STATE OF ALASKA

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DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE

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BULLETIN 93-07

RE: REQUIRED OFFERS OF CERTAIN DENTAL, VISION, AND HEARING INSURANCE COVERAGE

HCS CSSB 404 (L & C), An Act Requiring An Offer Of Certain Dental, Vision, And Hearing Insurance Coverage, takes effect July 1, 1993. The act amends AS 21.42 by adding AS 21.42.385 -- Dental, Vision, and Hearing Coverage. An admitted insurer that wrote more than $300,000.00 in Alaskan premium in 1992 and that is authorized to offer, issue for delivery, deliver or renew an individual or group disability insurance policy for medical coverage on an expense-incurred basis in Alaska, or a hospital or a medical service corporation authorized to offer or renew a subscriber's contract in Alaska, is required to offer minimum dental, vision, and hearing coverage, either as a rider or in the form of a limited benefit policy, directly or under contract with another insurer or another hospital or medical service corporation. The offer, including the acceptance or rejection of the minimum dental, vision, and hearing coverage by each policyholder or subscriber, must be included in the records of the insurer or hospital or medical service corporation.

The minimum coverage required to be offered may not be less than the dental, vision, and hearing coverage provided on January 1, 1992 to persons entitled to medical benefits under AS 39.35.535 (Public Employees' Retirement System of Alaska). The Division of Retirement and Benefits in the Department of Administration has provided to the Division of Insurance a copy of the Dental-Vision-Audio Plan, a copy of which is attached to this bulletin. Any questions regarding the scope of the coverage should be directed to the Division of Retirement and Benefits.

AS 21.42.385(d) provides that in Medicare supplement policies the mandatory offer of dental, vision, and hearing coverage will be governed by applicable federal laws. Pursuant to such federal laws, the Division of Insurance adopted regulations regarding Disability Insurance Marketed As Medicare Supplements, see 3 AAC 28.410 and 510. The Omnibus Budget Reconciliation Act of 1990 (42 USE 1395ss) required establishment of ten standard plans for Medicare supplement insurance. To the extent that dental, vision, and hearing coverage is available under Medicare and covered under the ten basic Medicare supplement plans, the offer of any one the standard Medicare supplement plans will satisfy AS 21.42.385. Therefore, no separate or additional offer of dental, vision, and hearing coverage is required for Medicare supplement insurance.

Effective this 14th day of May, 1993.

Dave Walsh
Director of Insurance

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Enclosure

08-H1151

PART II:
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 correct booklet by contacting the Division of Retirement and Benefits.

The DVA carrier is Aetna Life Insurance Company, P.O. Box 21645, Seattle, Washington 98111.

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. If coverage is elected, the premiums are paid by deductions from the retiree's benefit warrant.

- Inlandboatmens' Union of the Pacific (IBU) members who retired from the State of Alaska under the provisions of the Northwest Marine Retirement Trust. If coverage is elected, the premiums are paid by personal check through the IBU, Alaska Region.

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 age 23 *only* if they are:

  — your natural children, stepchildren, foster children, 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.

HOW TO ELECT COVERAGE

You must elect this coverage within 60 days of the later of:

- the date you are appointed to receive benefits from one of the retirement systems; or

- the date you are notified of your appointment to receive benefits.

To meet this deadline, your DVA enrollment form (available from the Division of Retirement and Benefits) must be postmarked or received by the above deadlines. If you do not elect this coverage within these timeframes, you waive your right to elect this coverage at a later date.

Coverage may be elected in the following manner:

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

WHEN DVA COVERAGE STARTS

If you elect coverage in a timely manner, coverage will begin on the first of the month after the premium is first deducted from your benefit warrant.

In general, if you elect coverage before your appointment date, DVA coverage will start on the first of the month after your appointment date. For example, people who are appointed to receive benefits on June 1 and have completed a DVA enrollment form before June 15 would have premiums deducted from their first benefit warrant issued in late June. DVA coverage would then start on July 1.

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 warrant is insufficient to pay the monthly premium, you may pay the premium directly to the health carrier. Contact the Division of Retirement and Benefits for information.

Ineligible Retirees

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

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, or
- 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, or
- coverage is discontinued for all dependents.

There are several options available for continuing DVA coverage if one of the above situations occurs. Options are described in the "How To Continue Health Coverage" section on page 74.

CHANGING YOUR COVERAGE

You may decrease your 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 only increase your coverage when one of the following has occurred:

- Marriage; or
- Birth or adoption of your first child.

Your written request to increase coverage must be postmarked or received within 120 days of 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.

If your written request is postmarked or received by the Division of Retirement and Benefits on or before the fifteenth of the month, your change will be effective on the first of the following month. If your request is received after the fifteenth, your change may be delayed for an additional month. **Coverage changes may be effective only after receipt of your written request and will not be retroactive.**

DENTAL PLAN HIGHLIGHTS

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

COVERED DENTAL SERVICES

Maximum Allowance Per Year

The State's Dental Plan pays up to $1,500 for all covered dental services for each eligible person during the calendar year. You pay a $50 deductible per person for Class II and Class III services each calendar year.

Charges or fees in excess of the applicable percentage of the usual, customary and reasonable charge, as determined by the health carrier, are your responsibility. (See page 7 for a definition of usual, customary, and reasonable charges.)

