Retiree Health Plan Advisory Board
Modernization Committee
Meeting Agenda

Date: Friday, August 28, 2026
Time: 10:00 am – 11:30 am
Location: Join the meeting now | ANC Atwood 19th Floor
Telephone Only: +1 907-202-7104, 738 523 232#
Committee Members: Paula Harrison, Mike Humphrey, Jennifer Mannix

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10:00 am Call to Order
- Roll Call and Introductions
- Approval of Agenda
- Ethics Disclosure

10:05 am Public Comment

10:10 am Modernization Topics/Priorities
- Division Updates on ongoing Requests for Proposals (RFPs):
  - Pharmacy Benefit Manager RFP
  - Oncology Support RFP
  - Voluntary Supplemental Benefits RFP
  - Political Subdivision Group Health Insurance RFP
- Modernization Topics
  - Travel
  - LMTs

11:20 am Public Comment

11:30 am Wrap up/Adjourn

injury.

c) Suited for use in the home.

d) Not normally of use to persons who do not have a disease or injury.

e) Not for use in altering air quality or temperature.

f) Not for exercise or training.

3.3.19 Travel

Travel must be precertified to receive reimbursement under the Medical Plan. Contact the claims administrator for precertification before you or your dependent travel.

Travel for Lantern benefits is set forth in section 3.3.26 Lantern Benefits.

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.

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, returning transportation costs to the site of illness or injury are eligible for reimbursement subject to the provisions as outlined in section b.

b) Round-trip transportation, not exceeding the cost of coach class commercial air transportation, from the site of the illness or injury to the nearest professional treatment. If you use ground transportation and the most direct one-way distance exceeds 100 miles, the Medical Plan pays $31 per day without overnight lodging or $80 per day if overnight lodging is required while enroute, for the most direct route. Only eligible persons are reimbursed. If a parent or legal guardian accompanies a child under age 18, the plan will pay an additional $31 per day per diem for ground transportation.

Travel does not include reimbursement of airline miles to purchase tickets, the cost of lodging, food, or local ground transportation such as airport shuttles, cabs, or car rental.

If the patient is a child under 18 years of age, a parent or legal guardian's travel charges are allowed. Also, when authorized by the claims administrator, travel charges for a physician or a registered nurse are covered.

Travel benefits apply only to the conditions covered under the Medical Plan. They do not apply to the audio, dental, or vision plans.

Travel, as described above, is covered only in the circumstances set forth in the following sections. Travel is not covered for diagnostic purposes.

Emergencies

Travel is covered if you have an emergency condition requiring immediate transfer to a hospital with special facilities for treating your condition. Precertification is waived if you are immediately transferred in a ground or air ambulance; you do not need to call

the claims administrator before this occurs.

An emergency condition is a recent, severe medical condition, including but not limited to severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health to believe their condition, sickness or injury is of such a nature that failure to get immediate medical care could result in:

a) Placing the person's health in serious jeopardy.
b) Serious impairment to bodily function.
c) Serious dysfunction of a body part or organ.
d) In the case of a pregnant woman, serious injury to the health of the fetus.

Treatment Not Available Locally

Travel is covered for you to receive treatment which is not available in the area you are currently located in. Treatment is defined as a service or procedure, including a new prescription, which is medically necessary to correct or alleviate a condition or specific symptoms of an illness or injury. It does not include any diagnostic procedures or follow-up visits to monitor a condition. **Treatment must be received for travel to be covered.**

Benefits for travel to receive treatment which is not available locally are limited during each benefit year to:

a) One visit and one follow-up visit for a condition requiring therapeutic treatment;
b) One visit for prenatal or postnatal maternity care and one visit for the actual maternity delivery;
c) One pre-surgical or post-surgical visit and one visit for the surgical procedure; and
d) One visit for each allergic condition.

If you need transportation for a nonemergency condition which cannot be treated locally, you must contact the claims

administrator **prior** to traveling. The claims administrator will provide you with written acknowledgement of your request.

