

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.

Essentials Plan for Eligible Substitutes

MEDICAL PLAN		2024 PLUS ESSENTIALS 7550	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
MEDICAL COST SHARE OPTIONS			
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$7,550 PCY	\$15,100 PCY	
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	30% Preferred/40% Participating	Hospital & Professional: 60% Non-Participating	
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	\$8,550 PCY	Unlimited	
Office Visit Cost Share	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION			
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Health Education (HE) (Unlimited)	Covered in Full	Covered In Full	
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Covered In Full	
CHRONIC CONDITION MANAGEMENT PROGRAMS			
Diabetes Prevention	Excluded	Excluded	
Diabetes Management	Excluded	Excluded	
Hypertension Management	Excluded	Excluded	
Weight Management	Excluded	Excluded	
PROFESSIONAL CARE			
Professional Office Visit (Includes Telemedicine)	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
APP-BASED VIRTUAL CARE SERVICES			
Telemedicine - General Medical (Virtual Care Only)	Covered in Full	Not Covered	
Telemedicine - Mental Health (Virtual Care Only)	Covered in Full	Not Covered	
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered	
Telemedicine - Chemical Dependency (Virtual Care Only)	Covered in Full	Not Covered	

MEDICAL PLAN		2024 PLUS ESSENTIALS 7550	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
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 & Professional: 60% Non-Participating	
Other Professional Diagnostic Imaging	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Other Professional Diagnostic Laboratory/Pathology	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Diagnostic Mammography	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
FACILITY CARE OPTIONS			
Inpatient Facility	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Inpatient Professional Services	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Outpatient Surgery Facility	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Outpatient Facility	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Skilled Nursing Facility (60 days PCY)	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
HOSPICE & HOME HEALTH CARE			
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Hospice Care (Home Health and Respite) (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Home Health Visits (130 visits PCY)	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
MATERNITY & REPRODUCTIVE CARE			
Contraceptive Management Services (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Sterilization - Female (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Sterilization - Male (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
MEDICAL CARE COORDINATION AND TRAVEL SERVICES			

MEDICAL PLAN	2024 PLUS ESSENTIALS 7550	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Centers of Excellence Packaged Services (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement), Spine & Gynecology)	Covered in Full	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 30% Preferred	In Network Deductible, then 30% 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)	Covered in Full	Covered in Full
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service
EMERGENCY CARE		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$450 Copay applies to the Out of Pocket Maximum; then In Network Deductible, 30%	\$450 Copay applies to the Out of Pocket Maximum; then In Network Deductible, 30%
Emergency Room Physician	In Network Deductible, then 30% Preferred	In Network Deductible, then 30% Preferred
Urgent Care Center	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Ambulance Transportation (Unlimited)	\$450 Copay applies to the Out of Pocket Maximum; then In Network Deductible, 30%	\$450 Copay applies to the Out of Pocket Maximum; then In Network Deductible, 30%
Non-Emergent Ground Ambulance (Unlimited)	\$450 Copay applies to the Out of Pocket Maximum; then In Network Deductible, 30%	\$450 Copay applies to the Out of Pocket Maximum; then In Network Deductible, 30%
Air Ambulance (Unlimited)	\$450 Copay applies to the Out of Pocket Maximum; then In Network Deductible, 30%	\$450 Copay applies to the Out of Pocket Maximum; then In Network Deductible, 30%
Non-Emergent Air Ambulance (Unlimited)	\$450 Copay applies to the Out of Pocket Maximum; then In Network Deductible, 30% Preferred/40% Participating	Out of Network Deductible, then 60% Non-Participating
ALTERNATIVE CARE		
Acupuncture (Not Covered)	Not Covered	Not Covered
Manipulations (Spinal and other) (Not Covered)	Not Covered	Not Covered
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	In Network Deductible, then 30% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Chemical Dependency Outpatient Professional Care (Unlimited)	In Network Deductible, then 30% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating

