will send the benefits check to you, along with the *EOB* form.

7.4. PHYSICIAN AND OTHER PROVIDER SERVICES

The fastest way to process your claim is to ask your **provider** to bill **Aetna** directly on a medical claim form. The claim forms are available from your human resources office, the **Division**, **Aetna**, or www.AlaskaCare.gov.

If your **provider** does not bill directly, complete *Part 1, Patient Information* and have your **provider** complete *Part 2, Medical Information* and/or attach an itemized bill.

The itemized bill must include:

- Your **provider's** name
- Your **provider's** employer identification number
- Your diagnosis (or the International Classification of Diseases diagnosis code)
- The date of service
- An itemized description of the service and charges

7.5. DENTAL SERVICES

You can get a *Dental Benefits Claim* form from your **provide**r, your human resources office, the **Division**, **Delta Dental**, or www.AlaskaCare.gov. Follow the instructions under section 7.4, *Physician and Other Provider Services*, for completing the form.

7.6. VISION SERVICES

You can get a *Vision Benefits Claim* form from your **provider**, your human resources office, the **Division**, **VSP**, or www.vsp.com. Follow the instructions under section 7.4, *Physician and Other Provider Services*, for completing the form.

7.7. PRESCRIPTION DRUGS

No claim filing is necessary if you obtain your drugs from a **network pharmacy**.

If you do not use a **network pharmacy**, be sure to obtain a receipt from the pharmacist. Cash register receipts are not acceptable. Medicines that do not require a **prescription** are not covered. Send the receipt with a medical claim form to **Aetna**. You can get these forms from your human resources office, the **Division**, **Aetna**, or www.AlaskaCare.gov.

The receipt must include the:

- Patient's name
- Date of purchase
- Prescription number
- Itemized purchase price for each drug
- Quantity
- Day supply
- Name of drug

- Name of **pharmacy**

The **medical plan** will pay benefits for **prescription drugs** purchased elsewhere only if actual drug receipts accompany your claim submission. If receipts are not submitted to **Aetna**, your claim will be held pending your submission of receipts.

If your prescription drug is denied for coverage at the pharmacy (point of sale), you may either:

- Pay for the prescription drug and **appeal** the **denial** of coverage at the point of sale by filing a *Medical Benefits Request* form with **Aetna**. You can get this form from your human resources office, the **Division**, **Aetna**, or www.AlaskaCare.gov.

- Delay filling the prescription and **appeal** the **denial** of coverage at the point of sale by filing a *Member Complaint and Appeal* form. You can get this form from your human resource office, the **Division**, **Aetna**, or www.AlaskaCare.gov.

7.8. MEDICAL BENEFITS

For covered medical services, the following are examples of the information needed to process your claim:

- Nursing care. If you need special nursing services at home or in the **hospital**, your claim must include the date, hours worked and the name of the referring **physician**.

- Blood and blood derivatives. You are encouraged to replace blood or blood derivatives that you use. If you do not, you must get a bill from the blood bank which includes the date of service, location where the blood was transported, and the total charge.

- Appliances (braces, crutches, wheelchairs, etc.). The bill must include a description of the item, indicate whether it was purchased or rented, list the name of the **physician** who prescribed the item, and show the total charge.

- **Ambulance**. The bill must include the date of the service, where you were transported to and from, and the total charge.

7.9. OTHER CLAIM FILING TIPS

You must list your participant account number on all bills or correspondence. The number is listed on your health ID card. Send all bills to the **claims administrator's** address listed in the front of this **plan**. This address is also in your welcome kit and on your health ID card.

If you have other health coverage in addition to the health **plan**, you should submit your claims to the primary plan first. Then send a copy of the claim and the *EOB* form from the primary plan to the secondary plan so that benefits will be coordinated properly between plans. See section 10, *Coordination of Benefits*, for information on how to determine which plan is primary.

If you have claim problems, call or write to the **claims administrator** and a customer service professional will help you. When you call, be sure to have your health ID card or *EOB* form available. Include your participant account number from your health ID card on any letter you write. The **claims administrator** needs this information to identify your particular coverage.

7.10. BENEFIT PAYMENTS

If you have not paid the **provider** and you include the **provider's** name, address and tax identification number, the **claims administrator** will pay the **provider** directly. If you have already paid the **provider** and this fact is clearly shown on the claim form, the **claims administrator** will send the benefit check to you along with the *EOB* form.

7.11. BEFORE FILING A CLAIM

When you file a claim:

- Submit your bills with a claim form for each family member.
- Always check to make sure your **physician** or **dentist** has not already submitted your claim. If you give the **physician** or **dentist** permission to submit a claim, do not submit one yourself.

Complete the claim form fully and include information on any other group health care programs covering you and your **dependents**. If you have other coverage which should pay first before this **plan**, include a copy of that plan's explanation of benefits showing the amount it paid for the services.

7.12. RECORDKEEPING

Keep complete records of expenses for yourself and each of your **dependents**. Important records include:

- Names of **physician**s and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

You should also keep all *EOB* forms sent to you.

7.13. PHYSICAL EXAMINATIONS

The **claims administrator** will have the right and opportunity to have a **physician** or **dentist** of its choice examine any person for whom **precertification** or benefits have been requested. This will be done at all reasonable times while **precertification** or a claim for benefits is pending or under review. This will be done at no cost to you.

7.14. IF A CLAIM IS DENIED

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7.14.1. Initial Claim for Benefits

Any claim to receive benefits under the **plan** must be filed with the **claims administrator** within the designated time period on the designated form, and will be deemed filed upon receipt.

If you fail to follow the claims procedures under the **plan** for filing an **urgent care claim** or a **pre-service claim**, you will be notified orally (unless you request written notice) of the proper procedures to follow, not later than 24 hours for **urgent care claims** and five days for **pre-service claims**. This special timing rule applies only to **urgent care claims** and **pre-service claims** that:

- are received by the person or unit customarily responsible for handling benefit matters; and
- specify a claimant, a medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

You must submit any required **physician** statements on the appropriate form. If the **claims administrator** disagrees with the **physician** statement, the terms of the **plan** will be followed in resolving any such dispute.

7.14.2. Initial Review of Claims

When a claim for health benefits has been properly filed, you will be notified of the approval or **denial** within the time period set forth in section 7.15.9, *Chart of Time Limits for Plan Claims*. For **urgent care claims**, the **claims administrator** will defer to the attending **provider** with respect to the decision as to whether a claim is an **urgent care claim** for purposes of determining the applicable time period.

7.14.3. Initial Denial of Claims

If your claim for benefits is denied in whole or in part, you will be given notice from the **claims administrator** that explains the following items:

- The specific reasons for the **denial**.
- References to **plan** provisions upon which the **denial** is based.
- A description of any additional material or information needed and an explanation of why such material or information is necessary.
- A description of the **plan's** review procedures and time limits, including information regarding how to initiate an **appeal**, information on the external review process (with respect to benefits under the **medical plan** and **dental plan**).
- The specific internal rule, guideline, protocol, or other similar criterion, if any, relied upon in making the **denial**, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon, with a copy free of charge upon request.
- If the **denial** is based on a **medical necessity** or an **experimental or investigational** treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.
- For **urgent care claims**, a description of the expedited review process applicable to such claims.
- For **denials** of benefits under the **medical plan** or **dental plan**:
  - information sufficient to identify the claim involved (including the date of service, the health care **provider**, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
  - the **denial** code and its corresponding meaning, as well as a description of the **claims administrator's** standard, if any, that was used in the **denial** of the claim; and
  - the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist individuals with the internal claims and appeals and external review processes.

For **urgent care claims**, the information in the notice may be provided orally if you are given notification within three days after the oral notification.

If you believe your claim should be covered under the terms of the **plan**, you should contact the **claims administrator** to discuss the reason for the **denial.** If you still feel the claim should be covered under the terms of the **plan,** you can take the following steps to file an **appeal**.

7.14.4. First Level Appeal of Initial Denial of Claim

You may initiate a first level of **appeal** of the **denial** of a claim by filing a written **appeal** with the **claims administrator** within the time period set forth in section 7.14.9, *Chart of Time Limits for Claims*, which will be deemed filed upon receipt. If the **appeal** is not timely filed, the initial decision of the **claims administrator** will be the final decision under the **plan**, and will be final, conclusive, and binding on all persons. For **urgent care claims**, you may make a request for an expedited **appeal** orally or in writing, and all necessary information will be transmitted by telephone, facsimile, or other similarly expeditious method.

7.14.5. Decision on First Level of Appeal of Initial Denial of Claim

You will receive notice of the **claims administrator's** decision on the first level of **appeal** within the time period set forth in section 7.14.9, *Chart of Time Limits for Claims.*

If the claim is denied on **appeal**, with respect to claims for benefits under the **plan,** the **claims administrator** will provide you with the following information free of charge as soon as possible and sufficiently in advance of the date on which the notice of **denial** is required to be provided to you that you have a reasonable opportunity to respond prior to that date:

- any new or additional evidence considered, relied upon, or generated by the **claims administrator** (or at the direction of the **claims administrator**) in connection with the claim; and

- any new or additional rationale that forms the basis of the **claims administrator's denial**, if any.

Additionally, if the claim is **denied** on **appeal** (including a **final denial**), you will be given notice with a statement that you are entitled to receive, free of charge, reasonable access to and copies of all documents, records, and other information that apply to the claim. The notice will also contain:

- The specific reasons for the **denial.**

- References to applicable **plan** provisions upon which the **denial** is based.

- A description of the review procedures and time limits, including information regarding how to initiate a second level **appeal**, and information on the external review process (with respect to benefits under the **medical plan** and **dental plan**).

- The specific internal rule, guideline, protocol, or other similar criterion, if any, relied upon in making the **denial**, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon, with a copy free of charge upon request.

- If the **denial** is based on a **medical necessity** or an **experimental or investigational** treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

- For **denials** of benefits under the **medical plan** and **dental plan**,

  - information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning),

  - the **denial** code and its corresponding meaning, as well as a description of the **claims administrator**'s standard, if any, that was used in the **denial** of the claim; and

  - the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist individuals with the internal claims and **appeals** and external review process.

- If the **denial** is a **final denial** under the plan, a discussion of the decision.

If a second level **appeal** is not available under Section 7.14.6, *Second Level Appeal of Denial of Claim*, the decision on the first level of **appeal** will be a **final denial,** that is final, conclusive, and binding on all persons, subject to external review under Section 7.14.10, *Application and Scope of External Review Process for Benefits Under the Health Plan.*

7.14.6. Second Level Appeal of Denial of Claim

You may initiate a second level of **appeal** of the **denial** of a claim, but only if the claim is not eligible for external review under section 7.14.10, *Application and Scope of External Review Process for Benefits Under the Medical Plan and Dental Plan*, because it does not involve medical judgment or a **rescission** of coverage under the **medical plan** or the **dental plan**.

7.14.7. Decision on Second Level Appeal of Denial of Claim

You may initiate the second level of appeal by filing a written appeal with the claims administrator within the time period set forth in section 7.14.9, *Chart of Time Limits for Claims*, which will be deemed filed upon receipt. If you do not file a timely second level of appeal, to the extent available under this section, the decision on the first level appeal will be the final decision, and will be final, conclusive and binding on all persons.

The **claims administrator** will provide you with notice of its decision on the second level of **appeal** within the time period set forth in section 7.14.9, *Chart of Time Limits for Claims*. If the claim is denied on the second level of **appeal**, the **claims administrator** will provide notice to you containing the information set forth in section 7.14.5, *Decision on First Level of Appeal of Claim Denial*. The decision on the second level of **appeal** will be a **final denial** that is final, conclusive and binding on all persons.

7.14.8. Ongoing Treatments

If the **claims administrator** has approved an ongoing course of treatment to be provided to you over a certain period of time or for a certain number of treatments, any reduction or termination under such course of treatment before the approved period of time or number of treatments end will constitute a **denial**. You will be notified of the **denial** within the time period set forth in section 7.14.19, *Chart of Time Limits for Claims*, before the reduction or termination occurs, to allow you a reasonable time to file an **appeal** and obtain a determination on the **appeal**. Coverage for the ongoing course of treatment that is the subject of the **appeal** will continue pending the outcome of such **appeal**.

For an **urgent care claim**, any request by you to extend the ongoing treatment beyond the previously approved period of time or number of treatments will be decided no later than 24 hours after receipt of the **urgent care claim**, provided the claim is filed at least 24 hours before the treatment expires.

7.14.9. Chart of Time Limits for Claims

	MAXIMUM TIME LIMITS FOR :							
	Claims administrator to decide initial claim (if no additional information is needed) (whether adverse or not)	**Extension of time by Plan for determining initial claim**	**Claims administrator to notify claimant of information needed from claimant to decide initial claim, if not provided by claimant**	**Claims administrator to notify claimant of claimant's failure to follow proper procedures**	**Claimant to then provide needed information (if extension allowed by claims administrator)**	**Claims administrator to decide initial claim after requesting additional information and notifying claimant (if applicable)**	**Claimant to file appeal**	**Claims administrator to decide appeal**
	For claims for **medical plan** benefits, no later than 72 hours after receipt of the claim by the **claims administrator.**	None	No later than 24 hours after receipt of incomplete claim by **claims administrator.**	No later than 24 hours after receipt of improper claim by **claims administrator.**	Not less than 48 hours after receipt of notice from **claims administrator.**	No later than 48 hours after earlier of (i) **claims administrator's** receipt of additional information from claimant, or (ii) end of time period given to claimant to provide additional information (48 hours).	180 days after receipt of **denial** by claimant.	All **appeals** must be decided within 72 hours after **claim administrator's** receipt of **appeal** from claimant.

	MAXIMUM TIME LIMITS FOR :							
	Claims administrator to decide initial claim (if no additional information is needed) (whether adverse or not)	**Extension of time by Plan for determining initial claim**	**Claims admini-strator to notify claimant of informa-tion needed from claimant to decide initial claim, if not provided by claimant**	**Claims admini-strator to notify claimant of claimant's failure to follow proper procedures**	**Claimant to then provide needed infor-mation (if extension allowed by claims administr ator)**	**Claims admini-strator to decide initial claim after requesting additional information and notifying claimant (if applicable)**	**Claimant to file appeal**	**Claims administra-tor to decide appeal**
	No later than 15 days after receipt of **claim** by the **claims administrator**.	One time 15-day extension allowed if (i) due to matters beyond **claims administrator's** control and (ii) **claims administrator** notifies claimant before end of initial 15-day time period of the circumstances requiring such extension and the date **claims administrator** expects to render decision. .	No later than 15 days after receipt of incomplete claim by **claims administrator.** Notice will describe required information. **Note: Claims administrator** may or may not allow extension due to claimant's failure to provide needed information.	No later than 5 days after receipt of improper claim by **claims admini-strator**.	No later than 45 days after receipt of notice from **claims admini-strator.** ***Note***: **Claims admini-strator** may or may not request needed informa-tion from claimant.	No later than 15 days after earlier of (i) **claims admini-strator 's** receipt of additional information from claimant, if requested, or (ii) end of time period given to claimant to provide additional information (45 days).	180 days after receipt of **denia**l by claimant.	One level **appeal and external review**: 30 days after **claims admini-strator's** receipt of **appeal** from claimant. Two level **appea**l no external review: *First level* - 15 days after **claims administra-tor's** receipt of claimant's first level **appeal** request. *Second level* – 15 days after **claims administra-tor's** receipt of claimant's second level **appeal** request.

	MAXIMUM TIME LIMITS FOR :							
	Claims administrator to decide initial claim (if no additional information is needed) (whether adverse or not)	**Extension of time by Plan for determining initial claim**	**Claims admini-strator to notify claimant of informa-tion needed from claimant to decide initial claim, if not provided by claimant**	**Claims admini-strator to notify claimant of claimant's failure to follow proper procedures**	**Claimant to then provide needed infor-mation (if extension allowed by claims administr ator)**	**Claims admini-strator to decide initial claim after requesting additional information and notifying claimant (if applicable)**	**Claimant to file appeal**	**Claims administra-tor to decide appeal**
	No later than 30 days after receipt of **claim** by the **claims administrator**.	One time 15-day extension allowed if (i) due to matters beyond **claims administrator's** control and (ii) **claims administrator** notifies claimant before end of initial 30-day time period of the circumstances requiring such extension and the date **claims administrator** expects to render decision.	No later than 30 days after receipt of incomplete claim by **claims administrator.** Notice will describe required information. **Note: Claims Administrator** may or may not allow extension due to claimant's failure to provide needed information.	N/A	No later than 45 days after receipt of notice from **claims admini-strator**. ***Note*: Claims admini-strator** may or may not request needed informa-tion from claimant.	No later than 15 days after earlier of (i) **claims admini-strator 's** receipt of additional information from claimant, if requested, or (ii) end of time period given to claimant to provide additional information (45 days).	180 days after receipt of **denial** by claimant.	One level **appeal and external review**: 60 days after **claims administra-tor's** receipt of **appeal** from claimant. Two level **appeal no external review**: *First level* - 30 days after **claims administra-tor's** receipt of claimant's first level **appeal** request. *Second level* – 30 days after **claims administra-tor's** receipt of claimant's second level **appeal** request.

7.14.10. Application and Scope of External Review Process for Benefits Under the Medical Plan and Dental Plan

Upon receipt of a **final denial** (including a deemed **final denial**) with respect to benefits under the **medical plan** or **dental plan**, you may apply for external

review. Upon receipt of a **denial** with respect to benefits under the **medical plan** or **dental plan** that is not a **final denial**, you may only apply for external review as provided in section 7.14.12, *Expedited External Review Process for Medical Plan and Dental Plan.* The external review process will apply only to:

- a **final denial** with respect to benefits under the **medical plan** or **dental plan** that involves medical judgment, including but not limited to, those based on the **medical plan's** or **dental plan's** requirements for **medical necessity**, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is **experimental or investigational**; and

- a **rescission** of coverage under the **medical plan** or **dental plan** (whether or not the **rescission** has any effect on any particular benefit at that time).

7.14.11. Standard External Review Process for Claims for Benefits under the Medical Plan and Dental Plan

a. Timing of Request for External Review. You must file a request for external review of a benefit claim under the **medical plan** and **dental plan** with the **claims administrator** no later than the date which is four months following the date of receipt of a notice of **final denial**. If there is no corresponding date four months after the date of receipt of such notice, then the request must be filed by the first day of the fifth month following receipt of the notice (*e.g.*, if a **final denial** is received on October 30, request must be made by the following March 1). If the last filing date would fall on a Saturday, Sunday, **State** holiday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, **State** holiday or Federal holiday.

b. Preliminary Review. The **claims administrator** will complete a preliminary review of the request for external review within five business days to determine whether:

- you are or were covered under the applicable **medical plan** or **dental plan** at the time the covered service was requested or provided, as applicable;

- the type of claim is eligible for external review;

- you have exhausted (or are deemed to have exhausted) the **medical plan's** or **dental plan's** internal claims and **appeals** process; and

- you have provided all the information and forms required to process an external review.

The **claims administrator** will issue a notification to the claimant within one business day of completing the preliminary review. If the request is complete, but ineligible for external review, the notification will include the reasons for its ineligibility. If the request is not complete, the notification will describe the information or materials needed to make the request complete, and you will be allowed to perfect the request for external review by the later of the four month filing period described above, or within the 48 hour period following the receipt of the notification.

c. Referral to Independent Review Organization (IRO). The **claims administrator** will assign an independent review organization (IRO) to your request for external review. Upon assignment, the IRO will undertake the following tasks with respect to the request for external review:

- Timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the IRO, within ten business days following the date of receipt of the notice, additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

- Review all documents and any information considered in making a **final denial** received by the **claims administrator**. The **claims administrator** will provide the IRO with such documents and information within five business days after the date of assignment of the IRO. Failure by the **claims administrator** to timely provide the documents and information will not delay the conduct of the external review. If the **claims administrator** fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the **final denial**. In such case, the IRO will notify you and the **claims administrator** of its decision within one business day.

- Forward any information submitted by you to the **claims administrator** within one business day of receipt. Upon receipt of any such information, the **claims administrator** may reconsider its **final denial** that is the subject of the external review. Reconsideration by the **claims administrator** must not delay the external review. The external review may be terminated as a result of reconsideration only if the **claims administrator** decides to reverse its **final denial** and provide coverage or payment. In such case, the **claims administrator** must provide written notice of its decision to you and IRO within one business day, and the IRO will then terminate the external review.

- Review all information and documents timely received under a *de novo* standard. This means the IRO will not be bound by any decisions or conclusions reached during the **claims administrator's** internal claims and **appeals** process. In addition to the information and documents provided, the IRO, to the extent the information and documents are available and the IRO considers them appropriate, will further consider the following in reaching a decision:

    - your medical records;
    - the attending **health care professional's** recommendation;
    - reports from appropriate **health care professionals** and other documents submitted by the **claims administrator**, you, or your **physician**;
    - the terms of the applicable **medical plan** or **dental plan** to ensure that the IRO's decision is not contrary to the terms of the **medical plan** or **dental plan**, unless the terms are inconsistent with applicable law;
    - appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
    - any applicable clinical review criteria developed and used by the **medical plan** or **dental plan**, unless the criteria are inconsistent with the terms of the **medical plan** or **dental plan** or with applicable law; and
    - the opinion of the IRO's clinical reviewer(s) after considering the information described in this paragraph to the extent the information or documents are available and the clinical reviewer(s) consider appropriate.

d. Notice of Final External Review Decision. The IRO will provide written notice of its decision within 45 days after the IRO receives the request for external review. Such notice will be delivered to you and the **claims administrator** and will contain the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care **provider**, the claim amount (if applicable), the diagnosis code and its

corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous **denial**);

- the date the IRO received the assignment to conduct external review and the date of the decision;
- references to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching the decision;
- a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied upon in making its decision;
- a statement that the determination is binding except to the extent that other remedies may be available under state or Federal law to the **medical plan**, **dental plan** or you;
- a statement that you may file an administrative **appeal** with the State of Alaska Superior Court; and ; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

e. Reversal of Plan's Decision. If the **final denial** of the **claims administrator** is reversed by the decision, the **medical plan** or **dental plan** will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for a claim, upon receipt of notice of such reversal.

f. Maintenance of Records. An IRO will maintain records of all claims and notices associated with an external review for six years. An IRO must make such records available for examination by you, the **claims administrator**, or a state or Federal oversight agency upon request, except where such disclosure would violate state or Federal privacy laws.

7.14.12. Expedited External Review Process for Medical Plan or Dental Plan

a. Application of Expedited External Review. You may make a request for expedited external review under the **medical plan** and **dental plan** at the time you receive either:

- a **denial** with respect to benefits under the **medical plan**, if the **denial** involves a medical condition for which the timeframe for completion of an internal **appeal** of an **urgent care claim** would

seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an **appeal** of an **urgent care claim**; or

- a **final denial** with respect to benefits under the **medical plan** or **dental plan**, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the **final denial** concerns admission, availability of care, continued **stay**, or a health care item or service for which you received **emergency** services, but have not been discharged from a facility.

b. Preliminary Review. Immediately upon receipt of a request for expedited external review, the **claims administrator** must determine whether the request meets the reviewability requirements set forth above. The **claims administrator** will immediately send a notice that meets the requirements set forth for standard external review of claims, as well as its eligibility determination.

c. Referral to Independent Review Organization (IRO). Upon a determination that a request is eligible for expedited external review following the preliminary review, the **claims administrator** will assign an IRO pursuant to the requirements set forth above for standard external review. The **claims administrator** must provide or transmit all necessary documents and information considered in making the **denial** or **final denial** determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard external review. In reaching a decision, the assigned IRO will review the claim *de novo*, meaning it is not bound by any decisions or conclusions reached during the **claims administrator's** internal claims and **appeals** process.

d. Notice of Final External Review Decision. The IRO will provide notice of its decision, in accordance with the requirements set forth above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing such notice, the assigned IRO will provide written confirmation of the decision to you and the **claims administrator**.

7.14.13. State Law Remedies

If the claim is denied on external review or, if not eligible for external review, on the second level appeal, you will have the right to file an administrative

appeal with the State of Alaska superior court. If you wish to appeal a decision under this section you must file a notice of appeal with the superior court within 30 days after the date that you receive notice of the denial on external review, or if not eligible for external review, within 30 days after receipt of notice of denial on the second level appeal.

a.

7.15. CLAIMS PROCEDURES APPLICABLE TO ALL CLAIMS

7.15.1. Authorized Representative

Your authorized representative may act on your behalf in pursuing a benefit claim or **appeal**, pursuant to reasonable procedures. In the case of an **urgent care claim**, a **health care professional** with knowledge of your medical condition will be permitted to act as your authorized representative.

7.15.2. Calculating Time Periods

The period of time within which an initial benefit determination or a determination on an **appeal** is required to be made will begin when a claim or **appeal** is filed regardless of whether the information necessary to make a determination accompanies the filing.

Solely for purposes of initial **pre-service claims** and **post-service claims**, if the time period for making the initial benefit determination is extended (in the **claims administrator's** discretion) because you failed to submit information necessary to decide the claim, the time period for making the determination will be suspended from the date notification of the extension is sent to you until the earlier of (1) the date on which response from you is received, or (2) the end of the time period given to you to provide the additional information, as set forth in section 7.14.9, *Chart of Time Limits for Claims.* .

7.15.3. Full and Fair Review

Upon request, and free of charge, you or your duly authorized representative will be given reasonable access to, and copies of, all documents, records, and other information relevant to your claim, or may submit to the appropriate person or entity written comments, documents, records, and other information relating to the claim. If timely requested, review of a denied claim will take into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim without regard to whether such information was submitted or considered in the initial benefit determination.

Appeals for health claims will be reviewed by an appropriate named fiduciary of the **plan** who is neither the individual nor subordinate of the individual who

made the initial determination. The **claims administrator** will not give any weight to the initial determination, and, if the **appeal** is based, in whole or in part, on a medical judgment, the **claims administrator** will consult with an appropriate **health care professional** who is neither the individual nor subordinate of the individual who was consulted in connection with the initial determination. The **claims administrator** will identify any medical or vocational experts whose advice was obtained without regard to whether the advice was relied upon in making the benefit determination. In the case of two levels of **appeal**, the second level reviewer will not afford deference to the first level reviewer, nor will the second level reviewer be the same individual or the subordinate of the first level reviewer.

7.15.4.Exhaustion of Remedies

If you fail to file a request for review of a **denial**, in whole or in part, of benefits in accordance with the procedures herein outlined, you will have no right to review and no right to bring an action, at law or in equity, in any court and the **denial** of the claim will become final and binding on all persons for all purposes.

With respect to claims under the **medical plan** and **dental plan**, except as provided below, if the **claims administrator** fails to strictly adhere to all the requirements with respect to a claim under section 7.14, *If a Claim Is Denied*, and section 7.15, *Claims Procedures Applicable to All Claims*, you are deemed to have exhausted the internal claims and **appeals** process with respect to such claims. Accordingly, you may initiate an external review with respect to such claims as outlined in section 7.14, *If a Claim Is Denied*. You are also entitled to pursue any available remedies under State law, as applicable, with respect to such claims.

Notwithstanding the above, the internal claims and **appeals** process with respect to claims under the **medical plan** or **dental plan** will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you, so long as the **claims administrator** demonstrates that the violation was for good cause or due to matters beyond the control of the **claims administrator** and that the violation occurred in the context of an ongoing, good faith exchange of information between the **claims administrator** and you. This exception is not available if the violation is part of a pattern of violations by the **claims administrator**. You may request a written explanation of the violation from the **claims administrator**, and the **claims administrator** will provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the process outlined in sections 7.14, *If a Claim Is Denied*, and section 7.15, *Claims Procedures Applicable to All Claims*, to be deemed exhausted. If the IRO or a court rejects your request for immediate review due to deemed exhaustion on the basis that the **claims administrator** met the standards for the exception described in this subsection, you will have the

right to resubmit and pursue the internal **appeal** of the **medical plan** or **dental plan** claim. In such case, within a reasonable time after the IRO or court rejects the claim for immediate review (not to exceed 10 days), the **claims administrator** will provide you with notice of the opportunity to resubmit and pursue the internal **appeal** of the **medical plan** or **dental plan** claim. Time periods for re-filing the **medical plan** or **dental plan** claim will begin to run upon your receipt of such notice.

8. *Consolidated Omnibus Budget Reconciliation Act (COBRA) and Extended Health Coverage*

8.1. INTRODUCTION

If you and/or your **dependents** lose coverage due to a qualifying event, you and/or your **dependents** may continue coverage under the **plan** by electing COBRA coverage and paying the required premium as described in this section.

You may elect coverage under the **plan** that is the same or less than the level of coverage that you or your **dependents** had at the time your coverage terminates under the **plan**. For example, if you are covered under the **medical plan** and have elected the standard plan, you may elect COBRA continuation coverage under either the standard plan or the economy plan, but not the premium plan. Additionally, you may elect COBRA continuation coverage:

- under the **medical plan** only; or
- under the **medical plan** and under the **dental plan** and/or the **vision plan**.

You may not elect COBRA continuation coverage under the **dental plan** or the **vision plan** without also electing COBRA continuation coverage under the **medical plan**.

8.2. RIGHT TO CONTINUATION COVERAGE

If you are a qualified beneficiary, you may elect to continue coverage under the **plan** after a qualifying event. Only those persons who are covered under the **plan** on the day before the event which triggered termination of coverage are eligible to elect COBRA continuation coverage, except that **dependent children** born to or placed for adoption with you while you are on continuation coverage may be added to your coverage if the **child** is otherwise eligible under the **plan**.

A qualified beneficiary is a person who is covered under the **plan** on the day before a qualifying event (but also including **dependent children** born to or placed for adoption with you during the continuation coverage) who is:

- an **eligible employee**;

- a **spouse**; or

- a **dependent child**.

The right to continued coverage is triggered by a qualifying event, which, but for the continued coverage, would result in a loss of coverage under the **plan**. A "loss of coverage" includes ceasing to be covered under the same terms and conditions as in effect immediately before the qualifying event or an increase in the premium or contribution that must be paid by a **covered person**. Qualifying events include:

- Your death.

- The termination (other than by reason of gross misconduct) of your employment or reduction of your hours that would result in a termination of coverage under the **plan**.

- Your divorce or legal separation from your **spouse.**

- Your becoming entitled to Medicare benefits under Title XVIII of the Social Security Act (42 USC § 1395-1395ggg).

- Your **child** ceasing to be a **dependent child** under the eligibility requirements of the **plan**.

