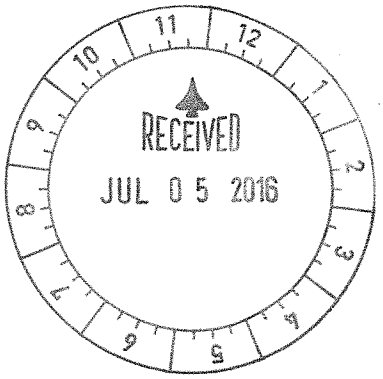
IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

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 CROSS-MOTION FOR SUMMARY JUDGMENT

Defendant Sheldon Fisher cross-moves for summary judgment pursuant to Alaska Rule of Civil Procedure 56(b). The parties agree on the material facts necessary to resolve a threshold legal question: Is the State's offer of dental-visual-audio ("DVA") coverage—which is not part of the contract of employment formed when the employee is hired—protected from diminishment by article XII, section 7 of the Alaska Constitution?

A ruling in defendant's favor would resolve plaintiff's claims and require the Court to dismiss plaintiff's complaint in its entirety. A ruling in plaintiff's favor would leave a factual question as to whether changes to the dental plan amounted to a diminishment of benefits and whether those changes have been offset by comparable advantages. Defendant agrees that resolving this threshold legal question first will conserve resources and promote judicial efficiency. Defendant's cross-motion for

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summary judgment is supported by the accompanying Memorandum in Opposition to Plaintiff's Motion for Partial Summary Judgment and In Support of Defendant's Cross-Motion for Summary Judgment.

DATED July 1, 2016.

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By:

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DEFENDANT'S MEMORANDUM IN OPPOSITION TO PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT AND IN SUPPORT OF DEFENDANT'S CROSS-MOTION FOR SUMMARY JUDGMENT

INTRODUCTION

The diminishment clause in article XII, section 7 of the Alaska Constitution protects retirement benefits that are a part of the employment contract when the public employee is hired. Most state employees who entered employment prior to July 1, 2006, are members of the Alaska Public Employee's Retirement System ("PERS").[1] Participation is a condition of employment, and the PERS system mandates that all PERS members—depending on eligibility criteria—receive major medical coverage. In *Duncan v. Retired Public Employees of Alaska, Inc.*, the Alaska Supreme Court held

[1] *See* AS 39.35.115(a) (stating the plan became effective on January 1, 1961); AS 39.35.095 (stating that the Defined Benefit Plan applies only to members first hired before July 1, 2006). The Defined Benefit Plan applies only to Tiers I, II, and III. *See* Pl's Exhibit A, at 5.

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that the diminishment clause protects major medical benefits, which were accepted as part of the employment contract and provided in exchange for the employee's performance of his or her duties.[2]

In these cross-motions for summary judgment, the parties ask this Court to address whether coverage under the State's optional dental-visual-audio ("DVA") policy is similarly protected by the diminishment clause. The State contends it is not. DVA coverage is not a PERS benefit, it is not offered as part of the employment contract, employment is not conditioned on acceptance of the coverage, and the benefits are entirely self-funded by the retirees as a group. The diminishment clause does not apply to the optional, 100% retiree-paid DVA coverage, and the State is entitled to summary judgment and dismissal of plaintiff's complaint in its entirety.

STATEMENT OF UNDISPUTED FACTS

I. PERS members have an option to purchase DVA coverage to supplement the major medical coverage guaranteed as part of their retirement benefits.

The purpose of the Alaska Public Employee's Retirement System[3] is to attract qualified public employees by offering a variety of benefits to members and their survivors.[4] Employees who entered PERS prior to July 1, 2006, are members of the

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2 71 P.3d 883, 888 (Alaska 2003).

3 The Teachers' Retirement System ("TRS") has the same purpose. The issues raised by plaintiff's complaint apply equally to TRS and PERS. For ease of reference, the State will refer only to PERS throughout this pleading.

4 AS 39.35.001.

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PERS Defined Benefit Plan.[5] A defined benefit plan "defines the benefit first, and then the plan administrator attempts to set the current contribution rates to pay for those future benefits."[6]

In 1975, the Alaska Legislature expanded PERS to mandate "major medical insurance coverage" for each person entitled to receive a monthly benefit.[7] The Legislature further specified that "[c]overage shall become effective on the same date as retirement benefits commence and cease when the retired employee or survivor is no longer eligible to receive a monthly benefit."[8]

The Department of Administration's Division of Retirement and Benefits ("DRB") published a health plan booklet in 1975 to provide information on the new benefits guaranteed to PERS members.[9] It states that "[t]he entire cost of this Medical Program . . . will be paid by the Public Employees Retirement or Teachers' Retirement Systems."[10]

In 1979, the Alaska Legislature enacted additional legislation to offer DVA coverage as an optional supplement to the major medical coverage PERS members were

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5 *See* AS 39.35.095 (stating that the Defined Benefit Plan applies only to members first hired before July 1, 2006).

6 *Moro v. State*, 351 P.3d 1, 9 (Or. 2015) (referring to 26 U.S.C. § 414(j)).

7 Exhibit 1, at 1 (Secs. 1, 2, ch. 200, SLA 1975).

8 Exhibit 1, at 1 (Secs. 1, 2, ch. 200, SLA 1975).

9 Exhibit 2, (State of Alaska Health Care Program for retired employees and their family members, effective date July 1, 1975 ("1975 Booklet")).

10 Exhibit 2, at 5 (1975 Booklet).

already entitled to receive.[11] Unlike the 1975 amendment, which mandated issuance of major medical insurance, this legislation provided that PERS members "may obtain" DVA coverage and that "[a] person electing to have insurance . . . shall pay the cost of the insurance."[12] The booklet published by DRB in 1979 further explained the coverage being offered to PERS members. This was a "supplementary [DVA] plan [that was] now available to those individuals receiving benefits" from PERS.[13] "Participation in this plan is voluntary and, should [a member] elect this coverage, the premium will be deducted from [the members'] monthly benefit warrant."[14] Coverage continues so long as the member receives a monthly benefit and the member continues to pay the premiums.[15]

The 1975 session law was codified as part of AS 39.35.535, and the 1979 session law was codified in AS 39.30.090. These statutes reflect the differences in what was being offered to retirees and how the retirees could accept these offers. Alaska Statutes 39.35 et seq. govern the PERS system, and AS 39.35.535(a) provides that certain retirees who receive a "monthly benefit from the plan" and elect coverage are "entitled to major medical insurance coverage." The specific eligibility requirements for each employee may differ slightly depending on age and type of employment, but

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[11] Exhibit 3 (Sec. 1, ch. 55, SLA 1979).

[12] Exhibit 3 (Sec. 1, ch. 55, SLA 1979).

[13] Exhibit 4, at 2 (State of Alaska Voluntary Group Dental-Vision-Audio Benefits, dated October 1, 1979 ("1979 Booklet")).

[14] Exhibit 4, at 2 (1979 Booklet)

[15] Exhibit 4, at 5 (1979 Booklet)

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every employee entitled to receive a monthly benefit has satisfied some "credited service" requirement.[16] In other words, they have served as public employees for a required length of time.

In comparison, AS 39.30.090(a) provides that the State "may obtain a policy or policies of group insurance covering state employees." The underlying session law—SLA 1955, chapter 151—makes clear that the State's purchase of group insurance was discretionary, not mandatory.[17] If purchased, this group insurance policy "shall provide *one or more* of the following benefits: life insurance, accidental death and dismemberment insurance, . . . dental expense insurance, audiovisual insurance, or other medical care insurance."[18] Subsection (a)(10) details the State's offer of DVA coverage to PERS members. They "*may* obtain auditory, visual, and dental insurance" if the member electing coverage pays the cost of the insurance.[19]

II. Retirees, as a group, bear the cost of receiving dental coverage.

Membership in PERS is a condition of employment for most state employees.[20] As a "joint contributory plan," both the employee and the employer jointly contribute to funding the cost of the benefits provided.[21]

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16 *See* AS 39.35.370.

17 *See* Exhibit 5 (Sec. 2, ch. 151, SLA 1955) ("Authority is hereby granted to a government unit . . . to procure a policy or policies of group insurance covering any class or classes of its employees, "subject to [certain conditions.]").

18 AS 39.30.090(a)(1) (emphasis added).

19 AS 39.30.090(a)(10) (emphasis added).

20 AS 39.35.120(b).

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Alaska Statute 39.30.091 allows the State to self-insure any benefit it is authorized to provide through group insurance. The State self-insures the DVA plan through the premiums paid by retirees that elect coverage.[22] Therefore, unlike major medical insurance, the State does not bear the cost of providing dental insurance to retirees. The retirees, as a group, pay for their coverage.

III. Retirees may accept dental coverage under the optional DVA plan by electing coverage at the appropriate time and continuing to pay the required premiums.

A retiree eligible to receive major medical coverage at no cost must elect DVA coverage either before the effective date of their retirement benefits, or with their application for survivor benefits.[23] A retiree that must pay premiums for major medical coverage may elect coverage at the same time as those retirees eligible to receive major medical coverage at no cost, or they may elect to receive coverage during an open enrollment period if they are electing the same or increased level of medical coverage for the first time.[24] Coverage under the DVA plan will end when the retiree does not pay

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21 *See* AS 39.35.115(d) ("[PERS] is a joint contributory plan."); *see also* AS 39.35.160–240 (defining contributions by employees); AS 39.35.255 (defining contributions by employers).

22 *See* AS 39.30.090(a)(10) (stating that a member electing coverage pays the cost of the insurance); *see also* 2 AAC 39.240 ("A benefit recipient who elects dental-vision-audio insurance coverage must pay for that coverage by paying the premium established by the administrator."); 2 AAC 39.280 ("When necessary to maintain the financial integrity of the plan, the administrator may change the premiums and the terms of coverage.").

23 Pl's Exhibit B, at 4.

24 Pl's Exhibit B, at 4

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a premium or becomes ineligible to receive a benefit from the retirement system.[25] Once discontinued, retirees are not allowed to re-enroll.[26]

IV. In 2014, the State amended the dental benefits offered under its DVA coverage.

Prior to 2014, a handbook published by DRB in 2000 detailed the dental coverage offered by the State to PERS members.[27] That handbook notified members that the benefits offered by the State "may change from time to time," and, consequently, members need to make sure they have the most updated version of the handbook before deciding whether they want to continue with coverage.[28] This language is supported by the relevant regulation, which allows the State to "change the premiums and terms of coverage" when "necessary to maintain the financial integrity of the plan."[29]

In 2014, the State amended the coverage offered under the dental portion of the DVA plan by substantially adopting the standard dental plan language used by Moda Health/Delta Dental of Alaska.[30] For example, the current plan ("the AlaskaCare plan") changed how often members may receive full-mouth x-rays, implemented a frequency

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25 Pl's Exhibit B, at 5.

