

HealthMatters



April 2016

Number 26

Making Changes to Your Coverage

Active Employees

Within 30 days (60 days if noted in the Plan Document) of a change in status or other applicable event, you may submit your request for a change to your elections, or if permitted by the plan, terminate your elections during the benefit year. Please see the Plan Document for a complete list of qualified status changes and other applicable events.

Changes in coverage under the medical plan, dental plan, vision plan, and health flexible spending account (HFSA) must be on account of the change in status, necessary or appropriate as a result of the change in status, and consistent with the terms and conditions of the benefit option. If you are required to participate in the medical plan and dental plan, you may not terminate your medical or dental coverage because of a change in status.

All employee changes to benefits must be made through the online insurance enrollment system. Your benefit options will be based on your current family structure. For this reason, it is important that you review your dependent information to ensure it accurately lists your covered family members. Please

review the information available on our web page, AlaskaCare.gov, to determine if you have a qualifying event or to review the Plan Document.

Retirees

Benefit recipients who are paying premiums for their health coverage, dental-vision-audio coverage, or long-term care coverage, may decrease their level of coverage at any time. For example, you may change from retiree and family coverage to retiree and spouse coverage at any time. To decrease your coverage, submit a written request to the Division of Retirement and Benefits stating the level of coverage you would like. Once you decrease your coverage, you cannot reinstate it except as described below.

You may increase dependent coverage only:

- During an open enrollment period (for qualified individuals),
- Upon marriage, or
- Upon birth or adoption of a child.

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Welcome to CHCS for the Long-Term Care Plan

AlaskaCare is pleased to introduce our new long-term care (LTC) claims administrator. In April, CHCS will take over the responsibilities of administering the LTC plan claims on behalf of AlaskaCare. CHCS has over 20 years experience providing LTC claims administration, including government plans. With this transition, our retirees will have increased access to plan and claims information as well as new online tools.



Your State of Alaska AlaskaCare health team has worked hard to transition your information to this new vendor to avoid as much disruption as possible. You may contact CHCS with the same phone number as the previous administrator, (888) 287-7116. We look forward to this new partnership with CHCS in providing the best service possible to our members. ❁❁

Understanding the ABC and Ds of Medicare

Medicare consists of four parts—A, B, C, and D—and knowing those parts is key to having a smooth transition to Medicare, avoiding late enrollment penalties, and receiving full benefits from your AlaskaCare Retiree Health Plan.

Part A covers inpatient hospital stays, skilled nursing care, home health care, and hospice care. It is generally provided free of charge beginning at age 65. Members who sign up to begin receiving Social Security benefits at age 65 will be automatically enrolled in Part A. Members who wish to postpone signing up for Social Security payments must contact Social Security within the three months prior to their 65th birthday to ensure that Medicare Part A begins promptly when they turn 65.

Part B covers outpatient provider services, emergency room care, diagnostic testing, and some preventive care. The 2016 premium for Part B is \$121.80 (some exceptions apply for high income members). As with Part A, you will be automatically enrolled in Part B if you are receiving Social Security at age 65 and the premium will be withheld from your Social Security benefit. If you are not receiving Social Security, you must enroll in Part B during **the 3 months before your 65th birthday**, at the same time as you enroll in Part A, and arrange to pay the premium directly. Waiting until the month of your birthday may delay the effective date of Medicare coverage.

Part C plans are Medicare Advantage plans provided by private insurers for members who live outside the State of Alaska. They cover the same services as Medicare Part A and B combined as well as some supplemental benefits, but are Preferred Provider Organizations (PPO) or Health Maintenance Organizations (HMO). These plans may not be the best choice for AlaskaCare members who already have the Retiree Health Plan to supplement Medicare.

Part D provides prescription drug coverage through private insurers. AlaskaCare members have prescription drug coverage which is as good as, and in most cases, better than Part D.