If a qualifying event occurs to a qualified beneficiary, then that qualified beneficiary may elect to continue coverage under the **medical plan**, **dental plan** and/or **vision plan**.

8.3. ELECTION OF CONTINUATION COVERAGE

Continuation coverage does not begin unless it is elected by a qualified beneficiary. Each qualified beneficiary who loses coverage as a result of a qualifying event has an independent right to elect continuation coverage, regardless of whether any other qualified beneficiary with respect to the same qualifying event elects continuation coverage.

The election period begins on or before the date the qualified beneficiary would lose coverage under the **plan** due to the qualifying event, and ends on or before the date that is 60 days after the later of:

- the date the qualified beneficiary would lose coverage due to the qualifying event; or

- the date on which notice of the right to continued coverage is sent by **PayFlex**.

The election of continuation coverage must be made on a form provided by **PayFlex** and payment for coverage, as described in the notice, must be made when due. An election is considered to be made on the date it is sent to **PayFlex**.

8.4. PERIOD OF CONTINUATION COVERAGE

8.4.1. Termination of Employment or Reduction in Hours

In the case of a qualifying event caused by termination of employment or reduction in hours, the qualified beneficiary may elect to extend coverage for a period of up to 18 months from the date of the qualifying event.

8.4.2. Second Qualifying Event

If a second or additional qualifying event occurs during the initial 18 month continuation coverage period (or during a 29 month maximum coverage period in the case of a disability), the qualified beneficiary may elect to extend the continuation coverage period for a period of up to 36 months from the date of the earlier qualifying event.

If you became entitled to Medicare within 18 months prior to a qualifying event caused by termination of employment or reduction in hours, qualified beneficiaries (other than you) may elect to extend coverage for a period of 36 months from the date of your entitlement to Medicare benefits.

8.4.3. Disability

If a qualified beneficiary is determined under Title II or XVI of the Social Security Act to be disabled within 60 days of the initial continuation coverage period due to termination of employment or reduction of hours (even if the disability commenced or was determined to be a disability before the first 60 days of the initial 18 month continuation coverage period), coverage may be continued for all qualified beneficiaries for a period of up to 29 months from the date of the qualifying event.

You must provide notice of a disability determination to **PayFlex** within 18 months of the qualifying event and within 60 days after the latest of:

- the date of the disability determination by the Social Security Administration;
- the date the qualifying event occurs;
- the date you lose or would lose coverage due to the qualifying event; or
- the date on which you are informed, via the **plan** or the general COBRA notice, of your obligation to provide such notice and procedures for providing such notice.

You are also responsible for notifying the **Division** within 30 days of the later of:

- the date of the final determination by the Social Security Administration that you are no longer disabled; or
- on the date which you are informed, via the **plan** or the general COBRA notice, of your obligation to provide such notice and procedures for providing such notice.

8.4.4. Other Qualifying Events

In the case of any qualifying event not otherwise described above, the qualified beneficiary may elect to extend coverage for a period of up to 36 months from the date of the qualifying event.

8.4.5. Health Flexible Spending Account (HFSA)

Notwithstanding the above, continuation coverage under the health flexible spending account (HFSA) will extend only until the end of the **benefit year** in which the qualifying event occurs.

8.5. END OF CONTINUATION COVERAGE

Continuation coverage will end upon the dates of the following occurrences, even if earlier than the periods specified under section 8.4, *Period of Continuation Coverage*.

- Timely payment of premiums for the continuation coverage is not made (including any grace periods).
- You first become covered under any other group health plan, after the date on which continuation coverage is elected, as an employee or otherwise, unless such other plan contains a limitation (other than a limitation which does not apply by virtue of HIPAA with respect to any pre-existing condition).
- You first become entitled to benefits under Medicare, after the date on which continuation coverage is elected.
- The **State** ceases to provide any group health plan to any **employee**.
- You cease to be disabled, if continuation coverage is due to the disability.

Notwithstanding the foregoing, the **plan** may also terminate the continuation coverage of a qualified beneficiary for cause on the same basis that it could terminate the coverage of a similarly situated non-COBRA beneficiary for cause (*e.g.*, in the case of submitting fraudulent claims to the **Division)**.

8.6. COST OF CONTINUATION COVERAGE

You are responsible for paying the cost of continuation coverage. The premiums are payable on a monthly basis. By law, premiums cannot exceed 102% of the full premiumcost for such coverage (or 150% for any extended period of coverage due to disability). After a qualifying event, **PayFlex** will provide a notice with the amount of the premium, to whom the premium is to be paid, and the date of each month that payment is due. Failure to pay premiums on a timely basis will result in termination of coverage as of the date the premium is due. Payment of any premium will only be considered to be timely if made within 30 days after the date due.

A premium must be paid for the cost of continuation coverage for the time period between the date of the event which triggered continuation coverage and the date continued coverage is elected. This payment must be made within 45 days after the date of election. **PayFlex** will provide you notice specifying the amount of the premium, to whom the premium is to be paid, and the date payment is due. Failure to pay this premium on the date due will result in cancellation of coverage back to the initial date coverage would have terminated.

8.7. NOTIFICATION REQUIREMENTS

8.7.1. General Notice to Covered Eligible Employee and Spouse The plan will provide, at the time of commencement of coverage, written notice to you and your spouse of your rights to continuation coverage. This general notice will be provided no later than the earlier of:

- 90 days after your coverage commencement date under the **plan**; or
- the date on which the **Division** is required to furnish a COBRA election notice.

8.7.2. Employer Notice to Division

Your employer will notify the **Division** in the event of your death, termination of employment (other than gross misconduct), reduction in hours, layoff, or entitlement to Medicare benefits within 30 days after the date of the qualifying event.

8.7.3. Covered Eligible Employee/Qualified Beneficiary Notice to Administrator

You must notify the **Division** of:

- your divorce or legal separation from your **spouse**;

- a **child** ceasing to be a **dependent child** under the eligibility requirements of the **plan**;
- a second qualifying event; or
- notice of disability entitlement or cessation of disability.

You must give notice as soon as possible, but no later than 60 days after the later of:

- the date of such qualifying event;
- the date that you lose or would lose coverage due to such qualifying event; or
- the date on which you are informed, via the **plan** or the general COBRA notice, of your obligation to provide such notice and the plan procedures for providing such notice.

See section 8.3, *Election of Continuation Coverage*, for timing of notices applicable to disability determinations.

You or another qualified beneficiary, or a representative acting on behalf of you or another qualified beneficiary, may provide this notice. The provisions of notice by one individual satisfies any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the qualifying event. Failure to provide timely notice will result in your loss of any right to elect continuation coverage.

8.7.4. Division's Notice to Qualified Beneficiary

Upon receipt of a notice of qualifying event, **PayFlex** will provide to each qualified beneficiary notice of his or her right to elect continuation coverage, no later than 14 days after the date on which **PayFlex** received notice of the qualifying event. Any notification to a qualified beneficiary who is your **spouse** will be treated as a notification to all other qualified beneficiaries residing with such **spouse** at the time such notification is made.

8.7.5. Unavailability of Coverage

If **PayFlex** receives a notice of a qualifying event or disability determination and determines that the person is not entitled to continuation coverage, **PayFlex** will notify the person with an explanation as to why such coverage is not available.

8.7.6. Notice of Termination of Coverage

PayFlex will provide notice to each qualified beneficiary of any termination of continuation coverage which is effective earlier than the end of the maximum period of continuation coverage applicable to such qualifying event, as soon as practicable following **PayFlex's** determination that continuation coverage should terminate.

8.7.7. Use of a Single Notice

Required notices must be provided to each qualified beneficiary or individual; however:

- a single notice can be provided to you and your **spouse** if you both reside at your address; and
- a single notice can be provided to you or your **spouse** for a **dependent child**, if the **dependent child** resides with you or your **spouse**.

8.8. CONTINUATION HEALTH BENEFITS PROVIDED

The continuation coverage provided to a qualified beneficiary who elects continued coverage will be identical to the coverage provided to similarly situated persons covered under the **plan** with respect to whom a qualifying event has not occurred. If coverage is modified under the **plan** for any group of similarly situated beneficiaries, the coverage will also be modified in the same manner for all individuals who are qualified beneficiaries under the **plan**. Continuation coverage will not be conditioned on evidence of good health.

You may change your elections during open enrollment for the **plan**.

8.9. BANKRUPTCY PROCEEDINGS

Special continuation coverage provisions apply in the event of bankruptcy of the **State**. Notwithstanding any of the preceding sections, in the event of a bankruptcy proceeding under Title XI of the United States Code, where a loss of coverage or substantial elimination of your coverage occurs on or before the date of the loss or substantial elimination of coverage and any other individual who, on the day before the bankruptcy proceeding, is a beneficiary (under the **plan** as a **spouse**, or **dependent child**) within one year before or after the date of the commencement of the bankruptcy proceeding, continuation coverage will be provided under the **plan** to the extent required under Code Section 4980(B).

8.10. EXTENDED COVERAGE FOR DISABLED EMPLOYEES OR DEPENDENTS

Eligible employees or **dependents** who are **totally disabled**, lose coverage under the **medical plan**, and waive their right to COBRA continuation coverage, are eligible for a limited extension of their coverage under the **medical plan**. This extended coverage is not available to an **employee** who is **totally disabled** and entitled to the protections under section 13.9, *Family and Medical Leave Act (FMLA)*.

Extended coverage under the **medical plan** is at no cost to the **totally disabled eligible employee** or **totally disabled dependent**.

You must be **totally disabled** due to **injury**, **illness**, or pregnancy when coverage under the **medical plan** terminates to be eligible for this benefit. Extended health benefits for **total disability** are provided for the number of months you have been covered under the **medical plan**, up to a maximum of 12 months. However, only the condition which caused the **total disability** is covered and coverage is provided only while you or your **dependent**, as applicable, is **totally disabled**.

To be eligible for extended health benefits, you or your **dependent**, as applicable, must be under a **physician**'s care and submit evidence of disability to the **claims administrator** within 90 days after you lose coverage under the **medical plan**. The **physician** must complete a *Statement of Disability* form available from the **Division** or the **claims administrator**. You must satisfy any unpaid portion of the **deductible** within three months of the date you lose coverage.

This extended coverage terminates when you or your **dependent**, as applicable, become covered under a group health plan with similar benefits.

9. *Coordination with Medicare*

9.1. PRIMARY COVERAGE TO MEDICARE

If coverage under the **medical plan** is primary to Medicare and you and/or your **dependents** who are eligible to be covered by Medicare incur a claim, the **medical plan** will pay for **covered expenses** subject to any applicable **deductible**, **copayment**, **coinsurance**, and any applicable **out-of-pocket limit**, exclusions or any other limits.

9.2. SECONDARY COVERAGE TO MEDICARE

To the extent allowable under applicable law, coverage under the **medical plan** for you and your **dependents** who are eligible to be covered under Medicare will be secondary to coverage of you and your **dependents** under Medicare. The benefit payable under the **medical plan** will be reduced by the greater of:

- the amount actually paid by Medicare Part A, Part B, Part C or Part D; or
- the amount Medicare would pay if you or your **dependents** were enrolled in Medicare Part A and Part B.

9.3. MEDICARE COVERAGE ELECTION

If you and your **dependents** choose not be covered by the **medical plan** and elect to be covered by Medicare, Medicare will provide the coverage and coverage under the **medical plan** will terminate.

9.4. ELIGIBILITY FOR MEDICARE

You and your **dependents** are considered eligible for all parts of Medicare for the purposes of the **medical plan** during any period you or your **dependents** have coverage under Medicare or, while otherwise qualifying for coverage under Medicare, do not have such coverage solely because you or your **dependents** have refused, discontinued, or failed to make any necessary application for Medicare Part A or Part B coverage.

10. *Coordination of Benefits*

10.1. WHEN COORDINATION OF BENEFITS APPLIES

This coordination of benefits (COB) provision applies to the **medical plan** and **dental plan** when you or your covered **dependent** has health coverage under more than one plan. The order of benefit determination rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

10.2. DEFINED TERMS

When used in this provision, the following words and phrases have the meaning explained herein.

a. **Allowable Expense**. Allowable expense means a health care service or expense, including **coinsurance** and **copayments**, without reduction of any applicable **deductible**, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services (for example, an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a **covered person** is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

- If a **covered person** is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense. This does not apply if one of the plans provides coverage for a private room.

- If a person is covered by two or more plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.

- If a person is covered by two or more plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.

- The amount a benefit is reduced or not reimbursed by the primary plan because a **covered person** does not comply with the plan provisions is not an

allowable expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

- If all plans covering a person are high deductible plans and the person intends to contribute to a health savings account established in accordance with Code Section 223, the primary high deductible plan's **deductible** is not an allowable expense, except as to any health expense that may not be subject to the **deductible** as described in Code Section 223(c)(2)(C).

If a person is covered by one plan that computes its benefit payments on the basis of reasonable or recognized charges, and another plan that provides its benefits or services on the basis of negotiated charges, the primary plan's payment arrangements will be the allowable expense for all the plans. However, if the secondary plan has a negotiated fee or payment amount different from the primary plan and if the provider contract permits, that negotiated fee will be the allowable expense used by the secondary plan to determine benefits.

b. **Closed Panel Plan(s)**. A plan that provides health benefits to **covered persons** primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

c. **Custodial Parent**. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the **child** resides more than one half of the calendar year without regard to any temporary visitation.

d. **Plan**. Any plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors.

- Other prepaid coverage under service plan contracts, or under group or individual practice.

- Uninsured arrangements of group or group-type coverage.

- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans.

- Medicare or other governmental benefits.

- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the plan includes medical, prescription drug, dental, and vision coverage, those coverages will be considered separate plans. For example, medical coverage will be coordinated with other medical plans and dental coverage will be coordinated with other dental plans.

The health plan is any part of the plan that provides benefits for health care expenses.

e. **Primary Plan/Secondary Plan.** The order of benefit determination rules state whether the health plan is a primary plan or secondary plan as to another plan covering the person.

- When the health plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.
- When the health plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.
- When there are more than two plans covering the person, the health plan may be a primary plan as to one or more other plans, and may be a secondary plan as to a different plan or plans.

10.3. WHICH PLAN PAYS FIRST

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage will be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
- The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

1. Non-**Dependent** or **Dependent**. The plan that covers the person other than as a **dependent**, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a **dependent** is secondary. However, if the person is a Medicare beneficiary and, as a result of Federal law, Medicare is secondary to the plan covering the person as a **dependent**; and primary to the plan covering the person as other than a **dependent** (*e.g.* a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

2. **Child** Covered Under More than One Plan. The order of benefits when a **child** is covered by more than one plan is:

    A. The primary plan is the plan of the parent whose birthday is earlier in the year if:

        i. The parents are married or living together whether or not married.

        ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

    B. If the specific terms of a court decree state that one of the parents is responsible for the **child**'s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the **dependent child**'s health care expenses, but that parent's spouse does, the plan of the parent's spouse is the primary plan.

    C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:

        - The plan of the custodial parent;
        - The plan of the spouse of the custodial parent;
        - The plan of the noncustodial parent; and then
        - The plan of the spouse of the noncustodial parent.

For a **dependent child** covered under more than one plan of individuals who are not the parents of the **child**, the order of benefits should be determined as outlined above as if the individuals were the parents.

3. Active Employee or Retired or Laid off Employee. The plan that covers a person as an employee who is neither laid off nor retired from the employer who sponsors the plan or as a **dependent** of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a **dependent** of a retired or laid off employee is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the non-**dependent** or **dependent** rules above determine the order of benefits.

4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's **dependent**) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the non-**dependent** or **dependent** rules above determine the order of benefits.

5. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, subscriber longer is primary.

If the preceding rules do not determine the primary plan, the allowable expenses will be shared equally between the plans meeting the definition of plan under this provision. In addition, the **plan** will not pay more than it would have paid had it been primary.

10.4. HOW COORDINATION OF BENEFITS WORKS

In determining the amount to be paid when the **medical plan** and **dental plan** is secondary on a claim, the secondary plan will calculate the benefits that it would have paid on the claim in the absence of other health insurance coverage and apply that amount to any allowable expense under the **medical plan** and **dental plan** that was unpaid by the primary plan. The amount will be reduced so that when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense.

In addition, a secondary plan will credit to its plan **deductible** any amounts that would have been credited in the absence of other coverage.

Under the COB provision of the **medical plan** and **dental plan**, the amount normally reimbursed for covered benefits or expenses under the **medical plan** and **dental plan** is reduced to take into account payments made by other plans. The general rule is that the

benefits otherwise payable under the **medical plan** and **dental plan** for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of the **medical plan** and **dental plan** and another plan both agree that the **medical plan** and **dental plan** determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a **covered person** is enrolled in two or more closed panel plans, COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans.

10.5. RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under the **medical plan** and **dental plan** and other plans. The **claims administrator** has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

10.6. FACILITY OF PAYMENT

Any payment made under another plan may include an amount which should have been paid under the **medical plan** and **dental plan**. If so, the **claims administrator** may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under the **medical plan** and **dental plan**. The **claims administrator** will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

10.7. RIGHT OF RECOVERY

If the amount of the payments made by the **claims administrator** is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the **covered person**. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

11. *Subrogation and Reimbursement Rights*

11.1. RIGHT OF SUBROGATION AND REIMBURSEMENT

The **plan** has the right to full subrogation and reimbursement of any and all amounts paid by the **plan** to, or on behalf of, a **covered person**, for which a third party is allegedly responsible. The **plan** will have a lien against such funds, and the right to impose a constructive trust upon such funds, and will be reimbursed therefrom.

11.2. FUNDS TO WHICH SUBROGATION AND REIMBURSEMENT RIGHTS APPLY

The **plan's** subrogation and reimbursement rights apply if the **covered person** receives, or has the right to receive, any sum of money, regardless of whether it is characterized as amounts paid for medical expenses or otherwise, paid or payable from any person, plan, or legal entity that is legally obligated to make payments as a result of a judgment, settlement, or otherwise, arising out of any act or omission of any third party (whether a third party or another **covered person** under the **plan**):

- who is allegedly wholly or partially liable for costs or expenses incurred by the **covered person**, in connection for which the **plan** provided benefits to, or on behalf of, such **covered person**; or

- whose act or omission allegedly caused **injur**y or **illness** to the **covered person**, in connection for which the **plan** provided benefits to, or on behalf of, such **covered person**.

11.3. AGREEMENT TO HOLD RECOVERY IN TRUST

If a payment is made under the **plan**, and the person to or for whom it is made recovers monies from a third party as a result of settlement, judgment, or otherwise, that person will hold in trust for the **plan** the proceeds of such recovery and reimburse the **plan** to the extent of its payments.

11.4. DISCLAIMER OF MAKE WHOLE DOCTRINE

The **plan** has the right to be paid first and in full from any settlement or judgment, regardless of whether the **covered person** has been "made whole." The **plan's** right is a first priority lien. The **plan's** rights will continue until the **covered person's** obligations hereunder to the **plan** are fully discharged, even though the **covered person** does not receive full compensation or recovery for his or her injuries, damages, loss or debt. This right to subrogation *pro tanto* will exist in all cases.

11.5. DISCLAIMER OF COMMON FUND DOCTRINE

The **covered person** will be responsible for all expenses of recovery from such third parties or other persons, including but not limited to, all attorneys' fees incurred in collection of such third-party payments, or payments by other persons. Any attorneys' fees and/or expenses owed by the **covered person** will not reduce the amount of reimbursement due to the **plan**.

11.6. OBLIGATIONS OF THE COVERED PERSON

The **covered person** will furnish any and all information and assistance requested by the **claims administrator**. If requested, the **covered person** will execute and deliver to the **claims administrator** a subrogation and reimbursement agreement before or after any payment of benefits by the **plan**. The **covered person** will not discharge or release any party from any alleged obligation to the **covered person** or take any other action that could impair the **plan's** rights to subrogation and reimbursement without the written authorization of the **claims administrator**.

11.7. PLAN'S RIGHT TO SUBROGATION

If the **covered person** or anyone acting on his or her behalf has not taken action to pursue his or her rights against a third party described in section 11.2, *Funds to Which Subrogation and Reimbursement Rights Apply*, or any other persons to obtain a judgment, settlement or other recovery, the **claims administrator** or its designee, upon giving 30 days' written notice to the **covered person**, will have the right to take such action in the name of the **covered person** to recover that amount of benefits paid under the **plan**; provided, however, that any such action taken without the consent of the **covered person** will be without prejudice to such **covered person**.

11.8. ENFORCEMENT OF PLAN'S RIGHT TO REIMBURSEMENT

If a **covered person** fails or refuses to comply with these provisions by reimbursing the **plan** as required herein, the **plan** has the right to impose a constructive trust over any and all funds received by the **covered person**, or as to which the **covered person** has the right to receive. The **plan** has the authority to pursue any and all legal and equitable relief available to enforce the rights contained in this section, against any and all appropriate parties who may be in possession of the funds described herein. The **plan** also has the right to terminate coverage for the **covered person** under the **plan**.

11.9. FAILURE TO COMPLY

If a **covered person** fails to comply with the requirements under this section, the **covered person** will not be eligible to receive any benefits, services or payments under the **plan**

for any **illness** or **injury** until there is compliance, regardless of whether such benefits are related to the act or omission of such third party or other persons.

11.10. DISCRETIONARY AUTHORITY OF ADMINISTRATOR

The **State** will have full discretionary authority to interpret the provisions of this section 11, *Subrogation and Reimbursement Rights*, and to administer and pursue the **health plan's** subrogation and reimbursement rights. It will be within the discretionary authority of the **State** to resolve, settle, or otherwise compromise its subrogation and reimbursement rights when appropriate. The **State** is under no legal obligation to reduce its lien or reimbursement rights unless, in its sole discretion, it determines that doing so is appropriate.

12. *Protected Health Information Under the Health Insurance Portability and Accountability Act (HIPAA)*

12.1. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The **plan** will use and disclose **protected health information** to the extent of and in accordance with the uses and disclosures permitted by HIPAA, as set forth in the **Privacy Regulations**. Specifically, the **plan** will use and disclose **protected health information** for purposes related to health care treatment, **payment** for health care and **health care operations**.

12.2. PLAN DOCUMENTS

In order for the **plan** to disclose **protected health information** to the **State** or to provide for or permit the disclosure of **protected health information** to the **State** by a health insurance issuer or HMO with respect to the **plan**, the **plan** must ensure that the **plan** documents restrict uses and disclosures of such information by the **State** consistent with the requirements of HIPAA.

12.3. DISCLOSURES BY THE PLAN TO THE STATE

The **plan** may:

- Disclose summary health information to the **State**, if the **State** requests the summary health information for the purpose of:
  - obtaining premium bids from health plans for providing health insurance coverage under the **plan**; or
  - modifying, amending, or terminating the **plan**.
- Disclose to the **State** information on whether an **individual** is participating in the **plan**, or is enrolled in or has disenrolled from a health insurance issuer offered by the **plan**.
- Disclose **protected health information** to the **State** to carry out plan administration functions that the **State** performs, consistent with the provisions of this section.
- With an authorization from the **covered person**, disclose **protected health information** to the **State** for purposes related to the administration of other employee benefit plans and fringe benefits sponsored by the **State**.

- Not permit a health insurance issuer with respect to the **plan** to disclose **protected health information** to the **State** except as permitted by this section.

- Not disclose (and may not permit a health insurance issuer to disclose) **protected health information** to the **State** as otherwise permitted by this section unless a statement is included in the **plan's** notice of privacy practices that the **plan** (or a health insurance issuer with respect to the **plan**) may disclose **protected health information** to the **State**.

- Not disclose **protected health information** to the **State** for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the **State**.

- Not disclose (and may not permit a health insurance issuer to disclose) **protected health information** that is genetic information about an individual for underwriting purposes as defined in Section 1180(b)(4) of the Social Security Act and underlying regulations.

12.4. USES AND DISCLOSURES BY STATE

The **State** may only use and disclose **protected health information** as permitted and required by the **plan**, as set forth within this section. Such permitted and required uses and disclosures may not be inconsistent with the provisions of HIPAA. The **State** may use and disclose **protected health information** without an authorization from a **covered person** for plan administrative functions including **payment** activities and **health care operations**. In addition, the **State** may also use and disclose **protected health information** to accomplish the purpose for which any disclosure is properly made pursuant to section 12.3, *Disclosures by the Plan to the State*.

12.5. CERTIFICATION

The **plan** may disclose **protected health information** to the **State** only upon receipt of a certification from the **State** that the **plan** documents have been amended to incorporate the provisions provided for in this section and that the **State** so agrees to the provisions set forth therein.

12.6. CONDITIONS AGREED TO BY THE STATE

The **State** agrees to:

- Not use or further disclose **protected health information** other than as permitted or required by the **plan** document or as required by law.

- Ensure that any agents, including a subcontractor, to whom the **State** provides **protected health information** received from the **plan** agree to the same

restrictions and conditions that apply to the **State** with respect to such **protected health information**, and that any such agents or subcontractors agree to implement reasonable and appropriate security measures to protect any **electronic protected health information** belonging to the **plan** that is provided by the **State**.

- Not use or disclose **protected health information** for employment-related actions and decisions unless authorized by an **individual**.

- Not use or disclose **protected health information** in connection with any other benefit or employee benefit plan of the **State** unless authorized by an **individual**.

- Report to the **plan** any **protected health information** use or disclosure that is inconsistent with the uses or disclosures provided for by this section, or any **security incident** of which it becomes aware.

- Make **protected health information** available to an **individual** in accordance with HIPAA's access requirements pursuant to 45 CFR § 164.524.

- Make **protected health information** available for amendment and incorporate any amendments to **protected health information** in accordance with 45 CFR § 164.526.

- Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528.

- Make internal practices, books and records relating to the use and disclosure of **protected health information** received from the **plan** available to the Secretary of the Department of Health and Human Services for the purposes of determining the **plan's** compliance with HIPAA.

- If feasible, return or destroy all **protected health information** received from the **plan** that the **State** still maintains in any form, and retain no copies of such **protected health information** when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the **electronic protected health information** that it creates receives, maintains, or transmits on behalf of the **plan**.

- Ensure that the separation and requirements of sections 12.3, *Disclosures by the Plan to the State*, section 12.4, *Uses and Disclosures by State*, and section 12.5, *Certification* of the **plan** are supported by reasonable and appropriate security measures.

12.7. ADEQUATE SEPARATION BETWEEN THE PLAN AND THE STATE

In accordance with HIPAA, only the persons identified in the **State**'s HIPAA policies and procedures may be given access to **protected health information**.

12.8. LIMITATIONS OF ACCESS AND DISCLOSURE

The persons described in section 12.3, *Disclosures by the Plan to the State*, may only have access to and use and disclose **protected health information** for **plan** administration functions that the **State** performs for the **plan**.

12.9. NONCOMPLIANCE

If the persons or classes of persons described in section 12.3, *Disclosures by the Plan to the State*, do not comply with this **plan** document, the **plan** and the **State** will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

13. *Other Mandated Coverages*

13.1. GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

The **plan** will comply with GINA, as amended, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any Federal law or regulations governing the **plan**. As part of such compliance, the **plan** will not:

- Adjust plan contribution amounts or premiums on the basis of genetic information.
- Request or require a **covered person** or any of the **covered person**'s family members to undergo a genetic test.
- Request, require, or purchase genetic information for underwriting purposes during coverage or with respect to any **covered person**, prior to such individual's enrollment in the **plan**.

Under this section, "genetic information" includes your genetic tests, the genetic tests of your family members, and your family medical history.

13.2. STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of **stay** in connection with childbirth for the mother or newborn **child** to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending **provider** (*e.g.*, your **physician**, nurse midwife, or **physician** assistant), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a **provider** obtain authorization from the **plan** for prescribing a length of **stay** that is 48 hours (or 96 hours) or less. However, to use certain **providers** or facilities, or to reduce your out-of-pocket costs, you may be required to obtain **precertification**. For information on **precertification**, contact **Aetna**.

Under Federal law, the **plan** may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) **stay** is treated in a manner less favorable to the mother or newborn than any earlier portion of the **stay**.

13.3. ELIGIBILITY FOR MEDICAID BENEFITS

Benefits will be paid in accordance with any assignment of rights made by or on behalf of any **eligible employee** or **dependent** as required by a state plan for medical assistance

approved under Title XIX, Section 1912(a)(1)(A) of the Social Security Act. For purposes of enrollment and entitlement to benefits, an **eligible employee's** or **dependent's** eligibility for or receipt of medical benefits under a state plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account. The **State** will have a right to any payment made under a state plan for medical assistance approved under Title XIX of the Social Security Act when the **plan** has a legal liability to make such payment.

13.4. PROHIBITION ON RESCISSIONS

The **plan** will comply with Section 2712 of the Public Health Service Act, as added by Section 1001 of the PPACA and incorporated into Section 9815 of the Internal Revenue Code, and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with any federal law or regulations governing the **plan**. As part of such compliance, the **plan** will not **rescind** your coverage or your **dependents**' coverage, except in the case where you or your **dependent** has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact, as prohibited by the terms of the **plan**. Failure to notify the **plan** of any change in status or other applicable events as required under the **plan** will be deemed by the plan to be an act that constitutes fraud and an intentional misrepresentation of material fact prohibited by the plan that may result in a retroactive termination of coverage. The **plan** will provide 30 days advance written notice to you or your **dependent**, as applicable, before rescinding your coverage. Notwithstanding the foregoing, the **plan** may still cancel or discontinue coverage effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. Nothing in this section will prohibit the **plan** from cancelling or discontinuing such coverage prospectively for any reason provided under the **plan**.

13.5. DEPENDENT STUDENTS ON MEDICALLY NECESSARY LEAVE OF ABSENCE

The **plan** will comply with Michelle's Law of 2008, as amended from time to time, and any regulations issued thereunder, to the extent required thereunder and not otherwise inconsistent with any federal law or regulations governing the **plan**. As part of such compliance, the health **plan** will extend coverage for up to one year when a full-time student otherwise would lose eligibility if the full-time student takes a medically necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless **dependent child** coverage ends earlier under another **plan** provision, such as the parent's termination of employment or the **dependent child's** age exceeding the **plan's** limit. A medically necessary leave of absence for purposes of full-time student medical leave occurs when a **child** who is a **dependent** and a full-time student (but who would not be a **dependent** if he or she were not a full-time student) takes a leave of absence from his or her educational institution or otherwise changes his or her enrollment status from full-time to part-time due to a serious illness or injury. The **plan** must receive written certification from the full-time student's **physician** confirming the serious illness or injury and the medical necessity of the leave or change

in status. **Dependent** coverage will continue during the leave as if the **dependent child** had maintained full-time student status. This requirement applies even if the **plan** changes during the extended period of coverage.

