Alaska Electrical Trust Funds

PENSION FUND – HEALTH AND WELFARE FUND – LEGAL FUND
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May 2018

Re: **Alaska Electrical Health & Welfare Fund**
Summary of Material Modifications

Dear Plan Participant:

The Board of Trustees has made the following revisions to your Plan benefits effective July 1, 2018.

Changes to the Plan's Prescription Drug Program

Your prescription drug benefit, as described on pages 74-79 of the plan booklet is amended by the following changes:

Prescription Drug Formulary
The Plan will move to a formulary based prescription benefit. The formulary helps highlight cost saving opportunities for you, helps guide selection for your doctor and provides overall value to the Plan. Individuals impacted by the changes will be provided advance notification. The formulary is accessible at www.caremark.com/acdruglist. You are encouraged to register on Caremark's web-site and/or download the smart phone app. Use the Check Drug Cost feature to help find cost saving opportunities. Always ask your doctor or pharmacist if there is a generic drug to treat your condition. If your doctor thinks there is a clinical reason why any of the drugs on the drug list won't work for you, your doctor can call CVS/caremark toll-free at (855) 582-2026 to request approval.

Cost Share
The plan currently has the following cost share structure, as reflected on page 74:

Category (Tier)	Retail Cost Share (up to 30 days' supply)	Mail Order Cost Share (up to 90 days' supply)
Affordable Care Act Preventive Drugs	$0.00	$0.00
Tier-1 (Generics)	$15.00	$30.00
Tier-2 (Brands)	$35.00	$70.00
Brands with a generic equivalent substitute	You pay 100% of the cost. An exceptions process may accommodate Medical Necessity. Brand cost share applies.	

Please read this notice carefully and keep it with your benefit booklet or insurance records for future reference.

Effective July 1, 2018, the Plan will move to the following cost share structure

Category (Tier)	Retail Cost Share (Up to 30 days' supply)	Mail Order Cost Share (Up to 90 days' supply)
Affordable Care Act Preventive Drugs	$0.00	$0.00
Tier-1 (Formulary Generics)	$15.00	$30.00
Tier-2 (Formulary Preferred Brands)	$35.00	$70.00
Tier-3 (Non-Formulary Brands, Non-Preferred Brands)	$50.00	$100.00
Formulary Exclusions and Brands with a generic equivalent substitute.	You pay 100% of the cost. An exceptions process may accommodate medical necessity. If approved, the applicable copay applies. You may be required to try more than one formulary or generic product. Any prior exception requests may be subject to review. The Plan may not cover all products.	

Utilization Management of Diabetic Test Strips
Effective July 1, 2018, the Plan will limit the quantity of diabetic test strips dispensed at one time. The limit will accommodate recommended testing guidelines by the American Diabetes Association (ADA). Your doctor may request higher limits from CVS/caremark.

Claims Review of Non-Specialty Drugs Exceeding $1,500
Effective July 1, 2018, non-specialty drugs exceeding $1,500 will be reviewed by a Consultant Pharmacist to help ensure appropriate use and billing (dose, quantity, days' supply, charged amounts) or to discuss possible alternatives. You, your doctor or pharmacy may be contacted by a Consultant Pharmacist.

Physical and Occupational Therapy Services – Annual Limitation of 25 Visits

The Plan's Physical Therapy, Occupational Therapy and Speech Therapy benefit, as reflected on pages 60-61 is amended to read as follows (the information in *italics* is the new language).

Physical Therapy, Occupational Therapy and Speech Therapy - for habilitative and rehabilitative services are covered as follows:

- If part of a prescribed treatment program, medically necessary habilitative therapy services, including occupational therapy, speech therapy, physical therapy and related therapies, to improve a mental health condition or congenital birth defect.

- If part of a prescribed treatment program, medically necessary rehabilitative therapy services on an outpatient basis, including occupational therapy, speech therapy and physical therapy to the extent the therapy will significantly restore and improve a lost function(s) following a severe illness, injury or surgery.

Habilitative and rehabilitative services are subject to the following conditions:

- The service must be necessary to improve function or to maintain function where significant deterioration in function would result without the therapy;

- The services must be prescribed by the attending Physician and administered by a Physician or a covered licensed therapist. The Plan may periodically request a review of the services by a Physician and the patient must continue under the care of the attending Physician during the time the therapy is being provided;

- ***(New)*** *Physical and Occupational therapy services in excess of 25 visits during a 12-month period will require review and approval by the Plan's medical management provider that the services continue to meet medical necessity, and*

- The services must not be custodial in nature.

Benefits for habilitative and rehabilitative therapy services will end when the Plan determines that no additional clinical improvement is expected as a result of the therapy.

Transportation Services Benefit for Non-Emergency Procedures

The Plan has been amended to augment the transportation services benefit described on pages 65-66 (the information in *italics* is the new language).

Transportation Services for you or your eligible Dependents will be considered as a Covered Charge if the expenses meet the following definition:

- Emergency transportation:
  - by a professional ambulance, to and from a Hospital; or
  - air or surface transportation by a regularly scheduled commercial carrier from any location where a covered individual becomes disabled to the nearest legally operated Hospital equipped to provide the special treatment necessary to treat the disabling condition not available in a local facility. Benefits are provided for round-trip coach transportation for the disabled individual and an accompanying adult if the disabled individual is a child under age 18 or an incapacitated adult.

- *Non-Emergency transportation of you or your eligible Dependents will be covered only if:*

  A. the condition or procedure cannot be treated locally (within 100 miles from your home),

  Or, on and after July 1, 2018,

  B. for certain conditions or procedures (examples below, but check with the Administrative Office for current list of conditions) at a Preferred Provider non-local facility if total cost of treatment and travel is less than the cost of the procedure locally and you provide Plan approved documentation of such lower cost in advance of the procedure.

  Approved procedures:

  - *Colonoscopy*
  - *Dye CT scan*
  - *Varicose Vein treatment*
  - *Non routine eye care*
  - *Neurology*
  - *MRI*
  - *Vasectomy*

Covered Charges for Non-Emergency Transportation will include:

- *air or surface transportation by a regularly scheduled commercial carrier to the location of the facility at which you are planning the procedure. The Plan will reimburse the actual cost of documented travel expenses, not exceeding the cost of coach class commercial air transportation, from the site of the Illness or Injury to the selected location.*
- *$50/day per person to defray costs of lodging, if any, provided receipts are submitted to the Administrative Office.*

Benefits for an accompanying adult if the patient is a child under age 18 or an incapacitated adult. Participants should contact the Administrative Office to precertify travel benefits.

Please contact the Administrative Office if you have any questions. Thank you.

Sincerely,

Gregory R. Stokes

Gregory R. Stokes
Administrator