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Memorandum

To: Retired Public Employees of Alaska, other concerned groups

From: Curtis Thayer, Commissioner

Date: April 18, 2014

Subject: Draft AlaskaCare Retiree Plan Booklet: Side-By-Side Analysis

This memo summarizes and explains in brief the attached Department of Law analysis of the Draft AlaskaCare Retiree Plan Booklet.

I. Background

A. New Third Party Administrators

On January 1, 2014, Aetna and Moda Health became the third party claims administrators and discount network providers for the retiree medical and retiree dental plans, respectively. Also on January 1, the Department of Administration adopted a 35 page plan amendment to the 2003 Retiree Insurance Information Booklet. Those documents may be found here:
http://doa.alaska.gov/drb/alaskaCare/retiree/publications/booklets.html

The 2003 Retiree Insurance Information Booklet as amended through January 2014 is the legal plan document for the retiree medical and retiree dental plans.

The Department of Administration is the plan administrator of the plans. The content of the plan document is entirely the responsibility of the Department of Administration. Aetna and Moda, as claims processing vendors of the plans, are contractually required to administer the plan document as written.

B. Draft Retiree Plan Document

In late January 2014, the Department of Administration released a draft retiree plan document for comment. The draft retiree plan document was a complete re-write of the 2003 retiree plan booklet, which suffers from being quite dated, and ambiguous or silent on many issues. The draft was written by the Department of Law, with assistance from

outside counsel, Ice Miller. This document was only draft, and was not used by Aetna or Moda to administer the processing of claims.

The Department requested comments on the draft by February 28, 2014. The Department subsequently extended comment through April 30, 2014. The Department conducted town hall meetings to engage in discussion, answer questions and receive comments in February in Anchorage, Fairbanks and Juneau. The Department will conduct further town hall meetings in late April.

As a product of such comments, the Department has determined to not adopt the draft retiree plan document in 2014. The Department's primary motivation in not adopting the draft plan document is limited staff resources. The Department has limited resources to administer the health plans, and needs to devote those to ensuring that the new third party administrators are administering the plans correctly. The Department recognizes that the adoption of a new plan booklet will consume a large amount of time and effort in the form of communication, education, meetings and dialogue. The time for such effort would best take place after the point in time that the transition to Aetna and Moda is completed successfully.

C. RPEA Analysis of Draft Retiree Plan Document

The Retired Public Employees of Alaska prepared an analysis of the draft retiree plan document. The Department of Law prepared a side-by-side of the RPEA analysis, which is attached hereto.

II. Department of Law Analysis

Attached hereto, is the Department of Law's analysis detailing the differences between the claims made by the RPEA and what the draft plan booklet actually states. Here are some notable findings from the Department of Law's analysis:

- The draft 2014 plan document constitutes a wholesale rewrite of the retiree health plan booklet. The RPEA analysis was often flawed because it failed to address each of the plan provisions that were relevant to the issue raised.

- Many of the "takeaways" identified by RPEA were not takeaways but rather were the result of provisions that were inferred under the 2003 plan language but made express in the draft 2014 plan language. There was a concerted effort when drafting the 2014 Plan to clarify, to the extent possible, the ambiguous language prevalent in the 2003 plan and thus make the Plan more transparent for members.

- The RPEA analysis consistently failed to take into account the definitions set forth in the draft plan document. While RPEA did note that the definition section was an improvement it did not appear that the definitions had actually been read as many of the "takeaways" were resolved by referring to a specific definition.

- Many of RPEA's comments seemed to infer its belief that the draft 2014 plan document was Aetna's document rather than the State's plan. This in part stems from the decision to replace the more generic term "claims administrator" with the proper name of the claims administrator in the plan document. This change was intended to make it easier for the member to know which TPA (i.e., Aetna or Moda) was responsible for administering a given provision of the Plan. However, RPEA seems to have incorrectly interpreted use of the TPA's name as an indication that the Plan was actually the TPA's plan.

RPEA Takeaway Comparison – 2003 Plan Document Compared To 2014 Plan Draft Document

AlaskaCare Retiree Health Plan

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
(1) Non-emergent travel outside US.	See exclusion for non-emergent care outside the U.S. (Sec 3.6, page 66): Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain medical services, prescription drugs or supplies, even if otherwise covered under the medical plan.	The 2003 plan document explicitly provides for worldwide coverage but also specifically excludes coverage for travel outside of the United States, travel when treatment is available locally and treatment not approved by the FDA. The 2003 plan language evidences the plan's intent to provide coverage when participants are travelling or living abroad but not for the sole purpose of seeking treatment outside of the United States. The draft 2014 plan document language states the plan's intent in more concise and explicit language.
(2) Changed definition of dependent	Spouse - Removes the "legally separated but not divorced" piece. Child – Removed language "exclusive of hospital nursery charges at birth and well-baby care." Does that mean that now those things are covered for a child under this plan? How will retirees know who qualifies as a child? Does the State get to determine case by case?	The verbiage "legally separated but not divorced" relative to spouses has not been removed from the plan language. It is contained under the definition of "spouse" in the draft 2014 plan document. The language "exclusive of hospital nursery charges at birth and well-baby care" has been removed in the draft 2014 plan document. Hospital nursery charges are covered under the 2014 draft plan – *See* sections 1.5.3 and 3.4.16 All Exclusions are set forth in Section 3.6 of the draft plan document. Exclusions for well-baby care would fall under exclusion numbers 21 and 44 respectively. Retirees will know who qualifies as a child because the term "child" is a defined term under Section 17 of the draft plan.
(3) Reduction in student coverage enrolled for five months and not in member's home ½ year	Requires five-month enrollment and that student reside with retiree more than one-half of year. What if you have a student enrolled out of state from Sept through May/June? Language is very distorted and should demand listing with the Dept of Education and Early Development as the criteria	The requirement that coverage for dependents up to age 23 is subject to attendance at a full time educational institution was added in 2004. However, the language of the 2004 amendment states that *all* children under age 23 must be registered at and attending on a full-time basis an accredited

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
	for recognized schools, not whether they are on-line or night schools, determined by whom? Recommend: requirement of listing at http://ope.ede.gov/accreditation/ or any state's dept of ed listings of recognized schools. Set the bar now not later.	educational or technical institution. The language in the draft plan corrects this drafting error and clarifies the different requirements for dependents under the age of 19 and those age 19-23. As evidenced by the 2004 amendment, the extension of dependent coverage until age 23 was designed to provide medical coverage to those dependents over the age of 18 *only* when those dependents are full time students (or totally & permanently disabled). Accordingly, the 5 calendar month provision is consistent with the plan's intent. Further, the term "full time student" is not defined in the 2003 plan document causing ambiguity in the plan language. The 2014 draft plan defines "full time." The definition is from the Internal Revenue Code. The 2003 plan language requires the child to be living with the parent in a "normal parent-child relationship" and states that only step-children living with the retiree more than 50% of the time are covered under the plan. The 2003 plan language evidences the plan's intent that the child be living with the parent for a majority of the benefit year. The language in the 2014 draft plan document requiring the child share the retiree's principal place of residence for more than one half of the year is clarifying language and is consistent with the 2003 requirements.
(4) Difficult for member to determine which schools may or may not qualify their student for coverage (definition of "school" nebulous)		The 2004 amendment to the 2003 plan document states "if your dependent 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." The 2003 plan document (as amended) did not define the term "full time student" causing ambiguity in the plan language. The 2014 draft plan defines "full time." The definition is from the Internal Revenue Code.