If you do not have time to receive written acknowledgement, you **must** call the claims administrator **before** you travel.

Second Surgical Opinions

Travel is covered if you require a second surgical opinion which cannot be obtained where you are currently located. This will count as a presurgical trip as shown above.

If you require transportation for a second surgical opinion which cannot be obtained locally, you must contact the claims administrator prior to traveling. The claims administrator will provide you with written acknowledgement of your request.

If you do not have time to receive written acknowledgement, you **must** call the claims administrator **before** you travel.

Surgery in Other Locations

Travel is covered if you have surgery which is provided less expensively in another location. When another insurance plan is primary, this provision may not apply.

If the actual cost of surgery, hospital room and board, and travel to another location for the surgery is less expensive than the recognized charge for the same expenses at the nearest location you could obtain the surgery, your travel costs may be paid. The amount of travel costs paid cannot exceed the difference between the cost of surgery and hospital room and board in the nearest location and those same expenses in the location you choose. Travel costs include round trip coach airfare or actual expenses for ground transportation if the most direct route exceeds 100 miles.

Precertification from the claims administrator is not required for this situation. Submit receipts for the travel costs to the claims administrator and the amount of reimbursement, if any, will be determined when the claim is processed.

from a GCIT Designated Network service provider.

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.

Covered Services and Procedures

When your doctor recommends a surgery, the Lantern Benefit will assist you with both planning and paying for the covered medical procedure, including necessary travel associated with the covered procedure. A Lantern Care Advocate can help you find a board certified, high-quality surgeon for your procedure, set up an initial consultation, schedule your procedure appointments, make travel reservations (if required), transfer your medical records and coordinate all your surgery bills. You can utilize the Lantern benefit for the non-emergent procedures listed below. This is not an exhaustive list, but a general guideline of the types of procedures the benefit will cover. Please contact the Lantern Care Advocate at 855-715-1680 for additional information.

a) Knee Knee Replacement Knee Arthroscopy

		Knee Replacement Revision	ACL/MCL/PCL Repair
b)	Hip	Hip Replacement Hip Replacement Revision	Hip Arthroscopy
c)	Shoulder	Shoulder Replacement Shoulder Arthroscopy	Rotator Cuff Repair Bicep Tendon Repair
d)	Foot and Ankle	Ankle Replacement Bunionectomy Hammer Toe Repair	Ankle Fusion Ankle Arthroscopy
e)	Spine	Laminectomy/Laminotomy Anterior Lumbar Interbody Fusion Posterior Lumbar Interbody Fusion	Anterior Cervical Disk Fusion 360 Spinal Fusion Artificial Disk
f)	Wrist and Elbow	Elbow Replacement Elbow Fusion Wrist Fusion	Wrist Replacement Carpal Tunnel Release
g)	General Surgery	Gallbladder Removal Hernia Repair	Thyroidectomy
h)	GI	Colonoscopy Endoscopy	
i)	GYN	Hysterectomy Bladder Repair	Hysteroscopy
j)	Bariatric	Gastric Bypass Laparoscopic Gastric Bypass	Laparoscopic Sleeve Gastrectomy
k)	ENT	Ear Tube Insertion Septoplasty	Thyroidectomy Sinuplasty

Limitations

Certain examinations, tests, treatments or other medical services may be required prior to, or following, a planned medical procedure with a Lantern provider. Any medical services performed by anyone other than a Lantern doctor, including pre- and post-care, shall be subject to the coverage limits and other terms on the **medical plan**.

Subsequent to an **Episode of Care**, if a member needs **emergency care** for any reason, this would be subject to coverage under the **medical plan**.

The Lantern **Episode of Care** ends when the member is discharged from the **facility**.

