

State of Alaska Long- Term Care

Bronze
Option



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Claims Administrator

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LONG-TERM CARE PLAN BRONZE OPTION

This option is available only to benefit recipients who retired prior to February 1, 2000.

INTRODUCTION

The State of Alaska is pleased to offer this voluntary Long-Term Care (LTC) Plan for benefit recipients and their spouses. This LTC Plan provides a range of health and social services for people who, because of a chronic condition, need help with the basic activities of daily living. These benefits may change from time to time. You should ensure that you have the current booklet by contacting the Division.

This Plan may not cover all costs associated with long-term care you may incur. You should carefully review all policy limitations.

TAX QUALIFICATION

This Plan is intended to be a qualified long-term care plan under section 7702(B) of the Internal Revenue Code of 1986 as amended. All terms and conditions for this Plan are intended to be and shall be interpreted consistent with the legal requirement of a “qualified long-term care plan” as that term is defined by that IRS code section due to the fact that this Plan was in effect in 1987 prior to the Code.

The Division retains the right to change the terms and conditions of this Plan when necessary to maintain the Plan as a qualified long-term care plan under the IRS code. If changes are made to the Plan, written notice of any changes will be provided to members as soon as possible.

WHO MAY BE COVERED

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) whose benefits began before January 31, 2000.

Dependents

You may elect to cover your spouse if you cover yourself. You may be legally separated but not divorced.

Spouses of benefit recipients who lose coverage because of death or divorce may continue coverage for themselves only but may not elect coverage for a new spouse if they remarry.

You may be covered by only one State of Alaska LTC Plan at a time. If you are covered by your own LTC Plan, your spouse cannot elect LTC coverage for you under their retirement benefit. If you are covered under your spouse's LTC Plan, notify the Division when you retire so the LTC coverage can be moved to your own retirement benefit, assuming you want to continue your current option.

PREMIUMS

Payment

Premiums are based on your or your spouse's age when the coverage is first effective. You pay the premiums for this coverage through deductions from your monthly retirement check. If you select joint coverage, premiums will be deducted for you and your spouse.

Waiver of Premium

Once the claims administrator begins to make benefit payments for you or your spouse under this LTC Plan, you will not need to pay LTC premiums for that person during that benefit period (see page 11). Premium payments will resume on the first of the month following the end of that benefit period.

Premium Changes

Premiums are subject to change. For the current premium costs, contact the Division.

HOW TO ELECT COVERAGE

You must have elected this coverage before appointment to your first benefit from any retirement system.

To meet this deadline, your *Retiree Health Benefits Enrollment/Waiver* form (available from the Division or download from our website at www.state.ak.us) must have been postmarked or received by the above deadline. **If you did not elect coverage at this time, you waived your right to elect this coverage at a later date.**

WHEN COVERAGE STARTS

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

WHEN COVERAGE ENDS

Coverage under the LTC Plan ends at the earliest time that one of the following occurs:

Failure to Pay Premium

Coverage ends on the last day of the calendar month in which you pay the required monthly 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 for more information.

A person who pays premiums for this coverage directly to the claims administrator will lose coverage if:

- A premium payment is delinquent by more than 60 days; or
- Premium payments are delinquent twice in any one calendar year by more than 31 days.

If your coverage ends due to failure to pay the premium, coverage may be reinstated back to the date it ended without requiring proof of good health; however, within 5 months of the date coverage ended you or your representative must:

- Provide proof acceptable to the Plan that you suffered a severe cognitive impairment or loss of functional capacity at the time your contribution was due, and
- Must pay all past due premiums.

Termination of Retirement Benefits

Coverage ends on the last day of the calendar month in which you cease to be eligible for a benefit from any of the retirement systems. A retiree whose benefit terminates because they return to employment may pay LTC premiums directly to the claims administrator and remain covered. When re-retired, you may have LTC coverage **only** if you have continued the premium payments for yourself and your spouse during your period of re-employment.