13.6. PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 (PPACA)

. The **State** has surrendered grandfather status of the **plan** effective January 1, 2017. The **plan** will comply with the 2010 federal health care reform law, called the PPACA. If Congress, federal or state regulators, or the courts make further changes or clarifications regarding the Affordable Care Act and its implementing regulations, the **plan** will comply with them even if they are not stated in this booklet or if they conflict with statements made in this booklet.

13.7. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

The **plan** will comply with HIPAA, as amended from time to time, and any regulations issued thereunder to the extent required thereunder and to the extent not otherwise inconsistent with any federal law or regulations governing the health plan. Such compliance will include (i) providing **eligible employees** certification of their coverage under the **plan** to the extent required by HIPAA and (ii) permitting eligible individuals to enroll in the **plan** during special enrollment periods upon the loss of other coverage or upon the acquisition of a new **dependent** to the extent required under HIPAA, or (iii) discrimination against any person in terms of eligibility, continued eligibility or level of required employee contribution based upon health status, medical condition (including both physical and mental illnesses, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

13.8. CONTINUATION OF COVERAGE UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

a. Generally

An **eligible employee** may be entitled to reemployment and other rights during and after a period of **service in the uniformed services** under USERRA. The **plan** will be administered in compliance with the requirements of USERRA to the extent applicable.

To be eligible for such USERRA benefits, before leaving for military service, the **eligible employee** is generally required to give the employer advance notice that such **eligible employee** is leaving the job for **service in the uniformed services**. When such **eligible employee** returns from military service, he or she must timely submit an application for reemployment with the employer and request information regarding such **eligible employee's** reemployment rights. Time limits for returning to work will depend on the length of time of such military service.

b. Continuation of Coverage

If an **eligible employee** is absent from a position of employment with the employer by reason of **service in the uniformed services** (whether voluntary or involuntary) and was covered under the **plan** immediately prior to his or her absence due to **service in the uniformed services**, such **eligible employee** will then be entitled to elect to continue health care coverage under the **plan** for the **eligible employee** and his or her covered **dependents** for the time period allowed under the **plan**. Thereafter, coverage will continue for a period equal to the lesser of (i) the 24 month period beginning on the date on which such **eligible employee** is absent from employment with the employer by reason of **service in the uniformed services** or (ii) the day following the date on which the **eligible employee** fails to apply for or return to a position of employment with the employer as determined pursuant to USERRA Section 4312(e). **Eligible employees** may elect to discontinue coverage under the **plan** during **service in the uniformed services** by submitting the applicable forms to the **Division.**

c. Election of USERRA Continuation Coverage

Continuation coverage does not begin unless it is elected by the **eligible employee.**

The **eligible employee** may elect to continue coverage described in section 1.3.1, *Eligible Employees* by reason of **service in the uniformed services** for himself or herself and his or her covered **dependents**. **Dependents** do not have an independent right to elect USERRA continuation coverage. The election period for continued coverage will begin on the date the **eligible employee** gives the employer advance notice that he or she is required to report for **uniformed service** (whether such service is voluntary or involuntary) and will end 60 days after the date the **eligible employee** would otherwise lose coverage under the applicable **plan**.

If the **eligible employee** is unable to give advance notice of **uniformed service**, the **eligible employee** may still be able to elect continuation coverage under this section if the failure to give advance notice was because giving such notice was impossible, unreasonable, or precluded by military necessity. In such a case, the election period will begin on the date the **eligible employee** leaves for **uniformed service** and will end on the earlier of: (i) the 24 month period beginning on the date on which the **eligible employee's** absence for the **uniformed service** begins; or (ii) the date on which the **eligible employee** fails to return from **uniformed service** or apply for a position of employment. For these purposes, "military necessity" occurs only when deemed to be so by a designated military authority as described in 20 CFR § 1002.86 and may include situations where a mission, operation, exercise or requirement is classified, or could be compromised or otherwise adversely affected by public knowledge. It may be impossible or unreasonable to give advance notice

under certain circumstances such as when the employer is unavailable or the **eligible employee** is required to report for **uniformed service** in an extremely short period of time.

The election of USERRA continuation coverage must be made on a form provided by the **claims administrator** and made within the sixty (60) day period described herein. An election is considered to be made on the date it is sent to the **claims administrator**. If timely elected pursuant to this section, coverage will be reinstated as of the date the **eligible employee** lost coverage due to absence for **service in the uniformed service** and will last for the period set forth in paragraph b; provided that the **eligible employee** pays all unpaid costs for the coverage pursuant to paragraph d.

d. Cost of USERRA Continuation Coverage

If an **eligible employee** elects USERRA continuation coverage for himself or herself and, if applicable, his or her eligible covered **dependent(s),** such **eligible employee** will be required to pay 102% of the full premium cost for such coverage; provided, however, with respect to such **eligible employee's** initial 31 days of **service in the uniformed services**, he or she will not be required to pay more for such coverage than is otherwise required for eligible persons.

Premiums are due on the first day of each month for which continuation coverage is desired. Failure to pay premiums on a timely basis will result in termination of coverage as of the date the premium is due. Payment of any premium, other than that referred to below, will only be considered to be timely if made within 30 days after the date due. A premium must also be paid for the cost of continuation coverage for the time period between the date that continuation coverage commences and the date continuation coverage is elected. This payment must be made within 45 days after the date of election. Failure to pay this premium on the date due will result in cancellation of coverage back to the initial date coverage would have terminated.

e. Coordination with COBRA

An **eligible employee** who is absent from work by reason of **service in the uniformed services** may be eligible for continuation coverage under section 8, *Consolidated Omnibus Budget Reconciliation Act* (*COBRA) and Extended Health Coverage*. The continuation coverage provided in this section will not limit or otherwise interfere with those continuation coverage rights; provided, however, any continuation coverage provided under this section will run concurrently with any continuation coverage available under section 8, *Consolidated Omnibus Budget Reconciliation Act* (*COBRA) and Extended Health Coverage*.

f. USERRA Continuation Health Benefits Provided

The continuation coverage provided to an **eligible employee** serving in the **uniformed services** who elects continued coverage (and his or her covered **dependents**) will be identical to the coverage provided under the group health coverage to similarly situated persons covered by the group health coverage who are active. If coverage is modified under the group health coverage for any group of similarly situated beneficiaries, such coverage will also be modified in the same manner for all individuals who are covered under USERRA continuation coverage. Continuation coverage may not be conditioned on evidence of good health. If the group health plan coverage under the **health plan** provides an open enrollment period during which similarly situated active employees may choose to be covered under another group health plan or under another benefit package within the group health plan coverage under the **health plan**, or to add or eliminate coverage of family members, the group health plan coverage under the **health plan** will provide the same opportunity to individuals who have elected USERRA continuation coverage.

g. Waiting Period and Exclusions Upon Reemployment

Notwithstanding any other provision herein, an **eligible employee** and his or her eligible covered **dependent**s whose benefit coverage is terminated by reason of **service in the uniformed services** will not be subject to any exclusion or waiting period upon reinstatement of such coverage under the group health coverage under the **health plan** following **service in the uniformed services**; provided, however, the above will not apply to any condition determined by the Secretary of Veterans Affairs to have been incurred in or aggravated during the performance of **service in the uniformed services**.

h. Reinstatement of Coverage Upon Reemployment

The **Division** will promptly reinstate the coverage under the **plan** at reemployment upon request.

i. Rights, Benefits, and Obligations of Employees Absent from Employment by Reason of Service in the Uniformed Services

An **eligible employee** who is absent from employment with the **State** by reason of **service in the uniformed services** will be considered on furlough or leave of absence while performing such service and will be entitled to such other rights and benefits as are generally provided by the **State** to **eligible employees** having similar status and pay who are on furlough or leave of absence; provided, however, an **eligible employee** who knowingly provides written notice of intent not to return to employment with the **State** will cease to be entitled to such rights and benefits. Furthermore, an **eligible employee**

who is absent from employment with the **State** by reason of **service in the uniformed services** will be permitted to apply any accrued paid vacation, annual or similar leave while on such leave by reason of **service in the uniformed services**.

13.9. FAMILY AND MEDICAL LEAVE ACT (FMLA)

a. Generally

The FMLA generally allows certain employees who worked at least 1,250 hours during the preceding 12 months the right to take an unpaid leave (or a paid leave if it has been earned) for a period of up to 12 work weeks during a 12 month period because of:

- The birth of a **child** and to care for such **child.**
- The placement of a **child** for adoption or foster care, and to care for such **child**.
- The need to care for a family member (**child**, spouse, or parent) with a "serious health condition" as defined under the FMLA.
- An employee's own "serious health condition" that makes the employee unable to do his or her job.
- Any "qualifying exigency" (as defined under the FMLA) arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation.

In addition, any spouse, son, daughter, parent, or nearest blood relative ("next of kin") of a "covered servicemember" will be granted leave not to exceed a total of 26 work weeks during a single 12 month period to care for the "covered servicemember." During the single 12 month period described above, an employee may be granted a combined total of 26 work weeks of leave for any combination of leaves under the FMLA. For purposes of this policy, the phrase "covered servicemember" means a member of the Armed Forces, including a member of the National Guard or Reserves, who:

- is undergoing medical treatment, recuperation, or therapy;
- is otherwise in an "outpatient status" (as defined by regulations); or
- is otherwise on the temporary disability retired list, for a "serious injury or illness" (as defined by regulations).

b. Continuation Coverage

Notwithstanding any other provisions in the **plan**, under the FMLA, an **eligible employee** who is covered under the **plan** is entitled to continue health benefit coverage under the **plan** during the period the **eligible employee** is on a FMLA leave. If paid leave runs concurrently with FMLA leave, employee contributions must be made by payroll deduction under the HFSA or by whatever alternative method is normally utilized for making such contributions when the **eligible employee** is on paid leave.

If the FMLA leave is unpaid leave, employee contributions must be paid at the same time as the contribution would be made if by payroll deduction, or as otherwise agreed to in writing between the **State** and the **eligible employee**. Failure of an **eligible employee** to pay his or her share of contributions within 30 days after the due date will result in termination of coverage, subject to this section. The **plan** coverage provided pursuant to the FMLA is the same as would be provided if the **eligible employee** had been employed during the leave period. The **eligible employee** may choose not to continue **plan** coverage during the FMLA leave. If the **eligible employee** chooses to discontinue coverage during the FMLA leave (or if coverage ends due to the failure to make timely contributions), the **eligible employee** will be immediately reinstated to **plan** coverage when the **eligible employee** returns from the FMLA leave without regard to any waiting period. The **eligible employee's** right to continue coverage for non-health benefits will be governed by the right to continue such coverages during non-FMLA type leaves. The **eligible employee** will be notified of such right, if any, to continue other benefit coverage during a FMLA leave.

c. Termination of FMLA Continuation Coverage

Except as provided under this section, FMLA benefit coverage will terminate when:

- The **eligible employee** informs the **State** of his or her intent not to return from FMLA leave.
- The **eligible employee** fails to return from the FMLA leave.
- The **eligible employee** exhausts his or her FMLA leave.
- The employment relationship would have been terminated if the **eligible employee** had not taken FMLA leave.

After the last day of FMLA leave, an **eligible employee** may be eligible for continuation of health coverage at the **eligible employee's** own expense under Federal law as described in section 8, *Consolidated Omnibus Budget Reconciliation Act* (*COBRA) and Extended Health Coverage*.

d. Employee Contributions

Eligible employees will pay any applicable employee contributions under the **health plan**.

The **State** may recover from the **eligible employee**: (i) contributions made by the **State** during a period of unpaid FMLA leave for maintaining the **eligible employee's** health benefit coverage if the **eligible employee** fails to return to work after the FMLA leave has been exhausted, unless the failure to return to work is due to a serious health condition of the **eligible employee** or a family member, or a serious injury or illness of a covered servicemen which would otherwise entitle the **eligible employee** to FMLA leave, or other circumstances beyond the **eligible employee's** control; or (ii) the **eligible employee's** share of contributions the **eligible employee** was obligated to make but which the **State** elected to make on the **eligible employee's** behalf in order to maintain the **eligible employee's** health benefit coverage (or non-health benefit coverage, as appropriate), regardless of whether the **eligible employee** returns from such leave.

13.10. STATEMENT OF RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending **physician** and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same **deductibles** and **coinsurance** applicable to other medical and surgical benefits provided under the **plan**. See section 2.1.1, *Medical Benefit Schedule*.

14. *Other Plan Provisions*

14.1. ACCESS TO RECORDS

All **covered persons** under the **plan** consent to and authorize all **providers** to examine and copy any portions of the **hospital** or medical records requested by the **plan** when processing a claim, **precertification**, or claim **appeal**.

14.2. PLAN LIABILITY

The full extent of liability under the **plan** and benefits conferred, including recovery under any claim of breach, will be limited to the actual cost of **hospital** and health services as described herein and will specifically exclude any claim for general or special damages that includes alleged "pain, suffering, or mental anguish."

14.3. FREE CHOICE OF HOSPITAL AND PROVIDER

You may select any **hospital** that meets the criteria in section 3.5.6, *Hospital Expenses*. You may select any **provider** who meets the definition of **provider** in section 15, *Definitions*.

The payments made under the **plan** for services that a **provider** renders are not construed as regulating in any way the fees that the **provider** charges.

Under the **plan**, payments may be made, at the discretion of the **claims administrator**, to the **provider** furnishing the service or making the payment, or to the **eligible employee**, or to such **provider** and the **eligible employee** jointly.

The **hospitals** and **providers** that furnish **hospital** care and services or other benefits to **covered persons** do so as independent contractors. The **plan** is not liable for any claim or demand from damages arising from or in any way connected with any **injuries** that **covered persons** suffer while receiving care in any **hospital** or services from any **provider**.

14.4. PLAN MUST BE EFFECTIVE

Health coverage is expense-incurred coverage only and not coverage for the **illness** or **injury** itself. This means that the **plan** will pay benefits only for expenses incurred while this coverage is in force. Except as described in section 8, *Consolidated Omnibus Budget Reconciliation Act* (*COBRA) and Extended Health Coverage*, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated, even if the expenses were incurred as a result of an **accident**, **injury**, or **illness** which occurred, commenced or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

14.5. MEDICAL OUTCOMES

Neither the **State** nor the **claims administrator** makes any express or implied warranties nor assumes any responsibility for the outcome of any covered services or supplies.

14.6. EPIDEMICS AND PUBLIC DISASTERS

The services this **plan** provides are subject to the availability of **hospital** facilities and the ability of **hospitals**, **hospital** employees, **physicians** and surgeons, and other **providers** to furnish services. The **plan** does not assume liability for epidemics, public disasters, or other conditions beyond its control which make it impossible to obtain the services that the **plan** provides.

14.7. VESTED RIGHTS

Except as cited in section 8, *Consolidated Omnibus Budget Reconciliation Act* (*COBRA) and Extended Health Coverage*, the **plan** does not confer rights beyond the date that coverage is terminated or the effective date of any change to the plan provisions, including benefits and eligibility provisions. For this reason, no rights from the **plan** can be considered vested rights. You are not eligible for benefits or payments from the **plan** for any services, treatment, medical attention, or care rendered after the date your coverage terminates.

14.8. AMENDMENT OR TERMINATION PROCEDURE

The following provisions will apply to the amendment and termination of the **plan**. To the extent that a benefit does not address amendment or termination of the benefit, the following provisions will also apply to such benefit. The **State**, through appropriate action of the **Commissioner** to take such action, will have the right in its sole discretion to amend the **plan**, the schedule of benefits or any underlying benefit, as applicable, at any time and from time to time and to any extent that it may deem advisable. Such modification or amendment will be duly incorporated in writing. The **State**, through appropriate action of the **Commissioner** to take such action, will have the right in its sole discretion to terminate the **plan** or any underlying benefit at any time and to the extent that it may deem advisable. Any amendment or termination of the **plan**, the schedule of benefits or underlying benefit will be effective as of the date the **State**, through the **Commissioner**, may determine in connection therewith. To the extent allowed by Internal Revenue Code and applicable **State** law, any such amendment may be effective retroactively.

14.9. CANCELLATION

The **State** may cancel any portion of the contract with the **claims administrator** without the consent of the **covered persons.**

14.10. RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

The **plan** may release or obtain information from any other plan it considers relevant to a claim made under this **plan.** This information may be released or obtained without the consent of or notice to you or any other person or organization. You must furnish the **plan** with information necessary to implement the **plan** provisions.

14.11. NONALIENATION

Except as otherwise required pursuant to a qualified medical child support, no benefit under the **plan** and underlying benefit prior to actual receipt thereof by any **eligible employee**, **spouse**, or his or her beneficiary will be subject to any debt, liability, contract, engagement, or tort of any **eligible employee**, **spouse**, or his or her beneficiary, nor subject to anticipation, sale, assignment (except in the case of medical benefits), transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation, or any other voluntary or involuntary alienation or other legal or equitable process, nor transferable by operation of law except as may be provided in the benefit.

14.12. ADDITIONAL TAXES OR PENALTIES

If there are any taxes or penalties payable by the **State** on behalf of any **covered person**, such taxes or penalties will be payable by the **covered person** to the employer to the extent such taxes would have been originally payable by the **covered person** had this **plan** not been in existence.

14.13. NO GUARANTEE OF TAX CONSEQUENCES

Neither the **claims administrators** nor the **State** makes any commitment or guarantee that any amounts paid to or for the benefit of a **covered person** under the **plan** will be excludable from the **covered person's** gross income for federal, state, or local income tax purposes or for Social Security tax purposes, or that any other federal or state tax treatment will apply to or be available to any **covered person**. It will be the obligation of each **covered person** to determine whether payment under the **plan** is excludable from the **covered person** gross income for federal, state, and local income tax purposes, and Social Security tax purposes, and to notify the **State** if the **covered person** has reason to believe that any such payment is not excludable.

14.14. EMPLOYMENT OF CONSULTANTS

The **State**, or a fiduciary named by the **State** pursuant to the **plan**, may employ one or more persons to render advice with regard to their respective responsibilities under the **plan**.

14.15. DESIGNATION OF FIDUCIARIES

The **State** may designate another person or persons to carry out any fiduciary responsibility of the **State** under the **plan**. The administrator will not be liable for any act or omission of such person in carrying out such responsibility, except as may be otherwise provided under applicable law.

14.16. FIDUCIARY RESPONSIBILITIES

To the extent permitted under applicable law, no fiduciary of the **plan** will be liable for any act or omission in carrying out the fiduciary's responsibilities under the **plan**.

14.17. ALLOCATION OF FIDUCIARY RESPONSIBILITIES

To the extent permitted under applicable law, each fiduciary under the **plan** will be responsible only for the specific duties assigned under the **plan** and will not be directly or indirectly responsible for the duties assigned to another fiduciary.

14.18. LIMITATION OF RIGHTS AND OBLIGATIONS

Neither the establishment nor maintenance of the **plan** nor any amendment thereof, nor the purchase of any benefit, including any benefit **plan** or insurance policy, nor any act or omission under the **plan** or resulting from the operation of the **plan** will be construed:

- as conferring upon any **covered person**, beneficiary, or any other person any right or claim against the **State**, or **claims administrator**, except to the extent that such right or claim will be specifically expressed and provided in the **plan** or provided under applicable law;
- as creating any responsibility or liability of the **State** or the **claims administrator** for the validity or effect of the **plan**; or
- as a contract or agreement between the **State** and any **covered person** or other person.

14.19. NOTICE

Any notice given under the **plan** will be sufficient if given to the **State** as administrator, when addressed to its office; if given to the **claims administrator**, when addressed to its office; or if given to a **covered person**, when addressed to the **covered person**, at his or her address as it appears in the records of the administrator or the **claims administrator**.

14.20. DISCLAIMER OF LIABILITY

Nothing contained herein will confer upon a **covered person** any claim, right, or cause of action, either at law or at equity, against the **plan**, the **State** or the **claims administrator** for the acts or omissions of any **provider** of services or supplies for any benefits provided under the **plan**.

14.21. RIGHT OF RECOVERY

If the **State** or the **claims administrator** makes any payment that according to the terms of the **plan** and the benefits provided hereunder should not have been made, the **State** or the administrator may recover that incorrect payment, whether or not it was made due to the **State's** or the **claims administrator's** own error, from the person to whom it was made, or from any other appropriate party. If any such incorrect payment is made directly to a **covered person**, then the **State** or the **claims administrator** may deduct it when making future payments directly to that **covered person**.

14.22. LEGAL COUNSEL

The **State** may from time to time consult with counsel, who may be counsel for the **State**, and will be fully protected in acting upon the advice of such counsel.

14.23. EVIDENCE OF ACTION

All orders, requests, and instructions to the **State** or the **claims administrator** by the **State** or by any duly authorized representative, will be in writing and the administrator will act and will be fully protected in acting in accordance with such orders, requests, and instructions.

14.24. PROTECTIVE CLAUSE

Neither the **State** nor the **claims administrator** will be responsible for the validity of any contract of insurance or other benefit contract or policy by any benefit **provider** issued to the **State** or for the failure on the part of any insurance company or other benefit **provider** to make payments thereunder.

14.25. RECEIPT AND RELEASE

Any payments to any **covered person** will, to the extent thereof, be in full satisfaction of the claim of such **covered person** being paid thereby, and the **State** may condition payment thereof on the delivery by the **covered person** of the duly executed receipt and release in such form as may be determined by the **State**.

14.26. LEGAL ACTIONS

If the **State** is made a party to any legal action regarding the **plan**, except for a breach of fiduciary responsibility of such person or persons, any and all costs and expenses, including reasonable attorneys' fees, incurred by the **State** in connection with such proceeding will be paid from the assets of the **plan** unless paid by the **State**.

No legal action can be brought to recover under any benefits after three years from the deadline for filing claims.

14.27. RELIANCE

The **State** will not incur any liability in acting upon any notice, request, signed letter, telegram, or other paper or document believed by the **State** to be genuine or to be executed or sent by an authorized person.

14.28. MISREPRESENTATION

Any material misrepresentation on the part of the **covered person** making application for coverage or receipt of benefits, will render the coverage null and void. Each **covered person** is required to notify the **State** or **claims administrator** of any change in status or other applicable events as required under this **plan** or the applicable benefit. Any failure to notify the **State** or c**laims administrator** of any change in status or other applicable events will be deemed by the **State** to be an act that constitutes fraud and an intentional misrepresentation of material fact prohibited by the **plan** that may result in a retroactive termination of coverage.

14.29. ENTIRE PLAN

The **plan** document and the documents, if any, incorporated by reference herein will constitute the only legally governing documents for the **plan**. No oral statement or other communication will amend or modify any provision of the **plan** as set forth herein.

14.30. APPLICABLE LAW AND VENUE

This **plan** is established and administered in the **State**, and is governed by the laws of the **State**. Any and all suits or legal proceedings of any kind that are brought against the **State** must be filed in the First Judicial District, Juneau, Alaska.

14.31. CHANGES TO THE PLAN

Neither the **claims administrator** nor any agent of the **claims administrator** is authorized to change the form or content of this **plan** in any way except by an amendment that becomes part of the **plan** over the signature of the **Commissioner**.

14.32. FACILITY OF PAYMENT

Whenever payments which should have been made under this **plan** are made under other programs, this **plan** has the right, at its discretion, to pay over to any organizations making other payments, any amounts it determines are warranted. These amounts are considered benefits paid under this **plan**, and, to the extent of such payments, this **plan** is fully discharged from liability.

14.33. PREMIUMS

The amount of the monthly premium may change. If you fail to pay any required premiums, your rights under this **plan** will be terminated, except as provided under disability extended benefits. Benefits will not be available until you have been reinstated under the provisions of the **plan** as defined in this **plan**.

15. *Definitions*

The following words have the defined meanings when used in the **plan**:

- "**Accident**" means a sudden, unexpected, and unforeseen, identifiable occurrence or event producing, at the time, objective symptoms of a bodily **injury**. The **accident** must occur while the person is covered under the **plan**. The occurrence or event must be definite as to time and place. It must not be due to, or contributed by, an **illness** or disease of any kind.

- "**Aetna**" means Aetna Life Insurance Company, an affiliate of **Aetna**, or a third party vendor under contract with **Aetna**. **Aetna** is the third party administrator of the **medical plan**.

- **"Affiliated provider"** means **providers** of covered services and materials who are not contracted as **VSP doctors** but who have agreed to bill **VSP** directly for vision services under the **vision plan**. Some **affiliated providers** may be unable to provide all vision services under the **vision plan**. **Covered persons** should discuss requested services with their **provider** or contact **VSP** for more information.

- "A**ggregate contract rate**" means the average of all discounts in the fee schedule negotiated with the preferred facility in Anchorage.

- "**Alveoloplasty**" is the surgical shaping of the bone of the upper or the lower jaw. It is performed most commonly in conjunction with the removal of a tooth or multiple teeth to have the gums heal smoothly for the placement of partial denture or denture.

- "**Ambulance**" means a professional land, water or air vehicle staffed with medical personnel and specially equipped to transport **injured** or sick people to a destination capable of caring for them upon arrival. Specially equipped means that the vehicle contains the appropriate stretcher, oxygen, and other medical equipment necessary for patient care en route.

- "**Anterior**" means teeth located at the front of the mouth.

- "**Appeal**" means review by the **claims administrator** of a **denial**.

- **"Average wholesale price (AWP)"** means the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons weekly price updates (or any other similar publication designated by the **claims administrator**) on the day that a **pharmacy** claim is submitted for adjudication.

- "**Behavioral health provider**" means a licensed organization or professional providing diagnostic, therapeutic, or psychological services for behavioral health conditions.

- "**Benefit option**" means the **medical plan**, **dental plan**, **vision plan**, and health flexible spending account (HFSA).

- "**Benefit year**" means January 1 through December 31.

- "**Birthing center**" means a freestanding facility that meets all of the following requirements:
  - Meets licensing standards.
  - Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
  - Charges for its services.
  - Is directed by at least one **physician** who is a specialist in obstetrics and gynecology.
  - Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period.
  - Extends staff privileges to **physicians** who practice obstetrics and gynecology in an area **hospital**.
  - Has at least two beds or two birthing rooms for use by patients while in labor and during delivery.
  - Provides, during labor, delivery and the immediate postpartum period, full-time **skilled nursing care** directed by a registered nurse or certified nurse midwife.
  - Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and **child**.
  - Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
  - Is equipped and has trained staff to handle **emergency** medical conditions and provide immediate support measures to sustain life if complications arise during labor or a **child** is born with an abnormality which impairs function or threatens life.
  - Accepts only patients with low-risk pregnancies.
  - Has a written agreement with a **hospital** in the area for **emergency** transfer of a patient or a **child**. Written procedures for such a transfer must be displayed and the staff must be aware of them.
  - Provides an ongoing quality assurance program. This includes reviews by **physicians** who do not own or direct the facility.
  - Keeps a medical record on each patient and **child**.

- **"Body mass index"** or **"BMI"** is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

- "**Brand name prescription drug**" is a **prescription drug** with a proprietary name assigned to it by the manufacturer or distributor and so indicated by Medi-Span or any other similar publication designated by **Aetna**.

- "**Bridge**" means a fixed partial denture. A **bridge** replaces one or more missing teeth using a **pontic** (false tooth or teeth) permanently attached to the adjacent teeth. **Retainer** crowns (crowns placed on adjacent teeth) are considered part of the **bridge**.

- "**Broken**" is the description of a tooth that has a piece or pieces that have been completely separated from the rest of the tooth. Note that cracks are not the same as **broken**.

- "**Cast restoration**" means crowns, inlays, onlays, and any other **restoration** to fit a specific **covered person's** tooth that is made at a laboratory and cemented into the tooth.

- "**Child**" or **"children"** means the **eligible employee's**, **spouse's** (i) natural child, (ii) stepchild, (iii) legally adopted child, (iv) child who is in the physical custody of the **eligible employee**, **spouse** and for whom bona fide adoption proceedings are underway, or (v) child who is placed with the **eligible employee**, **spouse** by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

- "**Claims administrator**" means a person, firm, or company which has agreed to provide technical or administrative services and advice in connection with the operation of all or a part of a benefit provided for under the **plan**, and perform such other functions, including processing and payment of claims, as may be delegated to it under such contract. The **claims administrator** may review claims **appeals** and, if applicable, coordinate external reviews, as provided by the **plan**.

- "**Coinsurance**" means the percentage of **covered expenses** which the **plan** pays after application of any applicable **deductible**.

- "**Commissioner**" means the Commissioner of the State of Alaska Department of Administration.

- "**Copayment**" means the specific dollar amount required to be paid by you or on your behalf under the **plan**.

- "**Cosmetic**" means services or supplies that alter, improve or enhance appearance.

- "**Covered expense**" means the medical, prescription drug, dental, or vision services and supplies shown as covered under the **plan**, including any applicable sales, excise, or other taxes.

- "**Covered person**" means each **eligible employee** and **dependent** who is covered under the **plan**.

- "**Custodial care**" means services and supplies, including **room and board** and other institutional services, that are primarily intended to help you meet personal needs. **Custodial care** can be prescribed by a **physician** or given by trained medical

personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of **custodial care** include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications.
- Care of a stable tracheostomy (including intermittent suctioning).
- Care of a stable colostomy/ileostomy.
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings.
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing).
- Watching or protecting you.
- Respite care, adult (or child) day care, or convalescent care.
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care.
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods.
- Any service that can be performed by a person without any medical or paramedical training.

- "**Day care treatment**" means a **partial confinement treatment** program to provide treatment for you during the day. The **hospital**, **psychiatric hospital** or **residential treatment facility** does not make a room charge for **day care treatment.** Such treatment must be available for at least four hours, but not more than 12 hours in any 24-hour period.

- "**Debridement**" means the removal of excess plaque. A periodontal "pre-cleaning" procedure done when there is too much plaque for the **dentist** to perform an exam.

- "**Deductible**" means the amount of **covered expenses** for which you are responsible each **benefit year** before any benefits are payable under the **plan**.

- "**Delta Dental**" means Delta Dental of Alaska. Delta Dental of Alaska is a business name used by Oregon Dental Service, which is a not-for-profit health insurer licensed in Alaska. **Delta Dental** is the **claims administrator** of the **dental plan**.

