AlaskaCare Retiree DB Insurance Information Booklet

Summary of Updates for Plan Year 2022

The table below outlines updates made to the AlaskaCare Retiree DB Insurance Information booklet effective January 1, 2022. The updates were primarily in response to *RHPAB Resolution 2021-01* related to the addition of prior authorizations for certain specialty medications and coverage for preventive care services for the AlaskaCare Defined Benefit Retiree Health Plan.

Legend:	Items highlighted in green were added.
	Items highlighted in yellow were updated
	Items highlighted in orange were removed.

<table>
<tr><th>2022 Plan Booklet Language</th><th>2021 Plan Booklet Language</th></tr>
<tr><td>
Section 1.1 Medical Benefits
• New language added to support RHPAB Resolution 2021-01.
Coinsurance
<table>
<tr><td>Preventive care with a network provider or when use of an out-of-network provider has been precertified.
• No deductible applies</td><td>100%</td></tr>
<tr><td>Preventive care with an out-of-network provider</td><td>80%</td></tr>
</table>
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 has been precertified)
</td><td></td></tr>
<tr><td>
Section 3.2 Precertification
• New language added to support RHPAB Resolution 2021-01.
You may request precertification of use of an out-of-network provider for preventive services if there are no network provider options in your area.
</td><td></td></tr>
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Section 3.2.1 Services Requiring Precertification • New language added to support *RHPAB Resolution 2021-01*. • Use of an out-of-network provider for preventive care services.	
Section 3.3.11 Preventive Care and Screening Services • New Section added to support *RHPAB Resolution 2021-01*. **Preventive Care and Screening Services** The purpose of providing preventive care benefits is to promote wellness, disease prevention and early detection by encouraging **covered persons** to have regular preventive examinations to identify potential health risks and provide the opportunity for early intervention. This section describes **covered expenses** for preventive care and supplies when you are well. The recommendations and guidelines referenced in this section will be updated periodically. This plan is subject to updated recommendations or guidelines that are issued by the following organizations beginning on the first day of the **benefit year**, one year after the recommendation or guideline is issued: a) Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; b) United States Preventive Services Task Force; c) Health Resources and Services Administration; and d) American Academy of Pediatric/Bright Futures Guidelines for Children and Adolescents. *Scope of Preventive Care Services* Services are considered preventive care when a **covered person**: a) does not have symptoms or any abnormal studies indicating an abnormality at the time the service is performed; b) has had a screening done within the age and gender guidelines recommended by the U.S. Preventive Services Task Force with the results being considered normal; c) has a diagnostic service with normal results, after which the **physician** recommends future	**Section 3.3.11 Radiation, X-rays and Laboratory Tests** The Medical Plan pays normal benefits for X-rays, radium treatments, and radioactive isotope treatments if you have specific symptoms. This includes diagnostic X-rays, lab tests, TENS therapy, and analyses performed while you are an inpatient. Charges for these services are not paid if related to a routine physical examination except as noted below. The plan provides coverage for the following routine lab tests: a) One pap smear per year for all women age 18 and older. b) Charges for a limited office visit to collect the pap smear are also covered. c) Prostate specific antigen (PSA) tests as follows: o One annual screening PSA test for men between ages 35 and 50 with a personal or family history of prostate cancer, and o One annual screening PSA test for men 50 years and older. d) Mammograms as follows: o One baseline mammogram between age 35 and 40, o One mammogram every two years between age 40 and 50, and o An annual mammogram at age 50 and above and for those with a personal or family history of breast cancer. These tests will be paid at normal plan benefits following the deductible. Other incidental lab procedures in connection with pap smears, PSA tests, and mammograms are not covered.

