Sec. 21.42.385. Dental, vision, and hearing coverage.

(a) Except for a fraternal benefit society, a health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan, including a Medicare supplement policy to the extent not prohibited by 42 U.S.C. 1395 (Social Security Act), shall offer to each plan sponsor or individual minimum dental, vision, and hearing coverage described in (b) of this section. Coverage required under this subsection may be offered as a rider or in a separate policy.

(b) The minimum coverage required under (a) of this section

(1) may be provided under contract with another health care insurer;

(2) may not be less than the dental, vision, and hearing coverage provided on July 1, 2009, to an individual entitled to medical benefits under AS 39.35.535 (public employees' retirement system of Alaska); and

(3) shall be adjusted by the director on July 1, 2012, and every three years thereafter to correspond to changes in coverage provided to individuals entitled to medical benefits under AS 39.35.535 .

(c) This section does not apply to a health care insurer that has written less than $300,000 in premiums in the previous calendar year. A health care insurer exempt under this subsection shall disclose the exemption when offering, issuing for delivery, delivering, or renewing a health care insurance plan or an excepted benefits contract, and shall advise the individual covered under the plan that health care insurers that have written more than $300,000 in premiums in the previous calendar year are required to offer coverage under (a) and (b) of this section.

(d) This section does not require an insurer who offers only group insurance coverage under AS 21.54 to offer dental, vision, and hearing coverage to an individual.

The following outlines the dental, vision, and hearing coverage provided as of July 1, 2012 to individual's entitled to medical benefits under AS 39.35.535:

Dental Benefits

Deductible	**Premium Plan**	**Standard Plan**	**Preventive Plan**
Annual Individual – Class I services	None	None	$25
Annual Individual—Class II and III (combined services	$25	$25	Not Covered
Orthodontia	$0	Not covered	Not Covered
Annual Family Maximum	$75	$75	$75

Coinsurance	**Premium Plan**	**Standard Plan**	**Preventive Plan**
Class I (preventive) Services	100%	100%	100%

Class II (restorative) services	85%	85%	Not Covered
Class III (prosthetic) services	75%	50%	Not Covered
Orthodontia	50%	Not Covered	Not Covered

Benefit Maximums	**Premium Plan**	**Standard Plan**	**Preventive Plan**
Annual Individual Maximum	$2,500	$1,500	$500
Orthodontia Individual Lifetime Maximum	$2,000	Not Covered	Not Covered

Vision Benefits

	Managed Care Plan	**Standard Plan**
Deductible	Exam $10 Lenses and Frames $25 combined	None
Exams	One every 12 months 100% at preferred provider	One per benefit year 90% covered
Lenses*	1 pair per 12 months	1 pair per benefit year
Frames	1 pair per 24 months $130 maximum retail allowance	1 pair every two benefit years $90 retail maximum per individual
Contacts	$105 in lieu of lenses/frames	$170 maximum
Annual Maximum	Not Applicable	$350/covered person

*includes coverage for Progressive lenses, Antireflective coating, Scratch resistant coating, and Polycarbonate lenses

Audio Benefits

Coinsurance	
All Services	80%
Benefit Maximum	
Individual Maximum/3 consecutive years	$800

DENTAL BENEFITS

DENTAL PLAN HIGHLIGHTS

- May select from three different plans; Preventive, Standard, or Premium.
- All plans cover 100% of the usual, customary, and reasonable charges for most preventive services (X-rays, exams, cleaning, etc.).

- Standard and Premium Plans cover most restorative (fillings, extractions, etc.) and prosthetic (crowns, dentures, etc.) services after the annual deductible is met.

- Premium Plan covers most orthodontic services after the annual deductible is met.

ABOUT THE DENTAL PLANS

There are three plans available; Preventive, Standard, and Premium. The plans cover different types of dental services and have different coinsurance amounts and deductibles.
Please refer to the Benefit Summary for details about how these items differ between the plans.

