Retiree Health Plan Advisory Board
Modernization Subcommittee Meeting Agenda

Date:	Monday April 11, 2022
Time:	01:00 pm – 03:00 pm
Location:	Video Tele-Conference & Atwood 19th Floor Conference Room
Teleconference:	855-244-8681 ID: 2464 379 9868 Pswd: 94972364 Join meeting
Committee Members:	Cammy Taylor, Nanette Thompson, Mauri Long

01:00 pm **Call to Order – Cammy Taylor, Modernization Subcommittee Chair**

- Roll Call and Introductions
- Approval of Agenda
- Ethics Disclosure

01:10 pm **Working Session**

- Establishing scope, process, and timing of review – AlaskaCare Retiree Health Plan's provisions regarding:
    a. coverage for experimental & investigational services and supplies;
    b. the precertification process; and
    c. travel penalty.

03:00 pm **Adjourn**

5 MEDICAL EXPENSES NOT COVERED

5.1 LIMITATIONS AND EXCLUSIONS

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The following is a list of services and supplies that are **not covered** and are not included when determining benefits:

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- Services or supplies that are, as determined by the claims administrator, experimental or investigational. A drug, device, procedure, or treatment **will** be determined to be experimental or investigational if:
    - There is insufficient data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;
    - Approval, as required by the FDA, has not been granted for marketing;
    - A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or
    - The written protocols or informed consent used by the treating facility or any other facility studying substantially the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

However, this exclusion **will not apply** to charges made for experimental or investigational drugs, devices, treatments or procedures, provided that all of the following conditions are met:

- You have been diagnosed with cancer or you are terminally ill
- Standard therapies have not been effective or are inappropriate
- The claims administrator or pharmacy benefit manager determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment
- There is an ongoing clinical trial. You are enrolled in a clinical trial that meets these criteria:
    - The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or group c/ treatment IND status
    - The clinical trial has passed independent scientific scrutiny and has been approved by an institutional review board that will oversee the investigation

- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food and Drug Administration or the Department of Defense) and conforms to the NCI standards
- The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI designated cancer center
- You are treated in accordance with protocol.

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1.1 MEDICAL BENEFITS

Deductibles	
Annual individual deductible	$150
Annual family unit deductible	3 per family
Coinsurance	
Most medical expenses	80%
Most medical expenses after out-of-pocket limit is satisfied	100%
Second surgical opinions • No deductible applies	100%
Preoperative testing • No deductible applies	100%
Outpatient testing/surgery • No deductible applies	100%
Skilled nursing facility	100%
In-patient mental disorder treatment without precertification	50%
Transplant services at an Institute of Excellence™ (IOE) facility	80%
Transplant services at a non-Institute of Excellence™ (IOE) facility or when out-of-network provider is used	60%
Preventive care with a **network provider** or when use of an out-of-**network provider** is precertified. No deductible applies	100%
Preventive care with an out-of-**network provider** • The deductible applies	80%

Out-of-Pocket Limit	
Annual individual out-of-pocket limit • Applies after the deductible is satisfied • Expenses paid at a coinsurance rate different than 80% do not apply against the out-of-pocket limit • Preventive care expenses from an out-of-**network provider** do not apply against the out-of-pocket-limit (unless use of an out-of-**network provider** is **precertified**)	$800
Benefit Maximums	
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	$2,000,000
Individual limit per benefit year on substance abuse treatment without precertification. *Subject to change every three years.*	$12,715
Individual lifetime maximum on substance abuse treatment without precertification. *Subject to change every three years.*	$25,430
Limit on travel for transplant services	$10,000 per transplant occurrence
Travel benefits without precertification	No benefits will be paid

Visit Limits	
Home health care	120 visits per benefit year Up to 4 hours = 1 visit
Outpatient hospice expenses	Up to 8 hours per day
Cognitive therapy, physical therapy, occupational therapy, and speech therapy rehabilitation benefits	No more than 2 hours of combined therapy in a 24-hour period
Travel Benefits: Therapeutic treatments	One visit and one follow-up per benefit year

Travel Benefits: • Prenatal/postnatal maternity care • Maternity delivery • Presurgical or postsurgical • Surgical procedures	One visit per benefit year
Travel Limitations	
Non-overnight stay traveling expenses	$31/day
Overnight lodging	$80/night
Overnight lodging (Transplants)	$50/person/night $100/night maximum
Companion expenses	$31/night
Precertification Penalties	
A $400 benefit reduction applies if you fail to obtain precertification for certain medical services.	

3.2 PRECERTIFICATION

Certain services, such as inpatient stays, certain tests and procedures, and outpatient surgery require precertification. Precertification is a process that helps you and your physician determine whether the services being recommended are covered expenses under the plan. It also allows Aetna to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

You do not need to pre-certify services if the plan is secondary to coverage you have from another health plan, including Medicare.

You do not need to pre-certify services provided by a network provider. Network providers will be responsible for obtaining the necessary precertification for you. Since precertification is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a network provider's failure to pre-certify services.

When you receive services from an out-of-network provider, you are responsible for obtaining the necessary precertification from Aetna for any services or supplies that require precertification as described under *section 3.2.2, Services Requiring Precertification*. If you do not pre-certify, your benefits may be reduced, or the medical plan may not pay any benefits.

You may request precertification of use of an out-of-network provider for eligible preventive services if there are no network provider options in your area.

3.2.1 The Precertification Process

Prior to being hospitalized or receiving certain other medical services or supplies, there are certain precertification procedures that must be followed.

You or a member of your family, a hospital staff member, or the attending physician, must notify Aetna to pre-certify the admission or medical services and expenses prior to receiving any of the services or supplies that require precertification under the medical plan. To obtain precertification, call Aetna at the telephone number listed on your ID card in accordance with the following timelines:

For non-emergency admissions:	You, your physician or the facility must call and request precertification at least 14 days before the date you are scheduled to be admitted.
For an emergency outpatient medical condition:	You or your physician must call prior to the outpatient care, treatment or procedure, if possible, or as soon as reasonably possible.
For an emergency admission:	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
For an urgent admission:	You, your physician or the facility must call before you are scheduled to be admitted.
For outpatient non-emergency medical services requiring precertification:	You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

Aetna will provide a written notification to you and your physician of the precertification decision. If Aetna pre-certifies your supplies or services, the approval is good for 60 days as long as you remain enrolled in the medical plan.

When you have an inpatient admission to a facility, Aetna will notify you, your physician and the facility about your pre-certified length of stay. If your physician recommends that your stay be extended, additional days will need to be pre-certified. You, your physician, or the facility must call Aetna at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. Aetna will review and process the request for an extended stay. You and your physician will receive a notification of an approval or denial.

If Aetna determines that the stay or services and supplies are not covered expenses, the notification will explain why and how Aetna's decision can be appealed. You or your provider may request a review of the precertification decision in accordance with the claim review

procedures of the Plan Booklet.

3.2.2 Services Requiring Pre-certification

The following list identifies those 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.

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)
- Autologous chondrocyte implantation, Carticel (injection into the knee of cartilage cells grown from tissue cultures)
- 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
- Hyperbaric oxygen therapy
- Limb prosthetics

- 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 implant
- Osteochondral allograft/knee (grafting of cartilage and bone from a cadaver to the knee joint)
- Proton beam radiotherapy
- Reconstruction or other procedures that may be considered cosmetic
- 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.

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. 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.

You are responsible for obtaining the necessary precertification from 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 Aetna. If your treatment is not pre-certified by you or your provider, the benefit payable will be reduced as follows:

a) 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*.

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

c) If precertification of travel expenses was not requested, no travel benefits will be paid.