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preventive care screenings using the appropriate age and gender guidelines recommended by the U.S. Preventive Services Task Force; or d) has a preventive service done that results in a diagnostic service being done at the same time because it is an integral part of the preventive service (*e.g.,* polyp removal during a preventive colonoscopy). If a health condition is diagnosed during a preventive care exam or screening, the preventive exam or screening still qualifies for preventive care coverage. Services are considered diagnostic care, and not preventive care, when: a) abnormal results on a previous preventive or diagnostic screening test requires further diagnostic testing or services; b) abnormal test results found on a previous preventive or diagnostic service requires the same test be repeated sooner than the normal age and gender guideline as recommended by the U.S. Preventive Services Task Force would require; or c) services are ordered due to current symptom(s) that require further diagnosis. *Coverage* Unless otherwise specified, preventive care services are not subject to a **copayment** or **deductible** and will be paid at 100% of the provider's rate, if the **provider** is a **network provider**. Preventive care services provided by an out-of-**network provider** are subject to payment under **medical plan** provisions governing non-preventive care services. If there are no **network providers** in the area where you live, you may contact **Aetna** and request to use an out-of-**network provider** for preventive care services under this section. If your request to use an out-of-**network provider** is authorized, the preventive care services you receive will not be subject to a **copayment** or **deductible** and will be paid at 100% of the **recognized charge**. If your request to use an out-of-**network provider** is denied, or if you fail to request **pre-certification**, all charges incurred for preventive care services will be subject to payment under the	

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medical plan provisions governing non-preventive care services. Unless otherwise specified, preventive care services under this section are limited to once per **benefit year**. *Routine Physical Exams* **Covered expenses** include charges made by your **physician** or other **health professional** for routine physical exams. This includes routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a **physician** or other **health professional** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes: a) Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. b) Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration Guidelines for Children and Adolescents. c) Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include, but are not limited to: • Screening and counseling services, such as: o Interpersonal and domestic violence; o Sexually transmitted diseases; and o Human Immune Deficiency Virus (HIV) infections. • Screening for gestational diabetes for women. • High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older. d) X-rays, lab, and other tests and radiological services given in connection with the exam. e) For covered children, from birth to age 2: • an initial **hospital** checkup • periodic well child exams • consultation between the health	

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professional and a parent *Newborn hearing screening exam* Covered expenses include screening test for hearing loss prior to the date the child is 30 days old and diagnostic hearing evaluation if the initial screening test shows the child may have a hearing impairment. *Preventive Care Immunizations* **Covered expenses** include charges made by your **physician** or a provider for immunizations for infectious diseases that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention: Immunizations for infectious disease; and materials for administration of immunizations. *Well Woman Preventive Visits* **Covered expenses** include charges made by your **physician,** obstetrician, or gynecologist for: a) A routine well woman preventive exam office visit, including pap smears. A routine well woman preventive exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**. b) Routine preventive care breast cancer genetic counseling and breast cancer (BRCA) gene blood testing. c) **Covered expenses** include charges made by a **physician** and lab for the BRCA gene blood test and charges made by a genetic counselor to interpret the test results and evaluate treatment. These benefits will be subject to any age; family history; and frequency guidelines that are: a) Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and b) Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.	

Routine Cancer Screenings

Covered expenses include, but are not limited to, charges incurred for routine cancer screening as follows:

a) Colonoscopies (removal of polyps performed during a screening procedure is a **covered expense**);
b) Digital rectal exams;
c) Double contrast barium enemas (DCBE)
d) Fecal occult blood tests;
e) Lung cancer screening
f) Mammograms;
g) Prostate specific antigen (PSA) tests; and
h) Sigmoidoscopies

These benefits will be subject to guidelines on the basis of age, family history, and frequency that are:

a) Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
b) Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration
c) Found in the American Cancer Society guidelines for colorectal cancer screening

Preventive Screening and Counseling Services

Covered expenses include screening and counseling by your **health professional** for some conditions.

a) Obesity and/or Healthy Diet

Screening and counseling services to aid in weight reduction due to obesity. **Covered expenses** include:

- Preventive counseling visits and /or risk factor reduction intervention;
- Nutrition counseling; and
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related disease.

