PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Highlights of your Health Care Coverage

Matanuska-Susitna Borough School District
Group Number: 4022091

Effective Date: 07/01/2024

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.
Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

MEDICAL PLAN	**2024 HDHP $1600 /20%/20%/30%/$7000 W/HEARING**	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family aggregate deductible 2x Individual)	$1,600 PCY/$3,200 PCY	Shared with In-Network
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20% Preferred/20% Participating	Hospital/CD & Professional; 30%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$7,000 PCY	$14,000 PCY
Office Visit Cost Share	In Network Deductible, then 20% Preferred/20% Participating	Out of Network Deductible, then Hospital/CD & Professional; 30%
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then Hospital/CD & Professional; 30%
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then Hospital/CD & Professional; 30%
Health Education (HE) (Unlimited)	Covered in Full	Covered In Full
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Covered In Full
PROFESSIONAL CARE		
Professional Office Visit (Includes Telemedicine)	In Network Deductible, then 20% Preferred/20% Participating	Out of Network Deductible, then Hospital/CD & Professional; 30%
APP-BASED VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	In Network Deductible, then 20% Preferred	Not Covered

This plan features a family aggregate deductible. If there is more than one person covered by the plan, the family deductible must be met before the plan begins to pay coinsurance. The family deductible can be met by any one person on the plan, or by a combination of family members.

Employees with self-only coverage are responsible for the individual deductible amount.

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MEDICAL PLAN	2024 HDHP $1600 /20%/20%/30%/$7000 W/HEARING	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	Not Covered
Telemedicine - Outpatient Rehab (Virtual Care Only) (Not Covered)	Not Covered	Not Covered
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in Full	Out of Network Deductible, then Hospital/CD & Professional; 30%
Other Professional Diagnostic Imaging	In Network Deductible, then 20% Preferred/20% Participating	Out of Network Deductible, then Hospital/CD & Professional; 30%
Other Professional Diagnostic Laboratory/Pathology	In Network Deductible, then 20% Preferred/20% Participating	Out of Network Deductible, then Hospital/CD & Professional; 30%
Diagnostic Mammography	In Network Deductible, then 20% Preferred/20% Participating	Out of Network Deductible, then Hospital/CD & Professional; 30%
FACILITY CARE OPTIONS		
Inpatient Facility	In Network Deductible, then 20% Preferred/20% Participating	Out of Network Deductible, then Hospital/CD & Professional; 30%
Inpatient Professional Services	In Network Deductible, then 20% Preferred/20% Participating	Out of Network Deductible, then Hospital/CD & Professional; 30%
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/20% Participating	Out of Network Deductible, then Hospital/CD & Professional; 30%
Outpatient Facility	In Network Deductible, then 20% Preferred/20% Participating	Out of Network Deductible, then Hospital/CD & Professional; 30%
Skilled Nursing Facility (60 days PCY)	In Network Deductible, then 20% Preferred/20% Participating	Out of Network Deductible, then Hospital/CD & Professional; 30%
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20% Preferred/20% Participating	Out of Network Deductible, then Hospital/CD & Professional; 30%
Hospice Care (Home Health and Respite) (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	In Network Deductible, then 20% Preferred/20% Participating	Out of Network Deductible, then Hospital/CD & Professional; 30%
Home Health Visits (130 visits PCY)	In Network Deductible, then 20% Preferred/20% Participating	Out of Network Deductible, then Hospital/CD & Professional; 30%
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital/CD & Professional; 30%
MEDICAL PLAN	**2024 HDHP $1600 /20%/20%/30%/$7000 W/HEARING**	