Cancellation of Coverage

You may cancel your participation in the Plan at any time by submitting a signed, written request to the Division. Your premium deductions will be stopped effective on the first of the month following receipt of your written request. Your coverage will end on the last day of the month in which the last premium is deducted. You may not retain spouse coverage if you cancel your coverage. **If you cancel your coverage, you forfeit all rights to future coverage and you are not eligible to re-enroll.**

Spouse Coverage

Your spouse's coverage will end on the same day your coverage ends, unless you divorce. Coverage for your spouse ends on the date the divorce is final, unless your spouse continues coverage as described below. You must notify the Division of your divorce. Premiums for your spouse will stop only **after** the Division receives your written notification. If you have selected coverage for your spouse and you divorce or die (and your spouse is not eligible for a continuing benefit), your spouse may continue coverage by paying the premiums directly to the claims administrator. To continue coverage, your spouse must elect coverage within 60 days following your death or divorce and pay the premiums retroactive to the date coverage ended. Contact the Division for more information.

CHANGING YOUR SPOUSE'S COVERAGE

You may terminate coverage for your spouse at any time. To terminate your spouse's coverage, submit a written request to the Division.

Your termination of spouse coverage will be effective on the first of the month following receipt of your written request to decrease coverage by the Division. Once you terminate your spouse's coverage, you cannot reinstate it except for a new spouse as described below.

If you choose coverage for yourself only because you are not married when you retire or if you remarry following a divorce or death of your spouse, you may request to cover your new spouse under the Silver, Gold, or Platinum Option but not under the Bronze Option. Your request must be postmarked or received by the Division within **120 days after your marriage**. Your new spouse will be required to provide information on his or her health and will be subject to approval or denial by the claims administrator. If your spouse's coverage is approved, he or she will be covered on the first of the month following the approval, assuming the premium is paid.

BENEFIT SUMMARY

This information is only intended to be a summary of coverages provided. Please refer to the booklet for additional information or exclusions.

BENEFIT	BRONZE OPTION
Deductible	90 days of covered long-term care
Benefit eligibility	Inability to perform 2 of 5 activities of daily living
Lifetime maximum	\$200,000 all services \$50,000 home health care (included in \$200,000 lifetime maximum)
Nursing home daily benefit	\$125 in Alaska \$75 outside Alaska
Assisted living facility daily benefit	Covered in lieu of other services if approved
Home health care daily benefit	\$75 in Alaska \$40 outside Alaska
Hospice daily benefit	Not covered
Respite care	Not covered
Inflation protection	None

COVERED LONG-TERM CARE EXPENSES

Benefits are available for covered expenses incurred for qualified long-term care services.

Covered expenses are those expenses incurred for care received in connection with a Covered Program of Care (see pages 11-12).

Benefit Eligibility

You are eligible to receive benefits if one or more licensed health care practitioners (see page 12) certifies that you are chronically ill. Chronically ill means that you are unable to perform, without substantial assistance from another individual, at least two activities of daily living (see pages 9-10) for at least 90 days due to a loss of functional capacity.

Long-term care benefits are available for qualified long-term care services which, as determined by the claims administrator, are needed by the chronically ill individual. Care can include:

- Skilled or intermediate nursing care,
- Home health care,
- Occupational therapy services,
- Physical therapy services, or
- Speech therapy services.

Qualified long-term care services which are appropriate and essential for diagnosis, treatment, rehabilitation, mitigating, curing, or maintenance of the disease or injury or for essential personal assistance with the activities of daily living listed below that are necessary as a result of a physical incapacity resulting from a covered disease or injury or the effects of aging. "Essential personal assistance" means the covered

individual requires substantial human assistance (i.e., hands-on or standby assistance) in at least two of the following activities of daily living (defined below):

- Eating
- Dressing
- Toileting
- Transferring
- Walking

Qualified long-term care services must be required by a covered member and provided pursuant to a Covered Program of Care as defined on page 11.