AlaskaCare Retiree Health Plan members need both Medicare Parts A and B at age 65 because the Retiree Health Plan

becomes supplemental to Medicare at that time (per State statute). When paying a claim, the Retiree Health Plan will assume the member has coverage under both Parts A and B and will deduct the amount Medicare would have paid prior to making payment. This is true even if the member has another health plan provided through the employment of the member or the spouse. Without Part A and B, the Retiree Health Plan member will be responsible for the portion Medicare would have paid, **regardless of any other coverage** they have. (Members who are not eligible for premium-free Part A should obtain and provide to the claims administrator a confirmation letter from Social Security and the Retiree Health Plan will not reduce benefits on the assumed Medicare reimbursement for Part A expenses.)

Retirees who receive coverage as an active employee or are covered under their spouse's active Employee Health Plan may enroll in Part A as soon as they are eligible, and Medicare will pay secondary to the Employee Plan. (The AlaskaCare Retiree Health Plan will pay as tertiary.) If the retiree is covered under his/her own active Employee Plan, Medicare allows delayed enrolling in Part B until they terminate employment but must enroll in Part B immediately when their employee health coverage ends in order to avoid a penalty or a delay in the start of Part B. **However, the requirement for Part B enrollment is not waived by the Retiree Health Plan.** Regardless if they enroll in Part B while they are working or wait to enroll until after their active employment has ended, the Retiree Plan will assume the member has coverage under Parts A and B and will deduct the amount Medicare would have paid prior to making payment.

More information about the impact of Medicare on your AlaskaCare coverage can be obtained by contacting the Division at (800) 821-2251, (907) 465-4460, or doa.dr.benefits@alaska.gov. Information regarding Medicare is available from the Alaska Medicare Information Office at (800) 478-6065 or (907) 269-3680 or Medicare.gov ❁❁

Vision Benefits

Vision benefits are optional for both active and retired employees. If you have enrolled in this optional coverage, it is important to understand what is covered under your plan before incurring expenses.

Active Employees

Coverage for AlaskaCare covered active employees is provided by Vision Services Plan (VSP). You may view your member specific benefits at vsp.com or in your AlaskaCare Employee Health Plan booklet. To maximize your benefits under this plan, look for a VSP participating provider in your area.

Retired Employees

Coverage for AlaskaCare covered retirees is currently provided by Aetna, in accordance with the AlaskaCare Retiree Health Plan. Vision plan information is listed in the May 2003 Retiree Insurance Information booklet, beginning on page 73.

The services that are covered under the plan are:

- One complete eye examination, including a required refraction, by a legally qualified ophthalmologist or optometrist, during a calendar year.
- Up to two single vision, bifocal, trifocal, or lenticular lenses per calendar year. (Normally one pair of lenses. They are billed individually.)
- Frames, but not more than one pair during any two consecutive calendar years.
- One pair of cosmetic contacts elected in lieu of glasses. These will be covered the same as any other single vision spectacle lenses. This means that you must pay the difference between the recognized charge for spectacle lenses and contact lenses.
- Certain lens options, limited to those listed below:
 - ~ Scratch resistant coating
 - ~ Antireflective coating
 - ~ Polycarbonate lenses

As it is uncommon to be prescribed only one pair of contacts, Aetna will apply the allowable amount for single vision spectacle lenses, based on your prescription, to your annual supply of contacts. If the cost of your annual supply of contacts



exceeds the allowable amount for single vision spectacle lenses, the excess amount will not be paid.

If you need contacts after cataract surgery, the maximum lifetime amount payable for medically necessary contact lenses is \$400. After you reach this maximum, the normal contact lens benefit will apply.

Only the services or lens options that are specifically listed in the Plan Document are covered. Non-covered supplies and services are the member's responsibility. Billed lens codes should include a specific code for a lens for each eye (if you are wearing glasses or wear a contact in each eye—they are not billed by "pair"). Codes for additional lens options are included when selected. Aetna will apply the appropriate recognized charge to the billed base lens code for single vision, bifocal, trifocal, or lenticular lenses and any covered options. Please note, Transitions® brand light sensitive (photochromatic) lenses are not the same as transition no-line bifocals. Light sensitive lenses are excluded under the plan.