MEDICAL PLAN		2024 PLUS ESSENTIALS 7550	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Mental Health Inpatient Facility Care (Unlimited)	In Network Deductible, then 30% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Mental Health Outpatient Professional Care (Unlimited)	In Network Deductible, then 30% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
PHARMACY			
Drug List	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs	
Enhanced Preventive Drug List (No Buy Up)	Subject to Standard Rx Cost share	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)	\$30/Ded then 30%/Ded then 30%/Ded then 50%	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)	\$90/Ded then 30%/Ded then 30%/Ded then 50%	Not Covered	
REHABILITATION & NEURO			
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain (45 visits PCY)	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
OTHER SERVICES			
Allergy/Therapeutic Injections	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Medical Supplies, Equipment, Prosthetics (MS: Unlimited, ME: Unlimited, Pro: Unlimited)	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
SUPPLEMENTAL BENEFITS			
Routine Vision Exam (Not Covered)	Not Covered	Not Covered	
Vision Hardware (Not Covered)	Not Covered	Not Covered	
Pediatric Vision Exam (Not Covered)	Not Covered	Not Covered	
Pediatric Vision Hardware (Not Covered)	Not Covered	Not Covered	
Routine Hearing Exam (Not Covered)	Not Covered	Not Covered	
Hearing Hardware (Not Covered)	Not Covered	Not Covered	
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.

Discrimination is Against the Law

Premera Blue Cross Blue Shield of Alaska (Premera) complies with 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 with disabilities to communicate effectively with us, such as qualified sign language interpreters and written 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 written 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 with: 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 with 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).

ATENCIÓN si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-508-4722 (TTY: 711).

I≡ 21 0, AfqofAIE 3-'F-, 2:j0, Al'B A-H:Jl:.....: -'FE. Olqof '4= '2,!qLICf. 800-508-4722(TTY711) Ei:£foH {jAl.2.

LUSEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 800-508-4722 (TTY: 711).

BHv1MAHv1E: Ecn Bbl roBopLne Ha pyccKoM f3bIKe, TO BaM AOCTynHbl 6ecHnaTHb1e ycnbnp nepeBOAa. 3B0H1ne 800-508-4722 (Tenerfin: 711).

_.i:q : frD5FcftL:-(JI\$ j\;q:i>,(ffl:tiJJ.,i,32,Jt'JJH 1\$"fi.J:j}J\$fi,'l:f% ° l1t¥5<'.. 800-508-4722 (TTY : 711) °

MOLOU SILAFIA Afai e le tautala Gagana fa'a Samoa, o loo iai auaunaga fesoasoan, e fai fua e leai se loloqi, mo oe, Telefoni mai 800-508-4722 (TTY 711).

1uad'Ju: 't7'JO'J UJ'JUCO'JW'J::J') :J'JO, muu:5:n'Jutio€JCQJEJC')JI'W'J::J'J, 1o€JUC:5J 'I, CCJ..IUDW! :ID?mui'Ju. Iurn 800-508-4722 (TTY 711).

!! \$-lji: E3*i! i! :h. "ijl: . Ull-© i! tl :... 'fIJfflt..f=f:lt'act"o 800-508-4722 (TTY711) ac:-c :li i!!:-C:... 'ji:Wr(t: L'o

PAKDAAR Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyanam. Awagan ti 800-508-4722 (TTY 711).

CHỦ Y N u b n n 6 i T i n q V i t. c 6 c a c d ! c h v 1,1 h 6 t r q n q 6 n n q O, m i n p h i d a n h c h o b n G Q i s 6 8 0 0 - 5 0 8 - 4 7 2 2 (T T Y : 7 1 1).

YBArAl flKLI.\0 BI-1 p03MOBnflETe yKpaYHCbKOfo MOBOfo, BI-1 MOmeTe 3B8PHYTI-1Cfl AO 6e3KOWTOBH0Y cnym61-1 MOBHOY niATPI-1MKI-1.

Tene<jloHyi:ciTe 3a HOMepoM 800-508-4722 (TeneTai:cin: 711).

tJ'W: t71f),t:"W'l:JAmtr1'1'Vil'Jf.Jru'i':i1m'J'f'l-nu1'm'J'liCJm'!!l 'el'Vl1'1il11:n'1Am b'Vl'J' 800-508-4722 (TTY: 711).

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

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy Językowej. Zadzwoń pod numer 800-508-4722 (TTY 711).

.(711 : IJ I <...0...>4A. !) 800-508-4722 y J.....;| .cJ...J¹/₂ cill _plfa 4,ipl ;; t.....Jl c.....\.....; ct-§ ;\.; Ill y...; 1 0= c.....wS i::S) 4.1: .1

ATANSYON. Si w pale Krey6l Ayisyen, gen sevis ed pou lang ki disponib gratis pou ou. Rele 800-508-4722 (TTY 711).

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 il numero 800-508-4722 (TTY 711).

...YIYw 800-508-4722 (TTY: 711) 1/2 ...& 1/2 CS" t"i >! ...& c5IY. uK.I) W J CS"1/2 ;, C-... , ...s: CS"CS"J.s u1/2 ;, t1:4.3.JI