Lantern **Episode of Care** does not cover:

a) diagnostic testing in advance to determine whether a procedure is necessary;
b) convenience expenses;
c) procedures or care that are not **medically necessary**; and
d) Serious Reportable Events (SREs) as defined by the National Quality Forum at *https://www.qualityforum.org/Topics/SREs/Serious_Reportable_Events.aspx*

Travel Expenses
Your Lantern benefit will help pay for necessary travel associated with the covered procedure. Only travel arrangements made through the Lantern Care Advocate are eligible for coverage under the Lantern benefits. The specific travel benefit depends on the procedure, the provider and the distance between the provider and a member's residence.

Covered expenses may include the following as arranged by the Lantern Care Advocate:

a) Roundtrip coach class commercial air transportation for patient.

b) Roundtrip coach class commercial air transportation for one companion.

c) Mileage credit to/from airport to hotel and hotel to doctor's office or **facility**.

d) Lodging away from home while traveling to receive pre-operative consult services and procedures covered under the Lantern benefits and through post-procedural consult, or until such time as the provider has advised that the patient is cleared to travel and does not require a near term in-person visit with the treating provider, or in any case where the member does not have easy access to primary care.

e) Pre-loaded debit card to cover $25 per patient per day ($50 per day for patient & companion) for meals and incidental expenses traveling away from home to receive services covered under the Lantern benefits, during the stay to obtain a Lantern **Episode of Care** and for the travel from the place of care to the member's home of residence.

f) When member uses ground transportation in lieu of air travel, and the most direct one-way distance
    a. is less than 100 miles from the member's residence, a pre-loaded debit card of $25 to help with fuel;
    b. exceeds 100 miles but is less than 200 miles from the member's residence, a pre-loaded debit card of $50 to help with fuel;
    c. is 200 miles or more from the member's residence, a pre-loaded debit card of $100 to help with fuel.

3.3.28 Virtual Physical Therapy

Hinge Health Services

The Hinge Health Digital Clinic provides additional care and treatment programs for **musculoskeletal** conditions. Hinge Health services and equipment provided through an approved program of care are not subject to a **deductible**, **coinsurance**, or **copay**. The plan covers 100% of the cost for approved services received through Hinge Health. Any medical services for **musculoskeletal** conditions performed by anyone other than a Hinge Health

AlaskaCare Retiree Travel Benefit

Hali Duran, Aetna AlaskaCare Sr. Account Manager

aetna™

August 28, 2026

Agenda

We'll Review the Travel Benefits and Limitations

1. **Treatment Not Available Locally**
2. **Surgery Provided at a Lesser Cost**
3. **Limitations**

Travel Benefits

Treatment not Available Locally

Surgery at a Lesser Cost

Treatment Not Available Locally

Treatment is defined by the plan as “a service or procedure, including a new prescription, which is medically necessary to correct or alleviate a condition or specific symptoms of an illness or injury. It does not include any diagnostic procedures or follow-up visits to monitor a condition”.

By the Same Definition this Includes:

- **Returning airfare from an Emergent transportation.**
- **Second Surgical Opinions that cannot be obtained locally**

Treatment Not Available Locally Continued

What is covered:

Transportation from the site of illness or injury to the nearest location in which services may be received.

1. **Commercial Class Airfare**
2. **Ground transportation (which includes sea transport)**
   - Per diem rate of $31 for day trips or $80 for trips requiring overnight stays and lodging.

Treatment Not Available Locally Continued

Benefit Maximums

2/condition/benefit year

- One visit and one follow-up visit for each condition requiring therapeutic treatment.
- One visit for prenatal or postnatal maternity care and one visit for the actual maternity delivery.
- One pre-surgical or post-surgical visit and one visit for the surgical procedure.
- Second surgical opinions which cannot be obtained locally (this will count as a presurgical trip).
- One visit for each allergic condition.

Precertification

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.

Surgery in Other Locations

Travel is covered if a member receives a surgery that is provided less expensively in another location.

- The travel reimbursement cannot exceed the cost savings.

- Precertification is not required for surgery which is provided less expensively in another location.