You will find that most routine vision services are excluded by Medicare. However, if your vision provider lists a medical code in lieu of a routine vision code, the office visit, contacts or glasses after cataract surgery, or other services that may be covered by Medicare will be pended for that explanation of benefits. If the medical diagnosis was billed in error, only your vision provider can correct the billing.

There is no network for vision benefits under the Retiree Health Plan. Providers have no obligation to bill AlaskaCare, but may do so as a courtesy to their patients. If your provider does not bill, please contact Aetna for instructions for submitting a claim for reimbursement. ❀

2016 Updates to Insurance Booklets on AlaskaCare.gov

All updates, addenda, and benefit clarifications made to the insurance booklets are posted to AlaskaCare.gov. It is a good idea to check the site regularly for updates and clarifications of the insurance plan. Go to AlaskaCare.gov and then to the section that applies to you—Retiree or Employee. Find the link to Plan Booklets and review the information there. Be sure to check back from time to time to see if anything new has been posted. ❀

Employee Health Plan Dependent Audit

We are all aware of how important it is to have adequate health care coverage. We also know how expensive paying for health care can be. What you may not know is that AlaskaCare is self-insured, which means health claims are paid by the plan, not an outside insurance company.

Part of our job is to keep costs down so we can maintain a competitive health care plan for all employees. We need to make sure that only those dependents who are actually eligible are the ones being provided with coverage. Data has shown that each dependent's health care costs are approximately \$4,700 each year. Covering dependents who are not eligible raises our cost for benefits which is reflected in the premiums deducted from our checks.

In an effort to control these costs, we have retained the services of an independent auditor, HMS Employer Solutions, to assist us with completing a dependent verification of our plans. The audit by HMS Employer Solutions will begin April 6, 2016 and conclude June 15, 2016. If you have dependents enrolled in an AlaskaCare benefit plan, you will receive a letter addressed to your home from HMS Employer Solutions. The letter will detail the steps and information required to keep coverage on your enrolled dependents. You will also be asked to submit evidence of eligibility directly to HMS Employer Solutions.



When you receive any correspondence from HMS Employer Solutions, please read it carefully as there are specific due dates when certain information needs to be returned. Failure to follow the instructions or respond to the audit request could result in loss of coverage for your dependents.

Detailed eligibility information, as well as a toll-free customer service number, fax number, and customized web address will be included in the upcoming correspondence from HMS Employer Solutions. Feel free to contact them if you have any questions or need additional information.

Thank you for helping us manage our plan expenses so we can continue to provide health care at a reasonable cost! ❀

Retiree Health Plan Dependent Eligibility

The AlaskaCare Retiree Health Plan is not subject to the provision in the Patient Protection and Affordable Care Act requiring some health plans to add coverage for older dependent children up to age 26.

Pages 6-7 of the Retiree Insurance Information Booklet list the criteria for dependent eligibility, in accordance with Alaska Statutes 39.35.680(12) and 14.25.220(13):

Dependents

The following dependents may be covered:

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:

- Your natural children, stepchildren, foster children placed through a State foster child program, legally adopted children, children in your physical custody and for whom bona fide adoption proceedings are underway, or children for whom you are the legal, court-appointed guardian;
- Unmarried and chiefly dependent upon you for support; and
- Living with you in a normal parent-child relationship.

If your dependent child is under 23 years old, they are required to be registered at, and attending on a full-time basis, an

accredited educational or technical institution recognized by the Department of Education and Early Development.

If your dependent child is age 19 or older and is not a full-time student, then the dependent is eligible for coverage only if he or she is totally and permanently disabled. Please contact the Division for additional information about eligibility and for information about how to provide proof of your dependent's disability.

Coverage for dependents ends the last day of the month in which they fail to meet all eligibility requirements, regardless of when notification is received. For example, if your dependent graduates college in June, the last day of coverage would be June 30th, even if notification is not received until a later date.

