AlaskaCare Retiree Defined Benefit Insurance Information Booklet

Summary of Updates for Plan Year 2027

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

Update to Support the Addition of Licensed Massage Therapists as Recognized Providers

1. Update section 3.3.3 Provider Services

The Medical Plan pays for covered medical treatment and surgery performed by a qualified provider. Providers who are covered by the plan are people licensed to practice:

a) Medicine and surgery (M.D.)

b) Osteopathy and surgery (D.O.)

c) Dentistry (D.D.S. or D.M.D.)

Also covered are:

- Acupuncturists
- Audiologists
- Chiropractors
- Christian Science Practitioners authorized by the Mother Church, First Church of Christ Scientist, Boston, Massachusetts
- Licensed clinical social workers
- Licensed family and marital therapists
- Licensed massage therapists
- Naturopaths
- Nurse practitioners
- Occupational therapists
- Ophthalmologists
- Optometrists
- Physical therapists
- Physician's assistants
- Podiatrists
- Practitioners with a master's degree in psychology or social work if supervised by a psychologist, medical doctor, or licensed clinical social worker
- Psychological associates
- Psychologists
- State-certified nurse midwives or registered midwives

All providers must be licensed by the state in which they practice and practicing within the scope of their license.

Clarified Provisions

2. Additional Notification of the Effect of Medicare

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*.
- Requires the plan to become supplemental to Medicare once you or your dependents reach age 65. Please refer to *section 3.1.7, Effects of Medicare* for additional information.
- Lifetime maximum benefit is $8,000,000 per person.

3. Clarify Section 3.1.7 Effect of Medicare

You or your eligible dependent ~~must~~ are expected to elect Medicare Part A and B at age 65, regardless of any other coverage you have. If you or your eligible dependent is eligible for Medicare coverage (and most people are eligible at age 65), the benefits available under this Plan become supplemental to ~~your~~ Medicare ~~coverage~~. The claims administrator will assume you and/or your dependents have coverage under Medicare Part A and B when you or your dependent reach age 65. If you are not provided with Medicare Part A free of charge, you should submit a copy of your Notice of Award letter from Social Security ~~Medicare~~ stating that you are not eligible to the Division. **Everyone is eligible for Medicare Part B.**

4. Clarify Travel Limitations

Section 1.1 MEDICAL BENEFITS

Travel Limitations	
Non-overnight stay traveling expenses – enroute via ground transportation	$31/day
Overnight lodging – enroute via ground transportation	$80/night

Overnight lodging (Transplants and Gene-Based, Cellular, and other Innovative Therapies (GCIT))	$50/person/night $100/night maximum
Companion expenses	$31/night

5. Section 3.3.19 Travel

The Medical Plan pays ambulance costs world-wide and travel costs within the contiguous ~~limits of the~~ United States, Alaska, and Hawaii. This includes:

a) Transportation to the nearest hospital by professional ambulance. A professional ambulance is a land or air vehicle specially equipped to transport injured or sick people to a destination capable of caring for them upon arrival. Specially equipped means the vehicle contains the appropriate stretcher, oxygen, and other medical equipment necessary for patient care enroute. A medical technician trained in lifesaving services accompanies the transported patient. Following an emergent event, if the ambulance service provided occurred within the contiguous ~~limits of the~~ United States, Alaska, and Hawaii, return transportation costs to the site of illness or injury are eligible for reimbursement subject to the provisions as outlined in section b.

6. Section 3.3.25 Transplant Services

Network Level of Benefits

The network level of benefits is paid only for a treatment received at a facility designated by the medical plan as an Institute of Excellence™ (IOE) for the type of transplant being performed. Each IOE facility has been selected to perform only certain types of transplants. Services obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as out-of-network services and supplies, even if the facility is a network provider or IOE for other types of services.

The medical plan covers:

a) Charges made by a physician or transplant team.

b) Charges made by a hospital, outpatient facility or physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another health plan or program.

c) Related supplies and services provided by the facility during the transplant process. These services and supplies may include physical, speech and occupational therapy; bio- medicals and immunosuppressants; and home health care expenses and home infusion services.

d) Charges for activating the donor search process with national registries.

e) Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an “immediate” family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.

f) Inpatient and outpatient expenses directly related to a transplant.

The medical claims administrator's Transplant IOE program's covered services also include:

- Travel and lodging expenses
    - If you receive care at a Transplant-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 Transplant 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.

7. Clarify section 3.3.27 Supplemental Surgery and Travel Covered Expenses

Covered expenses include travel and charges incurred during a covered Episode of Care with a Lantern surgeon and facility. Services received outside an Episode of Care or with a surgeon or facility outside the Lantern network will be subject to coverage under other provisions of the medical plan.

Services covered under this section are paid at 100%. Lantern negotiates all costs before you have surgery, then coordinates the payment for you.

Lantern travel benefits may not be used in conjunction with other AlaskaCare travel benefits provided in *section 3.3.19, Travel* and *section 3.3.25, Transplant Services*.

NOTE: The travel benefit available through Lantern, is only available through the Retiree Plan members' primary AlaskaCare health plan; it does not coordinate with additional AlaskaCare or other health plans. The travel benefit available through Lantern is limited to travel within the contiguous United States, Alaska, and Hawaii.