State of Alaska

Long-Term Care

Silver, Gold, and Platinum Options

April 2002

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LONG-TERM CARE PLAN
Silver, Gold, and Platinum Options

These options are available only to benefit recipients who retire after December 31, 1999, or those who applied for and were approved for coverage during the enrollment period in 2000.

INTRODUCTION

The State of Alaska is pleased to offer this voluntary Long-Term Care (LTC) Plan for benefit recipients and their spouses. The options available under this LTC Plan provide a range of health and social services for people who suffer a severe cognitive impairment or, because of a chronic condition, need help with the basic activities of daily living. There are three options available. 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 and shall be interpreted consistent with all legal requirements of a qualified long-term care plan as that term is defined by that IRS code section.

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

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).

Dependents

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

Spouses of benefit recipients who lose coverage because of death or divorce may elect coverage for themselves only. No coverage may be elected for a new spouse if you 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 have 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 or terminated if you elect a new option.

PREMIUMS

Payment

Premiums are based on your or your spouse's age at the time coverage begins. 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 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 APPLY FOR COVERAGE

You must apply for 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 web site at alaska.gov/drb) must be postmarked or received by the deadline. **If you do not apply for coverage at this time, you waive your right to apply for this coverage at a later date.**

WHEN COVERAGE STARTS

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

WHEN COVERAGE ENDS

Coverage under the LTC Plan ends at the earliest time 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 will remain covered. When re-retired, you may have LTC coverage only if you have continued the premium payments for you 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 the first of the month following receipt of your request. Your coverage will end on the last day of the month in which the last premium is deducted. You may not cancel your coverage and retain coverage for your spouse. If you cancel participation, 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 apply for coverage within 60 days following your death or divorce and pay 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 by the Division. Once you terminate your spouse's coverage, you cannot reinstate it except as described below.

If you choose coverage for yourself only because you are not married when you retire or if you remarry following divorce or the death of your spouse, you may request to cover your new spouse. 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.

DECREASING YOUR LEVEL OF COVERAGE

You may decrease the coverage option for yourself or your spouse at any time before you begin a Covered Program of Care (see page 12) by notifying the Division in writing. For example, you may decrease from the Platinum Option to the Gold Option. Changes in your option are effective on the first of the month following receipt of your written request.

The Bronze Option is closed and may not be selected. You may not increase coverage at any time.

BENEFIT SUMMARY

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

SILVER OPTION	GOLD OPTION	PLATINUM OPTION
Lifetime maximum benefit		
$400,000 all services	$300,000 all services to start	$300,000 all services to start
Inflation protection		
None.	Simple at 5% of original benefit each year. Applies to all daily and lifetime maximums.	Compound at 5% of prior year's benefit each year. Applies to all daily and lifetime maximums.
The following provisions are the same for all three options:		
Deductible	90 days of covered long-term care	
Benefit Eligibility	Inability to perform two of six activities of daily living or severe cognitive impairment	
Nursing Care Facility Daily Benefit	$200	
Assisted Living Facility Daily Benefit	$150	
Home Health Care Daily Benefit	$125	
Hospice Care Daily Benefit	$125	
Respite Care Daily Benefit	Up to $200, maximum of 14 days per calendar year	

COVERED LONG-TERM CARE EXPENSES

Benefits are available for covered expenses. Covered expenses are those expenses incurred for care received in connection with a Covered Program of Care (see pages 12-13).

Benefit Eligibility

You are eligible to receive benefits if one or more licensed healthcare practitioners (see page 13) 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; or
- You require substantial supervision to protect you from threats to health and safety due to a severe cognitive impairment (see page 10-11).

Long-term care benefits are available for qualified long-term care services which, as determined by the claims administrator, are needed by a 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 are those which are appropriate and essential for the diagnosis, treatment, rehabilitation, mitigating, curing, or maintenance of disease or injury or for 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 on pages 9-10):

- Bathing
- Continence
- Dressing
- Eating
- Toileting
- Transferring

Essential personal assistance may also mean the covered individual requires substantial human assistance due to severe cognitive impairment.

