IN THE SUPREME COURT OF THE STATE OF ALASKA

Kelly Tshibaka, Commissioner of the Department of Administration in her Official Capacity, Appellant, v. The Retired Public Employees of Alaska, Appellee.	)	Supreme Court No. **S-17577**

Trial Court Case No. **3AN-16-04537 CI**

APPEAL FROM THE SUPERIOR COURT
THIRD JUDICIAL DISTRICT AT ANCHORAGE
THE HONORABLE ERIC AARSETH

APPELLANT, STATE OF ALASKA, COMMISSIONER OF THE DEPARTMENT OF ADMINISTRATION'S EXCERPT OF RECORD

KEVIN C. CLARKSON
ATTORNEY GENERAL

/s/ Katherine Demarest
Katherine Demarest (1011074)
Assistant Attorney General
Department of Law
1031 West Fourth Avenue, Suite 200
Anchorage, AK 99501
(907) 269-5275

Filed in the Supreme Court
of the State of Alaska
on July __, 2020

MEREDITH MONTGOMERY, CLERK
Appellate Courts

By: _____
Deputy Clerk

TABLE OF CONTENTS

Page

IN THE SUPERIOR COURT OF THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

THE RETIRED PUBLIC EMPLOYEES OF ALASKA, INC.,

Plaintiff,

v.

SHELDON FISHER, COMMISSIONER OF THE ALASKA DEPARTMENT OF ADMINISTRATION,

Defendant.

Case No. 3AN-16-04537 CI

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

Jurisdiction and Parties

1. This is a complaint for declaratory and injunctive relief brought pursuant to AS 09.40.230, AS 22.10.020(g), and Alaska Civil Procedure Rules 57 and 65.

2. The court has jurisdiction over the parties and the subject matter of this dispute pursuant to AS 09.05.015 and AS 22.10.020(g).

3. Plaintiff, the Retired Public Employees of Alaska, Inc. ("RPEA"), is a nonprofit corporation in good standing, organized and operating under the laws of the State of Alaska. The primary purpose of RPEA is to educate retired persons who were employed by the State of Alaska about their retirement benefits and to assist them in obtaining the benefits to which they are legally entitled.

REEVES AMODIO LLC
500 L STREET, SUITE 300
ANCHORAGE, ALASKA 99501-1990
PHONE (907) 222-7100, FAX (907) 222-7199

4. RPEA has standing to sue on behalf of its constituents, and has done so in the past.

5. Defendant, Sheldon Fisher, is the current Commissioner of the Alaska Department of Administration ("DOA"). He is sued in his official capacity. Alaska statutes designate the Commissioner as the Administrator of the public employee retirement systems established under AS 39.35, AS 14.25, and AS 22.25.

6. Venue in Anchorage is appropriate because RPEA is headquartered in Anchorage and many retired state employees reside in Anchorage and are affected by the actions of the defendant at issue in this suit.

Legal Framework

7. Alaska statutes have long provided for retirement benefits to state employees. The stated purpose of the retirement benefit system is to encourage qualified personnel to enter and remain in service to the state.

8. For many years, the Alaska statutes have provided that retirees who are eligible for monthly retirement benefits are also eligible for health insurance coverage. The health insurance coverage established by state law has several components, including major medical insurance, dental-vision-audio ("DVA") insurance, and long-term care ("LTC") insurance.

REEVES AMODIO LLC
500 L STREET, SUITE 300
ANCHORAGE, ALASKA 99501-1990
PHONE (907) 222-7100, FAX (907) 222-7199

REEVES AMODIO LLC
500 L STREET, SUITE 300
ANCHORAGE, ALASKA 99501-1990
PHONE (907) 222-7100, FAX (907) 222-7199

9. State employees eligible for retirement benefits are entitled to receive major medical insurance coverage at no cost, if they complete the required forms and do not choose to waive this coverage.

10. Those who select major medical insurance coverage have an option also to select other health insurance, including DVA and/or LTC insurance coverage. The employee may select this coverage just for himself or herself or may choose to have dependents covered as well. Premiums for DVA and LTC insurance, if selected, are deducted from the monthly benefit payable to the retiree or the retiree's survivor.

11. Major medical insurance coverage and DVA insurance coverage, if selected, both begin on the same date as the monthly retirement benefits begin.

12. The Alaska Constitution, Article XII, § 7 provides that membership in a state employee retirement system constitutes a contractual relationship and that the accrued benefits of these systems "shall not be diminished or impaired."

13. The Alaska Supreme Court has interpreted Article XII, § 7 to mean that a retiree's rights to benefits accrue at the time the employee is hired, and that the state may not thereafter reduce or diminish the retirement benefits available to the employee.

14. The Alaska Supreme Court has held specifically that medical benefits available to retirees are part of the benefits protected by the Alaska Constitution, and that health insurance coverage therefore may not be diminished or impaired. Changes are

permitted, but only to the extent that any disadvantages are offset by comparable advantages.

Statement of Facts

15. Since 1975, the state has provided health insurance benefits to retirees under a plan now known as the AlaskaCare Retiree Health Plan. Benefits available to retirees are described in the Retiree Insurance Information Booklet, published in 2003 and amended periodically thereafter. The Booklet contains terms of the AlaskaCare Retiree Health Plan, including major medical insurance coverage and DVA coverage.

16. Effective January 1, 2014, DOA repealed substantially all of the provisions of the retiree dental insurance plan in effect through 2013, and replaced that plan with a different plan provided by Moda Health/Delta Dental of Alaska ("the Moda plan").

17. The adoption of the Moda plan significantly reduced the dental benefits and coverage available to retirees who had selected DVA insurance coverage. For example:

(a) The previous plan covered annual full-mouth x-rays. The Moda plan covers full-mouth x-rays only once in five years.

(b) The previous plan contained no limit on coverage for dental cleanings that a dentist determined were medically necessary. The Moda plan covers no more than two cleanings per year for most people, and no more than four cleanings per year for patients with diabetes or periodontal disease.

REEVES AMODIO LLC
500 L STREET, SUITE 300
ANCHORAGE, ALASKA 99501-1990
PHONE (907) 222-7100, FAX (907) 222-7199

(c) The previous plan covered topical fluoride treatments. The Moda plan does not cover fluoride treatments for adults unless the patient has a recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment; risk of decay due to poor diet or poor oral hygiene is specifically excluded as a basis for covering fluoride treatment.

(d) The previous plan covered tooth sealants that a dentist determined were medically necessary. The Moda plan covers sealants only on specified teeth and only once per tooth in any five-year period.

(e) The previous plan covered new dentures every five years. The Moda plan covers new dentures only every seven years.

(f) The previous plan covered general anesthesia during dental procedures when deemed necessary by the dentist. The Moda plan covers general anesthesia only for dental surgical procedures or when necessary due to another medical condition.

(g) The previous plan covered pulp capping. The Moda plan covers pulp capping only when there is exposure of the pulp.

(h) The Moda plan penalizes patients who use services from a provider who is not part of the Moda network. The previous plan imposed no such penalty.

18. The Moda plan does not contain comparable advantages to offset these and other disadvantages.

REEVES AMODIO LLC
500 L STREET, SUITE 300
ANCHORAGE, ALASKA 99501-1990
PHONE (907) 222-7100, FAX (907) 222-7199

REEVES AMODIO LLC
500 L STREET, SUITE 300
ANCHORAGE, ALASKA 99501-1990
PHONE (907) 222-7100, FAX (907) 222-7199

19. Representatives of RPEA made multiple requests to DOA in 2014 and in 2015, asking to have the Moda plan repealed and to have the previous retiree dental insurance plan reinstated.

20. Commissioner Fisher and his predecessor both refused to reinstate the benefits and coverage provided to retirees under the previous dental insurance plan.

21. Commissioner Fisher and his predecessor have not provided RPEA with an analysis that even purports to show that the disadvantages of the Moda plan are offset by comparable advantages.

22. Instead, Commissioner Fisher and his predecessor have taken the position that DVA insurance is optional for retirees and therefore it is not part of the vested retirement benefits package protected against diminishment or impairment by the Alaska Constitution.

First Cause of Action
Violation of Alaska Constitution Article XII, § 7

23. State employees hired before January 1, 2014, have the right, as part of their retirement benefits, to obtain dental insurance coverage that provides the scope of coverage available at the time they were hired.

24. The defendant's adoption of the Moda plan, and repeal of the previous dental insurance plan, diminished and impaired the accrued benefits of state employees who were hired before January 1, 2014. This diminishment violates the Alaska Constitution Article XII, § 7.

REEVES AMODIO LLC
500 L STREET, SUITE 300
ANCHORAGE, ALASKA 99501-1990
PHONE (907) 222-7100, FAX (907) 222-7199

25. The fact that dental insurance benefits are optional, such that a retiree may choose not to pay premiums for dental insurance, does not mean this category of benefits is not an accrued and vested benefit protected against diminishment under Alaska case law and the Alaska Constitution.

26. The defendant's position that the state without restriction may change the coverage or benefits of the retirees' dental insurance plan means that there is an active controversy between RPEA and the defendant.

27. Under AS 22.10.020(g), RPEA is entitled to a determination by this court declaring the rights and legal relations of retired state employees with respect to the state's ability to diminish the dental insurance benefits available to current and future retired state employees.

Request for Relief

Based upon the legal framework and facts set forth above, RPEA requests judgment in its favor and against the defendant as follows:

A. For declaratory judgment that the retiree health plans for DVA and LTC insurance are part of the accrued and vested medical benefits protected by Alaska Constitution Article XII, § 7, and that adoption of the Moda plan violated the Alaska Constitution by diminishing the accrued benefits of state employees who were hired by the state before January 1, 2014;

B. For permanent injunctive relief prohibiting the defendant from continuing to use the Moda plan for employees who were hired by the state before January 1, 2014, and requiring that the defendant either reinstate the dental insurance plan in effect as of December 31, 2013, or adopt a plan that offers comparable advantages to covered employees;

C. For an award of RPEA's costs and attorney fees incurred in connection with obtaining relief in this proceeding; and

D. For such other relief as the court deems just and equitable.

DATED this 28th day of January, 2016.

REEVES AMODIO LLC

Susan Orlansky [ABA 8106042]

REEVES AMODIO LLC
500 L STREET, SUITE 300
ANCHORAGE, ALASKA 99501-1990
PHONE (907) 222-7100, FAX (907) 222-7199

Anc.law.ecf@alaska.gov

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

THIRD DISTRICT

BY:

THE RETIRED PUBLIC EMPLOEES 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

ANSWER

Defendant, Sheldon Fisher, Commissioner of the Department of Administration, by and through the Office of the Attorney General, answers the complaint in this action as follows:

JURISDICTION AND PARTIES

1. Defendant admits that Plaintiff seeks declaratory and injunctive relief pursuant to AS 09.40.230, AS 22.10.020(g), and Alaska Civil Procedure Rules 57 and 65. Except as expressly admitted herein, Defendant denies the allegations of paragraph 1.

2. The allegations in paragraph 2 state legal conclusions to which no response is required. To the extent a response is deemed necessary, Defendant denies the allegations in paragraph 2.

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

3. Defendant lacks knowledge or information sufficient to form a belief as to the truth or falsity of the allegations contained in Plaintiff's paragraph 3 and, therefore, denies such allegations.

4. Defendant admits that Retired Public Employees of Alaska, Inc. ("RPEA") has had standing to sue on behalf of its constituents in the past. The remaining allegations in paragraph 4 state legal conclusions to which no response is required. To the extent a response is deemed necessary, Defendant denies the allegations in paragraph 4.

5. Defendant admits that he is the Commissioner of Alaska's Department of Administration ("DOA") and that Plaintiff sues him in his official capacity. Defendant admits that Alaska statutes designate the Commissioner, or the Commissioner's designee, as the Administrator of the public employee retirement systems under AS 39.35, AS 14.25, and AS 22.25. Except as expressly admitted herein, Defendant denies the allegations of paragraph 5.

6. Defendant admits that many retired State employees reside in Anchorage and venue in Anchorage is proper. To the extent this paragraph alleges Defendant failed to comply with legal requirements, Defendant denies the allegations in paragraph 6. Defendant lacks knowledge or information sufficient to form a belief as to the truth or falsity of the allegations contained in Plaintiff's paragraph 6 regarding where RPEA is headquartered and, therefore, denies such allegation.

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

LEGAL FRAMEWORK

7. Defendant admits that Alaska statutes provide for retirement benefits to State employees and that the stated purpose of the retirement benefit system is to encourage qualified personnel to enter and remain in service to the State. Except as expressly admitted herein, Defendant denies the allegations of paragraph 7.

8. Defendant admits that for a period of time starting in 1975, Alaska statutes provided that retirees who are eligible for monthly retirement benefits are also eligible for major medical insurance coverage. Eligibility requirements for major medical insurance coverage depend on whether the retiree is a member of the Defined Contribution Plan or Defined Benefit Plan. Defendant further admits that since 1979, the State has offered an optional dental-visual-audio ("DVA") plan to supplement the major medical insurance coverage. Since 1987, the State has offered an optional long term care ("LTC") plan. Participation in the DVA and LTC plans are optional. Except as expressly admitted herein, Defendant denies the allegations of paragraph 8.

9. Defendant admits that some State employees eligible for retirement benefits are entitled to receive major medical insurance coverage at no cost, if they complete the required forms and do not choose to waive this coverage. Other retirees are eligible for retirement benefits but are not entitled to receive major medical insurance coverage at no cost. Except as expressly admitted herein, Defendant denies the allegations of paragraph 9.

10. Defendant admits that eligible retirees who select major medical insurance coverage have an option to select coverage under the DVA and/or LTC plans. Retirees

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

who are not eligible for premium free major medical coverage may also elect coverage under the optional DVA and/or LTC plans. Depending on the retirees' selection, DVA coverage may be provided to the benefit recipient and their eligible dependents. A retiree may select individual or joint coverage under the LTC plan. Retirees pay the premiums for coverage under the DVA and and/or the LTC plans. Except as expressly admitted herein, Defendant denies the allegations of paragraph 10.

11. Defendant admits that major medical insurance coverage, when elected by an eligible retiree, begins when monthly retirement benefits begin, but not before July 1, 1975. Coverage under the optional DVA plan started no earlier than October 1, 1979 and was initially effective on the 1st of the month following the month in which the premium was first deducted from the retirees' monthly benefit. Subsequently, coverage for new benefit recipients began on the date of their appointment to receive retirement benefits. Except as expressly admitted herein, Defendant denies the allegations of paragraph 11.

12. The allegations in paragraph 12 state legal conclusions to which no response is required. To the extent this paragraph alleges that Defendant failed to comply with legal requirements, Defendant denies the allegations in paragraph 12.

13. The allegations in paragraph 13 state legal conclusions to which no response is required. To the extent this paragraph alleges that Defendant failed to comply with legal requirements, Defendant denies the allegations in paragraph 13.

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

14. The allegations in paragraph 14 state legal conclusions to which no response is required. To the extent this paragraph alleges that Defendant failed to comply with legal requirements, Defendant denies the allegations in paragraph 14

STATEMENT OF FACTS

15. Defendant admits that in 1975 the State granted major medical insurance coverage for all members of the Alaska Public Employees' Retirement System ("PERS") and Teachers'' Retirement System ("TRS") Defined Benefit Plans. Defendant also admits that this plan is now known as the "AlaskaCare Retiree Health Plan" and DOA published a Retiree Insurance Information Booklet in May 2003 that generally describes the plan. Defendant further admits that DOA published booklets prior to 2003 and that DOA has subsequently amended the 2003 version. The booklet contains terms of the AlaskaCare Retiree Health Plan, including major medical insurance coverage and the optional DVA coverage. Except as expressly admitted herein, Defendant denies the allegations of paragraph 15.

16. Defendant admits that, effective January 1, 2014, DOA substantially adopted the standard dental plan language used by Moda Health/Delta Dental of Alaska for the dental portion of its optional DVA plan ("the AlaskaCare plan"). The dental portion of the DVA plan offered prior to 2014 is no longer available. Except as expressly admitted herein, Defendant denies the allegations of paragraph 16.

17. Defendant admits that the AlaskaCare plan amended the dental benefits previously available to retirees who selected the optional DVA insurance coverage.

a. Defendant admits the allegations of paragraph 17(a).

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

b. Defendant admits that the previous plan did not indicate a frequency for dental cleanings. The AlaskaCare plan covers no more than two cleanings per year for most people, and no more than four cleanings per year for patients with diabetes or periodontal disease.

c. Defendant admits that the previous plan covered topical fluoride treatments but coverage was conditioned on those treatments being "necessary for diagnoses or treatment of dental condition as determined by the claims administrator." Defendant admits the second sentence of paragraph 17(c).

d. Defendant admits that the previous plan covered dental sealants for children through age 18 and did not indicate what teeth or a frequency. The AlaskaCare plan covers sealants to the unrestored, occlusal surfaces of permanent molars, and benefits are limited to one sealant per tooth, during any 5-year period. The AlaskaCare plan provides no age limit.

e. Defendant admits that the previous plan covered denture replacements when the existing dentures were at least five-years-old and could not be made serviceable. The AlaskaCare plan covers denture replacements when the existing dentures are at least seven-years-old and cannot be made serviceable.

f. Defendant admits the allegations of paragraph 17(f).

g. Defendant admits the allegations of paragraph 17(g).

h. Defendant admits that the AlaskaCare plan's covered expenses are based on a "recognized charge." The recognized charge for network dentists is the lesser of 100% of the covered expense, 100% of the dentist's accepted filed fee with Delta

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

Dental, or 100% of the dentist's billed charge. For out-of-network providers in Alaska, the recognized charge is the lesser of what the dentist bills or submits for that service or 75% of the 80th percentile of the prevailing charge rate as determined by Delta Dental. For out-of-network providers outside of Alaska, the recognized charge is the lesser of what the dentist bills or submits for that service or the prevailing charge rate as determined by Delta Dental.

Except as expressly admitted herein, Defendant denies the allegations of paragraph 17 and its subparagraphs. To the extent this paragraph alleges that Defendant failed to comply with legal requirements, Defendant denies the allegations in paragraph 17 and its subparagraphs.

18. Defendant denies the allegations of paragraph 18.

19. Defendant lacks knowledge or information sufficient to form a belief as to the truth or falsity of the allegations contained in Plaintiff's paragraph 19 and, therefore, denies such allegations.

20. Defendant admits that Defendant declines to repeal the 2014 amendments to the dental portion of its optional DVA coverage. Defendant lacks knowledge or information sufficient to form a belief as to the truth or falsity of the remaining allegations contained in Plaintiff's paragraph 20 and, therefore, denies such allegations.

21. Defendant admits that RPEA has not been provided with an analysis on whether the enhancements in dental coverage offered in the current AlaskaCare plan offset any alleged disadvantages. To the extent this paragraph alleges that Defendant

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

failed to comply with legal requirements, Defendant denies the allegations in paragraph 21.

22. Defendant admits that eligible retirees have the option of selecting coverage under the DVA plan. Defendant lacks knowledge or information sufficient to form a belief as to the truth or falsity of the allegations contained in Plaintiff's paragraph 22 pertaining to the previous positions alleged to have been taken by Defendant or his predecessor and, therefore, denies such allegations. To the extent paragraph 22 states legal conclusions, no response is required. To the extent a response is deemed necessary, Defendant denies the allegations of paragraph 22.

FIRST CAUSE OF ACTION
VIOLATION OF ALASKA CONSTITUTION ARTICLE XII, § 7

23. The allegations in paragraph 23 state legal conclusions to which no response is required. To the extent a response is deemed necessary, Defendant denies the allegations in paragraph 23.

24. The allegations in paragraph 24 state legal conclusions to which no response is required. To the extent a response is deemed necessary, Defendant denies the allegations in paragraph 24.

25. The allegations in paragraph 25 state legal conclusions to which no response is required. To the extent a response is deemed necessary, Defendant denies the allegations in paragraph 25.

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

26. The allegations in paragraph 26 state legal conclusions to which no response is required. To the extent a response is deemed necessary, Defendant denies the allegations in paragraph 26.

27. The allegations in paragraph 27 state legal conclusions to which no response is required. To the extent a response is deemed necessary, Defendant denies the allegations in paragraph 27.

AFFIRMATIVE DEFENSES

1. The complaint and cause of action fail to state a claim for which relief can be granted.

2. Plaintiff's claims may be barred by AS 09.50.250, the doctrines of sovereign and discretionary immunity, and/or official immunity.

3. The individual State officer is entitled to qualified immunity with respect to any constitutional claims for damages asserted by Plaintiff.

4. The court lacks jurisdiction to consider Plaintiff's request for a declaratory judgment as it pertains to the LTC plan as there is no actual controversy.

5. Defendant reserves the right to assert additional defenses and other matters as the case proceeds.

PRAYER FOR RELIEF

Defendant seeks the following relief:

1. That the complaint be dismissed in its entirety with prejudice.

2. That Plaintiff's prayer for relief be denied.

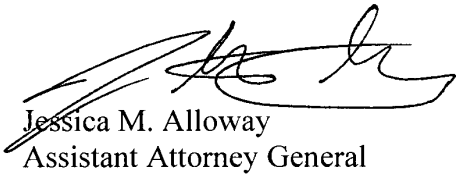
3. That Defendant be awarded its costs and fees in the action.

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

4. That the Court award Defendant such other relief as may be just and equitable under the circumstances.

DATED March 14, 2016.

CRAIG W. RICHARDS
ATTORNEY GENERAL

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

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

STATE OF ALASKA

PUBLIC EMPLOYEES' RETIREMENT SYSTEM

Tiers I, II and III
Retirement Application Instruction Booklet

Alaska Division of Retirement and Benefits
PERS

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

Alaska.gov/drb

PERS035 (April 2016)

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

Table of Contents

Introduction

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

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

What Tier Am I?