We have asked the claim administrator, Aetna, to verify full-time student attendance on our behalf. They will mail a form to the address on file approximately 60 days prior to your dependent's 19th birthday and annually prior to the fall semester. It is the responsibility of the retiree to provide proof of full-time school attendance by the date requested in order to avoid a lapse in coverage. Additionally, if your dependent no longer meets the criteria for eligibility, you must notify the Division of this change in writing. If you need to reduce coverage due to a dependent no longer being eligible, that change must also be submitted in writing and the change is not retroactive. ❀

Travel Benefits

Both the AlaskaCare Employee Health Plan and the AlaskaCare Retiree Health Plan provide coverage for reimbursement of travel expenses subject to plan provisions.

The Medical Plan has a benefit provision to reimburse members for covered travel costs within the contiguous limits of the United States, Alaska, and Hawaii. Travel benefits apply only with respect to conditions covered under the medical plan and within the limitations of the plan. There are no travel benefits for the dental plan or vision plan.

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.

Travel is covered only in the circumstances set forth in the Plan Document. Travel is not covered for diagnostic purposes under the AlaskaCare Retiree Health Plan.

Travel reimbursement for a companion is only covered in certain circumstances. If the patient is a child under 18 years of age, a parent or legal guardian's travel charges are allowed. Travel expenses for your spouse or another companion are not covered by the plan.

Treatment Not Available Locally

If you need transportation for a nonemergency condition which cannot be treated locally, you must pre-certify the travel through the claims administrator by calling the Aetna concierge at (855) 784-8646. **Failure to complete certification prior to travel will result in a denial of benefits.**

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.** The absence of a network provider in the area does not qualify the travel for reimbursement.

The plan reimburses qualified expenses for 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 chose to

travel farther than the nearest location, travel will be reimbursed only to the amount it would have cost to travel to the nearest location.

If you use ground transportation and the most direct one-way distance exceeds 100 miles, the Medical Plan pays your documented travel expenses while en route for fares, mileage, food, and lodging for the most direct route, up to the limitations outlined in the Plan Document. Only eligible persons are reimbursed. Passenger travel on the Alaska Marine Highway ferry system is included under this provision. Covered ground transportation expenses cannot exceed the cost of coach air fare noted above.

Surgery in Other Locations

Travel is also covered if you have surgery which is provided less expensively in another location. 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.

Travel Related to Organ Transplant Services

A separate travel benefit for charges incurred during an organ transplant, up to \$10,000, is available for those members that require a transplant. There are strict requirements for transplant services and the qualifications for this travel benefit. These benefits and services should be coordinated by your Nurse Case Manager. Please contact your Nurse Case Manager for precertification, or if you have not yet been assigned a Nurse Case Manager, please contact Aetna Concierge to request one be assigned to you. ❀

Making Changes to Your Coverage

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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.

Per Regulation 2 AAC 39.260, changes in coverage are effective on the first of the month following the receipt of your written request. Changes in coverage are effective only after receipt of your written request and are not retroactive. The Division cannot make change for you without a written request. ❀

Retiree Medical Coverage of Durable Medical Equipment and Other Devices

For those eligible for Medicare, Medicare Part B covers outpatient medical visits, diagnostic work, labs, and other outpatient provider items. It also covers some “Durable Medical Equipment,” known as DME, which includes home oxygen equipment, hospital beds, walkers, wheelchairs, syringes, orthotic items, and prostheses, among others.

How do you get the DME you need?

If you need Durable Medical Equipment, your healthcare provider must prescribe the equipment for you. Some items (such as hospital beds or wheelchairs) require your doctor or a staff person to complete a special form, called a Certificate of Medical Necessity, to get approval. Your DME supplier will work with your provider to see that all the required information is submitted to Medicare. You must get the DME from an approved Medicare supplier with a Medicare supplier number. There are strict standards for suppliers to qualify. Excellent options are available in Alaska for DME suppliers. The Alaska Medicare Information Office can help you find one in your area

or you can go to **Medicare.gov** and select “Find Suppliers of Medical Equipment in Your Area.” Remember, if you receive your DME from a supplier that has opted out of Medicare, the AlaskaCare Retiree Health Plan cannot pay either.