All plans cover you and your eligible dependents as described in those sections.

Benefit Year
The benefit year for all plans begins July 1 and ends June 30.
All benefits limited in a benefit year are reset on July 1 each year.

Usual, Customary, and Reasonable Charges (UCR)
Payment under all plans is based on usual, customary, and reasonable charges for covered services. Charges or fees in excess of the usual, customary, and reasonable charge level, as determined by the claims administrator, are your responsibility to pay.

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

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

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

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

COVERED DENTAL SERVICES

The Preventive Plan covers only Class I preventive services while the Standard and Premium Plans both cover Class I preventive, Class II restorative, and Class III prosthetic services. The Premium Plan covers orthodontic services. Following is a description of the services covered in each class.

Class I Preventive Services

Covered by all plans:

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

Class II Restorative Services

Covered by the Standard and Premium Plans:

- 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).
- Periodontic services (treatment of the supporting tooth structures), including periodontal prophylaxis.

Class III Prosthetic Services

Covered by the Standard and Premium Plans:

- Inlays and onlays.
- Crowns.
- Fixed and removable bridges, initial placement.
- Full and partial dentures, initial placement.

Orthodontic Services

The Premium Plan is the only plan that covers the orthodontic services for diagnosis and correction of a misalignment of the teeth, the bite or the jaw or jaw joint relationship. This includes:

- consultations and office visits;
- removable or fixed appliance therapy;
- ongoing active treatment including all active retention appliances.

Not included is any surgical procedure to correct malocclusion.

PREVENTIVE PLAN

Annual Maximum Benefit
The Preventive Plan pays up to the annual limit shown in the Benefits Summary for all covered dental services for each eligible person during the benefit year.

Deductible
You pay the annual deductible amount shown in the Benefit Summary for each person, up to a maximum family deductible amount.

Coinsurance
The Preventive Plan covers Class I preventive services at the coinsurance amount shown in the Benefit Summary of the usual, customary, and reasonable charges after the deductible.
Class II restorative, Class III prosthetic, and orthodontia services are not covered.

STANDARD PLAN

Annual Maximum Benefit
The Standard Plan pays up to the annual maximum shown in the Benefit Summary for all covered dental services for each eligible person during the benefit year.

Deductible
You pay the annual deductible shown in the Benefit Summary for each person for Class II and III services, combined. The maximum annual family deductible is shown in the Benefit Summary.

Coinsurance
The Standard Plan covers Class I preventive, Class II restorative, and Class III prosthetic services at the coinsurance amounts shown in the Benefit Summary for each eligible person.

PREMIUM PLAN

Annual Maximum Benefit
The Premium Plan pays up to the annual and lifetime maximum benefits shown in the Benefit Summary for each eligible person.

Deductible
You pay the annual deductible shown in the Benefit Summary for each person for Class II and III services combined. The maximum annual family deductible is shown in the Benefit Summary.

Coinsurance
The Premium Plan pays coinsurance amounts shown in the Benefit Summary for all services.

DENTAL SERVICES NOT COVERED

The Dental Plans do not provide benefits for:

- Services for congenital deformities (these are covered by the medical plan) or for purposes of improving personal appearance.
- Services that the dentist is not licensed to perform.
- Charges that are higher than would have been charged if there were no Dental plan.
- Services for dentures, bridges, crowns, or other devices started before the effective date of coverage.
- Charges made after your coverage ends, unless they are for prosthetic devices fitted and ordered while you were covered and arriving within 90 days of the date coverage ends.
- 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 except as specified under the Premium Plan.
- Services for straightening teeth or correcting bite (orthodontics) except tooth extractions necessary to proceed with orthodontic services or as specified under the Premium plan.
- 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.
- Special techniques or personalized restoration for the construction of a denture beyond the standard procedure charges.
- Myofunctional therapy including in-mouth appliances to correct or control harmful habits.