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
		The 2003 plan document (as amended) limits coverage to accredited educational or technical institutions recognized by the State of Alaska Department of Education and Early Development. As drafted, dependent eligibility over age 18 is thus limited to full time attendance at schools in Alaska as those are the only schools that can be accredited by the State's Department of Education. Further, the Department of Education does not accredit technical institutions or colleges or universities. Thus, as written, the 2003 language is very limiting. The draft 2014 plan document broadens coverage by defining the term "educational institution" to mean a school maintaining a regular faculty and established curriculum, and having an organized body of students in attendance. It includes primary and secondary schools, colleges, universities, normal schools, technical schools, mechanical schools, and similar institutions, but does not include non-educational institutions, on-the-job training, on-line schools, correspondence schools, or night schools.
(5) Changes incapacitated dependent definition	Change of age requirement as 19 or 23, not simply 23. Change to notify claims administrator removes this eligibility information from the Division. This seems to replace the responsibility of eligibility from the Division to the TPA. Changes "incapacitated" designation to permanently and totally disabled.	The 2004 addendum referenced age 19. The 2004 addendum used the language "totally and permanently disabled." The 2004 addendum did not define "totally and permanent disabled" creating ambiguity in the plan language. The 2014 draft plan document provides a definition consistent with the Internal Revenue Code. A determination of total and permanent disability is a medical determination; therefore, the responsibility is with the TPA subject to appeal rights. The Division had delegated this task to the prior TPA. The language was revised to conform to practice.
(6) Dental/Vision/Audio elections can be changed only after two years of coverage	Section 1.4.2 – adds language "DVA coverage can only be changed after enrolled for two benefit years.	Under the 2003 plan document, a retiree receiving automatic coverage (no cost) had to elect DVA coverage before the effective date of the retirement benefit, or with the application for survivor benefit. Under the 2014 draft plan document, this restriction would no longer exist.

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
		Under the 2003 Plan document, members selecting voluntary coverage (paying a premium) can only elect DVA coverage before the effective date of their retirement benefits, with the application for survivor benefits, or at open enrollment. However, selections during open enrollment are limited in that DVA elections can only be made if the same or increased level of medical coverage was being elected for the first time during that open enrollment. Under the draft 2014 draft plan document, this restriction would no longer exist. The draft 2014 draft plan document would allow retirees to select DVA coverage at any time provided that changes can only be made after enrollment in the current selection for 2 benefits years. This provision is consistent with the employee plan provision and is intended to prevent adverse selection.
(7) "Decreasing Coverage" section added allowing benefit recipient the right to terminate coverage	Section 1.6.2 (decreasing coverage) Adds "decreasing coverage" section. Adds a paragraph stating if you fail to timely notify the Division of dependent ineligibility – repayment of benefits required and ongoing and future coverage may be forefeited at the State's discretion. Doesn't say what criteria will be used for the "State's discretion" in determining who may or may not forfeit benefits. Allows discretionary power to the "authority" for the plan.	This is not a new section. The language referenced by RPEA is found in both the 2003 and 2014 plan documents under the respective headings "Changing your Dependent Coverage" and "Changing Your Coverage." The 2014 draft plan document breaks this section down into subsections for easier reading. The 2003 plan document contains a right of recovery provision. In the 2014 draft plan document, this provision has been incorporated into both sections 1.6.2 and 16.14 for easier reference. The repayment of benefits language in the 2003 plan document contains discretionary language. The draft 2014 plan language also contains discretionary language. Any action by the Division is subject to appeal rights. The draft 2014 plan language adds language providing for forfeiture of future coverage at the State's discretion (for

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
		example if someone falsified documents). Again, any action by the Division is subject to appeal rights.
(8) Dependents can be dropped without a life event	Can a parent simply drop dependent from coverage at their whim?	Election and termination of coverage for dependent children has always been at the discretion of the retiree. Neither the 2003 nor the 2014 plan documents require the retiree to elect dependent coverage for children.
(9) Precertification requirements increased substantially (no payment at all if some are not met)	Adds many procedures to pre-cert list – tied directly to in and out-of-network provider participation.	The 2003 plan document contains numerous provisions regarding precertification, certification, referral and preauthorization. All of these requirements have been consolidated into one section within the draft 2014 plan document for easier reference. The 2003 plan document applies penalties for failure to precertify regardless of whether the provider is a network provider or an out-of-network provider. The draft 2014 plan document (and January 2014 amendment) eliminates penalties when the member uses a network provider. Under the draft 2014 document (and January 2014 amendment), penalties are applied only when utilizing an out-of-network provider and there is a failure to precertify. The 2003 plan document requires certification for all inpatient stays (including hospital stays, treatment facilities and skilled nursing facilities), home healthcare, skilled nursing services, mental health treatment, chemical dependency treatment, MRI knee and MRI spine. The draft 2014 document (and January 2014 plan amendment) continues to require precertification for these services. The 2003 plan document (prior to the 2009 addendum) required precertification for 13 procedures (in addition to inpatient stays, home healthcare, skilled nursing services, mental health and chemical dependency treatment). The 2009 amendment reduced this list to 2 procedures. The draft 2014 plan document (and January 2014 plan amendment) adds 20 new procedures to the list requiring

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		precertification. Hospice care is new coverage under the draft 2014 plan document (and January 2014 amendment). As such hospice service has been added to the precertification list. The 2003 plan document did not address organ transplants. The draft 2014 plan document (and January 2014 amendment) does specify coverage for transplants, including precertification requirements. The 2003 plan document requires preauthorization for all travel except travel associated with surgery provided less expensively in another location. The draft 2014 plan language (and January 2014 amendment) continues to require precertification for all travel, including travel associated with surgery provided less expensively in another location. The 2003 plan document applied various penalties for failure to precertify: (1) $400 penalty for failure to certify hospitals and treatment facilities; (2) $200 penalty for failure to certify home health care, skilled nursing facilities, skilled nursing care or supplies, MRI Knee, and MRI spine. The draft 2014 plan document (and January 2014 amendment) makes consistent the penalty for failure to precertify ($400). However, the penalty is only applied when using an out-of-network provider. The 2003 plan document applies a 50% reduction in covered expenses for failure to certify mental disorders. The draft 2014 plan document (and January 2014 amendment) maintains the same penalty. The 2003 plan document applies various penalties for failure to certify chemical dependency treatment including a $400

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		penalty for hospital or treatment facilities and a cap on benefits of $12,715 every 2 benefit years and $25,430 per person/lifetime. The draft 2014 plan book (and January 2014 amendment) maintains the same penalties with the exception that the $12,715 cap on benefits is now an annual cap (as opposed to every 2 benefit years). The 2003 plan document requires certification for traditional outpatient mental health and substance abuse treatment. The draft 2014 plan document (and January 2014 amendment) no longer requires pre- certification for these services. The 2003 plan document contains penalties for failure to follow plan referral with respect to mental health and chemical dependency treatments. The draft 2014 plan language (and January 2014 amendment) no longer contains a plan referral requirement. Precertification requirements are not a takeaway. They serve to alert members when there is a chance of higher costs and balance bills. They also provide the opportunity for members to obtain information on treatment alternatives and the availability of in-network care.
(10) Changes plan from open choice of providers to PPO plan, payments reduced for choosing out-of-network providers	Page 109 of old booklet. "Free choice of Hospital and Provider." "You may select ANY provider who meets the def on pages 19-20." (Dentist is included here specifically). The determining factor of how much will be reimbursed was not previously based solely on the participation status of the dentist. The AlaskaCare dental plan was NOT designed to do this, Delta Dental's dental plan is designed to do this…Note LESSER OF! Wording is not found in the old booklet.	Plan participants may still select any provider covered by the medical and dental plan. *See* page 18 of 2003 plan document and Sections 3.2.1, 3.2.3, 3.4.2 and 4.2.3 of the draft 2014 plan document. The participation status of the participating dentist was always a factor in reimbursement. Under the 2003 plan, if a member utilized an out-of-network dentist, the member was subject to balance billing. The 2003 plan language relative to the dental plan clearly stated "*Payment is based on the recognized charge for covered services. Charges or fees in excess of the recognized charge, as determined by the claims*