What if you are not eligible for Medicare?

The AlaskaCare Retiree Health Plan does cover some Durable Medical Equipment/Supplies. Please see pages 39-41 of the Plan Document or contact the Aetna Concierge at (855) 784-8646 for further details. Using a network DME provider can save you money and protect you from balance billing. A list of network DME providers is available in the online DocFind tool on the **AlaskaCare.gov** website or can be provided through the Aetna Concierge at the number listed above. If using DocFind, click on “Directories and Resources” from the list at the left and then select “National DME Provider Listing”. To access other local contracts, scroll down towards the bottom of the main DocFind page under Common Searches. Under “Hospitals and Facilities” select “more”, then “Medical Equipment Suppliers”. ❁❁

Why Might I Receive a Letter and Questionnaire from The Rawlings Group?

AlaskaCare health plans include subrogation and reimbursement provisions. The Rawlings Group is an Aetna sub-contractor who provides certain subrogation support services to the AlaskaCare health plans. There may be situations where Rawlings may need to contact AlaskaCare plan participants.

Rawlings performs review of medical claims after payment has been made. You might receive a letter with an attached questionnaire from Rawlings based on certain treatment billing codes related to an injury, illness, or condition for which the health plan has paid medical claims. This may include events such as an accident involving a motor vehicle, a slip and fall, injury on the job, medical malpractice, or defective product.

Do I have an obligation to respond?

Yes. Members are expected to respond to the letter/questionnaire and provide complete, accurate information to the best of their knowledge.

Using the reference number provided in your letter from Rawlings, a member can respond to Rawlings in one of three ways:

- Return the completed questionnaire in a postage paid envelope
- Reply online at **TRGClaimsInfo.com**
- Call Rawlings toll free at 1-888-285-1616

How does the process help the AlaskaCare health plan?

The AlaskaCare contract contains a section about the subrogation and reimbursement rights of the plan. This is one way to help the health plan remain financially healthy for the benefit of plan participants and their dependents.

If a third party payer is identified as having responsibility for the claim, the recovered payments are returned back to the health plan. These funds are once again available to pay claims on behalf of all beneficiaries of the health plan.

Rawlings is authorized to perform this service on behalf of the health plan, and complies with all legal requirements (HIPAA) for handling your confidential information. ❁❁

File Claims Timely

Remember to file your health claims as soon as possible. You or your provider must file a claim within 12 months of the date of service for the claim to be considered for payment. This limit applies even if another health plan, such as Medicare, is your primary insurance and your claim is pending with them. Claims received after the 12-month filing limitation cannot be considered for payment. ❁❁

Save Time with the Rx AutoFill Prescription Refill and Renewal Service

If you are using Aetna RX Home Delivery, wouldn't it be great if you did not have to contact Aetna each time you needed to refill or renew your prescriptions? If you like, you can use the free Rx AutoFill service. It can automatically refill and renew your prescriptions and send them right to your mailbox or anywhere you choose. There is no charge for this service.

With Rx AutoFill, Aetna Will:

- Automatically mail your enrolled prescriptions before the refill or renew due date.
- Contact your doctor for a new prescription once the last refill is up or the prescription has expired.
- Alert you at least 10 days before we refill or renew your prescription, so you can cancel if you need to.

If you do not cancel the order or we do not reach you, Aetna will send your refill order and your current payment method will be charged for your copay (if applicable). Please note that your medication cannot be returned for credit.



You Decide How You Want to Manage Your Prescriptions

With this service you stay in control with the freedom to change or stop your service at any time. You can save time and enjoy peace of mind.

You refill your prescriptions each time, or Aetna can refill your prescriptions automatically with Rx AutoFill. You can elect auto refill or renewal for all your mail order medications or only for selected prescriptions. It only takes a few minutes to sign up.