- "**Denial**" means any of the following: a denial, reduction, termination, or failure to provide or make payment (in whole or in part) for a benefit, including determinations based on eligibility, and, with respect to benefits under the **plan,** a denial, reduction, termination or failure to provide or make payment for a benefit based on utilization review or a failure to cover a benefit because it is determined to be **experimental or investigational** or not **medically necessary**. With respect to the **medical plan** and **dental plan**, it also means a **rescission** of coverage whether or not, in connection with the **rescission**, there is an adverse effect on any particular health benefit at the time.

- "**Dental care provider**" means a **dentist**, registered hygienist or certified dental therapist who is operating within the scope of his or her license, certification or registration.

- **"Dental plan"** means dental benefits under the **plan**, as set forth in section 4, *Dental Plan*.

- "**Dentally necessary**" means services that:
  - are established as necessary for the treatment or prevention of a dental **injury** or disease otherwise covered under the **dental plan**;
  - are appropriate with regard to standards of good dental practice in the **service area**;
  - have a good prognosis; and/or
  - are the least costly of the alternative supplies or levels of service that can be safely provided. For example, coverage would not be allowed for a crown when a filling would be adequate to restore the tooth appropriately.

  The fact that a **dentist** may recommend or approve a service or supply does not make the charge **dentally necessary.**

- "**Dentist**" means a licensed **dentist** or a **physician** licensed to do the dental work he or she performs, who is operating within the scope of his or her license as required under law within the state of practice.

- "**Dependent**" means an **eligible employee's spouse,** or **child**.

- **"Detoxification"** means the process by which an alcohol-intoxicated or drug-intoxicated, or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:
  - intoxicating alcohol or drug;
  - alcohol or drug-dependent factors; or
  - alcohol in combination with drugs;

  as determined by a **physician**. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

- "**Division**" means the State of Alaska, Division of Retirement and Benefits.

- "**Durable medical equipment**" means equipment and the accessories needed to operate it that is:
  - made for and mainly used in the treatment of an **illness** or **injury**;
  - suited for use in the home;
  - not normally of use to persons who do not have an **illness** or **injury**;
  - not for use in altering air quality or temperature; and
  - not for exercise or training.

Durable medical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids, and telephone alert systems.

- "**Electronic protected health information**" means "electronic protected health information" as defined at 45 CFR § 160.103, which generally means **protected health information** that is transmitted by, or maintained in, electronic media. For these purposes, "electronic media" means: (i) electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or (ii) transmission media used to exchange information already in electronic storage media (*e.g.*, the internet, extranet, leased lines, dial up lines, private networks, and the physical movement of removable/transportable electronic storage media).

- "**Eligible employee**" means a permanent or long-term nonpermanent **employee** of the **State** whose bargaining unit or employee group participates in the **plan** and who meets the criteria set forth in section 1.3.1, *Eligible Employees*. An **eligible employee** does not include temporary employees, leased employees, or employees who are scheduled to work less than 15 hours per week, except if the employee otherwise meets the criteria outlined under the employer shared responsibility provisions in section 26 U.S. Code § 4980H.

- "**Emergency"** means a sudden and unexpected change in a person's condition, including severe pain, such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in loss of life or limb, significant impairment to bodily function or permanent dysfunction of a body part, or with respect to a pregnant woman, the health of the woman and her unborn child.

- "**Emergency care"** means the treatment given in a **hospital**'s emergency room to evaluate and treat an **emergency** medical condition.

- "**Employee**" means a common law employee of the **State** who is actively at work and receiving earnings.

- "**EOB**" means an *Explanation of Benefits* form.

- "**Experimental or investigational**" means, except as provided for under any clinical trials benefit provision, a drug, a device, a procedure, or treatment where:
  - there is not enough outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved;
  - approval required by the FDA has not been granted for marketing;
  - a recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational** or for research purposes;

- it is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- the written protocols or informed consent used by the treating facility or any other facility studying substantially the same drug, device, procedure or treatment, states that it is **experimental or investigational**, or for research purposes.

- "**Facility**" means a freestanding **birthing center**, dialysis clinic, free standing imaging center, **hospital, hospice facility, psychiatric hospital, rehabilitation facility, surgery center, residential treatment facility, skilled nursing facility** or **urgent care provider.**

- "**Final denial**" means a **denial** of benefits under the **medical plan** or **dental plan** that has been upheld by the **claims administrator** at the completion of the internal **appeals** process or a **denial** of benefits under the **medical plan** or **dental plan** with respect to which the internal **appeals** process has been deemed exhausted (a "deemed **final denial**").

- "**Formulary**" means a listing of **prescription drugs** (both **generic prescription drugs** and **brand-name prescription drugs**) established by the plan administrator. The **formulary** will tell you if a drug is covered and tell you what plan payment tier it is in. You can also see if there are alternatives that cost less. The list is subject to periodic review and modification. This list is outlined in the **Preferred Drug Guide.** The **Preferred Drug Guide** also includes an Exclusion List of drugs that are identified as excluded under the plan, subject to periodic review and modification.

- "**Generic alternative prescription drug"** means a **prescription drug** used for the same purpose as the **brand-name prescription drug,** but can have different ingredients or different amounts of ingredients as the **brand-name prescription drug**.

- "**Generic prescription drug**" means a **prescription drug**, whether identified by its chemical, proprietary, or nonproprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medispan or any other publication designated by **Aetna**.

- "**Geographic area**" means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.

- "**Health care operations**" means "health care operations" as defined by 45 CFR § 164.501, as amended. Generally, **health care operations** include, but are not limited to, the following activities taken by or on behalf of the **plan**:
  - Quality assessment.
  - Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care **providers** and patients with information about treatment alternatives and related functions.
  - Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities.
  - Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance).
  - Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs.
  - Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the **plan**, including **formulary** development and administration, development or improvement of **payment** methods or coverage policies.
  - Business management and general administrative activities of the **plan**, including, but not limited to:
    - Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements.
    - Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers.
    - Resolution of internal grievances.
    - Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.
    - Any other activity considered to be a "health care operation" activity pursuant to 45 CFR § 164.501.

- "**Health care professional**" means a **physician** or other health care professional licensed, accredited, or certified to perform health services consistent with state law.

- "**Home health care agency**" means an organization that meets all of the following requirements:
  - provides **skilled nursing services** and other therapeutic services in the patient's home;
  - is associated with a professional policy-making group (of at least one **physician** and one full-time supervising registered nurse) which makes policy;
  - has full time supervision by a **physician** or registered nurse;

- keeps complete medical records on each patient;
- is staffed by an administrator; and
- meets licensing standards.

- "**Home health care plan**" means a plan that provides for continued care and treatment of an **illness** or **injury** in a place of confinement other than a **hospital** or **skilled nursing facility**. The attending **physician** must prescribe care treatment in writing.

- "**Homebound**" means that you are confined to your place of residence:
  - due to an **illness** or **injury** which makes leaving the home medically contraindicated; or
  - because the act of transport would be a serious risk to your life or health.

  Situations where you would not be considered **homebound** include, but are not limited to, the following:
  - you do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
  - you are wheelchair bound but could safely be transported via wheelchair accessible transport.

- "**Hospice care**" means care given to a **terminally ill** person by or under arrangements with a **hospice care agency**. The care must be part of a **hospice care program**.

- "**Hospice care agency**" means an agency or organization that meets all of the following requirements:
  - Has **hospice care** available 24 hours a day.
  - Meets any licensing or certification standards established by the jurisdiction where it is located.
  - Provides:
    - Skilled nursing services;
    - Medical social services; and
    - Psychological and dietary counseling.
  - Provides, or arranges for, other services which include:
    - **Physician** services;
    - Physical and occupational therapy;
    - Part time home health aide services which mainly consist of caring for **terminally ill** people; and
    - Inpatient care in a **facility** when needed for pain control and acute and chronic symptom management.
  - Has at least the following personnel:
    - One physician;

- One registered nurse; and
- One licensed or certified social worker employed by the agency.

  - Establishes policies about how **hospice care** is provided.
  - Assesses the patient's medical and social needs.
  - Develops a **hospice care program** to meet those needs.
  - Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency.
  - Permits all area medical personnel to utilize its services for their patients.
  - Keeps a medical record on each patient.
  - Uses volunteers trained in providing services for non-medical needs.
  - Has a full time administrator.

- "**Hospice care program**" is a written plan of **hospice care** which meets all of the following requirements:
  - Is established by and reviewed from time to time by a **physician** attending the person, and appropriate personnel of a **hospice care agency**.
  - Is designed to provide palliative and supportive care to **terminally ill** persons, and supportive care to their families.
  - Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.

- "**Hospice facility**" means a facility, or distinct part of one, that meets all of the following requirements:
  - Mainly provides inpatient hospice care to **terminally ill** persons.
  - Charges patients for its services.
  - Meets any licensing or certification standards established by the jurisdiction where it is located.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program including reviews by physicians other than those who own or direct the facility.
  - Is run by a staff of **physicians**. At least one staff **physician** must be on call at all times.
  - Provides 24-hour-a-day nursing services under the direction of a registered nurse.
  - Has a full-time administrator.

- "**Hospital**" means an institution providing inpatient medical care and treatment of sick and **injured** people. It must:
  - be accredited by the Joint Commission on the Accreditation of Healthcare Organizations; be a medical care, psychiatric, or tuberculosis hospital as defined by Medicare; or have a staff of qualified **physicians** treating or supervising treatment of the sick and **injured**; and
  - have diagnostic and therapeutic facilities for surgical and medical diagnosis on the premises; 24-hour-a-day nursing care provided or supervised by

registered graduate nurses; and continuously maintain facilities for operative surgery on the premises.

In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative hospital, or facility primarily for rehabilitative or custodial services.

- "**Illness**" means a pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

- "**Implant**" is an artificial, permanent tooth root replacement used to replace a missing tooth or teeth. It is surgically placed into the upper or lower jaw bone and supports a single crown, fixed **bridge**, or partial or full denture.

- "**Implant abutment**" is an attachment used to connect an **implant** and an **implant supported prosthetic** device.

- "**Implant supported prosthetic**" means a crown, **bridge**, or removable partial or full denture that is supported by or attached to an **implant**.

- "**Individual**" means any person who is the subject of **protected health information**.

- "**Infertility**" or **"infertile"** means the condition of a presumably healthy **covered person** who is unable to conceive or produce conception after:
  - *for a woman who is under 35 years of age*: one year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
  - *for a woman who is 35 years of age or older*: six months or more of timed, unprotected coitus, or 6 cycles of artificial insemination.

- "**Injury**" means an accidental bodily injury that is the sole and direct result of an unexpected or reasonably unforeseen occurrence or event, or the reasonable unforeseeable consequences of a voluntary act by the person.

- "**Mail order pharmacy**" means an establishment where **prescription drugs** are legally given out by mail or other carrier.

- "**Maintenance care**" means care made up of services and supplies that:
  - are given mainly to maintain, rather than to improve, a level of physical, or mental function; and
  - give a surrounding free from exposures that can worsen the person's physical or mental condition.

- "**Medical plan**" means medical, prescription drug, and employee assistance benefits under the **plan**, as set forth in section 3, *Medical Plan*.

- "**Medically necessary**" or "**medical necessity**" has the meaning set forth in section 3.5.1, *Medically Necessary Services and Supplies*.

- "**Mental disorder**" means an **illness** commonly understood to be a **mental disorder**, whether or not it has a physiological or organic basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a **psychiatric physician**, a psychologist or a psychiatric social worker. A **mental disorder** includes but is not limited to:
  - Schizophrenia
  - Bipolar disorder (manic/depressive)
  - Pervasive Mental Development Disorder (Autism)
  - Panic disorder
  - Major depressive disorder
  - Psychotic depression
  - Obsessive compulsive disorder
  - Anorexia/bulimia nervosa
  - Psychotic disorders/delusional disorder
  - Schizo-affective disorder

- "**Negotiated charge**" means the maximum charge that a **network provider** has agreed to make as to any service or supply for the purpose of benefits under the **plan**.

- "**Network pharmacy**" means a **pharmacy** that has contracted with **Aetna** to furnish services or supplies for the **plan**.

- "**Network provider**" means a health care **provider** or **pharmacy** that has contracted with a **claims administrator** to furnish services or supplies for the **plan**, but only if the **provider** is a **network provider** for the service or supply involved.

- "**Network service(s) or supply(ies)"** means health care service(s) or supply(ies) that is/are furnished by a **network provider**.

- "**Night care treatment**" means a **partial confinement treatment** program provided when you need to be confined during the night. A room charge is made by the **hospital**, **psychiatric hospital**, or **residential treatment facility**. Such treatment must be available at least eight hours in a row at a night and five nights per week.

- "**Non-preferred brand-name drug (non-formulary)**" means a **brand-name prescription drug** that does not appear on the **Preferred Drug Guide.**

- "**Other health care**" means a health care service or supply that is neither **network service(s) or supply(ies)** nor out-of-**network service(s) and supply(ies). Other health care** can include care given by a **provider** who does not fall into any of the categories in your **provider** directory or in DocFind® at www.aetna.com/docfind/custom/alaskacare.

- "**Out-of-pocket limit**" means the maximum amount you are responsible to pay for benefits under the **plan** each **benefit year**, including **coinsurance** not paid by the

plan. Expenses applied towards a **deductible**, premiums, charges over the **recognized charge**, **precertification** benefit reductions, and non-**covered expenses** do not accrue toward the **out-of-pocket limit**. A separate **out-of-pocket limit** applies with respect to the medical benefit portion and **prescription** benefit portion of the **medical plan.**

- "**Partial confinement treatment**" means a plan of medical, psychiatric, nursing, counseling or therapeutic services to treat **substance abuse** or **mental disorders** which meets all of the following requirements:
  - It is carried out in a **hospital**, **psychiatric hospital**, or **residential treatment facility** on less than a full-time inpatient basis.
  - It is in accord with accepted medical practice for the condition of the person.
  - It does not require full-time confinement.
  - It is supervised by a **psychiatric physician** who weekly reviews and evaluates its effect.

  Day care treatment and **night care treatment** are considered **partial confinement treatment**.

- "**PayFlex**" means PayFlex Systems USA, Inc., the flexible spending account and COBRA **claims administrator** under the **plan**.

- "**Payment**" means "payment" as defined by 45 § CFR 164.501, as amended. Generally, **payment** activities include, but are not limited to, activities undertaken by the **plan** to obtain premiums or determine or fulfill its responsibility for coverage and provision of **plan** benefits that relate to an **individual** to whom health care is provided. These activities include, but are not limited to, the following:
  - Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and **copayments** as determined for an **individual's** claim).
  - Coordination of benefits.
  - Adjudication of health benefit claims (including **appeals** and other payment disputes).
  - Subrogation of health benefit claims.
  - Establishing **eligible employee** contributions.
  - Risk adjusting amounts due based on an **eligible employee's** health status and demographic characteristics.
  - Billing, collection activities and related health care data processing.
  - Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to an **eligible employee's** inquiries about payments.
  - Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance).
  - **Medical necessity** reviews or reviews of appropriateness of care or justification of charges.
  - Utilization review, including **precertification**, preauthorization, concurrent review and retrospective review.

- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following **protected health information** may be disclosed for **payment** purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or **plan**).
- Reimbursement to the **plan.**
- Any other activity considered to be a "**payment**" activity pursuant to 45 CFR § 164.501.

- "**Periodontal maintenance**" is a periodontal procedure for **covered persons** who have previously been treated for periodontal disease. In addition to cleaning the visible surfaces of the teeth (as in **prophylaxis**), surfaces below the gum line are also cleaned. This is a more comprehensive service than a regular cleaning (**prophylaxis**).

- "**Pharmacy**" means an establishment where **prescription drugs** are legally dispensed. **Pharmacy** includes a retail **pharmacy**, **mail order pharmacy** and **specialty pharmacy network pharmacy**.

- "**Physician**" means a duly licensed member of a medical profession who:
  - has an M.D. or D.O. degree;
  - is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
  - provides medical services which are within the scope of his or her license or certificate.

  A **physician** also includes a health professional who:
  - is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
  - provides medical services which are within the scope of his or her license or certificate;
  - under applicable insurance law is considered a **physician** for purposes of this coverage;
  - has the medical training and clinical expertise suitable to treat your condition;
  - specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, **substance abuse** or a **mental disorder**; and
  - is not you or related to you.

- "**Plan**" means the AlaskaCare Employee Health Plan, the terms of which are set forth in this document, as may be amended from time to time.

- "**Pontic**" is an artificial tooth that replaces a missing tooth and is part of a **bridge**.

- "**Post-service claim**" means any claim for a medical benefit that is not an **urgent care claim** or a **pre-service claim.**

- "**Pre-service claim**" means any claim for a medical benefit the **health plan** conditions receipt of such benefit, in whole or in part, on approval of the benefit prior to obtaining medical care.

- "**Precertification**" or "**precertify**" means a process where the **claims administrator** is contacted before certain services are provided. It is not a guarantee that benefits will be payable.

- "**Preferred brand-name drug**" means a **brand-name prescription drug** that appears on the **Preferred Drug Guide.**

- "**Preferred Drug Guide**" is a listing of **prescription drugs** established by the **claims administrator** or an affiliate, which includes **brand-name prescription drugs.** This list is subject to periodic review and modification by the **claims administrator.** A copy of the **Preferred Drug Guide** will be made available upon request or may be accessed at www.AlaskaCare.gov.

- "**Prescription**" means an order for the dispensing of a **prescription drug** by a **physician** or **dentist,** acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**. If it is an oral order, it must be promptly put in writing by the **pharmacy**.

- "**Prescription drug**" means a drug, biological, or compounded **prescription** which, by state and Federal law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal law prohibits dispensing without prescription." This includes a **self-injectable drug** prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid **health care professional**. Covered **self-injectable drugs** include injectable insulin.

- "**Prevailing charge rate**" means rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. **Aetna** updates its systems with these changes within 180 days after receiving them from FAIR Health.

- "**Privacy Regulations**" mean the regulations under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164, as amended).

- "**Prophylaxis**" is cleaning and polishing of all teeth.

- "**Protected health information**" means "protected health information" as defined at 45 CFR § 164.501 which, generally, means information (including demographic information) that (i) identifies an **individual** (or with respect to which there is a reasonable basis to believe the information can be used to identify an **individual**), (ii) is created or received by a health care **provider**, a health plan, or a health care clearinghouse, and (iii) relates to the past, present, or future physical or mental health or condition of an **individual**; the provision of health care to an **individual**; or the past, present, or future **payment** for the provision of health care to an **individua**l.

- "**Provider**" means any recognized **health care professional**, **pharmacy** or **facility** providing services within the scope of its license.

- "**Psychiatric hospital**" means an institution that meets all of the following requirements:
  - Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, **substance abuse** or **mental disorders**.
  - Is not mainly a school or a custodial, recreational or training institution.
  - Provides infirmary-level medical services.
  - Provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
  - Is supervised full-time by a **psychiatric physician** who is responsible for patient care and is there regularly.
  - Is staffed by **psychiatric physicians** involved in care and treatment.
  - Has a **psychiatric physician** present during the whole treatment day.
  - Provides, at all times, psychiatric social work and nursing services.
  - Provides, at all times, **skilled nursing care** by licensed nurses who are supervised by a full-time registered nurse.
  - Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatric physician**.
  - Makes charges.
  - Meets licensing standards.

- "**Psychiatric physician**" means a **physician** who:
  - Specializes in psychiatry; or
  - Has the training or experience to do the required evaluation and treatment of alcoholism, **substance abuse** or **mental disorders**.

- "**Recognized charge**" means the **negotiated charge** contained in an agreement the **claims administrator** has with the **provider** either directly or through a third party. If there is no such agreement, the **recognized charge** is determined in accordance with the provisions of this section. An out-of-**network provider** has the right to bill the difference between the **recognized charge** and the actual charge. This difference will be the **covered person's** responsibility.

  - **<u>Medical Expenses</u>**

    As to medical services or supplies, the **recognized charge** for each service or supply is the <u>lesser of</u>:

    - what the **provider** bills or submits for that service or supply; or

    - the 90th percentile of the **prevailing charge rate**; for the **geographic area** where the service is furnished as determined by **Aetna** in accordance with **Aetna** reimbursement policies.

- **Facility Expenses in Anchorage and outside of Alaska**

  As to out-of-network **facility** services or supplies received in the Municipality of Anchorage or outside of Alaska, the **recognized charge** for each service or supply is the lesser of:

  - what the **facility** bills or submits for that service or supply; or
  - 185% of the Medicare allowed rate for those services.

- **Free standing imaging centers**

  As to out-of-network **facility** expenses at a free standing imaging center, the **recognized charge** for a service or supply is 50% of the amount billed by the **provider**.

- **Prescription Drug Expenses**

  As to **prescription drug** expenses, the **recognized charge** for each service or supply is the lesser of:

  - what the **provider** bills or submits for that service or supply; or
  - 110% of the **average wholesale price** or other similar resource.

- **Dental Expenses**

  As to dental expenses, the **recognized charge** for each service or supply provided by a network **dentist**, is the lesser of: 100% of the **covered expense**, 100% of the **dentist's** accepted filed fee with **Delta Dental**, or 100% of the **dentist's** billed charge.

  For out-of-network **dentists** or **dental care providers** in the **State**, the **recognized charge** is the lesser of:

  - what the **dentist** bills or submits for that service or supply; or

  75% of the 80th percentile of the **prevailing charge rate** as determined by **Delta Dental** in accordance with its reimbursement policies; except in the case of services rendered by an endodontist, 100% of the 80th percentile of the **prevailing charge rate** as determined by **Delta Dental** in accordance with its reimbursement policies. For out-of-network **dentists** or **dental care providers** outside the **State**, the **recognized charge** is the lesser of:

  - what the **dentist** bills or submits for that service or supply; or
  - the **prevailing charge rate** as determined by **Delta Dental** in accordance with its reimbursement policies.

- **Vision Expenses**

  As to vision expenses, the **recognized charge** for a service or supply is the amount billed by the **provider**.

Medical/Dental/Vision/Prescription Drug Expenses

A service or supply (except as otherwise provided in this section) will be treated as a **covered expense** under the **other health care** benefits category when **Aetna** determines that a **network provider** is not available to provide the service or supply. This includes situations in which you are admitted to a **network hospital** and non-**network physicians**, who provide services to you during your **stay**, bill you separately from the network **hospital.** In those instances, the **recognized charge** for that service or supply is the lesser of:

- what the **provider** bills or submits for that service or supply; and
- for professional services: the 90th percentile of the **prevailing charge rate**; for the **geographic area** where the service is furnished as determined by **Aetna** in accordance with **Aetna** reimbursement policies.

If **Aetna** has an agreement with a **provider** (directly, or indirectly through a third party) which sets the rate that **Aetna** will pay for a service or supply, then the **recognized charge** is the rate established in such agreement.

Aetna may also reduce the **recognized charge** by applying **Aetna** reimbursement policies. **Aetna** reimbursement policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- the duration and complexity of a service;
- whether multiple procedures are billed at the same time, but no additional overhead is required (excluding physical therapy);
- whether an assistant surgeon is involved and necessary for the service;
- if follow up care is included;
- whether there are any other characteristics that may modify or make a particular service unique; and
- when a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

Aetna reimbursement policies are based on **Aetna's** review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with **physician** or dental specialty society recommendations; and the views of **physicians** and **dentists** practicing in the relevant clinical areas. **Aetna** uses a commercial software package to administer some of these policies.

Aetna periodically updates its systems with changes made to the **prevailing charge rates**. What this means to you is that the **recognized charge** is based on the version of the rates that is in use by **Aetna** on the date that the service or supply was provided.

- **Additional Information**

  Aetna's website www.aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to **Aetna** Navigator to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools, or contact our Customer Service Department for assistance.

- "**Rehabilitation facility**" means a facility, or a distinct part of a facility which provides **rehabilitative care**, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

- "**Rehabilitative care**" means the combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by **illness** or **injury**.

- "**Reline**" means the process of resurfacing the tissue side of a denture with new base material.

- "**Rescission**" or "**rescind**" means a cancellation or discontinuance of coverage under the **medical plan** or **dental plan** that has retroactive effect. A rescission does not include the cancellation or discontinuance of coverage that has only a prospective effect or is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the rest of coverage.

- "**Residential treatment facility (mental disorders)**" means an institution that meets all of the following requirements:
  - On-site licensed **behavioral health provider** 24 hours per day/7 days a week.
  - Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
  - Patient is admitted by a **physician**.
  - Patient has access to necessary medical services 24 hours per day/7 days a week.

- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least a registered nurse or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for **children** and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **behavioral health provider** who, while not needing to be individually contracted, needs to (1) meet **Aetna's** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

- "**Residential treatment facility (substance abuse)**" means an institution that meets all of the following requirements:
  - On-site licensed **behavioral health provider** 24 hours per day/7 days a week.
  - Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
  - Patient is admitted by a **physician**.
  - Patient has access to necessary medical services 24 hours per day/7 days a week.
  - If the **covered person** requires **detoxification** services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending **physician**.
  - Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
  - Offers group therapy sessions with at least a registered nurse or Masters-Level Health Professional.
  - Has the ability to involve family/support systems in therapy (required for **children** and adolescents; encouraged for adults).
  - Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy.
  - Has peer oriented activities.
  - Services are managed by a licensed **behavioral health provider** who, while not needing to be individually contracted, needs to (1) meet **Aetna's** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
  - Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.

- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.
- Has the ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
- 24-hours per day/7 days a week supervision by a **physician** with evidence of close and frequent observation.
- On-site, licensed **behavioral health provider**, medical or **substance abuse** professionals 24 hours per day/7 days a week.

- "**Restoration**" means the treatment that repairs a **broken** or decayed tooth. **Restorations** include, but are not limited to, fillings and crowns.

- "**Retainer**" means a tooth used to support a prosthetic device (**bridges**, partial dentures or overdentures).

- "**Room and board**" means charges made by an institution for **room and board** and other **medically necessary** services and supplies. The charges must be regularly made at a daily or weekly rate.

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- "**Security incident**" means "security incident" as defined at 45 CFR § 164.304, which, generally, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

- "**Security Regulations**" mean the regulations under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Parts 160 and 164, as amended).

- "**Self-injectable drugs**" mean **prescription drugs** that are intended to be self-administered by injection to a specific part of the body to treat certain chronic medical conditions.

- "**Service area**" means the **geographic area**, as determined by **Delta Dental**, in which **network providers** for the dental coverage portion under the **dental plan** are located.

- "**Service in the uniformed services**" means (i) the performance of a duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, and National Guard duty under Federal law, (ii) a period for which an **eligible employee** is absent from a position of employment for the purpose of an examination to determine the fitness of the **eligible employee** to perform any such duty, (iii) a period for which the **eligible employee** is absent from employment to perform funeral honors duty as authorized by law, and (iv) service as an intermittent

disaster-response appointee upon activation of the National Disaster Medical System ("NDMS") or as a participant in an authorized training program.

- "**Skilled nursing care**" means:
  - Those services provided by a visiting registered nurse or licensed practical nurse for the purpose of performing specific skilled nursing tasks; and
  - Private duty nursing services provided by a registered nurse or licensed practical nurse if the patient's condition requires **skilled nursing care** and visiting nursing care is not adequate.

- "**Skilled nursing facility**" means an institution that meets all of the following requirements:
  - Licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **illness** or **injury**:
    - professional nursing care by an registered nurse or a licensed practical nurse directed by a full-time registered nurse; and
    - physical restoration services to help patients to meet a goal of self-care in daily living activities.
  - Provides 24 hour a day nursing care by licensed nurses directed by a full-time registered nurse.
  - Is supervised full-time by a **physician** or a registered nurse.
  - Keeps a complete medical record on each patient.
  - Has a utilization review plan.
  - Is not an institution for rest or care of the aged, drug addicts, alcoholics, people who are mentally incapacitated, or people with **mental disorders**.
  - Charges patients for its services.
  - An institution or a distinct part of an institution that meets all of the following requirements:
    - It is licensed or approved under state or local law.
    - Is primarily engaged in providing **skilled nursing care** and related services for residents who require medical or nursing care, or **rehabilitation services** for the rehabilitation of injured, disabled, or sick persons.
  - Qualifies as a **skilled nursing facility** under Medicare or as an institution accredited by:
    - The Joint Commission on Accreditation of Health Care Organizations;
    - The Bureau of Hospitals of the American Osteopathic Association; or
    - The Commission on the Accreditation of Rehabilitative Facilities.

Skilled nursing facilities also include rehabilitation **hospitals** (all levels of care, *e.g.* acute) and portions of a **hospital** designated for skilled or **rehabilitation services**. **Skilled nursing facilities** do not include institutions which provide only (i) minimal

care, (ii) c**ustodial care** or educational care, (iii) ambulatory services, or (iv) part-time care services, or institutions which primarily provide for the care and treatment of alcoholism, **substance abuse** or **mental disorders**.

- "**Skilled nursing services**" means services that meet all of the following requirements:
  - The services require medical or paramedical training.
  - The services are rendered by a registered nurse or licensed practical nurse. within the scope of his or her license.
  - The services are not custodial.

- "**Specialty care drugs**" means **prescription drugs** that include injectable, infusion, and oral drugs prescribed to address complex, chronic disease with associated co-morbidities such as cancer, rheumatoid arthritis, hemophilia, and multiple sclerosis, which are listed in the specialty care drug list.

- "**Specialty pharmacy network**" means a network of pharmacies designated to fill **specialty care drugs.**

- "**Spouse**" means the person to whom the **eligible employee** is legally married under state law. A **spouse** includes a person to whom the **eligible employee** is legally separated, but not divorced.

- "**State**" means the State of Alaska.

- "**Stay**" means a full-time inpatient confinement for which a **room and board** charge is made.

- "**Substance abuse**" means a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered **dependents**.) This term does not include conditions not attributable to a **mental disorder** that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.

- **"Summary health information"** means "summary health information" as defined by 45 CFR § 164.504(a), as amended, which generally is information that may be individually identifiable health information, and:
  - that summarizes the claims history, claims expenses, or type of claims experienced by **individuals** for whom the **State** has provided health benefits under the **health plan**; and
  - from which the information described at § 164.514(b)(2)(i) of the **Privacy Regulations** has been deleted, except that the geographic information described in § 164.514(b)(2)(i)(B) of the **Privacy Regulations** need only be aggregated to the level of a five digit zip code.