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

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

Advance Claim Review

Before beginning treatment for which charges are expected to exceed $1,000, ask your dentist to file a description of the proposed course of treatment and expected charges with the claims administrator. The claims administrator will then review the proposal and advise 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 such a condition. Emergency treatments, oral

examinations, cleanings, 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 claims administrator has the right to require you to obtain an oral examination at its expense. You must furnish to the claims administrator all diagnostic and evaluative material required to establish your right to benefits. Evaluative material includes dental X-rays, models, charts, and written reports.

In many cases, 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 or baked porcelain restorations, crowns, and jackets. If a tooth can be restored with amalgam or similar material and you and your dentist select another type of restoration, your benefits are limited to the appropriate charges for amalgam or similar material.
- Reconstruction. Covered expenses only include charges for procedures necessary to eliminate oral disease and replace missing teeth. Appliances or restorations to increase vertical dimension or restore the occlusion are considered optional and are not covered except under the Premium Plan.

Examples of alternative services or supplies for prosthodontic care are:

- Partial dentures. If cast chrome or acrylic partial dentures will restore a dental arch satisfactorily and you and your dentist choose a more elaborate precision appliance, covered expenses are limited to the appropriate charges for cast chrome or acrylic.
- Complete dentures. If you and your dentist decide on personalized restorations or specialized techniques, as opposed to standard dentures, covered expenses are limited to appropriate charges for the standard dentures.
- Replacement of existing dentures. Charges for 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

VISION PLAN HIGHLIGHTS

- May choose between two vision plans.
- Covers eye examination, lenses, and frames at specified intervals.
- Standard Plan allows use of any qualified provider.
- Managed Care Plan requires use of a member doctor to receive the best benefit.

ABOUT THE VISION PLANS

There are two plans available, Standard and Managed Care.
The plans cover the same services but at different time intervals and provide different reimbursements. The Managed Care Plan requires the use of a member doctor to receive the best benefit. Please refer to the Benefit Summary for details about how these items differ between the plans.

You choose which plan you want during the times described starting on page 7. All plans cover you and your eligible dependents as described in those sections.

STANDARD PLAN

The Standard Plan allows the use of any licensed optometrist or ophthalmologist. You do not have to receive certification for these services. Claims are filed to the claim administrator listed in the front of this booklet. Your provider may file for you or may require you to pay for the services and file for reimbursement.

Benefit Year
The benefit year for this plan begins July 1 and ends June 30.
All benefits limited in a benefit year are reset on July 1 each year.

Annual Maximum Benefit
The Standard Plan pays up to the annual maximum shown in the Benefit Summary for all covered vision services for each eligible person during the benefit year.

Deductible
You pay no deductible under this plan.

Coinsurance
The plan pays the coinsurance amount shown in the Benefit Summary of the usual, customary, and reasonable charges for vision and optical services.

Usual, Customary, and Reasonable Charges (UCR)

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

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

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

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

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

COVERED VISION AND OPTICAL SERVICES

The following services and supplies are covered:

- One complete vision examination including required refraction, by a legally qualified ophthalmologist or optometrist, each benefit year.
- Up to two single vision, bifocal, trifocal, or lenticular lenses per benefit year.
- One set of frames every two benefit years, up to the limit shown in the Benefit Summary.
- One pair of cosmetic contacts each benefit year, up to the annual limit shown in the Benefit Summary.
- One pair of contact lenses required following cataract surgery or because visual acuity is correctable to 20/70 or better only with the use of contact lenses.

MANAGED CARE VISION PLAN

The Managed Care Plan has a panel of member doctors who provide vision services and supplies. By using a member doctor, you obtain a better benefit than if you used a doctor who is not a member. If you see a nonmember doctor, you receive the benefits listed on page 16.

For a list of member doctors, call the Managed Care Plan administrator at the number listed in the front of this booklet or visit their web site. Select a doctor from the list and make an appointment. You must identify yourself as a Managed Care member when you make the appointment. The doctor will contact the claims administrator to determine what benefits you are eligible for.