Visit [Aetna.com](https://www.aetna.com) and log in to Aetna Navigator. Click "Aetna Pharmacy" from the top of the page. Then click "Refill by Mail". From there, you will be able to select the prescription(s) you want enrolled. You can also check the status of an order online through Aetna Navigator and the Aetna Pharmacy webpage. 🌟

Learn More About Your Health Care Benefits When Traveling and/or Residing Outside the U.S.

Your AlaskaCare plan provides coverage for emergency or urgent care as well as for other medically necessary services—within the U.S. and out of the country—as follows:

- Physician, hospital, and other services received abroad are subject to the same calendar year deductible and coinsurance rate applicable to claims for services received in the U.S.
- The same plan precertification requirements that apply in the United States also apply while traveling abroad.
- The same coverage rules apply internationally as they do in the U.S. If a service or medication is not covered within the U.S., it would also not be covered abroad.
- The AlaskaCare plan of benefits does not include coverage for repatriation of remains. "Repatriation" means to return to one's own country.
- The AlaskaCare plan only pays travel costs within the contiguous limits of the U.S., Alaska, and Hawaii; these costs are not covered abroad.

Since international providers do not utilize Tax Identification Numbers, Aetna cannot pay them directly in the same manner they can for providers within the U.S. Therefore, you are

responsible to pay the provider at the time the services are rendered and submit a claim for reimbursement. Reimbursement for these claims will be based on the exchange rate that applies on the date the services are rendered.

Please be sure to include the following items when submitting your claim:

- Medical documentation describing your medical condition and treatment
- An itemized bill describing what services were provided
- Proof of your payment

Claim Mailing Address:

Claims Department
P.O. Box 14079
Lexington, KY 40512-4079

The Aetna toll-free AlaskaCare Concierge number cannot be accessed directly from locations outside the U.S. If you need to contact Aetna while abroad, you can call the Aetna Corporate Contact Center at (860) 273-0123 and they can route your call to the (855) 784-8646 Concierge line. The Corporate Contact Center is available Monday-Friday, 7 a.m. – 7 p.m. EST. 🌟



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Lena Gilbertson
Editor

333 Willoughby Avenue
State Office Building
6th Floor
P.O. Box 110203
Juneau, AK 99811-0203

**Member Services
Contact Center**

M-Th: 8:30 a.m. - 4 p.m.

Fr: 8:30 a.m. - 3 p.m.

(907) 465-4460

(800) 821-2251

TDD: (907) 465-2805

Fax: (907) 465-3086

doa.drb.mscc@alaska.gov



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[Twitter.com/AlaskaDRB](https://twitter.com/AlaskaDRB)

The Alaska Department of Administration complies with Title II of the 1990 Americans with Disabilities Act (ADA). This health newsletter is available in alternative communication formats upon request. To make necessary arrangements, contact the ADA Coordinator for the Division of Retirement and Benefits at (907) 465-4460 or contact the TDD for the hearing impaired at (907) 465-2805.

Disclaimer: Information in this newsletter summarizes the plan provisions, is supplemental only, and does not supersede the applicable Information Booklet's provisions. The Division is unable to unsubscribe members from our mailing list at this time.

**State of Alaska Division of Retirement and Benefits
P.O. Box 110203
Juneau, AK 99811-0203**

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Prescription Drug Alternatives Can Save Money

Much information circulates in the news about the high cost of prescription drugs. Nearly half of all Americans regularly take at least one prescription medication, and that percentage increases to 70% for people over age 55 and 77% for those over age 65.

It's no secret that drugs are one of the leading costs to any health plan—U.S. drug spending was \$297.7 billion in 2014 according to Centers for Medicare and Medicaid Services—and the AlaskaCare plans are no exception. When reviewing the plans' performance, an entire section is devoted to prescription costs and the ability to save money if members switched from a brand name drug to a generic drug or to a lower cost alternative drug if no generic exists. If all members who are taking a drug that falls in the top ten drugs purchased under the plans switched to the lowest cost generic or alternative medication, this could result in significant annual savings to the plan.

When discussing your medications with your doctor, consider asking for a generic, a lower cost brand name, or even an over-the-counter drug to save both you and the plan money. 🌱