Medicare Age Members

Geographic variation in Medicare reimbursement rates for surgical services is generally minimal. The additional reimbursement often exceeds any savings to the plan. However, if a member conducts a comparison and provides supporting documentation, those circumstances can be considered on a case-by-case basis.

Precertification is waived for Surgery provided at a lesser cost.

Limitations

➢ It's a Medical benefit, covered under the Medical plan, therefore:

- Only services covered by the Medical plan are eligible (for example if Aetna receives a claim, it must be paid/not denied by other plan provisions).
- Does not apply to dental, vision or audio services.
- Deductible and Coinsurance may apply

➢ Travel is only covered within the United States.

➢ Transportation to and from care.

- Does not include expenses once you are in the location in which services are received.

➢ Expenses for only the member receiving treatment

- Unless the member is a minor in which a parent or legal guardian's expenses will be covered.

LANTERN | AlaskaCare Health Plans

Meet Lantern, Your Guide to Excellent Surgery Care

Commonly Covered Procedures

Lantern covers more than 1,500 different procedure types. If you need a non-emergency, pre-planned procedure that you do not see below, Call a Care Advocate to confirm if your procedure is covered.

Joint Replacement and Revision

- Ankle
- Knee
- Elbow
- Shoulder
- Hip
- Wrist

Spine

- Artificial Disk Replacement
- Cervical Disk Fusion
- Laminectomy
- Laminotomy
- Lumbar Interbody Fusion
- 360 Spinal Fusion

Orthopedic

- Arthroscopy (Knee/Shoulder)
- Bunionectomy
- Carpal Tunnel Release
- Ligament Repair
- Rotator Cuff Repair

Cardiac

- Cardiac Ablation
- Defibrillator Implant
- Pacemaker Implant
- Pacemaker Replacement
- Valve Surgery

Bariatric

- Gastric Bypass
- Sleeve Gastrectomy
- Lap Band / Lap Sleeve

Gynecological

- Hysteroscopy
- Hysterectomy
- Myomectomy
- Ovary Removal

General Surgery

- Hernia Repair
- Gall Bladder/ Laparoscopic Cholecystectomy
- Thyroid
- Excision of Mass

Interventional Spine/Pain

- Cervical Epidural
- Lumbar Epidural Steroid
- Stellate Ganglion Block
- Epidural Blood Patch

Gastroenterology (GI)

- Colonoscopy
- Upper GI Endoscopy

Ear, Nose, Throat (ENT)

- Ear Tube Insertion
- Ear Infection
- Septoplasty
- Sinuplasty

Care and Support When You Need It Most

Your Lantern benefit includes support from your Care Advocate . They will help you understand your benefit, find the right care and make sure you feel informed at every stage of the journey.

Lantern Care Advocates can:

- Answer questions about your benefit
- Explain what surgeries and costs are covered
- Help match you with the best surgeon for your care
- Coordinate any travel associated with your surgery
- Support your needs throughout your surgical journey

Travel Program Details

If you do need to travel, your benefit covers your travel costs to ensure that you have access to the best providers.

Mileage (car)*

Miles Traveled	0 – 99	100 – 199	200+
Allowance	**$25**	**$50**	**$100**

*includes travel to/from airport to hotel and hotel to doctor's office or facility.

Airfare

Lantern will book economy flights, if appropriate, for the member and a companion

Hotel

Hotels must be 3 stars or higher and are booked by your Care Advocate in advance of your trip

Per Diem

$25 per person per day is provided to member and one companion on a debit card to cover meals and travel-related expenses

From:	rpea.ak.president@gmail.com
To:	Murray, Chris (DOA); Alaska Retiree Health Plan Advisory Board (DOA sponsored)
Cc:	Michael Humphrey; Jennifer Mannix; Stephanie Rhoades; Cammy Taylor
Subject:	Proposed Revised Travel Policy from the RPEA"s Health Benefits Committee
Date:	Wednesday, August 26, 2026 1:59:57 PM
Attachments:	Travel Benefit 08-25-2026 final.docx

Good afternoon, Chris and RHPAB Members!