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

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

Section I. Minimum Requirements for Pension Benefits

Retirement Effective Date

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

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

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

Retirement Eligibility

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

Age Requirements

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

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

Service Requirements

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

You must have at least:

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

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

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

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

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

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

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

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

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

1) You have worked part-time, or

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

Simultaneous PERS and TRS Credit

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

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

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

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

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

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

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

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

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

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

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

Health Plan – Who May Be Covered

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

In accordance with Alaska Statutes 39.35.680(12):

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

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

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

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

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

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

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

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

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

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

Medical Benefits Highlights

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

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

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

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

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

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

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

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

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

You may only increase coverage:

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

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

Dental-Vision-Audio (DVA)

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

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

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

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

PERS RETIREMENT APPLICATION

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

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

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

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

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

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

FIRST RETIREMENT CHECK

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

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

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

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

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

PERS Application for Retirement Benefits

I. EMPLOYEE INFORMATION

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

II. PENSION BENEFIT ELECTION

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

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

A. Survivor Options (Married members)
Survivor Information

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

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

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

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

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

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

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

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

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

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

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

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

Social Security Number / RIN_____

III. INDEBTEDNESS PAYMENT

❑ I HAVE NO INDEBTEDNESS

I hereby **irrevocably** elect:

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

❑ by check

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

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

IV. EMPLOYEE VOLUNTARY SAVINGS ACCOUNT

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

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

Lump sum:

❑ Lump sum payment of total account balance.

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

Annuities:

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

The annuity options available are:

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

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

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

Installments over a Designated Period of Time:

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

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

V. APPLICATION FOR ALASKA COST-OF-LIVING ALLOWANCE

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

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

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

Name _____ Social Security Number or R_____

Retirement Effective Date _____

VI. ELECTRONIC DIRECT DEPOSIT AUTHORIZATION

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

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

Check One: ❑ Savings ❑ Checking

BANK ROUTING NUMBER	ACCOUNT NUMBER
FINANCIAL INSTITUTION	

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

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

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

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

VII. HEALTH BENEFIT ENROLLMENT

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

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

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

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

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

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

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

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

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

Retiree coverage:

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

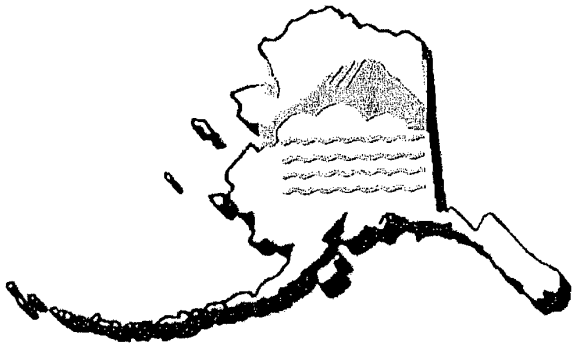
❑ I am covered under my spouse's LTC plan. Spouse's SSN _____

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

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

DVA Enrollment

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



STATE OF ALASKA

RETIREE GROUP INSURANCE INFORMATION BOOKLET

2000

DENTAL-VISION-AUDIO PLAN

INTRODUCTION

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

WHO MAY BE COVERED AND PREMIUM PAYMENT

The following individuals may elect coverage:

Benefit Recipients

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

Dependents

You may elect to cover the following dependents:

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

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

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

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

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

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

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

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

HOW TO ELECT COVERAGE

DVA coverage may be elected for:

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

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

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

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

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

WHEN DVA COVERAGE STARTS

New Benefit Recipients

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

Open Enrollees

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

WHEN COVERAGE ENDS

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

Failure to Pay Premium

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

Ineligible Retirees

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

Discontinuance of Coverage

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

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

Dependents

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

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

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

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

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

CHANGING YOUR COVERAGE

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

You may increase coverage only:

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

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

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

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

DENTAL PLAN HIGHLIGHTS

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

Benefit Year

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

Annual Maximum Benefit

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

Deductible

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

Usual, Customary, and Reasonable Charges

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

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

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

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

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

COVERED DENTAL SERVICES

Class I Preventive Services

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

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

Class II Restorative Services

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

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

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

Class III Prosthetic Services

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

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

DENTAL SERVICES NOT COVERED

The Dental Plan does not provide benefits for:

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

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

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

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

Advance Claim Review

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

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

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

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

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

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

Examples of alternative services or supplies for restorative care are:

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

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

Examples of alternative services or supplies for prosthodontic care are:

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

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

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

Retiree Dental Insurance 2003 - Updated 2012

Wednesday, August 19, 2015
10:49 AM

ALASKACARE

Retiree Health Plan

Retiree Insurance Information Booklet

May 2003

DENTAL-VISION-AUDIO PLAN

INTRODUCTION

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

WHO MAY BE COVERED AND PREMIUM PAYMENT

The following individuals may elect coverage:

Benefit Recipients

- People receiving a benefit from the Public Employees', Teachers', Judicial, or Elected Public Officers' Retirement Systems (excluding alternate payees under a Qualified Domestic Relations Order). If coverage is elected, the premiums are paid by deductions from your retirement check.
- People receiving a benefit from the Marine Engineers Beneficial Association (MEBA) who retired from the State of Alaska after July 1, 1983. If coverage is elected, the premium is paid annually by the member.

Dependents

You may elect to cover the following dependents:

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

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

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

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

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

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

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

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

HOW TO ELECT COVERAGE

DVA coverage may be elected for:

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

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

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

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

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

WHEN DVA COVERAGE STARTS

New Benefit Recipients

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

Open Enrollees

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

Marine Engineers Beneficial Association Members

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

Dependents

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

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

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

WHEN DVA COVERAGE ENDS

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

Failure to Pay Premium

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

Ineligible Retirees

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

Discontinuance of Coverage

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

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

Dependents

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

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

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

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

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

CHANGING YOUR DVA COVERAGE

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

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

You may increase coverage only:

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

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

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

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

DENTAL PLAN HIGHLIGHTS

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

HOW DENTAL BENEFITS ARE PAID

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

Benefit Year

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

Annual Maximum Benefit

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

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

Deductible

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

Recognized Charge

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

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

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

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

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

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

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

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

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

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

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

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

Advance Claim Review

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

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

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

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

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

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

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

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

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

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

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

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

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

COVERED DENTAL SERVICES

Class I Preventive Services

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

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

Class II Restorative Services

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

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

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

Class III Prosthetic Services

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

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

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

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

DENTAL SERVICES NOT COVERED

The Dental Plan does not provide benefits for:

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

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

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

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

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

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

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

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

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

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

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

Attached.

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

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

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

Section 1: Repealed Provisions

The following provisions of the Plan are hereby repealed:

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

Section 2: Amended Provisions

(1) Benefit Summary

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

a. Medical Benefit Schedule

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

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

b. Prescription Drug Schedule

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

c. Dental Benefit Schedule (if elected)

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

Benefit Maximums	
Annual individual maximum	$2,000

d. Vision Benefit Schedule (if elected)

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

e. Audio Benefit Schedule (if elected)

Coinsurance	
All services	80%
Benefit Maximums	
Individual limit • Maximum applies to a rolling 36 month period	$2,000

(2) Precertification

Insert at p. 26, Plan Booklet:

1. Precertification

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

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

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

(7) Recognized Charge

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

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

- Medical, Vision, and Audio Expenses

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

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

- Prescription Drug Expenses

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

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

- Dental Expenses

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

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

- 100% of the dentist's billed charge.

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

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

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

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

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

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

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

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

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

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

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

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

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

- Additional Information

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

(8) Dental Services

Dental Services are covered as follows:

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

1. Class I Preventive Services

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

a. Diagnostic Services and Limitations

Services:

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

Limitations:

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

b. Preventive Services and Limitations

Services:

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

Limitations:

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

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

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

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

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

2. Class II Restorative Services

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

a. Restorative Services and Limitations

Services: Fillings on teeth for the treatment of decay.

Limitations:

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

b. Oral Surgery Services and Limitations

Services:

- Extractions (including surgical)
- Other minor surgical procedures

Limitations:

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

c. Endodontic Services and Limitations

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

Limitations:

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

d. Periodontic Services and Limitations

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

Limitations:

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

e. Anesthesia Services

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

3. Class III Prosthetic Services

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

a. Restorative Services and Limitations

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

Limitations:

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

b. Prosthodontic Services and Limitations

Services:

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

Limitations:

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

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

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

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

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

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

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

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

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

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

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

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

c. Other Services and Limitations

Services: Athletic mouthguard

Limitations:

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

4. General Limitation – Optional Services

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

5. Oral Health, Total Health Program and Benefits

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

The following covered persons should consider enrolling this program:

Diabetics

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

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

Pregnant Persons

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

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

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

(9) Appeals

1. If a Claim is Denied

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

a. Initial Claim for Health Plan Benefits

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

for food or clothing for

ng area" means an area
ily important for sub-
nlikely that subsistence
hunting including hunting
or if certain methods and

mediately in accordance

5

LAWS OF ALASKA

1975

Source HCSSB 195 am H

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.

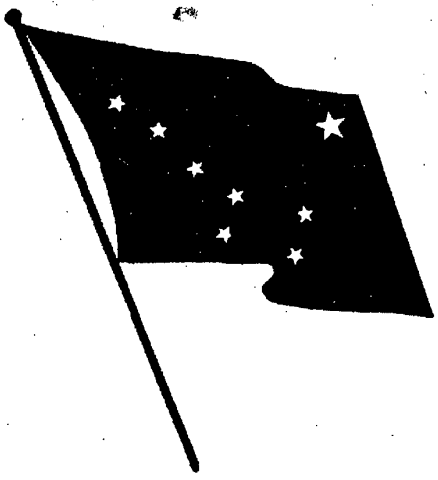
* Sec. 3. AS 39.35.680(14) is amended to read:

Exhibit 1
Page 1 of 2
000243

(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)

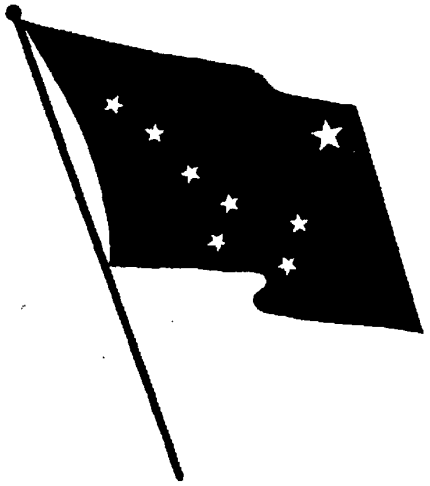
Chapter 55

AN ACT

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

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.

Eligibility

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

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.

crowd

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

Exhibit 5
Page 1 of 2

000289

for employees of the Terri-
is.

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

g benefits: life insurance,
al death and dismember-
surance, weekly indemnity
e, hospital expense insur-
urgical expense insurance,
edical care insurance.

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
married children who are
dependent upon the employ-
support and maintenance.

No eligible employee shall
insured unless he has
o the governmental unit in
he is employed, a written
ization to withhold from his
or wage the premium con-
n necessary to pay for one-
cost of such employee's in-
. Governmental units are
authorized to pay the re-
r of the total premium on
their insured employees, not
ed $2.00 per month for each
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

Exhibit 5
Page 2 of 2
000290

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

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

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

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

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

REEVES AMODIO LLC
500 L STREET, SUITE 300
ANCHORAGE, ALASKA 99501-1990
PHONE (907) 222-7100, FAX (907) 222-7199

Dated at Anchorage, Alaska, this 8th day of December, 2016.

~~Gregory Miller~~ Larsen
Superior Court Judge

* Findings and reasoning as stated on record at the conclusion of the December 7, 2016 Oral Argument are incorporated by reference. The defendants' Cross-motion on the same issue is DENIED.

I certify that on 12/9/16 a copy of the following was mailed/faxed/hand delivered to each of the following at their addresses of record.

Administrative Assistant

REEVES AMODIO LLC
500 L STREET, SUITE 300
ANCHORAGE, ALASKA 99501-1990
PHONE (907) 222-7100, FAX (907) 222-7199

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT

RETIRED PUBLIC EMPLOYEES OF ALASKA, INC.,

Plaintiff,

vs.

COMMISSIONER OF THE ALASKA DEPARTMENT OF ADMINISTRATION,

Defendant.

No. 3AN-16-04537 CI

VOLUME VII

TRANSCRIPT OF ORAL ARGUMENT

BEFORE THE HONORABLE ERIC A. AARSETH
Superior Court Judge

Anchorage, Alaska
December 7, 2016
3:27 p.m.

APPEARANCES:

FOR THE PLAINTIFF: SUSAN C. ORLANSKY
Attorney at Law
Reeves Amodio LLC
500 L Street, Suite 300
Anchorage, Alaska 99501

FOR THE DEFENDANT: JESSICA M. ALLOWAY
Attorney General's Office
1031 West Fourth Avenue
Suite 200
Anchorage, Alaska 99501

PROCEEDINGS

Courtroom 604

03:27:57

THE CLERK: Please rise. Superior Court for the State of Alaska is now in session, Honorable Eric Aarseth presiding.

THE COURT: Thank you. Please be seated. All right. We're on record. This is in case number 3AN-16-4537 Civil, captioned Retired Public Employees of Alaska versus Sheldon Fisher. I have the briefing, gone through it. Counsel did a very good job. Understood your arguments. Are you folks ready?

MS. ORLANSKY: We are, Your Honor.

THE COURT: All right. Okay. So 20 minutes for each side. Ms. Orlansky, do you want to reserve five minutes, then, of your time?

MS. ORLANSKY: That sounds about right. Thank you.

THE COURT: Okay. Great. Anything we need to discuss before we get started?

MS. ORLANSKY: I --

THE COURT: No?

MS. ORLANSKY: I don't think so.

THE COURT: Okay. Let's go.

MS. ORLANSKY: I -- Your Honor, I'd simply introduce at counsel table -- this is Sharon Hoffbeck. She's the current president of RPEA.

THE COURT: All right. Ms. Hoffbeck.

MS. ORLANSKY: She's my client representative here today. So you've read the briefing. The cross-motions present one straightforward legal question for this court to resolve: Does the nondiminishment clause of the Alaska Constitution protect retiree dental insurance benefits in the same way that it protects retiree medical insurance benefits, or is the retiree dental insurance plan legally distinguishable.

RPEA asserts that they are not distinguishable. Based on the language of Article 12, Section 7 of the Alaska Constitution, Alaska case law, and persuasive decisions from other states, RPEA asks this court to declare that retiree dental insurance benefits are constitutionally just like medical insurance benefits, which in Duncan the Alaska Supreme Court declared equivocally are protected against diminishment. And that means that a retiree's dental insurance benefits, the ones that are offered to a state employee on the day that he or she is hired, which the employee accepts as part of the employment contract by working for the state for a number of years, may not be reduced and must be available as promised when the employee retires.

THE COURT: So to clarify, these changes were in 2014, so the distinction here is going to be then those employees that started their employment prior to the 2014 changes have one package, those that are post-2014 have a different package.

MS. ORLANSKY: That's correct.

THE COURT: Okay.

MS. ORLANSKY: If we're correct -- if the state were correct, everybody would have the same new package. The plans --

THE COURT: Right.

MS. ORLANSKY: The plans do not apply only prospectively, from the state's perspective. But if we're correct, the state can't do that, and our position would be that of course they can make any changes they want for new hires without running afoul of the Constitution. But employees who were hired before the effective date of the change need to be allowed to keep the benefits they had when they were hired. So I think, Your Honor, that a simple starting place --

THE COURT: And let me ask, Ms. Orlansky --

MS. ORLANSKY: Yeah.

THE COURT: It's -- it -- I guess it's the sanction -- in terms of the benefits that they had, and your argument is, if I understand it correctly -- is that -- and then I'm sure Ms. Alloway's going to discuss this as well. But the benefits they had, the benefits available to them, the option that they had --

MS. ORLANSKY: Yes.

THE COURT: -- in terms of having a -- so it's not just retirees, it's also active employees that would have -- when they reach retirement, would have had the option to actually choose those benefits.

MS. ORLANSKY: Precisely.

THE COURT: Okay. Got it.

MS. ORLANSKY: So we're looking -- and I think that a really simple starting place is the retiree insurance information booklet that the state makes available to employees and that anybody could look at, even on the first day of hire. They're available on the web; they're in our briefing.

A typical one is the 2003 booklet, which is in the record and which describes to employees the medical and dental benefits that will be available to retirees before the 2014 changes. And I think it's worth looking at the medical and dental pages in some detail to see how similar they are. They're all in the record, but if it would be convenient to the court, I brought just a couple of pages that I'm going to refer to, if Your Honor would like me to hand you those, rather than flipping through the --

THE COURT: Sure.

MS. ORLANSKY: -- whole file.

THE COURT: That would be great.

MS. ORLANSKY: Copy for Ms. Alloway as well.

THE COURT: Any objection, Ms. Alloway?

MS. ALLOWAY: No.

THE COURT: Thank you.

MS. ORLANSKY: Just thought that might be easier. There is a stack of the exhibits. And I've put them in the order in

which I'm going to refer to them. So it's exhibit F, exhibit A, and exhibit C, illogically, but that's how I want to talk about them.

So the medical benefits are set forth in exhibit F, starting at page 6, the first page of the packet I handed you. This page proclaims how the state retirement systems provide extensive and valuable benefits for the diagnosis and treatment of injury and disease. It states that the benefits may change from time to time. It explains, going on a couple pages, how the benefits are available at no out-of-pocket cost to many benefit recipients of PERS, TRS, and other public employee retirement programs, but it also says that some benefit recipients must pay premiums.

Page 8 then discusses how a retiree may select which exact type of coverage he or she wants at the time of retirement. And page -- exhibit A, page 17, which I've included a couple of pages into the packet, is the actual enrollment form.

And then for comparison purposes, I'd ask Your Honor to look at exhibit C, which is the third stapled set I gave you. And the relevant pages of that same booklet -- it got confusing in the exhibits, but they're in exhibit C rather than exhibit F, starting at page 3. This page proclaims that the state offers a dental-vision-audio plan for benefit recipients. In other words, only exactly the same people who are eligible for medical insurance benefits, the members of the state employees

retirement system, are eligible for dental insurance benefits. The booklet states --

THE COURT: Ms. Orlansky, may I --

MS. ORLANSKY: Yeah.

THE COURT: -- ask -- I guess I'm -- when I saw these exhibits in the briefing, I was a little unsure as to how I should rely upon those. I know there's an agreement to the parties that there are no facts in issue. And these pamphlets are interpretations, I guess, of the -- of a state -- by a state employee of what the law says or what the benefits are.

MS. ORLANSKY: Uh-huh.

THE COURT: And I guess my concern is that part -- I'm not sure -- are you asking me to consider this as an admission against interests by the state or as a -- part of a subjective -- what a subjective belief would be by a employee? I mean, how would I --

MS. ORLANSKY: More -- I -- more the latter, Your Honor. I think I'd ask you to consider them as a statement by the state, by -- it's (indiscernible) vetted by a number of people in the Department of Administration or whoever produces it, and handed -- made available to all state employees. And it is what -- it is -- because there's no written insurance -- there's no written employment contract that most employees sign on the day that they start work with the state. If there were, I'm sure it would have come up in the initial disclosures. And it

just evidently does not seem to be the practice of the state to have people sign an actual written contract that defines their rate of pay and the benefits they're going to get in the future. So employees -- they probably fill out a W-2 form or something. But employees have to look to various documents that the state makes available to understand what their long-term future benefits would be.

THE COURT: Okay.

MS. ORLANSKY: And I'd ask you to look at these documents as an illustration of what the state makes available to employees, so they know what their future benefits will be.

THE COURT: Okay.

MS. ORLANSKY: So the -- exhibit C on the DVA benefits says that this is available only to the same people who are eligible for medical insurance benefits; that is, you have to be a member of a state employee retirement system. It states, just like for medical benefits, the benefits may change over time. In terms of premiums, it says that anybody selecting DVA coverage must pay the premiums and that they'll typically be deducted from the member's monthly benefit check.

Page 5 discusses how a retiree selects which type of coverage he or she wants, and the enrollment form is exactly the same as the enrollment form for medical insurance benefits. It's exhibit A, page 17, just one line below.

In other words, from the perspective of a new hire starting

work as a state employee, from looking at the state's booklet, the offers of future medical insurance and future dental insurance are essentially identical. Both plans are offered only to members of a public employee retirement system. Neither is selected on the day the employee is hired. Both, in fact, are selected at the time the employee applies for retirement benefits. Both could be declined at that time. And neither is static. The employee is told that the details of both programs are subject to change. Based on that, RPEA asserts that the retiree dental insurance program is just as much a part of the contract between employees and the state as the medical insurance program.

Now, in the briefing defendant pointed to a number of supposed differences between the programs to attempt to justify excluding dental insurance benefits from protection under Article 12, Section 7. And I'd like to go through a number of those, because RPEA believes that none of the alleged differences is legally significant.

First, the defendant focused on how dental benefits are elective and optional, meaning that only retirees who select the benefits receive them. But I think the documents we just looked at show it's not a legally meaningful difference, because medical insurance benefits also must be selected. If a retiree never fills out a form, medical insurance benefits are not available, and medical insurance benefits may be declined, just

like DVA benefits may be declined. So the optional or elective nature of dental insurance benefits does not seem to support treating them differently under the Constitution.

Second argument defendant offered is that the programs differ because retirees who want dental insurance benefits must pay premiums, whereas retirees don't pay premiums for medical insurance. But that's also not a legally meaningful difference, because it's uncontested -- exhibit F shows it, we talked about it in the briefing -- some retirees actually do pay premiums if they want medical insurance coverage. And defendant's briefing acknowledged in its briefing, if I understand them correctly, that it doesn't contend that the retirees who have to pay their premiums for medical insurance have any less constitutional protection than the retirees who receive medical insurance without paying monthly premiums. So the fact of paying premiums doesn't support treating the plans differently under the Constitution.

Third, defendants pointed to the regulation that says the dental insurance benefits may change over time. It is also undisputed that medical insurance benefits may change over time. Benefits booklet that we looked at states this expressly, and the Supreme Court in Duncan discussed how they may change.The package may be changed prospectively, as Your Honor indicated right at the beginning. New hires may receive fewer benefits than earlier hires. And the entire package of benefits

available at the time of hiring might be adjusted, so long as overall the new advantages to retirees as a class offset the new disadvantages. So the fact that the benefit package may change and that employees are advised they may change is not a constitutionally significant difference between the two programs.

Fourth, defendant's briefing emphasized that dental benefits are in one chapter of Title 39, whereas medical benefits are in a different chapter of Title 39. But if placement in A.S. 39.35 were required to make benefits protected under the Constitution, then the pension benefits and medical benefits available to teachers in A.S. 14.25, a whole different title, or to judges in A.S. 22.25, yet a different title, wouldn't be protected. So plainly, it's not the placement of benefits in A.S. 39.35 that's constitutionally significant.

