



# Summary of Coverage

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**Employer:** Anchorage School District

**Group Policy:** GP-658742

**SOC:** 1B

**Issue Date:** December 21, 2005

**Effective Date:** November 1, 2005

The benefits shown in this Summary of Coverage are available for you and your eligible dependents.

The accident and health benefits described in this Booklet-Certificate are integrated with certain benefits for which the Employer is liable. Aetna is liable for such benefits to the extent that they are not the liability of the Employer. Aetna, however, will process all benefit payments.

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## Eligibility

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### Employees

You are in an Eligible Class if you are a regular full-time employee participating in the Low Option Plan and you are in an area in which there are Preferred Care Providers. Your Employer will provide you with this information.

Classified employees must work at least 25 hours per week to be in an Eligible Class. Permanent Members of the Anchorage Council of Education employees must work at least 20 hours per week to be in an Eligible Class.

Your Eligibility Date, if you are then in an Eligible Class, is the Effective Date of this Plan. Otherwise, it is the first day of the calendar month coinciding with or next following the date you commence active service for your Employer, unless the first falls on a Saturday or Sunday, or Monday is the second, in which case coverage is to begin on the first day of the calendar month you commence active service for your Employer or, if later, the date you enter the Eligible Class.

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## Dependents

You may cover your:

- wife or husband; and
- unmarried children who are under 25 years of age.

Primarily dependent upon the subscriber for support, your children include:

- Your or your spouse's biological children.
- Your or your spouse's adopted children.
- Your or your spouse's stepchildren.

A foster child is not eligible.

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## Enrollment Procedure

You will be required to enroll in a manner determined by Aetna and your Employer. This will allow your Employer to deduct your contributions from your pay. Be sure to enroll within 31 days of your Eligibility Date.

Your contributions toward the cost of this coverage will be deducted from your pay and are subject to change. The rate of any required contributions will be determined by your Employer. See your Employer for details.

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## Effective Date of Coverage

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### Employees

Your coverage will take effect on the later to occur of:

- your Eligibility Date; and
- the date you return your signed form.

If you don't sign and return your form within 31 days of your Eligibility Date, coverage will take effect as provided in the Late Enrollee section of this Summary of Coverage.

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### Dependents

Coverage for your dependents will take effect on the date yours takes effect if, by then, you have enrolled for dependent coverage. You should report any new dependents. This may affect your contributions. If you do not do so within 31 days of any dependent's eligibility date, coverage will take effect as provided in the Late Enrollee section of this Summary of Coverage.

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## Late Enrollee

A "Late Enrollee" is a person (including yourself) for whom you do not elect Health Expense Coverage within 31 days of the date the person becomes eligible for such coverage.

### Enrollment Procedure

You may elect coverage for a Late Enrollee only during the annual late entrant enrollment period established by your Employer.

Coverage for a Late Enrollee will become effective on the first day of the second calendar month following the end of the late entrant enrollment period during which you elect coverage for the Late Enrollee.

Any preexisting condition limitation will apply to a Late Enrollee.

### Exceptions

A person will not be considered to be a Late Enrollee if all of the following are met:

- you did not elect Health Expense Coverage for the person involved within 31 days of the date you were first eligible (or during an open enrollment) because at that time:
  - the person was covered under other "creditable coverage", as defined below; and
  - you stated, at the time you submitted the refusal, that the reason for the refusal was because the person had such coverage; and
- the person loses such coverage because:
  - of termination of employment in a class eligible for such coverage;
  - of reduction in hours of employment;
  - your spouse dies;
  - you and your spouse divorce or are legally separated;
  - such coverage was COBRA continuation and such continuation was exhausted; or
  - the other plan terminates due to the employer's failure to pay the premium or for any other reason; and
- you elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

As used above, "creditable coverage" is a person's prior medical coverage as defined in the Alaska Statutes 21.54.500 (7). Such coverage includes coverage issued on a group or individual basis; Medicare; Medicaid; military-sponsored health care; a program of the Indian Health Service; a state health benefits risk pool; the Federal Employees' Health Benefit Plan (FEHBP); a public health plan as defined in the regulations; and any health benefit plan under Section 5(e) of the Peace Corps Act.

If you are not considered a Late Enrollee, Health Expense Coverage will become effective on the date of the election. Any limitation as to a preexisting condition may apply.