Attached to this email is a proposal to revise the travel provisions of the AlaskaCare retiree health plan. As you all are aware, the travel provisions the retiree health plan have been the source of long-standing comment and debate.

I am sending it today in the hope that it can at least be introduced at this coming Friday's Modernization Subcommittee meeting where I note that "travel" is one of two specific "Modernization Topics."

This proposal reflects the thoughts and discussion of the members of the RPEA's Health Benefits Committee (HBC). It is provided to the DRB, the RHPAB Modernization Subcommittee, and the members of the RHPAB itself for consideration and discussion.
Hopefully, the proposal is at least entertained over the next weeks and that it elicits important consideration and debate. Once it has been reviewed and (probably) further edited by the parties to this matter, I will introduce the draft product of those discussions to the RPEA Executive Board for its consideration and action, if any.

Thanks, as always, for being open to further efforts to modernize the retiree health plan in the face of the ongoing debate and discussion of its many provisions.

Randall
Randall Burns
RPEA President

RPEA Submission

Partner Travel Coverage

- The plan should cover travel costs for the retiree and a travel companion.
- The plan will cover 4 trips for each medical event for the retiree and partner.
- Only coach airfare is covered.
- Miles and credit card credits are not reimbursable.

Alaska Ferry System Travel

- Basic travel costs should be covered for both the retiree and travel companion.
- The cost to transport one standard vehicle should be covered for a regular-sized car, SUV, or standard pickup truck.
- Motor homes will only be covered at the SUV rate.

Diagnostic Travel Coverage When It Is Not Available Locally

- The plan should cover travel costs for the retiree and a travel companion.
- The plan should cover 1 trip for a diagnostic testing for each medical event for the retiree and partner per calendar year.
- Only coach airfare is covered.
- Miles and credit card credits are not reimbursable.
- The cost to transport via the ferry system - one standard vehicle should be covered for a regular-sized car, SUV, or standard pickup truck.
- Motor homes will only be covered at the SUV rate

Ground Transportation and Lodging

- Basic ground transportation in the surgery city may include Uber, Lyft, train, or taxi services; actual receipts are required.
- Covered ground transportation includes travel from the airport and travel between the hotel, doctor's office, and medical center.

Executive Summary	Licensed Massage Therapists (R035)
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	01/01/2027
Reviewed By	RHPAB Modernization Committee
Review Date	08/28/2026

1) Background

The AlaskaCare Retiree Health Plan (Plan) provides coverage for outpatient rehabilitative care, including massage therapy, designed to restore and improve bodily functions lost due to injury or illness. According to the terms of the Plan, rehabilitative care is only a covered Plan benefit when it's part of a formal written program of care and is considered medically necessary only if significant improvement in body function is occurring and is expected to continue.

The Plan utilizes the claim administrator's current medical clinical policy bulletins (CPB) to assess medical necessity for eligible services. For massage therapy, medical necessity is reviewed under the clinical policy bulletin for physical therapy[1], which states the following regarding massage therapy:

> Massage therapy is considered medically necessary as adjunctive treatment to another therapeutic procedure on the same day, which is designed to restore muscle function, reduce edema, improve joint motion, or for relief of muscle spasm. Massage therapy is not considered medically necessary for prolonged periods and should be limited to the initial or acute phase of an injury or illness (i.e., an initial 2-week period).

The AlaskaCare Retiree Insurance Information Booklet[2] (Booklet), under Section 3.3.3 Provider Services, lists the specific licensed provider types covered by the Plan. Massage therapists were not recognized providers requiring professional licensing in the State of Alaska at the time the Plan was established, and therefore, massage therapists were not listed as recognized providers in the Plan Booklet. Legislation[3] enacted in 2014 established the Alaska Board of Massage Therapists and required massage therapists to become licensed providers with the State in order to continue practicing, effective July 1, 2015. No changes were made to the Plan to add licensed massage therapists (LMTs) to the list of recognized providers following this change.