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		administrator, are your responsibility to pay. The recognized charge is the charge contained in an agreement the claims administrator has with the provider either directly or through a third party." Thus, under the 2003 plan, the recognized charge for network dentists was the charge contained in an agreement the claims administrator had with the provider either directly or through a third party. This has not changed with the draft 2014 plan. The "lesser of" language is found in both the 2003 and 2014 plan books. The 2003 plan state, *for out of network providers, the recognized charge is "the **lowest** of:* *• The provider's usual charge for furnishing the service.* *• The charge the claims administrator determines to be appropriate based on factors such as the cost for providing the same or similar service or supply and the manner in which charges for the service or supply are made.* *• The charge the claims administrator determines to be the recognized charge percentage made for that service or supply*." The 2014 draft plan document states "*for out-of-network **dentists** or **dental care providers** in the **State**, the **recognized charge** is the lesser of:* • *what the **dentist** bills or submits for that service or supply; or* • *75% of the 80th percentile of the **prevailing charge rate** as determined by **Delta Dental** in accordance with its reimbursement policies.*
(11) Usual, customary and reasonable (UCR) method of calculating payments changed to "Recognized Charge" at discretion of claims administrator	Turns the entire reimbursement process and decisions about the percentage of coverage over to Aetna and Delta Dental. Aetna has a stranglehold on rates and uses their own policies to determine coverage using a "commercial software package." Periodically updates to current	In the 2003 plan document, reimbursement is based on the recognized charge for covered services. Under the 2003 plan document, the recognized charge percentage is the charge determined by the claims administrator on a semi-annual basis to be in the 90th percentage of the charges made for a service or supply by providers in the geographic area where

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	prevailing charge rates.	it is furnished. The 2014 plan document still uses the 90th percentile for the medical plan. The 2014 draft plan document uses the 80th percentile for network providers and 75 percent of the 80th percentile for out-of-network providers as the recognized charge for the dental plan. The 2003 Plan document is silent with respect to the recognized charge for pharmacy claims. The draft 2014 plan document identifies the recognized charge for pharmacy claims as 110% of the average wholesale price. In both the 2003 and draft 2014 plan documents, the recognized charge percentage is set by the plan – not the claims administrators. Change in recognized charge plan language made pursuant to OAH Case No. 10-0577-PER. The recognized charge percentile for the medical plan is determined based on rates reported by FAIR Health, a nonprofit company – not rates reported by Aetna. FAIR Health is the same company utilized by the prior TPA to determine the recognized charge.
(12) Change to reimbursement of Rx drugs at 110% AWP or billed charge	Drugs at 110% AWP or billed.	The 2003 Plan document is silent with respect to the recognized charge for pharmacy claims. The draft 2014 plan document identifies the recognized charge for pharmacy claims as 110% of the average wholesale price. Change in recognized charge plan language made pursuant to decision issued in OAH Case No. 10-0577-PER.
(13) Removes responsibility for appeals process from the Plan Administrator and gives rights fully over to the discretion of the claims administrator	Removes the Division (Plan Administrator) from any responsibility for the health plan coverage or denials by TPA.	The original 2003 plan language conducted the **first level** of appeal at the claims administrator level. The amendment effective 6/30/2005 conducts the first level of appeal at the claims administrator level. The draft 2014 plan document (and January 2014 amendment) conducts the first level of

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		appeal at the claims administrator level. The original 2003 plan language conducted the **second level** of appeal at the plan administrator level. Under the 2003 plan, the Plan Administrator reviewed the appeal to determine whether to cover the claim under the terms of the health plan or refer the appeal to an Independent Review Organization. Under the 2003 plan language, the Plan Administrator issued the written decision, even if the appeal was reviewed by an IRO. The amendment effective 6/30/2005 conducted second level appeals with the TPA. The draft 2014 plan language (and January 2014 amendment) conducts the second level of appeal with the Claims Administrator if the subject of the appeal is non-clinical in nature. If the subject of the second level of appeal is clinical in nature, the second level of appeal is conducted by an IRO. The original 2003 plan language allowed a **third level** of appeal to the Board in limited circumstances (could not appeal claim reduced due to UCR or denied because coverage not provided under the plan). The amendment effective 6/30/2005 removed the Board as the third level of appeal and substituted the plan administrator as the third level of appeal. Under the 6/30/2005 amendment, the Plan Administrator retained the discretion to send the appeal to an IRO. Under the 6/30/2005 amendment, the Plan Administrator issued the decision even if the review was conducted by the IRO. The 2005 amendment created a fourth level of appeal – the Office of Administrative Hearings (OAH). The draft 2014 plan language (and January 2014 amendment) creates a third level of appeal at the OAH. The new appeals language comes from the Affordable Care Act. The appeals language in the Retiree plan document is consistent with the Employee plan document.

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		The draft 2014 plan language (and January 2014 amendment) streamlines the appeals process from 4 levels of appeal to three levels of appeal and retains the use of Independent Review Organizations. The 2014 plan language (and January 2014 amendment) with respect to IROs requires the plan to immediately effectuate the decision of the IRO when that decision is in the member's favor. The 2014 draft language (and January 2014 amendment) comports with due process by mandating that appeals related to clinical decisions are reviewed by an independent medical review organization rather than staff at the Division level who have no medical background.
(14) Dental coverage changed to "Delta Dental" standard coverage (many changes)		The dental plan is an optional benefit requiring the member to independently and voluntarily choose coverage and pay the governing premium. Frequency limits set forth in the draft 2014 plan document reflect current standards of dental care. **Class I Preventive** Oral Examinations: No frequency indicated under 2003 plan document. Frequency identified as once in any six month period under 2014 draft plan document. Full Mouth X-Rays: Once per year under 2003 plan document. Once every 5 years in 2014 plan document. Bitewing X-Rays: No frequency indicated under 2003 plan document. Under 2014 plan document, frequency identified as one series in any 12-month period. Prophlaxis: No frequency indicated under 2003 plan document. Under 2014 plan document, frequency identified as once in any 6 month period. Covered persons diagnosed with periodontal disease are eligible for up to a total of four

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		cleanings per benefit year. Additional cleanings may be authorized if dentally necessary. Additional cleaning benefits available for members with diabetes and female members in their third trimester of pregnancy. Fluoride Application: No frequency indicated under 2003 plan document. Under 2014 plan document, frequency identified as once in any 6 month period through age 18; for 19 and over, only if specific criteria met. Sealants: Through age 18 w/no indication of teeth/frequency under 2003 plan document. Under 2014 plan document, limited to the unrestored occlusal surfaces of permanent molars; one per tooth during any 5 year period; no age limitation. Space Maintainers: Under 2003 plan document, covered Under Class II; no indication of teeth/frequency. Under 2014 plan document, covered under Class I; once per space up to age 14 for primary posterior teeth. Periodontal Maintenance: Under 2003 plan document, covered under class II. No indication of frequency. Under 2014 plan document, benefited as prophylaxis **or** periodontal maintenance; covered under Class I once in every 6 month period. **Class II Restorative** Root Canal Therapy: Under 2003 Plan Document, re-treatment is not addressed. Under 2014 plan document, re-treatment is allowed after 24 months; benefit payable on date of completion. Pulp Capping: Under 2003 plan document, indirect pulp capping not addressed. Under 2014 plan document, indirect

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		pulp caps are not covered. Periodontal Scaling: Under 2003 plan document, no frequency indicated. Under 2014 plan document, once in any 24 month period. Full Mouth Debridement: Under 2003 plan document, not addressed. Under 2014 plan document, covered once in a 3-year period and only if there has been no cleaning within 24 months. Fillings: Under 2003 plan document, fillings of silver amalgam, silicate and plastic restoration. Under 2014 plan document, composites only covered on anterior teeth. Brush Biopsy: Under 2003 plan document, not addressed. Under 2014 plan document, covered once in any 6 month period. Benefit is limited to the sample collection and does not include coverage for pathology (lab) services. **Class III Prosthetic** Crowns: Under 2003 plan document, no frequency indicated. Under 2014 plan document, covered once in any 7-year period on any tooth; benefit payable on seat date. Inlays: Under 2003 plan document, no frequency indicated. Under 2014 plan document, once in any 7-year period if inlay is a replacement. If initial placement, an alternative benefit of an amalgam restoration is provided. Bridges: 2003 Plan language ambiguous regarding whether coverage is for initial placement only. Under 2003 plan, covered if completed within 90 days of termination. Under 2014 plan document, frequency is limited to once in any 7-year period and covered if completed within 31 days of