There are actually, I think, two apparent reasons -- I don't know the why legislature put them in different chapters -- but common sense, looking at them, gives me two apparent reasons. One, in A.S. 39.35, like 14.25 and 22.25, the legislature has chosen to mandate certain benefits for state employees. These the legislature could change or remove prospectively, but only the legislature could do that.

A.S. 39.30, by contrast, has two completely different purposes. First, it describes a way that the state could choose to pay for all kinds of benefits, that is, to a group insurance

plan. My understanding is that's not what the state is doing. But the legislature authorized them to do that, and that's one of the purposes of A.S. 39.30.

The other thing that A.S. 39.30 does is it describes benefits that the state could choose to offer but is not required to offer, such as DVA insurance, long-term care, or life insurance. Because the statute served different purposes, that's a reason to have them in different chapters. Another reason for putting the so-called optional benefits in a separate chapter --

THE COURT: Am I understanding those -- you agree with that portion of the state's argument that says the state, in fact, does have the ability to decide whether or not they're actually going to have a DVA insurance policy or not.

MS. ORLANSKY: Yes, we agree --

THE COURT: So --

MS. ORLANSKY: -- with that.

THE COURT: So the argument here really seems to come down to in terms of -- it's an option argument, whether the option to purchase this has value that should be included in the employee package at their start, not something that can be taken away later on.

MS. ORLANSKY: I think that's fair. That is a fair way to put it. Once the state has exercised the -- its choice to offer the program, the question is can it take it away while people

are still employed and before they're retired. Or --

THE COURT: That were employed at the time that that --

MS. ORLANSKY: That it was offered.

THE COURT: -- policy was in existence. Got it.

MS. ORLANSKY: That's right.

THE COURT: Okay.

MS. ORLANSKY: That's right. So as I say, the other reason that the optional benefits may be in a separate chapter of Title 39 is that they actually -- if you read that statute section, it's offered -- the optional benefits are offered to multiple state retirement systems. And I just think it's probably easier, if I were a legislature, to lump them all together and cross-reference the multiple retirement systems rather than repeating all the provisions in Title 14, Title 22, and Title 39. I'm just guessing. I'm not the legislature. I'm not the one who decided to stick them in a different chapter, but I think there were reasonable bases.

The bottom line is that what is legally significant is not whether the benefit programs are contained in different chapters, but whether the benefit programs offered in the different chapters are all conditioned on membership in a state retirement system, and clearly they are. And we think that's what brings them within the protection of Article 12, Section 7.

The final point that the state made in distinguishing between medical and dental insurance is it asserts in the

briefing repeatedly that medical insurance is not part of the employee's contract with the state -- I mean, the medical insurance is a part of the contract between the employee and the state, but dental insurance is not. I think that's a legal conclusion and not a statement of fact.

As I said earlier, there's no actual written contract, so saying that one kind of insurance is promised for retirees as a part of the contract that the employee accepts when the employee starts working and the other is not is precisely the legal question that this court is being asked to resolve. It's not a statement of fact that you can deduce from any of the documents.

RPEA believes the defendant has drawn the legally wrong conclusion, for all the reasons I've been discussing. I think RPEA has showed that there's nothing in the information provided to a new hire that makes the promise of medical insurance when you retire look like a part of the contract, while the promise of dental insurance at the time you retire looks like something else. And to let the state hold out a promise of dental insurance coverage but then to let the state unilaterally withdraw it or to keep some dental insurance but to alter the terms dramatically could be seriously prejudicial to retirees who relied on the promise that was made when they were hired, and that's exactly what Article 12, Section 7 prohibits.

That's the core of our argument. I'd like to say just a couple of minutes' worth about the two out-of-state cases that

defendant has relied on and why RPEA believes that they're persuasive precedent. First is the Michigan case that defendant gave notice of just yesterday. It is, when you read the case, based on reasoning and on a definition of accrued benefits that's completely at odds with the Alaska Supreme Court's decision in Duncan.

Michigan used a definition of accrued that focuses on growth over time. It's one dictionary definition of accrued. Using that same definition, Michigan earlier had held that health insurance benefits are not an accrued financial benefit protected by the state's constitution, because they don't grow over time.

The Alaska Supreme Court has used the word accrued for purposes of Article 12, Section 7 in a completely different way. It's like -- we use the term accrued to say when a claim accrues; that is, when it comes into existence as an enforceable right. And that's a different dictionary definition. Because Michigan uses a completely different definition of accrued that's incompatible with the Alaska Supreme Court's definition, I think the Michigan cases are not instructive precedent.

And I think we can say much the same for the Nebraska case. Livingston's a little closer on the facts in the sense that it discusses optional benefits, but its holding would be different in Alaska, because opposite to Livingston, the Alaska Supreme Court held in Hammond versus Hoffbeck that disability payments

are protected by the nondiminishment clause.

In Nebraska -- and Livingston disapproved the earlier Nebraska case that had protected medical insurance benefits. In other words, what's going on in both Michigan and Nebraska is that those courts distinguish not between optional and mandatory benefits but between pensions and other benefits. And the Duncan decision in this state precludes this court from adopting that reasoning.

RPEA believes that defendant has failed to establish any legal basis for distinguishing retiree dental insurance benefits from retiree medical insurance benefits for purposes of their protection under the nondiminishment clause in Article 12, Section 7. RPEA therefore asks this court to enter partial summary judgment in its favor on that legal question. Your Honor has got no other questions, I'll turn the podium over to Ms. Alloway.

THE COURT: Thank you.

MS. ALLOWAY: Thank you. May it please the court. My name is Jessie Alloway, and I represent the defendant Sheldon Fisher, the Commissioner of the Department of Administration.

Alaska is one of the nine states with a constitutional amendment that specifically protects pension benefits. However, even with this provision, not every law that the -- that benefits the interests of a retiree creates a legally enforceable right. For instance, the Michigan Supreme Court

case that opposing counsel just discussed and I referenced yesterday in the letter of supplemental authority held that its constitutional provision does not protect the tax exempt status of pension benefits. So clearly, the right to have your pension benefits be tax exempt benefits the retiree. That was something that was available to retirees in Michigan during the course of their employment.

Nevertheless, the court found that the legislature may eliminate that exempt status for pension incomes without running afoul of their state's constitutional provision, because that benefit was not in the form of deferred compensation. So it --

THE COURT: Ms. Alloway --

MS. ALLOWAY: -- talked about accrued benefits --

THE COURT: Right.

MS. ALLOWAY: -- but it also talked about deferred compensation. And that was one of the reasons that the court found that it is the -- their constitutional provision didn't apply. And that's the same reason I'm arguing to the court here --

THE COURT: But why does this court want to look at Michigan when we've got case law here in Alaska that talks about our retiree benefits?

MS. ALLOWAY: Well, the -- that's a good question, Your Honor. The reason for that is that our case law, the Duncan case, they talk about deferred compensation. So essentially, as

a state employee -- like in Duncan, as a state employee, I accept the position, I'm promised under the statute to receive major medical benefits if I'm entitled to a monthly benefit, right. That's deferred compensation under the Duncan case.

I've worked for 30 years, for example, as a state employee, receiving less in -- less salary than I may have received in the private industry under the promise that I would get major medical coverage as a retiree. And during the course of my employment, I've asked -- I've also mandatorily contributed to the cost of the major medical insurance that I would receive in retirement, and so has the state.

In Duncan, the court held that that was, in a sense, deferred compensation. That's something that you accepted when you began your state employment and that's compensation that you've earned throughout the course of your employment. You're just not obligated anymore to provide any more services to the state, but you're still entitled to that compensation.

I'm asking the court to look at the Michigan cases as well as the Nebraska cases, because DVA benefits are different. No matter what plaintiffs say, they are different. They're different for a number of reasons. One, they're not deferred compensation. The state does not make any contribution towards DVA coverage during the course of the employee's employment, nor does the employee.

THE COURT: So let's get to the heart of this. And this is

what I was asking Ms. Orlansky. If -- this state is an oil state, okay. And if I do -- if I decide that I want to go out to Cook Inlet and I want to do some research, and I think that I might be able to find oil out there, I might sign for a lease with the state and say, I want the option to go do an investigation out here to do research to see if I can develop that as an oilfield. Would you think that that option to go do that would be of value?

MS. ALLOWAY: I do.

THE COURT: Okay. So then why, when employees -- they start their employment, and the state says, when you retire, you're going to have this option to buy these different things, okay. The state's not going to give it to you, you got to buy it, but you're going to get the option to buy it. Why doesn't that have value, then?

MS. ALLOWAY: My response, Your Honor, is in Duncan the court required us to look at the contract of employment. And in McMillan later -- I think that was in 2014 -- the court instructed us to look -- the contract in employment is defined by the statutes, the regulations, and the department policy.

So this option contract that you're talking about, Your Honor, is set forth in the statutes. And the statutes that I'd point you to is A.S. 30.090(a)(10), right.

THE COURT: But in Duncan, the very beginning of Duncan, though, it talks about the general principles that we're dealing

with, which is retiree benefits, and those are the benefits available at the time of employment. Right?

MS. ALLOWAY: Yes.

THE COURT: I mean, that -- that's what drove that entire reasoning of the court, was to say, look, this is what's -- this is a benefit that's available to you at the time of employment. Then they went on to explain accrued. But that was the general principle, wasn't it, in terms of this is that benefit, these are the things that are of value to you when you start. You would agree with that, right?

MS. ALLOWAY: Yes, Your Honor.

THE COURT: Okay. All right. Go ahead.

MS. ALLOWAY: But the thing is, is I think that we have to go a step further and define what that actual benefit is. So I'd like to draw Your Honor's attention back to that statute, A.S. 30.010.

THE COURT: 39.30?

MS. ALLOWAY: Yes, A.S. --

THE COURT: Right.

MS. ALLOWAY: -- 39.30.010. You're right, Your Honor.

THE COURT: Got it. Oh, you told me. I read your brief.

MS. ALLOWAY: And I think we got to go back a little bit in history to sort of talk up -- talk about and flesh out how this mental -- or this -- these medical benefits arose.

So in 1955, governmental units within the Territory of

Alaska were granted the authority, but not mandated, to procure group insurance policies for active employees. Then in 1975, the legislature mandated that major medical insurance be provided to all PERS members entitled to a monthly benefit. But importantly, the legislature did not mandate that the state also provide supplemental health coverage in the form of DVA coverage. This was limited only to major medical insurance.

So in 1990 -- in 1975, a retiree was entitled to major medical coverage, but they yet didn't have the authority to purchase DVA coverage even if it was offered by the state. That changed in 1979 when the legislature passed, I guess, the provision within A.S. 39.30.090. That legislation says that a PERS member may obtain DVA coverage -- may obtain. So unlike major medical provision, which is codified in 39.35 with the other PERS benefits, this is codified in 39.30, and it says that a DV -- or a retiree is entitled to purchase DVA coverage if it is offered by the state. And --

THE COURT: So that's the part -- is that the -- it -- that part of the statute says the employee -- the retiree is entitled to push it.

MS. ALLOWAY: Yes.

THE COURT: And so when -- if you (indiscernible) --

MS. ALLOWAY: Or may purchase it if -- and that's the next --

THE COURT: I got it. I got it.

MS. ALLOWAY: -- step.
THE COURT: But it's entitle -- entitled to purchase it. So what -- doesn't then the employee go back to day one? I'm a brand-spanking-new attorney at the Department of Law, and I start on day one, and I can't even imagine what the retirement is going to be, but I know that it tells me that -- oh, and look at that; if I ever make it 30 years in the Department of Law, I get to purchase dental, vision, and audio benefits.
MS. ALLOWAY: Yes. But -- hold on, because that comes with a caveat --
THE COURT: Okay.
MS. ALLOWAY: -- Your Honor. There's a but to my answer. And --
THE COURT: Okay.
MS. ALLOWAY: -- yes, you got to look at what the retiree looked at on day one. So when I was a new state attorney in 2012, what could I look at. I could look at A.S. 39.30.090, right. And it says, Jessie, when you're retired, you have the option to purchase DVA coverage as a retiree. However, it says under this section, subsection (a) provides that the Department of Administration may obtain a policy or policies of group insurance covering state employees, retirees, or others.
So the section does not say that the state must obtain these policies for the groups. It says that it may. And then the statute also says that even if the DVA -- (a)(1) provides

that the group insurance policy shall provide one or more of the following benefits, which includes DVA coverage. So even if the Department of Administration decides to produce or procure a group insurance policy for active employees and retired employees, it's not even mandated to purchase DVA coverage.
So if you look at what actually -- as a state employee, I was entitled to in 2012 -- I know these employees go back even further -- you have to look at the entirety of the statute to see what is actually being promised. And the only thing that's being promised is that, as a retiree, if the Department of Administration chooses to offer DVA coverage, I have the option to purchase it. So in other words, the Department of Administration, if it procures a group insurance policy, it can't merely offer the DVA coverage to an active employee. Retirees are also given the option of purchasing that. And that -- if the court doesn't rule like I've argued in the brief that DVA coverage is not deferred compensation and is not protected by the diminishment clause and rules that there's some benefit protected by the diminishment clause, I'd argue, if you read the entirety of the statute, the only thing that is -- should be protected by the diminishment clause is what the employee could reasonably expect at the time of their employment, and that is the ability to purchase DVA coverage if it is offered by the State of Alaska. So next year --
THE COURT: But doesn't the state get its choice then at

the time that it has got this group of employees that are being hired in a big picture? I mean, isn't that what the state's option is? And they've made their -- they -- that may language -- they don't have to offer anybody DVA coverage at all.
So I have no idea what the law is right now in terms of new hires, but they could decide tomorrow, if the legislature could actually pass something that quickly -- but they could decide something tomorrow to say nobody's getting any DVA coverage when they retire, period, amen, end of story, that's it, right? The statute says they can do that.
MS. ALLOWAY: Yes.
THE COURT: But once they've made that decision and they've said for this -- starting now, this is going to be what the coverage is going to be and this is what we have, haven't they made that decision then for every new hire that comes in under that umbrella of coverage?
MS. ALLOWAY: I don't think so, and I don't think that's required by the court's decision in Duncan. And that gets back to the fact that Duncan protects deferred compensation. And the retiree is not accepting -- unlike major medical insurance, the retiree is not accepting this offer of contract at the time of employment, because they're not working throughout the entire course of their employment by contributing part of their salary to major medical, nor is the state making contributions on their

behalf throughout the entire -- the entirety of their employment. The contract is only accepted at the time of retirement, when the retiree chooses to pay the premiums. There's no compensation, there's no deferred compensation, there's no exchange that's going on until that point in time. And that, I would argue, is not a contract that's protected by the diminishment clause for the reasons that were articulated in the Livingston decision, as well as articulated by the Michigan court in the case that I cited to the court yesterday.
THE COURT: I'm just having a difficult time -- when you use the term deferred compensation, I go back to my example of the option to do something. People pay money for the option to go do something, because that option itself has value. How is that not a deferred compensation for the employee when they get started? It's not something that they can grab a hold of. It's not something they may never be able to grab a hold of, because they may never qualify as a retiree, they may never vest. But it's there for them, that value, that -- somehow down the road. It's just that it's a little further out to reach.
MS. ALLOWAY: Well, I still think, Your Honor, that the import of what Duncan is telling us as well as the Livingston case is that it doesn't -- the diminishment clause doesn't protect every benefit that could potentially be offered to a retiree. So we have to look at what is actually being offered, right.

And the -- Livingston -- granted, Nebraska doesn't have a constitutional provision, but they're relying on the contract model. Clearly, Alaska relies on the contract model. That's set forth in the diminishment clause. So what is the contract, Your Honor?

So yes, there is an offer on the table from the state to purchase DVA coverage if it is made available. But there's no offer on the state -- on part of the state that it's going to make a DVA coverage available for eternity. Clearly, the statute says that the Department of Administration has the discretion to offer DVA coverage. So it also has the discretion not to offer it.

Unlike major medical insurance, the state employee doesn't accept that offer when -- at the time of their employment. And there's nothing that they're giving up in retirement if that coverage is not offered, because the state made no contribution on their behalf, nor did they contribute anything. So this is -- these differences, unless what plaintiffs argue -- I would argue are legally significant and gets us outside of the realm of what Duncan was saying in something else. And that's why I believe that the Livingston court decision and the Michigan decision are relevant.

THE COURT: Okay. Thank you.

MS. ALLOWAY: Yes. I'd also like to point out, totally off of my outline, the --

THE COURT: That's our game plan when we have to ask questions, so --

MS. ALLOWAY: Right. Yeah. I get you.

THE COURT: It's not -- I'm sorry. Take -- please take your time. If you need --

MS. ALLOWAY: No, no, no, no.

THE COURT: -- more time, that's okay.

MS. ALLOWAY: -- that's okay. I think I've actually covered most everything that I wanted to cover in the outline. I just also wanted to point out that one of the reasons that plaintiffs argued in their brief that Livingston was not persuasive authority for this court was that Livingston -- Nebraska relies on the contracts clause to protect its pension benefits and doesn't have a specific constitutional provision.

I didn't mention this in my briefing, but I'd like to mention it now. The Alaska Supreme Court has routinely looked at states that follow the contract model yet don't have a specific constitutional provision for guidance when interpreting our own diminishment clause. So, for example, in Hoffbeck, the court relied heavily on a long line of cases from California when it decided to adopt the limited vesting approach, and California does not have a specific constitutional provision protecting pension benefits. It has -- it relies merely on the contract clause. So this court -- or the Alaska Supreme Court has no qualms about relying on case law which just relies on the

contract clause and don't -- doesn't have a constitutional provision. So unless the court has any questions --

THE COURT: I don't have any more --

MS. ALLOWAY: -- for me --

THE COURT: -- questions for you.

MS. ALLOWAY: No more?

THE COURT: No.

MS. ALLOWAY: Okay. Thank you.

THE COURT: You're welcome. Ms. Orlansky.

MS. ORLANSKY: Thank you. I -- I'll try to just very, very briefly -- I'm going to call the court back to the language of the state Constitution, because Ms. Alloway's argument looked a lot at the term deferred compensation. And that absolutely appears in Duncan, but Duncan's trying to interpret the state Constitution.

The state Constitution doesn't use the term deferred compensation. The state Constitution talks about membership in the employee retirement system as a contractual relationship. And that, I think, is the key. Once you are hired, you have to be a member of the state employee retirement system. And that's the contract. You're a member. So what are they offering to members at that point in time. The second sentence in Article 12, Section 7 starts: The accrued benefits of these systems shall not be diminished or impaired.

And Duncan, I think, is most significant for us in terms of

its discussion of what does it mean to accrue. And Duncan, as well as the earlier cases like Hammond versus Hoffbeck, define accrued in that sense of being -- becoming entitled to it because you've accepted employment.

So I think that the constitutional language -- I mean, I know the Supreme Court spends pages and pages and pages trying to interpret it, but I think if we boil it down to its absolute essence, the Supreme Court -- the language of the Constitution has to guide this court's decision in this case.

THE COURT: All right. Thank you.

MS. ORLANSKY: Thank you.

THE COURT: I am granting the RPEA's motion for partial summary judgment. I'm denying the state's cross-motion for partial summary judgment. I think the language in Duncan is fairly straightforward. The principle that everybody agreed with at the beginning of the arguments here is that the -- that the benefits -- the employees' rights to benefits under the retirement vest on employment and enrollment in the system, and then it gives a -- the -- it says what it's not. It says rather than at the time when the employee becomes eligible to receive those benefits. That language in itself is inconsistent with the state's argument today in terms of that somehow there's not a benefit that is available to them until they actually can purchase that option.

I use the -- may not have been a -- the best example, but I

used in terms of the value of an option to buy an -- or option to purchase, an option to lease, an option to explore. Options are something that have -- are recognized in terms of having value. Having that choice sometime in the future to be able to exercise an option has value. And the language that we're talking about under Article 7 of Section 7 in the diminishment clause -- when we talk about accrued benefits, Duncan said very clearly it is accrued benefits and there's no limitation to the definition of that. It is a very broad term.

And so the state in the statutes that it has passed and what the legislature has explained in terms of what the executive branch can do in terms of when they're purchasing thing -- and they're making these choices, is that you don't have to offer DVA to the employees of the State of Alaska. But if you do, then the logical reading of this is that they then are going to have that right to take advantage of that and to purchase those as an option and a part of their employment.

That's what we're talking about, is that at the time that an employee starts their employment, the state has defined in their exercise of, one, whether or not they're going to have a DVA group life insurance policy in existence, and if there is one in existence, then that is what defines the terms of that option to purchase in the future.

So for those reasons, the -- I am agreeing with RPEA's interpretation of the legal issue before this court, and for the

reasons that I've just stated, granting their partial summary judgment motion. So next.

MS. ORLANSKY: The next --

THE COURT: At some point in time --

MS. ORLANSKY: Right.

THE COURT: -- we're going to have to have a big, long evidentiary hearing weighing whether or not we're going to -- the -- there's been a diminishment or not.

MS. ORLANSKY: Exactly, Your Honor. And I think the only reason I hesitate is the next obvious course would be a discovery phase. I've deliberately postponed discovery of what would be the state's bases and justifications for the changes in the dental insurance plan. Probably that's where we go.

I'd like to talk to Ms. Alloway out of court about whether the state has an interest in a petition for review. We obviously don't know whether the Supreme Court would take it, but obviously I -- I'm very comfortable with Your Honor's ruling, but we all know that the final decision is made somewhere else. And maybe we need the legal decision before we engage in the discovery and the trial process, and that's not entirely up to us, but I think the state needs to make a choice about whether they want to attempt to get the Supreme Court to grant a petition for review. My clients need to make a decision about whether they would oppose or not oppose that if they did it.

So I think perhaps if we could get back to you in writing in a week or two. Jessie, does that work? Tell the court what we're doing or --

MS. ALLOWAY: I don't know whether I'll have an answer from --

MS. ORLANSKY: Okay.

MS. ALLOWAY: -- on the petition for review within a week --

MS. ORLANSKY: Okay.

MS. ALLOWAY: -- but we can certainly --

MS. ORLANSKY: A week, two --

MS. ALLOWAY: -- check in.

MS. ORLANSKY: -- weeks, a month. I mean, I think there's some value in letting both sides talk to various players and higher-ups about what the next step should be. So we could respond to Your Honor --

THE COURT: Are --

MS. ORLANSKY: -- about what the next step is after we've had a chance to have that conversation.

THE COURT: Why don't I set this for a trial-setting conference in either late January, early February, and at that point in time I'll either see notice that a petition has been filed or you'll be in here asking for a trial date because your clients have decided they want to do something different.