- "**Surgery center**" means a freestanding ambulatory surgical facility that meets all of the following requirements:
  - Meets licensing standards.
  - Is set up, equipped and run to provide general surgery.
  - Charges for its services.
  - Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
  - Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
  - Extends surgical staff privileges to:
    - **Physicians** who practice surgery in an area **hospital**; and
    - **Dentists** who perform oral surgery.
  - Has at least two operating rooms and one recovery room.
  - Provides, or arranges with a medical **facility** in the area for, diagnostic x-ray and lab services needed in connection with surgery.
  - Does not have a place for patients to stay overnight.
  - Provides, in the operating and recovery rooms, full-time **skilled nursing services** directed by a registered nurse.
  - Is equipped and has trained staff to handle **emergency** medical conditions.
  - Must have all of the following:
    - a **physician** trained in cardiopulmonary resuscitation;
    - a defibrillator;
    - a tracheotomy set; and
    - a blood volume expander.
  - Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients.
  - Written procedures for such a transfer must be displayed and the staff must be aware of them.
  - Provides an ongoing quality assurance program. The program must include reviews by **physicians** who do not own or direct the **facility**.
  - Keeps a medical record on each patient.

- **"Terminally ill"** means a medical prognosis of 12 months or less to live.

- **"Totally disabled"** or "**total disability**" means, for purposes of extended coverage under the **medical plan**, your complete inability to perform everyday duties appropriate for your employment, age or sex. The inability may be due to disease, **illness**, **injury**, or pregnancy. The **State** reserves the right to determine **total disability** based upon the report of a duly qualified **physician** or **physicians** chosen by the **claims administrator**.

- "**Uniformed Service"** means the Armed Forces, the Army National Guard, the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commission corps of the Public Health Service, and any other category of persons designated by the President of the United States of America in time of war or emergency. For purposes of USERRA coverage only, services as an intermittent disaster response appointee of the NDMS when federally activated or attending authorized training in support of their Federal mission is deemed service in the uniformed services, although such appointee is not a member of the "uniformed services" as defined by USERRA.

- "**Urgent admission**" means a **hospital** admission by a **physician** due to:
  - The onset of or change in an **illness**, the diagnosis of an **illness**, or an **injury**; and
  - The condition, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a **hospital** within two weeks from the date the need for the confinement becomes apparent.

- "**Urgent care claim**" means any claim for medical care or treatment where the failure to make a non-urgent care determination quickly (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or (ii) in the opinion of a **physician** with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

- "**Urgent care provider**" means:
  - A freestanding medical facility that meets all of the following requirements.
    - Provides unscheduled medical services to treat an **urgent condition** if the person's **physician** is not reasonably available.
    - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
    - Makes charges.
    - Is licensed and certified as required by any state or Federal law or regulation.
    - Keeps a medical record on each patient.
    - Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.
    - Is run by a staff of **physicians**. At least one **physician** must be on call at all times.
    - Has a full time administrator who is a licensed **physician**.
  - A **physician's** office, but only one that:

- Has contracted with **Aetna** to provide urgent care; and
- Is, with **Aetna's** consent, included in the **directory** as a network **urgent care provider.**

➢ It is not the emergency room or outpatient department of a **hospital**.

- "**Urgent condition**" means a sudden **illness**, **injury,** or condition that:
  - ➢ is severe enough to require prompt medical attention to avoid serious deterioration of your health;
  - ➢ includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
  - ➢ does not require the level of care provided in the emergency room of a **hospital**; and
  - ➢ requires immediate outpatient medical care that cannot be postponed until your **physician** becomes reasonably available.

- "**Veneer**" means a layer of tooth-colored material attached to the surface of an **anterior** tooth to repair chips or cracks, fix gaps and change the shape and size of teeth. A chairside **veneer** is a **restoration** created in the **dentist's** office. A laboratory **veneer** is a **restoration** that is created (cast) at a laboratory. Chairside and laboratory **veneers** may be paid at different benefit levels.

- **"Vision plan"** means vision benefits under the **plan**, as set forth in section 5, *Vision Plan*.

- "**VSP**" means Alaska Vision Services, Inc., the **claims administrator** for the **vision plan**.

- **"VSP doctor"** means an optometrist or opthalmologist licensed and otherwise qualified to practice vision care or provide vision care materials who has contracted with **VSP** to provide such services for the **plan**.

WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

www.wpath.org

Standards of Care

for the Health of Transsexual, Transgender, and Gender Nonconforming People

The World Professional Association for Transgender Health

7th Version

WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

Standards of Care

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The World Professiona Association for Transgender Health

7th Version[1] | www.wpath.org

1 This is the seventh version of the Standards of Care. The original SOC were published in 1979. Previous revisions were in 1980, 1981, 1990, 1998, and 2001.

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communication treatment can be considered in developing an individualized therapy plan (Carew, Dacakis, & Oates, 2007; Dacakis, 2000; Davies & Goldberg, 2006; Gelfer, 1999; McNeill, Wilson, Clark, & Deakin, 2008; Mount & Salmon, 1988).

Feminizing or masculinizing the voice involves non-habitual use of the voice production mechanism. Prevention measures are necessary to avoid the possibility of vocal misuse and long-term vocal damage. All voice and communication therapy services should therefore include a vocal health component (Adler et al., 2006).

Vocal Health Considerations after Voice Feminization Surgery

As noted in section XI, some transsexual, transgender, and gender nonconforming people will undergo voice feminization surgery. (Voice deepening can be achieved through masculinizing hormone therapy, but feminizing hormones do not have an impact on the adult MtF voice.) There are varying degrees of satisfaction, safety, and long-term improvement in patients who have had such surgery. It is recommended that individuals undergoing voice feminization surgery also consult a voice and communication specialist to maximize the surgical outcome, help protect vocal health, and learn non-pitch related aspects of communication. Voice surgery procedures should include follow-up sessions with a voice and communication specialist who is licensed and/or credentialed by the board responsible for speech therapists/speech-language pathologists in that country (Kanagalingam et al., 2005; Neumann & Welzel, 2004).

XI
Surgery_

Sex Reassignment Surgery Is Effective and Medically Necessary

Surgery – particularly genital surgery – is often the last and the most considered step in the treatment process for gender dysphoria. While many transsexual, transgender, and gender nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria (Hage

3. Non-genital, non-breast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures.

Reconstructive Versus Aesthetic Surgery

The question of whether sex reassignment surgery should be considered "aesthetic" surgery or "reconstructive" surgery is pertinent not only from a philosophical point of view, but also from a financial point of view. Aesthetic or cosmetic surgery is mostly regarded as not medically necessary and therefore is typically paid for entirely by the patient. In contrast, reconstructive procedures are considered medically necessary – with unquestionable therapeutic results – and thus paid for partially or entirely by national health systems or insurance companies.

Unfortunately, in the field of plastic and reconstructive surgery (both in general and specifically for gender-related surgeries), there is no clear distinction between what is purely reconstructive and what is purely cosmetic. Most plastic surgery procedures actually are a mixture of both reconstructive and cosmetic components.

While most professionals agree that genital surgery and mastectomy cannot be considered purely cosmetic, opinions diverge as to what degree other surgical procedures (e.g., breast augmentation, facial feminization surgery) can be considered purely reconstructive. Although it may be much easier to see a phalloplasty or a vaginoplasty as an intervention to end lifelong suffering, for certain patients an intervention like a reduction rhinoplasty can have a radical and permanent effect on their quality of life, and therefore is much more medically necessary than for somebody without gender dysphoria.

Criteria for Surgeries

As for all of the *SOC*, the criteria for initiation of surgical treatments for gender dysphoria were developed to promote optimal patient care. While the *SOC* allow for an individualized approach to best meet a patient's health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional. For some surgeries, additional criteria include preparation and treatment consisting of feminizing/masculinizing hormone therapy and one year of continuous living in a gender role that is congruent with one's gender identity.

These criteria are outlined below. Based on the available evidence and expert clinical consensus, different recommendations are made for different surgeries.

Received
MAY 30 2017
EEOC SEATTLE

EEOC Form 6 (5/01)

CHARGE OF DISCRIMINATION

This form is affected by the Privacy Act of 1974. See enclosed Privacy Act Statement and other information before completing this form.

Charge Presented to: ___ FEPA X EEOC

Agency(ies) Charge No(s): #551-2017-01334

Alaska State Human Rights Commission and EEOC
State or local Agency, if any

Name (*indicate Mr., Ms., Mrs.*)	Home Phone (Incl. Area Code)	Date of Birth
Ms. Jennifer Fletcher	[redacted]	[redacted]

Street Address: [redacted] City, State and ZIP Code: [redacted]

Named is the Employer, Labor Organization, Employment Agency, Apprenticeship Committee, or State or Local Government Agency That I believe Discriminated Against Me or Others. (*If more than two, list under PARTICULARS below.*)

Name	No. Employees, Members	Phone No. (Include Area Code)
State of Alaska	More than 500	(907) 465-2200
Street Address: 333 Willoughby Avenue, 10th Floor SOB	City, State and ZIP Code: Juneau, AK 99801	
Name	No. Employees, Members	Phone No. (Include Area Code)
Street Address	City, State and ZIP Code	

DISCRIMINATION BASED ON (*Check appropriate box(es).*)

__ RACE __ COLOR X SEX __ RELIGION __ NATIONAL ORIGIN

__ RETALIATION __ AGE __ DISABILITY __ GENETIC INFORMATION

__ OTHER (Specify below.)

DATE(S) DISCRIMINATION TOOK PLACE
Earliest: 11/30/2016 Latest: Ongoing

X CONTINUING ACTION

THE PARTICULARS ARE (*If additional paper is needed, attached extra sheet(s)*):

I am a transgender woman, employed by the State of Alaska. The State of Alaska provides health insurance to its employees through an employer-funded plan with claims administered by the Aetna Life Insurance Company (Aetna). This plan actively discriminates on the basis of sex against transgender individuals by denying coverage for treatments and procedures which are routinely provided for other persons.
(Continued on Attachment A)

I want this charge filed with both the EEOC and the State or local Agency, if any. I will advise the agencies if I change my address or phone number and I will cooperate fully with them in the processing of my charge in accordance with their procedures.

NOTARY – *When necessary for State and Local Agency Requirements*

I declare under penalty of perjury that the above is true and correct.

5/30/2017
Date

Charging Party Signature

I swear or affirm that I have read the above charge and that it is true to the best of my knowledge, information and belief.
SIGNATURE OF COMPLANANT

SUBSCRIBED AND SWORN TO BEFORE ME THIS DATE
(*month, day, year*)

ATTACHMENT A

THE PARTICULARS ARE (*If additional paper is needed, attached extra sheet(s)*): **-- Continued**

I have worked for the State of Alaska since 2012, and am currently employed as a Legislative Librarian within the Legislative Affairs Agency. In 2014 I started living openly as female, after having sought appropriate care, and in early 2015 had updated my relevant identification and employment documents to reflect this change, including those related to health insurance.

For transgender individuals in general, medical care related to transition is medically necessary. On November 30, 2016 I sought pre-authorization for such care from Aetna. Pre-authorization was denied on December 1, due to plan exclusions, at which time I sought to change my planned treatment to comply with the plan. I was informed that would not be possible due to plan exclusions. I noted regulations had been promulgated under Sec. 1557 of the Affordable Care Act which would require the removal of those exclusions, and Aetna noted they did not have information on exclusions in the 2017 plan. On January 1, 2017 the new health insurance plan booklet was signed into effect, exclusions still intact.

The exclusions are for "any treatment, drug, service or supply related to changing sex or sexual characteristics" and include surgery, hormones, and counseling (sec. 3.7.37 of the 2017 plan booklet). For cisgender persons, reconstructive surgeries for injury, illness, birth defect, intersex condition, or other conditions such as cancer treatment are covered. Hormone replacement therapy is covered for all other medically necessary purposes, including for post-menopausal women. Counseling is covered for the vast majority of other diagnoses. As a result of these exclusions I am paying out of pocket for medically necessary care.

The very wording of these exclusions requires judgments based on sex. It requires the State of Alaska assert that a person is "changing sex" in every denial, or to put it differently it requires the State of Alaska to assert that I am not female. Even if the State were to word the exclusion differently, it is narrowly targeted against transgender persons, a group which can only be defined by how we do not adhere to sex stereotypes. These practices limit, segregate, and classify me in a way that deprives me of opportunities and adversely affects my status as an employee.

Sex discrimination claim: The State of Alaska actively discriminates against transgender persons by excluding coverage for medically necessary care in its employee health insurance plan. These exclusions violate Title VII of the Civil Rights Act of 1964 by discriminating against transgender persons on the basis of sex in the terms, conditions, and privileges of employment, which include compensation. This discrimination includes but is not limited to the use of sex stereotypes, transgender status, gender identity, and gender transition.

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(https://www.aetna.com/)

Breast Reconstructive Surgery

Clinical Policy Bulletins | Medical Clinical Policy Bulletins

Number: 0185

Policy

Aetna considers reconstructive breast surgery medically necessary after a medically necessary mastectomy or a medically necessary lumpectomy that results in a significant deformity (i.e., mastectomy or lumpectomy for treatment of or prophylaxis for breast cancer and mastectomy or lumpectomy performed for chronic, severe fibrocystic breast disease, also known as cystic mastitis, unresponsive to medical therapy). Medically necessary procedures include capsulectomy, capsulotomy, implantation of Food and Drug Administration (FDA)-approved internal breast prosthesis, mastopexy, insertion of breast prostheses, the use of tissue expanders, or reconstruction with a latissimus dorsi (LD) myocutaneous flap, Ruben's flap, superficial inferior epigastric perforator (SIEP) flap, superior or inferior gluteal free flap, transverse upper gracilis (TUG) flap, transverse rectus abdominis myocutaneous (TRAM) flap, deep inferior epigastric perforator (DIEP) flap, superficial inferior epigastric artery (SIEA) flap, superior gluteal artery perforator (SGAP) flap, profunda artery perforator flap, or similar procedures, including skin sparing techniques.

Aetna considers the body lift perforator flap technique for breast reconstruction experimental and investigational because there is insufficient evidence to support the effectiveness of this approach.

Policy History

Last Review

07/31/2018

Effective: 11/13/1997

Next Review: 02/14/2019

Review History

Definitions

Additional Information

Clinical Policy Bulletin Notes

Aetna considers harvesting (via of lipectomy or liposuction) and grafting of autologous fat as a replacement for implants for breast reconstruction, or to fill defects after breast conservation surgery or other reconstructive techniques medically necessary.

Aetna considers the use of the following acellular dermal matrices medically necessary for breast reconstruction:

- Alloderm (LifeCell Corp., Branchburg, NJ)
- Alloderm-RTU (LifeCell Corp., Branchburg, NJ)
- Cortiva (formerly known as AlloMax, NeoForm) (Davol, Inc., Warwick, RI)
- DermACELL (Novadaq Technologies, Bonita Springs, FL)
- DermaMatrix (Musculoskeletal Transplant Foundation/Synthes CMF, West Chester, PA)
- FlexHD (Musculoskeletal Transplant Foundation/Ethicon, Inc., Somerville, NJ)
- Strattice (LifeCell Corp., Branchburg, NJ)

Aetna considers the following acellular dermal matrices experimental and investigational for breast reconstruction:

- SurgiMend (TEI Biosciences, Boston, MA)

Aetna considers associated nipple and areolar reconstruction and tattooing of the nipple area medically necessary. Reduction (or some cases augmentation) mammoplasty and related reconstructive procedures on the unaffected side for symmetry are also considered medically necessary.

Aetna considers breast reconstructive surgery to correct breast asymmetry cosmetic except for the following conditions:

- Surgical correction of chest wall deformity causing functional deficit in Poland syndrome when criteria are met in
  CPB 0272 - Pectus Excavatum and Poland's Syndrome: Surgical Correction (../200_299/0272.html)
  ; *or*
- Repair of breast asymmetry due to a medically necessary mastectomy or a medically necessary lumpectomy that results in a significant deformity. Medically necessary procedures on the non-diseased/unaffected/contralateral breast to produce a symmetrical appearance may include areolar and nipple reconstruction, areolar and nipple tattooing, augmentation mammoplasty, augmentation with implantation of FDA-

approved internal breast prosthesis when the unaffected breast is smaller than the smallest available internal prosthesis, breast implant removal and subsequent re-implantation when performed to produce a symmetrical appearance, breast reduction by mammoplasty or mastopexy, capsulectomy, capsulotomy, and reconstructive surgery revisions to produce a symmetrical appearance; *or*

- Prompt * repair of breast asymmetry due to trauma (* Note: See CPB 0031 - Cosmetic Surgery (../1_99/0031.html) for criteria related to surgical repair of cosmetic disfigurement due to trauma).

Aetna considers Biodesign Nipple Reconstruction Cylinder experimental and investigational becasue its effectiveness has not been established.

See also CPB 0017 - Breast Reduction Surgery and Gynecomastia Surgery (../1_99/0017.html), and CPB 0244 - Wound Care (../200_299/0244.html).

Background

Breast reconstruction surgery rebuilds a breast's shape after a mastectomy. The surgeon forms a breast mound by using an artificial implant or autologous tissue from the abdomen, back or buttocks. Implants are silicone sacs filled with saline (salt water) or silicone gel. The type of reconstruction performed depends on body type, age, general health status, type of cancer treatment or other reason for reconstruction.

Breast reconstruction may require multiple surgeries, such as nipple and areola reconstruction and tattoo pigmentation, revision surgery involving the breast and/or donor site, and surgery on the opposite breast to correct asymmetry.

Breast reconstruction may involve insertion of tissue expanders or breast implants, capsulotomy, capsulectomy or removal of breast implants. Examples of breast reconstruction techniques include, but may not be limited to, transverse rectus abdominis muscle (TRAM), deep inferior epigastric perforator (DIEP), latissimus dorsi (LD), superficial inferior epigastric artery (SIEA), transverse upper gracilis (TUG) and superior gluteal artery perforator (SGAP) flap procedures. Procedure names are related to the muscles or blood supplying vessels used and involve surgically removing tissue, typically fat and muscle, from one area of the body to create a breast mound. Pedicled flaps are positioned with their vascular origin intact while free flaps require

microsurgery to connect the tiny blood vessels needed to supply the transplanted tissue.

Breast reconstruction using autologous tissue is most commonly performed using the transverse rectus abdominis myocutaneous (TRAM) flap. This flap has been in use for 20 years and has provided excellent aesthetic results. However, a drawback of the TRAM flap is related to donor site morbidity of the abdomen. The pedicle TRAM flap frequently requires use of the entire rectus abdominis muscle, while the free TRAM flap requires use of as little as a postage-stamp size portion of the muscle. Abdominal complications resulting from a sacrifice of all or a portion of the rectus abdominis muscle include a reduction in abdominal strength (10 to 50 %), abdominal bulge (5 to 20 %), and hernia (less than 5 %).

Perforator flaps have gained increasing attention with the realization that the muscle component of the TRAM flap does not add to the quality of the reconstruction and serves only as a carrier for the blood supply to the flap. Thus, the concept of separating the flap (skin, fat, artery, and vein) from the muscle was realized as a means of minimizing the morbidity related to the abdominal wall and maintaining the aesthetic quality of the reconstruction.

The deep inferior epigastric perforator (DIEP) flap was introduced in the early 1990's and is identical to the free TRAM flap except that it contains no muscle or fascia. Use of this flap has been popular in the Europe for a number of years and is now gaining popularity in the United States. The DIEP flap has been performed at Johns Hopkins for several years. Candidates for this operation are similar to those for the free TRAM in that there must be adequate abdominal fat to create a new breast. However, caution must be exercised in performing this technique in women who require large volume reconstruction to prevent the occurrence of fat necrosis or hardening of the new breast. The operation can be performed immediately following mastectomy or on a delayed basis. Performance of this operation is slightly more difficult than the free TRAM flap because it requires meticulous dissection of the perforating vessels from the muscle. Deep inferior epigastric perforator flaps tend to have less robust blood flow than is typical with a standard TRAM reconstruction, so careful patient selection is important. In patients who are non-smokers, who require no more than 70 % of the TRAM flap skin paddle to make a breast of adequate size, and who have at least 1 perforating vessel greater than 1-mm in diameter with a detectable pulse, the incidence of flap complications reportedly is similar to that seen in standard free TRAM flap reconstruction.

The superficial inferior epigastric artery (SIEA) flap uses the same abdominal tissue as the DIEP flap but different blood supplying vessels.

Superior gluteal artery perforator (SGAP) flap or gluteal free flap procedures use tissue from the buttock to create the breast shape. It is an option for women who cannot or do not wish to use

the abdominal sites due to thinness, incisions, failed abdominal flap or other reasons. The method is much like the free TRAM flap mentioned above. The skin, fat, blood vessels SGAP flaps may be performed on women who are not candidates for a TRAM flap or who have had a failed TRAM flap. Thin women who may not have much tissue in the lower abdominal area often have an adequate amount of tissue in the gluteal region. The inferior gluteal artery perforator (IGAP) flap shares the same indications as the superior gluteal flap, namely the inability to use the TRAM flap and an abundance of soft tissue in the gluteal region.

The transverse upper gracilis (TUG) flap uses tissue from the upper posterior thigh and lower buttock area and is an option for women with insufficient lower abdominal fat for breast reconstruction.

The latissimus dorsi (LD) flap is tunneled through the axilla, leaving the blood supplying vessels (the thoracodorsal artery and vein) intact. The LD flap has less tissue volume and is usually used in combination with a saline or silicone implant.

Poland syndrome is an extremely rare developmental disorder that is present at birth (congenital). It is characterized by absence (agenesis) or under-development (hypoplasia) of certain muscles of the chest (e.g., pectoralis major, pectoralis minor, and/or other nearby muscles), and abnormally short, webbed fingers (symbrachydactyly). Additional findings may include underdevelopment or absence of 1 nipple (including the darkened area around the nipple [areola]) and/or patchy hair growth under the arm (axilla). In females, 1 breast may also be under-developed (hypoplastic) or absent (amastia). In some cases, affected individuals may also exhibit under-developed upper ribs and/or an abnormally short arm with under-developed forearm bones (i.e., ulna and radius) on the affected side. In most cases, physical abnormalities are confined to one side of the body (unilateral). In approximately 75 % of the cases, the right side of the body is affected. The range and severity of symptoms may vary from case to case. The exact cause of Poland syndrome is not known.

Autologous fat grafting (or lipomodeling) uses the patient's own fat cells to replace volume after breast reconstruction, or to fill defects in the breast following breast-conserving surgery (NICE, 2012). It can be used on its own or as an adjunct to other reconstruction techniques. The procedure aims to restore breast volume and contour without the morbidity of other reconstruction techniques. With the patient under general or local anesthesia, fat is harvested by aspiration with a syringe and cannula, commonly from the abdomen, outer thigh or flank. The fat is usually washed and centrifuged before being injected into the breast. Patients subsequently undergo repeat treatments (typically 2 to 4 sessions) (NICE, 2012). Autologous fat grafting may be delayed for a variable period of time after mastectomy. Most of the evidence for the use of autologous fat grafting in breast reconstruction is as a technique to repair contour

defects and deformities. There is less information about the use of autologous fat grafting for complete breast reconstruction.

Guidance from the National Institute for Health and Clinical Excellence (NICE, 2012) states that current evidence on the efficacy of breast reconstruction using lipomodelling after breast cancer treatment is adequate and the evidence raises no major safety concerns. The guidance noted that there is a theoretical concern about any possible influence of the procedure on recurrence of breast cancer in the long term, although there is no evidence of this in published reports. The guidance notes that a degree of fat resorption is common in the first 6 months and there have been concerns that it may make future mammographic images more difficult to interpret.

A technology assessment on autologous fat injection for breast reconstruction prepared for the Australian and New Zealand Horizon Scanning Network (Humphreys, 2008) found that the technique has the potential to improve some contour defects; however, the results appear to be highly variable, with 2 case series finding that following autologous fat injection between 21 % and 86.5 % of patients showed substantial improvement at post-operative assessment. Patient satisfaction with the procedure was not reported. The assessment stated that longer-term follow-up is needed to determine how much of the injected fat survives and how much is eventually re-absorbed by the body. There are also important safety issues with the procedure, especially in association with the lipo-necrotic lumps that can form in the breast from the injected fat. Both case series reported this to occur in approximately 7 % of cases, and there is concern that such lumps will impede future cancer detection.

Hyakusoku et al (2009) reported several cases of complications following fat grafting to the breast. These investigators retrospectively reviewed 12 patients who had received autologous fat grafts to the breast and required breast surgery and/or reconstruction to repair the damage presenting between 2001 and 2007. All 12 patients (mean age of 39.3 years) had received fat injections to the breast for augmentation mammaplasty for cosmetic purposes. They presented with palpable indurations, 3 with pain, 1 with infection, 1 with abnormal breast discharge, and 1 with lymphadenopathy. Four cases had abnormalities on breast cancer screening. All patients underwent mammography, computed tomography, and magnetic resonance imaging to evaluate the injected fats. The authors concluded that autologous fat grafting to the breast is not a simple procedure and should be performed by well-trained and skilled surgeons. Patients should be informed that it is associated with a risk of calcification, multiple cyst formation, and indurations, and that breast cancer screens will always detect abnormalities. Patients should also be followed-up over the long-term and imaging analyses (e.g., mammography, echography, computed tomography, and magnetic resonance imaging) should be performed.

The American Society of Plastic Surgeons (ASPS) fat grafting task force (Gutowski, 2009) concluded that autologous fat grafting is a promising and clinically relevant research topic. The current fat grafting literature is limited primarily to case studies, leaving a tremendous need for high-quality clinical studies.

Mizuno and Hyakusoku (2010) stated that recent technical advances in fat grafting and the development of surgical devices such as liposuction cannulae have made fat grafting a relatively safe and effective procedure. However, guidelines issued by the ASPS in 2009 announced that fat grafting to the breast is not a strongly recommended procedure, as there are limited scientific data on the safety and efficacy of this particular type of fat transfer. Recent progress by several groups has revealed that multi-potent adult stem cells are present in human adipose tissue. This cell population, termed adipose-derived stem cells (ADSC), represents a promising approach to future cell-based therapies, such as tissue engineering and regeneration. In fact, several reports have shown that ADSC play a pivotal role in graft survival through both adipogenesis and angiogenesis. Although tissue augmentation by fat grafting does have several advantages in that it is a non-invasive procedure and results in minimal scarring, it is essential that such a procedure be supported by evidence-based medicine and that further research is conducted to ensure that fat grafting is a safe and effective procedure.

Acellular dermal matrices are considered a standard-of-care as an adjunct to breast reconstruction. The clinical literature on acellular dermal matrix product in breast reconstruction primarily consists of single institution case series focusing on surgical technique. Much of the early literature focused on AlloDerm brand of acellular dermal matrix, since this product was first to market, but more recent literature has considered other acellular dermal matrix products. Recent literature has provided comparisons of AlloDerm to certain other acellular dermal matrix products, with the authors concluding that there is no significant difference among products (see, e.g., Ibrahim, et al., 2013; Cheng, et al., 2012). While different acellular dermal matrix products are processed differently, these appear to result in minor differences in performance in breast reconstruction.

The Biodesign Nipple Reconstruction Cylinder is intended for implantation to reinforce soft tissue where weakness exists in patients requiring soft tissue repair or reinforcement in plastic and reconstructive surgery. It is supplied sterile and is intended for 1-time use. There is a lack of evidence regading the clincial value of this product in breast reconstructive surgery.

Llewellyn-Bennett et al (2012) noted that latissimus dorsi (LD) flap procedures comprise 50 % of breast reconstructions in the United Kingdom. They are frequently complicated by seroma

formation. In a randomized study, these researchers investigated the effect of fibrin sealant (Tisseel(®)) on total seroma volumes from the breast, axilla and back (donor site) after LD breast reconstruction. Secondary outcomes were specific back seroma volumes together with incidence and severity of wound complications. Consecutive women undergoing implant-assisted or extended autologous LD flap reconstruction were randomized to either standard care or application of fibrin sealant to the donor-site chest wall. All participants were blinded for the study duration but assessors were only partially blinded. Non-parametric methods were used for analysis. A total of 107 women were included (sealant = 54, control = 53). Overall, back seroma volumes were high, with no significant differences between control and sealant groups over 3 months. Fibrin sealant failed to reduce in-situ back drainage volumes in the 10 days after surgery, and did not affect the rate or volume of seromas following drain removal. The authors concluded that the findings of this randomized study, which was powered for size effect, failed to show any benefit from fibrin sealant in minimizing back seromas after LD procedures.

Allen et al (2012) stated that the use of perforator flaps has allowed for the transfer of large amounts of soft tissue with decreased morbidity. For breast reconstruction, the DIEP flap, the superior and inferior gluteal artery perforator flaps, and the transverse upper gracilis flap are all options. These investigators presented an alternative source using posterior thigh soft tissue based on profunda artery perforators, termed the profunda artery perforator flap. Pre-operative imaging helped identify posterior thigh perforators from the profunda femoris artery. These are marked, and an elliptical skin paddle, approximately 27 × 7 cm, is designed 1 cm inferior to the gluteal crease. Dissection proceeded in a supra-fascial plane until nearing the perforator, at which point sub-fascial dissection was performed. The flap has a long pedicle (approximately 7 to 13 cm), which allowed more options when performing anastomosis at the recipient site. The long elliptical shape of the flap allowed coning of the tissue to form a more natural breast shape. All profunda artery perforator flaps have been successful. The donor site was well-tolerated and scars have been hidden within the gluteal crease. Long-term follow-up is needed to evaluate for possible fat necrosis of the transferred tissue. The authors presented a new technique for breast reconstruction with a series of 27 flaps. They stated that this is an excellent option when the abdomen is not available because of the long pedicle, muscle preservation, ability to cone the tissue, and hidden scar.

Tanna et al (2013) presented the findings of the largest series of microsurgical breast reconstructions following nipple-sparing mastectomies. All patients undergoing nipple-sparing mastectomy with microsurgical immediate breast reconstruction treated at New York University Medical Center (2007 to 2011) were identified. Patient demographics, breast cancer history, intraoperative details, complications, and revision operations were examined. Descriptive statistical analysis, including t-test or regression analysis, was performed. In 51 patients, 85 free flap breast reconstructions (n = 85) were performed. The majority of flaps were performed for

prophylactic indications [n = 55 (64.7 %)], mostly through vertical incisions [n = 40 (47.0 %)]. Donor sites included abdominally based [n = 66 (77.6 %)], profunda artery perforator [n = 12 (14.1 %)], transverse upper gracilis [n = 6 (7.0 %)], and superior gluteal artery perforator [n = 1 (1.2 %)] flaps. The most common complications were mastectomy skin flap necrosis [n = 11 (12.7 %)] and nipple necrosis [n = 11 (12.7 %)]. There was no correlation between mastectomy skin flap or nipple necrosis and choice of incision, mastectomy specimen weight, body mass index, or age ($p > 0.05$). However, smoking history was associated with nipple necrosis ($p < 0.01$). The authors concluded that the findings of this series represented a high-volume experience with nipple-sparing mastectomy followed by immediate microsurgical reconstruction. When appropriately executed, it can deliver low complication rates.