Members have access to massage therapy as a benefit available under the Rehabilitative Care provisions. However, the services must be billed under a provider type recognized by the Plan, which limits retiree access to medically necessary massage to services provided or billed by physical therapists, occupational therapists, chiropractors, and other recognized providers.

2) Objectives

1 Aetna Clinical Policy Bulletin No. 0325: Physical Therapy
https://www.aetna.com/cpb/medical/data/300_399/0325.html
2 AlaskaCare Retiree Health Insurance Information Boolet
https://drb.alaska.gov/docs/booklets/DB-RetireeInsuranceBooklet_WEB.pdf
3 House Bill 328: Board/Licensing of Massage Therapists
https://www.akleg.gov/basis/Bill/Text/28?Hsid=HB0328A

Update the Plan to include LMTs as recognized providers to modernize the Plan and increase member access to medically necessary massage therapy.

3) Summary of Proposed Change

This proposal seeks to add LMTs to the list of recognized providers under section 3.3.3 Provider Services of the Booklet to increase access to medically necessary massage therapy. Massage therapy services would continue to be evaluated for medical necessity in accordance with the Plan provisions regarding Medically Necessary Services and Supplies and Rehabilitative Care.

4) Impacts

Actuarial Impact to AlaskaCare | Neutral

Segal, the Division's contracted benefit consultants, indicate the addition would be considered an expansion of provider options, which does not impact the actuarial value of the Plan.

Financial Impact to AlaskaCare | Increase

Segal indicated the anticipated financial impact of this change, based on the most recent retiree medical and pharmacy claims projection of $912,500,000 for 2026 (dated September 24, 2025), and trended forward for a projected cost of $974,900,000 for 2027, equates to an annual cost increase to the Plan of less than 0.1%, or $650,000 - $750,000.

Member Impact | Enhancement

It's anticipated that members of the Plan would benefit from increased access to qualified providers.

Operational Impact (DRB)| Minimal

The Division anticipates minimal operational impacts. The Division will follow the standard process for making plan changes per 2 AAC 39.390 and provide directions to the Third-Party Administrator to implement the update. Once the implementation activities are complete the Division does not anticipate any additional operational impact.

Operational Impact (TPA) | Minimal

The impact to the Third-Party Administrator (TPA) is anticipated to be low. Aetna will need to update and test their internal claim processing workflows and systems to ensure the changes are appropriately applied and implemented. After implementation, the ongoing operational impacts are anticipated to be minimal, and will include preparing reporting, fiscal impact monitoring, and updates to communication materials as appropriate.

Provider Impact | Moderate

The impact to providers is expected to be positive, as this removes potential barriers to care for their patients. LMTs will be positively impacted by the ability to bill for medically necessary massage therapy provided to Plan members.

5) Considerations

This change is anticipated to result in members having increased access to medically necessary massage therapy due to increased provider options. Since Medicare does not recognize LMTs as an eligible provider

type, the Plan will pay as primary payer for medically necessary massage received from an LMT.

6) Implementation and Communication Overview

Division staff will follow the standard process for making changes to the Plan, which includes completion of the following:

- Proposal analysis and stakeholder input
- Public comment period(s)
- Any needed language updates to the Retiree Insurance Information Booklet

7) Proposal Recommendations

DRB Recommendation

The Division recommends adopting the proposal and adding LMTs to the list of recognized providers.

RHPAB Board Recommendation

The RHPAB board voted on ##/##/## to recommend/not to recommend…

Description	Date
Proposal Drafted	August 2026
Reviewed by Modernization Committee	August 2026
Reviewed by RHPAB	

Segal

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Memorandum

To: Chris Murray, Chief Health Administrator, Division of Retirement and Benefits

From: Richard Ward, FSA, FCA, MAAA

Date: July 23, 2026

Re: **Allowing Access to Licensed Massage Therapists (Retiree Plan)**

The State is considering recognizing Licensed Massage Therapists (LMTs) as an eligible provider type to allow additional access under the Retiree Plan.

