Public Education HEALTH TRUST

Anchorage Education Association
New Hire Presentation
School Year 2024/2025

www.pehtak.com
907-274-7526

Public Education
HEALTH TRUST

- Created by public education employees in 1996.
- You elect the Board of Trustees that governs PEHT, and all benefit decisions are made by your peers.
- Not-for-Profit insurance provider with no profit motivation.
- Your claim activity is always protected and kept private.
- Your association has selected three (3) medical plans to offer, providing flexibility to meet the individual family needs.

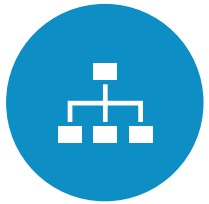
RESPONSIVE TO MEMBER NEEDS

PEHT has one purpose. To serve its members with high quality service and access to reasonable health insurance plans.

We protect your health claims data.

Our governance board of trustees is elected by you, the member.

The board designs plans to meet the needs of education employees.



Administrative costs are less than 5% of total costs.

Last five years of premium increases have been below National medical inflation numbers.

We are consistent with no spikes or surprises.

Public Education
HEALTH TRUST

THREE LOCAL STAFF TO ASSIST YOU

Rhonda Prowell-Kitter

Plan Administrator/CFO

rpk@pehtak.com

Rebecca Hubbard

Trust Claims Analyst

rgh@pehtak.com

Tia Allard

Administrative Assistant

tda@pehtak.com

907-274-7526

BENEFIT ENHANCEMENTS/ CHANGES Effective July 1, 2024

HDHP maintains HSA qualification – HDHP deductible increased to $1,600 for individual policies and $3,200 for family policies.

Mental Health Access – Increased access to mental health need through Teladoc. Virtual mental health appointments with therapist or psychiatrist.

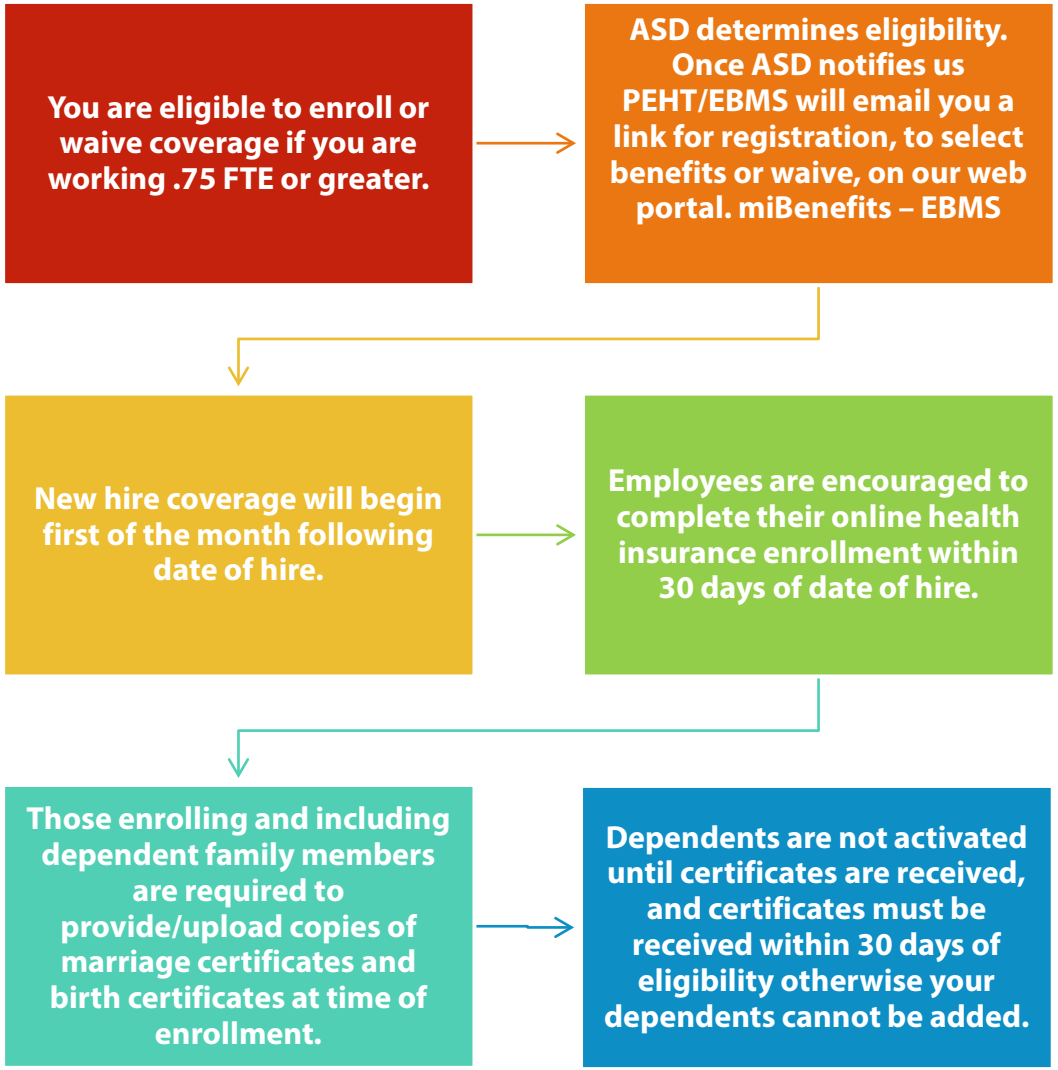
Generic Medications – Will not have a cost share increase. Preferred and Non-Preferred have a minimal increase.

