IN THE SUPERIOR COURT OF THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

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| THE RETIRED PUBLIC EMPLOYEES OF ALASKA, INC.,<br><br>Plaintiff,<br>v.<br><br>SHELDON FISHER, COMMISSIONER OF THE ALASKA DEPARTMENT OF ADMINISTRATION,<br><br>Defendant. | ) | Case No. 3AN-16-04537 CI |

REEVES AMODIO LLC
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**MOTION FOR PARTIAL SUMMARY JUDGMENT**

Plaintiff RPEA – The Retired Public Employees of Alaska, Inc. – moves pursuant to Alaska Civil Procedure Rule 56(a) for partial summary judgment on the central legal question in this case:

> Are the elective benefits available to a retired public employee, specifically the dental, vision, and audio ("DVA") insurance benefits, subject to the non-diminishment clause of Alaska Constitution Article XII, § 7?

For the reasons set forth in the accompanying memorandum, this court should grant partial summary judgment to RPEA and hold that DVA insurance benefits are protected against diminishment by Article XII, § 7. Partial summary judgment is appropriate because there are no material disputes of fact that need to be resolved before ruling on this point of law, although factual disputes preclude complete summary judgment in favor of RPEA. That is, there is no dispute that defendant Fisher, acting in

his official capacity as the Commissioner of the Department of Administration, implemented changes to retirees' dental insurance coverage effective January 1, 2014.[1] RPEA contends that these changes disadvantage retirees without simultaneously adopting offsetting advantageous changes.[2] Fisher denies that the changes are overall disadvantageous.[3] Thus, if this court determines that DVA insurance benefits are protected constitutionally against diminishment, then the court must resolve the factual question whether the dental benefits have been diminished; additional proceedings will be necessary to resolve that question. The parties have agreed to this bifurcated process – resolving the legal question ahead of the factual questions – because they believe that obtaining a clear answer on the pure legal question will conserve resources and promote judicial efficiency.

Respectfully submitted, this 1st day of June, 2016.

REEVES AMODIO LLC

Susan Orlansky

Susan Orlansky [ABA 8106042]
*Counsel for Plaintiff*

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1 *See* Complaint ¶ 16; Answer ¶ 16.

2 *See* Complaint ¶¶ 17, 18, 24.

3 *See* Answer ¶¶ 17, 18, 24.

**Certificate of Service**

I certify that I caused a copy of the foregoing Motion for Partial Summary Judgment and the accompanying Memorandum, Exhibits, and Proposed Order to be served by hand delivery on:

Jessica Alloway
Attorney General's Office
1031 W. 4th Ave., Suite 200
Anchorage, AK 99501

By: _____

Date: 6.1.16

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**[Proposed]**
**ORDER GRANTING PARTIAL SUMMARY JUDGMENT**

The court has considered the plaintiff's Motion for Partial Summary Judgment, filed on June 1, 2016, the supporting memorandum and exhibits, the defendant's opposition and exhibits, and any reply and oral argument. The court finds that there are no material facts in dispute and that partial summary judgment should be granted in accordance with Alaska Civil Procedure Rule 56(a). Accordingly, the court grants partial summary judgment as requested by plaintiff and declares as follows:

The court finds as a matter of law that retiree dental-vision-audio insurance benefits offered to public employees when they are hired are an accrued benefit within the meaning of Alaska Constitution Article XII, § 7, and accordingly they may not be diminished or impaired.

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Dated at Anchorage, Alaska, this ____ day of _____, 2016.

_____
Gregory Miller
Superior Court Judge

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## MEMORANDUM IN SUPPORT OF MOTION FOR PARTIAL SUMMARY JUDGMENT

### INTRODUCTION

Plaintiff RPEA – The Retired Public Employees of Alaska, Inc. – asks this court to declare that health insurance benefits that public employees may

The Alaska Supreme Court has held unambiguously that the nondiminishment clause in Alaska Constitution Article XII, § 7 protects medical insurance benefits.[1] The language of the Constitution and precedent from the Supreme Court require the same result for elective health insurance benefits, such as dental-vision-audio insurance.

[1] *See Duncan v. Retired Public Employees of Alaska, Inc.*, 71 P.3d 882, 886-89 (Alaska 2003).

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## LEGAL FRAMEWORK:
## ALASKA'S CONSTITUTION PROTECTS PUBLIC EMPLOYEES' RETIREMENT BENEFITS

Article XII, § 7 of the Alaska Constitution states:

> Membership in employee retirement systems of the State or its political subdivisions shall constitute a contractual relationship. Accrued benefits of these systems shall not be diminished or impaired.

The central purpose of the state's public employees' retirement system is "to induce persons to enter and continue in public service."[2] Thus, retirement benefits "are regarded as an element of the bargained-for consideration given in exchange for an employee's assumption and performance of the duties of his employment."[3] Retirement benefits are "in the nature of deferred compensation."[4]

The Supreme Court has held repeatedly that a public employee's benefits "accrue" on the day that he or she is hired.[5] Therefore, the benefits available on the day of hiring are protected against subsequent diminishment.[6] This means that, when an employee retires, he or she must receive all the benefits available at the time of hiring, plus any improvements added during the employee's tenure.[7]

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2 *State v. Allen*, 625 P.2d 844, 846 (Alaska 1981) (internal quotes omitted).

3 *Hammond v. Hoffbeck*, 627 P.2d 1052, 1056 (Alaska 1981).

4 *Id.* at 1057.

5 *See, e.g.*, *Duncan*, 71 P.3d at 886; *Hoffbeck*, 627 P.2d at 1057.

6 *See Duncan*, 71 P.3d at 886; *Hoffbeck*, 627 P.2d at 1057.

7 *See Duncan*, 71 P.3d at 886 ("system benefits offered to retirees when an employee is first employed and as improved during the employee's tenure may not be 'diminished or impaired'"); *Hoffbeck*, 627 P.2d at 1057.

The Court further has made clear that the constitutional protection extends to "*all* retirement benefits that make up the retirement benefit package that becomes part of the contract of employment when the public employee is hired."[8] The constitutional term "accrued benefits" is interpreted broadly.[9] As the Supreme Court observed:

> The term "accrued benefits" is used in article XII, section 7 without limitation, suggesting that whatever benefits might be provided by state retirement systems were meant to be covered.[10]

As a result, the Court in *Duncan v. Retired Public Employees of Alaska, Inc.*, found unequivocally that retirees' medical insurance benefits are a part of a public employee's benefit package, and "the whole package is an element of the consideration that the state contracts to tender in exchange for services rendered by the employee."[11]

The *Duncan* Court specifically rejected the argument that the benefit protected is the premium amount and whatever it will buy, rather than the actual coverage provided by that amount: "The natural and ordinary meaning of 'benefits' in a health insurance context refers to the coverage provided rather than the cost of the insurance."[12] And the Court was unmoved by a policy argument that stressed the rising costs of medical care

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8 *Duncan*, 71 P.3d at 888 (emphasis added); *see also Sheffield v. Alaska Public Employees' Ass'n, Inc.*, 732 P.2d 1083, 1087 (Alaska 1987) (referring to the rights and benefits protected by Article XII, § 7 as the "whole complex of provisions").

9 *See Duncan*, 71 P.3d at 887 ("Our case law suggests that 'accrued benefits' should be defined broadly.").

10 *Id.* at 888.

11 *See id.* at 887.

12 *Id.* at 888-89.

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and medical insurance, saying in essence that economic realities cannot alter the plain meaning of Article XII, § 7.[13] The Court reiterated the holding from its previous case, *Hammond v. Hoffbeck*, that changes in the coverage package are allowed, but only when the benefits provided under the new system are comparable to the benefits under the older system.[14]

The single legal question presented by this motion is whether "elective benefits" – such as DVA insurance coverage, which retirees may select or reject and for which retirees who opt in must pay a monthly premium – are legally the same as other medical insurance benefits and consequently are protected from diminishment, or whether the elective nature of these benefits exempts them from the constitution. Before turning to that analysis, the material undisputed facts should be outlined.

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13 *See id.* at 888.

14 *See id.* at 889; *see also id.* at 892 (reiterating that "equivalent value must be proven by a comparison of the benefits provided – merely comparing old and new premium costs does not establish equivalency"); *Hoffbeck*, 627 P.2d at 1057 ("any changes in the system that operate to a given employee's disadvantage must be offset by comparable new advantages to that employee"). *Duncan* departed from *Hoffbeck* only to the extent of providing that, for health insurance benefits, unlike death and disability benefits, the State may prove equivalence on a *group* basis. *See* 71 P.3d at 891-92. Whether the changed package of DVA benefits is equivalent to the previous package is not at issue in this motion.

## MATERIAL UNDISPUTED FACTS

RPEA believes that the following material facts are undisputed:

Since 1975, the State of Alaska has offered employees major medical insurance as a benefit of state employment.[15] Employees who vest in the system – typically by working for at least five years – are eligible for major medical insurance as retirees.[16] To receive these benefits, retirees must submit a form electing coverage.[17] Retirees may waive the benefit.[18] Most retirees do not pay out-of-pocket for major medical insurance, but some retirees who are eligible to select medical insurance coverage pay for that coverage.[19] The exact package of major medical insurance coverage has changed over time, but, under *Duncan*, the plan available to a retiree may not be less favorable to retirees than the plan that was available to retirees at the time the employee was hired and as improved during the employee's tenure.[20]

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15 *See* Answer ¶ 8. For the current statute, see AS 39.35.535. For a simple summary of retirees' medical benefits and the way the benefit program is implemented for at least some categories of public employees, see Exhibit A (Retirement Application Instruction Booklet) at 8-12. The factual differences among the benefits available to different Tiers of state employees are not relevant to the issues presented in this motion.

16 *See* AS 39.35.370, .535; *see also* Exh. A at 6, 11.

17 *See* AS 39.35.535(c); Exh. A at 17.

18 *See* AS 39.35.510; Exh. A at 17.

19 *See* Answer ¶ 9; Exh. A at 8, 11.

20 *See Duncan*, 71 P.3d at 886-89.

Since 1979, the package of retirement benefits that the State of Alaska has offered its employees also has included the right to elect dental-vision-audio insurance coverage.[21] This coverage is "elective" or "optional," meaning that retirees eligible for the coverage may select it when they retire,[22] and they may discontinue the coverage at any time.[23] The State offers retirees other optional benefits too, including life insurance and long-term care insurance.[24] Retirees who select one or more of the optional insurance benefits pay premiums for these benefits; for most retirees, the premium is deducted from the retiree's monthly retirement payment.[25] The premium is adjusted as needed "to maintain the financial integrity of the plan."[26]

As with the benefits available through the major medical insurance coverage, some benefits provided through the DVA insurance coverage have changed over the years; until

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21 *See* Answer ¶ 8. For the current statute and regulations, see AS 39.30.090(a)(10) and 2 AAC 39.210 *et seq.* For the State's current description of eligibility for these benefits (covering certain categories of public employees), see Exhibit A at 8, 13. *See also, e.g.*, Exh. C (Retiree Insurance Information Booklet, updated 2012) at 3-5.