MS. ORLANSKY: That would be fine by us.

THE COURT: So -- that okay?

MS. ALLOWAY: Yes.

THE COURT: All right. How about February 1st at 4:00 o'clock? Ms. Alloway?

MS. ALLOWAY: I think that works, Your Honor.

MS. ORLANSKY: Probably, yeah.

THE COURT: Did your iPhone say it's okay or --

MS. ALLOWAY: It does. Thank you.

THE COURT: It did? Okay.

MS. ALLOWAY: Yes.

THE COURT: All right. Very well briefed, counsel, both of you, well argued. I appreciate it. It made it a fairly easy process for me in terms of coming to a decision and announcing a decision today, so thank you for your hard work. I appreciate it. All right.

MS. ALLOWAY: Thank you.

THE COURT: We'll go off record.

THE CLERK: Please rise. Court stands adjourned.

(Court recessed)

04:11:45

END OF REQUESTED PORTION

TRANSCRIBER'S CERTIFICATE

I, Teresa K. Combs, hereby certify that the foregoing pages numbered 1285 through 1316 are a true, accurate, and complete transcript of proceedings in Case No. 3AN-16-04537 CI, Retired Public Employees of Alaska, Inc. v. Commissioner of the Alaska Department of Administration, transcribed by me from a copy of the electronic sound recording to the best of my knowledge and ability.

12/11/19 — Teresa K. Combs

Date — Teresa K. Combs, Transcriber

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	)	
Defendants.	)	Case No. 3AN-16-04537CI

ORDER DENYING DEFENDANT'S REQUEST FOR RECONSIDERATION

This Court has considered Defendant's Request for Reconsideration and DENIES the request.

The Defendant first argues that an "accrued benefit" protected by the diminishment clause is not equivalent to dental-visual-audio (DVA) coverage. Although retirees self-fund their DVA coverage, the option to buy the insurance is still part of the benefit they are offered at the time of employment. This court has already addressed this issue and it is not necessary to reconsider. Therefore, this Court DENIES the Defendant's Request for Reconsideration with regard to the question of whether the State's offer of DVA coverage is protected by Article XII, § 7 of the Alaska constitution.

The Defendant raises a second issue, on whether the diminishment clause protects only contracts formed at the time of employment or extends the right if the Department had offered coverage at any point during the employee's state employment. In *Duncan v. Retired Public Employees of Alaska, Inc.,*, the Alaska Supreme Court held that the term "accrued benefits," referred to "all retirement benefits that becomes part of the contract of employment when the public employee is hired,"[1] and that 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.'"[2] A preliminary reading of that sentence suggests that a benefit offered at any time during employment is protected from diminishment, but this was not directly raised in either the Motion for Partial Summary Judgment or the Cross- Motion. Because an answer on this would be an advisory opinion, the Court declines to address the issue.

Defendant also argued that the Court failed to consider how the law protects a benefit when the benefit package offered in this circumstance is paid for by the employee, which was not at question during the summary judgment motion. The Defendant appears to be asking the Court either to provide a comprehensive test for determining how to value plan decisions, or to begin to assess the factual issue of whether adoption of the Moda plan adopted by the State violated the Alaska Constitution. The Parties submitted one question to the Court for consideration of Summary Judgment: is

---

[1] *Duncan v. Retired Public Employees of Alaska, Inc.,*71 P.3d 882, 888 (Alaska 2003).
[2] *Id.* at 886 (quoting Alaska Const. Art. XII, section 7) (emphasis added).

the retired state employees' optional DVA plan subject to the non-diminishment clause of Alaska Constitution Article XII?[3] An opinion on how to assess value is beyond the scope of this question and therefore would be advisory. The Court declines to address this issue.

IT IS SO ORDERED

DATED at Anchorage, Alaska on this 27 day of February, ~~2017.~~

ERIC A. AARSETH

Superior Court Judge

2/27/17

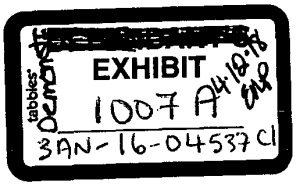
at the

Judicial Assistant / Deputy Clerk

[3] Joint Report to the Court 2-3 (Mar. 30, 2016).

Class I Preventive Services

Service	Coverage Under 2013 Retiree Dental Plan	Coverage Under 2014 Retiree Dental Plan
Oral exam (routine)	Covered with no frequency limitation indicated (Bates #508)	Covered once in any 6-month period (Bates #6405)
Dental x-rays for diagnosis	Covered for the diagnosis of a specific condition; no limitations indicated (Bates #508)	Covered for diagnosis, but only the following intra-oral x-rays are covered: complete series or panoramic, periapical, occlusal, and bitewing (Bates #6405)
Full mouth x-rays (routine)	Covered with a frequency limit of one per year (Bates #508, 7334)	Covered with a frequency limit of once in any 5-year period (Bates #6405)
Routine supplementary bite-wing x-rays	Covered with no limitations indicated (Bates #7334; see also Bates #508) Document prepared after litigation commenced notes a limit of once per year (Bates #7386)	Covered once in any 12-month period (Bates #6405)
Diagnostic casts and study models	Covered (Bates # 7334)	Diagnostic aids such as study models and certain lab tests are not covered (Bates #6405)
Topical fluoride treatment	Covered, with no age or frequency limitation indicated (Bates #508)	Covered once in any 6-month period if patient is age 18 and under; not covered if patient is 19 or over, except when there is a recent history of periodontal surgery or a high risk of decay due to a medical disease, chemotherapy, or similar treatment (and not due to poor diet or poor oral hygiene) and then covered once in a 6-month period (Bates #6406)



Prophylaxis (cleaning, scaling, and polishing)	Covered, with no frequency limitation indicated (Bates #508)	Covered once in any 6-month period, with additional coverage for patients who are diabetic, in the third trimester of pregnancy, or who have periodontal disease, or when determined by Moda to be dentally necessary (Bates #6405-06, 7636)
Sealants	Covered through age 18; no other limitation indicated (Bates #508)	Covered, with no age limitation, but coverage is limited to treatment of unrestored occlusal surfaces of permanent molars, with a frequency limit of one sealant per tooth during any 5-year period (Bates #6406)
Periodontal maintenance	Covered under Class II periodontic services; no other limitations indicated (Bates #509)	Now covered under Class I for once in any 6-month period, with additional coverage allowed for those with diabetes, periodontal disease, or in the third trimester of pregnancy (Bates #6405-06)
Space Maintainers	Covered under Class II; no limitations indicated (Bates #509)	Now covered under Class I with limitations of once per space, and no coverage for primary anterior teeth, missing permanent teeth, or persons age 14 or over (Bates #6406)

Class II Restorative Services

Service	Coverage Under 2013 Retiree Dental Plan	Coverage Under 2014 Retiree Dental Plan
Fillings	Covered with no specific limitation on filling material (allows silver amalgam, silicate, and plastic restoration) (Bates #508)	Covered but allows composite fillings only for anterior teeth (Bates #6406, 7387)
Bridge and denture repair and relining	Covered; no frequency limitation indicated (Bates #508)	Now covered under Class III; see below for other limitations (Bates #6409)
Palliative emergency treatment	Covered with no limitations indicated (Bates #508)	Not addressed

14	Extractions (removal of teeth) and other oral surgical procedures	Covered with no limitations indicated (Bates #508)	Covered with specific limitation that alveoloplasty done in conjunction with surgical removal of teeth is not covered as a separate service; also specifies that only minor surgical procedures are covered and that surgery on larger lesions or malignant lesions is not considered minor surgery (Bates #6407)
15	Brush biopsy	Not mentioned; not a covered service	Covered once in any 6-month period; coverage limited to sample collection and not pathology (lab) services (Bates #6407)
16	Pulp capping	Covered with no limitations indicated (Bates #000508)	Covered only when there is exposure of the pulp (Bates #6407)
17	Root canal treatment	Covered with no limitations indicated (Bates #508)	Covered, except no coverage for retreatment by the same dentist within 24 months of a root canal (Bates #6407)
18	Apicoectomy (surgical removal of a root tip)	Covered with no limitations indicated (Bates #509)	Not specifically addressed
19	Periodontal scaling and root planing (periodontal prophylaxis)	Covered with no limitations indicated (Bates #509, 7334)	Coverage limited to once per quadrant in any 24-month period (Bates #6407)
20	Periodontal splinting	Covered if approved by the TPA's dental consultant (Bates #7335)	Not specifically addressed
21	Gold foil restoration	Covered (Bates #7335)	Not specifically address
22	Full mouth debridement	Covered with no specific limitations (communication from K. Farmer)	Coverage limited to once in a 3-year period, and only if no cleaning was provided within 24 months (Bates #6407)

Local and general anesthesia	Covered as necessary for dental procedures (Bates #509) Some limitations noted at Bates #7335	General anesthesia and IV sedation are covered only for surgical procedures performed in a dentist's office or when necessary due to a concurrent medical condition (Bates #6407)
Nitrous oxide	Covered (Bates #7335)	Initially not covered but coverage added retrospectively through Benefit Clarification dated 9/11/2014 (Bates #7635)

Class III Prosthetic Services

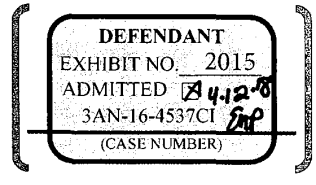
Service	Coverage Under 2013 Retiree Dental Plan	Coverage Under 2014 Retiree Dental Plan
Crowns and onlays	Covered with no limitation on frequency or material indicated (Bates #509)	Covered with limitations of once in a 7-year period on any tooth; no coverage for the cost of porcelain restorations on the upper second or third molars or the lower first, second or third molars to the extent the cost of porcelain restoration exceeds the cost of gold restoration. If a tooth can be restored with an amalgam, coverage is limited to the cost of the amalgam restoration. (Bates #6408, 6410)
Inlays	Covered with no limitations indicated (Bates #509)	Not covered; inlays are considered an optional service; an alternate benefit of an amalgam filling will be provided and covered under Class II (Bates #6406)
Bridges	Covered with no limitations indicated (Bates #509) Temporary bridges covered (Bates # 7336)	Covered once in 7 years and only if the tooth site or teeth involved have not received a cast restoration benefit in the last 7 years; fixed bridges are not covered for persons under age 16 (Bates #6408, 6410) Temporary bridges are not addressed

Dentures	Covered with no limitations indicated (Bates #509) Temporary complete dentures covered (Bates #7336)	Covered, but only if the tooth site has not received a cast restoration in the past 7 years (Bates #6408) Temporary (interim or provisional) complete dentures are not covered (Bates #6408)
Dentures (partial)	Covered with no limitations indicated (Bates #509) Temporary partial dentures covered (Bates #7336)	Covered but limited to once in a 7-year period, and only if the tooth site has not received a cast restoration benefit within 7 years (Bates #6408) Temporary partial dentures are covered only when placed within 2 months of the extraction of an anterior tooth or for missing anterior permanent teeth of persons age 16 or under; coverage is limited to the cost of a standard cast partial denture; no coverage for cast restorations for partial denture retainer teeth unless the tooth requires a cast restoration due to decayed or broken teeth (Bates #6409)
Denture adjustments, repairs, and relines	Repairs and relines covered under Class II, with no limitation indicated; adjustments not specifically mentioned (Bates #508)	No coverage for adjustments, repairs, or relines done within 6 months after initial placement; coverage for subsequent relines limited to once per denture in a 12-month period; coverage for subsequent adjustments limited to two per denture in a 12-month period (Bates #6409)
Denture replacement or additions to existing dentures	Covered if the replacement or addition of teeth is necessary to replace teeth extracted after the current denture was installed, if the present denture is at least 5 years old and cannot be made serviceable, if the present denture is an immediate temporary one and cannot be made permanent and replacement by a permanent denture is made within 12 months of the installation of the temporary denture (Bates #509)	Replacement covered once in 7 years (Bates #6408)

Tissue conditioning	Covered, although not explicitly listed in plan booklet (communication from K. Farmer)	Covered but no more than twice per denture in 36-month period (Bates #6409)
Implants	Surgical placement of implant covered under retiree medical plan if needed due to disease or accident; implant-supported abutment crowns, partial or dentures are covered if necessary due to disease or accident; replacement limited to once in 5 years (Bates #7336)	Retiree medical plan covers implant and anesthesia if implant needed due to disease or accident; dental plan covers the appliance (crown); implant not due to disease or accident may be covered by dental plan; implants limited to once per lifetime per tooth space; implant-supported bridge or abutment limited to once per tooth space in 7 years (Bates #6409-6410, 7634)
Athletic mouth guard	Not covered	Covered once in any 12-month period for persons age 15 or under, and once in any 24-month period for persons age 16 and over (Bates #6410)

Historical Retiree Rate Information

	Medical					Dental, Vision, Audio			
	Composite	Retiree Only	Retiree & Spouse	Retiree & Children	Retiree & Family	Retiree Only	Retiree & Spouse	Retiree & Children	Retiree & Family
1/1/2017						$ 66.00	$ 131.00	$ 119.00	$ 187.00
1/1/2016	$ 1,374.00	$ 823.00	$ 1,647.00	$ 1,163.00	$ 1,987.00	$ 63.00	$ 125.00	$ 113.00	$ 178.00
1/1/2015	$ 1,374.00	$ 823.00	$ 1,647.00	$ 1,163.00	$ 1,987.00	$ 63.00	$ 125.00	$ 113.00	$ 178.00
7/1/2014	$ 1,223.00	$ 823.00	$ 1,647.00	$ 1,163.00	$ 1,987.00	$ 63.00	$ 125.00	$ 113.00	$ 178.00
1/1/2013	$ 1,223.00	$ 823.00	$ 1,647.00	$ 1,163.00	$ 1,987.00	$ 70.00	$ 139.00	$ 125.00	$ 198.00
1/1/2012	$ 1,200.00	$ 807.00	$ 1,615.00	$ 1,140.00	$ 1,948.00	$ 69.00	$ 136.00	$ 123.00	$ 194.00
1/1/2011	$ 1,075.00	$ 791.00	$ 1,583.00	$ 1,117.00	$ 1,910.00	$ 63.00	$ 124.00	$ 112.00	$ 176.00
1/1/2010	$ 1,068.00	$ 719.00	$ 1,439.00	$ 1,016.00	$ 1,736.00	$ 57.00	$ 113.00	$ 102.00	$ 160.00
1/1/2009	$ 937.00	$ 631.00	$ 1,262.00	$ 891.00	$ 1,523.00	$ 57.00	$ 113.00	$ 102.00	$ 160.00
1/1/2008	$ 876.00	$ 590.00	$ 1,179.00	$ 833.00	$ 1,423.00	$ 54.00	$ 108.00	$ 97.00	$ 152.00
1/1/2005	$ 850.00	$ 573.00	$ 1,146.00	$ 809.00	$ 1,382.00	$ 54.00	$ 108.00	$ 97.00	$ 152.00
1/1/2004	$ 806.00	$ 543.00	$ 1,086.00	$ 767.00	$ 1,310.00	$ 48.00	$ 96.00	$ 87.00	$ 136.00
1/1/2003	$ 720.00	$ 485.00	$ 970.00	$ 685.00	$ 1,170.00	$ 48.00	$ 96.00	$ 87.00	$ 136.00
1/1/2002	$ 668.00	$ 450.00	$ 900.00	$ 635.00	$ 1,084.00	$ 48.00	$ 96.00	$ 87.00	$ 136.00
1/1/2001	$ 610.00	$ 410.00	$ 820.00	$ 580.00	$ 990.00	$ 48.00	$ 96.00	$ 87.00	$ 136.00
1/1/2000	$ 530.00	$ 356.00	$ 713.00	$ 505.00	$ 862.00	$ 41.00	$ 83.00	$ 74.00	$ 116.00
1/1/1999	$ 442.00	$ 297.00	$ 594.00	$ 421.00	$ 718.00	$ 39.00	$ 78.00	$ 70.00	$ 109.00
2/1/1997	$ 368.00	$ 247.40	$ 494.70	$ 350.90	$ 598.30	$ 33.00	$ 66.00	$ 59.30	$ 92.30
2/1/1995	$ 350.50	$ 235.60	$ 471.10	$ 334.20	$ 569.80	$ 30.00	$ 60.00	$ 53.90	$ 83.90
2/1/1994	$ 336.05	$ 225.90	$ 451.70	$ 320.40	$ 546.20	$ 30.00	$ 60.00	$ 53.90	$ 83.90
2/1/1993	$ 309.72	$ 208.20	$ 416.30	$ 295.30	$ 503.40	$ 27.40	$ 54.80	$ 49.20	$ 76.60
7/1/1991	$ 226.90	---	---	---	---	$ 24.90	$ 49.80	$ 44.70	$ 69.60
2/1/1991	$ 243.98	---	---	---	---	$ 24.90	$ 49.80	$ 44.70	$ 69.60
2/1/1990	$ 243.98	---	---	---	---	$ 27.65	$ 55.30	$ 49.70	$ 77.30
2/1/1989	$ 252.83	---	---	---	---	$ 29.10	$ 58.20	$ 52.30	$ 81.40
7/1/1988	$ 211.22	---	---	---	---	$ 38.70	---	---	$ 91.15
11/1/1987	$ 140.25	---	---	---	---	$ 27.00	---	---	$ 63.60
7/1/1986	$ 165.00	---	---	---	---	$ 22.50	---	---	$ 53.00
7/1/1985	$ 175.00	---	---	---	---	$ 22.50	---	---	$ 53.00
7/1/1984	$ 191.85	---	---	---	---	$ 22.50	---	---	$ 53.00

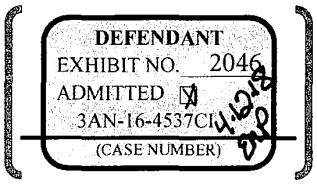


Incurred Plan Year	Allowed	Member Paid*	Plan Paid**	Allowed PMPM	Member Paid PMPM	Plan Paid PMPM	Actuarial Value
2013	$29,557,548	$8,965,183	$20,592,498	$50.67	$15.37	$35.31	**69.7%**
2014	$27,676,613	$7,711,971	$19,964,642	$47.45	$13.22	$34.23	**72.1%**
2015	$31,211,812	$8,565,174	$22,646,638	$51.28	$14.07	$37.20	**72.6%**
2016	$33,189,091	$8,976,113	$24,212,979	$52.81	$14.28	$38.53	**73.0%**
2017* **	$30,689,066	$8,000,776	$22,688,290	$47.54	$12.39	$35.14	**73.9%**

* Member paid figures represent the members' out-of-pocket costs (deductibles, coinsurance, etc).
** Plan paid figures represent the portion of costs paid by the DVA trust net of member out-of-pocket costs and any amounts paid by other plans.
*** Claims experience for 2017 was not complete at the time of this analysis.

In the initial analysis, it was necessary to estimate the actuarial value for 2013. Utilizing the 2013 HealthSmart data, it was possible to calculate the 2013 actuarial value directly.

Incurred Plan Year	Allowed	Member Paid	Plan Paid	Actuarial Value
2013	$40,519,817	$13,738,077	$26,781,739	**66%**



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

The Retired Public Employees of Alaska, Inc., Plaintiff, vs. Leslie Ridle, Commissioner of the Alaska Department of Administration, Defendants.	3AN-16-4537 CI

ORDER

Adopting RPEA's Proposed Findings of Facts and Conclusions of Law

The court adopts the findings and conclusions proposed by RPEA and incorporates the same by reference as a part of this order. The court makes the following additional findings:

1. The defendant, Department of Administration, was the only party with complete access and control to relevant records necessary for the comparison of the 2013 and 2014 dental plans.

2. The defendant owed a duty to all public employees, both active and retired, to maintain complete records of the dental plans offered and the manner in which they managed.

3. The defendant was in the best position to provide a complete and thorough evaluation of the 2013 and 2014 dental plans, but did not conduct that evaluation except to prepare for litigation.

4. The analysis/comparison by the defendant was biased with a view to protect the decision to change the third-party administrator, MODA, rather than to provide an objective and neutral comparison of the two plans.

5. The defendant's focus was solely on the premium paid rather than the impact on the benefits offered.

6. The plaintiffs, having the burden of proof, had to resort to using less than optimal evidence to prove the scope and extent of the benefits offered in the 2013 dental plan. The defendants were unable to rebut that evidence. The defendant, if it had properly maintained the records of the 2013 dental plan, should have been able to present the best evidence regarding scope and extent of the benefits as well as the management of the plan.

7. The defendants challenge plaintiffs' evidence and argument such as Exhibit 1001, Exhibit1007 and Table 1 as unreliable, but defendant was unable to present better evidence. If those plaintiffs' exhibits were inaccurate, despite being based on information received from the defendant, then defendant should have been able to produce better evidence to rebut the plaintiffs' argument.

8. The court rejects the defendant's argument that there is no evidence that the defendant approved of HealthSmart's practices of administrating the 2013 plan. The only evidence that could have existed would have been in the defendant's complete control. In this instance, the absence of evidence is held against the defendant, not the plaintiff.[1] Retirees are at the mercy of the defendant when it comes to recordkeeping and as such, the defendant effectively has a fiduciary duty to maintain complete and accurate records.

Conclusion

The court finds in favor of the plaintiffs. The effective date of this order is 1 May 2019. Motions for additional/alternate remedies are due no later than 17 May 2019. Motion for fees and cost bill is due no later than 1 May 2019.

IT IS SO ORDERED.

Dated at Anchorage, Alaska this 17th day of April 2019.

Eric A. Aarseth
Superior Court Judge

I certify that on 4/17/19 a copy of the following was mailed/faxed/hand delivered to each of the following at their addresses of record.
Orlansky/Alloway/Paton-Walsh
Administrative Assistant

[1] See CPJI 2.23 – Failure to Present Evidence

IN THE SUPERIOR COURT OF THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

THE RETIRED PUBLIC EMPLOYEES OF ALASKA, INC., Plaintiff, v. LESLIE RIDLE, COMMISSIONER OF THE ALASKA DEPARTMENT OF ADMINISTRATION, Defendant.	)	Case No. 3AN-16-04537 CI

[RPEA'S Proposed]
FINDINGS AND CONCLUSIONS

SEP 18 2018

Background Facts

1. The Retired Public Employees of Alaska, Inc. ("RPEA") is a non-profit corporation whose primary purpose is to educate retired public employees about their retirement benefits and to assist them in obtaining the benefits to which they are legally entitled.