The Retiree Plan currently covers outpatient rehabilitative care designed to restore and improve bodily functions lost due to injury or illness. This includes physical therapy which may incorporate massage to provide relief using manual soft tissue manipulation. Because LMTs are not recognized as eligible providers, these services are currently being performed by physical therapists, occupational therapists, chiropractors, and other currently recognized provider types.

In order to practice, LMTs must have a state license and complete required training and examinations. By recognizing LMTs as eligible providers, retirees and their dependents would have additional access to providers. This change would bring alignment with the Employee Plan which already recognizes LMTs as eligible providers.

Below is a table outlining the current benefits offered under the Plan:

Deductibles

Description	Amount
Annual individual / family unit deductible	$150 / up to 3x per family

Coinsurance

Description	Percentage
Most medical expenses	80%
Most medical expenses after out-of-pocket limit is satisfied	100%
Second surgical opinions, Preoperative testing, Outpatient testing/surgery • No deductible applies	100%

Out-of-Pocket Limit

Description	Amount
Annual individual out-of-pocket limit • Applies after the deductible is satisfied • Expenses paid at a coinsurance rate other than 80% do not apply against the out-of-pocket limit	$800

Benefit Maximums

Description	Amount
Individual lifetime maximum • Prescription drug expenses do not apply against the lifetime maximum	$8,000,000

Prescription Drugs

Prescription Drugs	Up to 90 Day or 100 Unit Supply	
Up to 90 Day or 100 Unit Supply	Generic	Brand Name
Network pharmacy copayment	$4	$8
Mail order copayment	$0	$0

Actuarial Value

This would be considered a provider expansion change and would not impact the cost share of benefits offered to the retirees. As a result, there will be no change anticipated in the actuarial value for the plan.

Financial Impact

Segal's analysis included a comprehensive review of massage therapy claims across the Retiree and Employee plans over the past two fiscal years based on data paid through June 2026. Because the Employee Plan currently recognizes LMTs as eligible providers, we used the utilization per 1,000 and average allowed costs as a benchmark for future expectations for the Retiree Plan. The estimated increase in cost is expected to be between $650,000 and $750,000 annually.

Using the most recent retiree medical and pharmacy claims projection of $912,500,000 for 2026 (dated September 24,2025) and trended forward for a projected cost of $974,900,000 for 2027, this equates to an increase of less than 0.1% in annual costs to the Plan. For the first year, expenses may be slightly lower due to the timing lag between eligibility and when claims will first be processed and paid.

In addition, Segal assumed that coverage for massage therapy services would remain unchanged to existing coverage provisions, with the only proposed modification being the expansion of eligible providers to include LMTs.

Since Medicare does not recognize LMTs as eligible providers either, we have also assumed that the AlaskaCare plans would pay primary for care provided by LMTs.

Care provided by non-LMTs would continue to be covered by Medicare on a primary basis (for those with Medicare), resulting in that care generally continuing to be covered with little to no member out-of-pocket costs.

Additional Notes

The data used for this analysis was reviewed, but not audited, and found to be sufficient and credible.

The above projection is an estimate of future cost and is based on information available to Segal at the time the projection was made. Segal has not audited the information provided. A projection is not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, change in demographics, overall inflation rates and claims volatility. Projection of retiree costs takes into account only the dollar value of providing benefits for current retirees during the period referred to in the projection. It does not reflect the present value of any future retiree benefits for active, disabled, or terminated employees during a period other than that which is referred to in the projection, nor does it reflect any anticipated increase in the number of those eligible for retiree benefits, or any changes that may occur in the nature of benefits over time.

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cc: Ronan Tagsip, Division of Retirement and Benefits
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