26 Pl's Exhibit B, at 5.

27 *See* Pl's Exhibit B.

28 Pl's Exhibit B, at 2.

29 2 AAC 39.280.

30 Complaint ¶ 16, Answer ¶ 16.

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limit for dental cleanings, and limited which members may receive topical fluoride treatments.[31]

The parties agree on these material facts and present to the Court a legal question in these cross-motions for summary judgment. Is the State's offer of DVA coverage—which is not part of the contract of employment formed when the employee is hired—protected from diminishment by article XII, section 7 of the Alaska Constitution?[32]

ARGUMENT

Dental coverage under the DVA plan—or any coverage under the DVA plan—is not offered as compensation for the state employees' public service and is therefore not protected by the diminishment clause. Pursuant to article XII, section 7, membership in PERS is a "contractual relationship" and benefits offered in the contract of employment formed when the employee is hired cannot be diminished or impaired. The State offers DVA coverage as a way for the retiree to supplement the benefits the retiree receives under the PERS plan. But, unlike other PERS benefits protected by the diminishment clause, a contract for DVA coverage does not form when the employee accepts employment. A contract exists only after the retiree elects coverage and begins paying

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[31] Complaint ¶¶ 17(a)–(c); Answer ¶¶ 17(a)-(c). For purposes of resolving the legal issue raised by the parties' cross-motions for summary judgment a detailed analysis of changes implemented through the 2014 version of the AlaskaCare plan is not required.

[32] These cross-motions do not address whether—assuming the diminishment clause applies to DVA coverage—the changes made by the State in 2014 were, in fact, a diminishment to retirees that were not accompanied by comparable new advantages. *See Duncan*, 71 P.3d at 886. The parties have agreed to present the legal question addressed in the cross-motions for summary judgment first and address the more fact intensive question of diminishment and corresponding advantages only if necessary.

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the required premium for that coverage. Because coverage under the DVA plan is not offered as consideration for the state employees' public service, and rights to DVA coverage vest only after the retiree elects coverage and begins to pay the premium, DVA coverage is not an "accrued benefit" protected by article XII, section 7.

I. A contract for dental benefits does not exist until the retiree elects coverage and pays the premium.

Article XII, section 7 provides that "[m]embership in employee retirement systems . . . shall constitute a contractual relationship." "Formation of a contract requires an offer, encompassing all essential terms, an unequivocal acceptance by the offeree of all terms of the offer, consideration, and intent to be bound by the offer."[33] Ordinarily, a promise contained within an offer becomes enforceable only when the offer is accepted.[34]

There are two types of contracts, bilateral contracts and unilateral contracts. "An offer for a bilateral contract invites the other party to accept with a return promise—that is, by *promising* some future performance."[35] "An offer for a unilateral contract invites the other party to accept with performance—that is, by actually *doing* the performance

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33 *Hall v. Add-Ventures, Ltd.*, 695 P.2d 1081, 1087 n.9 (Alaska 1985).

34 *Moro*, 351 P.3d at 20 (citing Restatement § 24 comment a ("In the normal case, . . . the offer itself is a promise[.]") and Richard A. Lord, 1 Williston on Contracts § 4.7, 449 (4th ed. 2007) (defining an ordinary offer as a "conditional promise")); *see also Kodiak Island Borough v. Large*, 622 P.2d 440, 447 (Alaska 1981) (describing an offer as an "invitation to contract").

35 *Moro*, 351 P.3d at 21 (emphasis in original) (citing *Corbin on Contracts* § 1.23).

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that the offering party seeks."[36] In other words, a unilateral contract is formed once the accepting party has fully performed its obligation under the contract.[37] The accepting party will therefore owe no future obligation to the offering party.[38]

These basic rules of contract formation apply to all contracts, including PERS contracts.[39] Before an employers' promise of PERS benefits becomes a contract, it is merely an offer that the employee may accept or reject.[40] And, because the State's offer of PERS benefits invites employees "to accept by providing current service for the employer—rather than by promising to provide some service in the future—the resulting PERS contract is a unilateral contract."[41]

Normally, an offeror may withdraw an offer for a unilateral contract at any time until the offeree has completed performance.[42] However, to prevent injustice, some contracts have "an implied term" preventing the employer from "revoking the employee's opportunity to vest those benefits."[43] "[A]n offer is impliedly irrevocable if

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36 *Id.* (emphasis in original) (citing *Corbin on Contracts* § 1.23).

37 *Id.*

38 *Id.*

39 *See id.* (stating that a PERS contract is a unilateral contract); *see also Williams v. Cordis Corp.*, 30 F.3d 1429, 1432 (11th Cir. 1994) ("[A] pension plan is a unilateral contract which creates a vested right in those employees who accept the offer it contains by continuing in employment for the requisite number of years." (internal quotation marks omitted)).

40 *Moro*, 351 P.3d at 21.

41 *Id.*

42 *Id.* at 35 & n.32 (citing Lord, 1 *Williston on Contracts* § 5:13 at 987).

43 *Id.* at 35.

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the invited form of acceptance takes time to complete and the accepting party is attempting to complete the acceptance."[44]

These basic principles are important because they refine the nature and the scope of the contracts protected by the diminishment clause in article XII, section 7. In *Duncan*, the Alaska Supreme Court held that the diminishment clause protects "all retirement benefits that make up the retirement benefit package that becomes *part of the contract of employment when the public employee is hired.*[45] This includes major medical insurance because "medical insurance is . . . part of an 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."[46] It is a form of "deferred compensation"—the State offers major medical insurance in exchange for the employees' public service, and the PERS members accept this offer by accepting employment and beginning work.[47]

Although the Court did not use these explicit words, it essentially held that the offer for major medical insurance was an offer to the state employee to enter into a unilateral contract of which the employee could accept by entering employment. Once the employee is eligible to receive payment of those benefits that employee has fully performed its obligation under the contract and owes no future performance. The

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44 *Id.*

45 71 P.3d at 888 (emphasis added).

46 *Id.* at 887.

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

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diminishment clause makes the offer irrevocable while the employee is attempting to complete the acceptance. The court applied similar reasoning in other cases when it held that article XII, section 7 protects (1) occupational disability and death benefits;[48] (2) the standard of eligibility for these benefits;[49] and (3) how the monetary benefit calculations are made.[50] These are all benefits offered to the employee as a unilateral contract through the PERS system and accepted by the employee when the employee entered employment with the State.

The occupational disability and death benefits at issue in *Hammond* are provided for under AS 39.35. Chapter 35 of Title 39 sets out the Public Employees' Retirement System. Alaska Statute 39.35.410(a) provided that "[a]n employee is eligible for an occupational disability benefit if employment is terminated because of a total and apparently permanent occupational disability." Alaska Statute 39.35.430(a), in relevant part, provided that if "the death of an employee . . . occurs before his retirement and before his normal retirement date . . . the surviving spouse's pension shall be equal to the amount the surviving spouse would have received if the employee has retired

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48 *Id.* at 1059–60 (stating that death benefits—which are essentially a life insurance policy—are an element of consideration offered to public employees in exchange for their services).

49 *Id.* at 1058 (concluding that the standard by which eligibility for benefits is determined is protected by the diminishment clause).

50 *Sheffield v. Alaska Public Employees' Ass'n, Inc.*, 732 P.2d 1083, 1084 (Alaska 1987) (holding that article XII, section 7 protects how the monetary value of the benefits are calculated, prohibiting the State from using factors that would reduce the amount of early retirement benefits the employee would receive compared to payments calculated under the system in place at the time of his employment).

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because of an occupational disability immediately before his death."[51] These benefits are funded by PERS and are automatically provided to an eligible employee.

At issue in *Sheffield v. Alaska Public Employees' Ass'n, Inc.*, was how to calculate state employees' early retirement benefits.[52] Prior to an amendment effective in 1986, the PERS Act provided that state employees' with at least five years of credited service could elect early retirement, subject to an actuarial adjustment of the amount of PERS benefits the employees would have received upon normal retirement.[53] The court held that the diminishment clause prohibited a change in the actuarial tables that would result in the employees receiving less in early retirement then they would have received through the tables in place at the time of their employment.[54] Again, under the contract they accepted at the time of employment, these employees relied on the fact that they could choose early retirement and that the benefits they would receive during early retirement would be calculated a certain way.[55]

> [T]o hold that employees have a right only to early retirement benefits which are subject to actuarial changes until retirement would vitiate Alaska's constitutional protection of accrued benefits for those employees who anticipated early retirement: they could not count on any particular amount of pension but only that they will each receive one.[56]

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51 *See Hammond*, 627 P.2d at 1054 n.3 (setting forth the relevant statute prior to the 1975 amendment).

52 732 P.2d at 1084.

53 *Id.* (citing AS 39.35.370(a)–(c)).

54 *Id.*

55 *Id.* at 1089.

56 *Id.*

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All of the retirement benefits addressed by the Alaska Supreme Court in its diminishment clause cases are governed by the Public Employees' System of Alaska Act, found within Chapter 35 of Title 39. The Act specifically provides that "[i]nclusion in the plan is a condition of employment for [most] employee[s]."[57] In other words, any employees hired prior to July 1, 2006—as a contractual condition of their employment—had to participate in PERS, but also received the benefits offered by PERS as compensation for their employment.

Unlike major medical insurance—and the other benefits the court has held protected by the diminishment clause—DVA benefits are not part of the contract of employment when the public employee is hired. Where the 1975 legislation mandated that PERS members were entitled to receive major medical coverage, the 1979 legislation provided that a retiree "may" receive DVA coverage and, if elected, the retiree must pay the cost of coverage.[58] The State therefore offers DVA coverage as an optional supplement to the major medical coverage employees receive through PERS. Being distinct and separate from benefits offered through PERS, optional supplemental insurance is governed by AS 39.30.

Because DVA coverage is not offered as a PERS benefit, the Court must separately consider when a contract for coverage is formed between the State and the retiree. A contract requires an offer, acceptance, consideration, and intent to be bound by the offer. For DVA coverage, acceptance does not occur at employment; instead, it

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57 AS 39.35.120(b).

58 *See* Exhibit 3 (Sec. 1, ch. 55, SLA 1979).

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occurs when the retiree elects supplemental insurance and agrees to pay the required premium. This is a classic bilateral contract. The employee accepts the contract with a return promise—that is, promising to pay premiums.[59] Until that time, the State has only offered DVA coverage and that "offer" may be revoked or amended.[60]

II. As long as the State continues to offer DVA benefits, retirees can continue accepting that offer by paying the premiums.