For persons age 22 and older, the **medical plan** will cover up to 26 visits per 12 consecutive months. However, of these only 10 visits will be allowed under the **medical plan** for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol)

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and other known risk factors for cardiovascular and diet related chronic disease. In determining the maximum visits, each session of up to one hour is equal to one visit. b) Misuse of Alcohol and/or Drugs Screening and counseling services to aid in prevention or reduction of the use of an alcohol agent or controlled substance. **Covered expenses** include preventive counseling visits, risk factor reduction intervention and a structured assessment. The **medical plan** will cover a maximum of five screening and preventive counseling visits of up to one hour in a 12 consecutive month period. These visits are separate from outpatient treatment visits. c) Use of Tobacco Products Screening and counseling services to aid in the cessation of the use of tobacco products. A tobacco product means a substance containing tobacco or nicotine including cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco, and candy-like products that contain tobacco. Coverage includes the following to aid in the cessation of the use of tobacco products: o Preventive counseling visits; o Treatment visits; and o Class visits. o Tobacco cessation prescription and over-the-counter drugs o **Eligible health services** include FDA- approved **prescription drugs** and over-the-counter (OTC)drugs to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing. The **medical plan** will cover a maximum of eight visits of up to one hour in a 12 consecutive month period. d) Sexually Transmitted Infections **Covered expenses** include the counseling services to help you prevent or reduce sexually transmitted infections.	

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e) Genetic Risk counseling for Breast and Ovarian Cancer **Covered expenses** include counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer. f) Prenatal Care Prenatal care will be covered as preventive care for pregnancy-related **physician** office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check, and fundal height) received in a **physician**'s, obstetrician's, or gynecologist's office. g) Comprehensive Lactation Support and Counseling Services 1. Lactation Support **Covered expenses** include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy, or at any time following delivery, for breast-feeding by a certified lactation support provider. **Covered expenses** also include the rental or purchase of breast-feeding equipment as described below. Lactation support and lactation counseling services are **covered expenses** when provided in either a group or individual setting. Benefits for lactation counseling services are subject to the visit a maximum of 6 visits in a 12 consecutive month period. Visits in excess of the lactation counseling maximum as shown above, are subject to the cost sharing provisions outlined in *Section 3.1 How Medical Benefits are Paid.* Coverage includes the rental or purchase of breast feeding **durable medical equipment** for the purpose of lactation support (pumping and storage of breast milk) as follows. 2. Breast Pump **Covered expenses** include the following: • The rental of a **hospital**-grade electric pump for a newborn **child** when the newborn **child** is confined in a **hospital**. • The purchase of:	

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o An electric breast pump (non-hospital grade). A purchase will be covered once every three years; or o A manual breast pump. A purchase will be covered once per pregnancy. If an electric breast pump was purchased within the previous three-year period, the purchase of another breast pump will not be covered until a three-year period has elapsed from the last purchase. 3. Breast Pump Supplies Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump. Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility. The plan reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided, as determined by the **claims administrator**. h) Family Planning Services – Female Contraceptives For females with reproductive capacity, **covered expenses** include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this preventive care benefit must be approved by the U.S. Food and Drug Administration (FDA). Coverage includes counseling services on contraceptive methods provided by a **physician**, obstetrician or gynecologist. Such counseling services are **covered expenses** when provided in either a group or individual setting. Contraceptive counseling services are subject to a two-visit maximum in a 12 consecutive month period. Visits in excess of this	

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maximum are subject to the cost sharing provisions outlined in *Section 3.1 How Medical Benefits are Paid*. The following contraceptive methods are **covered expenses**: 1. Voluntary Sterilization **Covered expenses** include charges billed separately by the provider for female and male voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants for women. **Covered expenses** do not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement. 2. Contraceptives Contraceptives can be paid either as a medical benefit or **pharmacy** benefit depending on the type of expense and how and where the expense is incurred. Benefits are paid as a medical benefit for female contraceptive **prescription drug**s and devices (including any related services and supplies) when they are provided, administered, or removed, by a **physician** during an office visit. *Limitations* Not covered under the Preventive Care and Screening Services benefit are charges incurred for: 1. Diagnostic lab, diagnostic tests, diagnostic procedures, or other labs, tests or procedures ordered, or given, in connection with any of the preventive care benefits described above; 2. Exams given during your inpatient stay for medical care; 3. Services not given by a **physician** or under his or her direction; 4. Immunizations that are not considered preventive care such as those required due to your employment or travel; 5. Pregnancy expenses (other than prenatal care as described above); 6. Services and supplies incurred for an abortion; 7. Services as a result of complications resulting from voluntary sterilization procedure and related follow-up care;	