22 *See* AS 39.30.090(a)(10); 2 AAC 39.220; Exh. A at 13; Exh. C at 5.

23 *See* 2 AAC 39.270; Exh. C at 7.

24 *See* AS 39.30.090(a)(7), (11).

25 *See* AS 39.30.090(a)(8), (10), (11); 2 AAC 39.240; Exh. C at 7. Retirees who elect optional benefits and whose monthly retirement payment does not cover the cost of the premiums must pay the premiums directly to the health plan. *See* 2 AAC 39.240; Exh. A at 8, 18; Exh. C at 7.

26 2 AAC 39.280. Both this regulation and the handbook provided to retirees state that the terms of coverage may be changed. *See id.*; Exh. C at 3. These words do not authorize changes that violate the nondiminishment clause.

recently, the changes have benefited retirees.[27] Prior to 2014, the most recent revision was in 2003. A copy of relevant portions of the retiree handbook, setting forth the key provisions of the DVA insurance coverage as of 2003, is attached as Exhibit C.[28]

In 2013, defendant decided to change the terms of the dental portion of the DVA insurance coverage.[29] The change involved cancelling the then-existing dental insurance plan and replacing it with a different plan provided by Moda Health/Delta Dental of Alaska.[30] The change took effect on January 1, 2014.[31] Differences in coverage in 2014, as compared to 2013 and previous years, include[32]:

- The previous plan covered annual full-mouth x-rays. The Moda plan covers full-mouth x-rays only once in five years.[33]
- The previous plan contained no predetermined limit on the frequency of dental cleanings that could be covered. The Moda plan covers no more than

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27 *Compare, e.g.*, Exh. B (DVA plan in effect in 2000) at 8 *with* Exh. C (DVA plan in effect in 2012) at 10; *compare* Exh. B at 9 *with* Exh. C at 11-13; *compare* Exh. B at 11 *with* Exh. C at 16.

28 Exhibit C is a portion of the Retiree Insurance Information Booklet referred to by the State in its Answer ¶ 15. This is a copy of the booklet printed in 2012; as shown in the footer, the substantive terms were adopted effective May 2003.

29 *See* Answer ¶¶ 16, 17.

30 *See* Answer ¶ 16.

31 *See* Answer ¶ 16; Exh. D (AlaskaCare Retiree Health Plan Amendment 2014-1) at 2.

32 The list here is by no means comprehensive. Because the parties have agreed not to address in the first stage of litigation the question whether the changes constitute a significant diminishment in coverage without corresponding advantages to the plan as a whole, a full discussion of all the changes is not required at this time – and some of the financially most disadvantageous changes are not discussed.

33 *See* Complaint ¶ 17(a); Answer ¶ 17(a); *compare* Exh. C at 15 *with* Exh. D at 9.

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two cleanings per year for most people, and no more than four cleanings per year for patients with diabetes or periodontal disease.[34]

- The previous plan covered topical fluoride treatments without any specified preconditions.[35] The Moda plan does not cover any fluoride treatments for adults unless the patient has a recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment; risk of decay due to poor diet or poor oral hygiene is specifically excluded as a basis for covering fluoride treatments.[36]

- The previous plan covered denture replacements after five years, if the existing dentures could not then be made serviceable. The Moda plan covers denture replacements only after seven years, if the existing dentures cannot then be made serviceable.[37]

- The previous plan covered general anesthesia during any restorative dental procedure when deemed necessary by the dentist. The Moda plan covers general anesthesia only for dental surgical procedures or when necessary due to another medical condition.[38]

- The previous plan covered pulp capping. The Moda plan covers pulp capping only when there is exposure of the pulp.[39]

Although RPEA representatives asked defendant to provide an analysis of the changes to demonstrate whether any enhancements to coverage offset any disadvantages,

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[34] *See* Complaint ¶ 17(b); Answer ¶ 17(b); *compare* Exh. C at 15 *with* Exh. D at 9-10, 14-15.

[35] As with all aspects of the dental insurance previously available, coverage was limited then – as now – to treatments necessary for diagnosis or treatment of a dental condition. *See* Answer ¶ 17(c); *compare* Exh. C at 17 *with* Exh. D at 9.

[36] *See* Complaint ¶ 17(c); Answer ¶ 17(c); *compare* Exh. C at 15 *with* Exh. D at 10.

[37] *See* Complaint ¶ 17(e); Answer ¶ 17(e); *compare* Exh. C at 16 *with* Exh. D at 12.

[38] *See* Complaint ¶ 17(f); Answer ¶ 17(f); *compare* Exh. C at 16 *with* Exh. D at 10, 11.

[39] *See* Complaint ¶ 17(g); Answer ¶ 17(g); *compare* Exh. C at 15 *with* Exh. D at 11.

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defendant has provided no such analysis.[40] Instead, defendant has taken the position that such a showing is not necessary because "[d]ental coverage is not an accrued benefit under the diminishment clause."[41]

## ARGUMENT

### AS A MATTER OF LAW, RETIREES' DVA INSURANCE COVERAGE IS AN ACCRUED BENEFIT PROTECTED AGAINST DIMINISHMENT BY THE ALASKA CONSTITUTION.

RPEA's argument is straightforward: DVA insurance coverage during retirement is one of the benefits made available to state employees when they are hired. Therefore, like other benefits that the Supreme Court has discussed explicitly, DVA coverage is constitutionally protected against being diminished or impaired.[42] In other words, the contract with a state employee hired before January 1, 2014, included the promise that, upon retiring, the employee could select DVA insurance coverage, and that the insurance benefits available at the time of retirement would be equivalent to or better than the benefits available to a retiree at the time the employee was hired.[43]

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40 *See* Complaint ¶ 21; Answer ¶ 21.

41 Exh. E (Defendant's Initial Disclosures) at 1.

42 *See Duncan*, 71 P.3d at 886-89; *Hoffbeck*, 627 P.2d at 1055-57; *see generally supra* at 2-4.

43 *See Duncan*, 71 P.3d at 886 ("system benefits offered to retirees when an employee is first employed *and as improved during the employee's tenure* may not be diminished or impaired") (emphasis added; internal quotes omitted).

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The fact that the benefit is "optional" – i.e., that some retirees select DVA insurance coverage and others choose to forgo it – does not change the legal analysis. The major medical insurance coverage that essentially all public retirees receive is also "optional": an employee may opt not to receive that benefit.[44] And retirees may select different amounts of coverage – for the retiree only, the retiree and a spouse, the retiree and children, or the retiree, spouse, and children.[45] Despite the availability of choices, the Supreme Court still treated medical insurance coverage as an accrued benefit protected by the Constitution.[46] When the Supreme Court discussed the benefits available to a state employee's spouse, in the context of addressing whether the State could discriminate against same-sex couples who could not legally marry, the Court again treated the right to retiree DVA insurance exactly the same as the right to other medical insurance.[47]

One way to see that the "optional" nature of the benefits does not change the law is to consider the most extreme type of diminishment of benefits. Absent protection by the nondiminishment clause, an employee hired in 2003, for example, would be promised the ability to select DVA insurance coverage upon retirement, and then, when the

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44 *See* AS 39.35.510.

45 *See* AS 39.35.535(a); Exh. A at 8-9, 17.

46 *See Duncan*, 71 P.3d at 886-89.

47 *See Alaska Civil Liberties Union v. State*, 122 P.3d 781, 783 n.4 (Alaska 2005) (listing benefits available to an employee's spouse).

employee retired, the State could say, sorry, we no longer offer DVA insurance to our retirees. The employee would have lost one of the benefits promised at the time of hiring, and the employee could be seriously harmed. Without having been promised the ability to select DVA insurance coverage upon retiring, the employee could have planned ahead and saved for purchasing such insurance upon retirement, or the employee could have made certain to obtain all possible dental care while he or she was still employed and covered by the dental plan applicable to active employees.

Nor is the legal analysis altered by the fact that retirees pay a premium for DVA insurance, or that the premium is adjustable.[48] Some retirees also pay premiums for their major medical insurance.[49] The Supreme Court has made clear that what is promised (and is therefore an accrued benefit protected against diminishment) is the scope of coverage, not the cost paid for the coverage.[50] If anything, the adjustable premium undermines the State's argument against application of the nondiminishment clause. To maintain coverage comparable to that promised to employees when they were hired, the State may adjust the premium paid by retirees; if any retiree decides that the increased cost is not warranted by the insurance coverage received, the retiree may opt out of the insurance at that time.[51]

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48 *See* AS 39.30.090(a)(10); 2 AAC 39.280; Exh. A at 8; Exh. C at 3.

49 *See* Exh. A at 11.

50 *See Duncan*, 71 P.3d at 888-89.

51 *See* 2 AAC 39.280; Exh. C at 7.

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In short, DVA insurance benefits are like every other retirement benefit promised to a public employee at the time of hiring. Constitutionally, the benefits are protected against diminishment. This court should declare that, as a matter of law, public employees' DVA insurance coverage is an accrued benefit subject to the nondiminishment clause in Alaska Constitution Article XII, § 7. The scope of DVA insurance coverage available to a retiree at the time the employee is hired must be maintained or improved, and may not be decreased during the employee's tenure or after the employee retires.

The scope of DVA insurance coverage unquestionably changed effective January 1, 2014. The parties dispute whether the changes constituted a diminishment of the benefit, as evaluated under *Duncan*. Additional proceedings will be required to address that fact question.

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## CONCLUSION

This court should grant partial summary judgment to RPEA on the central legal question of this case and should declare that public employees' DVA insurance coverage is an accrued benefit protected by the Alaska Constitution, Article XII, § 7, and accordingly it may not be diminished. The court should set a status conference to discuss the further proceedings necessary to resolve the fact question whether DVA insurance benefits were diminished by the adoption of the Moda plan effective January 1, 2014.

Respectfully submitted, this 1st day of June, 2016.

REEVES AMODIO LLC

Susan Orlansky [ABA 8106042]
*Counsel for Plaintiff*

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**AFFIDAVIT OF COUNSEL**

STATE OF ALASKA )
)ss
THIRD JUDICIAL DISTRICT )

SUSAN ORLANSKY, first being duly sworn, upon oath states:

1. I am counsel of record for the plaintiff in this case. The following statements are based on my first-hand knowledge and are offered to explain and authenticate the exhibits submitted with the plaintiff's Motion for Partial Summary Judgment.