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
		termination. Dentures: Under 2003 plan document, covered once in any 5-year period; covered if completed within 90 days of termination. Under 2014 plan document, covered once in any 7-year period. Repair Dentures/Bridges: Under 2003 plan document, covered under Class II. Under 2014 plan, covered under Class III. Adjustment of Dentures: Under 2003 plan document, not addressed. Under 2014 plan document, not a benefit within 6 months of initial placement. Subsequent adjustments are limited to 2 per denture in a 12-month period. Reline Dentures: Under 2003 plan document, covered under Class II. Under 2014 plan, covered under Class III; not a benefit within 6 months of initial placement. Subsequent relines are limited to 1 in any 12 month period. Rebase Dentures: Under 2003 plan document, not addressed. Under 2014 plan document, covered under Class III. Tissue Conditioning: Under 2003 plan document, not addressed. Under 2014 plan document, covered twice per denture in a 36-month period. Implants: Under 2003 plan document, not addressed under dental. Under 2014 plan document, surgical placement and removal of implants are covered. Limited to once per lifetime per tooth space. A crown or bridge (including pontic) over an implant is covered once per lifetime. General Anesthesia: Under 2003 plan document, coverage

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
		under Class II. Under 2014 plan document, benefit with covered endodontic surgery, periodontal surgery, oral surgery, or when medically necessary; covered as Class III. Nitrous Oxide: Under 2003 plan document, not addressed. Under 2014 plan document, nitrous oxide not covered.
(15) Reduction in teeth cleanings (from up to four down to two per year, unless diabetic, pregnant in 3rd trimester or diagnosis of periodontal disease)	Reduction in teeth cleanings (from up to four down to two per year, unless diabetic, pregnant in 3rd trimester or diagnosis of periodontal disease)	Prophlaxis: No frequency indicated under 2003 plan document. Under 2014 plan document, frequency identified as once in any 6 month period. Covered persons diagnosed with periodontal disease are eligible for up to a total of four cleanings per benefit year. Additional cleanings may be authorized if dentally necessary. Additional cleaning benefits available for members with diabetes and female members in their third trimester of pregnancy.
(16) Reimbursement policies instituted as determined by claims administrator, not "90th percentile" of all claims for like services – out of network providers would be paid at "80th percentile"	Turns the entire reimbursement process and decisions about the percentage of coverage over to Aetna and Delta Dental. Gives total control over to Aetna policies and Delta Dental for RC and whether service qualifies or not. Reduces dental Recognized Charge to 80th percentile, rather than previous 90th percentile. Reimbursement was never based on participation status of provider before.	*See* response for numbers 10 & 11.
(17) No indication of how claims administrator is to determine "allowed charges" in areas too infrequent to determine amount		Change in recognized charge plan language made pursuant to decision issued in OAH Case No. 10-0577-PER. The explanation for how allowed charges are determined in areas too infrequent to determine amount is set forth in the definition section of the draft plan document (*See* definition of recognized charge). By way of example, for medical plan expenses under the draft 2014 plan document, the recognized charge for an out-of-network provider is the 90th percentile of the **prevailing charge rate** for the **geographic area** where the service is

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		furnished. **The prevailing charge rates** means the rates reported by FAIR Health in their database. Fair Health reviews, and if necessary, changes these rates periodically. Aetna updates its systems with these changes within 180 days after receiving changes from Fair Health. Fair Health is the same company utilized by the prior TPA to determine the recognized charge. The **Geographic Area** means an expense area grouping defined by the first 3 digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample.
(18) "Recognized charge" can be reduced by Aetna policies		The 2003 plan document allows the claims administrator to use various criteria for determining the recognized charge when data is insufficient. The 2014 plan language clarifies that such criteria may be used to reduce recognized charge in accordance with the claims administrator's (Aetna's) reimbursement policies. Both plans set forth the criteria that can be used. **The 2003 plan criteria:** • The recognized charge in a greater geographic area. • The complexity of the service or supply. • The degree of skill needed. • The type or specialty of the provider. • The range of services or supplies provided by a facility. If two or more surgical procedures are performed during the same operative session, payment will be calculated as follows: • The claims administrator will determine which procedures are primary, secondary or tertiary, taking into account the

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		billed amounts. • payment for each procedure will be made at the lesser of the billed charge or the following percentage of the recognized charge: — primary 100% — secondary 50% — all others 25% Incidental procedures, those that take little or no additional resources or time when performed at the same time as another procedure, are not covered by the plan. Charges in excess of the recognized charge as determined by the claims administrator are not paid by the plan. **The 2014 plan criteria:** • the duration and complexity of a service; • whether multiple procedures are billed at the same time, but no additional overhead is required; • whether an assistant surgeon is involved and necessary for the service; • if follow up care is included; • whether there are any other characteristics that may modify or make a particular service unique; and • when a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.
(19) "Semi-annual" review to update "recognized charge" changed to "periodically" by claims administrator		Change in recognized charge plan language made pursuant to OAH Case No. 10-0577-PER. *See* response to number 17 above.
(20) Transplants paid at 60% for non-Institute of Excellence facility is used	Introduces an entire section on Transplant services and requirements to go to an Institute of Excellence, as determined by Aetna.	The 2003 plan document did not address coverage provisions regarding transplants. The 2014 draft plan document contains a new coverage section regarding transplants. The network level of benefits is paid only for a

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
		treatment received at a facility designated by the **medical plan** as an Institute of Excellence™ (IOE) for the type of transplant being performed. The Institute of Excellence network has over 120 hospitals in network including the premier transplant facilities in the country.
(21) Rx does not apply to lifetime maximum	Sec. 3.2.9 pp 20. Rx does not apply. Pp 166. Not noted in old book.	The 2003 plan language specified that all covered *medical* expenses applied towards the $2,000,000 lifetime maximum. The draft 2014 plan language removes prescription drug expenses from inclusion in the calculation of the lifetime maximum.
(22) Travel not paid AT ALL if not preauthorized	Defines that travel claims will be **denied if not precertified.**	The 2003 plan document required precertification for all travel in order to receive reimbursement – with one exception – travel for surgery that can be performed less expensively in another location. The 2014 draft plan language continues to require precertification for all travel but removes the exception for travel for surgery that can be performed less expensively in another location. The draft 2014 plan instead instructs the member to contact the claim administrator for assistance with identifying less expensive options for surgery. As drafted, the 2003 plan document created exposure to the member if travel costs were first incurred but the claims administrator determined after he travel/surgery had occurred that the surgery was not performed less expensively. The 2014 draft language removes this exposure by requiring all travel to be preauthorized.
(23) Physical therapy coverage excluded for chronic conditions	Coverage excludes physical therapy for chronic conditions. Speech therapy only covered for non-chronic or as a result of a gross anatomical defect present at birth. The speech therapy from birth defect was not covered previously.	The 2003 plan only covered outpatient rehabilitative care. The draft 2014 plan covers both inpatient and outpatient rehabilitative care. Under the 2003 plan language, rehabilitative care is considered medically necessary only if significant improvement in body function is occurring and is expected to continue. In the 2014 plan document, the use of the term

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
		"non-chronic conditions" is consistent with the 2003 improvement requirement. Under the 2014 draft plan language, the speech therapy coverage provision has been expanded to include speech impairment and speech delays associated with gross anatomical defects present at birth.
(24) Ground transportation changed to per diem (overnight and non-overnight) amount rather than actual documented costs	Changes benefit amount to a per diem amount rather than documented expenses enroute.	The 2003 plan language contains inconsistent provisions with respect to travel expenses. In one paragraph, the plan document states that documented travel expenses for fares, mileage, food and lodging were reimbursed for ground transportation in excess of 100 miles (when using the most direct one-way route). However, in a separate paragraph, the plan document states that travel does not include reimbursement for the cost of lodging, food, or local ground transportation. The draft 2014 plan language eliminates this inconsistency. The draft 2014 plan language is also easier to administer and eliminates the need for members to document these expenses.
(25) Depo-Provera injections limited to five per year	Not listed specifically in old booklet.	The 2003 plan language was silent with respect to this provision. This provision added for clinical reasons.
(26) $2,000 every two years audio limit reduced to "rolling three-year period"	Changes to "more than once in a rolling three yr period." May reduce the benefit by timing.	Under the 2003 plan document, the audio plan maximum was applied against a three-year period consisting of the current and two previous years. Under the draft 2014 plan document, the maximum is applied against a rolling 36-month period. Under both plans, the maximum was intended to apply against a 36 month period. However, under the 2003 plan language, a member can be subject to the limitation for a period of less than 36 months depending upon the date of service. The draft 2014 plan language is consistent with the plan's intent.
(27) Current medical necessity definition replaced by Aetna Clinical Policy Bulletins	Uses Aetna specific Coverage Policy Bulletins. If not in a CPB more criteria applies. States even if the service or supply meets medical necessity criteria, it still may not be covered as there are day or visit limitations in the plan. Same list of	The 2003 plan document contains a generic definition of medical necessity and sets forth general information the TPA must take into account when making determinations of medical necessity. The 2003 plan document does not

