AlaskaCare Retiree DB Insurance Information Booklet

Summary of Updates for Plan Year 2023

Contents

Legend	Items highlighted in green were added.	Items highlighted in orange were removed.

Clarified Provisions

1. Clarifies Section 1.2.1 Standard Benefit

	~~Supply Limit~~
~~Depo-Provera (injectable contraceptive)~~	~~5 vials per benefit year~~

2. Clarifies section 3. Medical Plan Highlights

- Requires that after the AlaskaCare deductible is met, the member is responsible for coinsurance of 20% until the $800 out-of-pocket maximum is met. ~~Pays 80% of first $4,000 in covered expenses for each person.~~ Then the plan pays 100% of ~~all~~ covered expenses for the remainder of the benefit year.
- Requires precertification from the claims administrator for all inpatient stays, ~~home health care~~, and other services and procedures as outlined in *section 3.2, Precertification*.

3. Clarifies section 3.3.11 Preventive Care and Screening Services

Covered expenses include the following:

- The rental of a **hospital**-grade electric pump for a newborn **child** when the newborn **child** is confined in a **hospital**.
- The purchase of:

An electric breast pump (non-hospital grade). A purchase will be covered once every 12 months ~~three years~~;

4. Clarifies section 4.2 Mail Order Program

The mail order copayment will apply to specialty medication obtained through the pharmacy benefit manager's specialty pharmacy~~, BriovaRx~~.

5. Clarifies section 4.3 Medicare Prescription Drug Plan

c) A United States citizen or lawfully present in the United States

There will be no interruption in coverage when a retiree or dependent becomes eligible for Medicare and is enrolled in the enhanced EGWP. However, you will be sent a new ID card that you should present to your pharmacy when purchasing your first prescription after receipt of the card ~~(but no earlier than January 1, 2019)~~.

6. Clarifies section 4.3.4 Premium Surcharge

Retirees with an income that exceeds an individual or household Monthly Gross Income Amount (MAGI) level set by Social Security, will be required by Medicare to pay an additional premium based on your income called the Part D Income Related Monthly Adjustment Amount (IRMAA). You will be notified of this requirement in the same way you are notified of your Medicare B IRMAA, through an annual letter sent by Social Security each November. ~~It is important you share a copy of this annual letter with the Division of Retirement and Benefits as soon as possible after receipt.~~ The MAGI and IRMAA surcharge amounts are set by Social Security and are subject to change annually.

~~Once the Division has the letter, a tax advantaged Health Reimbursement Arrangement (HRA) account will be established and prefunded by the Plan. You can access the HRA to be reimbursed monthly for the Part D IRMAA either by mail or through an electronic direct deposit into your bank account.~~

For all Medicare plans, the IRMAA will be deducted directly from your monthly Social Security check (if you qualify for Social Security) or will otherwise be invoiced to you directly each month. If you are charged a Medicare Part D IRMAA for your prescription drug coverage, the Division of Retirement and Benefits will reimburse you for the full cost of the Medicare Part D premium surcharge each month, through a tax-advantaged Health Reimbursement Arrangement (HRA) account. If you receive a bill from Medicare, you should pay the bill timely, and contact the Division to learn about your reimbursement options.
To receive reimbursement for the Part D IRMAA surcharge, you should submit the HRA claim as soon as possible, but not later than 12 months after the date you incurred the expenses.

7. Clarifies section 4.6 Medical Necessity

To be covered under the plan, prescription drugs must be medically necessary and clinically appropriate. Determination of medical necessity will be based on recommendations by the federal Food and Drug Administration (FDA), combined with the pharmacy benefit manager's standard coverage policies designed to ensure the medication prescribed is safe and effective. ~~This provision does not require the use of generic drugs~~.