2. Leslie Ridle is the Commissioner of the Alaska Department of Administration. She is sued in her official capacity. In accordance with the parties' conventions, the defendant in this case is generally referred to as "the State."

3. Since 1979, the State has provided retired public employees the opportunity to purchase dental insurance as one of their retirement benefits.

4. The State provides retiree dental insurance as part of a combined plan that

also includes visual and audio insurance. The combination is often referred to as "DVA insurance." Retirees may not select just dental insurance.

5. Retirees who desire dental insurance must select DVA coverage at the time they retire.

6. Retirees who select DVA insurance must pay a monthly premium to the State for this insurance.

7. The premium is determined by the State, based on the costs incurred by the covered insurance plans, the cost of administering the plans, and the need to keep a reserve. The premium is adjusted regularly, and historically it has increased, due principally to the rising cost of health care. The DVA plan is designed to be self-sustaining.

8. The State does not itself administer the retiree dental plan – or any of the benefit plans it offers to employees and retirees. The State contracts with a private company to administer the benefit plans. This company is called the Third Party Administrator or TPA.

9. From July 1, 2009, through December 31, 2013, Wells Fargo and then HealthSmart served as the TPA for the retiree dental plan. (HealthSmart acquired Wells Fargo early in that period.)

10. Effective January 1, 2014, Moda became the TPA for the retiree dental plan.

11. Although the TPA is assigned principal responsibility for the day-to-day claim-handling process, the State is ultimately responsible for ensuring that the TPA administers the plan in accordance with its terms.

12. To discharge this responsibility, representatives of the State meet extensively with representatives of an incoming TPA to be sure the TPA understands the plan it will administer. Historically, the State also wanted to ensure continuity in claim-handling, although that was not desired when Moda took over as the TPA.

13. Once the TPA begins handling claims, representatives of the State meet regularly with representatives of the TPA, including formal weekly and quarterly meetings and frequent informal communications that address particular claims and how they should be handled. The State also receives information on claim-handling practices by reviewing appeals from members and by responding to complaints from members. The State has the authority to make the final decision on how any claim is handled.

14. The State has the authority to audit the claim-handling by a TPA. The State exercised this authority at least once by conducting an audit while Wells Fargo or HealthSmart was the TPA of the retiree dental plan.

15. If the State determines that the TPA wrongly paid a claim that should not have been paid, the State may require the TPA to repay the plan.

16. The retiree dental plan offered by the State has changed a number of times over the years.

17. The retiree dental plan in effect in 2013 was largely unchanged since 2003. In accordance with the parties' conventions, this is referred to as the "2013 plan."

18. Effective January 1, 2014, the State adopted and implemented a revised retiree dental insurance plan. This is referred to as the "2014 plan."

19. RPEA contends that the changes in the retiree dental plan that took effect in 2014 diminish or impair the benefits available to retirees as compared to the benefits available under the 2013 plan. The State disputes this.

20. The court previously ruled, as a matter of law, that the retiree dental plan is covered by the guarantee against diminishment of benefits in Alaska Constitution Article XII, Section 7.

21. A six-day trial was held in April and July 2018 for the purpose of presenting evidence so that the court could determine whether or not the 2014 plan diminishes retirees' benefits as compared to the 2013 plan.

Changes in the Plan

22. The coverages provided to retirees under the 2013 plan are largely set forth in the Retiree Insurance Information Booklet (May 2003). [Exhibit 1000] This document is referred to as the 2013 plan booklet.

23. The 2013 plan booklet is not the exclusive document that describes coverage under the 2013 plan. The court accepts as credible the testimony by Katherine ("Kelly") Farmer that Exhibit 1001 also describes coverage provided by the 2013 plan. Ms. Farmer was certain that Exhibit 1001 would not have been available to her on her work computer, which it was, if it had not been approved by the State as a summary of how claims should be handled.

24. The court also accepts as credible the testimony of Ms. Farmer that the 2013 plan covered services not listed in either Exhibit 1000 or 1001 – in particular brush

biopsies, full-mouth debridement, and tissue conditioning. The non-exclusive language in the 2013 plan is consistent with the testimony that the 2013 plan document should not be interpreted as excluding coverage of all services not explicitly listed.

25. The court also accepts the testimony and exhibit prepared by Richard Ward that reflect his review of HealthSmart's claim-handling data and determined that root canal therapy (retreatment) and denture adjustments were services regularly treated as covered under the 2013 plan.

26. The coverages provided to retirees under the 2014 plan are largely set forth in the 2014 amendment to the AlaskaCare Retiree Health Plan. [Exhibit 1003] This document is referred to as the 2014 plan booklet.

27. Coverages under the 2014 plan are also set forth in a series of benefit clarifications, as stated in Exhibits 1004, 1005, and 1006.

28. Based on the express language in the 2014 plan booklet that states that the listed services are covered, indicating that non-listed services are not covered, the court finds that, for the 2014 plan, any service not specifically listed in the booklet or in a formal benefit clarification is not covered.

29. The court finds that both Exhibit 1007 (as discussed at trial) and Table 1 (submitted by RPEA post-trial to summarize the trial evidence) are largely accurate statements of the coverages provided under the 2013 and 2014 plans and of the nature of the changes that took effect in 2014.

30. Both plans organize the covered services into classes. The rate of reimbursement varies by class. Services in class I are covered at 100% of the recognized charge, and no deductible must be satisfied. For services in class II and class III, a $50 deductible applies. After the deductible is satisfied, services in class II are covered at 80% of the recognized charge, and services in class III are covered at 50% of the recognized charge.

31. The 2014 amendments did not change the overall organization of the plan into three classes or the reimbursement rate for each class. A few services were moved to a different class.

32. Based on the trial evidence, the court finds the following as to the respective coverages and changes:

Service	2013 Plan	2014 Plan	Change
Oral exam	Covered – no express limitations	Covered once in 6 months	Imposes a frequency limitation
X-rays for diagnosis	Covered – no express limitations	States both that it covers "only" intra-oral x-rays, and that it covers only panoramic, periapical, occlusal, and bite-wing x-rays	Imposes limitations on types of x-rays covered
Routine full-mouth x-rays	Covered once per year	Covered once in 5 years	Imposes a frequency limitation
Routine bite-wing x-rays	Covered – no express limitations	Covered once/year	Imposes a frequency limitation
Diagnostic casts and study models	Covered	Not covered	Deletes coverage

Topical fluoride	Covered – no express limitations	Covered once in 6 months for persons 18 and under; if 19 or older, covers once in 6 months if there is a recent history of periodontal surgery, or high risk of decay due to disease, chemotherapy, or similar treatment	Imposes a frequency limitation for all ages; deletes coverage for adults except for specified dental conditions
Prophylaxis	Covered – no express limitations	Covered once in 6 months; also covers up to 3/year for person in third trimester of pregnancy and up to 4/year for person with diabetes, periodontal disease, or when determined dentally necessary by Moda	Imposes a frequency limitation; allows specified exceptions based on dental condition or if Moda determines it is dentally necessary
Sealants	Covered through age 18	Covered once in 5 years, with no age limitation, but limited to the unrestored occlusal surface of a permanent molar	Deletes age limitation; imposes a frequency limitation and a tooth limitation
Periodontal maintenance	Covered – no express limitations	Covers prophylaxis *or* periodontal maintenance once in 6 months; allows up to 2 periodontal maintenance treatments per year in addition to two prophylactic treatments if person is pregnant or has diabetes or periodontal disease	Changes from Class II to Class I; imposes frequency limitations, with higher limits for certain specified conditions

Space maintainers	Covered – no express limitations	Covered only if under age 14 and only once per tooth space, with no coverage for primary anterior teeth or missing permanent teeth	Changes from Class II to Class I; imposes age limitation. tooth limitation, and frequency limitation
Fillings	Covered	Covered	No change
Bridges and dentures – repair and relining	Covered – no express limitations	No coverage within 6 months of initial placement; subsequent relining is limited to one/year	Changes from Class II to Class III; imposes time and frequency limitations
Palliative emergency care	Covered – no express limitations	No coverage	Deletes coverage
Extractions and other oral surgery	Covered – no express limitations	Covered; precludes separate charge for alveoplasty	Deletes coverage for alveoplasty as a separate charge
Brush biopsy	Covered	Covers 2/year (but not the lab services)	No change
Root canal and retreatment	Covered – no express limitations	Covered, but no coverage for retreatment by the same dentist within 24 months	Imposes frequency limitation
Pulp capping	Covered – no express limitations	Covers direct but not indirect pulp capping	Deletes coverage for indirect pulp capping
Apicoectomy	Covered – no express limitations	Not mentioned	Deletes coverage
Periodontal scaling and root planing	Covered – no express limitations	Covered once per quadrant in 24 months	Imposes frequency limitation
Periodontal splinting	Covered if approved by ADE	Not covered	Deletes coverage
Gold foil restoration	Covered – no express limitations	Not covered	Deletes coverage

Full-mouth debridement	Covered – no express limitations	Covered once in 3 years but only if there was no prophylaxis within 2 years	Imposes frequency limitation
Local and general anesthesia	General anesthesia covered as necessary for dental procedures	General anesthesia covered only for surgical procedures or if needed due to a medical condition	Imposes restrictions on use of general anesthesia
Nitrous oxide	Covered	Covered	No change
Crowns and onlays	Covered with no time limitations; extra cost for porcelain not covered for 2d or 3d molar	Covered once per 7 years; extra cost for porcelain not covered for upper 2d or 3d molar and lower 1st to 3d molar	Imposes frequency limitation and a material limitation for first lower molar
Inlays	Covered with no time limits; extra cost for porcelain not covered for certain teeth	Not covered	Deletes coverage
Bridges	Covered – no express limitation; temporary bridges also covered	Covered once in 7 years, and only if there was no crown; temporary bridges not covered	Imposes frequency limitation; deletes coverage for temporary bridge
Dentures (full)	Covered – no express limitation; temporary full denture also covered	Covered once in 7 years and only if there was no crown; temporary complete denture is not covered	Imposes frequency limitation; deletes coverage for temporary complete denture
Dentures (partial)	Covered – no express limitation; temporary partial denture also covered	Covered; temporary partial denture covered only if placed within 2 months of tooth extraction	Imposes a time limitation for temporary partial denture

Denture adjustment, repair, and relining	Covered – no express limitation	Covered, but no coverage within 6 months of initial placement; subsequent adjustments covered at 2 per denture in 12 months; relining covered once per 12 months	Changes from class II to class III; imposes time and frequency limitations
Denture replacement	Covered after 5 years, if denture cannot be repaired	Covered after 7 years, if denture cannot be repaired	Increases the frequency limitation
Tissue conditioning	Covered – no express limitation	Covered 2 times per denture within 36 months	Imposes a frequency limitation
Implants	Covered for the making of the artificial tooth, when medical plan covered the surgery when implant is needed due to accident or disease	Covered once per tooth for the making of the artificial tooth, when the medical plan covers the surgery when implant is needed due to accident or disease; covers implants not covered by the medical plan	May expand coverage, but the record does not establish when implants would be needed and are not covered by the medical plan
Athletic mouthguard	Not covered	Covered once in 12 months if patient is 15 or younger; covers once in 24 months if patient is 16 or older	Adds a new coverage

33. The changes, individually and collectively, affect thousands of people. The clearest evidence concerned fluoride treatment for adults. The number of approved claims for fluoride treatment for adults dropped from over 7000 in 2013 to under 1250 (and most likely to no more than about 750) in 2014.

34. In addition to changing coverage for particular services as described above, the 2014 plan introduced a network with steerage, which was not a part of the 2013 plan.

35. Under the 2014 plan, in Alaska, a patient who sees a non-network provider is reimbursed at only 75% of the otherwise-allowed reimbursement.

36. Members of the retiree dental plan who reside outside Alaska are also financially penalized if they see a non-network provider, but Moda has not disclosed the nature or amount of the penalty. It varies state-by-state.

37. The financial penalty for seeing a non-network provider applies even if the member resides in a community that has no network provider. This includes members who live in communities where they have access to a non-network provider but no in-network provider. This description applies to a number of communities in rural Alaska, and likely applies to some members in rural communities outside Alaska.

38. Only 53% of dentists in Alaska were members of the Moda network as of 2017.

39. The percentage of claims submitted in Alaska for seeing a non-network provider was 34% in 2014; 28% in 2015; and 25% in 2016. Outside Alaska, the percentage of claims submitted for seeing a non-network provider is lower (between 12% and 17% in each year between 2014 and 2016). It is impossible to determine how many of these claims come from members without easy access to a network provider, as compared to members who had access to a network provider but who chose to see a non-network dentist.

40. Members of insurance plans – particularly older members – value having a fully restricted choice to choose their dental provider without incurring a financial penalty. This freedom has been curtailed.

Findings About Diminishment

41. Based on all of the testimony and exhibits, the court finds that coverage for the following services has been diminished by the adoption of the 2014 plan:

Oral examinations
Diagnostic x-rays
Routine full-mouth x-rays
Routine bite-wing x-rays
Diagnostic casts and study models
Topical fluoride
Prophylaxis
Space maintainers
Bridge and denture repair and relining
Palliative emergency care
Extractions and oral surgery
Pulp capping
Periodontal scaling and root planing
Periodontal splinting
Gold foil restoration
Full-mouth debridement
General anesthesia
Crowns and onlays
Inlays
Bridges
Dentures
Partial dentures
Denture replacement
Tissue conditioning

42. Based on all of the testimony and exhibits, the court finds that coverage for the following services has been enhanced by the adoption of the 2014 plan:

Sealants
Periodontal maintenance
Athletic mouthguards

43. The court has not placed implants on either the diminishments list or the enhancements list, because, while it is clear that coverage has not been diminished, the

preponderance of the evidence does not demonstrate that coverage for implants has been enhanced.

44. The court finds that overall the enhancements are not equivalent to the diminishments. The court would make the same finding even if it concluded that coverage for implants has been enhanced.

45. The court has not simply counted the number of entries on each list. Rather, the court has considered the magnitude of each change, the number of members affected by the changes, the fact that two of the enhancements are in themselves a mix of an enhancement (improvement of the class of coverage) and a diminishment (frequency limitations were imposed), and the fact that the only unequivocal enhancement (coverage for athletic mouthguards) is of limited utility to a largely retired population.

46. The court's own analysis is supported by the expert testimony of Todd Allen. Mr. Allen was accepted as an expert in benefit plan evaluation, based on his training and work experience. The court found his testimony helpful and accepts as credible his evaluation that overall the enhancements in the 2014 plan are not equivalent to the diminishments.

47. The court also finds impairment of benefits based on the loss of the freedom to choose one's dental provider without financial penalty. Evidence established that members value freedom of choice; burdening this choice with a financial penalty impairs the benefits previously granted.

48. The court finds that it is not true as a matter of fact that the changes that impose frequency limitations and other such limitations do no more than eliminate payments for services that should not have been treated as covered under the 2013 plan, even assuming that the 2013 plan only covered dentally necessary services. The court accepts in full the testimony of the dentists who testified as experts that many of the 2014 changes deny coverage for dentally necessary care, where such coverage was available under the 2013 plan.

49. The court does not find that the retiree dental plan was or is intended to be administered in such a way as to eliminate coverage for all treatments that are not dentally necessary, regardless of the language in the plan booklets. The court accepts the testimony of the State's witnesses that efficient and responsible administration of a plan does not require the TPA to scrutinize every claim for dental necessity, particularly if the claim is within a recognized reasonable frequency limit. Thus, the court finds it is not true that coverage under the 2013 plan was limited to dentally necessary treatment.

50. The State presented testimony by Richard Ward, who calculated what he defined as the "actuarial value" of the 2013 plan as compared to the "actuarial value" of the 2014 plan as it was administered in each year between 2014 and 2017. The court does not find that Mr. Ward's testimony (summarized in his Exhibit 2046) supports a conclusion that the enhancements in the 2014 plan are equivalent to the diminishments.

51. The court finds that RPEA articulated a number of sound reasons for not accepting Mr. Ward's testimony and Exhibit 2046, and the court adopts RPEA's reasoning on this point.

51. In rejecting Mr. Ward's testimony and Exhibit 2046, the court relies particularly on the following findings:

a. Mr. Ward did not compare the value of the 2013 plan to the value of the 2014 plan, nor did he assess the comparative value of the benefits available to an average member during his or her lifetime under the two plans. At most, Mr. Ward compared certain aspects of the claim-handling experience in each of a number of discrete years. He did not show that any one year was representative of how a typical employee (or the full membership) would benefit under any plan over a lifetime.

b. Mr. Ward excluded all non-network claims from his analysis of the value of the 2014 plan in each year the plan was in effect. This is an incomplete analysis, and its effect is to overstate the value of the plan, using Mr. Ward's definition of actuarial value, because, on average, the plan pays for a greater percentage of the allowed charge in network claims as compared to non-network claims. The Moda data highlighted in Exhibit 1030 (showing per member per month allowed costs and per member per month costs paid by the plan) corroborate this commonsense conclusion about the effect of eliminating non-network claims from the comparison.

c. Mr. Ward calculated an "actuarial value" of the 2013 plan in two ways. The court finds neither offers a reliable value.

d. Mr. Ward calculated a value for 2013 using HealthSmart data, but he first described the data as incomplete and untrustworthy. The court cannot accept as valid and reliable a valuation based on the data set he described.

e. Mr. Ward also calculated a value for 2013 by projecting backward from the 2014 data and making adjustments based on changes in the plan. For his calculation to have any meaning, it was essential for him to have an accurate understanding of the changes – and Mr. Ward's understanding was not accurate. He found no changes as to particular services when there were in fact diminishments; he found enhancements in coverage of particular services when there were in fact no changes. The errors are largely due to his reliance on only the 2013 plan booklet to describe coverage under the 2013 plan; the court by contrast has found that Exhibit 1001 and the testimony of Ms. Farmer also must be accepted in determining coverage of services under the 2013 plan.

53. Mr. Ward's errors in listing the actual diminishments and enhancements also make unreliable the analysis he provided in Exhibit 2050. The court does not find this document helpful in determining whether new enhancements are equivalent to new diminishments.

54. The largest enhancement that Mr. Ward identified in Exhibit 2050 is in the coverage for implants. As discussed earlier, the court is not persuaded that coverage in fact has changed. Even if it has, the court cannot accept that an enhancement in coverage for implants is sufficient to offset all the remaining diminishments. *Duncan* requires that, to be an offsetting advantage, an improvement must relate to the diminishment it

supposedly offsets. Enhancing coverage for implants while diminishing coverage for preventative and restorative treatments does not satisfy this test.

55. Besides the substantive problems with Mr. Ward's analyses, his demeanor on the stand made him incredible. He plainly did not testify as a disinterested expert.

56. In sum, the court accepts RPEA's evidence that shows diminishments in coverage, and the qualitative analysis that RPEA offered that shows the diminishments in coverage are not offset by new enhancements in coverage. The court rejects the testimony the State offered through Mr. Ward as a way to show quantitatively that the enhancements are equivalent to the diminishments.

57. The court therefore finds, by a preponderance of the evidence, that the 2014 plan diminishes and impairs the benefits available to retirees under the 2014 plan.

Conclusions of Law

58. The court held in its pretrial order granting partial summary judgment to RPEA that the guarantee of the Alaska Constitution Article XII, Section 7 applies to the retiree dental plan. The court adheres to that conclusion and incorporates its reasoning into these findings and conclusions.

59. The State has reiterated arguments that the constitutional guarantee does not apply because retirees pay a premium for their participation in the DVA plan, whereas the State pays the premiums (for most retirees) for the retiree medical insurance that was at issue in *Retired Public Employees of Alaska, Inc. v. Duncan*, 71 P.3d 882 (Alaska 2003). In *Duncan*, the Supreme Court held that the Alaska Constitution protects retirees' benefits,

not the premium paid for the benefits, and this court believes that holding applies regardless of who pays the premium.

60. The State has argued that a quantitative analysis is required under *Duncan* to prove that new diminishments are not offset by new enhancements. This court does not read *Duncan* that way. *Duncan* stated that reliable quantitative analysis, based on actual experience and reliable actuarial sources, could be used to prove equivalency, but *Duncan* did not state this is the only approved method of showing equivalency or the lack of equivalency.

61. Quantitative analysis might be a necessary part of the analysis when the changes in the plan affect coverage in many ways that only can be measured monetarily – for example, changing reimbursement rates per class, changing the deductible, and changing the annual or lifetime maximum. There were few such changes in the amendments to the retiree dental plan at issue in this case: the coverage class for three services was changed (two moved from 80% coverage to 100%, and one moved from 80% coverage to 50%). All other changes deleted – or in a few instances – added coverage for a service or imposed frequency limitations or other limitations; these are easily assessed as diminishments or enhancements without the need for quantitative analysis.

62. If a quantitative analysis were used to compare two plans, the court believes that, under *Duncan*, a valid comparison would have to consider the effect on the entire group of members over the members' lifetimes. It is not meaningful to compare the value

of claims covered in two isolated years, without a showing that those years are representative.

63. For purposes of a qualitative analysis, the changes at issue in this case can be understood by a layperson, and the court concludes that *Duncan* authorizes the court to analyze the overall effect of the changes qualitatively. If the balance were close, the court would want to defer to an expert – but the comparison here is not close.

64. When considering the effects of the changes to the retiree dental plan, the court, as explained earlier, relied on the testimony that establishes the coverage that actually was provided to members under the 2013 plan (as listed in Exhibit 1001 and as described by Ms. Farmer and as established by Mr. Wards's data). Based on the testimony, the court did not find that the benefits under the 2013 plan were limited to the coverage explicitly listed in the 2013 plan booklet.

65. In accepting this broader view of coverage under the 2013 plan, the court is persuaded by the fact that the State selects the TPA, supervises the TPA, requires regular reports from the TPA, has the right to audit the TPA, and has the right to require the TPA to repay the plan if the State determines that the TPA improperly paid a claim that was not covered. When a practice of covering certain claims was established while Wells Fargo and HealthSmart served as the TPA, the court finds that the State must have known or at least should have known about the practice. Therefore, the State is responsible for allowing all coverage that was routinely allowed. That makes these services "covered" by the 2013 plan, even if the service was not listed in the 2013 plan booklet.

66. This is especially true based on the language of the 2013 plan, which was inclusive and not exclusive. The plan booklet states that services covered within each class "include[e]" the listed services, not that coverage is limited to the listed services.