Activities of Daily Living

- Dressing—refers to a person’s ability to get clothes—including undergarments, outer garments, braces, or artificial limbs, if worn—from closets or drawers and put them on using necessary fasteners. A person is dependent if he or she cannot dress without substantial assistance from another person.
- Eating—refers to a person’s ability to feed himself or herself by getting food into the body from a receptacle such as a plate, cup, or table, or by a feeding tube or intravenously. (Eating does not include shopping for, preparing, or serving food.) A person is dependent if he or she cannot feed him or herself without substantial assistance from another person.
- Toileting—refers to a person’s ability to maintain control of urination and bowel movement and, when unable to control bladder or bowel function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag). A person is dependent if he or she loses

bladder control three times per week or more or loses bowel control two times per week or more, and is unable to perform associated personal hygiene without substantial assistance from another person.

- Transferring—refers to a person’s ability to move into or out of a bed, chair, or wheelchair. A person is dependent if he or she is unable to move into or out of a bed, chair, or wheelchair without substantial assistance from another person.
- Walking—refers to a person’s ability to ambulate independently, using a cane or walker if required.

The claims administrator will make the determination of the loss of functional capacity. In making the determination, they will take into account, as appropriate, evidence furnished by the covered member and written documentation furnished by the covered member’s attending physician and other licensed health care practitioners. A covered member who otherwise meets the requirements described above will not be determined to have suffered a loss of functional capacity unless, within the preceding 12-month period, a licensed health care practitioner (see page 12) has certified the covered member meets either requirement.

The Plan provides coverage for covered expenses for custodial care when it is received in connection with a Covered Program of Care. The benefit amount is based on where services are received.

The patient’s licensed healthcare provider (see page 12) must order the needed care. The care received must not be at the insistence of, or for the convenience of, the patient or the patient’s family.

HOW LONG-TERM CARE BENEFITS ARE PAID

Benefit Period

A benefit period begins on the first day of a Covered Program of Care and ends 30 days after the Covered Program of Care is no longer necessary. A Covered Program of Care is no longer necessary when the covered individual doesn't meet the benefit eligibility described on page 8. It does not include any day prior to your effective date of coverage under this Plan.

Deductible

You must first meet the deductible period of 90 days of covered long-term care. Only one deductible period applies during any one benefit period. At the end of any benefit period, any subsequent Covered Program of Care will be subject to the deductible period before any benefits are paid.

Coinsurance

After you meet the deductible, the Plan pays 100% of the covered long-term care services up to the daily and lifetime maximums.

Lifetime Maximum Benefit

The maximum lifetime benefit for each person for all covered long-term care expenses is \$200,000.

Covered Program of Care

A Covered Program of Care is a written program of care that one or more licensed healthcare practitioners prescribes for qualified long-term care services. A Covered Program of Care will be considered continuous even if you move from one facility or level of care to another or if you change licensed healthcare practitioners.

The Covered Program of Care must include one or more of the following services:

- Registered nursing;
- Licensed practical nursing;
- Home health aides (provided through a home health care agency);
- Physical therapy;
- Occupational therapy; or
- Speech therapy.

The claims administrator determines whether you are under a Covered Program of Care and eligible for benefits. This determination will be made after receiving evidence furnished by your licensed healthcare practitioner.

A licensed healthcare practitioner is defined as:

- Any physician as defined in section 1861(r)(1) of the Social Security Act;
- A registered nurse (R.N.);
- A licensed social worker including any social worker who has been issued a license, certificate, or similar authorization by a State or jurisdiction or body authorized by the State or jurisdiction to issue such authorization;
- Any other individual who meets such requirement as may be prescribed by the Secretary of the Treasury.

Pre-existing Conditions Limitation

No benefits are payable for any Covered Program of Care which was provided or begun prior to the effective date of your coverage or during the first 12 months of coverage, and which is caused by a pre-existing condition. Pre-existing conditions are conditions 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.