Activities of Daily Living

- Bathing—refers to a person's ability to wash by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower. A person is dependent if he or she cannot bathe without substantial assistance from another person.

- Continence—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 time 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.

- 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/herself without substantial assistance from another person.

- Toileting—refers to a person's ability to get to or from the toilet, getting on and off the toilet and performing associated personal hygiene. A person is dependent if he or she cannot perform these tasks 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.

Severe Cognitive Impairment

Severe cognitive impairment means the covered member has been certified by one or more licensed healthcare practitioners as requiring substantial supervision or verbal cueing by another person in order to protect the covered member and others from serious threats to health and safety.

Severe cognitive impairment means a deterioration or loss in the covered member's intellectual capacity that is measured by clinical evidence and standardized tests which reliably measure impairment in short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

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 healthcare practitioners. A covered member who otherwise meets either of 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 healthcare practitioner (see page 13) has certified the covered member meets the requirements.

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 practitioner (see page 13) 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 90 days after the Covered Program of Care is no longer necessary. A Covered Program of Care is no longer necessary when the covered member no longer meets the benefit eligibility described on page 8. It does not include any day prior to the 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 period, the Plan pays 100% of the charges for 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:

SILVER OPTION	GOLD OPTION	PLATINUM OPTION
$400,000	$300,000	$300,000
	Increases annually by 5% simple inflation protection	Increases annually by 5% compound inflation protection

Inflation protection terminates at age 85.

Covered Program of Care

A Covered Program of Care is a written program of care that one or more licensed healthcare practitioners prescribe for qualified long-term care services. A Covered Program of Care will be considered continuous even if the covered member moves from one facility or level of care to another or changes 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; or
- 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 provided or begun prior to the effective date of your coverage or during the first 12 months of coverage 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. 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.

This provision does not apply to those benefit recipients who applied and were accepted for new or increased coverage under one of these options during the 2000 enrollment period.

Nursing Care Facility Benefits

If you or your covered spouse incur 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 Plan will pay an amount equal to the lesser of the charges for the covered expenses or the maximum daily benefit. The maximum daily benefit for a nursing care facility is:

SILVER OPTION	GOLD OPTION	PLATINUM OPTION
$200	$200	$200
	Increases annually by 5% simple inflation protection	Increases annually by 5% compound inflation protection

Inflation protection terminates at age 85.

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 or intermediate nursing care or custodial care rendered by a registered nurse (RN) or by a licensed practical nurse (LPN) under the direction of an RN; or physical restoration services to assist patients to reach a degree of body functioning that permits self-care in essential daily living activities;

- Provides services 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;

- Keeps a complete medical record on each patient; 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 State of Alaska retiree health plan; or
- The cost of food or preparation of meals, if separate from the cost of the room.

Assisted Living Facility Benefits

If you or your covered spouse are confined to an assisted living facility, the Plan will pay a benefit for each day of care after the deductible period (90 days).

Maximum Daily Benefit

The Plan will pay a benefit equal to the lesser of the charges for the covered expenses or the maximum daily benefit. The maximum daily benefit for an assisted living facility is:

SILVER OPTION	GOLD OPTION	PLATINUM OPTION
$150	$150	$150
	Increases annually by 5% simple inflation protection	Increases annually by 5% compound inflation protection

Inflation protection terminates at age 85.

Assisted Living Facility Definition

An assisted living facility is one that meets any applicable licensing requirements and all of the following criteria:

- As its primary purpose, it provides 24-hour care and services to support its patients' needs resulting either from the inability to perform certain activities of daily living or from severe cognitive impairment.
- It charges its patients for the services it provides.
- It provides trained staff at all times to provide care.
- It has procedures in place for overseeing the administration of medications.
- It is not a hospital, a nursing facility, or similar establishment.
- It is not a place for care of individuals who are chemically dependent or mentally retarded or for educational care or care of mental disorders.

Home Health Care Benefits

If you or your covered spouse incur covered expenses for home health care, 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.