	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Sterilization - Female (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital/CD & Professional; 30%
Sterilization - Male (Unlimited)	In Network Deductible, then 20% Preferred/20% Participating	Out of Network Deductible, then Hospital/CD & Professional; 30%
MEDICAL CARE COORDINATION AND TRAVEL SERVICES		
Centers of Excellence Packaged Services (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement), Spine & Gynecology)	In Network Deductible, then 0%	Covered as any other service
Centers of Excellence Travel and Care Coordination (See Elective Procedure Travel)	See Elective Procedure Travel	See Elective Procedure Travel
Medical Access Transportation (3 round trips PCY for patient (includes 3 round trips PCY for parent or guardian if pt. under 19 yrs of age))	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Transplants (Unlimited; $75,000 donor)	Covered as any other service	Not Covered
Transplant Travel & Lodging ($7,500 travel and lodging)	Subject to Deductible, then 0%	Subject to Deductible, then 0%
Elective Procedure Travel (Prior Approval Required: Member & Medically Necessary Companion - Air: 1 round-trip per episode; Surface Transportation & Parking: $35/day; Ferry Transportation $50 per person each way; Lodging $50/day per person)	$1,600 PCY/$3,200 PCY Deductible, then 0%	$1,600 PCY/$3,200 PCY Deductible, then 0%
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service
EMERGENCY CARE		
Emergency Care	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Emergency Room Physician	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Urgent Care Center	In Network Deductible, then 20% Preferred/20% Participating	Out of Network Deductible, then Hospital/CD & Professional; 30%
Ambulance Transportation (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred/20% Participating	Out of Network Deductible, then CD & Professional; 30%
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	In Network Deductible, then 20% Preferred/20% Participating	Out of Network Deductible, then Hospital/CD & Professional; 30%
Manipulations (Spinal and other) (12 visits PCY)	In Network Deductible, then 20% Preferred/20% Participating	Out of Network Deductible, then Hospital/CD & Professional; 30%
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital/CD & Professional; 30%
MEDICAL PLAN	**2024 HDHP $1600 /20%/20%/30%/$7000 W/HEARING**	

	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Chemical Dependency Outpatient Professional Care (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital/CD & Professional; 30%
Mental Health Inpatient Facility Care (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital/CD & Professional; 30%
Mental Health Outpatient Professional Care (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital/CD & Professional; 30%
PHARMACY		
Drug List	Open A1 No Tiers	Open A1 No Tiers
Enhanced Preventive Drug List (PV Core Plus (Buy-Up))	Covered in Full	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Prescription Drugs - Retail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	In Network Deductible, then 20% Preferred	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Prescription Drugs - Mail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	In Network Deductible, then 20% Preferred	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 20% Preferred/20% Participating	Out of Network Deductible, then Hospital/CD & Professional; 30%
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain (45 visits PCY)	In Network Deductible, then 20% Preferred/20% Participating	Out of Network Deductible, then Hospital/CD & Professional; 30%
OTHER SERVICES		
Allergy/Therapeutic Injections	In Network Deductible, then 20% Preferred/20% Participating	Out of Network Deductible, then Hospital/CD & Professional; 30%
Medical Supplies, Equipment, Prosthetics (MS: Unlimited, ME: Unlimited, Pro: Unlimited)	In Network Deductible, then 20% Preferred/20% Participating	Out of Network Deductible, then Hospital/CD & Professional; 30%
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (1 PCY)	$25 Copay	Out of Network Deductible, then Hospital/CD & Professional; 30%
Vision Hardware ($300 PCY)	Covered in Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	$25 Copay	$25 Copay
Pediatric Vision Hardware (Under age 19: One pair of glasses PCY (frames & lenses). 12 month supply of contacts PCY, in lieu of glasses (frames & lenses).)	Covered in Full	Covered In Full
Routine Hearing Exam (1 every 2 calendar years)	In Network Deductible, then 20%	In Network Deductible, then 20%
Hearing Hardware ($3,000 every 3 calendar years)	In Network Deductible, then 20%	In Network Deductible, then 20%
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

Benefits provided at 100% of allowable charges; not subject to deductible or coinsurance.
Seasonal immunizations provided at a pharmacy will be covered in full up to maximum allowable amount.
Autism: Mental Health, Psychological & Neuropsychological Testing, Outpatient Professional & Facility Care covered as any other service.

Copays are not subject to the deductible unless otherwise noted.
Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.
PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross Blue Shield of Alaska. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms of the plan.This benefit highlight is not a contract and may change. Please see your benefit booklet or call Customer Service for full coverage information including a description of waiting periods, limitations, and exclusions.