The contractual relationship between the State and PERS members does not become static once a contract is formed.[61] This concept works differently depending on whether the Court is analyzing a unilateral contract or a bilateral contract. For unilateral

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[59] The State recognizes that not all PERS members are entitled to receive major medical insurance at no cost and that these retirees must pay premiums. *See* Pl's Exhibit A, at 11. The State does not contend that major medical was not a part of the employment contract for those employees that must pay premiums. Unlike DVA coverage, major medical is a part of PERS and all employees participate in, and make contributions to PERS as a condition of their employment. A unilateral contract for major medical is therefore formed at the time of employment as opposed to when a retiree first pays premiums. *See* AS 39.35.120(b) ("Inclusion in [PERS] is a condition of employment."); AS 39.35.115(d) ("[PERS] is a joint contributory plan."); AS 39.35.160–240 (defining contributions by employees); AS 39.35.255 (defining contributions by employers).

[60] As discussed by the Oregon Supreme Court in *Moro*, in some circumstances an offer for a unilateral contract may contain an implied term preventing the offeror from revoking the offer. 351 P.3d at 35. This implied term may arise "[w]hen the performance necessary to accept the offer takes time to complete," and it alleviates the "concern that the offering party will revoke the offer after receiving partial performance but before receiving the complete performance necessary to form the unilateral contract." *Id.* The State's offer of DVA coverage does not contain such an implied term because (1) it is not an offer for a unilateral contract dependent on performance by the employee; and (2) acceptance does not take time to complete. Instead, the retiree may accept the offer of coverage at the time of retirement by electing coverage and paying the premium.

[61] *Moro*, 351 P.3d at 22.

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contracts such as the PERS contract, "[a]s long as the [State] continues offering PERS benefits, PERS members can continue accepting that offer and, thereby, earn additional contractual rights to additional PERS benefits."[62] A PERS member may therefore accept improvements to the benefits offered by continuing employment, but article XII, section 7 prevents those benefits from being "diminished or impaired."[63]

Bilateral contracts, such as those formed when a retiree agrees to pay premiums for DVA coverage, work differently. The State's offer to provide DVA coverage is a continuing offer. The contract reaches only as far as a member has accepted the offer, and the member's acceptance reaches only as far as the premium that the member has paid.[64] In 2014, the State offered a new dental plan and revoked the DVA plan offered in 2000. Up through 2014, the retiree accepted coverage offered by the 2000 plan through payment of their monthly premium.[65] However, the State may choose to change or revoke an unaccepted offer of DVA coverage for future premiums. This occurred in 2014. The retiree may choose to accept the State's new offer of dental coverage by continuing to pay their premium or they may reject that offer by not paying their premium. But, as discussed in more detail below, the State is under no obligation to keep the offer of coverage under the 2000 plan open indefinitely.

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62 *Id.*

63 *Duncan*, 71 P.3d at 886 ("This means that system benefits offered to retirees when an employee is first employed and as improved during the employees' tenure may not be 'diminished or impaired.'").

64 *See Moro*, 351 P.3d at 22–23.

65 Pl's Exhibit B, at 57.

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III. The diminishment clause does not prevent the State from revoking or modifying its offer of DVA coverage.

The diminishment clause protects "all retirement benefits that make up the retirement benefit package that becomes *part of the contract of employment when the public employee is hired.*[66] This is because "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.'"[67] They serve as "deferred compensation" to qualified public employees who have provided the required length of public service and can establish their eligibility.

All of the "retirement benefits" the Alaska Supreme Court has held protected by article XII, section 7 are provided via the Public Employees' Retirement System and governed by Chapter 35 of Title 39.[68] Participation in this system—in other words acceptance of this contract—is a condition for most state employees.[69] These employees are required to make contributions to the system throughout the course of their public employment, and, as a result, the Alaska Supreme Court had held that the

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66 *Duncan*, 71 P.3d at 888 (emphasis added).

67 *Id.* at 888 (quoting *Hammond*, 627 P.2d at 1056).

68 *Hammond*, 627 P.2d at 1059–60 (holding death benefits offered through PERS are protected by the diminishment clause); *id.* at 1058 (concluding that the standard by which eligibility for benefits is determined is protected by the diminishment clause); *Sheffield*, 732 P.2d at 1084 (stating that the diminishment clauses protects how benefits are calculated).

69 AS 39.35.120(b).

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"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.'"[70]

But DVA coverage is different. In *Livingston v. Metropolitan Utilities District*, the Nebraska Supreme Court recognized the significance of this difference when it held that the Metropolitan Utilities District ("MUD") had the right to modify the long-term disability ("LTD") policy it offered as optional coverage to its employees.[71] Similar to the plaintiff in this case, Livingston argued "that at the time he was offered and accepted employment with MUD, he was promised that he would have the option to obtain lifetime LTD coverage."[72] And, similar to the Alaska Supreme Court's diminishment clause jurisprudence, "Nebraska has long recognized that pensions are not gratuities."[73] Previously, the Nebraska Supreme Court "held that a pension plan offered to officers of the Nebraska State Patrol . . . was 'deferred compensation, earned in exchange for services rendered [and created] in the employees reasonable expectations entitled to legal protection.'"[74]

Nevertheless, despite its previous decision, the Nebraska Supreme Court held that optional coverage under the LTD plan is not a pension protected by the Contracts

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70 *Duncan*, 71 P.3d at 886.

71 692 N.W.2d 475, 477 &479 (2005).

72 *Id.* at 479.

73 *Id.* at 480.

74 *Id.* (quoting *Haplin v. Nebraska State Patrolmen's Retirement Sys.*, 20 N.W.2d 910 (Neb. 2000)).

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Clause.[75] Deferred compensation is "compensation which is earned in exchange for services rendered."[76] But—as with the State's DVA coverage—enrollment in the "LTD plan was purely voluntary[,] and the accrual of coverage under this policy was not contingent upon the rendering of services, but instead depended upon the payment of premiums and the occurrence of an injury."[77]

Further support that DVA coverage is not protected by the diminishment clause is provided in the session laws and statutes codifying the same. The State is not obligated to provide group insurance policies. [78] Alaska Statute 39.30.090(a) provides that the State "may obtain a policy or policies of group insurance covering state employees." This group insurance policy "shall provide *one or more* of the following benefits: life insurance, accidental death and dismemberment insurance, . . . dental expense insurance, audiovisual insurance, or other medical care insurance."[79] In other words, the statute provides that any group insurance policy offered by the State must provide at least one of the delineated benefits, but it does not have to provide all of them. In 1979, the Legislature granted PERS members the ability to participate in group insurance policies offered by the State. Alaska Statute 39.30.090(a)(10) provides that

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75 *Id.*

76 *Id.*

77 *Id.*

78 *See* Exhibit 5 (Sec. 2, ch. 151, SLA 1955) (providing "authority" to procure group insurance policies).

79 AS 39.30.090(a)(1) (emphasis added).

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PERS members "*may* obtain auditory, visual, and dental insurance" if the member electing coverage pays the cost of the insurance.[80]

Alaska courts generally give popular or common words in a statute their ordinary meaning.[81] The use of the word "may" implies that the action is permissive or discretionary.[82] The Alaska Legislature's use of the word "may" when referring to optional DVA coverage—when it used "shall" in the context of major medical coverage[83]—further supports a conclusion that the State retains the discretion to modify or revoke its offer of DVA coverage to PERS members.[84]

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[80] Emphasis added; *see also* Exhibit 3 (Sec. 1, ch. 55, SLA 1979) (stating that PERS members "may obtain" DVA coverage and that "[a] person electing to have insurance . . . shall pay the cost of the insurance").

[81] *See Wilson v. State, Dep't of Corrections*, 127 P.3d 826, 829 (Alaska 2006).

[82] *See State, Dep't of Transp. and Pub. Facilities v. Sanders*, 944 P.2d 453, 457 (Alaska 1997) (holding that the use of "may" indicate that officials maintained discretion); *Putnam v. State*, 930 P.2d 1290, 1292 (Alaska Ct. App. 1996) (stating that the use of the permissive "may" implies the existence of other alternatives); *see also Livingston*, 692 N.W.2d at 481 (concluding that the use of the "word 'may' in this statute implies that the MUD board of directors has discretion with regard to whether any LTD plan is implemented," and that use of the word "may" "gives the board the discretion to modify those terms of employment enumerated in the statute").

[83] *See* Exhibit 1, at 1 (Secs. 1, 2, ch. 200, SLA 1975).

[84] The following example illustrates why the diminishment clause is simply not an applicable concept in an optional, 100% retiree-paid context under AS 39.30. In year 1, the State offers a dental plan to retirees at $100 per month, and the plan pays for fluoride treatment for any patient whose dentist prescribes fluoride treatments. In year 5, the costs go up and the State modifies the plan to allow for the same fluoride treatment coverage but the cost is $200 per month. Arguably, if the *Duncan* analysis applied, this would be a diminishment. However, the retirees, not the State, pay in the increase in cost.

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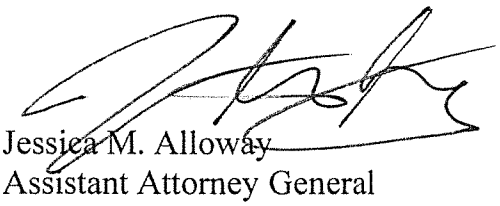
Simply put, DVA coverage does not serve as "deferred compensation" to retirees and participation in the system that funds DVA coverage is not required of all state employees. It is a program that the employee or the retiree may opt into by agreeing to pay premiums. It is entirely self-funded by the retirees as a group and the State does not bear the cost of providing dental insurance to the retirees. Retirees, as a group, get what they pay for, and DVA coverage is not an "accrued benefit" protected by article XII, section 7.

CONCLUSION

Article XII, section 7 protects state employees from losing benefits they contracted for in return for their public service. DVA coverage is not a benefit offered to retirees as consideration for their state service. It is something that the State offers to retirees separate from their employment contract, their employment was not conditioned on the retirees accepting coverage under the plan, and the benefits are entirely funded by the retirees as a group. For the reasons stated, the State is entitled to summary judgment in its favor, dismissing plaintiff's complaint in its entirety.

DATED July 1, 2016.

JAMES E. CANTOR
ACTING ATTORNEY GENERAL

By: 
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LAWS OF ALASKA

1975

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Chapter No.

200

AN ACT

Relating to retirement; and providing for an effective date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 14.25.168 is repealed and re-enacted to read:

Sec. 14.25.168. MEDICAL BENEFITS. Each person who is entitled to receive a monthly benefit from the retirement system shall be provided with major medical insurance coverage. Coverage shall become effective on the same date as retirement benefits commence and cease when the retired employee or survivor is no longer eligible to receive a monthly benefit. The level of coverage for persons over age 65 shall be the same as that available prior to reaching age 65 except that the benefits payable shall be supplemental to those afforded under the federal Old Age Survivor and Disability Insurance Program, if any.