67. Thus, the court rejects the State's argument that the court must compare the services listed as covered in the 2013 booklet with the services listed as covered in the 2014 plan booklet and base its decision on whether the enhancements are equivalent to the diminishments soley on that comparison.

68. In considering whether a particular treatment was covered under the 2013 plan or is covered under the 2014 plan, the court resolves any ambiguities in favor of RPEA. The State writes the plan booklets and has the responsibility to be clear.

69. The State has suggested that *Duncan* does not require the court to compare the 2014 plan to the 2013 plan to evaluate whether benefits were diminished. Instead, the State suggests that *Duncan* requires only that the new plan be a reasonable plan in the mainstream of retiree dental plans offered to public employees around the country. The court disagrees. The Alaska Constitution protects retirees against diminishment of the benefits they had. Alaska retirees are not necessarily protected against diminishment of their benefits even if the new Alaska plan is in the mainstream of plans offered in places outside Alaska. The court therefore finds that Cathye Smithwick's testimony and conclusions are largely irrelevant to the issue before this court.

70. The State also has suggested that the guarantee against diminishment is satisfied so long as the current retiree dental plan is like the dental plan the State offers to

current active employees. The court disagrees. The Alaska Constitution protects retirees against diminishment of the benefits they had. Retirees are not necessarily protected against diminishment of benefits if the new retiree plan is comparable to the benefits offered to current employees. The Constitution does not forbid diminishing the benefits offered to active employees. The court therefore finds that testimony and conclusions about the dental plans available to current employees are irrelevant to the issue before this court.

71. Based on all of the above, this court concludes that, because the 2014 retiree dental plan diminishes the benefits that were available to retirees under the 2013 retiree dental plan, the State violated the Alaska Constitution in implementing the 2014 changes to the plan.

Order

Based upon the above findings and conclusions, it is ordered as follows:

A. The court declares that the 2014 changes to the retiree dental plan are unconstitutional.

B. The court enjoins the State from continuing to offer the 2014 retiree dental plan as the only dental plan available to retirees.

C. The State may (1) return to the 2013 retiree dental plan; (2) provide individual retirees the option of returning to the 2013 plan or continuing with the 2014 plan; or (3) negotiate a new alternative plan that RPEA accepts as comparable and not diminishing retirees' benefits.

D. On motion of either party, the court will set a schedule for additional briefing on remedy.

E. RPEA is the prevailing party, and, as a constitutional litigant, RPEA is awarded its full reasonable costs and attorney fees in accordance with AS 09.60.010(c).

Dated at Anchorage, Alaska, this 16th day of April 2019.

Eric ~~A.~~ Aarseth
Judge of the Superior Court

I certify that on 4/17/19 a copy of the following was mailed/faxed/hand delivered to each of the following at their addresses of record.
Orlansky/Allenby/Paton-Walsh
Administrative Assistant

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

THE RETIRED PUBLIC EMPLOYEES OF ALASKA, INC., Plaintiff, v. KELLY TSHIBAKA, in her official capacity as Commissioner of the Department of Administration,* Defendant.	Case No. 3AN-16-04537 CI

~~[PROPOSED]~~ FINAL JUDGMENT #15

Pursuant to the Court's orders dated December 8, 2016 and April 17, 2019, final judgment is hereby entered in favor of Plaintiff Retired Public Employees of Alaska and against Defendant Kelly Tshibaka, the Commissioner of the Department of Administration.

Plaintiff is the prevailing party in this action, and may move for an award of attorney's fees and costs. ~~This final judgment may be amended following the Court's ultimate resolution of any such motion.~~ The Court will continue to exercise jurisdiction of this case to ensure the state complies with the Court's order.

Dated at Anchorage, Alaska this 8th day of ~~April~~ August, 2019.

Eric A. Aarseth
Superior Court Judge

I certify that on 8/15/19 a copy of the following was mailed/emailed to each of the following at their addresses of record.

Administrative Assistant

* Kelly Tshibaka is substituted for her predecessor, Leslie Ridle, as Commissioner of the Department of Administration. Alaska Rule of Civil Procedure 25(d)(1).

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

AlaskaCare Retiree DVA Plan:
2020 Dental Benefit Enrollment Guide

Effective January 1, 2020, eligible AlaskaCare retirees will have a choice between the current dental plan (standard plan) and the dental plan in place prior to 2014 (legacy plan) as part of their Dental, Vision, and Audio (DVA) coverage. You can choose the plan that works best for you and your family for the upcoming benefit year.

DVA Open Enrollment Period: October 16 through November 27, 2019

Find the online enrollment form at www.AlaskaCare.gov/DVA

For more information about the DVA plan, to view the FAQs, or to sign up for the AlaskaCare Retiree e-newsletter visit: www.AlaskaCare.gov/DVA

The Division of Retirement and Benefits will host a retiree DVA plan open enrollment period from October 16 through November 27, 2019.

Open enrollment was originally set to begin November 6. We know this process is new, so we expanded the enrollment window to begin October 16. The enrollment period for the 2020 benefit year will begin early to give you more time to consider your options and make your choice! We want you to make an informed decision and choose the option that best meets your needs.

This enrollment guide contains information about your choices, and instructions for participating in open enrollment. It is designed to answer questions about your options and how to enroll.

Open enrollment is a four step process:

1. **Learn**: Learn about the open enrollment process
2. **Verify**: Verify your eligibility to participate in open enrollment
3. **Compare**: Compare your options for dental benefits in the DVA plans
4. **Enroll**: Enroll in the plan of your choice

Need more information?

There are additional Frequently Asked Questions (FAQ) on our website. You can find answers to questions retirees have asked. Check our FAQ page often, new questions are added regularly! **www.AlaskaCare.gov/retiree/faqs**

Send us an email at doa.drb.benefits@alaska.gov or call us toll-free at (800) 821-2251 or in Juneau at (907) 465-4460.

This document is to supplement, but not replace, the information in the AlaskaCare plan documents. Should there be a conflict between this document and the relevant plan document, the plan document prevails.

Frequently Asked Questions

What are some of the differences between the standard plan benefits and the legacy plan benefits?

Standard Plan

- Features an additional dental network with deeper discounts that save you more money when you use a network dentist. This allows you to receive coverage for more services before you reach your annual benefit maximum.
- Supports evidence-based coverage limitations, including those developed by the American Dental Association, such as frequency and age limitations for exams, cleanings, and periodontal maintenance.
- Pays less if you visit an out-of-network dentist.
- Has lower premiums.

Legacy Plan

- Does not have pre-determined frequency or age limitations on most services.
- Features a wide dental network that saves you money when you use a network dentist.
- Pays out-of-network dentists at a higher rate.
- Has higher premiums.

Some dental procedures fall into different service classes, depending on which plan you elect. If you would like to know how a specific service would be covered under each plan, call Delta Dental of Alaska at (855) 718-1768.

Please consult the AlaskaCare Retiree DVA Plan: 2020 Dental Benefit Comparison for more details about the differences between the plans. The AlaskaCare Retiree Insurance Information Booklets will contain the complete benefit provisions for both the standard and legacy dental plans.

This document is to supplement, but not replace, the information in the AlaskaCare plan documents. Should there be a conflict between this document and the relevant plan document, the plan document prevails.

What are some of the similarities between the standard plan benefits and the legacy plan benefits?

- Both plans have the same annual benefit maximum: $2,000.
- Both plans provide coverage for dental preventive, restorative, and prosthetic services.
- Both plans have the same coinsurance levels:
  - Class I (Preventive): 100%
  - Class II (Restorative): 80%
  - Class III (Prosthetic): 50%
- Both plans have the same annual deductible: $50 per individual (Class II and III Services).
- Both plans are fully funded by member premiums.
- Vision and audio benefits are the same.

Can I see any dentist?

Yes, both the standard plan and the legacy plan let you see any licensed dentist you want. Both plans give you access to a wide network of dental providers that will save you money. If you choose the legacy plan and see an out-of-network provider, the plan will cover a greater portion of the charges so you may pay less for out-of-network services. If you choose the standard plan, you have access to an additional network of providers that offer deeper discounts, saving you more money, but you may pay more if you use out-of-network dentists.

Remember, if you use an out-of-network dentist, you may receive additional bills for charges that the plan will not cover.

Why are monthly premiums different for the two plans?

The dental plan monthly premiums are set to reflect the overall value of each plan across all enrolled members. The value of each plan varies based on differences in benefit design, network access, and how much the plan pays out-of-network providers. The rates are not impacted by how many people elect one plan or the other.

Is the DVA Open Enrollment mandatory?

Open enrollment is not mandatory, but it is the time period during which you can make changes to your dental benefits. **We encourage all eligible AlaskaCare retirees to review the plan options and participate in open enrollment.** If you currently have AlaskaCare DVA coverage and do not make a plan selection during open enrollment, you will remain enrolled in your current dental plan (standard plan).

If I have dental services scheduled before the end of 2019 will this impact my benefits?

The benefit election you make during open enrollment will become effective January 1, 2020. This means that the coverage you have today will still apply through December 31, 2019, including any claims for services provided before the end of 2019. If you are not currently enrolled in the DVA plan but are eligible to do so during open enrollment, your coverage under the plan does not take effect until the new benefit year beginning January 1, 2020.

Can I change my plan next year?

You will be able to change your dental plan during the open enrollment period for as long as the State offers two dental plans. Outside of the open enrollment period, you will not be able to make changes to your selections unless you have a qualifying life event or would like to decrease your coverage. You may decrease your coverage at any time by contacting the Division.

Remember, if you are a current DVA plan member and do not take action during open enrollment, you will remain enrolled in your current dental plan (standard plan). **We encourage all eligible AlaskaCare retirees to review the plan options and participate in open enrollment.**

Will I get a new ID card?

Yes, you should expect to receive a new dental benefit ID card in early January 2020. **You can continue to use your current card until your new card arrives, even if you changed dental plans.**

I am currently enrolled in the DVA plan with coverage for myself and my dependent spouse. Can I choose the legacy plan, and can my spouse choose the standard plan?

No, a retiree may only select one plan for themselves and any covered dependents. However, if you and your spouse each have a separate AlaskaCare DVA policy, you may select different plans and cover each other as dependents.

I don't currently have DVA coverage but am eligible to enroll during the upcoming open enrollment period. Will I have another opportunity to enroll?

If you retired on or after January 1, 2014 and did not elect DVA coverage at the time of retirement, or you disenrolled from DVA coverage on or after January 1, 2014, the fall 2019 open enrollment is a one-time opportunity for you to enroll in DVA coverage. If you elect coverage during this year's open enrollment, you can change your coverage options at every open enrollment going forward.

Key Terms

- ☐ **Deductible** is the amount you pay each benefit year before a portion of your costs are paid by the dental plan. The deductible for both the standard and legacy retiree dental plans is $50 for class II and III services.
- ☐ **Coinsurance** is the percent of covered expenses paid by AlaskaCare once you meet your deductible. Coinsurance levels vary depending on the class of service.
- ☐ **Annual Benefit Maximum** is the total amount that the plan will pay for dental services you receive during that benefit year. The annual maximum for both the standard and legacy retiree dental plans is $2,000.

This document is to supplement, but not replace, the information in the AlaskaCare plan documents. Should there be a conflict between this document and the relevant plan document, the plan document prevails.

Ready to Enroll?

Find the Online Enrollment Form at www.AlaskaCare.gov/DVA

You can make elections 24 hours a day, 7 days a week from **October 16, 2019 through November 27, 2019** at 5 p.m. Alaska Time.

Online Enrollment Instructions

- **Open your web browser** and **navigate** to www.AlaskaCare.gov/DVA
- Click on the enrollment link: "**Ready to Enroll? Click Here!**" You will be taken to the Retiree DVA Plan Open Enrollment online form.
- The online enrollment form is completed in four easy steps. Click on Get Started to begin!

Step 1. Learn

Open enrollment begins with important reminders about your plan options, eligibility information, and where to find answers if you have questions. After reviewing the information, click the Next button to move on.

Step 2. Verify

You will be prompted to enter information to verify that you are eligible to enroll. Enter the information and click on Check Eligibility

- If your eligibility was confirmed, you will see the message Eligibility Verified! Confirm or update your contact information and click the Next button.
- If your eligibility was not confirmed, you will see the message Unable to Verify
- *If the system is unable to verify your identity, please contact the Division at (800) 821-2251 or (907) 465-4460 in Juneau as soon as possible so we can help.*

Step 3. Compare

Review the monthly premium rates, the benefit comparison table, and your plan booklet to decide which plan is best for you. After reviewing the information, click the Next button to move on.

Step 4. Enroll

Make your plan election, choose your coverage level, and click Enroll

- Please print the confirmation page for your records.

- If you need to update your dependent information, complete the Retiree Health Dependent Change Form provided on this page and submit it to the Division of Retirement and Benefits.
- If you click on the Exit to AlaskaCare webpage button, you will close the enrollment site. Congratulations! You have successfully completed your AlaskaCare DVA open enrollment!
- You may change your plan election at any time during the open enrollment period by filling out the online enrollment form. The last election you make before open enrollment closes on November 27 at 5:00 p.m. Alaska Time will determine your plan election for the 2020 benefit year.

If you need assistance to complete your enrollment, or if you need a paper enrollment form contact:

Member Services Contact Center:
Juneau: (907) 465-4460 | Outside Juneau: (800) 821-2251
Email: doa.drb.benefits@alaska.gov
Monday - Thursday: 8:30 a.m. to 4 p.m. (Alaska Time)
Friday: 8:30 a.m. to 3 p.m. (Alaska Time)

If you have questions about how a specific service would be covered under each plan, contact Delta Dental of Alaska at (855) 718-1768.

AlaskaCare Retiree DVA Plan:
2020 Dental Benefit Comparison

AlaskaCare retiree Dental-Vision-Audio (DVA) plan members have a choice between the Standard Dental Plan and the Legacy Dental Plan for the 2020 benefit year. You can choose the plan that works best for you and your family.

This comparison provides an overview of the two plans and highlights some, but not all, of the benefit provisions. For complete coverage details, please consult the plan booklets available at www.AlaskaCare.gov.

2020 Retiree DVA Plan Monthly Premiums

Coverage	Standard	Legacy
Retiree Only	$66	$73
Retiree and Spouse	$131	$145
Retiree and Child(ren)	$119	$132
Retiree and Family	$187	$207

Plan Structure, Annual Deductible, Coinsurance, and Maximum Benefit

	Standard (Current)	**Legacy** (Prior to 2014)
Covered household member options	✓ Retiree only Retiree and spouse Retiree and child(ren) Retiree and family	✓ Retiree only Retiree and spouse Retiree and child(ren) Retiree and family
Plan funding	✓ 100% funded by member-paid premiums.	✓ 100% funded by member-paid premiums.
Annual deductible	✓ $50 per individual. Applies to class II (restorative) and class III (prosthetic) services.	✓ $50 per individual. Applies to class II (restorative) and class III (prosthetic) services.
Coinsurance	✓ Class I (preventive): 100% Class II (restorative): 80% Class III (prosthetic): 50%	✓ Class I (preventive): 100% Class II (restorative): 80% Class III (prosthetic): 50%
Annual individual benefit maximum	✓ Plan will pay up to $2,000 for dental services each benefit year.	✓ Plan will pay up to $2,000 for dental services each benefit year.

Network Provisions

	Standard (Current)	**Legacy** (Prior to 2014)
Access to a broad network of dental providers	✓ Yes	✓ Yes
Access to an additional exclusive network of preferred dental providers who accept reduced fees for the same services.	✓ Yes	⊘ No
Recognized charge: In-Network	✓ Lesser of 100% of negotiated fees, billed charges, or covered expense.	✓ Lesser of 100% of negotiated fees, billed charges, or covered expense.
Recognized charge: Out-of-Network	✓ 75% of the 80th percentile; members may be billed for additional charges.	✓ 100% of the 90th percentile; members may be billed for additional charges.

Dental Necessity Requirement

	Standard (Current)	**Legacy** (Prior to 2014)
To be eligible for coverage, dental services and supplies must meet these dental necessity requirements and be a covered service or supply under the plan.	✓ The Retiree Standard Dental Plan covers dental services and supplies when performed by a dentist or dental care provider and when determined to be dentally necessary.	✓ The Retiree Legacy Dental Plan does not provide benefits for dental services or supplies that are not necessary for diagnosis or treatment of dental condition as determined by the claims administrator even if prescribed, recommended, or approved by a dental professional.

This document is to supplement, but not replace, the information in the AlaskaCare plan documents. Should there be a conflict between this document and the relevant plan document, the plan document prevails.

Covered Dental Services: Class I - Preventive

	Standard (Current)	**Legacy** (Prior to 2014)
Diagnostic		
Oral exam	✓ Covered 2 times per benefit year.	✓ Covered
Complete series x-rays/panoramic	✓ Covered once every five years.	✓ Covered if required for diagnosis; not more than one full mouth or series per year.
Bitewing x-rays	✓ Covered once per benefit year.	✓ Covered
Diagnostic casts & study models	⊘ Not covered	✓ Covered
Preventive		
Cleanings (prophylaxis)	✓ Covered 2 times per benefit year; additional cleanings available for persons with diabetes, periodontal disease, or in last trimester of pregnancy. Other exceptions allowed.	✓ Covered
Periodontal maintenance	✓ Covered as a class I service at 100% and no deductible. 2 times per benefit year; additional cleanings available for persons with diabetes, periodontal disease, or in last trimester of pregnancy. Other exceptions allowed.	✓ Covered as a class II service at 80% and $50 deductible.
Topical fluoride: 18 years or younger	✓ Covered 2 times per benefit year.	✓ Covered
Topical fluoride: 19 years or older	✓ Covered 2 times per benefit year if recent periodontal surgery or high risk of decay due to chemotherapy or medical disease.	✓ Covered
Sealants: 18 years or younger	✓ Covered once every five years with tooth limitations.	✓ Covered
Sealants: 19 years or older	✓ Covered once every five years with tooth limitations.	⊘ Not Covered
Space maintainers	✓ Covered for 14 years and younger, once per tooth space with tooth limitations.	✓ Covered as a class II service at 80% and $50 deductible.

Covered Dental Services: Class II - Restorative

	Standard (Current)	**Legacy** (Prior to 2014)
Restorative		
Fillings	✓ Covered	✓ Covered
Inlays	✓ Covered, considered an optional service. Alternate benefit of composite filling. Covered as a class II service at 80% and $50 deductible.	✓ Covered as a class III service at 50% and $50 deductible.
Crown buildups	✓ Covered as a class II service at 80% and $50 deductible if necessary for tooth retention.	✓ Covered as a class III service at 50% and $50 deductible.
Oral Surgery		
Extractions (including surgical)	✓ Covered	✓ Covered
Alveoplasty (procedure to smoothen or re-shape jaw bone)	✓ Covered when performed as part of other covered service. Not covered as a separate charge.	✓ Covered
Brush Biopsy	✓ Covered 2 times per benefit year.	✓ Covered
Endodontic		
Root canal & treatment	✓ Covered; retreatment not covered for same tooth by same dentist within 24 months. Initial service should include retreatment within this timeframe if necessary.	✓ Covered
Pulpal therapy (pulp capping)	✓ Covered when pulp is exposed.	✓ Covered

Covered Dental Services: Class II - Restorative Continued

	Standard (Current)	**Legacy** (Prior to 2014)
Periodontic		
Gum disease and supporting tissue treatment	✓ Covered	✓ Covered
Periodontal maintenance	✓ Covered as a class I service, 100% and no deductible. Two per benefit year; additional cleanings available for persons with diabetes, periodontal disease, or in last trimester of pregnancy. Other exceptions allowed.	✓ Covered as a class II service at 80% and $50 deductible.
Periodontal scaling & root planing	✓ Once per quadrant in any 2 year period.	✓ Covered
Periodontal splinting	⊘ Not covered	✓ Covered
Full mouth debridement	✓ Covered once in a 3-year period if no cleaning (prophylaxis) occurred within preceding 24 months.	✓ Covered
Anesthesia		
Nitrous Oxide	✓ Covered	✓ Covered
General anesthesia/ IV sedation	✓ Covered for surgical procedures only or if needed due to a medical condition.	✓ Covered
Other		
Palliative care	✓ Covered	✓ Covered
Apicoectomy (surgical removal of root tip)	✓ Covered	✓ Covered
Denture repair	✓ Covered as a class III service, 50% coverage and $50 deductible.	✓ Covered
Denture reline	✓ Covered as a class III service, 50% coverage and $50 deductible.	✓ Covered
Denture adjustments	✓ Covered as a class III service, 50% coverage and $50 deductible.	✓ Covered
Tissue conditioning	✓ Covered as a class III service, 50% coverage and $50 deductible.	✓ Covered

Covered Dental Services: Class III - Prosthetic

	Standard (Current)	**Legacy** (Prior to 2014)
Restorative		
Crowns (cast restoration)	✓ Covered once in 7 year period on any tooth.	✓ Covered
Onlays (cast restoration)	✓ Covered once in 7 year period on any tooth.	✓ Covered
Lab veneers (cast restoration)	✓ Covered once in 7 year period on any tooth.	✓ Covered
Inlays	✓ Covered, considered an optional service. Alternate benefit of composite filling. Covered as a class II service at 80% and $50 deductible.	✓ Covered as a class III service at 50% and $50 deductible.
Crown buildups	✓ Covered as a class II service at 80% and $50 deductible if necessary for tooth retention.	✓ Covered as a class III service at 50% and $50 deductible.
Porcelain restorations	✓ Covered for visible teeth. Coverage limited to cost of metallic prosthetic if placed on upper second or third molars or lower first, second, or third molars.	✓ Not covered if tooth can be restored with amalgam (metallic) filling. Coverage limited to appropriate charges for amalgam or similar material.
Prosthodontic		
Bridges	✓ Covered once in 7 year period if tooth, tooth site, or teeth have not received a cast restoration benefit in last 7 years.	✓ Covered

Covered Dental Services: Class III - Prosthetic Continued

	Standard (Current)	**Legacy** (Prior to 2014)
Prosthodontic		
Dentures full & partial	✓ Covered once in 7 year period if tooth, tooth site, or teeth have not received a cast restoration benefit in last 7 years.	✓ Covered once every 5 years if previous dentures cannot be made serviceable or if previous denture was temporary and installed within previous 12 months.
Dentures temporary	✓ Partial denture covered if placed within 2 months of anterior tooth extraction. Additional limitations may apply.	✓ Covered
Denture adjustment	✓ Covered twice in 12-month period, unless received within first 6 months of initial placement (this is included in the initial placement charge).	✓ Covered as a class II service, 80% coverage and $50 deductible.
Denture repairs	✓ Covered unless received within first 6 months of initial placement (this is included in the initial placement charge).	✓ Covered as a class II service, 80% coverage and $50 deductible.
Denture reline	✓ Covered once in 12-month period, unless received within first 6 months of initial placement (this is included in the initial placement charge).	✓ Covered as a class II service, 80% coverage and $50 deductible.
Tissue conditioning	✓ Covered twice per denture in a 36-month period.	✓ Covered as a class II service, 80% coverage and $50 deductible.
Implants	✓ Covered. Limited to once per lifetime per tooth space. Some implant charges may be eligible for coverage under medical plan. Associated cast restoration over implant and other implant related procedures are covered as a Class III prosthetic service.	⊘ No coverage for implants under dental plan. Some implant charges may be eligible for coverage under medical plan. Associated cast restoration over implant and other implant related procedures are covered as a Class III prosthetic service.
Other		
Athletic mouthguards	✓ Covered once per year if 15 or younger; covered once every 2 years if 16 or older.	⊘ Not covered

Other Services and Benefits

	Standard (Current)	**Legacy** (Prior to 2014)
Orthodontics	⊘ Orthodontics services are not covered in the AlaskaCare Dental Plan.	⊘ Orthodontics services are not covered in the AlaskaCare Dental Plan.
Vision Benefits	✓ No changes to plan benefits.	✓ No changes to plan benefits.
Audio Benefits	✓ No changes to plan benefits.	✓ No changes to plan benefits.