Levine et al (2013) stated that recent evolutions of oncologic breast surgery and reconstruction now allow surgeons to offer the appropriate patients a single-stage, autologous tissue reconstruction with the least donor-site morbidity. These investigators presented their series of buried free flaps in nipple-sparing mastectomies as proof of concept, and explored indications, techniques, and early outcomes from their series. From 2001 to 2011, a total of 2,262 perforator-based free flaps for breast reconstruction were reviewed from the authors' prospectively maintained database. There were 338 free flaps performed on 215 patients following nipple-sparing mastectomy, including 84 patients who underwent breast reconstruction with 134 buried free flaps. Ductal carcinoma in-situ and BRCA-positive were the most common diagnoses, in 26 patients (30.9 %) each. The most common flaps used were the DIEP (77.6 %), transverse upper gracilis (7.5 %), profunda artery perforator (7.5 %), and superficial inferior epigastric artery flaps (3.7 %). An implantable Cook-Swartz Doppler was used to monitor all buried flaps. Fat necrosis requiring excision was present in 5.2 %of breast reconstructions, and there were 3 flap losses (2.2 %); 78 flaps (58.2 %) underwent minor revision for improved cosmesis; 56 (41.8 %) needed no further surgery. The authors concluded that nipple-sparing mastectomy with immediate autologous breast reconstruction can successfully and safely be performed in a single stage; however, the authors are not yet ready to offer this as their standard of care.

Healy and Allen (2014) noted that it is over 20 years since the inaugural DIEP flap breast reconstruction. These investigators reviewed the type of flap utilized and indications in 2,850 microvascular breast reconstruction over the subsequent 20 years in the senior author's practice (Robert J. Allen). Data were extracted from a personal logbook of all microsurgical free flap breast reconstructions performed between August 1992 and August 2012. Indication for surgery; mastectomy pattern in primary reconstruction; flap type, whether unilateral or bilateral; recipient vessels; and adjunctive procedures were recorded. The DIEP was the most commonly performed flap (66 %), followed by the superior gluteal artery perforator flap (12 %), superficial inferior epigastric artery perforator flap (9 %), inferior gluteal artery perforator flap (6 %), profunda artery perforator flap (3 %), and transverse upper gracilis flap (3 %). Primary

reconstruction accounted for 1,430 flaps (50 %), secondary 992 (35 %), and tertiary 425 (15 %). As simultaneous bilateral reconstructions, 59 % flaps were performed. With each flap, there typically ensues a period of enthusiasm which translated into surge in flap numbers. However, each flap has its own nuances and characteristics that influence patient and physician choice. Of note, each newly introduced flap, either buttock or thigh, results in a sharp decline in its predecessor. In this practice, the DIEP flap has remained the first choice in autologous breast reconstruction.

Weichman et al (2013) examined patients undergoing autologous microsurgical breast reconstruction with and without the adjunct of autologous fat grafting to clearly define utility and indications for use. A retrospective review of all patients undergoing autologous breast reconstruction with microvascular free flaps at a single institution between November 2007 and October 2011 was conducted. Patients were divided into 2 groups as follows: (i) those requiring postoperative fat grafting and (ii) those not requiring fat grafting. Patient demographics, indications for surgery, history of radiation therapy, patient body mass index, mastectomy specimen weight, need for rib resection, flap weight, and complications were analyzed in comparison. A total of 228 patients underwent 374 microvascular free flaps for breast reconstruction. One hundred (26.7 %) reconstructed breasts underwent post-operative fat grafting, with an average of 1.12 operative sessions. Fat was most commonly injected in the medial and superior medial poles of the breast and the average volume injected was 147.8 ml

per breast (22 to 564 ml). The average ratio of fat injected to initial flap weight was 0.59 (0.07 to 1.39). Patients undergoing fat grafting were more likely to have had DIEP and profunda artery perforator flaps as compared to muscle-sparing transverse rectus abdominis myocutaneous. Patients additionally were more likely to have a prophylactic indication 58 % (n = 58) versus 42 % (n = 117) (p = 0.0087), rib resection 68 % (n = 68) versus 54 % (n = 148) (p < 0.0153), and acute post-operative complications requiring operative intervention 7 % (n = 7) versus 2.1 % (n = 8) (p < 0.0480). Additionally, patients undergoing autologous fat grafting had smaller body mass index, mastectomy weight, and flap weight. The authors concluded that fat grafting is most commonly used in those breasts with rib harvest, DIEP flap reconstructions, and those with acute post-operative complications. It should be considered a powerful adjunct to improve aesthetic outcomes in volume-deficient autologous breast reconstructions and additionally optimize contour in volume-adequate breast reconstructions.

The “body lift” perforator flap technique allows for a double fat layer in each breast when both breasts are being reconstructed. This is offered to the thin patient with ample breasts in the setting of bilateral mastectomy when volume preservation and projection are desired, yet the fat deposits in the waist and tummy are minimal. A body lift incision design in the waist gives both a tummy tuck effect and a lift of the buttocks in the donor site. There is currently insufficient

evidence to support the use of the body lift perforator flap technique for breast reconstruction.

DellaCroce et al (2012) stated that for patients with a desire for autogenous breast reconstruction and insufficient abdominal fat for conventional abdominal flaps, secondary options such as gluteal perforator flaps or latissimus flaps are usually considered. Patients who also have insufficient soft tissue in the gluteal donor site and preference to avoid an implant, present a vexing problem. These researchers described an option that allows for incorporation of 4independent perforator flaps for bilateral breast reconstruction when individual donor sites are too thin to provide necessary volume. They presented their experience with this technique in 25 patients with 100 individual flaps over 5 years. The “body lift” perforator flap technique, using a layered deep inferior epigastric perforator/gluteal perforator flap combination for each breast, was performed in this patient set with high success rates and quality aesthetic outcomes over several years. Patient satisfaction was high among the studied population. The authors concluded that the body lift perforator flap breast reconstruction technique can be a reliable, safe, but technically demanding solution for patients seeking autogenous breast reconstruction with otherwise inadequate individual fatty donor sites. This sophisticated procedure overcomes a limitation of autogenous breast reconstruction for these patients that otherwise resulted in a breast with poor projection and overall volume insufficiency. The harvest of truncal fat with a circumferential body lift design gave the potential added benefit of improved body contour as a complement to this powerful breast reconstructive technique.

Also, UpToDate reviews on “Principles of grafts and flaps for reconstructive surgery” (Morris, 2013) and “Breast reconstruction in women with breast cancer” (Nahabedian, 2013) do not mention the body lift perforator flap technique as a management tool for breast reconstruction.

Surgimend:

In May 2015, the FDA warned the manufacturer of Surgimend that it was not cleared for marketing for use in breast reconstruction (FDA. 2015).

Dermacell:

Decellularized human skin has been used in a variety of medical applications, primarily involving soft tissue reconstruction, wound healing, and tendon augmentation. Theoretically, decellularization removes potentially immunogenic material and provides a clean scaffold for cellular and vascular in growth. DermACELL acellular dermal matrix offers advanced processing in order to attempt to decrease bio-intolerance and complications in breast reconstruction and other procedures. There are little published data on the use of DermACELL in breast reconstruction.

Bullocks (2014) reported on 10 consecutive patients that presented for breast reconstruction and were candidates for tissue expanders underwent the procedure with the use of an acellular dermal matrix. The patients underwent postoperative expansion/adjuvant cancer therapy, then tissue expander exchange for permanent silicone breast prostheses. Patients were followed through the postoperative course to assess complication outcomes. Histologic evaluation of host integration into the dermal matrix was also assessed. Of the ten patients included in the study, eight completed reconstruction while two patients failed reconstruction. The failures were related to chronic seromas and infection. Histology analysis confirms rapid integration of mesenchymal cells into the matrix compared to other acellular dermal matrices.

Vashi described the use of DermACELL acellular dermal matrix in two-stage postmastectomy breast reconstruction. Ten consecutive breast cancer patients were treated with mastectomies and immediate reconstruction from August to November 2011. There were 8 bilateral and 1 unilateral mastectomies for a total of 17 breasts, with one exclusion for chronic tobacco use. Reconstruction included the use of a new 6 × 16 cm sterile, room temperature acellular dermal matrix patch (DermACELL) soaked in a cefazolin bath. Results. Of the 17 breasts, 15 reconstructions were completed; 14 of them with expander to implant sequence and acellular dermal matrix. Histological analysis of biopsies obtained during trimming of the matrix at the second stage appeared nonremarkable with evidence of normal healing, cellularity, and vascular infiltration.

Zenn and Salzberg (2016) reported on their experience with Dermacell to Alloderm-RTU.. The authors stated that retrospective study draws on the experience of 2 expert surgeons with a history of long-standing use of the Alloderm-RTU (LifeCell Corporation, Branchburg, NJ) product who switched to the DermACELL acellular dermal matrix (LifeNet Health, Virgina Beach, Va) product. The authors stated that the consecutive nature of these data over this change allowed comparison between the 2 products without the confounding effects of patient selection or change in technique. The postoperative complications of seroma, infection, implant loss, and unplanned return to the operating room were studied, and no statistical differences were noted between these 2 products. The overall complications rates were low, with implant loss and infection less than 2% in 249 cases. The authors recommended use of acellular dermal matrix in breast reconstruction and product selection based on price and availability.

Pittman et al (2017) compared the clinical outcomes between available acellular dermal matrixes DermACELL and AlloDerm RTU. A retrospective chart review was performed on 58 consecutive patients (100 breasts) reconstructed with either DermACELL(n=30 patients; 50 breasts) or AlloDerm RTU (n=28 patients; 50 breasts). The mastectomies were performed by three different breast surgeons. All reconstructions were performed by the same Plastic surgeon (TAP). Statistical analysis was performed by Fisher's exact test. The average age, BMI, percent having

neo-djuvant/adjuvant chemotherapy or breast irradiation, and numbers of therapeutic and prophylactic mastectomies between the two groups was not statistically significant (p<0.05). Complications in both cohorts of patients were clinically recorded for 90 days post immediate reconstruction. The authors reported that, when comparing outcomes, patients in the DermACELL group had significantly less incidence of 'red breast' (0% vs 26%, p=0.0001) and fewer days before drain removal(15.8 vs 20.6, p=0.017). No significant difference was seen in terms of seroma, hematoma, delayed healing, infection, flap necrosis, and explantation.

Expander-Implant Breast Reconstruction:

Chen and associates (2016) noted that immediate expander-implant breast reconstruction (EIBR) with external beam radiation therapy (XRT) is pursued by many breast cancer patients; however, there is still a lack of consensus on the expected clinical outcomes. These researchers performed a critical analysis of post-operative outcomes in EIBR patients with XRT exposure through a retrospective review from January 2007 to December 2013. Patients were stratified into 3 groups: (i) exposure to pre-operative XRT (XRT-pre), (ii) post-operative XRT (XRT-post), or (iii) no XRT (control). A subset of XRT patients with bilateral EIBR was assessed using a matched-pair analysis with the patients serving as their own controls. A total of 76 patients were included in the study. Major complications were observed in 6 of 8, 26 of 38, and 14 of 30 patients in the XRT-pre, XRT-post, and control groups, respectively, and were not statistically different ($p > 0.05$). Failure rates of EIBR were 13.3 % in the control group compared to 50.0 % in the XRT-pre group ($p = 0.044$) and 26.3 % in the XRT-post group ($p > 0.05$). In the matched-pair analysis, 16 of 26 irradiated breasts developed complications compared to only 7 of 26 contralateral non-irradiated breasts ($p = 0.043$). The authors detected a significantly increased risk of complications in patients with pre-mastectomy radiotherapy. Patients with this history of XRT should strongly consider autologous reconstruction instead of EIBR to avoid the high risk of developing complications and subsequently losing their implant. They stated that increased complications in irradiated breasts when compared to the contralateral non-irradiated breasts in bilateral EIBR patients confirmed the detrimental role of XRT in the setting of EIBR.

Nipple Reconstruction:

Winocour and colleagues (2016) stated that many techniques have been described for nipple reconstruction, with the principal limitation being excessive loss of projection. The ideal reconstructed nipple provides sustained projection, the fewest complications, and high levels of patient satisfaction. A variety of materials are available for projection augmentation, including autologous, allogeneic, and synthetic materials. To date, there has been no systematic review to study the efficacy, projection, and complication rates of different materials used in nipple reconstruction. Medline, Embase, and PubMed databases were searched, from inception to August of 2014, to identify literature reporting on outcomes of autologous, allogeneic, and

August of 2014, to identify literature reporting on outcomes of autologous, allogeneic, and synthetic grafts in nipple reconstruction. Retrospective and prospective studies with controlled and uncontrolled conditions were included. Studies reporting the use of autologous flap techniques without grafts and articles lacking post-operative outcomes were excluded. Study quality was assessed using the Newcastle-Ottawa Scale. A total of 31 studies met the inclusion criteria. After evidence review, 1 study represented 2 of 9 stars on the Newcastle-Ottawa Scale, 2 studies represented 3 stars, 6 studies represented 4 stars, 7 studies represented 5 stars, 11 studies represented 6 stars, and 4 studies represented 7 stars. The authors concluded that the findings of this review revealed heterogeneity in the type of material used within each category and inconsistent methodology used in outcomes assessment in nipple reconstruction. Overall, the quality of evidence was low. Synthetic materials had higher complication rates and allogeneic grafts had nipple projection comparable to that of autologous grafts. They stated that further investigation with high-level evidence is needed to determine the optimal material for nipple reconstruction.

CPT Codes / HCPCS Codes / ICD-10 Codes

Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by "+":

Code	Code Description
CPT codes covered if selection criteria are met:	
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
11921	6.1 to 20.0 sq cm
+ 11922	each additional 20.0 sq cm (List separately in addition to code for primary procedure)
11970	Replacement of tissue expander with permanent prosthesis
11971	Removal of tissue expander(s) without insertion of prosthesis
15877	Suction assisted lipectomy; trunk
19316	Mastopexy
19318	Reduction mammaplasty
19324	Mammaplasty, augmentation; without prosthetic implant
19325	with prosthetic implant
19328	Removal of intact mammary implant

Code	Code Description
19330	Removal of mammary implant material
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19350	Nipple/areola reconstruction
19355	Correction of inverted nipples
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
19361	Breast reconstruction with latissimus dorsi flap, without prosthetic implant
19364	Breast reconstruction with free flap
19366	Breast reconstruction with other technique
19367	Breast reconstruction with transverse rectus abdominus myocutaneous flap (TRAM), single pedicle, including closure of donor site;
19368	with microvascular anastomosis (supercharging)
19369	Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site

19370	Open periprosthetic capsulotomy, breast
19371	Periprosthetic capsulectomy, breast
19380	Revision of reconstructed breast
19396	Preparation of moulage for custom breast implant
Other CPT codes related to the CPB:	
19120 - 19126	Excision lesion of breast
19300 - 19307	Mastectomy procedures
21740 - 21743	Reconstructive repair of pectus excavatum or carinatum
HCPCS codes covered if selection criteria are met:	
C1781	Mesh (implantable) [Cortiva]
C1789	Prosthesis, breast (implantable)
L8600	Implantable breast prosthesis, silicone or equal
Q4116	Alloderm, per square centimeter
Q4122	DermACELL, per sq cm

Code	Code Description
Q4128	Flex HD, Allopatch HD, or Matrix HD, per square centimeter
Q4130	Strattice TM, per sq cm
S2066	Breast reconstruction with gluteal artery perforator (GAP) flap, including harvesting of the flap, microvascular transfer, closure of donor site and shaping the flap into a breast, unilateral
S2067	Breast reconstruction of a single breast with "stacked" deep inferior epigastric perforator (DIEP) flap(s) and/ or gluteal artery perforator (GAP) flap(s), including harvesting of the flap(s), microvascular transfer, closure of donor site(s) and shaping the flap into a breast, unilateral
S2068	Breast reconstruction with deep inferior epigastric perforator (DIEP) flap or superficial inferior epigastric artery (SIEA) flap, including harvesting of the flap, microvascular transfer, closure of donor site and shaping the flap into a breast, unilateral
HCPCS codes not covered for indications listed in the CPB:	
C9358	Dermal substitute, native, non-denatured collagen, fetal bovine origin (surgimend collagen matrix), per 0.5 square centimeters
C9360	Dermal substitute, native, non-denatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters
Other HCPCS codes related to the CPB:	
L8020 - L8039	Breast prostheses
ICD-10 codes covered if selection criteria are met:	
C50.011 - C50.929	Malignant neoplasm of breast
C79.81	Secondary malignant neoplasm of breast
D05.00 - D05.92	Carcinoma in situ of breast
N60.11 - N60.19	Diffuse cystic mastopathy [severe fibrocystic disease]
Z85.3	Personal history of malignant neoplasm of breast
Z90.10 - Z90.13	Acquired absence of breast [following medically necessary mastectomy or lumpectomy resulting in significant deformity]

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Breast Reduction Surgery and Gynecomastia Surgery

Clinical Policy Bulletins | Medical Clinical Policy Bulletins

Number: 0017

Policy

Reduction Mammoplasty:
Aetna considers breast reduction surgery cosmetic unless breast hypertrophy is causing significant pain, paresthesias, or ulceration (see selection criteria below). Reduction mammoplasty for asymptomatic members is considered cosmetic.

Aetna considers breast reduction surgery medically necessary for non-cosmetic indications for women aged 18 or older or for whom growth is complete (i.e., breast size stable over one year) when *any* of the following criteria (I, II, or III) is met:

I. Macromastia: *all* of the following criteria must be met:

A. Member has persistent symptoms in at least 2 of the anatomical body areas below, directly attributed to macromastia and affecting daily activities for at least 1 year:

- Headaches
- Pain in neck
- Pain in shoulders
- Pain in upper back
- Painful kyphosis documented by X-rays

Policy History

Last Review

02/14/2018

Effective: 10/06/1995

Next Review: 01/10/2019

Review History

Definitions

Additional Information

Clinical Policy Bulletin Notes

- Pain/discomfort/ulceration from bra straps cutting into shoulders
- Skin breakdown (severe soft tissue infection, tissue necrosis, ulceration, hemorrhage) from overlying breast tissue
- Upper extremity parasthesias;

and

B. *All* of the following criteria are met:

1. Photographic documentation confirms severe breast hypertrophy; *and*

   a. There is a reasonable likelihood that the member's symptoms are primarily due to macromastia; *and*
   b. Reduction mammoplasty is likely to result in improvement of the chronic pain; *and*
   c. Pain symptoms persist as documented by the physician despite at least a 3-month trial of therapeutic measures such as:

      - Analgesic/non-steroidal anti-inflammatory drugs (NSAIDs) interventions and/or muscle relaxants
      - Dermatologic therapy of ulcers, necrosis and refractory infection
      - Physical therapy/exercises/posturing maneuvers
      - Supportive devices (e.g., proper bra support, wide bra straps)
      - Chiropractic care or osteopathic manipulative treatment
      - Medically supervised weight loss program
      - Orthopedic or spine surgeon evaluation of spinal pain;

   and

2. Women 40 years of age or older are required to have a mammogram that was negative for cancer performed within the two years prior to the date of the planned reduction mammoplasty;

and

C. The surgeon estimates that at least the following amounts (in grams) of breast tissue, not fatty tissue, will be removed from each breast, based on the member's body surface area (BSA) calculated using the Mosteller formula:

Table: Weight of breast tissue removed, per breast, as a function of body surface area

Body Surface Area (m^2)	Weight of tissue removed per breast (grams)
1.40	324
1.41	330
1.42	335
1.43	340
1.44	350
1.45	355
1.46	360
1.47	365
1.48	375
1.49	380
1.50	385
1.51	395
1.52	400
1.53	405
1.54	415
1.55	420
1.56	430
1.57	435
1.58	445
1.59	455
1.60	460
1.61	470
1.62	480
1.63	485
1.64	495
1.65	505
1.66	510
1.67	520

Body Surface Area (m^2)	Weight of tissue removed per breast (grams)
1.68	530
1.69	540
1.70	550
1.71	560
1.72	570
1.73	580
1.74	590
1.75	600
1.76	610
1.77	620
1.78	635
1.79	645
1.80	655
1.81	665
1.82	680
1.83	690
1.84	705
1.85	715
1.86	730
1.87	740
1.88	755
1.89	770
1.90	780
1.91	795
1.92	810
1.93	825
1.94	840
1.95	855
1.96	870
1.97	885

Body Surface Area (m^2)	Weight of tissue removed per breast (grams)
1.98	900
1.99	915
2.00	935
2.01	950
2.02	965
2.03	985
2.04	1000
2.05	1000
2.06	1000
2.07	1000
2.08	1000
2.09	1000
2.10	1000
2.11	1000
2.12	1000
2.13	1000
2.14	1000
2.15	1000
2.16	1000
2.17	1000
2.18	1000
2.19	1000
2.20	1000

To calculate body surface area (BSA) see:

BMI and BSA (Mosteller) Calculator (https://qxmd.com/calculate/calculator_28/bmi-and-bsa-mosteller)

OR

BSA (m2) = ([height (in) x weight (lb)]/3131)^{½} (^{½} denotes square root)

BSA (m^2) = ([height (cm) x weight (kg)]/3600)^{½} (^{½} denotes square root)

Note: Breast reduction surgery will be considered medically necessary for women meeting the symptomatic criteria specified above, regardless of BSA, with more than 1 kg of breast tissue to be removed per breast.

Note: Chronic intertrigo, eczema, dermatitis, and/or ulceration in the infra-mammary fold in and of themselves are not considered medically necessary indications for reduction mammoplasty. The condition not only must be unresponsive to dermatological treatments (e.g., antibiotics or antifungal therapy) and conservative measures (e.g., good skin hygiene, adequate nutrition) for a period of 6 months or longer, but also must satisfy criteria stated in section I above.

Aetna considers liposuction-only reduction mammaplasty experimental and investigational because of insufficient evidence of its effectiveness.

II. Gigantomastia of Pregnancy:

The member has gigantomastia of pregnancy accompanied by *any* of the following complications, and delivery is not imminent:

- Massive infection;
- Significant hemorrhage;
- Tissue necrosis with slough;
- Ulceration of breast tissue.

III. Asymmetry:

For medical necessity criteria for surgery to correct breast asymmetry, see CPB 0185 - Breast Reconstructive Surgery (../100_199/0185.html).

Gynecomastia Surgery:

Aetna considers breast reduction, surgical mastectomy or liposuction for gynecomastia, either unilateral or bilateral, a cosmetic surgical procedure. Medical therapy should be aimed at correcting any reversible causes (e.g., drug discontinuance). Furthermore, there is insufficient evidence that surgical removal is more effective than conservative management for pain due to

evidence that surgical removal is more effective than conservative management for pain due to gynecomastia.

See also CPB 0031 - Cosmetic Surgery (0031.html), and
CPB 0185 - Breast Reconstructive Surgery (../100_199/0185.html).

Background

Reduction Mammaplasty

Reduction mammoplasty or breast reduction surgery reduces the volume and weight of the female breasts by removing excess fat, glandular tissue and skin. The goals of the surgery are to relieve symptoms caused by heavy breasts, to create a natural, balanced appearance with normal location of the nipple and areola, to maintain the capacity for lactation and allow for future breast exams/mammograms with minimal scarring or decreased sensation.

The traditional method of breast reduction requires an open incision around the areola extending downward to the crease beneath the breast. The surgeon removes excess tissue, fat and skin before adjusting the placement of the nipple and areola appropriately.

In a liposuction-only reduction mammoplasty, a small access incision is made in one of the following locations: axillary (under the arm), periareolar (around the nipple) or in the inframammary fold (under the breast). Anesthesia may be injected along with saline solution until the tissue is firm, and a suction cannula is used to extract fat from the breast.

Reduction mammaplasty is among the most commonly performed cosmetic procedures in the United States. Reduction mammaplasty performed solely for cosmetic indications is considered by insurers to be not medically necessary treatment of disease and subject to the standard cosmetic surgery plan exclusion.

Reduction mammaplasty has also been used for relief of pain in the back, neck and shoulders. Because reduction mammaplasty may be used for both medically necessary and cosmetic indications, Aetna has set forth above objective criteria to distinguish medically necessary reduction mammaplasty from cosmetic reduction mammaplasty.

Reduction mammaplasty has been performed to relieve back and shoulder pain on the theory that reducing breast weight will relieve this pain. For pain interventions, evidence of effectiveness is necessary from well controlled, randomized prospective clinical trials assessing

effects on pain, disability, and function. Well-designed trials are especially important in assessing pain management interventions to isolate the contribution of the intervention from placebo effects, the effects of other concurrently administered pain management interventions, and the natural history of the medical condition. Because of their inherently subjective nature, pain symptoms are especially prone to placebo effects.

In the case of reduction mammaplasty for relief of back, neck and shoulder pain, Aetna has considered this procedure medically necessary in women with excessively large breasts because it seems logical, even in the absence of firm clinical trial evidence, that this excessive weight would contribute to back and shoulder pain, and that removal of this excessive breast tissue would provide substantial pain relief, reductions in disability, and improvements in function.

The goal of medically necessary breast reduction surgery is to relieve symptoms of pain and disability. If an insufficient amount of breast tissue is removed, the surgery is less likely to be successful in relieving pain and any related symptoms from excessive breast weight (e.g., excoriations, rash).

Insurers have commonly used the amount of breast tissue to be removed as a criterion for evaluating the medical necessity of breast reduction surgery. In a survey of managed care policies regarding breast reduction surgery, Krieger and colleagues reported (2001) found that most of the respondents stated that they use weight of excised tissue as the main criterion for allowing the procedure, with an average cut-off value of 472 grams for a typical woman. Seitchik (1995) reviewed the amount of breast tissue removed from a series of 100 patients that underwent breast reduction surgery. The author average amount of breast tissue removed for women in 5 kg weight bands, ranging from 45-49 kg to 90+ kg. The average amount of breast tissue removed ranged from 430 g per breast to 1.6 kg per breast, with increased body weight associated with an increased amount of breast tissue to be removed. The average amount of tissue removed from an average weight woman (within the 70 to 74.9 kg weight band) in this study was 60 g per breast, with a range of 502 g to 700 g of tissue removed per breast.

Schnur et al (1991) reported on a sliding scale assigns a weight of breast tissue to be removed based on body weight and surface area. The study by Schnur et al was based on a survey of 92 plastic surgeons who reported on their care for 591 patients. Each surgeon who participated in the study reported on the height, weight, and volume of reduction of their last 15 to 20 patients, and each surgeon provided their “intuitive sense” regarding the motivation of each patient for breast reduction surgery. Schnur subsequently refuted the validity of the Schnur sliding scale and stated that the scale should no longer be used as a criterion for the determination of insurance coverage for breast reduction surgery (Nguyen et al, 1999).

Some individuals, however, have argued that reduction mammaplasty may be indicated in any woman who suffers from back and shoulder pain, regardless of how small her breasts are or how little tissue is to be removed (ASPS, 2002). They have argued that removal of even a few hundred grams of breast tissue can result in substantial pain relief. These individuals cite evidence from observational studies to support this position (e.g., Chadbourne et al, 2001; Kerrigan et al, 2001). These studies did not find a relationship between breast weight or amount of breast tissue removed and the likelihood of response or magnitude of relief of pain after reduction mammaplasty.

It is not intuitively obvious, however, that breast weight would substantially contribute to back, neck and shoulder pain in women with normal or small breasts. Nor is it intuitively obvious that removal of smaller amounts of breast tissue would offer significant relief of back, shoulder or neck pain.

Criteria for reduction mammaplasty surgery from the American Society of Plastic Surgeons (ASPS, 2002; ASPS, 2011) states, among other things, that breast weight or breast volume is not a legitimate criterion upon which to distinguish cosmetic from functional indications. This conclusion is based primarily upon the Breast Reduction Assessment of Value and Outcomes (BRAVO) study, which is described in several articles (Kerrigan et al, 2001; Kerrigan et al, 2002;

Collins et al, 2002). There are also several earlier, smaller studies that found reductions in symptoms and improvements in quality of life after reduction mammaplasty (Glatt et al, 1999; Bruhlmann and Tschopp, 1998; Blomqvist et al, 2000; and Behmand et al, 2000).

As explained below, the studies used to support the arguments for the medical necessity of breast reduction surgery are poorly controlled and therefore subject to a substantial risk of bias in the interpretation of results. Furthermore, the lack of an expected "dose-response" relationship between the amount of breast tissue removed and the magnitude of symptomatic relief in these studies raises questions about the validity of these studies and the effectiveness of breast reduction as a method of relieving shoulder and back pain.

A study reporting on a survey of health insurer policies on breast reduction surgery (Nguyen et al, 2004) found that no insurer medical policies could be supported by the medical literature. The authors (Nguyen et al, 2004) argue, based primarily on the results of the ASPS-funded BRAVO study (described below), that (with a single exception) no objective criteria for breast reduction surgery are supportable, including criteria based upon the presence of particular signs or symptoms, requirements based upon breast size or the amount of breast tissue removed, any minimum age limitations, any limitation based upon maximum body weight, requirements for a

trial of conservative therapy, or the exclusion of certain procedures (liposuction). The only criterion that the authors found supportable was a requirement for a pre-operative mammogram for women aged 40 years and older. The authors leave the reader with the conclusion that decisions about the medical necessity of breast reduction surgery in symptomatic women should be left entirely to the surgeon's discretion.

Several important points should be considered in evaluating these challenges to insurers' criteria for breast reduction surgery. First, the opinions and guidelines of medical professional organizations and consensus groups are considered according to the quality of the scientific evidence and supporting rationale. Second, it is the burden of the proponent of an intervention to provide reliable evidence of its effectiveness, not the burden of ones who question the effectiveness an intervention to provide definitive proof of ineffectiveness. Third, reliable evidence is especially important for pain interventions, because of the waxing and waning nature of pain and the susceptibility of this symptom to placebo effects and other biases that may confound interpretation of study results. Fourth, insurers have provided coverage for reduction mammaplasty in women with excessively large breasts; thus, the debate is about the effectiveness of removal of smaller amounts of breast tissue from women whose breast size most persons would consider within the normal range.