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8. Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA; 9. Male contraceptive methods, sterilization procedures or devices; 10. The reversal of voluntary sterilization procedures, including any related follow-up care; or 11. Charges incurred for family planning services while confined as an inpatient in a **hospital** or other **facility** for medical care.	
Section 3.3.18 Travel • Updated to clarify return transportation. 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, returning transportation costs to the site of illness or injury may be covered subject to the provisions as outlined in section b.	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
Section 3.3.20 Medical Treatment of Mouth, Jaws and Teeth • Updated bullet d) to reflect new standard of care. d) Dental implants if necessary due to disease, including periodontal disease, or accident. False teeth for use with the implants are covered only under the *dental plan* as a Class III service.	d) Dental implants if necessary due to disease, including periodontal disease, or accident but only if dentures or bridges are inappropriate or ineffective. False teeth for use with the implants are covered only under the *dental plan* as a Class III service.
Section 3.3.25 COVID-19 Vaccinations • Update to clarify COVID vaccine coverage. COVID-19 Vaccinations The medical plan will cover FDA approved COVID-19 vaccinations 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.

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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)*.	
Section 4.4 Covered Vaccines • Section 4.3.5 was replaced with 4.4 to align with *RHPAB Resolution 2021-01*. In addition to the immunizations covered under *section 3.3.11, Preventive Care and Screening Services*, **covered expenses** include other immunizations for communicable diseases, including serums administered by a nurse or **physician**. Charges for office visits in connection with the immunizations are not covered.	**Section 4.3.5 Covered Vaccines** **Medicare Part D-Eligible Vaccines** The pharmacy benefits under the Plan cover some vaccines regardless of whether you are eligible for Medicare. Covered vaccines are listed in the formulary available at AlaskaCare.gov under the therapeutic drug class "viral vaccine". Vaccines covered under the pharmacy plan are those that fall on the Medicare Part D covered vaccine list that are: a) Vaccines administered at the pharmacy. b) Vaccines administered in a doctor's office **only if** they coordinate with a pharmacy to bill the Plan for the entire cost of the vaccination, including the injection of the vaccine. c) If you receive a vaccination in a doctor's office that does not coordinate with a pharmacy, your provider will bill you for the entire cost of the vaccination. You will have to pay the entire bill up front and request reimbursement from the pharmacy benefits manager. It is important to know that your provider may charge you more than the recognized charge amount for the vaccination, but your plan will only reimburse up to the approved amount. You will be responsible for any amount you pay the provider above the recognized charge. Vaccines that are not covered by the Plan include: a) Influenza vaccines (flu shots), including seasonal flu vaccine and the H1N1 (swine flu) vaccine. b) Pneumococcal vaccine (pneumonia shot). For a complete list of vaccines and participating pharmacies contact the pharmacy benefit manager 24 hours a day, 7 days a week or visit the Division's

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	website at *AlaskaCare.gov*. COVID-19 Vaccines The pharmacy benefits under the Plan will cover FDA approved COVID-19 vaccinations at 100%, subject to recognized charge.
Section 5.1 Limitations and Exclusions • Updated to align with *RHPAB Resolution 2021-01*. Marital examinations except as provided in *section 3.3.11, Preventive Care and Screening Services*	Routine physical and marital examinations except as provided in *Section 3.3.11 Radiation, X-rays, and Laboratory Tests*
Section 7.6 Changing your DVA Coverage • Updated to clarify that you can increase coverage or change from or to the Standard or Legacy plans. You may increase coverage or change DVA plans only:	You may increase coverage only: