

Health Matters



January 2011



Requirements change for Health Flexible Spending Account

Recent federal health care legislation has changed the documentation requirements for reimbursement of over-the-counter (OTC) drugs and medicines from a Health Flexible Spending Account (HFSA).

Effective January 1, 2011, OTC drugs and medicines may be reimbursed from a HFSA only if the claim is accompanied by a written prescription from a health care provider who is licensed to prescribe drugs.

Members enrolled in a HFSA were sent a letter from the division in November with more details about the requirements for reimbursement of OTC drugs. A copy of this letter can be found on the division's website, under Health Flexible Spending Account.

We have added addenda to the *ALASKACARE Employee Health and Optional Benefits Information Booklet* (formerly *Select Benefits*, pages 113-114, 117) addressing the change to OTC drug reimbursement requirements.

Health fair coming to Juneau on Saturday, February 5

A health fair for all ALASKACARE members will be held on the 8th floor of the State Office Building in Juneau on Saturday, February 5, from 8:00 a.m. to 1:00 p.m. Look for more details via e-mail and on our website.

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Take good care of yourself!

1-800-807-2997

24/7 Health Line

to speak with a registered nurse about your *nonemergency* health concerns

Free to ALASKACARE members

This article provided by the state's Medicare Information Office. More information is available online at www.medicare.alaska.gov or by calling 800-478-6065 or 269-3680 in Anchorage.

Note: The state's Medicare Information Office urges you to review authoritative coverage information in the publications referenced at the end of this article. You may also call 1-800-478-6065 (in Alaska only; 269-3680 in Anchorage) or the toll-free national Medicare number, 1-800-633-4227, to speak to a certified Medicare counselor.

For travel coverage under the ALASKACARE *Health Plans*, see pages 42-26 in the ALASKACARE *Retiree Insurance Information Booklet* and pages 49-53 in the ALASKACARE *Employee Health and Optional Benefits Information Booklet* (formerly *Select Benefits*)

Travel and medical coverage under Medicare

Many people have questions regarding what Medicare will cover in terms of travel inside or outside the United States. What follows is some guidance from Medicare. In the next issue of *Health Matters*, we will discuss ambulance coverage under Medicare.

Travel for routine medical needs

Medicare does not generally cover travel for routine medical needs. If your health provider in Alaska recommends another provider or specialist in Seattle or elsewhere, it is possible that the cost of the medical procedures or supplies will be covered (through Medicare Part B, outpatient medical). Medicare does not cover travel costs unless travel meets guidelines for ambulance travel. (Please see travel coverage under the ALASKACARE *Health Plans*.)

Travel outside the United States

In most cases, Medicare does not cover health care if you are living abroad or while you're traveling outside the U.S. (the "U.S.," according to Medicare, includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa). There are some exceptions, including some cases where Medicare may pay for services that you get while on board a ship within the territorial waters adjoining the land areas of the U.S. Medicare may pay for inpatient hospital, doctor, or ambulance services you get in a foreign country in the following *rare* situations:



- If an emergency arises within the U.S. and the foreign hospital is closer than the nearest U.S. hospital that can treat your medical condition.
- If you're traveling through Canada without unreasonable delay by the most direct route between Alaska and another state when a medical emergency occurs and the Canadian hospital is closer than the nearest U.S. hospital that can treat the emergency.
- If you live in the U.S. and the foreign hospital is closer to your home than the nearest U.S. hospital that can treat your medical condition, regardless of whether an emergency exists.
- Medicare may cover medically-necessary ambulance transportation to a foreign hospital only with admission for medically-necessary covered inpatient hospital services.

Medicare publications

The following publications are available at www.medicare.gov/Publications or by calling 1-800-633-4227:

Medicare & You 2011: ID# 10050

Medicare and Ambulance Services: ID# 11398

Medicare Coverage Outside the United States: ID# 11037

What is the meaning of the term “Usual, Customary, and Reasonable?”

The ALASKACARE Health Plans pay for covered services up to the *usual, customary, and reasonable* (UCR) charge, sometimes referred to as the *recognized charge*.

What is UCR?

UCR is the prevailing rate charged in the geographic area where the service is provided or the provider's usual charge, whichever is less.

UCR is determined by collecting the claims submitted for each procedure code in a specific geographic area. The highest and lowest charges are ignored. A dollar amount that would allow 90% of the claims to be paid in full is then set as the UCR for the procedure in that geographic area.

Most provider charges fall within the UCR. However, if you see a non-preferred provider, and the charge is more than the UCR, you may be responsible for the amount over the UCR charge in addition to any deductibles and coinsurance/co-payments.

The UCR database

The ALASKACARE plans use the nation's largest health care database for determining UCR. Most health plans and insurance companies nationwide use this database. Updated every six months, it uses billing information collected from health insurance payers in each geographic area and includes claims from both ALASKACARE and non-ALASKACARE members.

Checking UCR

A preferred provider's charges will be within UCR. If you see a non-preferred provider, the charges will still most likely be within UCR. To check this, you can call the third party administrator (TPA) with the provider's contact information, procedure code, and provider's charge. The TPA can then tell you whether the proposed charge is within the UCR.

Over UCR options

If an amount is over the UCR charge, wait for your bill as the provider may adjust the amount after reviewing the claim payment. If not, talk to your provider and ask if he/she:

1. will review the bill to ensure the correct procedure code and amount were used and submit a corrected bill if necessary;
2. charged the normal fee for the service or a higher one due to unusual circumstances and to either submit a corrected bill or provide a written explanation so you may file an appeal; or
3. will consider reducing the fee to the UCR.

More information

Specific plan language regarding the recognized charge (or UCR) is on pages 13 & 14 in the ALASKACARE *Retiree Insurance information Booklet* and on pages 23 & 24 in the ALASKACARE *Employee Health and Optional Benefits Information Booklet* (formerly *Select Benefits*). Both are available on the division's website at doa.alaska.gov/dr/b.



Ask “KYP” is a regular feature, helping members to better understand their health plan.

“KYP”
Know Your
Plan





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

Disclaimer:

Information in this newsletter summarizes the plan provisions, is supplemental only, and does not supersede the applicable Information Booklet's provisions.

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2011 premiums increase for retirees

Premiums for the **ALASKACARE Retiree Health Plan** increased as of January 1, 2011. Medical premiums apply to Tier II & III retirees *without* system-paid medical. New premiums for medical and dental-vision-audio (DVA) coverage, effective January 1, 2011, are listed below:

Tier II & III without system-paid medical	Medical Premium	DVA Premium
Retiree only	\$791	\$63
Retiree & spouse or same-sex partner	\$1,583	\$124
Retiree & child(ren)	\$1,117	\$112
Retiree and family	\$1,910	\$176

Life insurance premiums remain unchanged but are recalculated each January based on the member's current age. As members change age brackets, their premiums will increase. Current life premiums are available on the division's website.