The plan will cover some drugs only if prescribed for certain uses, or durations. Certain medications have specific dispensing limitations for quantity, age, gender and maximum dose. ~~Determination of medical necessity will be based on recommendations by the federal Food and Drug Administration (FDA), combined with the pharmacy benefit manager's standard coverage policies designed to ensure the medication prescribed is safe and effective~~. For this reason, some prescription medications may be subject to prior authorization to determine that the requested prescription drug is medically necessary. The prior authorization ensures you are getting the most appropriate care and will occur in the best setting. This helps produce improved health outcomes and lower health care costs by reducing duplication, waste, and unnecessary treatments.

This provision does not require the use of generic drugs.

8. Clarifies section 4.7 Definitions

Prescription drugs are medical substances that, in accordance with 20 U.S.C. § 353(b)(1) and (4)(A), must bear a label that states, "Rx only." The drug or active ingredient must be assigned a valid unique National Drug Code (NDC) identifier number by the FDA to be considered for coverage. If a prescription drug is prescribed and obtained outside of the United States and the drug or active ingredient does not have an NDC identifier number, it must have the same active ingredient as a drug with a valid NDC identifier number to be considered for coverage. ~~which must bear a label that states, "Caution: Federal law prohibits dispensing without a prescription."~~ Coverage includes prescription drugs, prescribed by a provider that may have an over-the-counter (OTC) equivalent, or covered medical foods that bear the same label. The plan may cover prescription compounds that contain a bioidentical hormone, an active ingredient that is a bulk chemical powder which is not an FDA approved medication, and thyroid compounds containing a bulk chemical active ingredient.

Active ingredients are the chemical component(s) responsible for a drug's intended therapeutic effect.

9. Clarifies section 4.8 Pharmacy Exclusions

j) Cosmetic drugs, medications or preparations used for cosmetic purposes or to promote hair growth

k) Drugs with active ingredients that do not have a valid NDC identifier number, or drugs prescribed and obtained outside the United States that do not have the same active ingredient as a drug with a valid NDC identifier number.

l) Products that meet all the following criteria are considered medical treatments and are not covered through the prescription drug benefit:

- designated as an orphan drug or exhibits Gene Therapy technology; and
- annual drug cost is over $500,000; and
- is not self-administered; and
- the first dose may be administered in an inpatient setting.

Products meeting the above criteria that appear on the Medicare Part D formulary (list of covered drugs) may still be eligible for coverage under the AlaskaCare EGWP benefit.

10. Clarifies section 7.2.1 Who May Be Covered and Premium Payment

b) People receiving a benefit from the Marine Engineers Beneficial Association (MEBA) who retired from the State of Alaska after July 1, 1983. If coverage is elected, the DVA premiums are paid to the plan on a monthly basis through the direct bill administrator ~~PayFlex~~.

11. Clarifies section 7.3 How to Elect Coverage

If you elect dental-vision-audio coverage you must apply for that coverage on a form provided by the Division of Retirement and Benefits. The submittal date on the form will be ~~of~~ the date of the postmark of the application, or if the postmark is illegible or the application does not bear a dated postmark, the postmark is rebuttably presumed to be five working days before the date the application is received by the Division of Retirement and Benefits.

A benefit recipient with multiple retirement accounts may elect dental-vision-audio insurance under each retirement account. If a benefit recipient elects coverage under multiple retirement accounts, different coverage tiers may be elected for each separate account so long as the same plan option (Standard or Legacy) is elected for all accounts.

12. Clarifies section 7.4.4 Dependents

If you increase your coverage to include dependents following a qualifying life event or a qualified change in family structure, their coverage begins on the first of the month following receipt of your written request, assuming the level of coverage you elect covers the new dependent.

To enroll your eligible dependent(s), you must complete and return the Retiree Health Dependent Change form to the Division within 120 days of the qualifying event.