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
	always considered unnecessary as the old booklet.	provide members with access to the TPA's specific medical necessity determinations. The draft 2014 plan document does provide members access to specific determinations of medical necessity. This provides greater transparency for the member. When the TPA does not have an applicable clinical policy bulletin, the draft 2014 plan document sets forth the criteria that must be used when making a determination of medical necessity. These criteria are substantially similar to the criteria set forth in the 2003 plan document.
(28) Reduces private room requirement for "medical necessity" as previously defined to "due to contagious illness or immune system" problem.	Changes medical necessity to contagious illness or immune problem.	The 2003 plan requires the member to pay the difference between a private room and a semi private room unless a private room is medically necessary. The draft 2014 plan language makes more specific the circumstances when a private room is covered: cases of infectious **illness** or a weak or compromised immune system.
(29) Limits inpatient coverage to specific list.		There is no support in the draft 2014 plan document for this conclusion.
(30) Covers ambulance under "hospitalization" coverage rather than medical.		In the draft 2014 plan document, Section 3.4.4 covers hospital expenses. Section 3.4.20 covers ambulance services. Both are included under the medical plan. Section 3.4.4 merely allows ambulance services, when provided by a hospital, to be an allowed expense subject to the provisions of Section 3.4.20.
(31) Outpatient Hospital introduced and stipulates room and board charges will be split 40% room/60% "other charges"	Assumption of40%-60% split for R&B and "other charges" if not itemization by facility.	Certain facilities, such as residential treatment centers, charge a flat daily rate that covers room and board as well as treatment and other services. The 2003 plan document does not address how to pay a claim when room and board charges are not itemized. Accordingly, the 2014 draft plan language has been updated to provide guidance to the TPA on how to process claims when room and board charges have not been itemized. This is important because in some cases there may be plan limits that apply to the services that do not apply to room and board. This provision only applies in the event the facility does not provide itemized billing charges.

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
(32) Limits ER visits to "when network urgent care facilities are not in the service area and you cannot reasonably wait to visit your physician"	Adds new section on when ER visits are covered. Adds new section on when Urgent Care visits are covered.	The 2003 plan document references urgent care facilities but does not specify coverage provisions applicable to such facilities. The 2014 draft plan document includes coverage provisions specific to urgent care facilities.
(33) Renames "Outpatient Ambulatory Surgery" section to "Alternatives to Hospital Stays", removing the 100% coverage without deductible assessment incentive for choosing outpatient surgery	Adds new section on "alternatives to hospitalization." Removes incentive of 100% coverage for same day ambulatory surgery w/no deductible if you are an OP. BIG! And all with no anesthetic! Wow!	The 2003 plan document provides for 100% coverage with no deductible for outpatient surgery in an ambulatory surgical center. The 2014 draft plan document provides the same coverage. *See* Section 2.1.1. The 2014 plan document specifies that this coverage includes the services of another physician for related post-operative care and administration of anesthesia – but not administration of a local anesthetic. The language does not state that anesthesia isn't covered. The language merely states that the costs of another physician (i.e. anesthesiologist) aren't covered for administration of a local anesthetic – because that service should be provided by the primary physician.
(34) Excludes local anesthesia in Surgery Centers and Birthing Centers		No such exclusion exists – see response to item #33 above.
(35) Removes language specific to how claims are handled if benefits or claims administrator changes while confined in a hospital (may be a reduction if not clear as to coverage)		Language regarding changes in benefits were removed from the hospital section in the draft 2014 plan language because, depending on the benefit, the change can affect more than just hospital coverage, or be inapplicable to hospital coverage. Transition issues relative to amended benefits will be addressed at the time of amendment. Processing of claims when there is a change in claims administrator is a contractual provision and not a plan benefit provision. Accordingly, claims run-out procedures are included in the TPA contract.
(36) Home health services not covered if home health provider is not available	Defines that if PV is not avail the services are not covered.	The 2003 plan document contains an exclusion for custodial care regardless of where the services are provided. The draft 2014 plan language merely incorporates the 2003 exclusion into the home healthcare section and specifies that the unavailability of custodial care providers does not allow such custodial care to become covered under the home healthcare coverage provision.
(37) Excludes home health benefits to a	Defines that if PV is not avail the services are not covered.	The 2003 plan document contains an exclusion for custodial

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
minor or dependent adult if family member or care giver is not present		care regardless of where the services are provided. The draft 2014 plan language is consistent with the 2003 exclusion by requiring custodial caregivers to be present when home healthcare services are being provided to an individual (minor or adult) dependent on others for unskilled (custodial) care.
(38) Excludes treatment of drug addiction, alcoholism, senility, mental retardation or any other mental illness from skilled nursing facility coverage (may now be covered under Hospice??)	Excludes certain conditions from SNF coverage.	The 2003 plan language specifically states that skilled nursing facilities are **not "**institution[s] for rest or care of the aged, people with mental disorders, or people who are chemically dependent or mentally retarded." The draft 2014 plan document excludes from skilled nursing facility coverage "charges for the treatment of drug addiction, alcoholism, senility, mental retardation or any other mental illness." The excluded services are consistent in both plan documents.
(39) Removes "Retiree-Elected Second Opinions" benefit		This provision was not removed, it was just renamed "Second Surgical Opinions." *See* Section 3.4.10 of draft 2014 plan document.
(40) Excludes coverage for laboratory and radiological studies unless "You have definite symptoms that start, maintain or change a plan of treatment prescribed by a physician"	Defines when these tests are covered and limits to symptoms that start, maintain or change a plan of treatment.	The 2003 plan document excludes from coverage "[m]edical examinations or tests for diagnostic purposes unless related to a specific illness, disease, or injury." The 2003 document also contains language to provide coverage for "X-rays, radium treatments, and radioactive isotope treatments if you have specific symptoms." The 2014 draft plan language providing coverage for radiological services if the member has definite symptoms that start, maintain or change a plan of treatment prescribed by a physician is updated language but is consistent with the 2003 language.
(41) Excludes coverage for repeated pre-operative blood tests	Excludes repeated tests. Defines that surgery will be covered if tests so indicate.	The 2003 plan document provides coverage for preoperative testing provided the tests are not repeated by the hospital or surgery center where the surgery is to be performed. The draft 2014 plan document contains the same language.
(42) Excludes payment for surgery if test results indicate that surgery should not be performed	Excludes repeated tests. Defines that surgery will be covered if tests so indicate.	Under the outpatient pre-operative testing provision, the 2003 plan document states "[i]f you cancel the surgery (other than when your physical condition prevents it), the testing is paid at normal plan benefits. The 2003 language

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
		infers that surgery may be canceled based upon test results. The 2014 draft plan document states "[i]f your tests indicate that surgery should not be performed because of your physical condition, the **medical plan** will pay for the tests, but surgery will not be covered. The 2014 draft plan document updates the 2003 language but the meaning has not materially changed.
(43) Penalties for non-precertification introduced for MANY procedures		The 2003 plan document applies penalties for failure to precertify regardless of whether the provider is a network provider or an out-of-network provider. The 2014 draft plan document only applies penalties when utilizing an out-of-network provider. The 2003 plan document requires preauthorization for all travel except travel associated with surgery provided less expensively in another location. The draft 2014 plan document continues to require precertification for all travel but eliminates the exception for travel associated with surgery provided less expensively in another location. The 2003 plan document applied various penalties for failure to precertify: (1) $400 penalty for failure to certify hospitals and treatment facilities; (2) $200 penalty for failure to certify home health care, skilled nursing facilities, skilled nursing care or supplies, MRI Knee, and MRI spine. The 2014 draft plan document makes consistent the penalty for failure to precertify ($400) but applies only when using an out-of-network provider. The 2003 plan document applies a 50% reduction in covered expenses for failure to certify mental disorders. The 2014 draft plan document maintains the same penalty. The 2003 plan document applies various penalties for failure to certify chemical dependency treatment including a $400 penalty for hospital or treatment facilities and a cap on benefits of $12,715/every 2 benefit years and $25,430 per