Primary 360 through Teladoc – Creation of a Virtual Primary Care. Routine check-ups to ongoing care at no cost. HDHP must meet deductible.

Frame Allowance with our VSP partner – In keeping with inflation, the frame allowance is increased to $225.00.

GLP-1's treatment for weight loss – Saxenda, Wegovy and Zepbound are excluded.

ELIGIBILITY AND ENROLLMENT FOR YOU AND YOUR DEPENDENTS



Anchorage School District
Public Education Health Trust Information

Welcome to the Anchorage School District!

Your position is eligible for health insurance, including medical, dental, vision and prescription for you and your dependents. Insurance is provided through the Public Education Health Trust, or PEHT. **You need to elect or decline your coverage options**. You will receive an email invitation, sent to the address provided below, from mibenefits (EBMS). Please note you must respond to the email invitation and complete the process if you are electing or declining coverage. Your insurance is effective the first of the month following eligibility and upon completion of the process. You only have 30 days to elect coverage and submit required marriage and or birth certficiates for your dependents.

PLEASE NOTE: YOU MUST COMPLETE THE INSURANCE ELECTION/WAIVE PROCESS

Last name:_____ First name:_____ MI:_____

Social Security number:_____ Date of birth:_____

Email:_____ Phone:_____

Position title:_____

Work location:_____ FTE:_____

Date of Hire:_____ Benefits eligibility date:_____

Please contact PEHT at 274-7526 or info@pehtak.com with any questions,

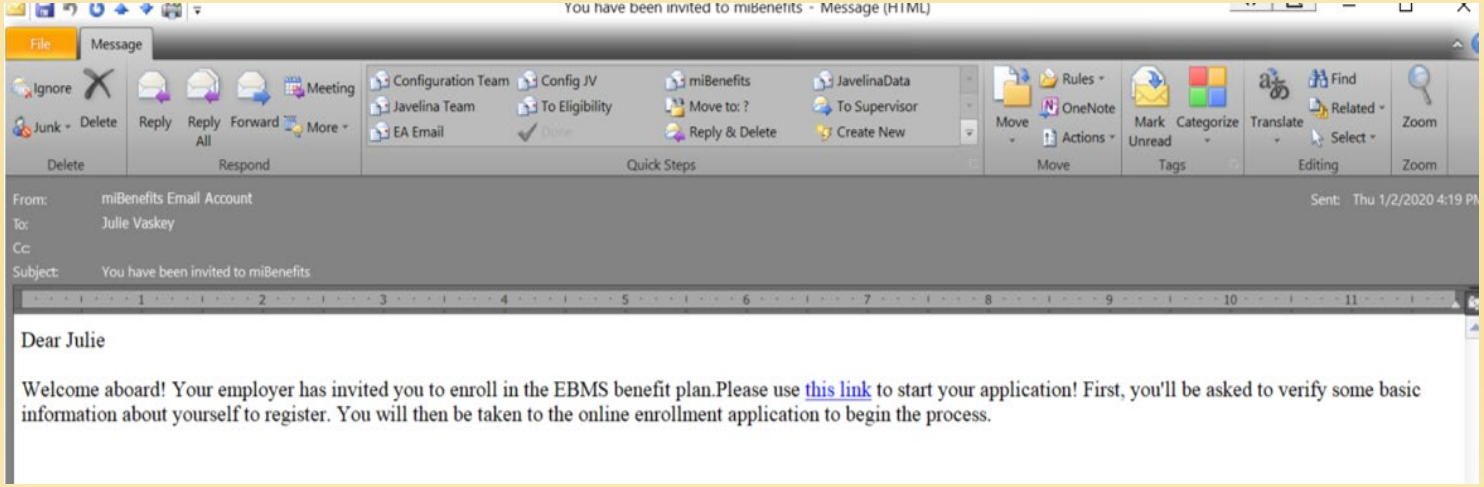
or if you do not receive the email invite within 5 days of completing this form.

Public Education HEALTH TRUST

You may receive the attached.
If you do, please complete.

Public Education
HEALTH TRUST

Look for an invitation in your email! It will come from mibenefits@ebms.com. The link within the email will start your enrollment application.



CHOOSING THE RIGHT PLAN FOR YOUR FAMILY MEDICAL

Medical Plan Summary	Plan C	Plan F	HDHP
Annual Deductible	$500/$1,500	$1,500/$3,000	**$1,600/**$3,200
Annual 20% Coinsurance Maximum (In-Network)	$2,000/$6,000	$3,000/$6,000	**$3,500/**$7,000