When you have your appointment, you will be required to pay any deductibles and for any services or supplies that are not covered. The balance of the covered services and supplies will be billed directly to the claims administrator for you.

Benefit Year
The benefit year is based on your individual service date. You are eligible for services every 12 or 24 months, depending on the type of service. For example, if you receive services in October, you would not be eligible until the following October for services which have a 12-month renewal.

Deductibles
You pay the separate deductible amounts shown in the Benefit Summary for each examination and a $25 deductible for materials (lenses and frames).

Coinsurance
The plan pays 100% of the member doctor's charges for covered vision and optical services, after the deductible.

COVERED VISION AND OPTICAL SERVICES

The following services and supplies are covered:

- One complete vision examination including required refraction, by a legally-qualified ophthalmologist or optometrist, during any 12 consecutive months.
- Up to two single vision, bifocal, trifocal, or lenticular lenses during any 12 consecutive months.
- One pair of frames, up to the Managed Care Plan limit, during any 24 consecutive months.
- One pair of cosmetic contact lenses during any 12 months in lieu of the lens and frame benefit for that year, up to the limit shown in the Benefit Summary.
- One pair of contact lenses required because of:
    - ➢ cataract surgery;
    - ➢ extreme visual acuity problems not correctable with spectacle lenses;
    - ➢ certain conditions of anisometropia; or
    - ➢ keratoconus.

VISION AND OPTICAL SERVICES NOT COVERED

Benefits are not payable under either plan for the following services:

- Antireflective coatings.
- Tinting.
- Two pairs of glasses in lieu of bifocals.
- Nonprescription glasses or special purpose visual aids, even if prescribed.
- Prescription sunglasses or light-sensitive lenses in excess of the amount which would be covered for nontinted lenses.
- Medical or surgical treatment of the eyes.

- Eye examinations which a labor agreement requires the employer to provide, which are required as a condition of employment, or which are required by any government law.
- Replaced or duplicate lenses if this benefit has been utilized in the current benefit period, regardless of the reason.
- Replacement or duplicate frames if this benefit has been utilized in the current or prior benefit period, regardless of the reason.
- Charges for special procedures such as orthoptics or vision training.
- Services or supplies provided under other provisions of this plan.
- Services or supplies which are covered in whole or in part under any workers' compensation law or any other law of similar purpose.
- Services or supplies you received prior to becoming eligible for coverage, including lenses and frames ordered as part of a prior examination, even if you receive the lenses and frames after becoming eligible for this plan.

AUDIO PLAN

AUDIO PLAN HIGHLIGHTS

- Requires no deductible.
- Allows a maximum benefit of $800 in a three-year period.

HOW AUDIO BENEFITS ARE PAID

Benefit Year

The benefit year for this plan begins July 1 and ends June 30.
All benefits limited in a benefit year(s) are reset on July 1.

Maximum Benefit

The Audio plan pays up to the maximum benefit shown in the Benefit Summary for each person in a covered three-year period consisting of the current and two previous years.

Deductible

You pay no deductible under this plan.

Coinsurance

The plan pays the coinsurance amount shown in the Benefit Summary up to the usual, customary, and reasonable charges for audio services.

Usual, Customary, and Reasonable Charges (UCR)

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

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

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

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

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

COVERED AUDIO SERVICES

The following services are covered:

- 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 followup consultation within 30 days following delivery of the hearing aid.
- Repairs, servicing or alteration of hearing aid equipment.
- You must provide the claims administrator with written certification from the examining physician explaining that you are suffering a hearing loss that may be lessened by the use of a hearing aid.

AUDIO SERVICES NOT COVERED

The Audio plan does not pay for:

- Replacement of a hearing aid, for any reason, more than once in a three benefit 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.
- Expenses incurred after coverage ends, unless you order a hearing aid before the termination and receive it within 90 days of the end date.