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*	$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.

***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

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Introducing Primary360, a convenient way to a**ccess 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)

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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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