Primary Care Physician, Mental Health Visits (In-network)	Subject to Deductible & Coinsurance	$25 Copay for first 6 in-network office visits	Subject to Deductible & Coinsurance
Preventive Services (In-Network)	100%	100%	100%
Telemedicine – Teladoc Now including Mental Health	100%	100%	$65 then 100% after deductible
Prescription Co-Insurance (maximum)	$3,000/$6,000	$3,000/$6,000	$2,050/$4,100 **after deductible***
Please Note: Out of Network is Reimbursed at Medicare 125% for all plan designs!			**Aggregated deductible family of 2 or more, the deductible is $3,200. No single deductible when more than one on the policy. ***You will pay 100% of all prescriptions until deductible(s) are met. Once met, member responsibility is 20% of the cost of the medication.

CHOOSING THE RIGHT PLAN FOR YOUR FAMILY DENTAL/VISION

Dental and Vision Plan Summaries	Plan C	Plan F	HDHP
Annual Dental Deductible	$75/$225	$75/$225	$75/$225
Annual Maximum	$3,000 per person	$3,000 per person	$3,000 per person
Preventive/Basic/Major	100%/80%/50%	100%/80%/50%	100%/80%/50%
Preventive Services (In-Network)	100%	100%	100%
Vision Exam (in-network w/VSP)	$0	$0	$0
Vision Frames/Lenses	$25 copay	$25 copay	$25 copay
Frames	1 year/2 every other year $225	1 year/2 every other year $225	1 year/2 every other year $225
Contacts	Up to $170 allowance	Up to $170 allowance	Up to $170 allowance

Public Education
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Use of in-network providers is critical. Out of Network providers are reimbursed at Medicare 125%, with no cap.
This could leave you with a substantial financial obligation.

PROVIDENCE is the Preferred Hospital in Anchorage for PEHT

This is different than other employees of the Anchorage School District. When water cooler/lunchroom conversations occur regarding benefits, it is important to clarify what insurance they are discussing. Coverage provided through PEHT has selected Providence as the preferred hospital, not Alaska Regional. We pay Alaska Regional as out of network at the Medicare 125% rate, You could see a significant bill from Alaska Regional if you have labs, x-rays, surgery, or imagining performed at that facility.