13. Clarifies section 7.6 Changing Your DVA Coverage

Your written request to increase coverage must be postmarked or received within 120 days after the date one of the above events occurs. You should state the level of coverage you would like, the reason for the change, and the date the event occurred. Coverage will be effective the date of the qualified event and the Division will collect past due premiums, if applicable. Coverage will be effective the date of the qualified event and the

Division will collect past due premiums, if applicable.
~~Changes in coverage based on an application that is postmarked or received on or before the 15th of a month are effective on the first of the month following the receipt of your written request. A change in coverage based on an application that is postmarked or received after the 15th of a month, will be effective no later than the first day of the second month after the date of postmark or receipt of the application. The division will make retroactive adjustments to premiums if necessary.~~

14. Clarifies section 8.1.3 Deductible

Each covered person must meet the annual individual deductible before the dental plan begins to pay benefits for that covered person. The deductible is waived for Class I preventive services. You pay a $50 deductible per person for Class II restorative and Class III prosthetic services each benefit year.

Updates to Support Retiree Health Plan Advisory Board *Resolution 2022-02*

15. Updates section 3.2 Precertification

You do not need to pre-certify services if the plan is secondary to coverage you have from another health plan, including Medicare. If you receive a service that is not covered by your other health plan coverage and your AlaskaCare coverage will be paying as primary, you or your provider need to obtain any necessary pre-certification.

16. Updates section 3.2.1 The Precertification Process

You are responsible for requesting pre-certification for eligible travel expenses. See *Section 3.3.18 Travel*. Your provider (both network and out-of-network) is not responsible for requesting pre-certification for any eligible travel expenses.

17. Updates 3.2.2 Services Requiring Pre-certification

Precertification is handled by the medical claims administrator and the list of services requiring precertification can be located at: *https://www.aetna.com/health-care-professionals/precertification/precertification-lists.html*.

All in-patient hospital, rehabilitation facility, and skilled nursing facility admissions require precertification. Certain outpatient surgery and other outpatient services may also require precertification.

In addition to the medical services listed on the medical claims administrator's website, travel expenses must be precertified. You are responsible for requesting pre-certification for eligible travel expenses. See *Section 3.3.18 Travel*.

The following list identifies ~~those~~ some, but not all, of the medical services and supplies requiring precertification under the medical plan. ~~Language set forth in parenthesis in the precertification list is provided for descriptive purposes only and does not serve as a limitation on when precertification is required.~~ Services requiring precertification are subject to change. Refer to the website listed above for the full and most current list.

Precertification is required for the following types of medical expenses:

- Stays in a hospital
- Stays in a skilled nursing facility
- Stays in a rehabilitation facility
- ~~Stays in a hospice facility~~
- ~~Outpatient hospice care~~
- ~~Home health care~~
- Private duty nursing care
- Transportation ~~(non-emergent)~~ by fixed wing aircraft (plane)
- ~~Transportation (non-emergent) by ground ambulance~~
- ~~Applied Behavioral Analysis (early intensive behavioral intervention for children with pervasive developmental delays)~~
- Arthroscopic hip surgery to repair impingement syndrome including labral repair
- Autologous chondrocyte implantation, Carticel (injection into the knee of cartilage cells grown from tissue cultures)
- Chiari malformation decompression surgery
- Cochlear implant (surgical implant of a device into the ear to try to improve hearing)
- ~~Cognitive skills development~~
- ~~Customized braces (physical – i.e., non-orthodontic braces)~~
- Dental implants and oral appliances
- Dialysis visits
- Dorsal column (lumbar) neurostimulators: trial or implantation (for relief of severe pain)
- Electric or motorized wheelchairs and scooters
- ~~Gastrointestinal tract imaging through capsule endoscopy~~
- Endoscopic nasal balloon dilation procedures
- Functional endoscopic sinus surgery (FESS)
- Gender affirmation surgery
- Hyperbaric oxygen therapy
- Infertility services and pre-implantation genetic testing
- Limb prosthetics
- Nonparticipating freestanding ambulatory surgical facility services, when referred by a participating provider
- ~~Oncotype DX (a method for testing for genes that are in cancer cells)~~
- Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (reconstructive surgeries to attempt to correct structural abnormalities of the jaw bones)
- Organ transplants
- Osseointegrated implants
- Osteochondral allograft/knee (grafting of cartilage and bone from a cadaver to the knee joint)
- Proton beam radiotherapy
- Reconstructive~~on~~ or other procedures that may be considered cosmetic
- Shoulder arthroplasty including revision procedures
- Surgical spinal procedures
- Uvulopalatopharyngoplasty, including laser-assisted procedures (surgery to reconfigure the soft palate to try to help with sleep apnea)