* Sec. 2. AS 39.35 is amended by adding a new section to read:

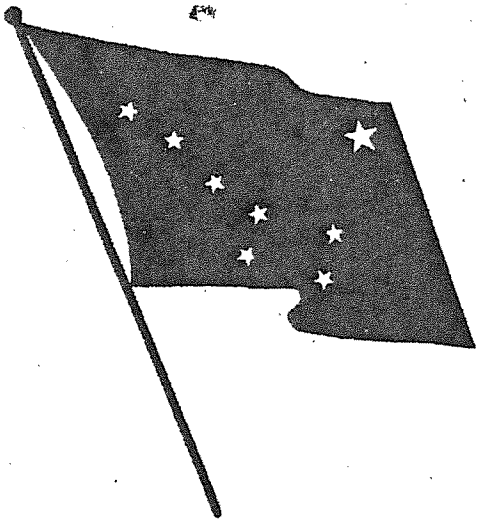
Sec. 39.35.535. MEDICAL BENEFITS. Each person who is entitled to receive a monthly benefit from the retirement system shall be provided with major medical insurance coverage. Coverage shall become effective on the same date as retirement benefits commence and cease when the retired employee or survivor is no longer eligible to receive a monthly benefit. The level of coverage for persons over age 65 shall be the same as that available prior to reaching age 65 except that the benefits payable shall be supplemental to those afforded under the federal Old Age Survivor and Disability Insurance Program, if any.

* Sec. 3. AS 39.35.680(14) is amended to read:

(14) "peace officer and fireman" means an employee who is employed full time in the state as a peace officer, chief of police, correctional officer, correctional superintendent, fish and game field biologist and technician, fireman or fire chief;

* Sec. 4. This Act takes effect on July 1, 1975.

Approved by governor: June 25, 1975
Actual effective date: July 1, 1975



State of Alaska
Health Care Program

for
retired employees and
their family members

State of Alaska Retirees

Effective Date July 1, 1975

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

Dear Retired Employee:

I am pleased that the Alaska Legislature amended the statutes to provide this comprehensive health care program for all retirees and their eligible dependents under the Public Employees' and Teachers' Retirement Systems.

We are all aware of these inflationary times in which medical costs have risen dramatically. Those on fixed incomes are especially hard hit by the higher cost-of-living.

I hope this program, underwritten by Blue Cross of Washington and Alaska will help you to enjoy the secure and relaxed retirement you deserve after your years of service to Alaska.

Sincerely,

Jay S. Hammond
Governor

TABLE OF CONTENTS

SECTION I

SECTION II

SECTION III

SECTION IV

SECTION I

BENEFITS AND COST

Your coverage under this Medical Program for Retired Employees will consist of the benefits described in this booklet. Please pay particular attention to the effect of Medicare on the computation of such benefits.

The entire cost of this Medical Program for Retired Employees and their eligible family members will be paid by the Public Employees Retirement or Teachers' Retirement Systems.

ELIGIBILITY AND EFFECTIVE DATE

Retired Employees

You will be eligible for this program on the effective date of your retirement, but not before July 1, 1975. You will continue to be covered as long as you are eligible to receive a monthly benefit from either retirement system.

Dependents

Eligible dependents are your spouse and unmarried dependent children from birth to 23 years of age. Age restrictions do not apply for those who are mentally or physically handicapped. If you die, your dependents will remain covered as long as they receive a monthly benefit from the Retirement Systems.

No person may be insured both as a retired employee and a dependent or as the dependent of more than one retired employee.

Effect of Medicare

When you or your covered dependent become eligible for Medicare, it will be assumed that you have applied for Medicare Part B (physicians expense). Medicare benefits for which you are eligible will be subtracted from total covered expenses before the benefits payable under this program are calculated.

SECTION II

SCHEDULE OF BENEFITS

If you or your dependents incur Covered Medical Expenses during a Benefit Year, your benefits, after subtracting any Medicare benefits payable, will be calculated as follows:

Deductible Amount $50

Co-insurance Percentage – 80% of the first $1,950 of Covered Medical Expenses which are in excess of the Deductible Amount in each Benefit Year, then 90% of the next $3,000 then 100% of Covered Expenses for the remainder of that benefit year up to the Lifetime Maximum.

Lifetime Maximum Benefit

The amount of the Maximum Benefit for all Covered Medical Expenses is $250,000. This $250,000 maximum applies separately to each insured family member. Any benefits paid which have not been previously restored will reduce the $250,000 Maximum Benefit available. Up to $5,000 will be restored on each July 1.

THE DEDUCTIBLE

The Deductible Amount each Benefit Year (July 1 to June 30) is:

Per individual $50.00

Per Family ..... Maximum of 3 Separate Deductibles

Only Covered Medical Expenses incurred after the effective date of the member's coverage may be used to meet the Deductible Amount.

Blue Cross of Washington and Alaska will automatically subtract the appropriate Deductible Amount from the first medical claims submitted during a Benefit Year.

The Deductible is applied against the incurred Covered Medical Expense of each person each Benefit Year, except that –

(1) Any medical expenses incurred during the last 3 months of a Benefit Year and used to satisfy all or part of the Deductible Amount for that year may be used also to satisfy all or part of the Deductible Amount for the next succeeding Benefit Year. This applies only to claims submitted under this group program.

(2) In the event of a common accident, not more than one Deductible Amount is applied to all medical expense incurred on account of 2 or more family members as a result

of injuries sustained in the accident in the Benefit Year in which the accident occurs and the next succeeding Benefit Year.

(3) The Deductible Amount will not be applied more than 3 separate times each Benefit Year regardless of the number of family members.

COVERED MEDICAL EXPENSES

The term "Covered Medical Expenses" means the usual, customary and reasonable charges incurred by yourself or your dependents upon the recommendation and approval of the attending physician, for the services and supplies listed below and required in connection with the treatment for an injury, sickness, or maternity.

Physicians' Services: Charges for the services of a duly qualified physician for:

(1) Performing a surgical procedure, and

(2) Other medical care and treatment, subject to the Section captioned "Mental or Nervous Disorder Restriction" on page 8.

Hospital Services: Charges made by a hospital for:

(1) Room and Board as follows:

(a) the hospital's most prevalent charge for semi-private room accommodations, and

(b) the charge for an intensive care unit or coronary unit when ordered by your physician.

If a private room is used the difference between the cost of semi-private accommodations and private room charges will be the member's responsibility.

Charges incurred for a child during the period immediately following the birth shall be covered *only* for the following conditions:

1) accidental injury
2) sickness
3) abnormal congenital condition
4) premature birth

(2) Other Hospital Services and Supplies, as defined herein.

Dentist's Services: Charges made by a duly qualified dentist (D.D.S. or D.M.D.) for treatment of fractures and dislocations of the jaw, and for removal of impacted or unerupted teeth.

Nursing Care: Charges for the services of a trained nurse (R.N. or L.P.N.) for nursing care, other than a nurse who is a relative by blood or connection by marriage or who ordinarily resides in your home, provided the nursing care is necessary as evidenced by a written statement of the attending physician.

Transportation Benefit: Charges for the one-way transportation of the retired employee or dependent, as the case may be, within the continental limits of the United States of America and Canada, and within the geographical boundaries of Puerto Rico, State of Hawaii, and the State of Alaska.

(a) by professional ambulance other than air ambulance to a hospital, or

(b) by commercial air transportation from the location where you or your dependent became disabled to the nearest location where professionally adequate treatment is available. In order to be eligible for this benefit, your disability must meet one of the following tests:

(a) It must be a life-endangering emergency requiring immediate transfer to a hospital that has special facilities or equipment that are necessary to treat the condition. Under certain extreme circumstances and when medically necessary, as determined by the Blue Cross Plan, the transportation charges for a physician and/or registered nurse will be recognized as an eligible expense.

(b) Or, it must be a condition that requires surgery which cannot be performed at the location where you became disabled.

(c) Or, it must be a condition that requires a specific and generally accepted treatment that is not available at the location where you became disabled.

NOTE: (b) and (c) only. The Member's doctor must provide written certification of medical necessity to the Blue Cross Plan office in Anchorage. Upon receipt of such certification the Plan will, in writing, advise the Member to what

extent transportation benefits will be provided. (See claim office on page 18.)

If the patient is a child under 12, the transportation charges of a parent or legal guardian accompanying the child will be allowed if the attending physician certifies the need for such attendance.

X-Ray and Laboratory Examinations: Charges made for X-ray examinations and for laboratory tests or analysis made for diagnostic or treatment purposes — except for x-ray and laboratory examinations related to routine physicals.

Radiation Therapy: Charges made for X-ray, radon, radium, and radioactive isotope treatments.

Anesthetic: Charges made for an anesthetic and its administration.

Pregnancy: Pregnancy and childbirth will be covered as any other medical condition, provided conception occurred while covered under this program.

Medical Supplies: Charges for the following:

(1) Drugs and medicines covered by written order of a physician. (Birth control pills or devices are not covered.)

(2) Bandages and surgical dressings.

(3) Surgical supplies such as appliances to replace lost physical organs or parts or to aid in their functions when impaired, except that only the initial charge for the first such appliance shall be included.

(4) Oxygen or rental of equipment for the administration of oxygen.

(5) Rental of a wheelchair or hospital-type bed.

(6) Rental of an iron lung or other mechanical equipment for the treatment of respiratory paralysis.

(7) Blood and Blood plasma to the extent it is not donated or otherwise replaced.

MENTAL OR NERVOUS DISORDERS RESTRICTION

Charges for the services of a duly qualified physician for medical care and treatment in the case of a mental or nervous disorder, will be provided, up to $15.00 per visit, for 1 visit per day as follows:

(a) if you or your dependent are not confined as a resident in-patient in a hospital,

(i) 3 visits per week during the first 3 calendar weeks of any one period of treatment.

(ii) 2 visits per week during the next 2 calendar weeks of any one period of treatment.

(iii) 1 visit per calendar week thereafter during any one period of treatment.

Any and all charges made on account of any one person while such person is covered under the program shall be considered made during one period of treatment.

(b) if you or your dependent are confined as a resident in-patient in a hospital,

(i) 1 visit per day during the first 4 calendar weeks during any one period of confinement,

(ii) 2 visits per calendar week thereafter during any one period of confinement.

Successive periods of hospital confinement separated by less than 90 days shall be considered one period of confinement.

WHAT MEDICAL EXPENSES ARE NOT COVERED

No payment shall be made on account of expenses incurred as a result of any of the following charges:

(1) Charges eligible for reimbursement under Medicare.

(2) Charges for the services of a dentist, except

(a) as may be required on account of accidental injury to natural teeth sustained while the individual is covered, and

(b) charges for Dentist's or Oral Surgeon's Services as described under Covered Medical Expenses.

(3) Charges incurred for

(a) eye refractions or hearing aids, or the fitting of eye glasses or hearing aids, and

(b) dental prosthetic appliances or the fitting thereof, except as may be required on account of accidental bodily injury to physical organs sustained while the individual is covered.

(4) Charges incurred on account of injury or other loss sustained as a result of war, or an act of war, whether war is declared or not, or any international armed conflict or conflict involving armed forces of any international authority.

(5) Charges incurred in connection with pregnancy, childbirth, or miscarriage, unless conception occurs while covered under this program.

