AlaskaCare Retiree Defined Benefit Insurance Information Booklet

Summary of Updates for Plan Year 2024

Contents

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

Updates to Support the change in Lifetime Maximum

1. Updates section 1.1 Medical Benefits

Benefit Maximums	
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum. • Gene-based, Cellular, and other Innovative Therapies (GCIT) products obtained through the medical claims administrator's GCIT Designated Network program do not apply against the lifetime maximum.	~~$2,000,000~~ $8,000,000

2. Updates section 3. Medical Plan

MEDICAL PLAN HIGHLIGHTS

- Requires an annual deductible of $150 per person, with a maximum of three deductibles per family per year.
- 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. 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 and other services and procedures as outlined in *section 3.2, Precertification*.
- Lifetime maximum benefit is ~~$2,000,000~~ $8,000,000 per person.

3. Updates section 3.1.5 Lifetime Maximum

The maximum lifetime benefit for each person for all covered medical expenses is ~~$2,000,000~~ $8,000,000.

~~At the end of each benefit year, up to $5,000 of medical benefits used is automatically restored regardless of your physical condition. If you have received more than $5,000 of covered medical benefits, your full annual spent maximum may be restored when you submit proof of good health satisfactory to the claims administrator within the following year. This provision will not provide benefits for covered expenses incurred before the date the maximum is restored.~~

~~EXAMPLE~~

~~Assume you have used $3,000 of medical benefits during the year and your lifetime benefit is decreased to $925,000. At the end of the year, the $3,000 would be restored and your maximum lifetime benefit available would be $928,000. If you had used $6,000 of medical benefits, your maximum lifetime benefit would be reset to $930,000, unless you submitted proof of your good health and were approved for a full reinstatement.~~

Updates to Support the End of COVID-19 Public Health Emergency

4. Removes section 3.3.25 COVID-19 Testing and Vaccinations

~~COVID-19 Testing~~

~~The medical plan will cover medically necessary, FDA approved COVID-19 testing at 100%, subject to recognized charge.~~

~~COVID-19 Vaccinations~~

~~The medical plan will cover FDA approved COVID-19 vaccinations at 100%, subject to recognized charge through the end of the COVID-19 national public health emergency.~~

~~The medical plan will cover medically necessary, FDA approved COVID-19 vaccinations per *section 4.4 Covered Vaccines* once the COVID-19 national public health emergency ends.~~

~~(See *section 4.4, Covered Vaccines).*~~

Clarified Provisions

5. Clarifies Section 2.2.2 Dependents

The following dependents may be covered:

a) Your spouse. You may be legally separated but not divorced.

b) Grandfathered same-sex partners as defined and documented by 2 AAC 38.010 – 2 AAC 38.100.

c) Your children from birth ~~(exclusive of hospital nursery charges at birth and well-baby care)~~ up to 23 years of age only if they are:

6. Clarifies Section 2.3 How to Elect Coverage

An alternate payee who elects coverage, must apply on a form provided by the Division of Retirement and Benefits within 60 days after the first monthly benefit paid under a qualified domestic relations order is mailed or otherwise delivered to the alternate payee. Failure to ~~make timely application~~ submit your application timely will result in the loss of all rights to apply for or obtain medical coverage under the Plan.

7. Clarifies Section 2.3.1 Changing Your Dependent Coverage

For all benefit recipients, if you want to increase coverage due to marriage or birth or adoption of your child, your written request to increase coverage must be postmarked or received within 120 days of the date of the event. Your request must include the level of coverage you would like, the new dependents to be covered, the reason for the change, and the date the event occurred.

~~Changes in coverage are effective on the first day of the month following the receipt of your written request.~~ Changes in coverage are effective ~~only after the receipt of your written request and are not retroactive.~~ retroactive to the date of the qualifying event if received within 120 days of the event.

8. Clarifies Section 2.5.4 Discontinuation of Coverage

If you are required to pay a premium for coverage, you may discontinue your participation in coverage at any time by submitting a signed, written request to the Division of Retirement and Benefits. Your

premium deductions will be stopped, and your coverage will end on the last day of the month the written request to discontinue coverage was received or postmarked. If you are a benefit recipient under a Qualified Domestic Relations Order (alternate payee) and ~~if~~ you discontinue participation, you waive all rights to future coverage, and you are not eligible to re-enroll.

9. Clarifies Section 3.2.2 Services Requiring Precertification

Precertification is required for the following types of medical expenses:

- ~~Infertility services and pre-implantation genetic testing~~

10. Updated Section 4. Prescription Drugs, 1.2 Prescription Drugs and 12.7 Prescription Drugs

The word ~~mail order~~ was changed to home delivery.

11. Clarifies Section 4.2 Home Delivery Program

If you take maintenance medication, you can take advantage of this optional program. The home delivery pharmacy provider is listed in the front of this booklet.

There is no cost to you for drugs filled through the home delivery program. The program bills the ~~medical~~ plan for the full cost.

12. Clarifies Section 5.1 Limitations and Exclusions

~~Sterilization or reversal of a sterilization procedure.~~ Tubal ligation and procedures, services and supplies to reverse voluntary sterilization.

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. 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. ~~Coverage will be effective the date of the qualified event and the Division will collect past due premiums, if applicable~~.

14. Clarifies Section 11.3 Audio Services Not Covered (formatting correction)

h) Charges in connection with an occupational injury or illness.

~~i)~~ An occupational injury or illness is one that arises out of or in the course of any work for pay or profit, or in any way results from any injury or illness which does. However, if proof is furnished that an individual is covered under workers 'compensation or similar law but is not covered for a particular illness under that law, that illness will not be considered occupational regardless of cause.

15. Clarifies Section 12.14.2 Initial Claim for Health Plan Benefits

If you fail to follow the claims procedures under the health plan for filing an urgent care claim or a pre-service claim, you will be notified ~~orally (unless you request written notice)~~ of the proper procedures to follow, not later than 24 hours for urgent care claims and five days for pre-service claims.