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
		person/lifetime. The 2014 draft plan book maintains the same penalties with the exception that the $12,715 cap on benefits is now an annual cap (as opposed to every 2 benefit years). The lifetime cap remains the same. The 2003 plan document contains penalties for failure to follow plan referral with respect to mental health and chemical dependency treatments. The 2014 draft plan language no longer contains a plan referral requirement.
(44) Excludes therapy coverage for persons with Down's Syndrome, Cerebral Palsy and other developmental delays	Excludes coverage for therapy for Down's Syndrom, Cerebral Palsy as examples of developmental and/or chronic in nature.	The 2003 plan document excludes from coverage services, treatment, education, testing, or training related to learning disabilities or developmental delay. The draft 2014 plan document also excludes coverage for treatment of developmental delays. The draft 2014 plan document is updated to include examples of conditions considered to be developmental delays such as Down's Syndrome or Cerebral Palsy.
(45) Excludes "cost" of anesthetic and limits coverage to "administration" of anesthetic	Changes "cost of anesthetics and its administration" to "cost of administration of anesthetics," and defines who can provide them.	The language governing the administration of anesthetics has been updated and expanded in the draft 2014 plan document to include administration of oxygen, administration of anesthetics by C.R.N.A.'s and administration of injections, muscle relaxants, local anesthesia and steroids. The cost of the medication itself is covered under other sections of the plan document such as medical necessity (section 3.4.1) and hospital expenses (section 3.4.4). The "cost" of anesthetic is not excluded under the plan.
(46) Removes high-risk pregnancy screening benefit	Removes high risk pregnancy screening. Includes coverage for newborn IP.	The draft 2014 plan language makes clear that charges for pregnancy and childbirth services and supplies are covered at the same level as any illness or injury. Thus, there was no need in the 2014 draft language to specifically address high risk pregnancies as such pregnancies are covered the same as any other illness or injury. Under the 2014 plan document, members still have the opportunity to consult with a nurse consultant regarding pregnancy risk factors and ways to reduce those risk factors. *See* section 3.4.3 – Nurse

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
		Advice Line. The 2014 draft plan language expands coverage by eliminating the exclusion for newborn care found in the 2003 plan document and including charges made by birthing centers and charges for services/supplies associated with circumcision of a newborn.
(47) Changes coverage requirements for durable medical equipment	Adds discretionary limit by TPA.	Under the 2003 plan document, coverage for durable medical equipment is predicated on the claims administrator being shown: (1) long term use is planned; (2) the equipment cannot be rented; (3) it is less costly to purchase rather than rent; (4) if repair/replacement – the equipment was needed due to a change in the person's physical condition or it was less costly to buy a replacement than repair or rent the equipment. These same factors are utilized in the draft 2014 plan document. The draft 2014 plan document includes the following language under the durable medical equipment section: "The medical plan may limit the payment of charges to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided." This language in the 2014 draft plan document is consistent with similar language in the 2003 plan document. The 2003 plan document required that for a service or supply to be deemed medically necessary, it must be "[n]o more costly than another service or supply (taking into account all health expenses incurred in connection with the service or supply) which could fulfill these requirements. The language has been updated and reorganized but it is not new to the plan.
(48) Excludes trusses and braces from medical plan (covered per page 41 of current Retiree Booklet)		Trusses and braces are explicitly covered under section 3.4.17 of the draft 2014 plan document.
(49) Rx can be denied at pharmacist discretion.	Introduces rejection by pharmacy of Rx at pharmacist's discretion.	The 2003 plan document includes the following language: "The claims administrator, before paying the claim, may require a new prescription, or evidence as to need. For example, the need may be questioned if the prescriber did not specify the number of refills, or if the frequency or

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
		number of prescriptions or refills appears excessive under the accepted medical practice standards." The draft 2014 plan document states "[b]efore recognizing charges, Aetna may require a new prescription or evidence as to need, if a prescription or refill appears excessive under accepted medical practice standards. This language is consistent with the 2003 plan document. The draft 2014 plan language also states "A **network pharmacy** may refuse to fill a **prescription** order or refill when in the professional judgment of the pharmacist the **prescription** should not be filled." Because pharmacy benefits are often managed at the point of sale, the discretion afforded the claims administrator needs to flow to the pharmacist. This is reflected in the updated draft 2014 plan language.
(50) FDA approved drugs "but which have not yet been reviewed by the Aetna Health Pharmacy Management Department and Therapeutics Committee" charged at out of network amount	Allows Aetna to charge out of network (OON) price for drugs they have not reviewed but are FDA approved. Gives Aetna sole discretion of Rx coverage.	This provision does not impact members of the retiree health plan because there is no difference in either the 2003 plan or the draft 2014 plan in the copayment amount for using a network or out-of-network pharmacy. *See* section 2.1.2 of draft 2014 plan document for prescription drug copay schedule.
(51) Aetna has the right to review all requests for reimbursement and <u>in its sole discretion make reimbursement determinations</u> subject to section 7.15	Gives Aetna sole discretion for Rx coverage.	The 2003 plan document contains the following language "[t]he claims administrator, before paying the claim, may require a new prescription, or evidence as to need." This language infers the right of the claims administrator to deny the claim. The draft 2014 plan language has updated this language to: "**Aetna** has the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to section 7.15, *If a Claim Is Denied*." Language has been updated but intent has not changed. Any denial by Aetna is still subject to appeal rights as referenced in the draft 2014 plan language.
(52) Excludes Rx coverage for	Of note: All drugs or medications in a therapeutic drug class	The 2003 plan document expressly states that the plan

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
compound medications if one of the drugs in that therapeutic drug class is not a prescription drug	if one of the drugs in that therapeutic drug class is not a prescription drug (Compounds??)	covers prescription drugs for the treatment of an illness, disease or injury if dispensed upon prescription of a provider acting within the scope of their license. The 2003 plan document defines a prescription drug as a medical substance which must bear a label that reads: "Caution: Federal law prohibits dispensing without a prescription." The draft 2014 plan document defines prescription drug as "a drug, biological, or compounded **prescription** which, by state and Federal law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal law prohibits dispensing without **prescription**." This includes a **self-injectable drug** prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid **health care professional**. Covered **self-injectable drugs** include injectable insulin." The 2003 and 2014 definitions of prescription drugs are consistent. The 2003 plan language was silent as to the issue of coverage when one drug in a therapeutic class is not a prescription drug. The draft plan language addresses that issue left silent in the 2003 plan document.
(53) Excludes replacement of lost or stolen prescriptions		The 2003 plan document was silent as to the issue of lost or stolen prescriptions. The draft 2014 plan document addresses this issue.
(54) Prescription drug that is in a similar or identical class, or has a similar or identical mode of action or exhibits similar or identical outcomes (over the counter) can be substituted for an Rx	They can substitute OTC for Rx??	The 2003 plan document states that the plan covers prescription drugs. The 2003 plan document defines prescription drugs as medical substances which must bear a label that states, "Caution: Federal law prohibits dispensing without a prescription." By definition, over the counter drugs are not covered under the 2003 plan book. The draft 2014 plan document makes this exclusion express rather than having to glean the exclusion by reading the definition. The exclusion of over the counter drugs in the draft 2014 plan document is consistent with the 2003 plan language.