(6) Charges you would not be required to pay if there were no insurance, other than charges for services which are normally furnished, paid for or reimbursable under the section of Maternal and Child Health and Crippled Children's Services of the Division of Public Health of the Department of Health and Social Services of the State of Alaska.

(7) Charges incurred in connection with (a) injuries sustained while doing any act or thing pertaining to any occupation of employment for remuneration or profit, or (b) disease for which benefits are payable in accordance with the provisions of any workmen's compensation or similar law.

(8) Charges incurred with respect to a dependent if such dependent is entitled to benefits as an employee or former employee of the State of Alaska.

(9) Charges incurred with respect to a dependent during or in connection with a period of hospital confinement which commenced prior to the date the dependent became covered under the program.

(10) Charges incurred for education, training, and bed and board while you or your dependent, as the case may be, is confined in an institution which is primarily a school or other institution for training, a place of rest, a place for the aged, or a nursing home.

(11) Charges incurred for Custodial Care. The term "Custodial Care" as used herein means that type of care, wherever furnished and by whatever name called, which is designed primarily to assist an individual in meeting his activities of daily living.

(12) Charges incurred or in connection with cosmetic treatment or surgery unless

(a) such treatment or surgery is rendered by a physician for injuries sustained in an accident which occurs while you or your dependent, as the case may be, is covered and such treatment or surgery is started within 90 days of the date of such accident, or

(b) such treatment or surgery is for a congenital anomaly in your child provided such child was born while you were covered for Comprehensive Medical Expense Benefits.

(13) Charges incurred for extraction of teeth or other dental processes, except that the Blue Cross Plan will provide hospital care when adequate care cannot be provided without the use of hospital facilities.

(14) Charges incurred for sterilization procedures.

(15) Charges for services or supplies not specifically listed as covered benefits.

(16) Charges incurred for mental, psychoneurotic and personality disorders, except as provided under Mental or Nervous Disorders Restriction.

(17) Charges for physical examinations or tests, including screening examinations, not connected with the care and treatment of an actual illness, disease or injury; x-ray, laboratory and pathological services and pathological services, and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms.

(18) Charges for the cost of blood and blood derivatives that is replaced by voluntary means.

(19) Charges for hospitalization primarily for diagnostic studies, physical examinations or checkups, medical evaluation or observation.

(20) Charges for admission or treatment primarily for rehabilitative care (including, but not limited to, speech and occupational therapy). Further when the type of care rendered during a continuous period of hospital confinement develops into primarily rehabilitative care, that portion of the stay beginning on the day of such development is not covered under this program.

(21) Charges for routine foot-care procedures such as the trimming of nails, corns, or calluses, fallen arches or other symptomatic complaints of the feet, impression casting

for prosthetics and appliances including prescriptions therefor and routine hygienic care.

(22) Charges for services or procedures which are not customary and accepted by the medical profession generally, and services or procedures which are experimental or for the purpose of research.

(23) Charges for services or supplies related to sex transformations or sexual misfunctions or inadequacies.

(24) Charges for services or supplies not medically necessary for treatment of disease, illness or injury; treatment for obesity.

(25) Charges for visual analysis, therapy, or training relating to muscular imbalance of the eye; orthoptics.

SECTION III

COORDINATION OF BENEFITS PROVISION

Many persons carry more than one group health care program to protect them against medical costs. As a result they often collect more than the actual cost of services received. This results in higher membership costs for everyone, including those who carry only one program. To prevent this and keep costs at a minimum, Blue Cross of Washington and Alaska will take into account any coverage you or your family members have under other *group* programs.

Specifically, the plan will provide the benefits of this program in full, or a reduced amount which, when added to the benefits paid by the other group program or programs, will pay up to 100 per cent of covered hospital and medical expenses.

In no event shall a member recover more than the total medical or hospital expense incurred.

USUAL, CUSTOMARY AND REASONABLE

What does "usual, customary and reasonable" mean?
The provision recognizes that there will be differences in physicians' charges because of such factors as geographical location, skill of the physician and the complexity of the service performed.

In determining the usual, customary and reasonable fee, the Plan takes into consideration:

- The usual charges or fee which the provider of services most frequently charges to the majority of his patients or customers for a similar service or medical procedure.
- The charges or fees which fall within the customary range of charges or fees in a locality for the performance of a similar service or medical procedure.
- The charges or fees which fall within the customary range of charges or fees in a locality for the performance of a similar service or procedure; (in the event there are too few providers in any given locality from which to determine a customary range of charges or fees for a given service or supply, the Plan will determine the amount payable based upon the customary range of charges or fees in a wider geographical area such as the State in which the provider of service is located.)
- Unusual circumstances or complications requiring additional time, skill, and experience in connection with a particular service or procedure.

The Plan makes the final determination as to whether or not the charge or fee is "usual, customary and reasonable." At the same time, the Plan doesn't tell a physician or other provider what he must charge. Any charge in excess of the Plan's "usual, customary and reasonable" standard is a matter between the member and the provider of service.

EXTENDED BENEFITS

Extended Benefit after Termination of the Retired Employees Medical Program

If, for any reason, coverage under this program should terminate while you or your dependent are totally disabled, coverage for the disabled person would be continued as follows:

(a) Any unpaid portion of the deductible amount must be satisfied within 3 months of the termination date.

(b) Only expenses relating to the illness or injury causing the disability will be recognized.

(c) Coverage would continue as long as the disability continued, but beyond 12 months following the termination date and not beyond the effective date of any other group or employer-sponsored medical program.

CONDITIONS UNDER WHICH HOSPITAL CARE WILL BE FURNISHED

Hospital care will be provided for disabilities arising from illness or injury, only while the member is under the care of a physician and surgeon and only while the member is necessarily confined as a registered bed patient in a hospital (as defined) and only when admission to the hospital was subsequent to the effective date of coverage hereunder.

The Retired Employees identification card should be presented at the time of admission or during the hospital stay.

If a person is hospitalized at the time when the benefits of this program are changed, the benefits that will apply are those in effect the day he first became hospitalized. Any change in benefits then will become effective the day he is discharged from the hospital.

Blue Cross of Washington and Alaska reserves the right to make payment for hospital and other services direct to the provider of such services, or, at the Plan's option, on a co-pay basis.

EFFECT OF MEDICARE

1. Persons Subject to This Provision
   Each Person Subject to Medicare (as defined below) covered under the program is subject to this Provision, but, except to the extent stated herein, the provisions of the program have full force and effect with respect to such persons.
2. Definitions
   The term "Person Eligible under Medicare" means a retired employee who is enrolled and covered under the voluntary portion of Medicare or has been eligible to enroll and be covered under such voluntary portion.
   For purposes of this Retired Medical Program, each person eligible for Medicare will be assumed to have at least Part B (physicians care) coverage. Except for certain retired teachers who are not provided with Part A of Medicare, all participants will be assumed to have coverage under both Part A and Part B of Medicare.
3. Effect of Medicare
   Any Medicare Benefits which a member of this Retired Employee Medical Program is eligible to receive will be subtracted from the total of Covered Medical Expense before benefits under this program are calculated.

SECTION IV

DEFINITIONS

Retired Employee Benefits

"Retired Employee Benefits" means the benefits provided hereunder with respect to the Retired Employee only.

Dependent Benefits

"Dependent Benefits" means the benefits provided with respect to the Retired Employee's dependents only.

The term "dependent" with respect to the Retired Employees Medical Program is limited to:

(a) The Retired Employee's wife or husband, as the case may be, and

(b) The Retired Employee's unmarried dependent children under 23 years of age.

However, any dependent child who attains the 23rd anniversary of his date of birth shall continue to be included within the term "dependent" with respect to the medical benefits if proof is furnished to the Plan within 30 days after such anniversary that on such anniversary such child is incapable of self-sustaining employment by reason of mental retardation or physical handicap and that such child became so incapable prior to his attainment of age 23 and while your coverage with respect to your dependents remains in force, provided such child meets all the requirements of the definition of "dependent" except age. Blue Cross of Washington and Alaska shall have the right to require proof of the continuance of such incapacity of such child from time to time while this program remains in force.

Children

The term "children" means

(a) the Retired Employee's own children and legally adopted children, and

(b) the Retired Employee's step-children, foster children, and other children wholly dependent on the Retired Employee for support and residing with the Retired Employee in a regular parent-child relationship.

Benefit Year

The term "Benefit Year" means a period of 12 consecutive calendar months commencing with July 1 and terminating the next succeeding June 30.

Totally Disabled

The term "totally disabled" means

(a) the complete inability of a Retired Employee to perform any and every duty pertaining to his occupation or employment (if employed), or

(b) the complete inability of a Retired Employee or dependent to perform the normal activities of a person of like age and sex.

The Plan reserves the right of determination of total disability based upon report of a duly qualified physician.

Hospital

The term "hospital" means an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an in-patient basis at the patient's expense and which fully meets all the tests set forth in (a) or (b) or (c) below:

(a) It is a hospital accredited by the Joint Commission on Accreditation of Hospitals.

(b) It is a hospital, a psychiatric hospital, or a tuberculosis hospital, as those terms are defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare.

(c) It is an institution which fully meets all of the following tests:

(1) It maintains on the premises diagnostic and therpeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified physicians; and

(2) It continuously provides on the premises 24 hour a day nursing service by or under the supervision of registered graduate nurses; and

(3) It is operated continuously with organized facilities for operative surgery on the premises.

Medicare
The term "medicare" means the Health Insurance For The Aged program under Title XVIII of the Social Security Act as such Act was amended by the Social Security Amendments of 1965 (Public Law 89-97), as such program is currently constituted and as it may be later amended.

Room and Board
The term "Room and Board" means room, board, general duty nursing, intensive care in an intensive care unit, and any other services regularly rendered by the hospital as a condition of occupance of the class of accommodations occupied, but not including professional services of physicians nor private duty or special nursing services rendered outside of an intensive care unit.

Other Hospital Services and Supplies
The term "Other Hospital Services and Supplies" means services and supplies rendered by the hospital and required for treatment, but not including Room and Board nor the professional services of any physician nor any private duty, special or intensive nursing services by whatever name called, regardless of whether such services are rendered under the direction of the hospital or otherwise.

Mental or Nervous Disorders
The term "mental or nervous disorder" means a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Physician
A physician means only one who is licensed to practice medicine and surgery (M.D.), osteopathy and surgery (D.O.), a licensed chiropractic physician, a licensed podiatrist or a Christian Science Practitioner authorized by The Mother Church, First Church of Christ Scientist, in Boston, Massachusetts.

HOW TO FILE A CLAIM
Your claims will be processed rapidly if you follow these instructions:

Hospital Claims
Simply show your Blue Cross Plan identification card at the time of admission. The hospital will bill the Plan directly. You will receive a copy of the hospital bill showing the hospital

charges and the payment made to the hospital by the Plan. You will be responsible to the hospital only for the difference.