Nursing Care Facility Benefits

If you or your covered spouse incurs covered expenses for skilled or intermediate nursing care while confined in a nursing care facility, the Plan will pay a benefit for each day of care after the deductible period (90 days).

Maximum Daily Benefit

The maximum daily benefit for a nursing care facility is \$125 within Alaska and \$75 outside Alaska. The Plan will pay an amount equal to the lesser of the charges for the covered expenses or the maximum daily benefit.

Nursing Care Facility Definition

A nursing care facility is an institution or part of an institution that:

- Is licensed to provide inpatient care for persons convalescing from injury or disease; skilled nursing care or intermediate nursing care by an RN or LPN under the direction of an RN; or physical restoration services to help patients reach a degree of bodily functioning that permits self-care in essential daily living activities;
- Charges patients for the services provided;
- Provides services for its patients under the full-time supervision of a physician or RN;

- Provides nursing services by licensed nurses (seven days a week on the day shift), under the direction of a full-time RN;
- Maintains a complete medical record on each patient;
- Has an effective utilization review plan; and
- Is not, other than incidentally, a place for rest, custodial or educational care or care of the aged, or a place for care of people with mental disorders, chemical dependency, or mental retardation.

Excluded Nursing Care Facility Benefits

No benefits are payable for:

- Expenses or services which are covered under the group health plan; or
- The cost of food or preparation of meals if separate from the cost of the room.

Home Health Care Benefits

If you or your covered spouse incur covered expenses for home health care while confined in a home health unit, the Plan will pay a benefit for each day of care after the deductible period (90 days). Care must be received in:

- Your home or any other private home;
- A home for the retired or the aged;
- An institution which provides residential care; or
- An adult day care center.

Maximum Daily Benefit

The maximum daily benefit for a home health unit is \$75 within Alaska and \$40 outside Alaska. The Plan will pay a benefit equal to the lesser of the charge for the covered expenses or the maximum daily benefit.

Lifetime Maximum Benefit

The maximum lifetime benefit for home health care for each covered person is \$50,000. This amount is deducted from the \$200,000 total LTC lifetime maximum.

Definitions

Home health care must be:

- Provided through a home health care agency and performed by a registered nurse (RN), licensed practical nurse (LPN), or home health aide; or
- Performed in an adult day care center; or
- Performed by a licensed, certified, or registered occupational therapist, speech therapist, or physical therapist.

A home health care agency is an agency or organization that meets all the following requirements:

- It is mainly engaged in and, if required, is licensed to provide skilled nursing services and other therapeutic services.
- It is associated with a professional policy-making group which has at least one physician and at least one RN to govern the services provided.
- It keeps a complete medical record on each patient.
- It has a full-time administrator.

An adult day care center is a program for six or more persons of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly, or other disabled adults who can benefit from care in a group setting outside the home.

The center must meet all the following requirements:

- It is established and operated as an adult day care center in accordance with any applicable laws.
- Its staff includes:
 - A full-time director;
 - One or more RNs in attendance during operating hours for at least four hours a day; and
 - Enough full-time staff members to maintain a client-to-staff ratio of eight-to-one or better;
- It operates at least five days a week for a daily minimum of six hours and a daily maximum of twelve hours.
- It maintains a written record of medical services given to each client.
- It has established procedures for obtaining appropriate aid if a medical emergency occurs.

Excluded Home Health Care Benefits

No benefits are payable for:

- Expenses or services which are covered under the group health plan; or
- The cost of food or preparation of meals.

Skilled Nursing Care

Skilled nursing care is care furnished under a physician's orders which:

- Requires the skills of technical or professional personnel; and
- Is provided daily (five days a week for restoration services) either directly by or under the supervision of licensed, certified medical professionals. Care must be part of a Covered Program of Care.

Intermediate Nursing Care

Intermediate nursing care is care furnished under a physician's orders which combines a medically oriented program of simple treatment plans under the supervision of licensed, certified, or registered medical professionals, with emphasis on:

- Physical activity;
- Intellectual stimulation; and
- Social motivation.