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### ***Additional Exceptions***

Also, the following individuals will not be considered to be Late Enrollees given any of the following circumstances:

- You, if you are eligible, but not enrolled, and your newly acquired dependents through marriage. You must request enrollment for your newly acquired dependent(s) and yourself, if you are not already enrolled, within 31 days of the marriage. Enrollment is effective on the date the completed request for enrollment is received. Any limitation to a preexisting condition may apply.
- You, if you are eligible, but not enrolled, and your newly acquired dependents through birth, adoption, or placement for adoption. You must request enrollment for your newly acquired dependent(s) and yourself, if you are not already enrolled, within 31 days of the birth, adoption, or placement for adoption. Enrollment is effective on the date of the child's birth, the date of the child's adoption, or on the date the child is placed with you for adoption. Any limitation to a preexisting condition may apply.
- Your child who would meet the definition of a dependent, if you are subject to a court order requiring you to provide health expense coverage for such child. You must request enrollment. Enrollment is effective on the date specified by your Employer. Any limitation to a preexisting condition may apply.
- Your spouse from whom you are separated or divorced, if you are subject to a court order requiring you to provide health expense coverage for such spouse. You must request enrollment within 31 days of the court order. Enrollment is effective on the date of the court order. Any limitation to a preexisting condition may apply.
- The individual is employed by an employer who offers multiple health care insurance plans and the individual elects a different health care insurance plan during an open enrollment period. Enrollment is effective on the first day of the second calendar month following the end of said open enrollment period. Any applicable limitation to a preexisting condition may continue to apply.

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### **Special Rules Which Apply to an Adopted Child**

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date your coverage becomes effective; and
- you make written request for coverage for the child within 31 days of the date the child is placed with you for adoption.

Coverage for the child will become effective on the date the child is placed with you for adoption. If request is not made within such 31 days, coverage for the child will be subject to all of the terms of this Plan.

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### **Special Rules Which Apply to a Child Who Must Be Covered Due to a Qualified Medical Child Support Order**

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent and for whom you are required to provide health coverage as the result of a qualified medical child support order issued on or after the date your coverage becomes effective. You must make written request for such coverage. Coverage for the child will become effective on the date specified by your Employer.

If you are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

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# Health Expense Coverage

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## Employees and Dependents

Your Booklet-Certificate spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in your Booklet-Certificate for a complete description of the benefits payable.

If a hospital or other health care facility does not separately identify the specific amounts of its room and board charges and its other charges, Aetna will use the following allocations of these charges for the purposes of the group contract:

|                         |     |
|-------------------------|-----|
| Room and board charges: | 40% |
| Other charges:          | 60% |

This allocation may be changed at any time if Aetna finds that such action is warranted by reason of a change in factors used in the allocation.

**Recognized Charge Percentage:** The charge determined by Aetna on a semiannual basis to be in the 90th percentile of the charges made for a service or supply by providers in the geographic area where it is furnished.

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## Prescription Drug Expense Coverage

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### *Payment Percentage*

100% as to:

| Preferred Pharmacy                          | Copay per Prescription or Refill                                  |   |
|---|---|---|
|   | Supply of up to 90 days   | Mail Order Drug Supply of over 90 days*                           |
| Generic Drugs                               | \$ 15   | \$ 30   |
| Brand Name Drugs<br>On Medication Formulary | 20% of cost of each prescription or refill to a maximum of \$ 120 | 20% of cost of each prescription or refill to a maximum of \$ 80  |
| Not on Medication Formulary                 | 20% of cost of each prescription or refill to a maximum of \$ 240 | 20% of cost of each prescription or refill to a maximum of \$ 160 |

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60% as to:

Non-Preferred Pharmacy

Copay per Prescription or Refill

Supply of  
Up to 90 days

Generic Drugs

\$ 15

Brand Name Drugs  
On Medication Formulary

20% of  
cost of each  
prescription  
or refill  
to a maximum  
of \$ 120

Not on Medication Formulary

20%  
cost of each  
prescription  
or refill  
to a maximum  
of \$ 240

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# Comprehensive Medical Expense Coverage

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All maximums included in this Plan are combined maximums between Preferred Care and Non-Preferred Care, where applicable, unless specifically stated otherwise.

## **Certification Requirement**

Certain types of care must be certified as necessary to avoid a reduction in the benefits payable. Read the Comprehensive Medical Expense Coverage section of the Booklet-Certificate for details of the types of care affected, how to get certification and the effect on your benefits of failure to obtain certification.

Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Skilled Nursing Care.

Excluded Amount \$ 200

This Excluded Amount applies separately to each type of admission and care listed above.

## **The Benefits Payable**

After any applicable deductible, the Health Expense Benefits payable under this Plan in a calendar year are paid at the Payment Percentage which applies to the type of Covered Medical Expense which is incurred, except for any different benefit level which may be provided later in this Booklet-Certificate. Benefits may vary depending upon whether a Preferred Care Provider is utilized. A Preferred Care Provider is a health care provider who has agreed to provide services or supplies at a "negotiated charge." See your Employer for a copy of the Directory which lists these health care providers.

If any expense is covered under one type of Covered Medical Expense, it cannot be covered under any other type.

## **Deductible Amounts**

Calendar Year Deductible \$ 1,500

This Calendar Year Deductible applies to all expenses except:

- Emergency Care provided in an Emergency Room
- Routine Screening for Cancer Expenses
- Fees of a physician for non-surgical office visits.

Family Deductible Limit \$ 4,500

Emergency Room Deductible \$ 200 per visit

This Emergency Room Deductible applies to Hospital Expenses incurred for emergency care provided by a **Non-Preferred Care Provider**. This amount is waived if the person becomes confined in a hospital.

Emergency Room Copay \$ 200 per visit

This Emergency Room Copay applies to Hospital Expenses incurred for emergency care provided by a **Preferred Care Provider**. This amount is waived if the person becomes confined in a hospital.

### Payment Percentage

The Payment Percentage applies after any deductible amounts.

#### *For Hospital Expenses\**

| <b>Preferred Care</b> | <b>Non-Preferred Care</b> | <b>Other Health Care</b> |
|-----------------------|---------------------------|--------------------------|
| 80%                   | 60%                       | 80%                      |

\* Emergency Room Treatment (Emergency Care), as defined in your Booklet-Certificate, will be covered at the Preferred Care Rate.

#### *For Physicians Fees*

| <b>Preferred Care</b>                                 | <b>Non-Preferred Care</b>                             | <b>Other Health Care</b> |
|---|---|--------------------------|
| Non-surgical Office Visits - 100% after a \$ 30 copay | Non-surgical Office Visits - 100% after a \$ 30 copay | 80%                      |
| Other - 80%   | 80%   | 80%                      |

#### *For Hospice Care Expenses*

For hospital charges refer to the applicable category of "**Hospital Expenses**" above.  
For charges of a physician, refer to the applicable category of "**Physician Fees**" above.  
For all other charges 80% \*

#### *For Other Covered Medical Expenses*

Covered Medical Expenses incurred in connection with routine screening for cancer

|                    |                           |
|--------------------|---------------------------|
| Preferred Care     | 100% after a \$ 30 copay* |
| Non-Preferred Care | 100% after a \$ 30 copay* |

\* Copay waived for routine mammograms

#### *Routine Physical Exam Expenses*

Covered Medical Expenses incurred in connection with a Routine Physical Exam

|                    |                          |
|--------------------|--------------------------|
| Preferred Care     | 100% after a \$ 30 copay |
| Non-Preferred Care | 100% after a \$ 30 copay |

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100% as to:

National Medical Excellence Travel and Lodging Expenses

80%\* as to:

Convalescent Facility Expenses

Home Health Care Expenses

All Other Medical Expenses for which a Payment Percentage is not otherwise shown.

\* However, if the providers of services or supplies for which expenses are incurred are of a type that has contracted in sufficient numbers, as determined by Aetna, to furnish services or supplies for a Negotiated Charge, then the Payment Percentage will be the applicable Preferred Care or Non-Preferred Care Payment Percentage as specified above for Hospital Expenses. Such types of providers may include, but are not limited to:

Home Health Care agencies;

Diagnostic laboratories;

Durable Medical Equipment suppliers;

Ambulance services.

To be sure that you will receive the full benefit available under this Plan, you should verify the provider's status by calling either the provider or the toll-free number shown on your ID card.