Doctor Services

The easiest way to get doctor bills processed is to ask the doctor to bill the Plan directly on a Physician's Service Report (Form 9 ALA).

If you prefer to submit the Form 9 ALA yourself, complete blocks 1 through 10 and attach the doctor's itemized bill which must include the patient's name; the diagnosis (condition for which the patient is treated); doctor's name and address; itemized description of services and charges; and the date of treatment or test. If treatment is for an accidental injury, include the date and time, and how and where the accident occurred. Send the Form 9 ALA, with the doctor's itemized bill attached, to the Plan.

Drugs and Medicines

When the doctor prescribes drugs or medicines, please obtain a prescription receipt (not cash register receipts) and submit the bill to the Plan on a Record of Drugs and Medicines (Form 10 ALA). Please use a separate Form 10 ALA for each member of the family.

Other Medical Expenses

The following are some examples of expenses which should be submitted on a Physician's Service Report (Form 9 ALA) for each member of the family:

Ambulance Services
Appliances (Braces, Crutches, Wheel Chairs, etc.)
Blood and Plasma
Services of Registered Nurses
Physical Therapy Services

Complete blocks 1 throuh 10 of Form 9 ALA, attach the itemized bill for services received and submit to the Blue Cross Plan office. If the patient is eligible for Medicare, be sure to include the Explanation of Benefits form you received from Medicare. Send all medical claims to either:

BLUE CROSS OF WASHINGTON AND ALASKA
P.O. Box 2480
Anchorage, Alaska 99510
Attention: Claims Department

BLUE CROSS OF WASHINGTON AND ALASKA
P.O. Box 327
Seattle, Washington 98111
Attention: Claims Department

To insure fast claims service be sure your group and membership numbers are shown on all claims or correspondence. The numbers are listed on your identification card.

Health Conversion Privilege

If a family member should become ineligible for coverage under this Retired Employees Medical Program, that person, by applying within 31 days, may obtain individual Blue Cross coverage. Subscription charges and benefits of the individual plan will be different from this Retired Employee Medical Program.

Information on the individual program may be obtained from the Division of Retirement Benefits or from Blue Cross of Washington and Alaska.

If you have any additional questions concerning the Retired Medical Program, you should contact the:

STATE OF ALASKA
DIVISION OF RETIREMENT AND BENEFITS
Juneau, Alaska 99811
Phone: (907) 465-4468

The statements contained in this pamphlet are an explanation of the salient features of this coverage offered through Blue Cross, Washington-Alaska, Inc., and do not constitute a contract.

The full terms and conditions of this coverage are set forth in a Master Agreement between the State of Alaska and Blue Cross of Washington and Alaska. Claims payments are based solely on that Agreement. A copy is maintained with the State and at the Blue Cross Plan office in Anchorage and is available for your examination.

Comprehensive Medical Benefits
Underwritten by

Blue Cross
of Washington and Alaska

3301 C Street/P.O. Box 2480
Anchorage, Alaska 99510
907/276 1775

GROUP 7502, 7502-01
123-3738 (2-76/1M)

Chapter 55

AN ACT

Relating to insurance coverage for persons receiving benefits under the public employees' and teachers' retirement systems.

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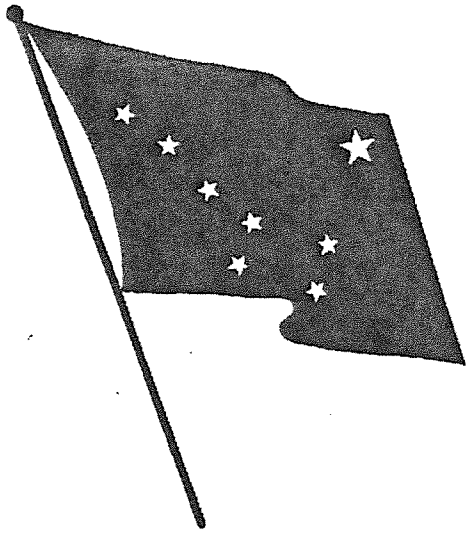
* Section 1. AS 39.30.090 is amended by adding a new paragraph to read:

(15) A person receiving benefits under AS 14.25 or AS 39.35 may obtain auditory, visual, and dental insurance for himself under this section. The level of coverage for persons over 65 shall be the same as that available before reaching age 65 except that the benefits payable shall be supplemental to those afforded under the federal old age, survivors, and disability insurance program, if any. A person electing to have insurance under this paragraph shall pay the cost of the insurance. The commissioner of administration shall adopt regulations implementing this paragraph.



State of Alaska

Voluntary Group Dental-Vision-Audio Benefits

For Individuals Receiving Benefits
From the Public Employees' or
Teachers' Retirement Systems

Retirement System Benefit Recipients

October 1, 1979

JAY S. HAMMOND
GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

October 1, 1979

Dear Benefit Recipient:

I am pleased to announce a supplementary audio-dental-visual plan which is now available to those individuals receiving benefits from the Public Employees' or Teachers' Retirement Systems.

Participation in this plan is voluntary and, should you elect this coverage, the premium will be deducted from your monthly benefit warrant.

This plan will provide you with an excellent supplement to the existing major medical insurance coverage which is provided to you through your retirement system.

Sincerely,

Jay S. Hammond
Governor

TABLE OF CONTENTS

ELIGIBILITY

WHO MAY BE COVERED

Any person receiving retirement, disability, or death/survivor benefits from the Public Employees' Retirement System or Teachers' Retirement System may elect coverage under this Voluntary Group Dental-Vision-Audio Plan. The coverage, which is for the benefit recipient alone and not his/her spouse or dependents, will consist of the benefits described in this booklet. The cost of the coverage, which is anticipated to be $27.63 per month, shall be paid by the person electing coverage.

WHEN YOUR COVERAGE STARTS

Existing Benefit Recipients

You will be eligible for this Plan only if application is made on or before October 1, 1979. Coverage will be effective the 1st of the month following the month in which the premium is first deducted from your benefit warrant.

New Benefit Recipients

You will be eligible for this Plan only if application is made within 60 days of the date you are appointed to receive benefits from either the Public Employees' or Teachers' Retirement Systems. Coverage will be effective the 1st of the month following the month in which the premium is first deducted from your benefit warrant.

WHEN YOUR COVERAGE ENDS

Existing Benefit Recipients

You will continue to be covered as long as you are eligible to receive a monthly benefit from either the Public Employees' or Teachers' Retirement Systems and as long as the premiums are continuously paid.

New Benefit Recipients

You will continue to be covered as long as you are eligible to receive a monthly benefit from either the Public Employees' or Teachers' Retirement Systems and as long as the premiums are continuously paid.

DENTAL BENEFITS

YOUR INCENTIVE TO MAINTAIN GOOD DENTAL HEALTH

This Dental Plan gives you added incentive to visit your dentist at least once each year. During the first calendar year of your coverage, the program will pay up to 70 percent of the usual, customary and reasonable charges for covered services as determined by the Blue Cross Plan. If you visit your dentist at least once during the calendar year in which your coverage commences, the amount paid the second year will increase to 80 percent. With continued yearly visits to the dentist, the percentage will increase 10 percent each year until you reach 100 percent. You must visit your dentist at least once each year that you are covered. If you miss a year, the percentage will drop by 10 percent, but never lower than 70 percent.

COVERED DENTAL EXPENSES

Maximum Allowance Per Year

This Dental Plan will pay up to $1,000 for all covered dental services during any one calendar year. You pay no deductible amount under this program.

COVERED DENTAL SERVICES

- Oral Examinations.
- Periapical and bitewing X-rays which are required.
- Topical fluoride application (painting the surface of the teeth with a fluoride solution).

Dental

- Prophylaxis, including cleaning, scaling and polishing.
- Repair of broken or fractured dentures and bridges.
- Fillings consisting of silver amalgam, silicate and plastic restorations.

For other types of fillings, such as gold foil, the allowance will be limited to what would otherwise have been allowed for an amalgam restoration.

Other services include:

- Extractions (removing teeth).
- Endodontics (treatment of disease of the tooth pulp) including pulpotomy, pulp capping and root canal treatment.
- Space Maintainers.
- Oral surgery consisting of fracture and dislocation treatment.
- Oral surgery for diagnosis and treatment of a cyst or abcess.
- Apicoectomy (surgical removal of a root tip).
- Periodontic services (treatment of the supporting tooth structures) consisting of surgical periodontic examination, subgingival curettage (scaling of root surfaces); gingivectomy and gingovoplasty (surgical removal or contouring of the gums), osseous (bone) surgery including flap entry and closure, mucogingivoplastic (contouring of the mucous membranes and gums) surgery, management of acute infection and oral lesions.

Prosthetic Replacement Services

The Plan pays up to 50 percent of the usual, customary and reasonable charges for:

- Inlays and Onlays.
- Crowns.
- Bridges -- fixed and removable.
- Dentures -- full and partial.

DENTAL SERVICES NOT COVERED

This Dental Plan will not provide benefits for:

- Appliances or restorations necessary to increase vertical dimensions or restore occlusion.
- Services for congenital deformities or for purposes of improving personal appearance; or for implants.
- Services for straightening teeth or correcting bite (orthodontia) except for tooth extraction that may be necessary in order to proceed with orthodontic services.
- Services that the dentist is not licensed to perform.
- Dental charges that are higher than what would have been charged if there were no dental program.
- Services for dentures, bridges, crowns or other such devices that had been started before the effective date of your dental coverage.

- Charges for services made after your coverage ends unless they are for prosthetic devices which are fitted and ordered before your coverage ends and are delivered within 90 days after coverage ends.

If you use the services of more than one dentist, the Plan will pay only the amount it would have paid if a single dentist had provided the services.

In all cases where there is more than one kind of treatment to choose from, the Plan will pay only for treatment which is the least expensive.

The Plan will not pay for denture replacement made less than five years after the last denture was obtained, whether or not that service was covered by this Plan. If a denture is lost or stolen, this Plan will not cover replacement costs.

Also, if in the construction of a denture, you and the dentist decide on a personalized restoration or decide to use special techniques (as opposed to standard procedures), the benefits provided under this program will be limited to the standard procedures for prosthetic services.

Note: When you receive covered dental services, the Plan will pay the proper percentage of the usual, customary and reasonable charge as determined by the Blue Cross Plan. The amount paid will not exceed the actual charge made by the dentist. Any amount not paid under this program will be your responsibility.

VISION AND OPTICAL BENEFITS

COVERED VISION AND OPTICAL EXPENSES

The Vision and Optical Plan provides 90 percent of the usual, customary and reasonable charges for the following benefits when services are performed and products are prescribed by a licensed ophthalmologist or optometrist.

(a) One complete visual examination including refraction during a calendar year.

(b) Single, bifocal, trifocal or lenticular lenses to correct vision with a maximum of two lenses during a calendar year.