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;

- Performed in an adult day care center; or
- Performed by a licensed, certified, or registered occupational therapist, speech therapist, or physical therapist.

Maximum Daily Benefit

The Plan will pay a benefit equal to the lesser of the charges for the covered expenses or the maximum daily benefit. The maximum daily benefit for home health care is:

SILVER OPTION	GOLD OPTION	PLATINUM OPTION
$125	$125	$125
	Increases annually by 5% simple inflation protection	Increases annually by 5% compound inflation protection

Inflation protection terminates at age 85.

Home Health Care Definitions

A home health care agency is one which:

- Mainly provides skilled nursing and other therapeutic services;
- Is associated with a professional policy-making group which has at least one physician and one registered nurse (RN);
- Has full-time supervision by a physician or an RN;
- Keeps complete medical records on each patient;
- Has a full-time administrator; and
- Meets licensing standards.

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 State of Alaska retiree health plan; or
- The cost of food or preparation of meals.

Hospice Care Benefits

If you or your covered spouse incur covered expenses for hospice care, the Plan will pay a benefit for each day of care after the deductible period (90 days).

Maximum Daily Benefit

The Plan will pay a benefit equal to the lesser of the charges for the covered expenses or the maximum daily benefit. The maximum daily benefit for hospice care is:

SILVER OPTION	GOLD OPTION	PLATINUM OPTION
$125	$125	$125
	Increases annually by 5% simple inflation protection	Increases annually by 5% compound inflation protection

Inflation protection terminates at age 85.

Hospice Care Agency Definition

A hospice care agency is an agency or organization which:

- Has hospice care available 24 hours a day;
- Meets any applicable licensing requirements;
- Provides:
  - » Skilled nursing services;
  - » Medical social services; and
  - » Psychological and dietary counseling.
- Provides or arranges for other services which include:
  - » Services of a physician;

  - » Physical and occupational therapy;
  - » Part-time home health aide services which mainly consist of caring for terminally ill persons; and
  - » Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel which include at least:
  - » One physician;
  - » One RN; and
  - » One licensed or certified social worker employed by the agency.
- Establishes policies governing the provision of hospice care;
- Assesses the patient's medical and social needs and develops a hospice care program to meet those needs;
- Provides an ongoing quality assurance program, including reviews by physicians other than those who own or direct the agency;
- Permits all area medical personnel to utilize its services for their patients;
- Keeps a medical record on each patient; and
- Has a full-time administrator.

Skilled Nursing Care Definition

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.

Intermediate Nursing Care Definition

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.

Respite Care Benefit

This Plan pays a benefit for each day of respite care, up to a maximum of 14 days during a benefit (calendar) year. Respite care is care furnished during a period of time when the covered member's family or usual primary caregiver is not attending to the covered member's needs. The respite care benefit for any one day is equal to 100% of the daily benefit amount respective to the setting of the benefit (i.e., nursing care facility, assisted living facility, etc.). For example, if respite care is received in a nursing home, expenses are reimbursed up to the nursing home daily benefit maximum. If assisted living facility care or home care services are used, expenses are covered up to those daily benefit maximums.

To qualify for respite care, you must have been under the equivalent of a Covered Program of Care (see page 12) or required qualified long-term care services as listed on page 8 for at least 90 days. However, you do not have to pay for the first 90 days of care as required by the deductible period.

Inflation Protection

The Gold and Platinum Options include automatic inflation protection which increases the lifetime maximum and daily benefit amounts annually. The benefit amounts will be increased annually by a factor of 5% as follows:

GOLD OPTION	PLATINUM OPTION
5% Simple	5% Compound

Example:

	NURSING FACILITY DAILY BENEFIT		LIFETIME MAXIMUM BENEFIT	
Year	Simple Inflation (Gold)	Compound Inflation (Platinum)	Simple Inflation (Gold)	Compound Inflation (Platinum)
Start	$200	$200	$300,000	$300,000
5	250	255	375,000	382,884
10	300	326	450,000	488,668
15	350	416	525,000	623,678
20	400	531	600,000	795,989
25	450	677	675,000	1,015,906
30	500	711	750,000	1,296,583

The Gold Option with 5% simple inflation protection increases the nursing facility daily benefit, for example, by $10 and your lifetime maximum by $15,000 each year. The Platinum Option with the 5% compound inflation protection increases the daily and lifetime maximum benefits by 5% of the prior year's benefit amount each year. This option increases the benefits by a larger amount over time. Inflation increases apply to all daily benefit amounts and the lifetime maximum.