2. Exhibit A is an excerpt from the State of Alaska Public Employees' Retirement System, Tiers I, II and III, Retirement Application Instruction Booklet. I downloaded these pages from the official website of the Department of Administration, Division of Retirement and Benefits during May 2016. The exact web address is: *doa.alaska.gov/drb/pdf/pers/persRetirementApplication.pdf.*

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3. Exhibit B is an excerpt from the State of Alaska, Retiree Group Insurance Information Booklet 2000. I downloaded these pages from a disc I received from counsel for the defendant as part of the Defendant's Initial Disclosures, as indicated by the Bates numbers assigned by the defendant (lower right hand corner of each page).

4. Exhibit C is an excerpt from the AlaskaCare Retiree Insurance Information Booklet, May 2003, as updated in 2012. I downloaded these pages from a disc I received from counsel for the defendant as part of the Defendant's Initial Disclosures, as indicated by the Bates numbers assigned by the defendant (lower right hand corner of each page).

5. Exhibit D is a copy of an email from Michael Barnhill, then Deputy Commissioner of the Department of Administration, followed by excerpts from his attachment of AlaskaCare Retiree Health Plan Amendment No. 2014-1. I downloaded these pages from a disc I received from counsel for the defendant as part of the Defendant's Initial Disclosures. When I printed the pages, the Bates numbers assigned by the defendant failed to print, so I added the hand-printed Bates numbers, copying the numbers assigned by the defendant.

6. Exhibit E is an excerpt from the Defendant's Initial Disclosures.

DATED this 1st day of June, 2016.

Susan Orlansky

REEVES AMODIO LLC
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SUBSCRIBED and SWORN to before me this 1st day of June, 2016.

NOTARY PUBLIC
AMBER FARMER
STATE OF ALASKA
My Commission Expires Oct. 15, 2019

Notary Public in and for Alaska
My Commission Expires: October 15, 2019

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# STATE OF ALASKA

## PUBLIC EMPLOYEES' RETIREMENT SYSTEM

*Tiers I, II and III*
*Retirement Application Instruction Booklet*

Alaska Division of Retirement and Benefits
PERS
PUBLIC EMPLOYEES' RETIREMENT SYSTEM

Alaska Public Employees' Retirement System
Division of Retirement and Benefits
P.O. Box 110203
Juneau, AK 99811-0203
Toll-Free: (800) 821-2251
In Juneau: (907) 465-4460

**Alaska.gov/drb**

PERS035 (April 2016)

*The Alaska Department of Administration complies with Title II of the 1990 Americans with Disabilities Act (ADA). 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.*

# Table of Contents

# *Introduction*

*Congratulations!* You are about to realize your retirement dreams! This packet has been designed to provide the information and forms necessary to apply for and begin receiving your retirement benefits from the Public Employees' Retirement System (PERS).

Your PERS retirement includes both pension and access to health benefits. Please read this information booklet carefully to be sure you understand all the benefit provisions to which you are entitled. Also, make sure you have taken advantage of any claimed service options that might increase your benefit and, most importantly, that you meet retirement eligibility requirements.

## What Tier Am I?

PERS is a four-tier system. Some benefits differ depending on your tier. This packet is intended for Tier I, II, and III **only**. If you are Tier IV, please contact the Division for information applicable to your benefit package. The following table will assist you in determining your tier.

| **Tier I – first entered PERS prior to July 1, 1986** | **Tier II – first entered PERS on or after July 1, 1986, but prior to July 1, 1996** | **Tier III – first entered PERS on or after July 1, 1996, but prior to July 1, 2006** |
|---|---|---|
| Early retirement at age 50. | Early retirement at age 55. | Early retirement at age 55. |
| Normal retirement at age 55 or any age with 30 years of service. | Normal retirement at age 60 or any age with 30 years of service. | Normal retirement at age 60 or any age with 30 years of service. |
| System-paid medical premiums at either early or normal retirement. | System-paid medical premiums at normal retirement age 60 or at any age with 30 years of service. | System-paid medical premiums at normal retirement age 60 with 10 years of credited PERS service or at any age with 30 years of service. |
| Peace Officer/Fire members have system-paid medical premiums at any age with 20 paid-up years of P/F service. | Peace Officer/Fire members have system-paid medical premiums at any age with 25 paid-up years of P/F service. | Peace Officer/Fire members have system-paid medical premiums at any age with 25 paid-up years of P/F service. |
| Average Monthly Salary (AMS) calculated using 3 highest consecutive salary years. | Average Monthly Salary (AMS) calculated using 3 highest consecutive salary years. | Average Monthly Salary (AMS) calculated using 5 highest consecutive salary years for non-police/fire members, 3 highest consecutive for P/F. |
| Geographic differential included in calculation of AMS. | Geographic differential included in calculation of AMS if 50% of service served in area with a differential. | Geographic differential included in calculation of AMS if 50% of service served in area with a differential. |
| Alaska Cost-of-Living Allowance available to eligible members at retirement. | Alaska Cost-of-Living Allowance available to eligible members at age 65. | Alaska Cost-of-Living Allowance available to eligible members at age 65. |
| Eligible for either Ad Hoc or Automatic Post Retirement Pension Adjustment. | Eligible for only Automatic Post Retirement Pension Adjustment. | Eligible for only Automatic Post Retirement Pension Adjustment. |

# *Section I. Minimum Requirements for Pension Benefits*

## Retirement Effective Date

By law, your retirement effective date will be the first of the month after all the following requirements are met:

- You meet the minimum service and age requirements for retirement. **You should not leave employment until you are absolutely certain that you are eligible to retire if you are close to being vested or completing other retirement requirements. It is your responsibility to be sure you are eligible for retirement before you terminate employment.**
- You have terminated employment.

  **Note:** if you terminate your employment on the first day of the month, you will not be appointed to retirement until the following month.
- Your Retirement Application is received by the Division of Retirement and Benefits prior to the date you plan to retire.

## Retirement Eligibility

You reach retirement eligibility by meeting either age or service requirements.

### *Age Requirements*

Under early retirement, your monthly benefit is actuarially reduced based on age by 1/2 percent per month for each month under normal age. The closer you are to normal retirement age, the smaller the reduction. Under normal retirement, your monthly benefit is not reduced.

**Caution:** If you request a refund of your PERS contributions and interest, you will not be eligible for PERS retirement benefits.

### *Service Requirements*

You will be eligible to retire after you reach retirement age and satisfy the following service requirements.

*You must have at least:*

- Five paid-up years of PERS service;
- 60 days of paid-up PERS service per session if you were an employee of the legislature during each of five legislative sessions and you were first hired as a legislative employee before May 30, 1987;
- 80 days of paid-up PERS service if you were an employee of the legislature during each of five legislative sessions and you were first hired under the PERS after May 29, 1987; or
- Two paid-up years of PERS service if you are vested in the Teachers' Retirement System (TRS).

*You may retire at any age and receive a normal (unreduced) benefit if you have:*

- 30 paid-up years of PERS service; or
- 20 paid-up years of PERS service as a peace officer or fire fighter.

Military service performed while not a member of PERS may NOT be used to satisfy the 20 or 30 years needed to retire at any age.

The following types of PERS service may count toward retirement eligibility:

- Permanent full-time and part-time employment with a PERS employer while the employer is participating in the PERS. Some PERS employers have agreed to pay additional contributions to allow employees to receive credit for their earlier service before the employer joined the PERS.
- Part-time State of Alaska service from 1961-1975.
- Earlier service before January 1, 1961.
- Past peace and correctional officer, fire fighter, and special officer service.
- Elected official service.
- Alaska Bureau of Indian Affairs service.
- Service earned while on occupational disability.
- Military service performed under an active call of duty while an active member of PERS.
- Leave Without Pay (LWOP) service after June 13, 1987, while receiving Workers' Compensation.

Accrued LWOP that exceeds 10 working days in any calendar year is not creditable under the PERS.

Military service performed while not a member of PERS that is claimed does not count toward retirement eligibility (vesting), but may increase your PERS service.

In some cases, temporary service may be used for retirement eligibility. Contact the Division for more information.

**It is always a good idea to ask your employer(s) to verify your PERS service before you terminate employment. Verifying your service is especially important if:**

**1) You have worked part-time, or**

**2) You just barely have enough PERS service to retire.**

## Simultaneous PERS and TRS Credit

If you are a member of the PERS and Teachers' Retirement System (TRS) at the same time, you may receive partial credit under both systems. To be eligible, you must be employed at least half-time in both the PERS and the TRS concurrently and you must make the required contributions.

The total combined PERS and TRS credit that you may earn during a school year (July 1 through June 30 of the following year) may not exceed one year.

*Concurrent PERS and TRS Credit:*
If you are a member of the Public Employees' Retirement System (PERS) and the Teachers' Retirement System (TRS) at the same time, you may receive partial credit under both systems. To be eligible, you must be employed at least half-time in both the PERS and TRS concurrently and you must make the required contributions.

*Concurrent Credit Adjustment:*
Credited service that exceeds one year must be adjusted and refunded. To ensure that you understand how the adjustment will affect your service, please contact the Division of Retirement and Benefits.

*Simultaneous PERS and PERS Credit:*
If you are a member of the PERS and you have employment with two or more employers that participate in the PERS, and you are employed in a PERS eligible position, the total combined PERS service may not exceed one year per calendar year.

# *Section IV. Medical Benefits and Optional Dental-Vision-Audio and Long-Term Care Programs*

All tiers must pay a premium for the optional insurance benefits if they are elected. Tier II and Tier III members must pay for medical insurance if elected and are not eligible for system paid benefits.

Premium payments will be deducted from your retirement check each month. If your monthly check is not sufficient to cover the cost of the premiums, you are responsible to pay the premiums directly to the health plan.

You will be sent a *Retiree Direct Bill Health Enrollment* form once you are appointed to retirement. You must submit this form directly to the claims administrator within 60 days of the date you were notified of your right to enroll in this plan. You will receive a monthly bill from the claims administrator. If you do not receive a form, please contact the Division.

If you fail to pay the monthly premiums your insurance benefits will be stopped and you will not be allowed to reinstate them.

Health benefits available from the Alaska Retiree Health Plan include medical, Dental-Vision-Audio (DVA), and Long-Term Care (LTC). Enrollment information and available options are summarized in this section. Please refer to *What Tier Am I?* in the introduction of this booklet to determine your tier for eligibility purposes.

This is only a summary of the benefits available. Complete descriptions are available in the *Retiree Insurance Information* booklet and *Long-Term Care* booklets, available on the Division web site. In the event of a conflict between this information and the plan booklets, the plan booklets will prevail.