LONG-TERM CARE EXPENSES NOT COVERED

Pre-existing Conditions Limitation

The Plan does not cover a Covered Program of Care which is provided or begun before the person's effective date or during the first 12 months of coverage and is caused by a pre-existing condition. Any condition that was diagnosed or treated within the 3 consecutive months before the individual's effective date is considered a pre-existing condition. (See page 13 for a full description of the pre-existing conditions limitation.)

Limitations and Exclusions

This Plan covers only losses resulting from nonoccupational accidental bodily injuries and nonoccupational diseases.

- **Nonoccupational Injury**—An injury is nonoccupational only if it is an accidental bodily injury. It cannot arise out of, or in the course of, any work for pay or profit or in any way result from an injury that does. However, if a covered individual provides proof to the claims administrator that a person covered under workers' compensation (or other similar laws) is not covered for a particular disease or injury under that law, that injury will be considered nonoccupational, regardless of its cause.
- **Nonoccupational Disease**—A disease is considered nonoccupational only if it does not arise out of any work for pay or profit and does not result from any work-related disease. However, if a covered individual provides proof to the claims administrator that a person covered under workers' compensation (or other similar laws) is not covered for a particular disease under that law, that disease will be considered nonoccupational, regardless of its cause.

In addition to the above, the following services are not covered and no benefits are payable for:

- A loss caused by declared or undeclared war or any such act.
- A loss caused by mental disease or disorder without demonstrative organic disease, excluding Alzheimer's.
- A loss caused by a suicide attempt or an intentionally self-inflicted injury.
- A confinement in a government institution, unless the covered individual is legally obligated to pay a charge.
- Services received or expenses incurred on any day the covered individual is confined to a hospital.

- Services or expenses which are covered by a State of Alaska group medical plan.
- Services received or expenses incurred outside the United States.
- Services provided by a person who usually resides in the covered individual's home or is a member of the covered individual's family, or when the person performing the service normally does not charge for the service.
- Services received for which the covered individual is not legally obligated to pay.
- Services received which are covered under Medicare.
- Services received that are not necessary or medically necessary.
- Services provided or required because of the past or present service of any person in the armed forces of a government.
- Services provided or required under any law or governmental program except Medicaid.

CLAIM FILING

INITIAL CLAIM

To start the claim process, you or your representative should call the claims administrator's toll-free number (listed in the front of this booklet or available from the Division). You should be prepared to provide information on your condition and care needs and proof you are chronically ill. If the claims administrator requires additional information, they may contact you, your representative, your physician, or another person familiar with your condition. You may be required to provide access to your medical records. The claims administrator has the right to have you examined, at the Plan's expense, by a healthcare provider and to conduct an on-site assessment.

The claims administrator has the right to review your continuing eligibility to receive benefits. In order to remain eligible for benefits, a licensed healthcare practitioner (see page 12) must recertify you as chronically ill at least every twelve months.

CLAIM FILING DEADLINE

To receive benefits, you should submit a claim within 90 days after treatment began. If, through no fault of your own, you are unable to meet the deadline for filing the claim, your claim will be accepted if you file as soon as possible, but not later than one year after the date you incurred the expenses.

BENEFIT PAYMENTS

If you have not paid the provider and you include the provider's name, address, and tax identification number, the claims administrator will pay the provider directly.

If you have already paid the provider and this fact is clearly shown on the claim form, the claims administrator will send the benefit check to you along with the *Explanation of Benefits* form.

RECORDKEEPING

Keep complete records of expenses. Important records are:

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

You should also keep **all** explanations and letters sent to you by the claims administrator.

IF A CLAIM IS DENIED

You will be sent a letter which explains the reasons why your claim or certification, or any portion, has been denied. It is important you understand these reasons. You should refer to this booklet and, if necessary, call the claims administrator for clarification. If you feel the claim should be covered under the terms of your Plan, you may take the following steps to file an appeal.