Contact Lenses

Contact lenses will be covered as a single vision lens unless prescribed after cataract surgery or unless the benefit recipient's visual acuity is correctable to 20/70 or better only with the use of contact lenses. In such event, payment will be 90 percent of the usual, customary and reasonable charge. The maximum lifetime amount payable for contact lenses is $400.

Frames

The Plan will pay up to $45 during any two consecutive calendar years for frames for prescribed lenses.

VISION AND OPTICAL SERVICES NOT COVERED

- Charges for medical or surgical diagnosis, treatment of the eyes, or special procedures such as orthoptics or vision training.

- Charges for sunglasses or other special purpose visual aids (even if prescribed).
- Charges for replacement of lost, broken or stolen lenses, frames or replacement of frames for any other reason unless required to accommodate replaced lenses which are covered under this benefit.
- Charges for duplicate or spare lenses or frames.
- Services for which no charge is made.
- Charges for services or supplies provided under other provisions of this Plan or your medical program.

AUDIO BENEFITS

COVERED AUDIO SERVICES including repairs

The Audio Plan will pay 80 percent of the usual, customary and reasonable charges for a hearing evaluation, examination or a hearing aid device for you provided a hearing aid is obtained as a result of the examination. The maximum benefit is $400 in a period of three consecutive years.

In order to receive a hearing benefit, you must be examined by a physician before obtaining a hearing aid and you must also provide the Blue Cross Plan with a written certificate from the examining physician stating that you are suffering a hearing loss that may be lessened by the use of a hearing aid. Benefits will not be provided without this certification. This certification must be obtained at least three (3) months prior to obtaining a hearing aid.

When the Plan provides benefits for a hearing aid, benefits will also be provided for:

(a) An otologic (ear) examination by a physician.

(b) An audiologic (hearing) examination and evaluation by a certified or licensed audiologist including a follow-up consultation.

The hearing aid (monaural or binaural) prescribed as a result of the examination includes ear mold(s), hearing aid instrument, initial batteries, cords and other necessary supplemental equipment as well as warranty and follow-up consultation within 30 days following delivery of the hearing aid.

Audio

AUDIO SERVICES NOT COVERED

- Replacement of a hearing aid for any reason more than once in a three year period.
- Examination when no hearing aid is obtained.
- Batteries or other supplementary equipment other than those obtained upon ~~purchase of the hearing aid.~~
- Repairs, servicing or alterations of hearing aid equipment.
- A hearing aid which exceeds the specifications prescribed for correction of hearing loss.

The Plan also will not pay expenses incurred after your coverage ends unless a hearing aid is ordered before your coverage ends and is delivered within 90 days after the day your coverage ends.

Covered

GENERAL INFORMATION

GENERAL EXCLUSIONS

In addition to the exclusions already listed in the Dental, Vision and Audio Benefits, no payment shall be made on account of expenses incurred as a result of any of the following charges:

(1) Charges eligible for reimbursement under Medicare.

(2) Charges incurred for dental, vision or audio services covered under your medical program.

(3) Charges incurred on account of injury or other loss sustained as a result of war, or an act of war, whether war is declared or not, or any international armed conflict or conflict involving armed forces of any international authority.

(4) Charges you would not be required to pay if there were no insurance, other than charges for services which are normally furnished, paid for or reimbursable under the section of Maternal and Child Health and Crippled Children's Services of the Division of Public Health of the Department of Health and Social Services of the State of Alaska.

(5) Charges incurred in connection with (a) injuries sustained while doing any act or thing pertaining to any occupation or employment for remuneration or profit, or (b) disease for which benefits are payable in accordance with the provisions of any workmen's compensation or similar law.

(6) Charges incurred by any dependent of a person receiving benefits from either the Public Employees' or Teachers' Retirement Systems.

(7) Charges incurred for or in connection with cosmetic treatment or surgery.

(8) Charges for services or supplies not specifically listed as covered benefits.

(9) Charges for physical examinations or tests, including screening examinations, not connected with the care and treatment of an actual illness, disease or injury; X-ray, laboratory and pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms.

(10) Charges for services or procedures which are not customary and accepted by the medical profession generally, and services or procedures which are experimental or for the purpose of research.

(11) Charges for services or supplies not medically necessary for treatment of disease, illness or injury; treatment for obesity.

COORDINATION OF BENEFITS PROVISION

Many persons carry more than one group health care program to protect them against medical costs. As a result, they often collect more than the actual cost of services received. This results in higher membership costs for everyone, including those who carry only one program. To prevent this and keep costs at a minimum, Blue Cross of Washington and Alaska will

take into account any coverage you have under other group programs.

Specifically, the Plan will provide the benefits of this program in full, or a reduced amount which, when added to the benefits paid by the other group program or programs, will pay up to 100 percent of covered dental, vision and audio expenses. In no event shall a person recover more than the total dental, vision or audio expenses incurred.

USUAL, CUSTOMARY AND REASONABLE

What does "usual, customary and reasonable" mean?

The Plan recognizes that there will be differences in physicians' charges because of such factors as geographical location, skill of the physician and the complexity of the service performed. In determining the usual, customary and reasonable fee, the Plan takes into consideration:

- The usual charges or fees which the provider of services most frequently charges to the majority of his patients or customers for a similar service or medical procedure.

- The charges or fees which fall within the customary range of charges or fees in a locality for the performance of a similar service or procedure; (in the event there are too few providers in any given locality from which to determine a customary range of charges or fees for a given service or supply, the Plan will determine the amount payable based upon the customary range of charges or fees in a wider geographical area such as the State in

which the provider of service is located.)

- Unusual circumstances or complications requiring time, skill and experience in connection with a particular service or procedure.

The Plan makes the final determination as to whether or not the charge or fee is "usual, customary and reasonable." At the same time, the Plan doesn't tell a physician or other provider what he must charge. Any charge in excess of the Plan's "usual, customary and reasonable" standard is a matter between you and the provider of service.

DEFINITIONS

Benefits

"Benefits" means the benefits being provided to the benefit recipient alone and not his/her spouse or dependents.

Calendar Year

"Calendar Year" means the twelve (12) month period from January 1 through December 31 of any year.

Medicare

The term "Medicare" means the Health Insurance For The Aged program under Title XVIII of the Social Security Act as such act was amended by the Social Security Amendments of 1965 (Public Law 89-97), as such program is currently constituted and as it may be later amended.

HOW TO FILE A CLAIM

Physicians' and Other Providers' Services

On occasion you will find it necessary to submit bills from physicians and other health care providers. These bills can be processed more rapidly if the forms are complete and accurate. You must submit your bills within 90 days of the start of the service or within 30 days after the service is completed. The Blue Cross Plan will not pay a bill submitted twelve (12) months after the date the service is received.

The fastest way to process your bills is to ask your provider to bill the Blue Cross Plan directly on a Provider's Service Billing Form (Form 400-009).

If your provider doesn't have a supply of these forms, you may obtain them from the nearest Blue Cross Plan office. If your provider does not bill directly, please complete Part 1 (Patient Information) and have your provider complete Part 2 (Medical Information). Or, if your provider sends you an itemized billing, complete Part 1 and attach the bill to the form. The itemized bill must include:

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

Please remember, your bills can be processed most rapidly when the Provider's Service Billing Form is used. Be sure to give all the information requested including any other group health care programs by which you are covered.

Note: If you pay your bill in full when the service is provided and wish the Blue Cross Plan to reimburse you directly, do not enter the provider's IRS tax number.

Vision Services

Obtain a Vision Service Report (Form 400-1935) from your physician or the nearest office of the Blue Cross Plan. Complete the form according to its instructions. After the physician completes his/her section, mail it to Blue Cross of Washington and Alaska (address below).

Dental Services

If your dentist has a Dental Service Billing Form (400-861), ask him/her to fill it out and send it directly to the Blue Cross Plan. If he/she doesn't have a form, obtain one from the nearest office of the Blue Cross Plan. Complete blocks 1 through 9 and have your dentist complete blocks 10 through 20.

Be sure your group and subscriber numbers are shown on all bills or correspondence. The numbers are listed on your Subscriber Identification Card.

SEND ALL BILLS TO:

Blue Cross of Washington
and Alaska
P.O. Box 327
Seattle, Washington 98111
Attention: Claims Department

SHOULD YOU NEED HELP

If you have a claims problem, write to the Blue Cross office in Seattle, or call this toll free number: (the long distance access code for your area plus) 800-426-6933. A claims examiner will be happy to assist you.

Have your Subscriber Identification Card or Explanation of Benefits form available when you call. Include your group numbers from the Subscriber Identification Card on any letter you write. This information is needed to identify your particular type of coverage.

If you feel that a decision on a claim is incorrect, you may ask that your claim be reviewed. The Explanation of Benefits form you will receive, informing you that a claim has been denied in whole or part, will give the reason for denial. It is important for you to understand these reasons before deciding if you want to appeal further and if additional information will be needed.

CONCLUSION

A good deal of time has been spent in developing this voluntary Dental, Vision and Audio Plan for benefit recipients of the Public Employees' or Teachers' Retirement Systems. The Plan offers a series of benefits which the benefit recipient would find virtually unavailable in the market place on either an individual or group basis. Together with the existing major medical insurance coverage already being provided to you by your retirement system, this supplementary plan completes a package of protection which we believe is truly outstanding.

CHAPTER 151

AN ACT

To authorize group life and health insurance for employees of the Territory of Alaska and its political subdivisions.

(C. S. for H. B. 55)

Be it Enacted by the Legislature of the Territory of Alaska:

Section 1. As used in the Act

(a) The term "governmental unit" means the Territory of Alaska, any department, board or other agency of the Territory, any municipal corporation, school district or other political subdivision thereof, and, where mutually agreeable, two or more of such units.

(b) The term "eligible employee" means any employee, including elected and appointed officials, who has served in full time employment with the same governmental unit for the ninety days next preceding his election to participate in this plan excepting employees classified in the following categories: hourly, part-time, seasonal, emergency, temporary, or provisional.

Section 2. Authority is hereby granted to a governmental unit, as defined in this Act, to procure a policy or policies of group insurance covering any class or classes of its employees, subject to the following conditions.

(a) A group insurance policy shall provide one or more of the following benefits: life insurance, accidental death and dismemberment insurance, weekly indemnity insurance, hospital expense insurance, surgical expense insurance, other medical care insurance.

(b) All eligible employees within the governmental unit may be insured under any such policy, provided at least 25 employees are so insured, with respect to losses incurred on their own behalf, or on their own behalf and behalf of their lawful spouses and those of their unmarried children who are chiefly dependent upon the employees for support and maintenance.

(c) No eligible employee shall become insured unless he has given, to the governmental unit in which he is employed, a written authorization to withhold from his salary or wage the premium contribution necessary to pay for one-half the cost of such employee's insurance. Governmental units are hereby authorized to pay the remainder of the total premium on each of their insured employees, not to exceed $2.00 per month for each employee desiring coverage on himself only, and not to exceed $4.50

per month for each employ
siring coverage of self and d
ents, and shall remit premi
the insurer on behalf of al
ered employees.