- **Out of network is reimbursed at Medicare 125% with no maximum.**

Public Education HEALTH TRUST

AEA has negotiated with ASD a flat dollar contribution towards health insurance benefits. AEA uses those employer contributions to calculate the employee's share based upon family tier and plan selected.

Monthly Premium	Plan C	Plan F	HDHP
Employee Only	$547.71	$239.35	$119.69
Employee + Spouse	$656.85	$306.34	$163.16
Employee + Child(ren)	$620.63	$277.39	$138.39
Employee + Family	$729.77	$346.60	$183.32

OTHER PROGRAM SUPPORT

Transcarent/SWORD

- Exclusive surgery network with top quality care
- Coverage of travel expenses, reduced medical costs for elective surgeries such as knee, hip, shoulder, etc.
- www.transcarent.com or 1-855-265-2874
- Virtual Physical Therapy through Sword Health
  - **Relieve pain from the comfort of home!**
  - **Pairs licensed therapists with FDA listed wearable technology to guide you through personalized treatment plans at no cost to you!**
  - **Experience.transcarent.com/peht/vpt/ or 1-855-265-2874**

Teladoc/P360

- 24 hours a day/7 days a week Medical Provider
- www.Teladoc.com
- 1-800-835-2362
- Schedule your free* medical consult (*nominal fee per consult for HDHP until annual deductible is met)
- P360 provides Primary Care Physicians

SupportLinc

- Guidance to help you and your family address and resolve everyday issues
- www.supportlinc.com
- 1-888-881-5462
- Access up to eight (8) no-cost counseling sessions with SupportLinc providers
- Completely confidential

Providence Express Care

(Do not confuse with Providence Urgent Care)

- Three (3) convenient locations in South Anchorage, Muldoon and Eagle River
- 7:00 a.m. to 7:00 p.m.
- Seven (7) days a week
- $25 copay for office visit* portion (*HDHP after deductible is met)

Visit www.pehtak.com for detailed information about each program

VITALITY WELLNESS
Become aware of your own health

Vitality was selected as the Wellness Platform and was rolled out January 1, 2024.

AEA has 16 Champs – reach out to Carolyn Morrill or Regina Pierce

Download the app, sign in with your PEHT Insurance number

Earn Rewards and Redeem Bucks

Public Education HEALTH TRUST

- Submit your online forms for new hire and sign your contract.
- Look for your email invitation to complete your enrollment/waiver selection.
- Please have all steps completed **no later than August 15,** for summer hires to ensure your profile is set and ready for benefits to begin on September 1st. Individuals hired later in school year will have alternate dates.
- Upon enrollment, look for mailings from PEHT, EBMS, VSP, Optum RX, Support Linc.

Contact our office with any questions

907-274-7526

www.pehtak.com

Public Education HEALTH TRUST

Understanding Your Benefits

The Public Education Health Trust wants you to use your benefits! It is important that you familiarize yourself with this information so that you can maximize the use of these benefits to provide the best possible outcome for you and your family's health care needs. It should be noted that this is a summary only and does not guarantee benefits. All benefits are subject to the terms, limitations, and exclusions set forth in the Public Education Health Trust Benefit Booklet. If there are any discrepancies between this summary and the Benefit Booklet, the Benefit Booklet shall prevail.

Questions regarding the Benefit Booklet, claims, Allowable Charge, or eligibility should be directed to EBMS at **1-866-247-1443**. Information regarding Plan administration should be directed to the Public Education Health Trust office at **1-907-274-7526** or **1-888-685-7526**.

Medical Plan

Deductible*	$500 per person or $1,500 per family
Medical Maximum Out of Pocket**	$2,000 per person or $6,000 per family *Use of non-preferred providers and facilities does not accumulate to Out-of-Pocket*
Coinsurance % (Percentage the Plan will pay once the deductible is met.)	
Preferred Facility and Providers***	80%
Non-Preferred Facility and Providers	Payable amount up to 125% of the Medicare equivalent rate

* Your deductible refers to the dollar amount that the covered person must pay before the plan pays. As a reminder, your annual deductible is on a calendar year.

