

MSEA AND CEA HEALTH PLAN OPTIONS (FY26)

Side-by-Side Health Plan Comparison: Below is a simplified side-by-side comparison of the two Premera health plan options for FY26.

The information below is based on in-network, medical necessity, and approved costs. Review the plan documents at www.matsuk12.us/rnb for comprehensive information, including out-of-network cost share.

Key Plan Cost Indicators	PPO (Mimic) Plan		HDHP (HSA Compatible)	
	Individual	Family	Individual	Family
Medical				
Deductible	\$500	\$1,500	\$1,650	\$3,300
	Embedded		Aggregate	
Max Out-Of-Pocket (Preferred/In-Network)	\$2,000	\$6,000	\$7,000	\$14,000
Coinsurance	20% Preferred/In-Network		20% Preferred/In-Network	
Prescriptions	Copay		Subject to deductible, then 20% coinsurance	
Preventive Care				
Preventive Care	Covered in full		Covered in full	
Alternative Care				
Acupuncture	Subject to deductible, then 20% coinsurance (24 per calendar year)		Subject to deductible, then 20% coinsurance (12 per calendar year)	
Manipulations (Spinal & Other)	Subject to deductible, then 20% coinsurance (24 per calendar year)		Subject to deductible, then 20% coinsurance (12 per calendar year)	
Rehabilitation				
Rehab outpatient care including Physical, Occupational, Speech, and Massage Therapy; Cardiac & Pulmonary Rehab; Chronic Pain (45 visits PCY combined)	Subject to deductible, then 20% coinsurance Prior Authorization is required for PT, OT, and Massage Therapy		Subject to deductible, then 20% coinsurance Prior Authorization is required for PT, OT, and Massage Therapy	
Weight Loss				
Weight loss medication (GLP-1s)	Subject to the Prescription Coverage		Excluded for weight loss; GLP-1s approved to treat diabetes are covered when medically necessary for diabetes	
Bariatric Surgery	Subject to deductible, then 20% coinsurance		Not Covered	
Dental				
Deductible	\$75	\$225	\$75	\$225
Maximum Benefit	\$3,000 Per Person		\$3,000 Per Person	
Preventive Care	Covered in full		Covered in full	
Basic Care Coinsurance	20% (UCR)		20% (UCR)	
Major Care Coinsurance	50% (UCR)		50% (UCR)	
Orthodontia Coinsurance	50% (\$2,000 Maximum Benefit)		50% (\$2,000 Maximum Benefit)	
Vision				
Routine Vision Exam Copay	\$25 (in-network)		\$25 (in-network)	
Lenses for Glasses	100% - 1 pair per calendar year		\$300 maximum benefit per calendar year for members age 19+ (1 pair of frames & lenses or 12 month supply of contacts per calendar year covered in full for members under the age of 19)	
Frames	\$195 maximum benefit per calendar year for members age 19+ (1 per calendar year covered in full for members under the age of 19)			
Contact Lenses	Up to \$170 per calendar year; in lieu of frames & lenses (12-month supply covered in full for members under the age of 19; in lieu of frames & lenses)			
Audiology/Hearing				
Routine Hearing Exam	Waive Deductible, then 20% One exam per calendar year		In-Network Deductible, then 20% One exam every 2 calendar years	
Hearing Hardware	Waive Deductible, then 20% (\$2,500 maximum benefit per ear, every 3 calendar years)		In-Network Deductible, then 20% (\$3,000 total maximum benefit, every 3 calendar years)	
Health Savings Account (HSA)				
District HSA contribution for eligible employees (See negotiated agreement for payment schedule.)	N/A		\$1,500	

Important Terms:

Deductible: The amount you must pay before the plan begins to pay for covered services.

Aggregate Deductible: The HDHP features an aggregate deductible. For self-only coverage (only one person on the plan), the individual deductible applies. If more than one person is covered, the family deductible must be met before the plan begins to pay coinsurance for any member's services. The family deductible can be met by any covered individual or a combination of members.

Embedded Deductible: The Mimic plan features an embedded deductible. Each plan member must pay a \$500 deductible before the plan begins to pay coinsurance. Family members collectively have a \$1,500 deductible limit, with no single member exceeding \$500. After the family deductible is met, the plan will begin to pay coinsurance for all members.

Coinsurance: A percentage of covered expenses you pay after you meet your deductible. The coinsurance amounts listed above are for in-network, covered services. See the plan documents at www.matsuk12.us/rnb for out-of-network cost share.

Copays: Fixed dollar amounts that a plan member pays for covered services.

Max Out-Of-Pocket: The most a plan member could pay during a coverage period, typically the calendar year, for their share of the cost of covered services. The cost share amounts listed above are for in-network, covered services. See the plan documents at www.matsuk12.us/rnb for out-of-network cost share.

Preferred Providers: Also known as In-Network Providers. A service provider who is part of the plan's established network, in which rates, discounts, and pricing have been negotiated.

Prior Authorization: Services must be reviewed and approved before they are provided for the services to be covered.

Health Savings Account (HSA): A savings account that may be used to pay for out-of-pocket medical, dental, and vision expenses. Individuals must meet IRS eligibility rules and open a health savings account with the District's HSA Administrator to receive contributions. [Review IRS eligibility rules.](#)

For plan documents, a comprehensive summary of benefits and coverage, and highlights, visit www.matsuk12.us/rnb