This document is to supplement, but not replace, the information in the AlaskaCare plan documents. Should there be a conflict between this document and the relevant plan document, the plan document prevails.

For questions about how specific services may be covered under each plan, please contact Delta Dental.

For more information about the DVA Plan, contact:

Dental: Moda/Delta Dental of Alaska
Toll Free (855) 718-1768

Vision and Audio: Aetna Concierge
Toll Free (855) 784-8646

www.AlaskaCare.gov/DVA

Contact the Member Services Contact Center:

Juneau: (907) 465-4460
Outside Juneau: (800) 821-2251
Email: doa.drb.benefits@alaska.gov
PO Box 110203 Juneau, AK 99811-0203

Monday - Thursday: 8:30 a.m. to 4 p.m. (Alaska Time)
Friday: 8:30 a.m. to 3 p.m. (Alaska Time)

REEVES AMODIO LLC
500 L STREET, SUITE 300
ANCHORAGE, ALASKA 99501-1990
PHONE (907) 222-7100, FAX (907) 222-7199

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

THE RETIRED PUBLIC EMPLOYEES OF ALASKA, INC., Plaintiff, v. LESLIE RIDLE, COMMISSIONER OF THE ALASKA DEPARTMENT OF ADMINISTRATION, Defendant.	Case No. 3AN-16-04537 CI

[Proposed]
ORDER AWARDING ATTORNEYS' FEES AND COSTS

The court has considered RPEA's motion for an award of full attorneys' fees and costs, as provided under AS 09.60.010, along with the supporting memorandum and exhibits, and any opposition and reply. The court finds that the attorneys' fees and costs for which RPEA requests reimbursement by the State were reasonably and necessarily incurred in connection with RPEA's constitutional claim. Therefore, the court awards RPEA the following to be paid by the State:

Attorneys' fees	$226,015.00
Rule 79 costs	11,595.21
Other reasonable costs	51,758.75
TOTAL	$289,368.96

Eric A. Aarseth
Superior Court Judge

I certify that on 10-8-19 a copy of the following was mailed/emailed to each of the following at their addresses of record.

Administrative Assistant

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

2019 SEP 17 PM 2:36
CLERK TRIAL COURTS
BY:
DEPUTY CLERK

THE RETIRED PUBLIC EMPLOYEES OF ALASKA, INC., Plaintiff, v. KELLY TSHIBAKA, COMMISSIONER OF THE ALASKA DEPARTMENT OF ADMINISTRATION, Defendant.	Case No. 3AN-16-04537 CI

~~[Proposed]~~

ORDER GRANTING RPEA'S MOTION TO ENFORCE COURT ORDER AND FOR RELATED RELIEF

The court has considered RPEA's motion, the State's response, and RPEA's reply. It concludes that the relief requested is reasonably necessary to enforce this court's order of April 16, 2019. Accordingly, the motion is granted, and the court orders as follows:

(1) The State is prohibited from continuing to offer only the unconstitutional 2014 plan throughout 2019; the State must offer members some short-term relief from the unconstitutional diminishment of benefits. ~~In particular, the State shall immediately~~ (a) cease enforcing the new frequency and age limitations that it added into the 2014 plan and (b) cease imposing out-of-network penalties on members who receive covered ~~services from a non-network~~ provider.

(2) The State is prohibited from establishing the unconstitutional 2014 plan as the default plan under the two-plan system it is designing for 2020. Any member who

002201

REEVES AMODIO LLC
500 L STREET, SUITE 300
ANCHORAGE, ALASKA 99501-1990
PHONE (907) 222-7100, FAX (907) 222-7199

SEP 17 2019

REEVES AMODIO LLC
500 L STREET, SUITE 300
ANCHORAGE, ALASKA 99501-1990
PHONE (907) 222-7100, FAX (907) 222-7199

does not affirmatively select participation in the 2014 plan shall be treated as having chosen to participate in the 2013 plan.

(3) The State is directed to begin promptly to conduct a complete retrospective review of claims denied under the 2014 plan that would have been granted had the 2013 plan remained in effect. The State shall notify the court and RPEA when the review begins, how long it should take, and when it is concluded. The State also shall provide RPEA with a complete copy of correspondence between the State and Moda or Segal (or whoever is engaged to conduct the review), so that RPEA is informed about the scope and nature of the review, and the data that are used. When the review is complete, the State shall provide a copy of the report that identifies the claims that were denied.[1]

(4) The State shall provide RPEA with its complete premium rate analysis and all data used in the analysis to determine the new rates. This information shall be provided as soon as it is available, and at least 30 days before the open enrollment period.

(5) The State shall disclose to RPEA and the court all costs it incurs to develop and implement the two-plan system, and shall specify which funds, if any, are taken from members' premiums. The initial disclosure shall be made within 10 days of this order, with follow-ups at regular intervals of not less than 30 days, as additional funds are expended.

---

[1] Such a report will be subject to the protective order in place in this case, which allows RPEA to receive HIPAA-protected information and requires RPEA to protect its confidentiality.

Entered at Anchorage, Alaska, this 19th day of November 2019.

Eric A. Aarseth
Superior Court Judge

I certify that on 11-20-19 a copy of the following was mailed/emailed to each of the following at their addresses of record.

Orlansky/Calloway
Administrative Assistant Paton Walsh

REEVES AMODIO LLC
500 L STREET, SUITE 300
ANCHORAGE, ALASKA 99501-1990
PHONE (907) 222-7100, FAX (907) 222-7199

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

THE RETIRED PUBLIC EMPLOYEES OF ALASKA, INC., Plaintiff, v. KELLY TSHIBAKA, COMMISSIONER OF THE ALASKA DEPARTMENT OF ADMINISTRATION, Defendant.	Case No. 3AN-16-04537 CI

11-20-19

[Proposed] REVISED

ORDER GRANTING RPEA'S MOTION TO ENFORCE COURT ORDER AND FOR RELATED RELIEF

The court has considered RPEA's motion, the State's response, and RPEA's reply and the statements of both counsel at the status conference held on November 19, 2019. The court concludes that the relief requested is reasonably necessary to enforce this court's order of April 16, 2019. Accordingly, the motion is granted, and the court orders as follows:

(1) The State is prohibited from continuing to offer only the unconstitutional 2014 plan throughout 2019; the State must offer members some short-term relief from the unconstitutional diminishment of benefits.

As long as the State is offering only the 2014 plan, the State shall inform members whose claims are denied if that claim would have been covered under the 2013 plan. If

REEVES AMODIO LLC
500 L STREET, SUITE 300
ANCHORAGE, ALASKA 99501-1990
PHONE (907) 222-7100, FAX (907) 222-7199

the State claims it cannot immediately begin making that determination for every claim denied, the State must instead inform all members whose claims are denied that "This claim might have been covered under the previous plan. The denial will be reviewed by the Division and further information will be provided as soon as feasible." The State must then complete that review as soon as possible and advise members when the State has determined that a claim that was denied would have been covered under the 2013 plan.

(2) The State is prohibited from establishing the unconstitutional 2014 plan as the default plan under the two-plan system it is designing for 2020. Any member who does not affirmatively select participation in the 2014 plan shall be treated as having chosen to participate in the 2013 plan.

(3) The State is directed to begin promptly to conduct a complete retrospective review of claims denied under the 2014 plan that would have been granted had the 2013 plan remained in effect. The State shall notify the court and RPEA when the review begins, how long it should take, and when it is concluded. The State also shall provide RPEA with a complete copy of correspondence between the State and Moda or Segal (or whoever is engaged to conduct the review), so that RPEA is informed about the scope

REEVES AMODIO LLC
500 L STREET, SUITE 300
ANCHORAGE, ALASKA 99501-1990
PHONE (907) 222-7100, FAX (907) 222-7199

and nature of the review, and the data that are used. When the review is complete, the State shall provide a copy of the report that identifies the claims that were denied.[1]

(4) The State shall provide RPEA with its complete premium rate analysis and all data used in the analysis to determine the new rates. This information shall be provided as soon as it is available.

(5) The State shall disclose to RPEA and the court all costs it incurs to develop and implement the two-plan system, and shall specify which funds, if any, are taken from members' premiums. The initial disclosure shall be made within 10 days of this order, with follow-ups at regular intervals of not less than 30 days, as additional funds are expended.

Entered at Anchorage, Alaska, this 21st day of November 2019.

Eric A. Aarseth
Superior Court Judge

I certify that on 11-21-19 a copy of the following was mailed/emailed to each of the following at their addresses of record.

Administrative Assistant

[1] Such a report will be subject to the protective order in place in this case, which allows RPEA to receive HIPAA-protected information and requires RPEA to protect its confidentiality.

REEVES AMODIO LLC
500 L STREET, SUITE 300
ANCHORAGE, ALASKA 99501-1990
PHONE (907) 222-7100, FAX (907) 222-7199

jnu.law.ecf@alaska.gov

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

THE RETIRED PUBLIC EMPLOYEES OF ALASKA, INC.,

Plaintiff,

v.

KELLY TSHIBAKA, in her official capacity as Commissioner of the Department of Administration,

Defendant.

Case No.: 3AN-16-04537CI

AFFIDAVIT OF EMILY RICCI

STATE OF ALASKA)
) ss.
FIRST JUDICIAL DISTRICT)

I, Emily Ricci, being duly sworn, states as follows:

1. I am the Chief Health Policy Advisor for the State of Alaska, Department of Administration, Division of Retirement and Benefits. I have personal knowledge of the matters stated in this affidavit.

2. In March of 2016, the Retired Public Employees of Alaska ("RPEA") filed suit against the Commissioner of the Department of Administration ("State"). At issue was whether the retiree dental plan adopted by the State, and effective January 1, 2014 ("the 2014 Plan), diminished or impaired the benefits available to retirees, when compared against the dental plan in place prior to 2014 ("the 2013 Plan").

ATTORNEY GENERAL, STATE OF ALASKA
Dimond Courthouse
PO Box 110300, JUNEAU, ALASKA 99811
PHONE (907) 465-3600

ATTORNEY GENERAL, STATE OF ALASKA
Dimond Courthouse
PO Box 110300, JUNEAU, ALASKA 99811
PHONE (907) 465-3600

3. On April 17, 2019, the Court issued an order finding in favor of RPEA and adopting RPEA's proposed findings of Fact and Conclusions of Law (the "April 2019 Order"). RPEA's proposed order, as adopted by the Court, provided that: "[t]he State may (1) return to the 2013 retiree dental plan; (2) provide individual retirees the *option of returning* to the 2013 plan or *continuing with the 2014 plan*; or (3) negotiate a new alternative plan that RPEA accepts as comparable and not diminishing retirees' benefits." (Emphasis added).

4. On May 7, 2019, the Court temporarily stayed implementation of the April 2019 Order pending resolution of the State's request for a longer stay.

5. To execute any of the options provided by the Court, the State would be required to operationalize a new plan. After review and analysis, we determined that the absolute soonest it could operationalize a new plan under any of the Court's options was January 1, 2020.

6. Ultimately, we determined that offering only the 2013 dental plan to retirees would be far more disruptive to the membership than providing retirees with a choice between the two plans. By offering two plans, members could make coverage decisions that work for them and their family. If a member would like to increase their benefit utilization frequency or receive a higher reimbursement for going to an out-of-network provider, they could choose the 2013 plan with the understanding that their premiums would also increase. Conversely, if a member was happy with their current coverage level, they could choose to retain their current coverage and would not experience a rise in premiums. Additionally, unlike creating a third new plan or forcing

ATTORNEY GENERAL, STATE OF ALASKA
Dimond Courthouse
PO Box 110300, JUNEAU, ALASKA 99811
PHONE (907) 465-3600

everyone into the 2013 Plan, offering two plans was most likely to reduce the Plan's exposure to additional litigation over diminishment brought by retirees. It is my understanding most retirees are not a part of RPEA.

7. On August 8, 2019, based upon the reasoning set forth above, the State notified the Court that it was proceeding with option 2 – providing individual retirees the option of returning to the 2013 plan or continuing with the 2014 plan. The Court also issued final judgment in favor of RPEA on this same date.

8. At the August 8, 2019 hearing the Court expressed concerns about retirees selecting the 2013 Plan and bearing the full brunt of the increased cost of that more expensive plan. As of that date, we forecasted the costs could be 25%-30% higher for the 2013 Plan in comparison to the 2014 Plan. This differential was based on the differences in plan value, provider payment levels and anticipated utilization. However, in response to the Court's concerns, we instead calculated premiums for 2020 based only on the differences in plan value and provider payment levels, which is 14.3%. Additionally, the actuary's analysis indicated that the 2014 Plan costs would be reduced by 4.6% due to the introduction of the Delta Dental PPO Network. The DVA plan's premiums are projected to be 4.3% lower than expenses in 2020. Rather than increase this funding differential, the Division made the policy decision not to reduce the 2014 Plan premiums by this amount. However, the 2013 Plan premiums were calculated from this lower cost level, resulting in a 9.7% premium differential (rather than 14.6%) in 2020 from the 2014 Plan premiums. An actuarial peer review of the underlying data and methodology supporting these premiums was performed by a separate actuarial

ATTORNEY GENERAL, STATE OF ALASKA
Dimond Courthouse
PO Box 110300, JUNEAU, ALASKA 99811
PHONE (907) 465-3600

firm, Buck Consultants. The results and supplemental materials were presented to the Retiree Health Plan Advisory Board (RHPAB) during a publicly noticed, special board meeting on October 8, 2019.

9. On August 16, 2019, the State filed a status report with the Court providing a comprehensive timeline of activities the State was undertaking to implement the Court's order (the "Implementation Plan").

10. The Implementation Plan identified that a determination would have to be made as to which plan would serve as the default plan.

11. Ultimately, the decision was made to designate the 2014 Plan as the default plan for purposes of open enrollment. This decision was made because it would not automatically subject retirees to the higher premium plan and because it was in keeping with the language of the Court's April 2019 Order: *"provide individual retirees the option of returning to the 2013 plan or continuing with the 2014 plan."* Designating the 2014 plan as the default plan allowed retirees to *continue* with the 2014 plan without having to take any action, or exercise the *option* during open enrollment of returning to the 2013 plan.

12. RPEA has intimated that the State has not communicated with RPEA regarding the implementation of the Court's April 2019 Order. That is not the case. In addition to being served with detailed notice via the court-filed Implementation Plan, the State presented updates at RPEA chapter meetings on September 9, 2019 and October 10, 2019 respectively. The State was scheduled to present at another RPEA

chapter meeting on December 10, 2019. However, since issuance of the Court's November 2019 Order, that invitation has been withdrawn by RPEA.

13. The State's primary way to communicate with retirees is not through RPEA, which does not represent all retirees. Rather, the *Retiree Health Plan Advisory Board*, ("Board") created by former Governor Walker, on September 29, 2017, through Administrative Order 288, is the board created to facilitate engagement and coordination between retirees, the Alaska Retirement Management Board, and the Commissioner of Administration regarding the administration of the retiree health plan. Accordingly, the State has updated the Board regarding implementation of the Court's order thereby allowing for public meetings and public comment. Specifically, Board meetings were held on August 22, 2019 and October 8, 2019 respectively to address implementation of the Court's April 2019 order.

14. RPEA has attended Board meetings and provided public comment with regard to the State's implementation of the Court's order. For example, on August 22, 2019, Brad Owens, officially speaking on behalf of RPEA, addressed the Board and provided comment on various aspects of the implementation plan, including the naming of the 2014 plan as the default plan for purposes of open enrollment.

15. On September 17, 2019, a full month after the State provided the Court and RPEA with the Implementation Plan, RPEA filed its *Motion to Enforce Court Order and for Related Relief.* RPEA's delay in raising any formal concern with the Court was particularly problematic given the expedited nature of the Department's work to operationalize the 2013 plan in time for open enrollment and a January 1, 2020 "go

ATTORNEY GENERAL, STATE OF ALASKA
Dimond Courthouse
PO Box 110300, JUNEAU, ALASKA 99811
PHONE (907) 465-3600

live" date. Through court filings, and its participation in Board meetings, RPEA was well aware of the decisions being made and the expedited time frame the Department was working under.

16. On October 7, 2019, the State filed its Opposition to RPEA's *Motion to Enforce Court Order and for Related Relief.* Exhibit C, attached to the State's Opposition, provided the Court with an updated implementation timeline (the "Updated Implementation Plan").[1] One of the problems with RPEA's motion from an implementation point of view was that this filing represented a request for new relief (having the 2013 plan be the default plan) and did so too late in the process to enable the State to communicate clearly to retirees. In our experience, when communicating time sensitive information to an older population, it is vital to get critical information to these individuals the first time. Again, in our experience, individuals who read the information regarding their plan for an upcoming year and do so once are unlikely to reread documents sent later that same season. A change of information not included in early mailers runs the high likelihood of blindsiding retirees.

17. On November 19, 2019, the Court issued its Order Granting RPEA's Motion to Enforce Court Order for Related Relief, and then revised this Order on November 21, 2019 (the "November 2019 Order").

18. The November 2019 Order creates unintended and negative consequences to retirees of which the Court may not be aware.

[1] The Implementation Plan and the Updated Implementation Plan are hereinafter referred to collectively as the "Implementation Plans".

ATTORNEY GENERAL, STATE OF ALASKA
Dimond Courthouse
PO Box 110300, JUNEAU, ALASKA 99811
PHONE (907) 465-3600

ATTORNEY GENERAL, STATE OF ALASKA
Dimond Courthouse
PO Box 110300, JUNEAU, ALASKA 99811
PHONE (907) 465-3600

19. For example, the November 2019 Order prohibits the State from offering the 2014 Plan as the default plan. Because of the sequential nature of the Implementation Plans, changing the default plan at this late date requires the State to go back and "re-implement" many of the implementation provisions thereby delaying compliance with the Court's order and negatively impacting retirees. For example:

(a) Changing the default plan results in placing all plan members in the higher premium plan without the retiree affirmatively selecting the higher premium plan.

(b) Changing the default plan creates confusion for members necessitating a new communication effort with retirees. Based on our experience, we anticipate a minimum of 6 weeks will be needed to communicate the new changes to retirees.

i. Because the retiree population is comprised of members who live all across the United States, some of whom travel a lot, and many of whom do not use email, communicating information to this population has unique challenges. Accordingly, a comprehensive communications plan was a vital component of the Implementation Plans.

ii. A complete listing of communications with retirees that occurred is attached hereto as Exhibit A.

iii. While the communication materials advised retirees to make a plan selection, if no plan selection was made then retirees would remain

covered under the 2014 Plan (Standard Plan). Pursuant to the Court's November 2019 Order, this is no longer true. Notifying retirees of this change at this late date will cause confusion and require a significant communication effort.

(c) Changing the default plan, and the resulting communication effort, will require an extension of the open enrollment process into the new plan year. Extending open enrollment means that members will not be able to receive their identification cards prior to the start of the new plan year. This may lead to potential issues with receiving services as providers are unable to verify coverage.

(d) Operationally, the dental plan third party administrator (Delta Dental of Alaska) will begin receiving claims for processing on January 1, 2020. However, with the extension of open enrollment, this means that Delta Dental will be receiving claims before the close of open enrollment meaning they won't know which plan to process a member's claim under creating delays.

20. While the Court's November 2019 Order creates unannounced consequences for the retirees, such as changing the default plan, the Order also contains provisions for other issues that are impossible to complete under the Court's timeframe despite ongoing good faith efforts to complete.

21. For example, the November 2019 Order requires the State to now begin to inform members whose claims are denied if that claim would have been covered under

ATTORNEY GENERAL, STATE OF ALASKA
Dimond Courthouse
PO Box 110300, JUNEAU, ALASKA 99811
PHONE (907) 465-3600

the 2013 plan. The claims administrator, Delta Dental of Alaska, is unable to currently provide this information because to do so requires processing the claim against the 2013 plan to determine if it would have been covered. The 2013 plan coding is still in the testing and audit phase and is thus not complete because the Implementation Plans contemplated a January 1, 2020 go live date. Once the coding and testing is complete, we will be able to comply with this provision of the November 2019 Order.

22. Additionally, payment statements for members that do not have DVA premiums deducted from their pension benefits will go out on December 9th. Our direct bill vendor that manages these statements recently informed us that since open enrollment has been extended to December 13, 2019 some member's January billing statement will not reflect accurate premium amounts. It is too late to correct these statements. A stay of the portion of court's order requiring the State to change the default plan would reduce the number of inaccurate statements.

23. The Court's November 2019 Order provides that if the State cannot identify whether a denied claim would have been paid under the 2013 plan, that it notify members with a specifically worded message on the claims denial. To add such a message requires programming and coding to Delta Dental's claims adjudication system. Such coding could not be completed before December 16, 2019. Because this date is so close to the completion date for coding and testing of the 2013 Plan as discussed above, it seems unnecessary in light of the Court's order regarding retrospective claims review.