### **Payment Percentage and Special Maximums for Alcoholism, Drug Abuse and Mental Disorders.**

|   | <b>Preferred Care</b> | <b>Non-Preferred Care</b> | <b>Other Health Care</b> |
|---|-----------------------|---------------------------|--------------------------|
| <b><i>Alcoholism and Drug Abuse</i></b> |                       |                           |                          |
| Inpatient Treatment                     | 80%                   | 80%                       | 80%                      |
| Outpatient Treatment                    | 80%                   | 80%                       | 80%                      |
| <b><i>Mental Disorders</i></b>          |                       |                           |                          |
| Inpatient Treatment                     | 50%                   | 50%                       | 50%                      |
| Outpatient Treatment                    | 50%                   | 50%                       | 50%                      |

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***Alcoholism and  
Drug Abuse***

|   |            |
|---|------------|
| Special Inpatient and Outpatient<br>Calendar Year Maximum | \$ 12,715* |
| Alcoholism and Drug<br>Abuse Lifetime Maximum             | \$ 25,425* |

\* This will be increased or decreased every 3 years. The change will be made by the Alaska Director of Insurance. It will be based on changes for the 3 preceding years in the medical care component of the Consumer Price Index for all urban consumers in the Anchorage metropolitan area.

***Mental Disorders***

|  |    |
|--|----|
| Special Inpatient<br>Calendar Year Maximum Days    | 15 |
| Special Outpatient<br>Calendar Year Maximum Visits | 40 |

**Payment Limits**

These limits apply only to Covered Medical Expenses which are payable at a rate greater than 50% and not applied against any deductible or copay amount.

It does not apply to expenses incurred for the effective treatment of alcoholism and drug abuse and for the treatment of mental disorders while not confined as a full-time inpatient.

***Payment Limit which Applies to Expenses for a Person***

When a person's Covered Medical Expenses for which no benefits are paid because of the Payment Percentage reach \$ 4,000 in a calendar year, benefits will be payable at 100% for all of his or her Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year.

**Benefit Maximums**

(Read the coverage section in your Booklet Certificate for a complete description of the benefits available.)

|   |                                     |
|---|-------------------------------------|
| Convalescent Days                                       | 120 per calendar year               |
| Home Health Care Maximum Visits                         | 130 per calendar year               |
| Private Duty Nursing Care<br>Maximum Shifts             | 70 per calendar year                |
| National Medical Excellence<br>Lodging Expenses Maximum | \$ 50.00                            |
| Travel and Lodging Maximum                              | \$ 10,000                           |
| Private Room Limit                                      | The institution's semiprivate rate. |
| Lifetime Maximum Benefit                                | \$ 2,000,000                        |
| Restoration Amount                                      | \$ 20,000                           |

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## **Pregnancy Coverage**

Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for a disease.

In the event of an inpatient confinement:

- Such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery. If, after consultation with the attending physician, a person is discharged earlier: benefits will be payable for inpatient care of the covered person and any newborn child; and additional benefits will be payable for 2 post-delivery home visits by a health care provider.
- Certification of the first 48 hours of such confinement following a vaginal delivery or the first 96 hours of such confinement following a cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. You, your physician, or other health care provider may obtain such certification by calling the number shown on your ID Card.

Normally, the expenses must be incurred while the person is covered under this Plan. If expenses are incurred after the coverage ceases, they will be considered for benefits only if satisfactory evidence is furnished to Aetna that the person has been totally disabled since her coverage terminated.

*Prior Plans:* Any pregnancy benefits payable by previous group medical coverage will be subtracted from medical benefits payable for the same expenses under this Plan.

## **Sterilization Coverage**

*Health Expense Coverage:* Benefits are payable for charges made in connection with any procedure performed for sterilization of a person, including voluntary sterilization, on the same basis as for a disease.

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## **Adjustment Rule**

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the group contract, except that an increase is subject to any Active Work Rule described in Effective Date of Coverage section of this Summary of Coverage.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

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## General

This Summary of Coverage replaces any Summary of Coverage previously in effect under the group contract. Requests for amounts of coverage other than those to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

The insurance described in this Booklet-Certificate will be provided under Aetna Life Insurance Company policy form GR-29.

**KEEP THIS SUMMARY OF COVERAGE  
WITH YOUR BOOKLET-CERTIFICATE**

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## **Additional Information Provided by Anchorage School District**

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### **Statement of Rights under the Newborns' and Mothers' Health Protection Act**

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

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### **Notice regarding Women's Health and Cancer Rights Act**

Under this health plan, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

- (1) reconstruction of the breast on which a mastectomy has been performed;
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (3) prostheses; and
- (4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.