## Health Plan – Who May Be Covered

- You.
- Your spouse. You may be legally separated, but not divorced.
- Your children from birth (exclusive of hospital nursery charges at birth and well-baby care) up to 23 years of age *only* if they are:
  - ~ Your natural children, stepchildren, foster children placed through a State foster child program, legally adopted children, children in your physical custody and for whom bona fide adoption proceedings are underway, or children for whom you are the legal, court-appointed guardian. If a child is not your natural born child, please provide a court-certified copy of the adoption paperwork or court orders.
  - ~ Unmarried and chiefly dependent upon you for support; and
  - ~ Living with you in a normal parent-child relationship.
    - o This provision is waived for natural/adopted children of the benefit recipient who are living with a divorced spouse, assuming all other criteria are met.
    - o Only stepchildren living with the retiree more than 50% of the time are covered under this plan.

In accordance with Alaska Statutes 39.35.680(12):

- If your dependent child is age 19 or older, they are required to be registered at, and attending on a full-time basis, an accredited educational or technical institution recognized by the Department of Education and Early Development.

- If your dependent child is age 19 or older and is not a full-time student, then the dependent is eligible for coverage only if he or she is totally and permanently disabled. Please contact the Division for additional information about eligibility, and for information about how to provide proof of your dependent's disability.

Children incapable of employment because of a mental or physical incapacity are covered even if they are past age 23. However, the incapacity must have existed before age 23 and the children must continue to meet all other eligibility criteria. You must furnish the Division with evidence of the incapacity, proof the incapacity existed before age 23, and proof of financial dependency. This proof must be submitted within 60 days of your retirement date or the date the child turns 23, whichever is later. Children are covered as long as the incapacity exists, they meet the definition of children except for age, and you continue to provide periodic proof of the continued incapacity as required.

Children are not eligible for Long-Term Care (LTC) coverage.

When you retire, you must list your dependents under the health plan so claims may be paid. If your dependents change later, you must complete a form to add or delete dependents from your account.

If more than one family member is retired under a retirement plan sponsored by the State of Alaska, each eligible family member may be covered by this program both as a benefit recipient and as a dependent, or as the dependent of more than one benefit recipient.

If you elect or are provided with coverage for dependents, your dependents are eligible for benefits on the same day you are eligible if they meet all eligibility requirements. Medical coverage provided by the retirement system is family coverage. If you must pay for Medical coverage, you are required to elect the level of coverage that you want. If you add new dependents, they will be covered immediately if you are purchasing coverage for them.

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

If you increase your coverage to include dependents following marriage or birth or adoption of a first child, their coverage begins on the first of the month following receipt of your written request.

**To report your eligibility for health insurance to the claims administrator timely, you must file your retirement application at least 60 days prior to your retirement date.** Once your eligibility has been reported, you will be sent a welcome kit with information and forms for using your health plan. Shortly afterward, the claims administrator will send you identification cards.

## Medical Benefits Highlights

| | |
|---|---|
| **Benefit Year** | January 1 – December 31 |
| **Annual Deductible** | The amount you must pay before the plan pays.<br>$150 per individual annually<br>Maximum 3 deductibles per family annually. |
| **Coinsurance** | The amount the plan pays – 80% of the recognized charge. |
| **Annual Out of Pocket Maximum** | When your 20% reaches this amount, the plan pays 100% for the rest of the year — $800 per person. |
| **Lifetime Maximum** | $2 million per person. |
| **Prescription Drugs** | Maximum allowed for each fill – 90 day supply:<br>Retail/local pharmacy:<br>• Brand-name drug – $8 co-pay<br>• Generic drug – $4 co-pay<br>Mail-order pharmacy:<br>• All drugs – No co-pay |
| **Outpatient Surgery, Preoperative Testing, Second Opinions** | 100% with no deductible. |
| **Skilled Nursing Facilities** | Subject to deductible. |
| **Travel** | • For treatment or second opinions not available locally.<br>• Round-trip.<br>• Must be pre-authorized. |
| **Healthy Pregnancy Program** | Available. |

Medical coverage provided by the retirement system or elected at retirement has no pre-existing conditions limitation. A pre-existing conditions limitation is applied if you select coverage for yourself or your dependents during open enrollment.

Pre-existing conditions are conditions, excluding pregnancy, for which you received diagnosis, tests, or treatment (including taking medication) during the three consecutive months before the most recent day you became covered under this plan. For example, if your coverage begins on April 1, a pre-existing condition would be one for which you received diagnosis, testing, or treatment during January, February, and/or March.

Under this provision, only the first $1,000 of covered medical expenses are paid for pre-existing conditions. If you or your dependent had other group coverage that ended less than 92 days before coverage under this plan began, some or all of this pre-existing condition limitation may be waived. After 12 consecutive months of coverage, this limitation is cancelled and the claims incurred after the 12-month period are covered the same as all other services with no pre-existing limitation.

| MEDICAL COVERAGE | Tier I | Tier II | Tier III |
|---|---|---|---|
| **Eligibility** | Vested and at least age 50-55; or 20 years of peace officer/fire fighter service; or 30 years of other service. | Vested and at least age 55-60; or with 20 years of peace officer/fire fighter service; or with 30 years of other service. | Vested and at least age 55-60 with 10 years of credited service; or with 20 years of peace officer/ fire fighter service; or with 30 years of other service. Access to medical benefits provided for those without 10 years of credited service. |
| **Premiums Required** | No premium payment required. | No premium required if age 60; or with 25 years of peace officer/fire fighter service; or with 30 years of other service. If under age 60 without service time, pay full premium until age 60. | No premium required if age 60; or with 25 years of peace officer/fire fighter service; or with 30 years of other service. If under age 60 without service time, pay full premium until age 60. Members without 10 years of credited service will pay full premium as long as coverage is desired. |
| **Medical Coverage Enrollment** | Automatic at retirement. | May enroll at retirement or during an annual open enrollment. Automatically enrolled at age 60. | May enroll at retirement or during an annual open enrollment. Automatically enrolled at age 60 with 10 years of credited service. |
| **Coverage Starts** | Effective date of your retirement. | Effective date of your retirement, January 1 of year following enrollment during an open enrollment or on the first of the month following age 60. | Effective date of your retirement, January 1 of year following enrollment during an open enrollment or on the first of the month following age 60 with 10 years of credited service. |
| **Coverage Ends** | When a pension benefit is no longer being paid. | When a pension benefit is no longer being paid or if required premiums are not paid. | When a pension benefit is no longer being paid or if required premiums are not paid. |
| **Pre-Existing Conditions Limit** | None. | None if elected at retirement or age 60. A limit may be applied if you elect medical coverage during an open enrollment. | None if elected at retirement or age 60. A limit may be applied if you elect medical coverage during an open enrollment. |

Tier I members have family coverage at retirement which includes the member, spouse, and dependent children.

Eligible Tier II and III members who are electing coverage may elect for:

- Retiree only;
- Retiree and spouse;
- Retiree and child(ren); or
- Retiree and family.

You may decrease the level of coverage at any time. For example, you may change from retiree and family coverage to retiree and spouse coverage at any time. To decrease your coverage, you must submit a written request to the Division. Changes in coverage are effective on the first of the month following the receipt of your written request. Once you decrease your coverage, you cannot reinstate it except as described below.

You may only increase coverage:

- During an annual open enrollment (Tiers II and III);
- Within 120 days of marriage to include a new spouse and their child(ren); or
- Within 120 days of birth or adoption of a child to include coverage for the new child.

Premiums for coverage are based on the level of coverage selected. It is your responsibility to notify the Division in writing if your level of coverage changes because your dependents no longer meet the eligibility requirements.

## Dental-Vision-Audio (DVA)

The DVA plan is optional and premiums are required from all tiers. No pre-existing conditions limitation applies to the DVA plan. The DVA benefit year is January 1 through December 31 of each year.

| Dental Plan Highlights |
| --- |
| • Pays 100% of the recognized charge for most preventive services (X-rays, exams, cleaning, etc.) with no deductible.<br>• Pays 80% of the recognized charge for most restorative services (fillings, extractions, etc.) after the annual deductible is met.<br>• Pays 50% of the recognized charge for most prosthetic services (crowns, dentures, etc.) after the annual deductible is met.<br>• Requires an annual deductible of $50 per person for restorative or prosthetic services.<br>• Pays up to $2,000 of covered expenses per person per year. |

| Vision Plan Highlights |
| --- |
| • Requires no deductible.<br>• Pays 80% of the recognized charges.<br>• Covers one complete eye examination, including a required refraction, per year.<br>• Covers two lenses during each calendar year.<br>• Covers one set of frames during every two consecutive calendar years. |

| Audio Plan Highlights |
| --- |
| • Pays 80% of the usual, customary, and reasonable charges.<br>• Requires no deductibles.<br>• Allows a maximum benefit of $2,000 in a three-year period. |

# PERS RETIREMENT APPLICATION

**TO ALLOW TIMELY PROCESSING OF YOUR RETIREMENT APPLICATION, ALL AREAS OF THE APPLICATION FORM MUST BE COMPLETED. FAILURE TO COMPLETE THE APPLICATION WILL DELAY THE PROCESSING OF YOUR APPLICATION AND THE PAYMENT OF YOUR BENEFIT.**

This packet includes a retirement application form. Please complete the form in its entirety and return it to the Division of Retirement and Benefits.

- Incomplete forms will cause a delay in the process of your benefits. You must sign the application on page F-11.
- The application form must be received by the Division or postmarked no later than the last day of the month prior to your desired retirement effective date.
- To avoid delays in health coverage reporting, we request you file your application 60 days prior to your retirement effective date.
- All retirement effective dates for eligible retirees are the first of the month following termination of employment and receipt of the retirement application. Health insurance coverage is effective on the date of your retirement if you enroll in the plans and the required premiums are paid either by direct deduction from your retirement check or self-payment to the health plan.

> *If you have been divorced or had your marriage dissolved during your PERS employment, you are required to submit a court-certified copy of your divorce or dissolution documents. You will not be appointed to retirement until all required court-certified documents are received.*

If you need assistance in completing the forms, please contact your regional retirement counselor toll-free at (800) 821-2251 or in Juneau at (907) 465-4460.

**IMPORTANT NOTICE!** When your retirement application has been processed, you will receive a letter from the Division summarizing your elections. Please read this letter carefully and report any discrepancies between the letter and your intended elections immediately. Corrections to your elections can only be made within 15 days of the date you receive your appointment letter or your first benefit check, whichever is later.

## FIRST RETIREMENT CHECK

Pension benefits are paid at the end of each month. **The processing of your first benefit check can take approximately six weeks from your retirement effective date.** Once your application has been processed, benefit checks will be automatically issued at the end of each month.

If you have elected electronic direct deposit, your checks will be electronically deposited into your bank account once the pre-notification process has been completed. The pre-notification process typically occurs around the 13th of each month. Please be aware that if we are unable to process your retirement before the pre-notification process, your first benefit check may be delivered to your mailing address. Each month your check is direct-deposited, you will receive a detailed accounting of the deposit called a "warrant advice."