Class I Services

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

- oral examinations;
- dental X-rays;
- topical fluoride application (painting the surface of the teeth with a fluoride solution); and
- prophylaxis, including cleaning, scaling and polishing.

Class II Services

Following the $50 deductible, the Dental Plan covers 80 percent of the usual, customary and reasonable charges for Class II 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); and
- periodontic services (treatment of the supporting tooth structures).

Class III Services

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

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

DENTAL SERVICES NOT COVERED

The Dental Plan does not provide benefits for:

- services for congenital deformities 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.

The health carrier 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 health carrier reserves the right to review your dental records, including X-rays, photographs and models. With respect to your dental services, the health carrier, at its expense, also has the right to request that you obtain an oral examination by a dentist of its choice.

Advance Claim Review

Before beginning treatment for which charges are expected to exceed $500, ask your dentist to file a description of the proposed course of treatment and expected charges with the health carrier. The health carrier 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 commences on the day the provider first renders the service to correct or treat s[illegible] 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 proof of loss for any claim, the health carrier, at its expense, has the right to require you to obtain an oral examination. You must furnish to the health carrier 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, alternate 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, 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.); and

- 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, in the provision of complete denture services, you and your dentist decide on personalized restorations or specialized techniques, as opposed to standard procedures, covered expenses are limited to appropriate charges for the standard procedures.); and
- 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.)

VISION PLAN HIGHLIGHTS

- Requires no deductible.
- Covers one complete eye examination, including a required refraction, during any calendar year.
- Pays 80 percent for two lenses during each calendar year.
- Pays 80 percent for one set of frames every two years.

COVERED VISION AND OPTICAL SERVICES

The Vision Plan pays 80 percent of the usual, customary and reasonable charges for covered expenses. Charges or fees in excess of the applicable percentage of the usual, customary and reasonable charge, as determined by the health carrier, are your responsibility. (See page 7 for the definition of usual, customary and reasonable charges.)

You pay no deductible under the Vision Plan. You are covered for:

- one complete eye examination, including a required refraction, by a legally qualified ophthalmologist or optometrist, during a calendar year;
- lenses, but not more than two during a calendar year;
- frames, but not more than one pair during any two consecutive calendar years.

- contact lenses necessary because of:

  — cataract surgery;

  — extreme visual acuity problems that cannot be corrected to at least 20/70 with spectacle lenses;

  The maximum lifetime amount payable for necessary contact lenses is $400.

- cosmetic contacts elected in lieu of glasses. These will be covered the same as any other single vision spectacle lenses. This means that you must pay the difference between the usual, customary and reasonable cost of normal lenses and contact lenses.

NOT COVERED VISION AND OPTICAL SERVICES

Benefits are not payable for:

- two pairs of glasses in lieu of bifocals;
- medical or surgical treatment of the eyes;
- vision care services or supplies covered under the Medical Plan;
- services or supplies provided under worker's compensation law or any law of similar purpose, whether benefits are payable for all or part of the charges;
- special procedures, such as orthoptics or vision training, or special supplies, such as nonprescription sunglasses and subnormal vision aids;
- antireflective coatings;

- eye examinations required as a condition of employment, under a labor agreement, or government law;
- replacement of lost, stolen, or broken lenses, if this benefit has been used in the current calendar year;
- replacement of lost, stolen, or broken frames if this benefit has been used in the current or prior calendar year;
- duplicate or spare eyeglasses, including lenses and frames; and,
- services or supplies received before coverage begins, including lenses and frames ordered as part of a prior examination.

AUDIO PLAN HIGHLIGHTS

- Pays 80 percent of the usual, customary and reasonable charges.
- Requires no deductibles.
- Allows a maximum benefit of $800 in a three-year period.

COVERED AUDIO SERVICES

The Audio Plan pays 80 percent of the usual, customary and reasonable charges for the covered expenses. Charges or fees in excess of the applicable percentage of the usual, customary and reasonable charge, as determined by the health carrier, are your responsibility. (See page 7 for the definition of usual, customary and reasonable charges.)

You pay no deductible under the Audio Plan. You receive coverage for:

- an otological (ear) examination by a physician or surgeon;
- an audiological (hearing) examination and evaluation by a certified or licensed audiologist, including a follow-up consultation;
- a hearing aid (monaural or binaural) prescribed as a result of the examination (This includes ear mold(s), hearing aid instrument, initial batteries, cords and other necessary supplementary equipment as well as warranty, and follow-up consultation within 30 days following delivery of the hearing aid.); and
- repairs, servicing or alteration of hearing aid equipment.

The maximum benefit for each person in a three-year period (current and two previous years) is $800. You must provide the health carrier with written certification from the examining physician. This certification should explain that you are suffering a hearing loss that may be lessened by the use of a hearing aid.

NOT COVERED AUDIO SERVICES

The Audio Plan does not pay for:

- replacement of a hearing aid, for any reason, more than once in a three-year period;
- batteries or other supplementary equipment other than those obtained upon purchase of the hearing aid;
- a hearing aid exceeding the specifications prescribed for correction of hearing loss; and
- expenses incurred after coverage ends, unless you order a hearing aid before the termination and receive it within 90 days of the end date.