Inflation protection increases are made on the anniversary of the effective date of your coverage. For example, if your coverage is effective May 1, 2002, your daily benefit amount will first be increased effective May 1, 2003. Increases will continue annually until the covered member reaches 85. The selected inflation protection will continue to increase the benefit amounts even while you are receiving benefits until the covered member reaches age 85.

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 three 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

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 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 that are covered by the State of Alaska retiree 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 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 health care 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 13) must recertify you as chronically ill at least every twelve months.

FILING DEADLINE

You must submit your claim in writing to the claims administrator and you must give proof of the nature and extent of the loss.

Be sure to report claims promptly. The deadline for filing a claim for benefits is 90 days after the start of a Covered Program of Care. If, through no fault of your own, you are unable to meet the deadline for filing a claim, your claim will be accepted if you file as soon as reasonably possible, but not later than one year after the deadline unless you are legally incapacitated. Otherwise, late claims will not be covered.

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;
- The dates expenses are incurred; and
- Copies of all bills and receipts.

You should also keep **all** *Explanation of Benefits* forms sent to you as it is not possible for the claims administrator to provide duplicate copies.

IF A CLAIM IS DENIED

Your *Explanation of Benefits* form 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 that 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 the denial is issued. Your appeal will be reviewed 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 that 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

COORDINATION WITH MEDICARE

If a covered member incurs charges for which benefits are payable under Medicare (including benefits that would be payable except for application of Medicare's deductible or coinsurance features), the benefits payable under this Plan for these charges will be reduced by the benefits payable under Medicare.

COORDINATION OF BENEFITS

Daily benefits are payable only for that portion of an expense which is not payable under:

- Any federal, state, or other governmental health care plan of law, except Medicaid.
- Any other plan which any employer contributes to or sponsors.
- Any occupational disease law.
- Any motor vehicle no-fault law.

Benefits will be reduced by the dollar amount paid by any of the above, to the extent that the combination of this Plan's benefit and the above exceeds 100% of the actual covered expenses.

LIFETIME MAXIMUM BENEFIT

No more than the lifetime maximum benefit for the option selected 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.

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,
- When you reach your lifetime maximum benefit; 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.

If the Long-Term Care Plan is terminated for all members, and is not replaced by a new plan within 31 days that has benefits which are substantially equivalent to those provided by this Plan and calculates premiums based on your age at the inception of coverage under this Plan, you may continue your coverage.

INDIVIDUAL CASE MANAGEMENT

If you have an illness 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.

GUARANTEED RENEWABLE

This Plan is guaranteed renewable. This means that you have the right to continue this coverage as long as you pay your premiums on time. Premiums may change on a class basis. Your coverage may not be cancelled or terminated on the grounds of your age or the deterioration of your mental or physical health.

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 during the initial open enrollment period, you were required to provide evidence of good health. Your approval for coverage under this Plan is based on your answers to questions on the application. If your answers are

incorrect or untrue or contain a material omission, the Plan has the right to deny benefits or rescind your 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 a dependent 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 Long-Term Care 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 dependents 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 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 that this Plan provides.

EVIDENCE OF NEED

The claims administrator may require any person who receives services under this Plan to 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 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.

Under this Plan, payments may be made, at the discretion of the claims administrator, 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 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

Long-term care coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that this 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 due to a rate change on a class basis. 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 dependent are confined in a facility, including home health care, while covered under a prior certificate or agreement and you or your dependent remains continuously confined past the date coverage begins under this Plan, the benefits of the prior certificate or agreement apply until you or your covered dependent 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 insurance 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.

TRANSFERS 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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