** The Plan will pay the designated percentage of the Allowable Charge until you meet your Medical Maximum Out of Pocket. Once your Medical Maximum Out of Pocket is met, the Plan will pay 100% of the remainder of the Allowable Charge for the rest of the calendar year unless stated otherwise.

***Public Education Health Trust has negotiated significant fee reductions with Aetna Signature Administrators (ASA) Network Facilities and providers for covered services. Log in to **www.aetna.com/asa** for easy access to up-to-date information on participating health care professionals and facilities.

Prescription Drugs

Optum Rx®

Prescription Maximum Out of Pocket	$3,000 per person or $6,000 per family
Retail (34 day supply)	30% (Generic $15min/$35max, Preferred $45min/$70max, Non-Preferred $70min/$115max)
Mail Order (90 day supply)	30% (Generic $30min/$70max, Preferred $90min/$140max, Non-Preferred $140min/$230max)
Specialty Pharmacy Program	Co-payment percentage and maximum co-payment per prescription - Value: 25% and $50; Formulary: 25% and $200; Non-Formulary: 50% and $600

Teladoc® HEALTH

Teladoc offers PEHT members 24/7 Physician Consultations, which provide access to licensed, U.S. based physicians by phone, secure e-mail, video, and mobile app at any time of the day. Physicians offer diagnoses, medical advice, and treatment recommendations and can even prescribe some medications over the phone at no cost to the member.

Introducing Primary360, a convenient way to **access virtual primary care and annual checkups** so you can become your healthiest self.

To learn more about Teladoc and Primary360, visit **teladoc.com** or call 1-800-Teladoc.

Dental Plan

Deductible	$75 per person or $225 per family (applies to Class B and C services)
Maximum (per calendar year)	$3,000 per person (applies to Class A, B, and C services)
Preventive Care (Class A Services)	100% up to Usual and Customary (two visits per person per year)
Basic (Class B Services)	80% subject to deductible and up to Allowable Charge
Major (Class C Services)	50% subject to deductible and up to Allowable Charge

Members are encouraged to use Aetna Dental Administrators www.aetna.com/docfind/custom/aetnadentalaccess/ when available for additional Plan discounts.

Vision (In VSP Network - for a list of VSP Providers go to www.vsp.com)

Co-pay	Examination - $0; Materials - $25
Annual Exam	Paid-in-Full every calendar year (after copayment)
Lenses (single vision, lined bifocal, lined trifocal, and Lenticular Lenses)	Paid-in-Full every calendar year (after copayment) Lens enhancement for anti-reflective and UV coating, and standard progressive lenses covered in full
Frames*	Paid-in-Full up to $225 every calendar year (after copayment), or up to $245 for Enhanced Featured Frame Brands, OR 2 pairs* of frames every other calendar year (after copayment)
Contact Lenses* (instead of spectacle lenses and frame)	Copay - Up to $60 for fitting and evaluation Elective - paid up to $170.00

*Maximum does not apply for dependents age 18 and under

Vision (Out of Network)

Copayment	Examination - $25; Materials - $25
Annual Exam	up to $50 (after copayment)
Lenses Annually	
Single Vision	up to $50 (after copayment)
Lined Bifocal	up to $75 (after copayment)
Lined Trifocal	up to $100 (after copayment)
Lenticular Lenses	up to $125 (after copayment)
Frames	up to $70 every other calendar year (after copayment) OR 2 pairs* of frames every other calendar year (after copayment)
Contact Lenses (Instead of spectacle lenses and frames)	Elective - Paid up to $105.00

*A second pair enhancement allows you to get a second pair of glasses or contacts, subject to the same copays and frequencies as the first pair.

Member Assistance Program (MAP)

supportlinc

MAP services are cost-free, convenient and confidential. MAP coverage includes a spouse or live-in partner and eligible dependent children. To contact your MAP, call 1-888-881-5462.