- Ventricular assist devices
- ~~Travel~~
- Use of an out-of-network provider for preventive care services.
- Whole exome sequencing

18. Updates section 3.2.3 How Failure to Pre-certify Affects Your Benefits

~~A precertification benefit reduction will be applied to the benefits paid~~ If you fail to obtain a required precertification prior to incurring medical expenses from an out-of-network provider, ~~This means that Aetna will reduce the amount paid towards your coverage, or~~ your expenses may not be covered. You will be responsible for ~~the unpaid balance of the bills~~ all expenses that are not covered.

You are responsible for obtaining the necessary precertification from the medical claims administrator ~~Aetna~~ prior to receiving services from an out-of-network provider. Your provider may pre-certify your treatment for you; however, you should verify with Aetna prior to the procedure that the provider has obtained precertification from the medical claims administrator ~~Aetna~~. ~~If your treatment is not pre-certified by you or your provider, the benefit payable will be reduced as follows:~~

~~Except as otherwise provided below, Aetna will apply a $400 benefit reduction for failure to obtain precertification for the medical services listed in *section 3.2.2, Services Requiring Precertification*.~~

~~If precertification of inpatient treatment for a mental disorder was not requested, your coinsurance for mental disorder benefits will be 50%.~~

If precertification of travel expenses was not requested, ~~no travel benefits will be paid.~~ maximum reimbursement for travel expenses will be limited to $500 per round trip travel claim, not to exceed eligible travel costs.

19. Updates section 3.3.5 Hospitalization

Important: Precertification is required for all hospital stays. (This requirement is waived if the patient is covered by another health plan that pays primary to AlaskaCare, including Medicare.) If precertification is not obtained, your expenses may not be covered. ~~A $400 penalty will be assessed before any benefits may be paid.~~ Please refer to *section 3.2, Pre-certification* for additional information.

20. Updates section 3.3.6 Home Health Care

~~Important: Precertification is required before any home health care is received. (This requirement is waived if the patient is covered by Medicare.) If precertification is not obtained, a $400 penalty will be assessed before any benefits may be paid. Please refer to *section 3.2, Precertification* for additional information.~~

21. Updates section 3.3.7 Hospice Services

~~Important: Precertification is required before any hospice service is received. (This requirement is waived if the patient is covered by Medicare.) If precertification is not obtained, a $400 penalty will be assessed before any benefits may be paid. Please refer to *section 3.2, Pre-certification* for additional information~~.

22. Updates section 3.3.8 Skilled Nursing Care

Important: Precertification is required before any skilled nursing care is received. (This requirement is waived if

the patient is covered by another health plan that pays primary to AlaskaCare, including Medicare.) If precertification is not obtained, your expenses may not be covered ~~a $400 penalty will be assessed before any benefits may be paid~~. Please refer to *section 3.2, Pre-certification* for additional information.

23. Updates section 3.3.9 Skilled Nursing Facility

Important: Precertification is required before any skilled nursing facility care is received. (This requirement is waived if the patient is covered by another health plan that pays primary to AlaskaCare, including Medicare.) If precertification is not obtained, your expenses may not be covered ~~a $400 penalty will be assessed before any benefits may be paid~~. Please refer to *section 3.2, Pre-certification* for additional information.

24. Updates section 3.3.18 Travel

Travel must be pre-certified to receive reimbursement under the Medical Plan. Contact the claims administrator for pre-certification before you or your dependent travel.

You are responsible for pre-certifying your travel expenses. If precertification of travel expenses was not requested, maximum reimbursement for travel expenses will be limited to $500 per round trip travel claim, not to exceed eligible travel costs.