Claims Administrator Appeals

If you feel the claim or certification should be covered under the terms of this Plan, you or your provider should make a written appeal to the claims administrator. You should include any documents, records, or other information which you would

like to have reviewed in connection with your appeal. Your appeal must be received within 60 days of the date of the *Explanation of Benefits* or certification denial is issued. Your appeal will be reviewed to ensure it was paid in accordance with the Plan and the claims administrator will send you a written response.

Plan Administrator Appeals

Claim denials can be appealed to the Plan administrator if:

- Benefits covered by the Plan have been denied; or
- The reimbursement is lower than the Plan provides.

Claim denials cannot be appealed if a claim is denied because it is not covered by the Plan.

If, after exhausting your appeal rights to the claims administrator, you feel the services should be covered under the terms of the Long-Term Care Plan, you may send a written appeal to the Division. Your appeal should include copies of the claim documents, benefit explanations, and all correspondence between you and the claims administrator. Your appeal must be postmarked or received within 45 days of the claims administrator's final decision.

The Division will review your appeal to determine if it should be covered under the terms of the Long-Term Care Plan or will refer your appeal to an independent medical review group. Once the review is complete, the Division will issue a written decision.

Emergency Procedures

If a member's life or health is threatened by delays inherent in the formal appeals process, you may request an emergency review. In making an emergency determination, we will generally rely on the opinion of your treating physician.

GENERAL PROVISIONS

LIFETIME MAXIMUM BENEFIT

No more than \$200,000—the lifetime maximum benefit—will be payable during the lifetime of any individual.

BENEFITS AFTER COVERAGE TERMINATION

If coverage terminates because the group policy is discontinued, the Plan will continue to provide benefits for individuals who are under a Covered Program of Care on the date of the discontinuance. This coverage will continue only until the earlier of:

- The date the individual is no longer under a continuous and uninterrupted Covered Program of Care;
 - The date of an individual's death; or
 - The date that any applicable maximum is exhausted.
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INDIVIDUAL CASE MANAGEMENT

If you have an illness, injury, or accident that may extend for some time, the Long-Term Care Plan provides for alternate means of care through Individual Case Management (ICM).

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

Through ICM, the claims administrator can consider recommendations involving expenses usually not covered for reimbursement. This includes suggestions to use alternative medical management techniques or procedures or suggestions for cost-effective use of existing Plan provisions.

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

CONTINUATION OF COVERAGE

Your coverage will terminate:

- When your retirement benefit stops,
- If you are required to pay your premium directly to the claims administrator and you fail to pay the premium on time, or
- If the Long-Term Care Plan is terminated for all members.

Your spouse's coverage terminates at the same times listed above unless you divorce. In that case, your spouse's coverage terminates on the date the divorce is final.

If coverage is terminated because your retirement benefit stops or if your spouse's coverage is terminated due to divorce, coverage may be continued by paying the premium directly to the claims administrator.

APPLICABLE LAW AND VENUE

This policy, issued and delivered in the State of Alaska, is governed by the laws of the State of Alaska. Any and all suits or legal proceedings of any kind brought against the State must be filed in the First Judicial District, Juneau, Alaska, within three years from the deadline for filing a claim.

The claims administrator will not attempt to reduce or deny a benefit payable for loss on the grounds that a disease or condition existed before coverage became effective if the loss occurs more than two years from the date coverage began. This provision will not apply to conditions specifically named as excluded from coverage on the date of the loss.

RIGHT OF EXAMINATION

The claims administrator has the right and opportunity to examine, at its own expense, a claimant as often as it may reasonably require during the pending claim, or while benefits are being paid.

OTHER PROVISIONS

The following additional provisions apply to your coverage:

- You cannot receive multiple coverage under this Plan. Spouses insured as retirees cannot be eligible dependents.
- If, under this Plan, a misstatement of facts affecting your coverage occurs, the actual facts will be used to determine the coverage in force.
- If you applied for coverage for your spouse following marriage, you were required to provide evidence of their good health. Their approval for coverage under this Plan is based on their answers to questions on the application. If the answers are incorrect or untrue or contain a material omission, the Plan has the right to deny benefits or rescind coverage. The best time to clear up any questions is before a claim arises. If for any reason, any of your answers are incorrect, contact the Division.