ATTORNEY GENERAL, STATE OF ALASKA
Dimond Courthouse
PO Box 110300, JUNEAU, ALASKA 99811
PHONE (907) 465-3600

ATTORNEY GENERAL, STATE OF ALASKA
Dimond Courthouse
PO Box 110300, JUNEAU, ALASKA 99811
PHONE (907) 465-3600

24. Because of these negative consequences that the State strongly feels are contrary to the best interests of retirees, the State is pursuing reconsideration while simultaneously complying with the Court's Order. To that end, the State has already begun working hard:

(a) we have extended open enrollment through December 13, 2019.

(b) we have called in programmers to program necessary changes to the online open enrollment portal.

(c) we have electronically notified members of the Order changing the default plan and let them know that while we intend to consider our legal options, they should proactively select the plan of their choice through open enrollment.

(d) we are in the process of physically generating, printing, and mailing notices of the open enrollment extension to members so they have sufficient time to make their enrollment decisions prior to the new closure date. The State could not timely notify members of the extended open enrollment date utilizing the State's procurement procedures. Accordingly, some portions of DRB operations have had to be suspended to divert staff to the manual process of preparing approximately 39,201 letters for mailing; and

(e) we are training call center staff regarding the Court's order, and what it may mean, in order to answer member inquiries.

ATTORNEY GENERAL, STATE OF ALASKA
Dimond Courthouse
PO Box 110300, JUNEAU, ALASKA 99811
PHONE (907) 465-3600

25. The State has worked diligently and in good faith to execute what it believed to be the Court's April 2019 Order. The status of the State's implementation progress is reflected in the updated Implementation Plan attached hereto as Exhibit B. Changing material components of the Implementation Plans so close to the "go live" date will negatively impact retirees.

26. Preliminary open enrollment numbers indicate that as of November 18th, 2369 of participants had selected the Standard Plan and 3792 of participants had selected the Legacy Plan. As of November 27th, 4051 of participants had selected the Standard Plan and 5447 of participants had selected the Legacy Plan. Since November 18th it appears that 1682 participants have selected the Standard Plan and 1655 participants have selected the Legacy Plan. These numbers do not account for duplicate selection or members that have changed elections.

27. In order to most expeditiously comply with the Court's April 2019 Order, and be able to process claims effective January 1, 2020 under that Order, immediate relief from the Court's November 2019 Order is required.

Emily Ricci

SUBSCRIBED AND SWORN TO before me this 27th day of November, 2019.

STATE OF ALASKA
OFFICIAL SEAL
Kevin M. Dilg
NOTARY PUBLIC
My Commission Expires With Office

Notary Public in and for Alaska
My Commission Expires: w/office

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

THE RETIRED PUBLIC EMPLOYEES OF ALASKA, Plaintiff, v. KELLY TSHIBAKA, COMMISSIONER OF THE ALASKA DEPARTMENT OF ADMINISTRATION, Defendant.	3AN-16-04537CI

Order Re:

I. Motion for Reconsideration and in the Alternative Motion for Clarification

Defendant Kelly Tshibaka, Commissioner of the Department of Administration (the State), requests that the Court reconsider its previous order and deny RPEA's motion to enforce in its entirety. In the alternative, the State requests that the Court suspend the portion of its order which changes the default plan being offered to retirees for 2020 and specify the period for which the State must perform the retroactive claims analysis and grant the State an extension until February 1, 2020 to begin such a review. The State also requests until February 1, 2020 to provide RPEA with discovery on the costs incurred by the State to implement the Court's April order.

Standard of Review

In Alaska, motions to reconsider are governed by Alaska Civil Rule 77(k), which provides in relevant part:

A motion to reconsider the ruling must be made within ten days after the date of notice of the ruling as defined in Civil Rule 58.1(c)[1] unless good cause is shown why a later filing should be accepted. In no event shall a motion to reconsider a ruling be made more than ten days after the date of notice of the final judgment in the case.

(1) A party may move the Court to reconsider a ruling previously decided if, in reaching its decision:

(i) The Court has overlooked, misapplied or failed to consider a statute, decision or principle directly controlling; or

(ii) The Court has overlooked or misconceived some material fact or proposition of law; or

(iii) The Court has overlooked or misconceived a material question in the case; or

(iv) The law applied in the ruling has been subsequently changed by court decision or statute.

The Court may request a response to the motion, and "a motion for reconsideration will ordinarily not be granted in the absence of such a request."[2] The Court must rule upon the motion within 30 days from the filing of the motion or within 40 days of the filing of a response.[3] Otherwise, "the motion shall be taken as denied."[4]

Discussion

A. Timeliness

The State's Motion for Reconsideration was timely per Alaska Civil Rule 77(k) because the Court ruled on a Revised Order Granting RPEA's Motion to Enforce Court Order and for Related Relief on November 21, 2019, and the State filed the Motion for Reconsideration on November 27, 2019, which is within 10 days.

---

[1] Alaska Civil Rule 58.1(a) states: "Orders and judgments become effective the date they are entered."
[2] Alaska Civil Rule 77(k)(3).
[3] Alaska Civil Rule 77(k)(4).
[4] Id.

B. Arguments for Reconsideration and Clarification

The Court must determine whether one of the requirements under Rule 77(k)(1)(i)-(iv) have been met. The State argues that the Court: (1) "[misunderstood] what occurred during the August status conference and since then;" (2) "[failed] to consider all of the consequences of a change in the 2020 default plan at this late date;" (3) overlooked State v. Alaska Civil Liberties Union (ACLU);[5] and (4) "overlooked the fact that RPEA, as an association suing on behalf of its members, does not have standing to seek damages on behalf of those individual members."[6]

(1) Occurrences during the August status conference and since then

The State argues that there was a miscommunication at the August 8 hearing. The State argues that the State would not be able to conduct the retroactive claims analysis until Delta Dental had coded the legacy plan into its system. Denta Dental is still working towards completing that process. Furthermore, the State argues that "the terms of what claims analysis is due (and to whom) has not been settled by Court order."[7]

The Court has already addressed the delay of implementation until Denta Dental has coded the legacy plan into its system. The Court ordered: "the State shall inform members whose claims are denied . . . if the State claims it cannot immediately begin making [the determination that the claim would have been covered under the 2013 plan] for every claim denied, the State must instead inform all members whose claims are denied that 'This claim might have been covered under the previous plan. The denial will

[5] 159 P.3d 513, 514 (Alaska (2006).
[6] Motion for Reconsideration 1-2.
[7] Motion for Reconsideration 6.

be reviewed by the Division and further information will be provided as soon as feasible.'"[8] Therefore, this argument is not grounds for reconsideration pursuant to Rule 77(k), and the Court denies reconsideration of this matter. The Court invites RPEA to respond regarding "the terms of what claims analysis is due (and to whom)" before the Court decides whether to clarify this matter.

(2) The consequences of a change in the 2020 default plan

The State argues that "the Court's decision to change the default plan creates overlooked consequences that not only impairs the State's ability to comply with the Court's April Order by January 1, 2020, but harms some retirees."[9] In the Affidavit of Emily Ricci, Paragraph 8 explains how the internal costs of the plans impacted the percentage premiums, which the Court may have overlooked in its decision. The Court did not factor in the cost, but the State was not authorized to require retirees to continue to remain in an constitutionally infirm plan. Only the retiree has the right to opt into the unconstitutional plan.

(3) State v. ACLU

The State argues that the Court overlooked State v. ACLU.[10] The Supreme Court held that the Superior Court exceeded its authority when it "subject[ed] individual details of the state's implementation plan to constitutional scrutiny" on remand.[11] The State argues, "[a]lthough the Court may retain jurisdiction to ensure that the State complies with its order by a certain deadline, it does not have the authority to subject the individual

[8] Order of Enforcement 1-2.
[9] Motion for Reconsideration 7.
[10] 159 P.3d 513 (Alaska (2006).
[11] State v. ACLU, 159 P.3d, 514.

details of the State's implementation plan to legal review."[12] For the reasons stated above, the State cannot legally require retirees to continue in an constitutionally infirm plan unless the retiree affirmatively and voluntarily makes that choice.

(4) RPEA's standing to seek damages on behalf of its members

The State argues that RPEA does not have standing to seek damages on behalf of its members because it has merely asserted associational standing. The State argues that the Court's order to retroactively change the retirees' dental plans requires the participation of the individual retiree because associational standing does not allow RPEA to seek relief apart from "declaration, injunction, or some other form of prospective relief."[13] This argument appears to fit Rule 77(k)(1)(i), but the State did not clarify the authority for reconsideration.

RPEA does not seek monetary damages in its complaint. The relevant relief sought by the RPEA is "short-term relief from the unconstitutional diminishment of benefits" for members' claims that are denied under the unconstitutional 2014 plan where the claims would not have been denied under the constitutional 2013 plan.[14] The State provides an example of how this relief may require different percentages of coverage for a particular service.[15] However, the State provides no support to suggest that a potential consequential monetary gain by a member due to implementation of the constitutional plan equates to monetary damages. Therefore, the Court denies reconsideration of this

[12] Motion for Reconsideration 3.
[13] Id., at fl 1 (citing Telecommunications Research & Action Center v. Allnet Communication Servs., Inc., 806 F.2d 1093, 1094-5 (C.A.D.C. 1986); Warth v. Seldin, 422 U.S. 490, 515 (1975)).
[14] Order of Enforcement 1.
[15] Motion for Reconsideration 4-5.

matter. Additionally, clarification would merely repeat that which the Court has outlined in the Order of Enforcement and is therefore unnecessary.

Conclusion

The Court DENIES reconsideration of the delay of implementation until Denta Dental has coded the legacy plan into its system, and relief sought by RPEA. The Court DENIES reconsideration of the possible harm to retirees as addressed in Emily Ricci's affidavit and the State's motion to stay and whether the Court exceeded its authority according to State v. ACLU. The Court invites RPEA to respond to reconsideration or clarification of the terms of what claims analysis is due, and to whom claims analysis is due.

IT IS SO ORDERED.

DATED at Anchorage, Alaska this 12th day of December, 2019.

ERIC A. AARSETH
Superior Court Judge

I certify that on 12 *December, 2019, a copy was mailed to:*
S. Orlansky; J. Allanna;
M. Paton-Walsh
Alison Shlom, Law Clerk

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

THE RETIRED PUBLIC EMPLOYEES OF ALASKA, INC., Plaintiff, v. KELLY TSHIBAKA, COMMISSIONER OF THE ALASKA DEPARTMENT OF ADMINISTRATION, Defendant.	Case No. 3AN-16-04537 CI

[Proposed] ORDER DENYING MOTION FOR STAY PENDING APPEAL #30

The court has considered the State's Emergency Motion for Stay Pending Appeal, RPEA's opposition, and the State's reply. The court finds that the State has not shown that it or retirees would suffer irreparable harm without a stay; it has not shown that RPEA or retirees would be adequately protected if a stay were granted; it has not shown that the balance of hardships tips in the State's favor; and it has not shown a clear likelihood of success in its appeal. Accordingly, the State's motion for stay pending appeal is DENIED.*

Dated at Anchorage, Alaska, this 12th day of December 2019.

Eric A. Aarseth
Superior Court Judge

* The 2014 plan was found to be unconstitutional. The State has provided no justification as to why it could ignore the court's order and require people to continue in that plan unless they opted out. Every retiree has a right to be enrolled in a constitutionally form plan, but they can voluntarily opt out of it and into a constitutionally infirm plan - not the other way around. EAA

REEVES AMODIO LLC
500 L STREET, SUITE 300
ANCHORAGE, ALASKA 99501-1990
PHONE (907) 222-7100, FAX (907) 222-7199

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

THE RETIRED PUBLIC EMPLOYEES OF ALASKA, INC., Plaintiff, v. KELLY TSHIBAKA, in her official capacity as Commissioner of the Department of Administration, Defendant.	Case No. 3AN-16-04537 CI

DEFENDANT'S STATUS REPORT

The purpose of this status report is to update the Court and RPEA on the State's progress towards complying with the Court's Revised Order Granting RPEA's Motion to Enforce Court Order and for Related Relief.

1. The Court prohibited the State from continuing to offer only the standard 2014 plan throughout 2019. As short-term relief, the Court ordered the State to provide all members whose claims were denied with the following notice: "This claim might have been covered under the previous plan. The denial will be reviewed by the Division and further information will be provided as soon as feasible."

To comply, the Division of Retirement and Benefits ("DRB") has taken the following actions:

- DRB worked with Delta Dental (the third party administrator) to implement a notice on all Explanation of Benefits ("EOBs"). This notice includes the exact language outlined in the Court order and will be

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

included on all 2019 claims processed on or after December 20, 2019. This was the earliest date Delta Dental could implement an EOB change. As an example, a redacted copy of an EOB with the notice is provided as Attachment 2.

- DRB worked with Delta Dental to review all pending level 1 and level 2 appeals as of the date of the April court order. DRB directed Delta Dental to evaluate the appeals under both plans and make a determination based on the plan that is most beneficial to the member. Delta Dental is finalizing the appeal letters and will be communicating the updated determinations to members in the next few weeks.
- Any claims denied since the date of the Court's April order through December 31, 2019 that were not appealed will be included in the retrospective claims review. As discussed in more detail below, DRB is still working with Dental Delta on the details of that review.

2. The Court prohibited the State from establishing the standard plan as the default plan.

Per the Court's order, any plan member that did not actively participate in open enrollment was automatically placed into the legacy plan. Per a separate request from RPEA, the State provides the final numbers from open enrollment.

Total population eligible—37,331

DVA elections for those who participated in open enrollment:
Standard Plan—12,632
Legacy Plan—7,253

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

DVA enrollment following January 1, 2020 default: [1]
Standard Plan—14,047
Legacy Plan—23,284

Of those members that participated in open enrollment, 63.5% selected the standard plan. Between the Court's November 21st order and the close of open enrollment, 10,128 members elected the standard plan compared to 2,751 legacy plan elections. Since January 1, 2020, DRB has received more than 400 contacts from retirees who were defaulted into the legacy plan, but wanted to stay enrolled in the standard plan. DRB has advised the retirees that this action was taken pursuant to a court order issued at the request of RPEA.

3. The Court ordered the State to begin a complete retrospective review of claims denied under the 2014 plan that would have been granted had the 2013 plan remained in effect. The State is to notify the Court and RPEA when the review begins, how long it should take, and when it is concluded. In addition, the State is to provide RPEA with a complete copy of correspondence between the State and Delta Dental or Segal.

Delta Dental could not begin a retrospective claims review until the legacy plan was coded, audited, and approved. That process was finalized last week. The State is currently working with Delta Dental to determine the logistics of the retrospective claims review. The State anticipates it will have a plan in the next four weeks; once it does, it will file another status report with the Court outlining that process. On February

[1] The 2020 enrollment numbers are reflective of retiree enrollment actions taken after the close of open enrollment.

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

3, 2020, the State separately provided RPEA with a copy of the only written correspondence between the State, Delta Dental, and Segal regarding the retrospective claims analysis.

4. The Court ordered the State to provide RPEA with "its complete premium rate analysis and all data used in the analysis to determine the new rates."

The State previously provided RPEA with some of this information,[2] including a copy of Segal's final premium recommendation and analysis, dated October 2, 2019,[3] as well as the memorandum detailing the result of Buck's peer review, dated October 7, 2019.[4] The State provided RPEA the underlying data used during Segal's review, as well as the information Segal shared with Buck, on February 3, 2020, along with this status report. This material included all data used or relied on by Segal when developing the DVA premiums. Segal redacted any Personally Identifiable Information or Personal Health Information, as defined by the Health Insurance Portability and Accountability Act; however, Segal confirmed that the redacted fields are not critical or necessary for

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

---

2 The State provided Segal's final analysis, Buck's peer review, and a presentation by Segal to RPEA during two special Retiree Health Plan Advisory Board meetings held in October and November 2019. The meeting minutes and materials are available here:

- http://doa.alaska.gov/drb/alaskaCare/retiree/RHPABMeetingMaterials20191008.pdf
- http://doa.alaska.gov/drb/alaskaCare/retiree/RHPAB-Audio-20191008.mp4
- http://doa.alaska.gov/drb/alaskaCare/retiree/RHPAB-MeetingMaterials-20191114.pdf
- http://doa.akaska.gov/drb/alaskaCare/retiree/RHPAB-Audio-20191114.mp4

3 This memorandum was provided during the Retiree Health Plan Advisory Board meetings and attached as Exhibit B to the State's Opposition to RPEA's Motion to Enforce Court Order and for Related Remedies.

4 This memorandum was provided during the Retiree Health Plan Advisory Board meetings; a copy of Buck's analysis is also provided as Attachment 3.

the analysis supporting its DVA premium recommendations. The files provided to Buck by Segal were preliminary. With the data provided by Segal, Buck reviewed Segal's analysis and confirmed the final plan change differential numbers.

5. The Court ordered the State to disclose to RPEA and the Court "all costs it incurs to develop and implement the two-plan system, and shall specify which funds, if any, are taken from members' premiums."

The State provided its first disclosure on December 2, 2019. Attached is an updated version of Attachment 1, which is a spreadsheet listing the estimated costs incurred to implement the legacy plan. All of these costs were charged to the DVA premium account.

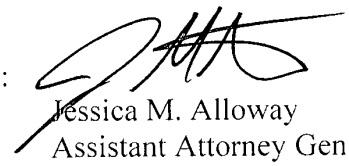
Contrary to RPEA's unfounded assumptions, these costs are not associated with "developing and implementing the two-plan system." As the Court and RPEA are well aware, Healthsmart administered the 2013 dental plan. In 2014, Moda (now known as Delta Dental) became the State's third party administrator. Because the terms of the legacy plan differ from the terms of a mainstream dental plan, and because the Court has found that the legacy plan contains benefits that are not written in the plan booklet, there was a significant amount of work needed to identify the terms and benefits of the legacy plan and operationalize them. Most of these costs are associated with the implementation of the legacy plan. Indeed, the State would have incurred a majority of these costs in 2014, even if there were no change to the dental plan. The only costs that are directly related to implementing the two-plan system are the costs associated with developing the open enrollment form and the third party administrator's file

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

programming, as well as the costs associated with the additional mailings, which were the result of the court-ordered change to the default plan. More importantly, the State would have incurred a majority of these costs under any of the options offered by the Court in its April order.

Dated: February 3, 2020.

KEVIN G. CLARKSON
ATTORNEY GENERAL

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

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

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

THE RETIRED PUBLIC EMPLOYEES OF ALASKA, Plaintiff, v. KELLY TSHIBAKA, COMMISSIONER OF THE ALASKA DEPARTMENT OF ADMINISTRATION, Defendant.	3AN-16-04537CI

Order Re:

I. Motion for Reconsideration and in the Alternative Motion for Clarification

Defendant Kelly Tshibaka, Commissioner of the Department of Administration (the State), requests that the Court reconsider or clarify its September 21, 2019 Order Granting RPEA's Motion to Enforce Order and for Related Relief. On December 12, 2019, this Court invited RPEA to respond to one issue: the State's Motion for Reconsideration and in the Alternative Motion for Clarification regarding the terms of what claims analysis is due (and to whom). The Court denied reconsideration and clarification of the other issues in the motion. RPEA filed a response on December 18, 2019 and the State filed a reply.

The State filed a Status Report on February 3, 2020. Regarding the claims analysis, the State reported that it planned to include "[a]ny claims denied since the date of the Court's April order through December 31, 2019 that were not appealed. . . in the

retrospective claims review."[1] The State reported that the legacy plan has been "coded, audited, and approved," and "the State is currently working with Delta Dental to determine the logistics of the retrospective claims review."[2]

Discussion

An Alaska Court will reconsider its order if one of the requirements under Alaska Civil Rule 77(k)(1)(i)-(iv) have been met. Rule 77(k) provides in relevant part:

> (1) A party may move the Court to reconsider a ruling previously decided if, in reaching its decision:
> (i) The Court has overlooked, misapplied or failed to consider a statute, decision or principle directly controlling; or
> (ii) The Court has overlooked or misconceived some material fact or proposition of law; or
> (iii) The Court has overlooked or misconceived a material question in the case; or
> (iv) The law applied in the ruling has been subsequently changed by court decision or statute.

The State bases its argument regarding reconsideration of what claims analysis is due (and to whom) on issues of which the Court denied reconsideration in its December 12, 2019 order.[3] The State has not explained why reconsideration is appropriate pursuant to Rule 77(k)(1)(i)-(iv), and the Court finds that none of the requirements under the rule have been met.

---

[1] Def.'s Status Report 2.
[2] Id. at 3.
[3] Def.'s Reply to RPEA's Resp. to Mot. to Clarify 5 ("RPEA wants the retrospective claims analysis to seek monetary relief on behalf of retirees. It did not ask for this relief in its complaint, this is not a class action, and RPEA does not have standing to seek this form of relief").

The State requests that the Court clarify the timespan for the retrospective claims analysis. The State requests that the Court limit the "analysis to all claims processed between August 13, 2019 and the end of the year," because "RPEA agreed to stay the Court's April order until the Court ruled on the States' motion for a longer stay."[4] The Court rejects the State's request that the Court limit the analysis to claims from August 13, 2019 through December 31, 2019.

RPEA requests that the analysis apply to the years that the 2014 plan was in effect, for claims denied in whole or in part, and claims for which out-of-network penalties were charged, from January 1, 2014 through December 31, 2019. Additionally, RPEA requests that the analysis show the difference in payment under the 2014 plan and identify the claims by a unique number and does not disclose any retiree's name, and that the State provide the report to RPEA and the Court.

The Court hereby clarifies that the claims analysis starts January 29, 2016, when RPEA filed its complaint and the State was on notice of the challenged claims. However, the analysis shall apply only to those retirees who have not affirmatively elected the 2014 plan in the 2020 open enrollment process. The Court orders that the State produce a rolling analysis starting from the April 17, 2019 decision working back to January 29, 2016.

Conclusion

The Court DENIES the State's motion for reconsideration and clarifies its claim analysis order as explained above.

[4] Id. at 6, n.9.

IT IS SO ORDERED.

DATED at Anchorage, Alaska this 19th day of February, 2020.

ERIC A. AARSETH
Superior Court Judge

I certify that on 19 *February, 2020, a copy was mailed to:*
S Orlansky; J. Alloway; M. Paton-Walsh

Alison Shlom, Law Clerk