(d) The group insurance
shall be issued to the governm
unit exercising the authority
tained in this Act, except
where two or more of such
join together in exercising su
thority, the policy shall be
to the governmental unit mu
agreeable to all such units so
ing together.

(e) The governmental unit
procure the insurance policy
any insurer authorized to tra
business in the Territory pur
to sections 42-1-10 and 42-1-1

C

To amend Sub-section 50-1-4 (
Session Laws of Alaska, 195
examination of applicants
operators' licenses and the

Be it Enacted by the Legislat
of the Territory of Alaska:

Section 1. Sub-section (e) of S

for employees of the Terri-
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(C. S. for H. B. 55)

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surance, weekly indemnity
e, hospital expense insur-
urgical expense insurance,
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ll eligible employees within
ernmental unit may be in-
nder any such policy, pro-
t least 25 employees are so
with respect to losses in-
on their own behalf, or on
wn behalf and behalf of
wful spouses and those of
ımarried children who are
dependent upon the employ-
support and maintenance.

To eligible employee shall
insured unless he has
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he is employed, a written
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or wage the premium con-
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: cost of such employee's in-
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authorized to pay the re-
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their insured employees, not
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ee desiring coverage on him-
ly, and not to exceed $4.50

per month for each employee desiring coverage of self and dependents, and shall remit premiums to the insurer on behalf of all covered employees.

(d) The group insurance policy shall be issued to the governmental unit exercising the authority contained in this Act, except that where two or more of such units join together in exercising such authority, the policy shall be issued to the governmental unit mutually agreeable to all such units so joining together.

(e) The governmental unit shall procure the insurance policy from any insurer authorized to transact business in the Territory pursuant to sections 42-1-10 and 42-1-11 (1) or section 42-1-11 (2) (a) of the ACLA 1949.

(f) Should the aggregate of any dividends payable under such group insurance policy exceed the governmental unit's share of the premium, the excess shall be applied by the governmental unit for the sole benefit of the employees.

(g) On or before May 15, 1955 the Territorial Treasurer shall hold an election of eligible Territorial employees to determine their intention to participate in this plan and to state their preference of insurance plan they wish to participate in.

Setcion 3. **Effective Date:** This Act shall take effect July 1, 1955.

Approved March 28, 1955

CHAPTER 152

AN ACT

To amend Sub-section 50-1-4 (e) ACLA 1949, Section 8 of Chapter 144, Session Laws of Alaska, 1953, and Section 50-3-1 ACLA, relating to the examination of applicants for, and the issuance of, motor vehicle operators' licenses and the collection of the fees therefor.

(H. B. 57)

Be it Enacted by the Legislature of the Territory of Alaska:

Section 1. Sub-section (e) of Section 50-1-4 ACLA 1949, is hereby amended to read as follows:

(e) To promulate rules and

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

[PROPOSED] ORDER GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT AND DENYING PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT

Plaintiff Retired Public Employees of Alaska, Inc. filed a motion for partial summary judgment on June 1, 2016. Defendant Sheldon Fisher opposed plaintiff's motion and cross-moved for summary judgment. The parties agree on the material facts necessary to resolve a threshold legal question: Is the State's offer of dental-visual-audio ("DVA") coverage—which is not part of the contract of employment formed when the employee is hired—protected from diminishment by article XII, section 7 of the Alaska Constitution?

The diminishment clause in article XII, section 7 protects retirement benefits that are a part of the employment contract when the public employee is hired.[1] Unlike other

[1] *Duncan v. Retired Public Employees of Alaska, Inc.*, 71 P.3d 883, 888 (Alaska 2003).

DEPARTMENT OF LAW
OFFICE OF THE ATTORNEY GENERAL
ANCHORAGE BRANCH
1031 W. FOURTH AVENUE, SUITE 200
ANCHORAGE, ALASKA 99501
PHONE: (907) 269-5100

benefits the Alaska Supreme Court has found protected by the diminishment clause,[2] DVA coverage does not serve as "deferred compensation" to retirees and participation in the system that funds DVA coverage is not required of all state employees.[3] It is a program that the employee or the retiree may opt into by agreeing to pay premiums. It is entirely self-funded by the retirees as a group and the State does not bear the cost of providing dental insurance to the retirees.

The Court finds the Nebraska Supreme Court's decision in *Livingston v. Metropolitan Utilities District*[4] persuasive. Similar to the plaintiff in this case, Livingston argued "that at the time he was offered and accepted employment with MUD, he was promised that he would have the option to obtain lifetime LTD [(long term disability)] coverage."[5] And, similar to the Alaska Supreme Court's diminishment clause jurisprudence, "Nebraska has long recognized that pensions are not gratuities."[6] Previously, the Nebraska Supreme Court "held that a pension plan offered to officers of

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2 *See id.* at 883 (concluding that the diminishment clause protects major medical benefits); *Hammond v. Hoffbeck*, 627 P.2d 1052, 1059–60 (Alaska 1981) (stating that death benefits—which are essentially a life insurance policy—are an element of consideration offered to public employees in exchange for their services); *id.* at 1058 (concluding that the standard by which eligibility for benefits is determined is protected by the diminishment clause); *Sheffield v. Alaska Public Employees' Ass'n, Inc.*, 732 P.2d 1083, 1084 (Alaska 1987) (holding that article XII, section 7 protects how the monetary value of the benefits are calculated, prohibiting the State from using factors that would reduce the amount of early retirement benefits the employee would receive compared to payments calculated under the system in place at the time of his employment).

3 *See* AS 39.35.120(b) ("Inclusion in [PERS] is a condition of employment.").

4 692 N.W.2d 475 (2005).

5 *Id.* at 479.

6 *Id.* at 480.

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the Nebraska State Patrol . . . was 'deferred compensation, earned in exchange for services rendered [and created] in the employees reasonable expectations entitled to legal protection.'"[7]

Nevertheless, despite its previous decision, the Nebraska Supreme Court held that optional coverage under the LTD plan is not a pension protected by the Contracts Clause.[8] Deferred compensation is "compensation which is earned in exchange for services rendered."[9] But—as with the State's DVA coverage—enrollment in the "LTD plan was purely voluntary[,] and the accrual of coverage under this policy was not contingent upon the rendering of services, but instead depended upon the payment of premiums and the occurrence of an injury."[10]

Further support that DVA coverage is not protected by the diminishment clause is provided in the session laws and statutes codifying the same. The State is not obligated to provide group insurance policies. [11] Alaska Statute 39.30.090(a) provides that the State "may obtain a policy or policies of group insurance covering state employees." This group insurance policy "shall provide *one or more* of the following benefits: life insurance, accidental death and dismemberment insurance, . . . dental

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[7] *Id.* (quoting *Haplin v. Nebraska State Patrolmen's Retirement Sys.*, 20 N.W.2d 910 (Neb. 2000)).

[8] *Id.*

[9] *Id.*

[10] *Id.*

[11] Sec. 2, ch. 151, SLA 1955 (providing "authority" to procure group insurance policies).

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expense insurance, audiovisual insurance, or other medical care insurance."[12] In other words, the statute provides that any group insurance policy offered by the State must provide at least one of the delineated benefits, but it does not have to provide all of them. In 1979, the Legislature granted PERS members the ability to participate in group insurance policies offered by the State. Alaska Statute 39.30.090(a)(10) provides that PERS members "*may* obtain auditory, visual, and dental insurance" if the member electing coverage pays the cost of the insurance.[13]

Alaska courts generally give popular or common words in a statute their ordinary meaning.[14] The use of the word "may" implies that the action is permissive or discretionary.[15] The Alaska Legislature's use of the word "may" when referring to optional DVA coverage—when it used "shall" in the context of major medical

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12 AS 39.30.090(a)(1) (emphasis added).

13 Emphasis added; *see also* Sec. 1, ch. 55, SLA 1979 (stating that PERS members "may obtain" DVA coverage and that "[a] person electing to have insurance . . . shall pay the cost of the insurance").

14 *See Wilson v. State, Dep't of Corrections*, 127 P.3d 826, 829 (Alaska 2006).

15 *See State, Dep't of Transp. and Pub. Facilities v. Sanders*, 944 P.2d 453, 457 (Alaska 1997) (holding that the use of "may" indicate that officials maintained discretion); *Putnam v. State*, 930 P.2d 1290, 1292 (Alaska Ct. App. 1996) (stating that the use of the permissive "may" implies the existence of other alternatives); *see also Livingston*, 692 N.W.2d at 481 (concluding that the use of the "word 'may' in this statute implies that the MUD board of directors has discretion with regard to whether any LTD plan is implemented," and that use of the word "may" "gives the board the discretion to modify those terms of employment enumerated in the statute").

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coverage[16]—further supports a conclusion that the State retains the discretion to modify or revoke its offer of DVA coverage to PERS members.[17]

Article XII, section 7 protects state employees from losing benefits they contracted for in return for their public service. DVA coverage is not a benefit offered to retirees as consideration for their state service. It is something that the State offers to retirees separate from their employment contract, their employment was not conditioned on the retirees accepting coverage under the plan, and the benefits are entirely funded by the retirees as a group.

The Court, having considered the parties' motions and supporting documents regarding the same, GRANTS defendant Sheldon Fisher's motion for summary judgment and DENIES plaintiff Retired Public Employees of Alaska, Inc.'s motion for partial summary judgment. This ruling resolves plaintiff's claims and requires the Court to dismiss plaintiff's complaint in its entirety.

DATED _____, 2016, at Anchorage, Alaska.

_____
Gregory Miller
Superior Court Judge

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16 *See* Secs. 1, 2, ch. 200, SLA 1975.

17 The following example illustrates why the diminishment clause is simply not an applicable concept in an optional, 100% retiree-paid context under AS 39.30. In year 1, the State offers a dental plan to retirees at $100 per month, and the plan pays for fluoride treatment for any patient whose dentist prescribes fluoride treatments. In year 5, the costs go up and the State modifies the plan to allow for the same fluoride treatment coverage but the cost is $200 per month. Arguably, if the *Duncan* analysis applied, this would be a diminishment. However, the retirees, not the State, pay in the increase in cost.

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

CERTIFICATE OF SERVICE

I hereby certify that on this date true and correct copies of the **Defendant's Cross-Motion for Summary Judgment, Defendant's Memorandum in Opposition to Plaintiff's Motion for Partial Summary Judgment and in Support of Defendant's Cross-Motion for Summary Judgment, Proposed Order** and this **Certificate of Service** were served via U.S. Mail on the following:

Susan Orlansky
Reeves Amodio, LLC
500 L Street, Suite 300
Anchorage, AK 99501

Shayne K. Wright July 1, 2016
Shayne K. Wright Date
Law Office Assistant I

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