- Up to 8 free counseling sessions per issue per year
- Legal advice - half hour face to face, unlimited telephone consultation
- Financial planning - unlimited telephone consultation

miBenefits

Your claims history and your Benefit Booklet are available in your personal online or mobile app miBenefits account! To log in to your miBenefits account, follow these easy steps!

1. Go to www.ebms.com or your app store (search EMBS miBenefits).
2. Click on the "Login" button at the top of the screen.
3. Fill out our short registration using your ID card, and EBMS will immediately verify your eligibility, giving you full access to miBenefits!

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Medical Plan

Deductible*	$1,500 per person or $3,000 per family
Medical Maximum Out of Pocket**	$3,000 per person or $6,000 per family *Use of non-preferred providers and facilities does not accumulate to Out-of-Pocket*
Coinsurance % (Percentage the Plan will pay once the deductible is met.)	
Preferred Facility and Providers***	80%
Non-Preferred Facility and Providers	Payable amount up to 125% of the Medicare equivalent rate
Office Visit Co-Pay (doesn't apply to specialists)	$25 (first 6 annual visits, with an in-network, primary care provider, are paid at 100% after co-pay; thereafter 80% after deductible)

* Your deductible refers to the dollar amount that the covered person must pay before the plan pays. As a reminder, your annual deductible is on a calendar year.

** The Plan will pay the designated percentage of the Allowable Charge until you meet your Medical Maximum Out of Pocket. Once your Medical Maximum Out of Pocket is met, the Plan will pay 100% of the remainder of the Allowable Charge for the rest of the calendar year unless stated otherwise.

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Prescription Drugs

Optum Rx®

Prescription Maximum Out of Pocket	$3,000 per person or $6,000 per family
Retail (34 day supply)	30% (Generic $15min/$35max, Preferred $45min/$70max, Non-Preferred $70min/$115max)
Mail Order (90 day supply)	30% (Generic $30min/$70max, Preferred $90min/$140max, Non-Preferred $140min/$230max)
Specialty Pharmacy Program	Co-payment percentage and maximum co-payment per prescription - Value: 25% and $50; Formulary: 25% and $200; Non-Formulary: 50% and $600

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To learn more about Teladoc and Primary360, visit **teladoc.com** or call 1-800-Teladoc.

Dental Plan

Deductible	$75 per person or $225 per family (applies to Class B and C services)
Maximum (per calendar year)	$3,000 per person (applies to Class A, B, and C services)
Preventive Care (Class A Services)	100% up to Usual and Customary (two visits per person per year)
Basic (Class B Services)	80% subject to deductible and up to Allowable Charge
Major (Class C Services)	50% subject to deductible and up to Allowable Charge

Members are encouraged to use Aetna Dental Administrators www.aetna.com/docfind/custom/aetnadentalaccess/ when available for additional Plan discounts.

Vision (In VSP Network - for a list of VSP Providers go to www.vsp.com)

Co-pay	Examination - $0; Materials - $25
Annual Exam	Paid-in-Full every calendar year (after copayment)
Lenses (single vision, lined bifocal, lined trifocal, and Lenticular Lenses)	Paid-in-Full every calendar year (after copayment) Lens enhancement for anti-reflective and UV coating, and standard progressive lenses covered in full
Frames*	Paid-in-Full up to $225 every calendar year (after copayment), or up to $245 for Enhanced Featured Frame Brands, OR 2 pairs* of frames every other calendar year (after copayment)
Contact Lenses* (instead of spectacle lenses and frame)	Copay - Up to $60 for fitting and evaluation Elective - paid up to $170.00

*Maximum does not apply for dependents age 18 and under

Vision (Out of Network)

Copayment	Examination - $25; Materials - $25
Annual Exam	up to $50 (after copayment)
Lenses Annually	
Single Vision	up to $50 (after copayment)
Lined Bifocal	up to $75 (after copayment)
Lined Trifocal	up to $100 (after copayment)
Lenticular Lenses	up to $125 (after copayment)
Frames	up to $70 every other calendar year (after copayment) OR 2 pairs* of frames every other calendar year (after copayment)
Contact Lenses (Instead of spectacle lenses and frames)	Elective - Paid up to $105.00