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
(55) Reduces benefit for Rx purchased "out of network", even in an emergency		This provision does not impact members of the retiree health plan because there is no difference in either the 2003 plan or the draft 2014 plan in the copayment amount for using a network or out of network pharmacy. *See* section 2.1.2 of draft 2014 plan document for prescription drug copay schedule.
(56) Limits reimbursement for out of network pharmacy to "recognized charge" tied to contracted rates		This provision does not impact members of the retiree health plan because there is no difference in either the 2003 plan or the draft 2014 plan in the copayment amount for using a network or out of network pharmacy. *See* section 2.1.2 of draft 2014 plan document for prescription drug copay schedule.
(57) Generic substitution of Rx at pharmacy allowed without notice	Generic substitute allowed without notice.	The 2003 plan document contains a provision requiring that mail order prescriptions be filled with the generic equivalent when available and permissible by law. The copay for a generic drug in both the 2003 and draft 2014 plan document is reduced by 50% over the copays for brand name drugs. The draft 2014 plan document extends the generic substitution provision from mail order pharmacies to retail pharmacies. Generic substitutions lower copays for members by 50%.
(58) Excludes self-injectable drugs		The draft 2014 plan document excludes from coverage under the medical plan self-injectable drugs and medications including any expenses for prescription drugs and supplies covered under the pharmacy benefit portion of the medical plan. Self-injectable drugs are set forth in the medical benefit exclusions because they are covered under the pharmacy benefit portion of the medical plan The draft 2014 plan document provides coverage for prescription drug expenses that are medically necessary. The draft 2014 plan document defines prescription drugs to be "a drug, biological, or compounded **prescription** which, by state and Federal law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal law prohibits dispensing without **prescription**." This

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
		includes a **self-injectable drug** prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid **health care professional**. Covered **self-injectable drugs** include injectable insulin." The 2014 plan document defines self-injectable drugs as **prescription drugs** that are intended to be self-administered by injection to a specific part of the body to treat certain chronic medical conditions. Self-injectable drugs are covered under the pharmacy benefit portion of the medical plan.
(59) Excludes injectable drugs if an oral form is available		The 2003 plan document is silent with respect to coverage for injectable drugs if an oral form of the drug is available. The draft 2014 plan document addresses this issue.
(60) Excludes food items, even if it is the only form of nutrition		The 2003 plan document contains an exclusion for megavitamin therapy but is silent as to other nutritional supplements. The 2014 draft plan document addresses this issue. The exclusion applies to the food itself not medical supplies related to feeding such as feeding tubes.
(61) Excludes specific spinal treatments (but allows it in other areas???)	Excludes chiropractic adjustments.	The 2003 plan document did not specify coverage provisions relative to spinal treatments. The draft 2014 plan document addresses this issue. In the draft 2014 plan document, there are 57 identified exclusions to coverage under the medical plan. However, the introductory language to this section specifically states "[c]harges made for the following are not covered **except** to the extent listed under section 3.4, *Covered Medical Expenses.*" (emphasis added). Accordingly, notwithstanding exclusion number 55 listed under section 3.6., treatment of spinal disorders is covered pursuant to section 3.4.24 of the draft 2014 plan document.
(62) Excludes treatment for obesity (but allows it in other areas???)	Excludes treatment for obesity.	In the draft 2014 plan document, there are 57 identified exclusions to coverage under the medical plan. However,

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
		the introductory language to this section specifically states "[c]harges made for the following are not covered **except** to the extent listed under section 3.4, *Covered Medical Expenses.*" (emphasis added). Accordingly, notwithstanding exclusion number 56 listed under section 3.6., treatment of obesity is covered pursuant to section 3.4.26 of the draft 2014 plan document.
(63) Excludes massage therapy (but allows it in other areas???)	Excludes charges for medically necessary massage therapy in this section but allows it in another.	Massage therapists were not listed as an authorized provider in the 2003 plan document. They are listed as authorized providers in the 2014 draft plan document. Neither the 2003 nor draft 2014 plan documents covers massage therapy as a stand-alone covered service. In the draft 2014 plan document, there are 57 identified exclusions to coverage under the medical plan. However, the introductory language to the exclusion section specifically states "[c]harges made for the following are not covered **except** to the extent listed under section 3.4, *Covered Medical Expenses.*" (emphasis added). As stated above, massage therapists are covered providers under the draft 2014 plan document (*see* section 3.4.2(c)) but massage therapy is not a stand-alone covered service under the 2014 draft plan document. Accordingly, this service is covered only when the massage therapist is working under the supervision of a licensed health care practitioner practicing within the scope of their license and providing massage therapy as a component of a covered service such as short term rehabilitation therapy.
(64) Mental health inpatient treatment allowed only if your condition requires services only available as an inpatient	Requires outpatient treatment unless care is only offered inpatient.	Both the 2003 and draft 2014 plan documents require precertification for inpatient mental health treatment. The purpose of precertification is to make a determination of medical necessity. If not medically necessary, the request for precertification is denied. The language in section 3.4.23 of the draft 2014 plan document stating that "[i]npatient

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
		benefits are available only if your condition requires services that are only available in an inpatient setting" merely reiterates the requirement that such treatment be medically necessary. The language in the draft 2014 plan document is consistent with the 2003 document.
(65) Removes "two consecutive years" requirement from substance abuse limit so that lifetime limit is reduced to two years of total annual benefit (limits benefit if relapsed after the first year benefit is paid)	Individual limit per benefit year $12,715 on inpatient substance abuse treatment without precertification. Subject to change every three years.	Under the 2003 plan document, chemical dependency treatment without plan certification/referral was subject to a benefit maximum of $12,715 over 2 consecutive benefit years. Under the draft 2014 plan document, such treatment without certification is subject to a benefit maximum of $12,715 per benefit year. Under both the 2003 and draft 2014 plan document the lifetime maximum of $25,430 remains for chemical dependency treatment w/out precertification.
(66) Reduces inpatient coverage for member by paying Medicare Part A premiums beginning Jan 1, 2015 (non-optional cost shift to Medicare)	January 1, 2015, the Division will pay for your part A premium rather than pay primary benefits for hospitalization for those members over 65. This shifts the cost for inpatient stays for those over 65 to Medicare, subject to their policies and limitations. This will save the plan thousands of dollars, but shifts coverage to Medicare.	The AlaskaCare Retiree Health Plan provides health benefits to retired employees, but only supplemental health care benefits to retirees who are eligible for Medicare. The 2003 plan document states "[t]he claims administrator will assume you and/or your dependents have coverage under Medicare Part A when you or your dependent reach age 65. If you are not provided with Medicare Part A free of charge, you should submit a copy of your letter from Medicare stating that you are not eligible to the Division." While the 2003 plan document is silent on this specific issue, the practice has been that, if a member is not eligible for Medicare Part A free of charge, the plan continues to pay as primary. However, because the enacting statutes make clear the AlaskaCare Retiree Health Plan is supplemental to Medicare after age 65, the plan administrator is considering enactment of a provision whereby the plan would pay for the member's Medicare Part A premium cost when the member is not entitled to Medicare A free of charge in lieu of the plan continuing to provide primary coverage for the member after age 65.
(67) Allows choice to terminate	There is no provision for in the law for you to terminate	The statutes governing retiree medical benefits *entitle*