The authors of the BRAVO study reached several conclusions about reduction mammaplasty, most notably that breast size or the amount of breast tissue removed does not have any relationship to the outcome of breast reduction surgery (Kerrigan et al, 2002; Collins et al, 2002). The authors reach the remarkable conclusion that a woman with normal sized breasts who has only a few ounces of breast tissue removed is as likely to receive as much benefit from breast reduction surgery as a women with large breasts who has substantially more breast tissue removed. However, the BRAVO study is not of sufficient quality to reach reliable conclusions about the effectiveness of breast reduction surgery as a pain intervention. Although the BRAVO study is described as a controlled study, the "control" group is obtained, not from the same cohort, but from a separate cohort of individuals recruited from newspaper advertisements and solicitations at meetings for inclusion in a study of the population burden of breast hypertrophy; 75 % of this control group were obtained from 2 centers, but the characteristics of those 2 centers were not described. The control group was not followed longitudinally or treated according to any protocol to ensure that they received optimal conservative management; conclusions about the lack of effectiveness of conservative management were based on their responses to a questionnaire about whether subjects tried any of 15 conservative interventions, and whether or not they thought these interventions provided relief of symptoms. Based largely upon these results, Nguyen et al (2004) reached the conclusion that a trial of conservative management is not an appropriate criterion for insurance coverage, even though responses to the BRAVO questionnaire indicated that operative candidates and hypertrophy controls received

at least some pain relief from all of the conservative interventions, and for some conservative interventions, virtually all subjects reported at least some pain relief. In addition, Nguyen et al (2004) ignored a wealth of published evidence of the effectiveness of physical therapy, analgesics and other conservative measures on back and neck pain generally.

The operative group in the BRAVO study was drawn from a number of surgical practices that volunteered to participate in the study; no details are provided about how each center selected candidates for reduction mammaplasty, or how they chose patients who underwent mammaplasty for inclusion in the study. Of 291 subjects who were selected for inclusion in the study, only 179 completed follow-up. Thus, more than 1/3 of operative subjects selected for inclusion in the study did not complete it; most of the operative subjects who did not complete the study were lost to follow-up. Although the BRAVO study nominally included a "control group", there was no comparison group of subjects selected from the same cohort, who were randomized or otherwise appropriately assigned to reduce bias, and treated with conservative management according to a protocol to ensure optimal conservative care. Clinical outcomes were measured by operative subjects' responses to a questionnaire about symptoms and quality of life. The authors stated that operative subjects were told that their responses to the questionnaire were not to be used for insurance and thus the subjects had no motivation to exaggerate symptoms prior to surgery in questionnaire responses; however, it is not clear whether operative subjects would be willing to submit responses to a questionnaire from the doctor that differed substantially from the history that they provided to the doctor during their preoperative evaluation. Although operative subjects were examined before and after surgery, there was no attempt to employ any blinded or objective measures of disability and function to verify these self-reports. Operative subjects who completed the study reported reductions in pain and improvements in quality of life; however, these improvements may be attributable to placebo effects, the natural history of back pain, other concurrent interventions, regression to the mean, improvements in cosmesis (for quality of life measures), or other confounding variables that may bias in interpretation of results. Thus, this study would not be considered of sufficient quality to provide reliable evidence of the effectiveness of a pain intervention.

Other references to smaller studies published prior to the BRAVO study have been cited, examining symptoms before and after reduction mammaplasty; each of these studies suffer from limitations similar to those identified with the BRAVO study. A study by Glatt et al (1999) was a retrospective analysis of responses to questionnaires sent to patients who underwent reduction mammaplasty regarding physical symptoms and body image. Of 110 subjects who were mailed questionnaires, approximately 50 % (61 subjects) provided responses. The investigators found little difference between obese and non-obese women concerning patient's reports of resolution of symptoms and improvement in body image. A study by Bruhlmann and Tschopp (1998) was a retrospective study of 246 patients from a surgical

practice, approximately 50 % (132) of whom returned a questionnaire about their symptoms and satisfaction with aesthetic results, and their recollection of symptoms prior to surgery. It should be noted that this study reported a strong correlation between the amount of tissue removed and pain amelioration. It was also found that only 3 % of subjects reported that they had no aesthetic motivation for surgery. Behmand et al (2000) reported on the results of a questionnaire pre- and post-surgery in 69 subjects from a single practice who underwent reduction mammaplasty. Subjects were compared to age-matched norms from another study cohort. No data were provided on loss to follow-up. The article by Blomqvist et al (2000) is to another questionnaire study about health status and quality of life before and after surgery. Approximately 25 % of the 49 subjects included in this study did not return the post-operative questionnaire. Subjects responses were compared to an age-matched comparison group of women, although no further details about how this comparison group were provided. The investigators reported that subjects who were of normal weight were as likely to report benefit from reduction mammaplasty as subjects who were over-weight.

The studies used to support the arguments for the medical necessity of breast reduction surgery are poorly controlled and therefore subject to a substantial risk of bias in the interpretation of results. Well-designed, prospective, controlled clinical studies have not been performed to assess the effectiveness of surgical removal of modest amounts of breast tissue in reducing neck, shoulder, and back pain and related disability in women. In addition, reduction mammaplasty needs to be compared with other established methods of relieving back, neck and shoulder pain. Well-designed clinical trials provide reliable information about the effectiveness of an intervention, and provide valid information about the characteristics of patients who would benefit from that intervention.

For these reasons, there is insufficient evidence to support the use of reduction mammaplasty, without regard to the size of the breasts or amount of breast tissue to be removed, as a method of relieving chronic back, neck, or shoulder pain.

The American Society of Plastic Surgeons' evidence-based clinical practice guideline on reduction mammaplasty (ASPS, 2011) states that in standard reduction mammaplasty procedures, evidence indicates that the use of drains is not beneficial. However, if liposuction is used as an adjunctive technique, the decision to use drains should be left to the surgeon's discretion.

The American Society for Plastic Surgery (2011) advises to delay surgery until breast growth ceases: “Although waiting may prolong the psychological awkwardness, it is advisable to delay surgery until breast growth ceases in order to achieve the best result.” This is similar to the American College of Obstetricians and Gynaecologists' 2011 Guidelines for Adolescent Health

Care chapter on breast concerns in adolescents, which states regarding breast hypertrophy: "Preferably, treatment should be deferred until breast growth has been completed. If breast growth has been completed, breast reduction surgery is an option." Marshall and Tanner (1969) shows that the final stage of breast maturity occurs about age 15 on average, but there is wide variation. Sabiston's Textbook of Surgery (Burns & Blackwell, 2008) states that breast size should be stable for one year: "There is no set lower age limit but, for the adolescent with breast hypertrophy, reduction is deferred until the breasts have stopped growing and are stable in size for at least 12 months before surgery."

Fischer et al (2014a) evaluated predictors of postoperative complications following reduction mammaplasty using the NSQIP) data sets. The NSQIP recorded two complication types: major complications (deep infection and return to operating room) and any complication (all surgical complications). Preoperative patient factors and comorbidities, as well as intraoperative variables, were assessed. Study subjects included 3538 patients with an average age of 43 years and body mass index of 31.6 kg/m(2) and most patients underwent outpatient surgery (80.5%) with an average operative time of 180 minutes.The incidence of overall surgical complications was 5.1% and the incidence of major surgical complications was 2.1%. The following factors were independently associated with any surgical complications: morbid obesity (odds ratio [OR], 2.1; P < .001), active smoking (OR, 1.7; P < .001), history of dyspnea (OR, 2.0; P < .001), and resident participation (OR, 1.8; P = .01) while factors associated with major complications included active smoking (OR, 2.7; P < .001), dyspnea (OR, 2.6; P < .001), resident participation (OR, 2.1; P < .001), and inpatient surgery (OR, 1.8; P = .01). The authors specified the value of these study results was in the identification of morbid obesity as a significant predictor of overall morbidity and active smoking as a strong predictor of major surgical morbidity.

Karamanos et al (2015) noted that although breast reduction mammoplasty accounts for more than 60,000 procedures annually, the literature remains sparse on outcomes. In this study the National Surgical Quality Improvement Program data set was queried for the Current Procedural Terminology code 19318 from the years 2005 to 2010, with principal outcome measurements of wound complications, surgical site infections, and reoperations. A total of 2779 patients were identified with a mean age of 42.7 (14.1) years and BMI of 31.6 (7.0) kg/m. Tobacco use was shown to have a higher rate of reoperation (p= 0.02) and BMI was identified as an independent risk factor for wound complications (odds ratio, 1.85, P = 0.005). The authors also noted that patients with BMI greater than 40 kg/m were significantly more likely to develop postoperative wound complications (p = 0.02). Karamanos et al (2015) identified their study as the largest sample on breast reduction in the literature, in which age and surgeon specialty did not correlate with negative results. In contrast, tobacco use and BMI were associated with worse breast reduction outcomes.

Nelson et al (2014a) analyzed population data from the 2005-2010 American College of Surgeons National Surgical Quality Improvement Program (NSQIP) database. They investigated effects of age on 30-day surgical outcomes for reduction mammaplasty with a goal of improving patient care, counseling, and risk stratification on 3537 patients. The study subjects were stratified into groups based on ages of <60 years and ≥60 years. Subgroup analysis further stratified the younger cohort into those <50 years and 50-60 years of age. Results illustrated that 3050 patients were <60 years of age (39.7 ± 11.8 years) and 487 were ≥60 years of age (65.1 ± 4.7 years). A total of 182 thirty-day postoperative surgical complications were documented, but stratifying patients into 2 age groups did not reveal an association between age and any surgical complication (P = .26). The authors concluded that with proper patient selection, reduction mammoplasty can be performed safely on older patients.

Nelson et al (2014b) separately conducted a population level analysis of the 2005-2011 NSQIP datasets, identifying patient who underwent reduction mammoplasty, to determine the impact of obesity on early complications after reduction mammaplasty. Data was then analyzed for surgical complications, wound complications, and medical complications within 30 days of surgery on 4545 patients. Within this study population, 54.4% of patients were obese (BMI > 30 kg/m2), of which 1308 (28.8%) were Class I (BMI = 30-34.9 kg/m2), 686 (15.1%) were Class II (BMI = 35-39.9 kg/m2), and 439 (9.7%) were Class III (BMI > 40 kg/m2). The investigators found that comorbid conditions increased across obesity classifications ($p < 0.001$), with significant differences noted in all cohort comparisons except when comparing class I to class II ($p = 0.12$). Early complications were rare (6.1%), with superficial skin and soft tissue infections accounting for 45.8% of complications. Examining any complication, a significant increase was noted with increasing obesity class ($p < 0.001$). This was further isolated when comparing morbidly obese patients to non-obese ($p < 0.001$), class I ($p < 0.001$), and class II ($p = 0.01$) patients. This population-wide analysis - the largest and most heterogeneous study to date - has demonstrated that increasing obesity class is associated with increased early postoperative complications. Morbidly obese patients are at the highest risk, with complications occurring in nearly 12% of this cohort.

Srinivasaiah et al (2014) stated that although reduction mammoplasty has been shown to benefit physical, physiological, and psycho-social health there are recognized complications. The authors recruited 67 consecutive female patients who underwent inferior pedicle reduction mammoplasty in order to determine the effects of resection weight, BMI, age, and smoking on complication rates following reduction mammoplasty. Data were prospectively gathered on complications as a part of randomized control trial (RCT) examining psycho-social & QOL benefits of reduction mammoplasty. Sixteen (23%) patients had complications and higher resection weight, increased BMI, and older age were found to have statistically significant

complication rates with p-values of $p < 0.001$, $p = 0.034$, and $p = 0.004$, respectively. The investigators also found that the incidence of complications was highest among current smokers and lowest among those who had never smoked with a 37% difference in the occurrence of complication ($p < 0.01$). They concluded that higher resection weight, increased BMI, older age, and smoking are risk factors for complication and that patients should therefore be adequately counseled about losing weight and stopping smoking.

Merkkola-von Schantz and colleagues (2017) stated that contralateral reduction mammaplasty is regularly included in the treatment of breast cancer patients. These investigators analyzed the incidence of occult breast cancer and high-risk lesions in reduction mammaplasty specimens of women with previous breast cancer. They also analyzed if timing of reduction mammaplasty in relation to oncological treatment influenced the incidence of abnormal findings, and compared if patients with abnormal contralateral histopathology differed from the study population in terms of demographics. The study consisted of 329 breast cancer patients, who underwent symmetrizing reduction mammaplasty between 1/2007 and 12/2011. The data were retrospectively analyzed for demographics, operative and histopathology reports, oncological treatment, and post-operative follow-up. Reduction mammaplasty specimens revealed abnormal findings in 68 (21.5 %) patients. High-risk lesions (atypical ductal hyperplasia [ADH], atypical lobular hyperplasia [ALH], and lobular carcinoma in situ [LCIS]) were revealed in 37 (11.7 %), and cancer in 6 (1.9 %) patients. Abnormal histopathology correlated with higher age ($p = 0.0053$), heavier specimen ($p = 0.0491$), and with no previous breast surgery ($p < 0.001$). Abnormal histopathological findings were more frequent in patients with reduction mammaplasty performed prior to oncological treatment ($p < 0.001$), and in patients with immediate reconstruction ($p = 0.0064$). The authors concluded that the incidences of malignant and high-risk lesions were doubled compared to patients without prior breast cancer. Patients with abnormal histopathology could not be pre-operatively identified based on demographics. If reduction mammaplasty was performed before oncological treatment, the incidence of abnormal findings was higher. They stated that in the light of these findings, contralateral reduction mammaplasty with histopathological evaluation in breast cancer patients offered a sophisticated tool to catch those patients whose contralateral breast needs increased attention.

Mistry and associates (2017) examined outcomes following breast re-reduction surgery using a random pattern blood supply to the nipple and vertical scar reduction. A retrospective review was conducted of patients who underwent bilateral breast re-reduction surgery performed by a single surgeon over a 12-year period. Patient demographics, surgical technique, and outcomes were analyzed. A total of 90 patients underwent breast re-reduction surgery. The average interval between primary and secondary surgery was 14 years (range of 0 to 42 years). The majority of patients had previously undergone primary breast reduction using an inferior pedicle [n = 37 (41 %)]. Breast re-reduction surgery was most commonly performed using a random

pattern blood supply, rather than recreating the primary pedicle [n = 77 (86 %)]. The nipple-areola complex was re-positioned in 60 % of patients (n = 54). The mean volume of tissue resected was 250 g (range of 22 to 758 g) from the right breast and 244 g (range of 15 to 705 g) from the left breast. Liposuction was also used adjunctively in all cases (average of 455 cc; range, 50 to 1,750 cc). Two patients experienced unilateral minor partial necrosis of the areolar edge but not of the nipple itself (2 %). The authors concluded that breast re-reduction can be performed safely and predictably, even when the previous technique is not known; and 4 key principles were developed: (i) the nipple-areola complex can be elevated by de-epithelialization rather than recreating or developing a new pedicle; (ii) breast tissue is removed where it is in excess, usually inferiorly and laterally; (iii) the resection is complemented with liposuction to elevate the bottomed-out inframammary fold; and (iv) skin should not be excised horizontally below the inframammary fold. Level of Evidence = IV.

Post-Operative Wound Drains in Reduction Mammoplasty

In a Cochrane review, Khan and colleagues (2015) stated that wound drains are often used after plastic and reconstructive surgery of the breast in order to reduce potential complications. However, it is unclear if there is any evidence to support this practice. These researchers compared the safety and effectiveness of the use of wound drains following elective plastic and reconstructive surgery procedures of the breast. For the first update of this review, these investigators searched the Cochrane Wounds Group Specialised Register (searched March 4, 2015); the Cochrane Central Register of Controlled Trials (CENTRAL) (The Cochrane Library 2015, Issue 2); Ovid Medline (2012 to March 3, 2015); Ovid Medline (In-Process & Other Non-Indexed Citations March 3, 2015); Ovid Embase(2012 to March 3, 2015); and EBSCO CINAHL (2012 to March 4, 2015). There were no restrictions on the basis of date or language of publication. Three review authors undertook independent screening of the search results. All RCTs that compared the use of a wound drain with no wound drain following plastic and reconstructive surgery of the breast (breast augmentation, breast reduction and breast reconstruction) in women were eligible. Two review authors undertook independent data extraction of study characteristics, methodological quality and outcomes (e.g., infection, other wound complications, pain, and length of hospital stay [LOS]). Risk of bias was assessed independently by 2review authors. These researchers calculated the risk ratio (RR) for dichotomous outcomes and mean differences (MD) for continuous outcomes, with 95 % confidence intervals (CI). Analysis was on an intention-to-treat basis. A total of 3 RCTs were identified and included in the review out of 190 studies that were initially screened; all evaluated wound drainage after breast reduction surgery. No new trials were identified for this first update. In total there were 306 women in the 3 trials, and 505 breasts were studied (254 drained, and 251 who were not drained). Apart from a significantly shorter LOS for those participants who did

not have drains (MD 0.77; 95 % CI: 0.40 to 1.14), there was no statistically significant impact of the use of drains on outcomes. The authors concluded that the limited evidence available showed no significant benefit of using post-operative wound drains in reduction mammoplasty, although LOS may be shorter when drains are not used. They stated that no data are available for breast augmentation or breast reconstruction, and this requires investigation.

Sugrue and associates (2015) evaluated the current practice patterns of drains usage by plastic and reconstructive and breast surgeons in United kingdom (UK) and Ireland performing bilateral breast reduction (BBR). An 18-question survey was created evaluating various aspects of BBR practice; UK and Irish plastic and reconstructive and breast surgeons were invited to participate by an e-mail containing a link to a web-based survey. Statistical analysis was performed with student t-test and chi-square test. A total of 211 responding surgeons were analyzed, including 80.1 % (171/211) plastic surgeons and 18.9 % (40/211) breast surgeons. Of the responding surgeons, 71.6 % (151/211) routinely inserted post-operative drains, for a mean of 1.32 days. Drains were used significantly less by surgeons performing greater than or equal to 20 BBRs ($p = 0.02$). With the majority of BBRs performed as an inpatient procedure, there was a trend towards less drain usage in surgeons performing this procedure as an out-patient; however, this was not statistically significant ($p = 0.07$). The authors concluded that even with the high level of evidence demonstrating the safety of BBR without drains, they are still routinely utilized. These investigators stated that in an era of evidence-based medicine, surgeons performing breast reductions must adopt the results from scientific research into their clinical practice.

Gynecomastia Surgery

Gynecomastia is a very common concern of male adolescence. Sixty to 70 % of males develop a transient subareolar breast tissue during their adolescence (Tanner Stages II and III). Causes may include testosterone-estrogen imbalance, increased prolactin levels, or abnormal serum binding protein levels.

Gynecomastia has been classified into 2 types. In Type I (idiopathic) gynecomastia, the adolescent presents with a tender, firm mass beneath the areola. Most cases of type I gynecomastia are unilateral, and 20 % of cases are bilateral. Type II gynecomastia is more generalized breast enlargement. Pseudo-gynecomastia refers to excessive fat tissue or prominent pectoralis muscles.

Gynecomastia may be drug-induced. Drugs commonly associated with the development of gynecomastia include amphetamines, marijuana, mebrobamate, opiates, amitriptyline, chlordiazepoxide, chlorpromazine, cimetidine, diazepam, digoxin, fluphenazine, haloperidol, imipramine, isoniazid, mesoridazine, methyldopa, perphenazine, phenothiazines, reserpine, spironolactone, thiethylperazine, tricyclic antidepressants, tirfluoperazine, trimeparazine, busulfan, vincristine, tamoxifen, , methyltestosterone, human chorionic gonadotropins, and

busulfan, vinblastine, tamoxifen, methyltestosterone, human chorionic gonadotrophins, and estrogens. Klinefelter's syndrome, testicular, adrenal, or pituitary tumors, and thyroid or hepatic dysfunction are also associated with gynecomastia.

Henley et al (2007) reported that repeated topical exposure to lavender and tea tree oils may be linked to prepubertal gynecomastia (idiopathic gynecomastia).

Management of gynecomastia should include evaluation, including laboratory testing, to identify underlying etiologies. Work-up of gynecomastia may include the following (GP Notebook, 2003):

- A detailed drug history, including list of medications, an assessment of indirect or environmental exposure to estrogenic compounds, and recreational drug use.
- A detailed physical examination, including testicular examination.
- Liver and thyroid function tests.
- Measurement of plasma gonadotrophins, human chorionic gonadotropin (hCG), testosterone, estradiol, and dehydroepiandosterone sulphate (DHEAS)
- An ultrasound scan of testicular masses
- Computed tomography scan of adrenal glands to identify adrenal lesions.

Treatment should be directed at correcting any underlying reversible causes. If gynecomastia is idiopathic, reassurance of the common, transient and benign nature of the condition should be given. Resolution of idiopathic gynecomastia may take several months to years. In a majority of boys with pubertal gynecomastia, the condition resolves within 18 months. Medical reduction has been achieved with agents such as dihydrotestosterone, danazol, and clomiphene. However, these medications should be reserved for those with no decrease in breast size after 2 years. Surgical removal is rarely indicated and the vast majority of the time is for cosmetic reasons, as there is no functional impairment associated with this disorder.

Many men with breast enlargement are found to have pseudo-gynecomastia. Removing the adipose tissue in pseudogynecomastia usually has no long term effect as adipose tissue reaccumulates unless the individual loses weight. A physician-supervised diet and exercise plan may be indicated in obese patients.

Transient pain that may occur as the breast enlarges and the capsule is stretched; these symptoms may be managed with analgesics. Mental health care professionals may be consulted to address psychological distress from gynecomastia.

In a review on "Surgical treatment of gynecomastia in children and adolescents", Fisher

In a review on "Surgical treatment of primary gynecomastia in children and adolescents", Fischer et al (2014b) concluded that surgical correction of gynecomastia remains a purely elective intervention.

Autologous Platelet Gel During Breast Surgery

In a within-patient, randomized, patient- and assessor-blinded, controlled study, Anzarut et al (2007) evaluated the use of completely autologous platelet gel in 111 patients undergoing bilateral reduction mammaplasty to reduce post-operative wound drainage. Patients were randomized to receive the gel applied to the left or right breast after hemostasis was achieved; the other breast received no treatment. The primary outcome was the difference in wound drainage over 24 hours. Secondary outcomes included subjective as well as objective assessments of pain and wound healing. No statistically significant differences in the drainage, level of pain, size of open areas, clinical appearance, degree of scar pliability, or scar erythema were noted. These investigators concluded that their findings do not support the use of completely autologous platelet gel to improve outcomes after reduction mammaplasty.

Appendix

Drugs associated with gynecomastia:

- Estrogens and estrogen like drugs, including:
  - Diethylstibestrol;
  - Exposure to partners using estrogen containing vaginal creams;
  - Cosmetics containing estrogens
  - Digitoxin
- Drugs that enhance estrogen formation, including:
  - Gonadotrophins such as hCG
  - Following withdrawal of clomiphene
- Drugs which inhibit testosterone synthesis, including
  - Ketoconazole,
  - Metronidazole,
  - Spironolactone,
  - Cancer chemotherapy (alkylating agents, methotrexate, vinca alkaloids, imatinib,

combination chemotherapy)

- Drugs that inhibit testosterone action, including
  - Androgen receptor blockers - bicalutamide
  - 5 α reductase inhibitors - finasteride, dutasteride
  - H2 blockers and proton pump inhibitors
  - Marijuana
- Drugs whose mechanism of action is unknown:
  - Tricyclic antidepressants
  - Angiotensin converting enzyme inhibitors (captopril, enalapril)
  - Heroin
  - Amiodarone
  - Busulfan
  - Methyldopa
  - Captopril
  - Growth hormone
  - Reserpine
  - Highly active antiretroviral therapy
  - Calcium channel blockers (diltiazem, nifedipine, verapamil)
  - Isoniazid

Others situations which can cause or lead to gynecomastia:

- Anabolic steroids (e.g., in body builders)
- Healing balms, scented soaps, skin lotions, shampoos and styling gels containing lavender oil or tea tree oil

Adapted from General Practice Notebook.

American Society of Plastic Surgeons' gynecomastia scale:

- Grade II: Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest.
- Grade III: Moderate breast enlargement exceeding areola boundaries with edges that are indistinct from the chest with skin redundancy present.
- Grade IV: Marked breast enlargement with skin redundancy and feminization of the

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breast.

CPT Codes / HCPCS Codes / ICD-10 Codes

Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by "+".

Code	Code Description
CPT codes covered if selection criteria are met:	
19318	Reduction mammaplasty
CPT codes not covered for indications listed in the CPB:	
15877	Suction assisted lipectomy; trunk
19300	Mastectomy for gynecomastia
Other CPT codes related to the CPB:	
17360	Chemical exfoliation for acne (eg, acne paste, acid)
19301	Mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy)
19316	Mastopexy
77065 - 77067	Diagnostic mammography, including computer-aided detection (CAD) when performed
96567	Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (eg, lip) by activation of photosensitive drug(s), each phototherapy exposure session
96573	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day
98925 - 98929	Osteopathic manipulative treatment
98940 - 98943	Chiropractic manipulative treatment
99450	Basic life and/or disability examination that includes: Measurement of height, weight, and blood pressure; Completion of a medical history following a life insurance pro forma; Collection of blood sample and/or urinalysis complying with "chain of custody" protocols; and Completion of necessary documentation/certificates
Other HCPCS codes related to the CPB:	
G0202 - G0206	Screening and diagnostic mammography
G0447	Weight management classes, non-physician provider, per session

Code	Code Description
S9449	Weight management classes, non-physician provider, per session

ICD-10 codes covered if selection criteria are met:

G56.00 - G56.93	Mononeuropathies of upper limb [upper extremity paresthesia]
I96	Gangrene, not elsewhere classified [tissue necrosis]
L98.491 - L98.494	Non-pressure chronic ulcer of skin of other sites
N62	Hypertrophy of breast [symptomatic-causing significant pain, paresthesias, or ulceration]
N64.89	Other specified disorders of breast [soft tissue infection]

The above policy is based on the following references:

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Cosmetic Surgery

Clinical Policy Bulletins | Medical Clinical Policy Bulletins

Number: 0031

Policy

Introduction

Aetna plans exclude coverage of cosmetic surgery that is not medically necessary, but generally provide coverage when the surgery is needed to improve the functioning of a body part or otherwise medically necessary even if the surgery also improves or changes the appearance of a portion of the body. Additionally, many Aetna plans specify that certain procedures are not considered to be cosmetic surgery (e.g., surgery to correct the result of injury, post-mastectomy breast reconstruction, surgery needed to treat certain congenital defects such as cleft lip or cleft palate). Please check benefit plan descriptions for details.

This policy statement supplements plan coverage language by identifying procedures that Aetna considers medically necessary despite cosmetic aspects, and other cosmetic procedures that Aetna considers not medically necessary. Please note that, while this policy statement addresses many common procedures, it does not address all procedures that might be considered to be cosmetic surgery excluded from coverage. Aetna reserves the right to deny coverage for other procedures that are cosmetic and not medically necessary.

Clinical Statements

The following procedures are considered cosmetic in nature:

Policy History

Last Review

03/16/2018

Effective: 08/03/1995

Next Review: 01/10/2019

Review History

Definitions

Additional Information

Clinical Policy Bulletin Notes

- Aesthetic alteration of the female genitalia (e.g., hymenoplasty, inverted V hoodoplasty, labiaplasty, and mons pubis pexy)
- Aesthetic operations on umbilicus
- Breast augmentation (breast implants and pectoral implants) (for medical necessity criteria for breast reconstruction, see CPB 0185 - Breast Reconstructive Surgery (../100_199/0185.html)) (see also CPB 0142 - Breast Implant Removal (../100_199/0142.html))
- Breast lift (mastopexy)
- Buttock lift or augmentation
- Cheek implant (malar implant/augmentation)
- Chin implant (genioplasty, mentoplasty)
- Correction of diastasis recti abdominis (see CPB 0211 - Abdominoplasty, Suction Lipectomy, and Ventral Hernia Repair (../200_299/0211.html))
- Correction of inverted nipple
- Ear or body piercing
- Electrolysis or laser hair removal

- Excision of excessive skin of thigh (thigh lift, thighplasty), leg, hip, buttock, arm (arm lift, brachioplasty), forearm or hand, submental fat pad, or other areas (see CPB 0211 - Abdominoplasty, Suction Lipectomy, and Ventral Hernia Repair (../200_299/0211.html))
- Gynecomastia surgery (see CPB 0017 - Breast Reduction Surgery and Gynecomastia Surgery (0017.html))
- Intense pulsed light laser for facial redness
- Lacrimal gland resuspension for lacrimal gland prolapse
- Mesotherapy (injection of various substances into the tissue beneath the skin to sculpt body contours by lysing subcutaneous fat)
- Neck Tucks
- Removal of frown lines
- Removal of spider angiomata
- Removal of supernumerary nipples (polymastia)
- Salabrasion
- Selective neurectomy of the gastrocnemius muscle for correction of calf hypertrophy
- Surgery for body dysmorphic disorder

- Surgery to correct moon face
- Surgery to correct tuberous breast deformity
- Surgical depigmentation (e.g., laser treatment) of nevus of Ito or Ota
- Tattoo removal
- Treatment with small gel-particle hyaluronic acid (e.g., Restylane) and large gel-particle hyaluronic acid (e.g., Perlane) to improve the skin's contour and/or reduce depressions due to acne, injury, scars, or wrinkles
- Vaginal rejuvenation procedures (clitoral reduction, designer vaginoplasty, hymenoplasty, re-virgination, G-spot amplification, pubic liposuction or lift, reduction of labia minora, labia majora surgery/reshaping, and vaginal tightening, not an all-inclusive list)

The following procedures are considered medically necessary when criteria are met. The requesting physicians may be required to submit documentation, including photographs, letters documenting medical necessity, chart records, etc.

- Blepharoplasty: Considered medically necessary when criteria in CPB 0084 - Eyelid Surgery (0084.html), are met.
- Breast reduction: Considered medically necessary when criteria in CPB 0017 - Breast Reduction Surgery and Gynecomastia Surgery (0017.html), are met.

