

**POLITICAL SUBDIVISION HEALTH PLAN  
BENEFIT SUMMARY  
PLAN I**

This is a summary of coverage's provided by the selected plan. Please refer to the Insurance Information Booklet for State of Alaska Political Subdivisions.

**Medical Benefits**

**Deductibles**

Calendar Year Individual.....	\$100 per person
Physician Office Visit.....	\$10 per visit

**Coinsurance**

Most Medical Expenses.....	90% of covered expenses
Second Surgical Opinions.....	90% of covered expenses
Preoperative Testing.....	90% of covered expenses
Outpatient Testing.....	90% of covered expenses
Hospital Expenses.....	90% of covered expenses
Chemical Dependency Treatment.....	90% of covered expenses
Mental or Nervous Disorders.....	50% of covered expenses

**Out-of-Pocket Limit**

After the deductible, the plan will pay the 90% coinsurance shown above until paid claims for an individual reach \$1,950, or, in other words, until out-of-pocket expenses for covered claims reach \$195 (not including the deductible). After paid claims reach \$1,950, the plan will pay 100% of most covered medical expenses for that person for the remainder of the calendar year. Expenses paid at a coinsurance different than 90% are not credited to this limit.

**Benefit Maximums—Individual**

**Chemical Dependency Treatment**

Two consecutive calendar years.....	\$12,475
Lifetime.....	\$24,950

*Subject to change every 3 years*

**Mental and Nervous Disorders**

Inpatient Calendar Year.....	21 days
Outpatient Calendar Year.....	25 visits

**Prescription Drugs**

The Plan pays normal plan benefits for a brand name drug after deductible. Generic drugs are covered at 100% after deductible.

Generic Drugs: You pay \$10.00 up to a 90 day supply.

Brand Name Drugs: You pay \$30.00 up to a 90 day supply.

**Dental Benefits**

**Deductible**

Individual Calendar Year (Class II and III combined).....	\$50
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**Coinsurance**

Class I (preventive) services.....	80%
Class II (restorative) services.....	80%
Class III (prosthetic) services.....	50%

**Benefit Maximum**

Individual Calendar Year.....	\$1,500
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**Vision Benefits**

**Coinsurance**

Examinations.....	80%
Lenses.....	80%
Frames.....	80%

**Benefit Maximums**

Examinations.....	1 per calendar year
Lenses.....	2 per calendar year
Frames.....	1 set every 2 calendar years

**Audio Benefits**

**Coinsurance**

All Covered Services.....	80%
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**Benefit Maximum**

Individual/3 consecutive calendar years.....	\$800
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