If you have not elected electronic direct deposit, your checks will be mailed to your correspondence address.

Pull this application form out from the center of the booklet and mail your completed form to:

**Alaska Public Employees' Retirement System**
**Division of Retirement and Benefits**
**P.O. Box 110203**
**Juneau, AK 99811-0203**

# PERS Application for Retirement Benefits

## I. EMPLOYEE INFORMATION

| NAME (FIRST, MI, LAST) | | | LAST 4 DIGITS OF SOCIAL SECURITY NUMBER OR RETIREMENT IDENTIFICATION NUMBER (RIN) |
|---|---|---|---|
| BIRTH DATE | SEX ❑ Male ❑ Female | MARITAL STATUS ❑ Married ❑ Divorced ❑ Single ❑ Widowed | DATE OF MARRIAGE |
| WORK/HOME TELEPHONE ( ) | EMAIL ADDRESS | | DATE OF DIVORCE |
| MAILING ADDRESS (STREET OR P.O. BOX, CITY, STATE, ZIP+4) | | | |

## II. PENSION BENEFIT ELECTION

**I hereby apply for ❑ Early ❑ Normal**
**retirement benefits to become effective the 1st day of _____(month), _____ (year).**

**Retirement Options. Choose from either A or B below. If widowed, please provide a certified copy of the death certificate.**

**A. Survivor Options** (Married members)
**Survivor Information**

| NAME (FIRST, M.I., LAST) | DATE OF BIRTH |
|---|---|
| SOCIAL SECURITY NUMBER | RELATIONSHIP ❑ Spouse |

See *Section V – Rights of Spouses and Dependents* for information about designating an incapacitated child as your survivor.

I elect: ❑ 75% Joint Survivor Option ❑ 50% Joint Survivor Option

❑ 66-2/3% Last Survivor Option *(Available if first hired before July 1, 1996).* In selecting the 66-2/3% Last Survivor Option, I understand if my spouse dies first, my entire benefit will be reduced to 66-2/3% for the rest of my life. If I die first, my spouse will receive the 66-2/3% survivor benefit for the rest of his/her life.

**B. No Survivor Option** (Single members. If you are married, you may only choose this option if your spouse signs the waiver below. All benefits including medical coverage will cease upon the death of the applicant.)

❑ Normal or Early Benefit: I do not elect a Survivor Option

❑ Level Income Option *(Available if first hired before July 1, 1996.)* I request my retirement benefits in an increased amount prior to age 65 and a reduced amount after age 65 for life regardless of any benefits I may receive from any other plan. I understand that any additional income I may be entitled to receive at age 65, including social security benefits, has no bearing on the amount of the reduction to my benefit under this option. *This option may only be selected if no survivor option has been selected.*

**SPOUSE'S WAIVER OF SURVIVOR OPTION**
(Complete only if married and NOT selecting a survivor option.)

I acknowledge and approve the benefit selected. I understand the terms of the selection and that by signing this waiver **I freely waive entitlement to continuing survivor benefits, including health coverage,** which may otherwise be payable to me, upon the death of the named applicant. By signing this consent, I agree to waive my right to any benefits that would be paid to me and consent to the naming of another beneficiary.

| SPOUSE'S SIGNATURE | |
|---|---|
| PRINTED NAME | DATE |
| SPOUSE'S SIGNATURE WITNESSED BY (DIVISION OF RETIREMENT AND BENEFITS REPRESENTATIVE, NOTARY PUBLIC OR POSTMASTER) | |

On this_____day of_____20____, (Spouse's Name)_____personally appeared before me whose identity I proved on the basis of satisfactory evidence to be the signer of the participant signature above, and he/she acknowledged that he/she executed it.

| NOTARY PUBLIC | RESIDING AT | SEAL OR POSTMASTER STAMP REQUIRED |
|---|---|---|
| STATE OF | BOROUGH/COUNTY OF | COMMISSION EXPIRES |

Social Security Number or RIN_____

## III. INDEBTEDNESS PAYMENT

❑ I HAVE NO INDEBTEDNESS

I hereby **irrevocably** elect:

❑ to pay my indebtedness in full prior to my retirement effective date.

❑ by check

❑ to pay my indebtedness by a pre-tax plan transfer **(must initiate request for transfer prior to retirement)**

❑ to cancel any outstanding indebtedness due by accepting an actuarial reduction to my retirement benefit for life.

## IV. EMPLOYEE VOLUNTARY SAVINGS ACCOUNT

Complete **only** if you elected to participate in the voluntary savings program. (This is **not** the Alaska Supplemental Annuity Plan or Alaska Deferred Compensation Plan.)

I request the balance in my Employee Savings Account be paid to me in the form of:

**Lump sum:**

❑ Lump sum payment of total account balance.

❑ Yes. Please withhold taxes. ❑ No. Do not withhold taxes.

**Annuities:**

Life Annuity payment options are irrevocable once payment option has been initiated and the member has received the first payment. Upon request, the Division of Retirement and Benefits will provide estimations of benefits to the member through factors provided by the Actuarial Analyst of the insurance company. These factors are subject to change and will be updated every quarter. Provided estimations are not to be construed or representative of actual benefits from the purchase of an annuity.

The annuity options available are:

❑ Life Annuity. A Life Annuity is a lifetime benefit to the member. All benefits cease upon the death of the member. There are no survivor or beneficiary benefits.

❑ Life Annuity with Five Year Term-Certain. Life Annuities are lifetime benefits paid to the member. If the member dies prior to the Five Year Term-Certain, the designated beneficiary would receive the remaining payments until a total of the Five Year Term-Certain payments have been paid.

❑ Life Annuity with Ten Year Term-Certain. Life Annuities are lifetime benefits paid to the member. If the member dies prior to the Ten Year Term-Certain, the designated beneficiary would receive the remaining payments until a total of the Ten Year Term-Certain payments have been paid.

**Installments over a Designated Period of Time:**

Installments are a monthly benefit that can be stated in terms of months (examples: 1-1/2 years can be expressed as 18 months). This is the Full Balance of the Voluntary Savings plus accrued interest to the date of retirement divided by the designated period of time as elected by the member. Should the member die prior to the designated period of time, the remaining payments will be paid to the designated beneficiary(s) in a lump sum.

❑ Installments expressed in months _____ (number of months).

## V. APPLICATION FOR ALASKA COST-OF-LIVING ALLOWANCE

(See *Section VII – After Retirement Benefit Increases* for eligibility requirements.)

By providing my physical address below, I hereby apply to receive the Alaska Cost-of-Living Allowance (COLA) payments to be effective the date of my appointment to retirement. I understand, for the purposes of AS 39.35.480, in order to be entitled to receive this cost-of-living allowance, **I must have first entered PERS before July 1, 1986,** or be age 65 if first entered after June 30, 1986, and must be ***domiciled*** and ***physically present*** in the State of Alaska. Further, I understand a standard legal definition of domicile is: "That place where a person has his or her true, fixed and permanent home and principal establishment, and to which whenever absent, has the intention of returning." I will notify the PERS whenever I plan to leave Alaska for a continuous period exceeding 90 days or when I have been out of Alaska for more than **90 days.** I understand if I am gone for 91 days or more, COLA will **not** be paid for the entire absence. I understand I am required to repay any overpayments to the Division of Retirement and Benefits for COLA received during any ineligible periods.

Physical Residence Address (not a P.O. Box) _____

Name _____ Social Security Number or RIN _____

Retirement Effective Date _____

## VI. ELECTRONIC DIRECT DEPOSIT AUTHORIZATION

**By providing my bank routing number and account number I hereby authorize the electronic deposit of my benefit directly to my financial institution.** *NOTE: If you do not elect the direct deposit program, your warrant will be mailed to your correspondence address.*

I hereby authorize the State of Alaska to make net payroll warrant deposits to my account as indicated below:

Check One: ❑ Savings ❑ Checking

| BANK ROUTING NUMBER | ACCOUNT NUMBER |
|---|---|
| FINANCIAL INSTITUTION | |

**ATTACH A VOIDED CHECK HERE**
**(used to verify your bank transit routing and account number)**

By completing this section, I authorize the State of Alaska, if necessary, to make adjustments to the above account to correct any credit entries made in error. I understand the State will make a reasonable effort to notify me within twenty-four (24) hours when an adjustment is made. This authority remains in effect as long as I am retired or until the State receives written notice from me. I understand that 30 days written notice is required to change financial institutions, account numbers, or type of account. I further understand direct deposit will begin ***after*** the above account information has been electronically verified.

I also understand that ***unless*** I inform the Division of Retirement and Benefits otherwise, the first payroll after such changes are made, my benefit will be ***electronically deposited*** to the previous financial institution. Changes ***do not*** take effect until the second payroll after the change was initiated.

Direct deposit is not available to financial institutions in foreign countries. **Due to federal regulations, funds cannot be transferred electronically if the funds will be forwarded to an account in another country.**

## VII. HEALTH BENEFIT ENROLLMENT

**MEDICAL BENEFITS (must mark a box)** — **Premium Payment Required – See Premium Rate Card**

I elect the following **medical** coverage: ❑ **No medical coverage**

❑ Retiree only ❑ Retiree and spouse ❑ Retiree and child(ren) ❑ Retiree, spouse, and child(ren)

❑ System-paid AlaskaCare medical (see pages 4-6 for eligibility requirements)

**DENTAL-VISION-AUDIO BENEFITS (must mark a box)** — **Premium Payment Required – See Premium Rate Card**

I elect the following **Dental-Vision-Audio (DVA)** coverage: ❑ **No Dental-Vision-Audio coverage**

❑ Retiree only ❑ Retiree and spouse ❑ Retiree and child(ren) ❑ Retiree, spouse, and child(ren)

**LONG-TERM CARE BENEFITS (must mark a box)** — **Premium Payment Required – See Premium Rate Card**

I elect the following **Long-Term Care (LTC)** option:

Retiree coverage:

❑ No Long-Term Care coverage ❑ Silver ❑ Gold ❑ Platinum

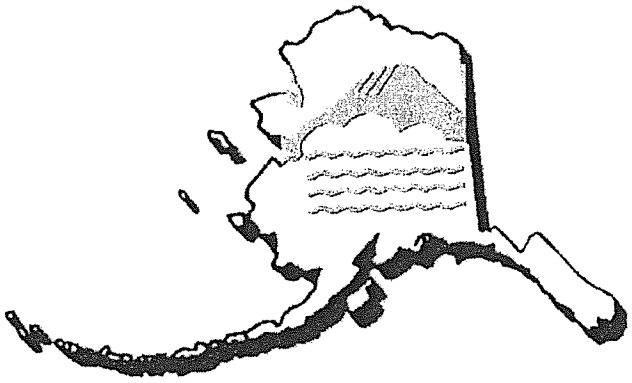
❑ I am covered under my spouse's LTC plan. Spouse's SSN _____