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Member Assistance Program (MAP)

supportlinc

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- Legal advice - half hour face to face, unlimited telephone consultation
- Financial planning - unlimited telephone consultation

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Medical Plan

Deductible*	$1,600 single coverage or $3,200 family coverage
Medical Maximum Out of Pocket**	$3,500 single coverage or $7,000 family coverage *Use of non-preferred providers and facilities does not accumulate to Out-of-Pocket*
Coinsurance % (Percentage the Plan will pay once the deductible is met.)	
Preferred Facility and Providers***	80%
Non-Preferred Facility and Providers	Payable amount up to 125% of the Medicare equivalent rate

* Your deductible refers to the dollar amount that the covered person must pay before the plan pays. As a reminder, your annual deductible is on a calendar year.

** The Plan will pay the designated percentage of the Allowable Charge until you meet your coinsurance maximum. Once your coinsurance maximum is met, the Plan will pay 100% of the remainder of the Allowable Charge for the rest of the calendar year unless stated otherwise.

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Prescription Drugs*

Optum Rx®

Coinsurance % (Percentage the Plan will pay once the deductible is met.)	80% after deductible
Prescription Maximum Out of Pocket**	$2,050 single coverage or $4,100 family coverage

*Participants are required to pay 100% at the pharmacy and are then reimbursed any applicable amount after the deductible has been met.

Certain FDA-approved, Physician-prescribed lifestyle drugs not covered by the Plan may be available at a discount price. To receive this discount, a Covered Person will be required to pay a 100% copayment at the time of purchase when his or her ID card is shown.

MAIL ORDER: The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer Covered Persons significant savings on their prescriptions. The mail order pharmacy is subject to change.

Specialty Pharmacy Program	Co-payment percentage and maximum co-payment per prescription - Value: 25% and $50; Formulary: 25% and $200; Non-Formulary: 50% and $600

Teladoc® HEALTH

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Introducing Primary360, a convenient way to access **virtual primary care and annual checkups** so you can become your healthiest self. Please keep in mind that, due to HDHP regulations, there are per visit fees until the deductible is met, then the plan covers visits at 100%. Initial visits are $165. Ongoing visits are $95. Annual visit is $165.

To learn more about Teladoc and Primary360, visit t**eladoc.com** or call 1-800-Teladoc.

Dental Plan

Deductible	$75 per person or $225 per family (applies to Class B and C services)
Maximum (per calendar year)	$3,000 per person (applies to Class A, B, and C services)
Preventive Care (Class A Services)	100% up to Allowable Charge (two visits per person per year)
Basic (Class B Services)	80% subject to deductible and up to Allowable Charge
Major (Class C Services)	50% subject to deductible and up to Allowable Charge

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Annual Exam	Paid-in-Full every calendar year (after copayment)
Lenses (single vision, lined bifocal, lined trifocal, and Lenticular Lenses)	Paid-in-Full every calendar year (after copayment) Lens enhancement for anti-reflective and UV coating, and standard progressive lenses covered in full
Frames*	Paid-in-Full up to $225 every calendar year (after copayment), or up to $245 for Enhanced Featured Frame Brands, OR 2 pairs* of frames every other calendar year (after copayment)
Contact Lenses* (instead of spectacle lenses and frame)	Copay - Up to $60 for fitting and evaluation Elective - paid up to $170.00

*Maximum does not apply for dependents age 18 and under

Vision (Out of Network)

Copayment	Examination - $25; Materials - $25
Annual Exam	up to $50 (after copayment)
Lenses Annually	
Single Vision	up to $50 (after copayment)
Lined Bifocal	up to $75 (after copayment)
Lined Trifocal	up to $100 (after copayment)
Lenticular Lenses	up to $125 (after copayment)
Frames	up to $70 every other calendar year (after copayment) OR 2 pairs* of frames every other calendar year (after copayment)
Contact Lenses (Instead of spectacle lenses and frames)	Elective - Paid up to $105.00

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3. Fill out our short registration using your ID card, and EBMS will immediately verify your eligibility, giving you full access to miBenefits!

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