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
AlaskaCare coverage and opt for Medicare coverage only	AlaskaCare by will.	retirees to medical benefits if they meet certain criteria. These statutes do not mandate that retirees avail themselves of these medical benefits. That decision remains the choice of the retiree.
(68) Excludes COB from audio and vision plan benefits	Removes COB payments from vision and audio plans.	Coordination of benefits is only conducted for the medical and dental plans.
(69) Excludes prescription vitamins in Rx benefit		The 2003 plan document contained exclusions for vitamin injections and megavitamin therapy. The 2014 draft plan document continues to exclude vitamins from coverage.
(70) Excludes charges for midwife at home birth	Excludes charges of a midwife for a home delivery.	State certified nurse midwives or registered midwives are covered providers under both the 2003 and draft 2014 plan document. The 2003 plan document references hospital stays for childbirth – but not birthing centers or home births. Coverage under the draft 2014 plan document was expanded to include birthing centers as a covered facility for childbirth. Home births are not included in either the 2003 or the draft 2014 plan document. Pursuant to its clinical policies, Aetna does not cover charges for home births due to the risk of infant mortality.
(71) Specifically excludes ambulance charges for routine transportation to receive inpatient or outpatient services	Excludes transportation costs, including ambulance services, for routine transportation to receive outpatient or inpatient services.	Under the 2003 plan document, ambulance service is included under the travel section. Thus, under the 2003 plan document, non-emergent travel, including ambulance service, required pre-certification for a determination of medical necessity. The 2003 plan document states that in no event will a service be considered medically necessary when furnished mainly for the personal comfort or convenience of the person, the person's family, anyone who cares for him or her, a health care provider, or health care facility. Accordingly, the draft 2014 plan document's exclusion for ambulance charges for routine transportation to receive inpatient or outpatient services is consistent with the 2003 plan document. The draft 2014 plan document does provide coverage for ambulance service from for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
		the member's medical condition. *See* section 3.4.20.
(72) Removes appeal process and inserts a complex chart of timelines that a member has to appeal		The Retiree Plan is not subject to the Affordable Care Act. However, the new appeal provisions reflect the requirements of the Affordable Care Act and were drafted to provide a uniform appeals process for both the employee and retiree health plans. The updated appeals provision includes important procedural protections for members.
(73) Introduces separate rules/time limits for Urgent Care Claims/Pre-service Claims/Post-service Claims		*See* response to number 72 above.
(74) Recognized Charge can no longer be appealed	Can no longer appeal UCR (or Recognized Charge as it is now called).	This is incorrect. As a matter of law, any adverse determination is subject to appeal rights, including UCR determinations.
(75) Reduces coverage for air, ground or water ambulance if "not required"		*See* response to number 71 above.
(76) Protective Clause absolves the State and TPA for failure to make payments under the terms of the contract	Absolves the State and TPA for failure to make payments under the terms of the contract. HUGE!	This comment is incorrect because it misconstrues the meaning of the language of Section 16.17 of the draft 2014 plan document. The draft language protects the plan, and its assets, in the event of litigation challenging the validity of an insurance policy issued to the State or for the failure of an insurance company to make payments under an issued policy. The language makes clear that in the event of any such dispute, the proper party is the insurance company. The medical, dental, vision and audio plans are self-insured plans and not subject to this provision. Life insurance proceeds are under a policy and this provision would be applicable in that circumstance.
(77) Receipt and Release states that any payment satisfies claim	Payments (any) satisfy claim.	This comment misconstrues the language of Section 16.18 of the draft 2014 plan document. The provisions of this section limit the liability of the plan to the cost of the claim. This provision is subject to Section 7 of the draft 2014 plan document. Thus, if a portion of a claim were denied, the portion denied would be subject to appeal rights under Section 7. As used in this section the word "any" does not mean partial payment, it means payment for the covered

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
		portion of the claim (whether covered initially by the TPA or covered as a result of an appeal).
(78) Misrepresentation introduces fraud resulting in retroactive termination of AlaskaCare benefits	Introduces fraud resulting in retroactive termination of health plan benefits.	The draft 2014 plan document does contain language that provides if an individual obtains benefits by means of fraud, the plan has the right to terminate coverage retroactive to the date of the fraud (and thus recoup payments that should not have been made). This is an appropriate provision for a plan document and consistent with the administrator's fiduciary duties.
(79) Dental plan entirely replaced by Delta Dental "standard plan"		*See* response to number 14 above.
(80) Full mouth x-rays paid once every five years rather than annually		*See* response to number 14 above.
(81) Dental services may be reduced to lowest benefit to treat condition, not what dentist did		Section 4.3.4 of the draft 2014 plan document provides: "[i]f a more expensive treatment than is functionally adequate is performed, the dental plan will pay the applicable percentage of the recognized charge for the least costly treatment." This language is consistent with page 70 (advance claim review) of the 2003 plan document which states: "the Plan pays for the least expensive, professionally adequate service."
(82) Restricts lens coverage to only "new" or "changed" prescription	Restricts lenses to only new and changed. Does not allow for the same lens Rx even if benefit is available.	The 2003 plan document excludes replacement or duplicate lenses if the benefit has been utilized in the current calendar year. However, the 2003 document also contains the following exclusion: "[d]uplicate or spare eyeglasses, including lenses and frames. These 2 exclusions in the 2003 plan document are inconsistent and in conflict. The draft 2014 plan document resolves this inconsistency and states: [c]overed expenses include prescription lenses prescribed for the first time and new lenses required due to a change in prescription."
(83) Excludes lens benefit if not changed or new, even if benefit is available	Restricts lenses to only new and changed. Does not allow for the same lens Rx even if benefit is available.	*See* response to number 82 above.
(84) Excludes frame coverage unless lens prescription is changed	What about when you don't need new lenses but your frames are in need of replacement? Ties frames to lens	The 2003 plan document excludes replacement or duplicate frames if the benefit has been utilized in the current or prior

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
	coverage.	calendar year. However, the 2003 document also contains the following exclusion: "[d]uplicate or spare eyeglasses, including lenses and frames. These 2 exclusions in the 2003 plan document are inconsistent and in conflict. The draft 2014 plan document resolves this inconsistency and states: "covered expenses include expenses for frames if the lenses are covered under this section.
(85) Removes lens options (scratch resistant coating, antireflective coating, polycarbonate lenses) from coverage	Was coverage for these options removed or missed?	The draft 2014 plan document provides coverage for prescription lenses prescribed for the first time and new lenses required due to a change in prescription. The only lens option specifically excluded under the plan is tinting – which is also excluded under the 2003 plan document. Accordingly, any lens option not specifically excluded, is covered subject to other governing terms of the vision plan. There has been no change in coverage with respect to lens options; the language has just been updated.
(86) Seems to indicate that if a non-participating provider is seen the member must pay and then self-submit a claim (does the plan not accept claims, electronically or otherwise, directly from out of network providers?)	Places burden on member to pay and file. Also uses language that does not apply: deductible. How will a person know how much will be covered? Why is the plan making it the member's responsibility to file claims for these services?	Section 5.2.3 (and section 7.4) of the draft 2014 plan language is consistent with page 88 of the 2003 plan document. This is not an issue of whether the plan accepts electronic claims from out of network providers but rather whether the out of network provider can/will bill the plan electronically. Some providers will not do so. To the extent an out of network provider will not bill the plan, this section notifies the member that he may be required to pay the provider at time of service and then request reimbursement from the plan.
(87) Removes 90th percentile as recognized charge for audio benefit (claims administrator determines recognized charge but doesn't say how)	Changes UCR to RC and allows Aetna to determine rate of reimbursement using their criteria rather than the 90th percentile language in existing book.	The 2003 plan document reimbursed vision and audio services at the 90th percentile of the recognized charge. The draft 2014 plan document did not change these 2003 provisions.
(88) Changes hearing aid benefit to a "rolling three year period"		*See* response to number 26 above.
(89) Parts C and D were included in Medicare coverage limitation	Includes Part C and D in the coverage limitation.	By statute, the Retiree Health Plan is supplemental to Medicare. Accordingly, the draft 2014 plan document has been updated to reflect all Medicare coverage options

ALLEGED TAKEAWAY	RPEA ANALYSIS	STATE OF ALASKA RESPONSE:
		available to a consumer.
(90) Allows financial pursuit of members for overpayments made in error by claims administrator	Does this mean that the TPA can pursue payments to individuals? To what extent?	Page 111 of the 2003 plan document contains a right of recovery provision allowing the plan to recoup payments made in error. The draft 2014 plan document (section 10.7) also contains a right of recovery provision. The language has been updated but the intent has not changed. The 2003 and draft 2014 plan provisions are consistent.
(91) Documents sent to Division or claims administrator may be disavowed unless member has proof they were sent (certified mail receipt or receipt stamp)	Adds that documents sent to the Div or TPA can be disavowed unless you have proof they were sent. Goes on to say that notice is sufficient if sent to address of State, TPA or covered person.	The 2003 plan document states that [a]ny notice required of the member is considered adequate if mailed to the principal office of the claims administrator at the address on your identification card." Section 1.8 of the draft 2014 plan document updates the adequate notice provision from the 2003 document and makes clear for the member the effect of failing to provide adequate notice. The 2003 and draft 2014 plan provisions are consistent.