25. Updates section 3.3.19 Mental Disorder, Habilitative Therapy, and Chemical Dependency Treatment

Important: Precertification is required for all treatment ~~listed~~ detailed in *section 3.2.2, Services Requiring Pre-certification* ~~in order to receive maximum Plan benefits.~~ If precertification is not obtained for these services, your expenses may not be covered ~~benefits will be reduced~~. Please refer to *section 3.2, Pre-certification* for additional information.

Mental Disorders

~~Provider services that are pre-certified in accordance with *section 3.2.2, Services Requiring Pre-certification*, are covered at normal plan benefits following the deductible. Provider services received without precertification are covered at normal plan benefit after a $400 penalty and the deductible.~~

~~Inpatient treatment that is pre-certified, excluding provider services which are described above, is covered at normal plan benefits. Inpatient treatment received without precertification is paid at 50% after the deductible~~.

Chemical Dependency

Treatment of chemical dependency is paid at normal Plan benefits following the deductible. If treatment is received without precertification as ~~outlined~~ detailed in section *3.2.2, Services Requiring Pre-certification*, your expenses may not be covered ~~the first $400 of inpatient treatment expenses and outpatient treatment expenses will not be covered.~~

~~Benefits for chemical dependency treatment received are limited to the maximums shown in the Benefit Summary.~~

~~These amounts are subject to change. Please check with the claims administrator or the Division for the most current maximum~~.

~~Treatment of medical complications of chemical dependency does not count towards the maximum~~.

26. Updates section 3.3.24 Transplant Services

Important: Precertification is required before any transplant services are received. (This requirement is waived if the patient is covered by another health plan that pays primary to AlaskaCare, including Medicare.) If precertification is not obtained, your expenses may not be covered ~~a $400 penalty will be assessed before any benefits may be paid~~.

New Section to Support Retiree Health Plan Advisory Board *Resolution 2022-01*

27. Adds section 3.3.26 Gene-Based, Cellular, and other Innovative Therapies (GCIT)

GCIT services help patients who have been diagnosed with certain genetic conditions that may be treated with the use of innovative FDA-approved GCIT products. GCIT services include cellular immunotherapy, genetically modified viral therapy, and cell and tissue therapy.

GCIT Designated Network Program

The medical claims administrator's GCIT Designated Network program provides benefits for specific GCIT services at GCIT-designated facilities as well as additional care coordination and support from a clinical team with specific GCIT experience. The medical claims administrator's GCIT Designated Network program's covered services include charges incurred for certain GCIT services and supplies provided by GCIT-designated facilities and providers and travel and lodging expenses as specified below.

GCIT therapies covered by the medical claims administrator's GCIT Designated Network program include, but are not limited to, the following:

- Zolgensma
- Spinraza
- Luxturna

For the current list of services included in the medical claims administrator's GCIT Designated Network program, call the number on the back of your insurance ID card.

The medical claims administrator's GCIT Designated Network program's covered services also include:

- Travel and lodging expenses
  - If you receive care at a GCIT-designated facility that is 100 or more miles away from where you live, travel and lodging expenses are covered services for you and a companion, for travel between home and the GCIT facility.
  - Expenses incurred by the patient and one adult companion for lodging is reimbursed at a rate of $50 per night per person ($100 per night total). The total travel and lodging benefit payable will not exceed $10,000 per episode of care.

The cost of GCIT products obtained through the medical claims administrator's GCIT Designated Network program do not accrue towards the plan's lifetime maximum. All other associated expenses, such as any inpatient charges or travel expenses are subject to all plan provisions.

Other GCIT Services

Some GCIT services are not included in the medical claims administrator's GCIT Designated Network program. These services will be covered according to the plan's provisions.

GCIT products that appear on the Medicare Part D formulary (list of covered drugs) may still be eligible for coverage under the AlaskaCare EGWP benefit.

Limitations

Any GCIT services included in the medical claims administrator's GCIT Designated Network program are only covered when received from a GCIT Designated Network service provider.