Highlights of your Health Care Coverage

MIMIC PLAN

Matanuska-Susitna Borough School District

Group Number: 4022091

Effective Date: 07/01/2023

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	**2023 HP $500 20%/20%/30%/$2000**	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 3X Individual)	$500 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 3X Individual)	$2,000 PCY	$45,000 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)	Covered in Full	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	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
Chronic Condition Management (Excluded)	Not Covered	Not Covered
DIAGNOSTIC SERVICE OPTIONS		

MEDICAL PLAN	2023 HP $500 20%/20%/30%/$2000	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
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	$500 copay per admission, for first 2 visits per calendar year. Subsequent visits are subject to deductible, then 20% coinsurance.	$500 copay per admission, deductible waived, then 30% for first 2 visits per calendar year. Subsequent visits are subject to deductible, then 30% coinsurance
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 (120 days PCY)	$500 copay per admission, for first 2 visits per calendar year. Subsequent visits are subject to deductible, then 20% coinsurance	$500 copay per admission, deductible waived, then 30% for first 2 visits per calendar year. Subsequent visits are subject to deductible, then 30% coinsurance
Surgical Treatment for Morbid Obesity	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)	$500 copay per admission, for first 2 visits per calendar year. Subsequent visits are subject to deductible, then 20% coinsurance	$500 copay per admission, deductible waived, then 30% for first 2 visits per calendar year. Subsequent visits are subject to deductible, then 30% coinsurance
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%
Sterilization - Female (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital/CD & Professional; 30%
Sterilization - Male (Unlimited)	Covered in Full	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)	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 PLAN	**2023 HP $500 20%/20%/30%/$2000**	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
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)	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)	$500 Copay. Waive Deductible and Co-insurance	$500 Copay. Waive Deductible and Co-Insurance
Emergency Room Physician	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Urgent Care Center	In Network Deductible, then 20%	In Network Deductible, then 20%
Ambulance Transportation (Unlimited)	In Network Deductible, then 20%	In Network Deductible, then 20%
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 20%	In Network Deductible, then 20%
Air Ambulance (Unlimited)	In Network Deductible, then 20%	In Network Deductible, then 20%
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 20%	In Network Deductible, then 20%
ALTERNATIVE CARE		
Acupuncture (24 visits PCY)	In Network Deductible, then 20% Preferred/ 20% Participating	Out of Network Deductible, then Hospital/CD & Professional; 30%
Manipulations (Spinal and other) (24 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)	$500 copay per admission, for first 2 visits per calendar year. Subsequent visits are subject to deductible, then 20% coinsurance.	$500 copay per admission, deductible waived, then 30% for first 2 visits per calendar year. Subsequent visits are subject to deductible, then 30% coinsurance
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)	$500 copay per admission, for first 2 visits per calendar year. Subsequent visits are subject to deductible, then 20% coinsurance.	$500 copay per admission, deductible waived, then 30% for first 2 visits per calendar year. Subsequent visits are subject to deductible, then 30% coinsurance
Mental Health Outpatient Professional Care (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital/CD & Professional; 30%

REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	$500 copay per admission, for first 2 visits per calendar year. Subsequent visits are subject to deductible, then 20% coinsurance	$500 copay per admission, deductible waived, then 30% for first 2 visits per calendar year. Subsequent visits are subject to deductible, then 30% coinsurance
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 PLAN	**2023 HP $500 20%/20%/30%/$2000**	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
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%
TMJ (Limit $1,000 PCY/$5,000 Lifetime)	In Network Deductible, then 20% Preferred/ 20% Participating	Out of Network Deductible, then Hospital/CD & Professional; 30%
Wigs (Covered up to $300 PCY)	In Network Deductible, then 20% Preferred/20% Participating.	In Network Deductible, then 20% Preferred/20% Participating.
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (Exam: 1 PCY)	$25 Copay	$25 Copay
Vision Hardware (1 set of frames up to $195 PCY, 1 set of Lenses covered in full PCY, Contacts up to $170 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 exam PCY)	Waive Deductible, then 20%	Waive Deductible, then 20%
Hearing Hardware ($2,500 per ear maximum every 36 months)	Waive Deductible, then 20%	Waive 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 Health Care Coverage

Matanuska-Susitna Borough School District

Group Number: 4022091

Effective Date: 07/01/2023

Below is a brief overview of your Pharmacy Benefits. For more information on your benefits, please refer to your benefit booklets. To find out what tiers apply to a specific medication, refer to our Preferred Drug List in your Pharmacy Packet or at www.premera.com

PHARMACY PLAN	**2023 RX $10/$20/50% UP TO $300/$30**
PRESCRIPTION DRUGS	
Drug List	Preferred B4 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands Tier 4 = specialty
Annual Benefit Maximum	Unlimited
Individual Deductible PCY	$0
Family Deductible PCY	No Family Deductible
Out of Network (Non-participating retail pharmacies)	Same as in-network cost share
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Enhanced Preventive Drug List	No Buy Up
Retail Cost Shares	$10/$20/$30/50% up to $300
Mail Cost Shares	$25/$50/$75/50% up to $300
Day Supply	Retail: 90 Days; Mail: 90 Days; Specialty: 30 Days
Mandatory Home Delivery for Maintenance Drugs	Excluded
Specialty Pharmacy	Mandatory - Exclusive
Weight Loss Drugs	Covered as any other medication

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Highlights of your Dental Coverage

Matanuska-Susitna Borough School District

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DENTAL PLAN	2023 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		

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DENTAL PLAN	2023 DENTAL OPTIMA	
	IN-NETWORK	**OUT-OF-NETWORK**
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%
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%

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DENTAL PLAN	2023 DENTAL OPTIMA	
	IN-NETWORK	**OUT-OF-NETWORK**
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		
Orthodontia Cost Share	50% up to Lifetime Max	50% up to Lifetime Max
Lifetime Maximum Benefit	$2,000 Lifetime Maximum	$2,000 Lifetime Maximum

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 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 U.S. 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: U.S. 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).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-508-4722 (TTY: 711) 번으로 전화해 주십시오.

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

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-508-4722 (телетайп: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-508-4722 (TTY：711）。

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 800-508-4722 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-508-4722 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-508-4722 （TTY:711）まで、お電話にてご連絡ください。

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

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-508-4722 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-508-4722 (телетайп: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 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).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-508-4722 (رقم هاتف الصم والبكم: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-508-4722 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-508-4722 (ATS : 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. 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).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-508-4722 (TTY: 711) تماس بگیرید.

037379 (07-01-2021)