Spouse coverage (may only elect if member is electing coverage):

❑ No Long-Term Care coverage ❑ Silver ❑ Gold ❑ Platinum Spouse's date of birth _____

## DVA Enrollment

| DENTAL-VISION-AUDIO (Optional Plan) | Tier I | Tier II | Tier III |
|---|---|---|---|
| **Enrollment** | One-time opportunity at retirement. If you do not enroll in DVA prior to your retirement, you waive your right to elect this coverage permanently. | You may elect DVA with or without the medical plan at retirement. You may elect DVA during an open enrollment only if you did not enroll in the medical plan at retirement and are electing medical for the first time. If you have not elected medical prior to age 60, you will have one final chance to enroll in DVA at age 60 if you first become eligible for automatic medical benefits at that time. | You may elect DVA with or without the medical plan at retirement. You may elect DVA during an open enrollment only if you did not enroll in the medical plan at retirement and are electing medical for the first time. If you have not elected medical prior to age 60, you will have one final chance to enroll in DVA at age 60 if you first become eligible for automatic medical benefits at that time. |
| **Premiums Required** | Monthly premiums are required based on the level of coverage elected. Premiums are deducted from your retirement benefit or if your benefit is insufficient, you pay the premiums directly to the claims administrator. | Monthly premiums are required based on the level of coverage elected. Premiums are deducted from your retirement benefit or if your benefit is insufficient, you pay the premiums directly to the claims administrator. | Monthly premiums are required based on the level of coverage elected. Premiums are deducted from your retirement benefit or if your benefit is insufficient, you pay the premiums directly to the claims administrator. |
| **Coverage Starts** | Effective date of your retirement. | Effective date of your retirement; January 1 of year following enrollment during an open enrollment; or the first of the month following your 60th birthday if first enrolling then. | Effective date of your retirement; January 1 of year following enrollment during an open enrollment; or the first of the month following your 60th birthday if first enrolling then. |
| **Coverage Ends** | When a pension benefit is no longer being paid, if premiums are not paid, or when you drop coverage. | When a pension benefit is no longer being paid, if premiums are not paid, or when you drop coverage. | When a pension benefit is no longer being paid, if premiums are not paid, or when you drop coverage. |



STATE OF ALASKA

# RETIREE GROUP INSURANCE INFORMATION BOOKLET

## 2000

# DENTAL-VISION-AUDIO PLAN

## INTRODUCTION

The State of Alaska is pleased to be able to offer this voluntary Dental-Vision-Audio (DVA) Plan for benefit recipients and their eligible dependents. These benefits may change from time to time. You should ensure that you have the current booklet by contacting the Division of Retirement and Benefits.

## WHO MAY BE COVERED AND PREMIUM PAYMENT

The following individuals may elect coverage:

### Benefit Recipients

- People receiving a benefit from the Public Employees', Teachers', Judicial or Elected Public Officers' Retirement Systems (excluding alternate payees under a Qualified Domestic Relations Order). If coverage is elected, the premiums are paid by deductions from your retirement check.

### Dependents

You may elect to cover the following dependents:

- Your spouse. You may be legally separated but not divorced.
- Your children from birth up to 23 years of age *only* if they are:

— your natural children, stepchildren, foster children placed through a State foster child program, legally adopted children, children in your physical custody and for whom bona fide adoption proceedings are underway, or children for whom you are the legal, court-appointed guardian;

— unmarried and chiefly dependent upon you for support; **and**

— living with you in a normal parent-child relationship.

- This provision is waived for natural/adopted children of the benefit recipient who are living with a divorced spouse, assuming all other criteria are met.

- Only stepchildren living with the retiree more than 50% of the time may be insured under this plan.

Children incapable of employment because of a mental or physical incapacity are covered even if they are past age 23. However, the incapacity must have existed before age 23 and the children must continue to rely chiefly on you for support. You must furnish the claims administrator evidence of the incapacity, proof that the incapacity existed before age 23, and proof of financial dependency. Children are covered as long as the incapacity exists and they meet the definition of children, except for age. Periodic proof of the continued incapacity may be required.

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

## HOW TO ELECT COVERAGE

DVA coverage may be elected for:

- Retiree only
- Retiree and spouse
- Retiree and child/children
- Retiree and family (spouse and child/children)

If you are covered by the medical plan automatically at no cost to you (see page 4), you must elect DVA coverage:

- before the effective date of your retirement benefit, or
- with your application for survivor benefits.

**If you do not elect coverage at this time, you waive the right to elect coverage at a later date.**

If you are required to pay premiums for your medical coverage (see pages 4-5), you may elect DVA coverage at the times shown above or during an annual open enrollment period. However, DVA may be elected during open enrollment only if the same or increased level of medical coverage is being elected for the first time during that open enrollment. For example, a retiree who has no medical or DVA coverage may elect medical for self and spouse and DVA for self only during an open enrollment. However, a retiree who is already enrolled in medical coverage may not elect to add DVA coverage during the open enrollment.

## WHEN DVA COVERAGE STARTS

### New Benefit Recipients

New benefit recipients who elect coverage at retirement will be covered under this plan on the date of their appointment to receive retirement, disability, or survivor/death benefits.

### Open Enrollees

Benefit recipients who are eligible for and elect coverage during an open enrollment are covered on January 1 of the year following the open enrollment, assuming they pay the required premium.

## WHEN COVERAGE ENDS

Coverage under the DVA plan ends at the earliest time that one of the following occurs:

### Failure to Pay Premium

Coverage ends at the end of the month in which you fail to pay the required premium. If at any time your benefit check is insufficient to pay the monthly premium, you may pay the premium directly to the claims administrator. Contact the Division of Retirement and Benefits for more information.

### Ineligible Retirees

Coverage ends at the end of the month in which you become ineligible to receive a benefit from the retirement system.

### Discontinuance of Coverage

You may discontinue your participation in DVA coverage at any time by submitting a signed, written request to the Division of Retirement and Benefits. Your premium deductions will be stopped as soon as possible. Your coverage will end on the last day of the month in which the last premium is deducted.

**If you discontinue participation, you waive all rights to future coverage and you are not eligible to re-enroll.**

## Dependents

If you have elected to cover your dependents, coverage will end for those dependents on the same day as your coverage ends, unless:

- you divorce. Coverage for your spouse ends on the date the divorce is final,
- your child no longer meets all eligibility requirements. Coverage ends at the end of the month in which the child first fails to meet these requirements,
- when you discontinue coverage for your dependents, or
- coverage is discontinued for all dependents.

You should notify the Division of Retirement and Benefits any time your dependents change so your coverage level can be adjusted if necessary. For example, if you divorce or your only child ceases to meet the eligibility requirements, you should request the division to discontinue coverage for them **Changes in coverage are effective only after your written request is received by the division.**

**Please note: the retirement system does not maintain information on your dependents and cannot make changes in coverage levels for you.**

There may be options available for continuing DVA coverage if some of the above situations occurs. These are described in the "How To Continue Health Coverage" section on pages 84-87.

## CHANGING YOUR COVERAGE

You may decrease your level of coverage at any time. For example, you may change from retiree and family coverage to retiree and spouse coverage any time. To decrease your coverage, submit a written request to the Division of Retirement and Benefits stating the level of coverage you would like. Once you decrease your coverage you cannot reinstate it except as described below.

You may increase coverage only:

- within 120 days after marriage or the birth or adoption of your first child, or
- during an open enrollment period, if you are eligible as noted on page 56.

Your written request to increase coverage must be postmarked or received within 120 days after the date one of the above events occurs. You should state the level of coverage you would like, the reason for the change, and the date the event occurred.

Changes in coverage are effective on the first of the month following the receipt of your written request.

**Changes in coverage are effective only after receipt of your written request and are not retroactive.**

**DENTAL PLAN HIGHLIGHTS**

- Pays 80% of the usual, customary, and reasonable charges for most preventive services (X-rays, exams, cleaning, etc.) with no deductible.
- Pays 80% of the usual, customary, and reasonable charges for most restorative services (fillings, extractions, etc.) after the annual deductible is met.
- Pays 50% of the usual, customary, and reasonable charges for most prosthetic services (crowns, dentures, etc.) after the annual deductible is met.
- Requires an annual deductible of $50 per person for restorative or prosthetic services.
- Pays up to $1,500 of covered expenses per person per year.

### Benefit Year

The benefit year for this Plan begins January 1 and ends December 31. All benefits limited in a benefit year are reset on January 1 each year.

### Annual Maximum Benefit

The State's Dental Plan pays up to $1,500 for all covered dental services for each eligible person during the benefit year.

### Deductible

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

## Usual, Customary, and Reasonable Charges

Payment is based on usual, customary, and reasonable charges for covered services. Charges or fees in excess of the usual, customary, and reasonable charge level, as determined by the claims administrator, are your responsibility to pay.

Usual, customary, and reasonable (UCR) means the charge the claims administrator determines to be the prevailing rate charged in the geographic area where the service is provided or the provider's usual charge, whichever is less.

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

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

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

# COVERED DENTAL SERVICES

### Class I Preventive Services

The Dental Plan covers 80% of the usual, customary, and reasonable charges with no deductible for Class I preventive services rendered by a dentist (D.D.S. or D.M.D.). Class I services include:

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

### Class II Restorative Services

Following the $50 annual deductible, the Dental Plan covers 80% of the usual, customary, and reasonable charges for Class II restorative services. These include:

- fillings of silver amalgam, silicate, and plastic restoration;
- repair of dentures and bridges;
- palliative (alleviation of pain) emergency treatment;
- extractions (removal of teeth);

- endodontics (treatment of disease of the tooth pulp) including pulpotomy, pulp capping, and root canal treatment;
- space maintainers;
- oral surgery, including surgical extractions;
- apicoectomy (surgical removal of a root tip);
- repair of bridges or dentures; and
- periodontic services (treatment of the supporting tooth structures), including periodontal prophylaxis.

**Class III Prosthetic Services**

Following the $50 annual deductible, the Dental Plan pays up to 50% of the usual, customary, and reasonable charges for Class III prosthetic services. These include:

- inlays and onlays;
- crowns;
- fixed and removable bridges, initial placement; and
- full and partial dentures, initial placement.