- Chemical peels (chemical exfoliation): Considered medically necessary when criteria in CPB 0251 - Dermabrasion, Chemical Peels, and Acne Surgery (../200_299/0251.html) are met.
- Collagen implant (e.g., Zyderm): Considered cosmetic except as a treatment for urinary incontinence when medical necessity criteria in CPB 0223 - Urinary Incontinence (../200_299/0223.html) are met.
- Dermabrasion: Considered medically necessary when criteria in CPB 0251 - Dermabrasion, Chemical Peel, and Acne Surgery (../200_299/0251.html) are met.
- Dermal injections of FDA-approved fillers (e.g., poly-L-lactic acid dermal injection (Sculptra) or calcium hydroxylapatite dermal injection (Radiesse)) for HIV lipoatrophy: Considered medically necessary for treating facial lipodystrophy syndrome due to antiretroviral therapy in HIV-infected persons; considered cosmetic for all other indications. Retreatments with FDA-approved fillers are considered medically necessary for facial lipodystrophy syndrome due to antiretroviral therapy in HIV-infected persons.
- Earlobe repair: Repair (e.g., tear) of a traumatic injury is considered medically necessary. Earlobe repair to close a stretched pierce hole, in the absence of a traumatic injury, is considered cosmetic.

- Excision or shaving of rhinophyma for the treatment of bleeding or infection refractory to medical therapy (i.e. the need for repeated cautery of bleeding telangiectasias or frequent courses of antibiotics for pustular eruptions). Excision or shaving of rhinophyma is considered cosmetic when the afore-mentioned criteria are not met.
- Keloids: Repair of keloids is considered medically necessary if they cause pain or a functional limitation. Note: For repair of keloids that do not cause pain or functional impairment, exceptions to cosmetic surgery exclusion may apply. Please check benefit plan descriptions. See also CPB 0551 - Radiation Treatment for Selected Nononcologic Indications (../500_599/0551.html) .
- Lip surgery: Considered medically necessary for neoplasm or trauma.
- Lipectomy or liposuction and autologous fat grafting are considered medically necessary for breast reconstruction according to the medical necessity criteria in CPB 0185 - Breast Reconstruction Surgery (../100_199/0185.html).
- Lipomas: Excision is considered medically necessary if lipomas are tender and inhibit the member's ability to perform daily activities due to the lipomas' location on body parts that are subject to regular touch or pressure.
- Otoplasty/Pinnaplasty: Considered medically necessary when performed to improve hearing by directing sound in the ear canal, whether the ears are absent or deformed from trauma, surgery, disease, or congenital defect. Otoplasty to correct large or protruding ears (bat ears) is considered cosmetic when the surgery will not improve hearing.
- Panniculectomy: Considered medically necessary when criteria are met, as set forth in CPB 0211 - Abdominoplasty, Suction Lipectomy, and Ventral Hernia Repair (../200_299/0211.html) .
- Phalloplasty for transgender (female to male) surgery: Consideded medically necessary when criteria are met, as set forth in CPB 0615 - Gender Reassignment Surgery (../600_699/0615.html).
- Pulsed-dye laser treatment and excision of port wine stains and other hemangiomas: Considered medically necessary when lesions are located on the face and neck. Also, removal of symptomatic scrotal hemangiomas and symptomatic cavernous hemangiomas is considered medically necessary. See also CPB 0559 - Pulsed Dye Laser Treatment (../500_599/0559.html).
- Rhinectomy: Considered medically necessary for neoplasm or frostbite.
- Rhinoplasty: Considered medically necessary for indications set forth in CPB 0005 - Septoplasty and Rhinoplasty (0005.html).
- Rhytidectomy (including meloplasty, face lift): Considered medically necessary when there is

functional impairment that cannot be corrected without surgery.

- Scar revision: Repair of scars that result from surgery is considered medically necessary if they cause symptoms or functional impairment. Note: Exceptions to cosmetic surgery exclusion may apply to repair of scars that do not cause pain or functional impairment. Please check benefit plan descriptions.
- Septoplasty: Considered medically necessary when criteria are met, as set forth in CPB 0005 - Septoplasty and Rhinoplasty (0005.html).
- Skin tag removal: Considered medically necessary when located in an area of friction with documentation of repeated irritation and bleeding.
- Tattoo: Considered medically necessary in conjunction with reconstructive breast surgery post-mastectomy, and for marking for radiation therapy. See CPB 0185 - Breast Reconstructive Surgery (../100_199/0185.html).
- Ventral hernia repair: Considered medically necessary when criteria are met, as set forth in CPB 0211 - Abdominoplasty, Suction Lipectomy, and Ventral Hernia Repair (../200_299/0211.html)

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Removal of injected silicone

Aetna considers removal of injected silicone experimental and investigational for prevention or treatment of autoimmune disease, including autoimmune/inflammatory syndrome induced by adjuvants (ASIA) syndrome.

Implantation and attachment of prostheses

Note: Most Aetna plans cover prosthetic devices that temporarily or permanently replace all or part of an external body part that is lost or impaired as a result of disease, injury or congenital defect. The surgical implantation or attachment of covered prosthetics is covered, regardless of whether the covered prosthetic is functional (i.e., regardless of whether the prosthetic improves or restores a bodily function). The following surgical implantations are covered when medical necessity criteria for the prosthetic device are met, even though the prosthetic device does not correct a functional deficit.

The following prostheses are considered medically necessary when criteria are met:

- Breast reconstruction: See CPB 0185 - Breast Reconstructive Surgery (../100_199/0185.html).
- Ear (auricular) prostheses: See

CPB 0620 - Facial Prostheses, External (../600_699/0620.html).

- Eye (ocular) prostheses: See CPB 0619 - Eye Prosthesis (../600_699/0619.html).
- Facial prosthesis. See CPB 0620 - Facial Prostheses, External (../600_699/0620.html).
- Hair transplant: Considered medically necessary when performed to correct permanent hair loss that is clearly caused by disease or injury. Hair transplants performed to correct male pattern baldness or age-related hair thinning in women are considered cosmetic
- Testicular prostheses: Considered medically necessary for replacement of congenitally absent testes, or testes lost due to disease, injury, or surgery.

See also the following CPBs that address other procedures that may be considered cosmetic:

- CPB 0050 - Varicose Veins (0050.html)
- CPB 0095 - Orthognathic Surgery (0095.html)
- CPB 0113 - Botulinum Toxin (../100_199/0113.html)
- CPB 0251 - Dermabrasion, Chemical Peels, and Acne Surgery (../200_299/0251.html)
- CPB 0272 - Pectus Excavatum and Poland's Syndrome: Surgical Correction (../200_299/0272.html)
- CPB 0310 - Thoracoscopic Sympathectomy (../300_399/0310.html)
- CPB 0419 - Graves' Ophthalmopathy Treatments (../400_499/0419.html)
- CPB 0422 - Vitiligo (../400_499/0422.html)
- CPB 0427 - Carbon Dioxide Laser for Actinic Lesions and Other Selected Indications (../400_499/0427.html)
- CPB 0547 - Rosacea (../500_599/0547.html)
- CPB 0566 - Strabismus Repair (../500_599/0566.html)
- CPB 0633 - Benign Skin Lesion Removal (../600_699/0633.html).

Background

Mest and Humble (2009) evaluated the long-term safety, duration of effect, and satisfaction with serial injections of poly-l-lactic acid (PLLA) for HIV-associated facial lipoatrophy. In this single-site, open-label, re-treatment study, 65 HIV-positive patients were treated with injectable PLLA every 5 weeks (until optimal re-correction). Presenting degree of lipoatrophy based on the James scale (1 = mild, 4 = severe) was reviewed. Skin thickness was measured at fixed points with calipers. Patients completed a post-retreatment satisfaction questionnaire. Nearly 10 % of patients had persistent correction greater than 36 months, based on patient report. Approximately 50 % required 3 or fewer re-treatments to maintain satisfactory correction

(determined by patient and physician). Milder facial lipoatrophy (james scale score 1 to 2) on initial presentation required fewer re-treatments and had more sustained correction. Time to first re-treatment varied according to James scale score: 1 (21.4 months) and 4 (13.0 months). The majority of patients required or asked for 4 re-treatments or less over a 24-month period. The mean patient satisfaction score was 4.9 (1 = dissatisfied, 5 = very satisfied) at study end. No serious adverse events were reported. The authors concluded that injectable PLLA is a safe and effective long-term treatment option for HIV-associated lipoatrophy.

The cosmetic surgery exclusion precludes payment for any surgical procedure directed at improving appearance. The condition giving rise to the patient's pre-operative appearance is generally not a consideration. The only exception to the exclusion is surgery for the prompt repair of an accidental injury or for the improvement of a malformed body member which coincidentally serves some cosmetic purpose. Since surgery to correct a condition of "moon face" which developed as a side effect of cortisone therapy does not meet the exception to the exclusion, it is not covered under Medicare (§1862(a)(10) of the Act).

An UpToDate review on “Overview of breast disorders in children and adolescents” (Banikarim and De Silva, 2012) states that “Tuberous breast is a variant of breast development in which the base of the breast is limited and the nipple and areola are overdeveloped. The etiology is unknown. If the breast examination is otherwise normal, the patient may be referred for

cosmetic surgery. The available surgical options vary depending on the location of the hypoplastic breast tissue …. Teenagers may seek breast augmentation for reconstructive purposes related to congenital defects (e.g., amastia, severe breast asymmetry, tuberous breast) or for purely aesthetic reasons”.

Fodd and Drug Administration-approved for the correction of moderate-to-severe facial wrinkles and folds, small gel-particle hyaluronic acid (SGP-HA, Restylane, Medicis Aesthetics, Inc., Scottsdale, AZ) and large gel-particle hyaluronic acid (LGP-HA, Perlane, Medicis Aesthetics, Inc., Scottsdale, AZ) were studied to evaluate their safety for the correction of oral commissures, marionette lines, upper perioral rhytides and naso-labial folds (NLFs). Brandt et al (2011) examined the safety of SGP-HA and LGP-HA in treating facial wrinkles and folds around the mouth; the secondary objective was to evaluate the effectiveness of these products. This open-label, 4-week study at 2 U.S. centers evaluated SGP-HA and LGP-HA in patients who intended to undergo intradermal injection for correction of perioral wrinkles and folds. At screening, a 5-grade Wrinkle Severity Rating Scale (WSRS) was used to evaluate the baseline appearance of bilateral NLFs, and a 6-grade Wrinkle Severity (WS) scale was used to evaluate the appearance of bilateral oral commissures, marionette lines and upper perioral rhytides. To qualify, each patient must have had moderate-to-severe wrinkles at 1 pair of marionette lines and upper

perioral rhytides. Each wrinkle was treated to optimal correction with either SGP-HA or LGP-HA at the discretion of the treating investigator. All reported local and systemic adverse events (AEs) were recorded. At 2 weeks after treatment or touch-up, the treating investigator and the patient assessed appearance using the Global Aesthetic Improvement Scale (GAIS). A total of 20 patients with a mean age of 59.6 years (range of 49 to 65) were treated with an average of 5.58 +/- 1.15 ml of HA for the entire perioral area. Treatment areas included NLFs, marionette lines, oral commissures and perioral rhytides; 18 of 20 patients received both SGP-HA and LGP-HA. Product was injected into the mid or deep dermis using primarily linear threading and multiple punctate pools. Patients experienced a total of 66 treatment-emergent AEs (TEAEs); each patient experienced at least 1 TEAE. The reported events in decreasing order of occurrence were bruising, tenderness, swelling, redness, headache and discomfort. Bruising was more common in the NLFs and marionette lines than in the oral commissures and perioral rhytides. Tenderness occurred more often in the perioral rhytides than in the other areas. The maximum intensity of all TEAEs was considered mild. Most TEAEs resolved within 7 days, with an average duration of 4 days. No serious TEAEs occurred during the study; 100 % of GAIS evaluations by both investigators and patients indicated improvement, regardless of filler used or area treated. The authors concluded that both SGP-HA and LGP-HA were found to be safe and effective for the correction of perioral wrinkles and folds, with few differences among treatment areas. Both investigator and patient GAIS evaluations indicated aesthetic improvement after SGP-HA and LGP-HA treatment in the perioral area.

Cohen et al (2013) systematically reviewed published evidence for aesthetic use of SGP-HA and LGP-HA. Clinical data on anatomic area, level of evidence, patient population, trial design, endpoints, efficacy, and safety were extracted from PubMed. A total of 53 primary clinical reports were analyzed. The highest-quality efficacy evidence was for the NLFs, with 10 randomized, blind, split-face, comparative trials. Several randomized, blind trials supported treatment of the glabella, lips, and hands. Lower-level evidence (from studies with non-randomized, open-label, or retrospective designs) was recorded for the naso-jugal folds (tear troughs), upper eyelids, nose, infra-orbital hollows, oral commissures, marionette lines, perioral rhytides, temples, and cheeks. Common AEs across anatomic areas were pain, bruising, swelling, and redness. Serious AEs were uncommon (8 events in 8 patients of 4,605 total patients) and were considered to be unrelated (7 events) or probably unrelated (1 event) to treatment. The authors concluded that the safety and effectiveness of SGP-HA and LGP-HA are well-established for NLFs; evidence for the glabella, lips, and hands is more limited. Preliminary reports in other anatomic regions suggested effectiveness without major complications.

While products containing a hyaluronic acid gel (e.g., Perlane and Restylane) are available to improve the contours of the skin, the presence of depressions and/or wrinkles is not a functional impairment. Thus, the use of SGP- HA and LGP-HA for improvement of the skin's contour

and/or reduce depressions due to acne, injury, scars, or wrinkles is cosmetic.

Aesthetic Alteration of the Female Genitalia:

Triana and Robledo (2015) noted that aesthetic surgery of the external genitalia in women encompasses many procedures and may address the labia minora, clitoral hood, labia majora, mons pubis, or vaginal opening. During the initial evaluation, the surgeon should consider all aspects of the external genitalia to develop an appropriate surgical plan. It may be necessary to perform 2 or more procedures during the same surgical session to achieve the desired aesthetic result. In this continuing medical education (CME) article, these investigators reviewed the literature and summarized the available cosmetic techniques for female external genitalia. Resection of the labia minora has been described in several peer-reviewed reports. They also discussed the procedures and modifications to direct resection, wedge resection, and de-epithelialization of the labia minora. Aesthetic surgery of the clitoral hood may involve straight-line resection, extended wedge resection, or inverted V hoodoplasty. The mons pubis may be treated with mons pubis pexy, wedge resection, or lipo-modeling. The labia majora can be managed with direct resection or lipo-modeling, and hymenoplasty may be performed to correct a wide vaginal opening.

Hunter and associates (2016) stated that aesthetic alteration of the genitalia is increasingly sought by women unhappy with the size, shape, and appearance of their vulva. Although the labia minora are usually the focus of concern, the entire anatomic region -- labia minora, labia majora, clitoral hood, perineum, and mons pubis -- should be evaluated in a pre-operative assessment of women seeking labiaplasty. Labiaplasty is associated with high patient satisfaction and low complication rates. These investigators discussed the 3 basic labia minora reduction techniques -- edge excision, wedge excision, and central de-epithelialization -- as well as their advantages and disadvantages to assist the surgeon in tailoring technique selection to individual genital anatomy and aesthetic desires. The authors presented key points of the pre-operative anatomic evaluation, technique selection, operative risks, peri-operative care, and potential complications for labia minora, labia majora, and clitoral hood alterations, based on a large operative experience. They stated that labiaplasty competency should be part of the skill set of all plastic surgeons.

Selective Neurectomy of the Gastrocnemius Muscle for Correction of Calf Hypertrophy:

Wang and colleagues (2015) stated that liposuction alone is not always sufficient to correct the shape of the lower leg, and muscle reduction may be necessary. These researchers evaluated the outcomes of a new technique of selective neurectomy of the gastrocnemius muscle to

the outcomes of a new technique of selective neurectomy of the gastrocnemius muscle to correct calf hypertrophy. Between October 2007 and May 2010, a total of 300 patients underwent neurectomy of the medial and lateral heads of the gastrocnemius muscle at the Department of Cosmetic and Plastic Surgery, the Second People's Hospital of Guangdong Province (Guangzhou, China) to correct the shape of their lower legs. Follow-up data from these 300 patients were analyzed retrospectively. Cosmetic results were evaluated independently by the surgeon, the patient, and a third party. Pre-operative and post-operative calf circumferences were compared. The Fugl-Meyer motor function assessment was evaluated 3 months after surgery. The average reduction in calf circumference was 3.2 ± 1.2 cm. The Fugl-Meyer scores were normal in all patients both before and 3 months after surgery. A normal calf shape was achieved in all patients; 6 patients complained of fatigue while walking and 4 of scar pigmentation, but in all cases, this resolved within 6 months. Calf asymmetry was observed in only 2 patients. The authors concluded that the findings of this case-series study suggested that neurectomy of the medial and lateral heads of the gastrocnemius muscle may be safe and effective for correcting the shape of the calves. Level of Evidence= V.

Body Dysmorphic Disorder:

Hundscheid and associates (2014) noted that patients suffering from body dysmorphic disorder (BDD) are preoccupied with a slight or imagined defect in appearance. First of all, to review the literature on the prevalence of BDD in cosmetic surgery and thereafter to review the literature on psychiatric co-morbidity and the outcome of surgical interventions. These investigators based their search strategy on Embase, Medline and PubMed, using the search terms "body dysmorphic disorder", "cosmetic surgery", "prevalence", "comorbidity" and "outcome". The search covered English and Dutch literature published after the introduction of BDD in DSM-III-R and before 1 November, 2013. A study of the relevant articles enabled these investigators to access additional articles mentioned in these texts. The initial search strategy turned out to be too narrow. It was therefore broadened to include "body dysmorphic disorder", "cosmetic surgery", and "prevalence". Eventually these researchers included 23 original articles. In 11 of these the prevalence of BDD varied from 3.2 to 53.6 %; 12 articles on psychiatric co-morbidity revealed predominantly mood and anxiety disorders on axis I and cluster C personality disorders on axis II. Only 2 studies reported on the outcome of cosmetic surgery performed on BDD patients; surgical interventions, however, seemed to result in new preoccupations with the prolongation of psychiatric co-morbidity. The authors concluded that BDD is a common psychiatric disorder that could sometimes lead to cosmetic surgery. Moreover, they stated that pre-operative screening of BDD patients is vital so that efficient psychiatric treatment can be initiated and patients are not subjected to surgical interventions that may be ineffective or even harmful.

Bowyer and colleagues (2016) stated that a high proportion of individuals with BDD undergo cosmetic treatments in an attempt to "fix" perceived defect(s) in their physical appearance. Despite the frequency with which such procedures are sought, few studies have prospectively examined the outcomes of cosmetic procedures in individuals with BDD. These investigators reviewed the literature and discussed the current debate that exists on outcomes of cosmetic treatment for individuals with BDD. An emerging literature suggests the majority of individuals with BDD have poor outcomes after cosmetic interventions; however, based on the current literature, it cannot be fully ruled out that certain individuals with mild BDD and localized appearance concerns may benefit from these interventions. The authors noted that gaps in the current literature were highlighted, alongside recommendations for future research. They stated that carefully conducted longitudinal studies with well-characterized patient populations are needed.

Sweis and co-workers (2017) noted that BDD is an often under-recognized yet severe psychiatric illness. There is limited guidance for plastic surgeons in the U.S. in how to recognize and manage patients with BDD and protect themselves from potential litigation and harm. Therefore, in collaboration with legal counsel, these investigators reminded their profession of the serious nature of patients with BDD, provided warning signs for recognizing BDD, and critically evaluated the validity of informed consent and the legal ramifications of operating on such patients in this country. These investigators performed a literature review to define the psychopathology of BDD and identify cases of patients with BDD who underwent cosmetic surgery resulting in potential threats to the surgeon. They also carried out an additional search of the legal literature in collaboration with legal counsel to identify key cases of patients with BDD attempting litigation following cosmetic surgery procedures. The diagnostic criteria and psychopathology of BDD were presented. Warning signs were highlighted to alert the plastic surgeon to patients at high risk for BDD. Strategies for legal protection include a pre-procedure check-list for patients who were suspected of having a BDD diagnosis. The authors concluded that BDD is prevalent in the cosmetic surgery population. Patients with BDD often have a poor outcome following aesthetic surgery, which can result in a dangerous or even deadly situation for the surgeon. The authors aimed to remind aesthetic plastic surgeons of the psychopathology, severity, and specific risks associated with operating on patients with BDD while suggesting specific protective strategies.

Surgical Removal of Silicone

Levy and Emer (2012) stated that various modalities including systemic and intralesional corticosteroids, minocycline, anti-tumor necrosis factor antibodies or surgical removal can be employed to treat silicone granuloma formation.

Park, et al. (2016) reviewed the management of silicone granulomas. The authors stated that

Park, et al. (2010) reviewed the management of silicone granulomas. The authors stated that a diverse spectrum of therapies has been utilized to treat silicone granulomas and some may resolve spontaneously, but most are excised surgically or given pharmacological therapy with varying success. The authors stated that surgical excision may be employed, but silicone is a permanent filler and is known to migrate to other areas of the body, making complete removal of the injected material impossible. They noted that this may lead to even more disfigurement, making it an unlikely treatment option particularly for facial granulomas.

Lopiccolo, et al. (2011) reviewed the management of silicone granulomas after soft tissue injection of the buttocks. The authors noted that the treatment of silicone granulomas can be challenging, and a number of modalities have been implemented with varying degrees of success. Surgical
excision was attempted in three reported cases. Two of the three resulted in complete resolution. The granulomas involved in both of these cases were well-circumscribed nodular lesions. In the case that did not result in complete resolution, adequate surgical margins could not be achieved because of the unknown extent of the granulomatous reaction.

CPT Codes / HCPCS Codes / ICD-10 Codes

Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by "+".

Code	Code Description
CPT codes covered if selection criteria are met:	
11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions [not covered for more than 15 lesions and billed with +11201]
11300 - 11313	Shaving of epidermal or dermal lesions
11400 -11446	Excision of benign lesions
11920 - 11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation
11950 - 11954	Subcutaneous injection of filling material (e.g., collagen)
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips, and/or mucous membranes; 2.5 cm or less
12051	Layer closure of wounds of face, ears, eyelids, nose, lips, and/or mucous membranes; 2.5 cm or less
15220 - 15221	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs

Code	Code Description
15780 - 15782	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis); segmental, face; or regional, other than face
15788 - 15793	Chemical peel
15820 - 15823	Blepharoplasty
15830	Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen infraumbilical panniculectomy [documentation required] [not covered for aesthetic operations on umbilicus]
15840 - 15845	Graft for facial nerve paralysis
15877	Suction assisted lipectomy; trunk [covered for medically necessary breast reconstruction and hyperhidrosis only]
17106 - 17108	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique)
17360	Chemical exfoliation for acne (e.g., acne paste, acid)
19318 - 19350, 19357 - 19396	Repair and/or reconstruction of breast [except breast lift (mastopexy)] [not covered to repair tuberous breast deformity]
20926	Tissue grafts, other (eg, paratenon, fat, dermis) [covered for medically necessary breast reconstruction only]
21740 - 21743	Reconstructive repair of pectus excavatum or carinatum

30120	Excision or surgical planing of skin of nose for rhinophyma
30150	Rhinectomy; partial
30160	Rhinectomy; total
30420, 30435, 30450, 30460, 30462	Rhinoplasty
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
37785	Ligation, division, and/or excision of varicose vein cluster(s), one leg
40500	Vermilionectomy (lip shave), with mucosal advancement
40510	Excision of lip; transverse wedge excision with primary closure
40520	Excision of lip; V-excision with primary direct linear closure
40525	Excision of lip; full thickness, reconstruction with local flap (eg, Estlander or fan)
[illegible]	Excision of lip, full thickness, reconstruction with cross lip flap (Abbe-Estlander)

Code	Code Description
40527	Excision of lip; full thickness, reconstruction with cross lip flap (Abbe-Estlander)
40530	Resection of lip, more than one-fourth, without reconstruction
51715	Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck
54660	Insertion of testicular prosthesis (separate procedure)
67901 - 67909	Repair of brow ptosis or blepharoptosis
CPT codes not covered for indications listed in the CPB:	
0419T	Destruction neurofibroma, extensive, (cutaneous, dermal extending into subcutaneous); face, head and neck, greater than 50 neurofibroma
0420T	trunk and extremities, extensive, greater than 100 neurofibroma
0437T	Implantation of non-biologic or synthetic implant (eg, polypropylene) for fascial reinforcement of the abdominal wall (List separately in addition to code for primary procedure)
+ 11201	Removal of skin tags, multiple fibrocutaneous tags, any area; each additional ten lesions (List separately in addition to code for primary procedure)
15775 - 15776	Punch graft for hair transplant
15783	Dermabrasion; superficial, any site (e.g., tattoo removal)
15786 - 15787	Abrasion; single lesion (e.g., keratosis, scar); each additional four lesions or less (List separately in addition to code for primary procedure)
15819	Cervicoplasty
15824 - 15829	Rhytidectomy
15832 - 15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy, thigh, leg, hip, buttock, arm, forearm or hand, submental fat pad, or other area
+ 15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g. abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy, head and neck
15878 - 15879	Suction assisted lipectomy; upper and lower extremity
17110	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular

	proliferative lesions; up to 14 lesions
17111	15 or more lesions

Code	Code Description
17380	Electrolysis epilation, each 30 minutes
19120	Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, 1 or more lesions [supernumerary nipples]
19300	Mastectomy for gynecomastia
19316	Mastopexy
19355	Correction of inverted nipples
21120 - 21123	Genioplasty
21125 - 21127	Augmentation, mandibular body or angle; prosthetic material or with bone graft, onlay or interpositional (includes obtaining autograft)
21137 - 21139	Reduction forehead
21270	Malar augmentation, prosthetic material
21280	Medial canthopexy (separate procedure)
21282	Lateral canthopexy
26590	Repair macrodactylia, each digit

27326	Neurectomy, popliteal (gastrocnemius)
30400 - 30410	Rhinoplasty, primary
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
31830	Revision of tracheostomy scar
49250	Umbilectomy, omphalectomy, excision of umbilicus (separate procedure)
49560 - 49561	Repair initial incisional or ventral hernia; reducible, incarcerated or strangulated
49565 - 49566	Repair recurrent incisional or ventral hernia; reducible, incarcerated or strangulated
+ 49568	Implantation of mesh or other prosthesis for incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)
56620	Vulvectomy simple; partial [not covered for cosmetic indications]
56800	Plastic repair of introitus [not covered for cosmetic indications]
56805	Clitoroplasty for intersex state [not covered for cosmetic indications]

Code	Code Description
56810	Perineoplasty, repair of perineum, nonobstetrical (separate procedure) [not covered for cosmetic indications]
57291 - 57292	Construction of artificial vagina; without or with graft [not covered for cosmetic indications]
57335	Vaginoplasty for intersex state [not covered for cosmetic indications]
69090	Ear piercing
69300	Otoplasty, protruding ear, with or without size reduction
HCPCS codes covered if selection criteria are met:	
C9800	Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies
D5914	Auricular prosthesis
D5916	Ocular prosthesis
D7995	Synthetic graft - mandible or facial bones, by report
G0429	Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)
L8000 - L8039	Breast prostheses
L8040 - L8049	Nasal, midfacial, orbital, upper facial, hemi-facial, auricular, partial facial, nasal septal, and maxillofacial prostheses
L8600	Implantable breast prosthesis, silicone or equal
L8603	Injectable bulking agent, collagen implant, urinary tract, 2.5 ml syringe, includes shipping and necessary supplies
L8610	Ocular implant
Q2026	Injection, Radiesse, 0.1 ml
Q2028	Injection, sculptra, 0.5 mg
Q3031	Collagen skin test
S2075	Laparoscopy, surgical; repair incisional or ventral hernia
S2077	Laparoscopy, surgical; implantation of mesh or other prosthesis for incisional or ventral hernia repair (List separately in addition to code for incisional or ventral hernia repair)
V2623 - V2629	Prosthetic eye
HCPCS codes not covered for indications listed in the CPB:	
D5919	Facial prosthesis

D5925	Facial augmentation implant prosthesis
Code	**Code Description**
S8948	Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes
ICD-10 codes covered if selection criteria are met:	
B20	Human immunodeficiency virus [HIV] disease [covered for facial lipodystrophy syndrome due to antiretroviral therapy in HIV-infected persons]
C00.0 - D49.9	Neoplasms [not covered for nevi of Ota and Ito]
E88.1	Lipodystrophy, not elsewhere classified [HIV related]
L57.0	Actinic keratosis
L70.0 - L70.9	Acne
L71.1	Rhinophyma
L74.510 - L74.519	Primary focal hyperhidrosis
L90.8	Other atrophic disorders of skin [wrinkling of skin]
L91.0	Hypertrophic scar [Keloid scar]
L91.8	Other hypertrophic disorders of the skin [wrinkling of skin]
N36.8	Other specified disorders of urethra
N39.3 - N39.9	Urinary incontinence
N39.41 - N39.49, R32	Urinary incontinence
N60.11 - N60.19	Diffuse cystic mastopathy
Q16.0 - Q16.9	Congenital malformations of ear causing impairment of hearing
Q36.0 - Q36.9	Cleft lip
Q82.5	Congenital non-neoplastic nevus
S01.501+ - S01.512+	Unspecified open wound of lip and oral cavity
S01.531+ - S01.552+	Puncture wound of lip and oral cavity without foreign body
S01.90x+ - S01.95x+	Open wound of unspecified part of head
S02.2xx+ -	Fracture of nasal bones

S02.2xx+	
Code	**Code Description**
S09.8xx+ - S09.93x+	Other specified injuries of head
T33.011+ - T34.99x+	Superficial frostbite and frostbite with tissue necrosis
Z21	Asymptomatic human immunodeficiency virus [HIV] infection status [HIV] infection status [covered for facial lipodystrophy syndrome due to antiretroviral therapy in HIV-infected persons]
Z85.3	Personal history of malignant neoplasm of breast
Z90.10 - Z90.13	Acquired absence of breast
ICD-10 codes not covered for indications listed in the CPB:	
F45.22	Body dysmorphic disorder
F52.0 - F52.9 F61.1 - F66	Sexual and gender identity disorders
L68.0 - L68.9	Hirsutism
M04.1 - M04.9	Auto inflammatory syndromes
M35.00 - M35.9	Other systemic involvement of connective tissue [autoimmune disease]

M62.08	Separation of muscle (nontraumatic), other site [diastasis recti]
N64.59	Other signs and symptoms in breast [inverted nipple]
N90.60 - N90.69	Hypertrophy of vulva
O92.011 - O92.03	Retracted nipple associated with pregnancy, the puerperium, and lactation
O92.20 - O92.29	Other and unspecified disorders of breast associated with pregnancy and the puerperium [inverted nipple]
Q67.7	Pectus carinatum
Q83.3	Accessory nipple [supernumerary nipple]

The above policy is based on the following references:

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