Highlights of your Dental Coverage

Matanuska-Susitna Borough School District

Group Number: 4022091

Effective Date: 07/01/2024

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DENTAL PLAN	2024 DENTAL OPTIMA	
	IN-NETWORK	**OUT-OF-NETWORK**
Dental Cost Share		
Individual Deductible	$75 / $225 PCY	$75 / $225 PCY
Family Deductible	$75 / $225 PCY	$75 / $225 PCY
Preventive Cost Share	Covered in Full	Covered in Full
Basic Cost Share	Deductible, then 20%	Deductible, then 20%
Major Cost Share	Deductible, then 50%	Deductible, then 50%
Dental Reimbursement (Dental Choice Network)	AK fee schedule	80th percentile (in-state) and 90th percentile (out-of-state)
Dental Annual Maximum	$3,000 PCY	Shared with In Network
Benefit Enhancement Rider		
Benefit Enhancement Rider	Endodontics & Periodontal Treatment (In Major)	Endodontics & Periodontal Treatment (In Major)
Office Visit		
Routine Comprehensive / Periodic Oral Exams (2 PCY)	Covered in Full	Covered in Full
Problem Focused/Emergency Exam (2 PCY)	Covered in Full	Covered in Full
Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine))	Covered in Full	Covered in Full
Preventive Services		
Prophylaxis - Cleaning (2 PCY)	Covered in Full	Covered in Full
Fluoride Treatments (2 PCY; under the age of 20)	Covered in Full	Covered in Full
Sealants (Under age 20 limited to permanent molars only, Replacements limited to once every 24 consecutive months)	Covered in Full	Covered in Full
Space Maintainers (Members under age 20)	Covered in Full	Covered in Full
Diagnostic Imaging		
Bitewings X-rays (Unlimited)	Covered in Full	Covered in Full
Panoramic X-ray or comparable Conebeam view (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)	Covered in Full	Covered in Full
Restorative		
Fillings (1 per surface every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%
Installation of Inlays, Onlays and Crowns (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%

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	IN-NETWORK	OUT-OF-NETWORK
Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Repair Crown/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Endodontics		
Endodontic Therapy - Root Canal (Once per tooth every 24 consecutive months)	Deductible, then 50%	Deductible, then 50%
Periodontics		
Periodontal Maintenance (4 PCY)	Deductible, then 20%	Deductible, then 20%
Full Mouth Debridement (Once every 36 consecutive months)	Deductible, then 50%	Deductible, then 50%
Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)	Deductible, then 50%	Deductible, then 50%
Periodontal Surgery (Once per quadrant every 36 consecutive months)	Deductible, then 50%	Deductible, then 50%
Periodontal Soft Tissue Grafts (Once per quadrant every 36 consecutive months)	Deductible, then 50%	Deductible, then 50%
Prosthodontics (Dentures/Bridges)		
Installation or Replacement of Dentures, Partials and Fixed Bridges (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Repair or Re-cement Bridgework and Dentures (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Implant Services		
Implant Crowns/Bridge/Denture (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Oral Surgery		
Simple Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%
Surgical Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%
Oral Surgery (Unlimited)	Deductible, then 20%	Deductible, then 20%
General Services		
Anesthesia - Intravenous or General (Unlimited)	Deductible, then 20%	Deductible, then 20%
Anesthesia - Nitrous Oxide (Unlimited)	Deductible, then 20%	Deductible, then 20%
Palliative (Emergency) Treatment of Dental Pain (Unlimited)	Deductible, then 20%	Deductible, then 20%
Orthodontia		

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DENTAL PLAN	2024 DENTAL OPTIMA	
	IN-NETWORK	**OUT-OF-NETWORK**
Orthodontia Cost Share	50% up to Lifetime Max	50% up to Lifetime Max
Lifetime Maximum Benefit	$2,000 Lifetime Maximum	$2,000 Lifetime Maximum
TMJ Rider		
TMJ Rider (Not Covered)	Not Covered	Not Covered

Diagnostic and Preventive Care Services aren't subject to the calendar year deductible. PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross Blue Shield of Alaska. Members are responsible for amounts in excess of the allowable charge.

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Discrimination is Against the Law

Premera Blue Cross Blue Shield of Alaska (Premera) complies vvith applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people wth disabilities to communicate effectively vvith us, such as qualified sign language interpreters and witten information in other formats (large print, audio, accessible electronic formats, other formats)_ Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information witten in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance wth: Civil Rights Coordinator-Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint wth the US Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: US. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html_

Language Assistance

PAUNAWA Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-508-4722 (TTY 711).

ATENCION si habla espafiol, tiene a su disposici6n servicios graluitos de asistencia linguistica. Llame al 800-508-4722 (TTY: 711).

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ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur VerfUgung. Rufnummer: 800-508-4722 (TTY: 711).

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ATTENTION : Si vous parlez franc;;ais, des services d'aide linguistique vous sont proposes gratuitement Appelez le 800-508-4722 (ATS : 711)

ATENCAO: Se fala portugues, encontram-se disponiveis servic;;os linguisticos, gratis Ligue para 800-508-4722 (TTY: 711)

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti Chiamare ii numero 800-508-4722 (TTY 711)

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