## DENTAL SERVICES NOT COVERED

The Dental Plan does not provide benefits for:

- services for congenital deformities (these are covered by the Medical Plan) or for purposes of improving personal appearance;

- services that the dentist is not licensed to perform;
- charges that are higher than would have been charged if there were no Dental Plan;
- services for dentures, bridges, crowns, or other devices started before the effective date of coverage;
- charges made after your coverage ends, unless they are for prosthetic devices fitted and ordered while you were covered and arriving within 90 days of the coverage end date;
- services rendered after the end of coverage, even if you are in the course of an approved treatment plan;
- charges of more than one dentist for the same services in the same visit;
- appliances or restorations necessary to increase vertical dimensions or restore occlusions;
- services for straightening teeth or correcting bite (orthodontics) except for tooth extractions necessary to proceed with orthodontic services;
- a denture replacement made less than five years after the last one was obtained, whether or not it was covered by this Plan;
- replacement costs of a lost or stolen denture if this benefit has been used within the last five years; and
- special techniques or personalized restoration for the construction of a denture beyond the standard procedure charges.
- myofunctional therapy, including in-mouth appliances to correct or control harmful habits.

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

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

### Advance Claim Review

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

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

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

As part of advance claim review and for any claim, the claims administrator, at its expense, has the right to require you to obtain an oral examination. You must furnish to the claims administrator all diagnostic and evaluative material required

to establish your right to benefits. Evaluative material includes dental X-rays, models, charts, and written reports.

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

Examples of alternative services or supplies for restorative care are:

- gold or baked porcelain restorations, crowns, and jackets. If a tooth can be restored with amalgam or like material and you and your dentist select another type of restoration, your benefits are limited to the appropriate charges for amalgam or similar material.

- reconstruction. Covered expenses only include charges for procedures necessary to eliminate oral disease and replace missing teeth. Appliances or restorations to increase vertical dimension or restore the occlusion are considered optional and not covered.

Examples of alternative services or supplies for prosthodontic care are:

- partial dentures. If cast chrome or acrylic partial dentures will restore a dental arch satisfactorily and you and your dentist choose a more elaborate precision appliance, covered expenses are limited to the appropriate charges for cast chrome or acrylic.

- complete dentures. If you and your dentist decide on personalized restorations or specialized techniques, as opposed to standard dentures, covered expenses are limited to appropriate charges for the standard dentures.

- replacement of existing dentures. Charges for existing denture replacements are covered only if the existing dentures are not or cannot be made serviceable; otherwise, covered expenses are limited to appropriate charges for services necessary to make appliances serviceable.

# Retiree Dental Insurance 2003 - Updated 2012

Wednesday, August 19, 2015
10:49 AM


# Retiree Insurance Information Booklet

## May 2003

# DENTAL-VISION-AUDIO PLAN

## INTRODUCTION

The State of Alaska is pleased to be able to offer this voluntary Dental-Vision-Audio (DVA) Plan for benefit recipients and their eligible dependents. These benefits may change from time to time. You should ensure that you have the current booklet by contacting the Division of Retirement and Benefits.

## WHO MAY BE COVERED AND PREMIUM PAYMENT

The following individuals may elect coverage:

### Benefit Recipients

- People receiving a benefit from the Public Employees', Teachers', Judicial, or Elected Public Officers' Retirement Systems (excluding alternate payees under a Qualified Domestic Relations Order). If coverage is elected, the premiums are paid by deductions from your retirement check.

- People receiving a benefit from the Marine Engineers Beneficial Association (MEBA) who retired from the State of Alaska after July 1, 1983. If coverage is elected, the premium is paid annually by the member.

## Dependents

You may elect to cover the following dependents:

- Your spouse. You may be legally separated but not divorced.
- Your children from birth up to 23 years of age *only* if they are:
  - — Your natural children, stepchildren, foster children placed through a State foster child program, legally adopted children, children in your physical custody and for whom bona fide adoption proceedings are underway, or children for whom you are the legal, court-appointed guardian;
  - — Unmarried and chiefly dependent upon you for support; **and**
  - — Living with you in a normal parent-child relationship.
    - This provision is waived for natural/adopted children of the benefit recipient who are living with a divorced spouse, assuming all other criteria are met.
    - Only stepchildren living with the retiree more than 50% of the time may be insured under this plan.

  Children incapable of employment because of a mental or physical incapacity are covered even if they are past age 23. However, the incapacity must have existed before age 23 and the children must continue to meet all other eligibility criteria. You must furnish the Division evidence of the incapacity, proof that the incapacity existed before age 23, and proof of financial dependency. This proof must be provided no later than 60 days after their 23rd birthday or after the effective date of your retirement, whichever is later. Children are covered as long as the incapacity exists, they meet the definition of children, except for age and you continue to provide periodic proof of the continued incapacity as required.

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

## HOW TO ELECT COVERAGE

DVA coverage may be elected for:

- Retiree only
- Retiree and spouse
- Retiree and child/children
- Retiree and family (spouse and child/children)

If you are covered by the medical plan automatically at no cost to you (see pages 5-6), you must elect DVA coverage:

- Before the effective date of your retirement benefit, or
- With your application for survivor benefits.

**If you do not elect coverage at this time, you waive the right to elect coverage at a later date.**

If you are required to pay premiums for your medical coverage (see pages 5-6), you may elect DVA coverage at the times shown above or during an annual open enrollment period. However, DVA may be elected during open enrollment only if the same or increased level of medical coverage is being elected for the first time during that open enrollment. For example, a retiree who has no medical or DVA coverage may elect medical for self and spouse and DVA for self only during an open enrollment. However, a retiree who is already enrolled in medical coverage may not elect to add DVA coverage during the open enrollment.

# WHEN DVA COVERAGE STARTS

## New Benefit Recipients

New benefit recipients who elect coverage at retirement will be covered under this plan on the date of their appointment to receive retirement, disability, or survivor/death benefits.

## Open Enrollees

Benefit recipients who are eligible for and elect coverage during an open enrollment are covered on January 1 of the year following the open enrollment, assuming they pay the required premium.

## Marine Engineers Beneficial Association Members

Eligible benefit recipients of the Marine Engineers Beneficial Association (MEBA) who elect coverage at retirement and pay the required premium will be covered on the date of their appointment to receive benefits from MEBA.

## Dependents

If you elect coverage for dependents, your eligible dependents are covered on the dates specified below. Note that the level of coverage you elect must cover the dependent. In order to have coverage for your children, for example, you must elect coverage for retiree and children or for retiree and family.

Your dependents are eligible for benefits on the same day you are eligible if they meet all eligibility requirements. If you add new dependents, they will be covered under this plan immediately assuming the level of coverage you have covers the new dependent as specified above.

If you increase your coverage to include dependents following marriage or birth of a child, their coverage begins on the first of the month following receipt of your written request, assuming the level of coverage you elect covers the new dependent.

# WHEN DVA COVERAGE ENDS

Coverage under the DVA plan ends at the earliest time that one of the following occurs:

### Failure to Pay Premium

Coverage ends at the end of the month in which you fail to pay the required premium. If at any time your benefit check is insufficient to pay the monthly premium, you may pay the premium directly to the claims administrator. Contact the Division of Retirement and Benefits for more information. MEBA members pay premiums directly to the MEBA office.

### Ineligible Retirees

Coverage ends at the end of the month in which you become ineligible to receive a benefit from the retirement system.

### Discontinuance of Coverage

You may discontinue your participation in DVA coverage at any time by submitting a signed, written request to the Division of Retirement and Benefits. Your premium deductions will be stopped as soon as possible. Your coverage will end on the last day of the month in which the last premium is deducted/paid.

**If you discontinue participation, you waive all rights to future coverage and you are not eligible to re-enroll.**

### Dependents

If you have elected to cover your dependents, coverage will end for those dependents on the same day as your coverage ends, unless:

- You divorce. Coverage for your spouse ends on the date the divorce is final,
- Your child no longer meets all eligibility requirements. Coverage ends at the end of the month in which the child first fails to meet these requirements,
- You discontinue coverage for your dependents, or
- Coverage is discontinued for all dependents.

You should notify the Division of Retirement and Benefits any time your dependents change so your coverage level can be adjusted if necessary. For example, if you divorce or your only child ceases to meet the eligibility requirements, you should request the Division to discontinue coverage for them. **Changes in coverage are effective only after your written request is received by the Division.**

**Please note: the health plan cannot make changes in coverage levels for you.**

There may be options available for continuing DVA coverage if some of the above situations occurs. These are described in the "Continued Health Coverage" section on pages 95-99.

## CHANGING YOUR DVA COVERAGE

You may decrease your level of coverage at any time. For example, you may change from retiree and family coverage to retiree and spouse coverage any time. To decrease your coverage, submit a written request to the Division of Retirement and Benefits stating

the level of coverage you would like. Once you decrease your coverage you cannot reinstate it except as described below.

You may increase coverage only:

- Within 120 days after marriage or the birth or adoption of your first child, or
- During an open enrollment period, if you are eligible as noted on pages 59-60.

Your written request to increase coverage must be postmarked or received within 120 days after the date one of the above events occurs. You should state the level of coverage you would like, the reason for the change, and the date the event occurred.

Changes in coverage are effective on the first of the month following the receipt of your written request.

**Changes in coverage are effective only after receipt of your written request and are not retroactive.**

DENTAL PLAN HIGHLIGHTS

- Pays 100% of the recognized charge for most preventive services (X-rays, exams, cleaning, etc.) with no deductible.
- Pays 80% of the recognized charge for most restorative services (fillings, extractions, etc.) after the annual deductible is met.
- Pays 50% of the recognized charge for most prosthetic services (crowns, dentures, etc.) after the annual deductible is met.
- Requires an annual deductible of $50 per person for restorative or prosthetic services.
- Pays up to $2,000 of covered expenses per person per year.

# HOW DENTAL BENEFITS ARE PAID

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

## Benefit Year

The benefit year for this Plan begins January 1 and ends December 31. All benefits limited in a benefit year are reset on January 1 each year.

## Annual Maximum Benefit

The State's Dental Plan pays up to $2,000 for all covered dental services for each eligible person during the benefit year.

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

## Deductible

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

## Recognized Charge

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

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

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

The recognized charge percentile is the charge determined by the claims administrator on a semiannual basis to be in the 90$^{th}$ percentile of the charges made for a service or supply by providers in the geographic area where it is furnished. The recognized

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

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

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

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

- The claims administrator will determine which procedures are primary, secondary or tertiary, taking into account the billed amounts.
- payment for each procedure will be made at the lesser of the billed charge or the following percentage of the recognized charge:

  — primary 100%
  — secondary 50%
  — all others 25%

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

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

## Advance Claim Review

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

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

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

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

In many cases, alternative services or supplies may be used to treat a dental condition. If so, benefit coverage is limited to the services and supplies customarily employed to treat the disease or

injury and recognized by the dental profession to be appropriate according to broadly accepted national standards of practice. The Plan takes into account your total oral condition.

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

- Gold or baked porcelain restorations, crowns, and jackets. If a tooth can be restored with amalgam or like material and you and your dentist select another type of restoration, your benefits are limited to the appropriate charges for amalgam or similar material.

