ASD Medical Insurance

FY 2009-2010

Anchorage School District
Active PPO Plan
Effective Date: 7-01-2009
Open Choice® (PPO) - Alaska

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY - Self Insured

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	$600 Individual $1,800 Family	$600 Individual $1,800 Family
All covered expenses accumulate toward both the preferred and non-preferred Deductible. Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.		
Member Coinsurance	20%	20%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$4,000 Individual	$4,000 Individual
All covered expenses accumulate toward both the preferred and non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Only those out-of pocket expenses resulting from the application of coinsurance percentage (except any deductibles, copays, and penalty amounts) may be used to satisfy the Payment Limit.		
Lifetime Maximum	$2,000,000 Includes $20,000 annual restoration provision	
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $200 per occurrence.		
PREVENTIVE CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Routine Adult Physical Exams/ Immunizations Age/ frequency schedule may apply.	$30 office visit copay; deductible waived	$30 office visit copay; deductible waived
Routine Well Child Exams/ Immunizations Age/ frequency schedule may apply.	$30 office visit copay; deductible waived	$30 office visit copay; deductible waived
Routine Gynecological Care Exams One exam per calendar year. Includes Pap smear and related lab fees.	$30 office visit copay; deductible waived	$30 office visit copay; deductible waived
Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Routine Digital Rectal Exam / Prostate-specific Antigen Test For covered males age 35 and over	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Colorectal Cancer Screening For all members age 50 and over.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
PHYSICIAN SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Office Visits (non surgical) to Non Specialist	$30 office visit copay; deductible waived	$30 office visit copay; deductible waived
Includes services of an internist, general physician, family practitioner or pediatrician for routine care as well as diagnosis and treatment of an illness or injury.		
Specialist Office Visits (non-surgical)	$30 office visit copay; deductible waived	$30 office visit copay; deductible waived
Office Visits for Surgery	20%	20%

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Maternity OB Visits	Covered same as Specialist Office Visit for initial visit only; thereafter covered 100%; deductible waived	20%
Allergy Testing	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	20%
Allergy Injections	20%	20%
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Diagnostic Laboratory and X-ray	20%	20%
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing		
EMERGENCY MEDICAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Emergency Room	$200 copay; deductible waived	Same as preferred care.
Non-Emergency care in an Emergency Room	20%	20%
Ambulance	20%	20%
HOSPITAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Coverage	20%	40%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Maternity Coverage	20%	40%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Hospital Expenses (including surgery)	20%	40%
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
MENTAL HEALTH SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	50%	50%
Limited to 15 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	50%	50%
Limited to 40 visits per calendar year. The member cost sharing applies to all covered benefits incurred during a member's outpatient visit Maximums are a combined limit for preferred and non-preferred services.		
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	20%	20%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	20%	20%
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
Benefit Maximum		
Alcohol/Drug abuse limited to $12,715 per calendar year and $25,425 per lifetime -- combined for inpatient and outpatient services. Maximums are a combined limit for preferred and non-preferred services.		
OTHER SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Convalescent Facility	20%	20%
Limited to 120 days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay		
Home Health Care	20%	20%
Limited to 130 visits per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.		
Hospice Care - Inpatient	20%	20%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		

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Hospice Care - Outpatient	20%	20%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
Private Duty Nursing - Outpatient (Limited to 70 eight hour shifts per calendar year)	20%	20%
Outpatient Short-Term Rehabilitation Includes speech, physical, and occupational therapy.	$30 office visit copay; deductible waived	$30 office visit copay; deductible waived
Spinal Manipulation Therapy - limit 30 visits per calendar year	$30 office visit copay; deductible waived	$30 office visit copay; deductible waived
Durable Medical Equipment	20%	20%
Diabetic Supplies	Covered same as any other medical expense.	Covered same as any other medical expense.
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	20% (payable as any other covered expense)	20% (payable as any other covered expense)
Transplants	20% Preferred coverage is provided at an IOE contracted facility only	40% Non-Preferred coverage is provided at a Non-IOE facility.
"Other" Health Care – 20% member coinsurance after the preferred (per calendar year) deductible for services that are neither "preferred" nor "non-preferred"		
FAMILY PLANNING	**PREFERRED CARE**	**NON-PREFERRED CARE**
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Voluntary Sterilization Including tubal ligatin and vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
PHARMACY		
Retail	$15 prescription co-pay for generics / 20% coinsurance (up to $120 cap) Tier 2 formulary drugs; 20% coinsurance (up to $240 cap) Tier 3 non-formulary drugs	
Mail Order -	$30 copay for generic drugs for 90-day supply (or cost if less than copay), 20% coinsurance (up to $80 cap) for formulary brand-name drugs, and 20% coinsurance (up to $160 cap) for non-formulary brand-name drugs.	Not applicable
Mandatory Generic with DAW override (MG W/DAW Override) - The member pays the applicable copay only, if the physician requires brand. If the member requests brand when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy, Diabetic supplies.		
Precert for growth hormones included		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 19, or to age 25 if attending school.	
Pre-existing Conditions Rule	90-day lookback period (prior to enrollment date/probationary-period start date) Excluded amount is $4,000; Maximum exclusion period is 365 days.	
Applies for an injury or disease for which a person received treatment/services or took prescribed drugs/medicines during the 90 days immediately preceeding the person's effective date of coverage (or, if required to serve a probationary period, the 90 days immediately preceeding the first day of the probationary period) AND the person did not have prior creditable coverage. Does not apply if the person had creditable coverage which terminated during this 90-day lookback period. Does not apply to pregnancies, newborns covered within 31 days of birth, and adopted children covered within 31 days of placement.		

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This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents;
Nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary.

They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are provided by Aetna Life Insurance Company.