REIMBURSEMENT PROVISION

If you or your spouse suffers a loss or injury caused by the act or omission of a third party, long-term care benefits for the loss or injury will be paid only if the person suffering the loss or injury, or the legally authorized representative, agrees in writing:

- To pay the retiree health plan up to the amount of the benefits received under the plan if damages are collected from the third party or their representative. Damages may be collected by action at law, settlement, or otherwise.
- To provide the claims administrator a lien for the amount of the benefit paid or to be paid. This lien may be filed with the third party, his or her agent, or a court which has jurisdiction in the matter.

ACCESS TO RECORDS

All members of the Plan consent to and authorize providers to examine and copy any portions of the facility or medical records requested by the Plan when processing a claim, certification, or claim appeal. Members are the retiree and eligible spouse covered by the Plan.

CANCELLATION

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

CHANGES TO PLAN

Neither the claims administrator nor any agent of the claims administrator is authorized to change the form or content of this Plan in any way except by an amendment that becomes part of the Plan over the signature of the Plan administrator.

CONTRACT LIABILITY

The full extent of liability under this Plan and benefits conferred, including recovery under any claim of breach, will be limited to the actual cost of hospital or facility and long-term care services as described here and will specifically exclude any claim for general or special damages that includes alleged “pain, suffering, or mental anguish.”

EPIDEMICS AND PUBLIC DISASTERS

The services this Plan provides are subject to the availability of facilities and the ability of facilities, facility employees, physicians and surgeons, and other providers to furnish services. The Plan does not assume liability for epidemics, public disasters, or other conditions beyond its control which make it impossible to obtain the services this Plan provides.

EVIDENCE OF NEED

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

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan are made under other programs, this Plan has the right, at its discretion, to pay over to any organizations making other payments any amounts it determines are warranted. These amounts are considered benefits paid under this Plan, and, to the extent of these payments, this Plan is fully discharged from liability under this contract.

FREE CHOICE OF PROVIDER

You may select any provider who meets the definitions as outlined in this Plan.

The payments made under this Plan for services rendered by a provider are not construed as regulating in any way the fees that the provider charges.

At the discretion of the claims administrator, payments may be made to the provider or other person or organization furnishing the service or making the payment, or to the retiree, or to such person or organization and the retiree jointly.

The providers that furnish care and services or other benefits to members do so as independent contractors. The Plan is not liable for any claim or demand from damages arising from, or in any way connected with, any injuries or illnesses that members suffer while receiving care in any facility or services from any provider.

NOTICE

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

PLAN MUST BE EFFECTIVE

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

MEDICAL OUTCOMES

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

PREMIUMS

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

PRIOR COVERAGE

If you or your spouse are confined in a facility, including home health care, while covered under a prior certificate or agreement and you or your spouse remain continuously confined past the date coverage begins under this Plan, the benefits of the prior certificate or agreement apply until you or your covered spouse is discharged.

RIGHT OF RECOVERY

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

- To require the return of the overpayment on request; or
- To reduce, by the amount of the overpayment, any future claim payment made to or on behalf of that person or another person in his or her family.

This right does not affect any other right of recovery this Plan may have as to the overpayment.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

TRANSFER OF BENEFITS, ASSIGNMENT, GARNISHMENT, AND ATTACHMENT

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

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

VESTED RIGHTS

This Plan does not confer rights beyond the date coverage is terminated or the effective date of any change to the Plan provisions, including benefits and eligibility provisions. For this reason, no rights from this Plan can be considered vested rights. You are not eligible for benefits or payments from this Plan for any services, treatment, medical attention, or care rendered after the date your coverage terminates.

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