- Reconstruction. Covered expenses only include charges for procedures necessary to eliminate oral disease and replace missing teeth. Appliances or restorations to increase vertical dimension or restore the occlusion are considered optional and not covered.

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

- Partial dentures. If cast chrome or acrylic partial dentures will restore a dental arch satisfactorily and you and your dentist choose a more elaborate precision appliance, covered expenses are limited to the appropriate charges for cast chrome or acrylic.

- Complete dentures. If you and your dentist decide on personalized restorations or specialized techniques, as opposed to standard dentures, covered expenses are limited to appropriate charges for the standard dentures.

- Replacement of existing dentures. Charges for existing denture replacements are covered only if the existing dentures are not or cannot be made serviceable; otherwise, covered expenses are limited to appropriate charges for services necessary to make appliances serviceable.

# COVERED DENTAL SERVICES

## Class I Preventive Services

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

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

## Class II Restorative Services

Following the $50 annual deductible, the Dental Plan covers 80% of the recognized charge for Class II restorative services. These include:

- Fillings of silver amalgam, silicate, and plastic restoration.
- Repair/relining of dentures and bridges.
- Palliative (alleviation of pain) emergency treatment.
- Extractions (removal of teeth).
- Endodontics (treatment of disease of the tooth pulp) including pulpotomy, pulp capping, and root canal treatment.

- Space maintainers.
- Oral surgery, including surgical extractions.
- Apicoectomy (surgical removal of a root tip).
- Local and general anesthetic necessary for dental procedures.
- Periodontic services (treatment of the supporting tooth structures), including periodontal prophylaxis.

### Class III Prosthetic Services

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

- Inlays and onlays.
- Crowns.
- Bridges, fixed and removable.
- Dentures, full and partial.

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

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

# DENTAL SERVICES NOT COVERED

The Dental Plan does not provide benefits for:

- Services or supplies that are not necessary for diagnosis or treatment of dental condition as determined by the claims administrator even if prescribed, recommended, or approved by a dental professional.
- Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.
- Services that the dentist is not licensed to perform.
- Charges that are higher than would have been charged if there were no Dental Plan.
- Services for dentures, bridges, crowns, or other devices started before the effective date of coverage.
- Charges made after your coverage ends, unless they are for prosthetic devices fitted and ordered while you were covered and arriving within 90 days of the coverage end date.
- Services rendered after the end of coverage, even if you are in the course of an approved treatment plan.
- Charges of more than one dentist for the same services in the same visit.
- Appliances or restorations necessary to increase vertical dimensions or restore occlusions.
- Services for straightening teeth or correcting bite (orthodontics) except for tooth extractions necessary to proceed with orthodontic services.

- A denture replacement made less than five years after the last one was obtained, whether or not it was covered by this Plan, except as noted on page 73.

- Replacement costs of a lost or stolen denture if this benefit has been used within the last five years.

- Special techniques or personalized restoration for the construction of a denture beyond the standard procedure charges.

- Myofunctional therapy, including in-mouth appliances to correct or control harmful habits.

- Those charges that the claims administrator determines are not recognized charges as defined under the medical plan.

- Benefits available under any law of government (excluding a plan established by government for its own employees or their dependents or Medicaid), even though you waive rights to such benefits.

- Charges in connection with an occupational injury or illness. An occupational injury or illness is one that arises out of or in the course of any work for pay or profit, or in any way results from any injury or illness which does. However, if proof is furnished that an individual is covered under workers' compensation or similar law, but is not covered for a particular illness under that law, that illness will not be considered occupational regardless of cause.

- Services or supplies not specifically listed as a covered benefit under the health plan.

- Services or supplies that are, as determined by the claims administrator, experimental or investigational as defined under the medical plan.

**From:** Barnhill, Michael A (DOA)
**Sent:** Tuesday, December 31, 2013 1:05 AM
**To:** Polizzotto, Rebecca C (LAW); Ricci, Emily K (DOA); Silverman, Mike (DOA sponsored); Puckett, Jim P (DOA); Michaud, Michele M (DOA)
**Subject:** Commr Amendment--Retiree Plan
**Attachments:** Retiree Plan Amendment.docx

Attached.

Mike Barnhill
Deputy Commissioner
Alaska Department of Administration
(907) 465-2200

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

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

## Section 1: Repealed Provisions

The following provisions of the Plan are hereby repealed:

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

## Section 2: Amended Provisions

### (1) Benefit Summary

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

a. Medical Benefit Schedule

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

| | |
|---|---|
| • Prenatal/postnatal maternity care<br>• Maternity delivery<br>• Presurgical or postsurgical<br>• Surgical procedure | one visit per benefit year |
| **Travel Limitations** | |
| Non-overnight stay traveling expenses | $31/day |
| Overnight lodging | $80/night |
| Overnight lodging (Transplants) | $50/person/night<br>$100/night maximum |
| Companion expenses | $31/night |
| **Additional Precertification Penalties** | |
| A $400 benefit reduction applies if you fail to obtain precertification for certain medical services. | |

b. Prescription Drug Schedule

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

c. Dental Benefit Schedule (if elected)

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

| Benefit Maximums | |
|---|---|
| Annual individual maximum | $2,000 |

d. Vision Benefit Schedule (if elected)

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

e. Audio Benefit Schedule (if elected)

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

**(2) Precertification**

Insert at p. 26, Plan Booklet:

**1. Precertification**

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

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

- Those furnished only because the person is in the hospital on a day when the person could safely and adequately be diagnosed or treated while not in the hospital; or
- Those furnished only because of the setting if the service or supply can be furnished in a doctor's office or other less costly setting.

**(7) Recognized Charge**

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

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

- Medical, Vision, and Audio Expenses

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

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

- Prescription Drug Expenses

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

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

- Dental Expenses

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

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

- 100% of the dentist's billed charge.

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

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

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

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

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

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

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

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

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

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

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

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

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

- Additional Information

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

**(8) Dental Services**

Dental Services are covered as follows:

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

1. Class I Preventive Services

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

a. Diagnostic Services and Limitations

Services:

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

Limitations:

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

b. Preventive Services and Limitations

Services:

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

Limitations:

- Prophylaxis (cleaning) or periodontal maintenance is covered once in any 6-month period. Additional cleaning benefit is available for covered persons with diabetes, covered persons in their third trimester of pregnancy, and covered persons with periodontal

disease under the DVA plan's Oral Health, Total Health program (see below, *Oral Health, Total Health Program and Benefits*).

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

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

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

2. Class II Restorative Services

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

a. Restorative Services and Limitations

Services: Fillings on teeth for the treatment of decay.

Limitations:

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

b. Oral Surgery Services and Limitations

Services:

- Extractions (including surgical)
- Other minor surgical procedures

Limitations:

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

c. Endodontic Services and Limitations

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

Limitations:

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

d. Periodontic Services and Limitations

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

Limitations:

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

e. Anesthesia Services

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

3. Class III Prosthetic Services

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

a. Restorative Services and Limitations

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

Limitations:

- Cast restorations (including pontics) are covered once in a 7-year period on any tooth.
- Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and the covered person is responsible for paying the difference.
- If a tooth can be restored with a material such as amalgam, but another type of restoration is selected by the covered person or dentist, covered expense will be limited to the cost of amalgam. Crowns are only a benefit if the tooth cannot be restored by a routine filling

b. Prosthodontic Services and Limitations

Services:

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

Limitations:

- A bridge or denture (full or partial denture) will be covered once in a 7-year period and only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the last 7 years.
- Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.

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

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

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

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

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

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

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

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

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

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

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

c. Other Services and Limitations

Services: Athletic mouthguard

Limitations:

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

4. General Limitation – Optional Services

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

5. Oral Health, Total Health Program and Benefits

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

The following covered persons should consider enrolling this program:

Diabetics

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

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

Pregnant Persons

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

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

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

**(9) Appeals**

**1. If a Claim is Denied**

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

a. Initial Claim for Health Plan Benefits

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

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT AT ANCHORAGE

| | | |
|---|---|---|
| THE RETIRED PUBLIC EMPLOYEES OF ALASKA, INC., | ) | |
| Plaintiff, | ) | |
| v. | ) | |
| SHELDON FISHER, in his official capacity as Commissioner of the Department of Administration, | ) | |
| Defendant. | ) | Case No. 3AN-16-04537 CI |

**DEFENDANT'S INITIAL DISCLOSURES**

Defendant provides the following initial disclosures pursuant to Alaska Rule of Civil Procedure 26(a)(1). These disclosures are based on information presently available to the defendant, and the defendant reserves the right to supplement and develop these disclosures and their defenses as new information becomes available through discovery and other stages of litigation.

**A. Factual basis for each defense.**

The dental-visual-audio (DVA) plan is an optional benefit; dental coverage is offered as an option for purchase by a retiree under AS 39.30, while protected PERS benefits are promised to all retirees under AS 39.35. Unlike PERS benefits, which are a form of deferred compensation, coverage under the DVA plan is self-funded by the retirees that invoke their optional benefit. Dental coverage is not an accrued benefit under the diminishment clause.

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Even if coverage under the DVA plan is an accrued benefit, the 2014 amendments provided comparable advantages to offset any alleged disadvantages. The State's chief dentist reviewed the amendments and concluded that the modified plan was appropriate and provided optimal benefits. Changes to the DVA plan, such as covering fluoride treatment for adults over the age of 19 only in limited circumstances was based on clinical recommendations and analysis. In addition, the State compared benefits, both costs and coverage, before implementing the modified plan and correspondingly reduced premiums in response to these changes.

Plaintiffs may lack standing to pursue their claims because none of their members have exhausted their administrative remedies. The Court also lacks jurisdiction to consider plaintiff's request for declaratory judgment as it pertains to the long term care plan as there is no actual controversy. Alaska Statute 22.10.020(g) requires "an actual controversy" and the plaintiff failed to raise any allegations that the State has modified or denied coverage under the long term care plan in violation of the diminishment clause. Defendant reserves the right to raise additional affirmative defenses as this matter proceeds.

**B. Persons likely to have discoverable information.**

**1. Current State Employees**

The following individuals are current state employees. The attorney client privilege applies and they may be contacted only through undersigned counsel.

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**E. Photos, diagrams and videotapes relevant to disputed facts alleged with particularity in the pleadings.**

Aside from those documents disclosed under section (D), defendant is not aware of any other relevant charts, photographs, diagrams, or videotapes.

**F. Insurance agreements.**

Not applicable.

**G. Category of damages claimed.**

If defendant prevails in this matter, the State will seek costs and attorney's fees as allowed by law.

**H. Identity of all potentially responsible persons.**

Not applicable.

DATED April 29, 2016.

CRAIG W. RICHARDS
ATTORNEY GENERAL

By:
Jessica M. Alloway
Assistant Attorney General
Alaska Bar No. 1205045

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