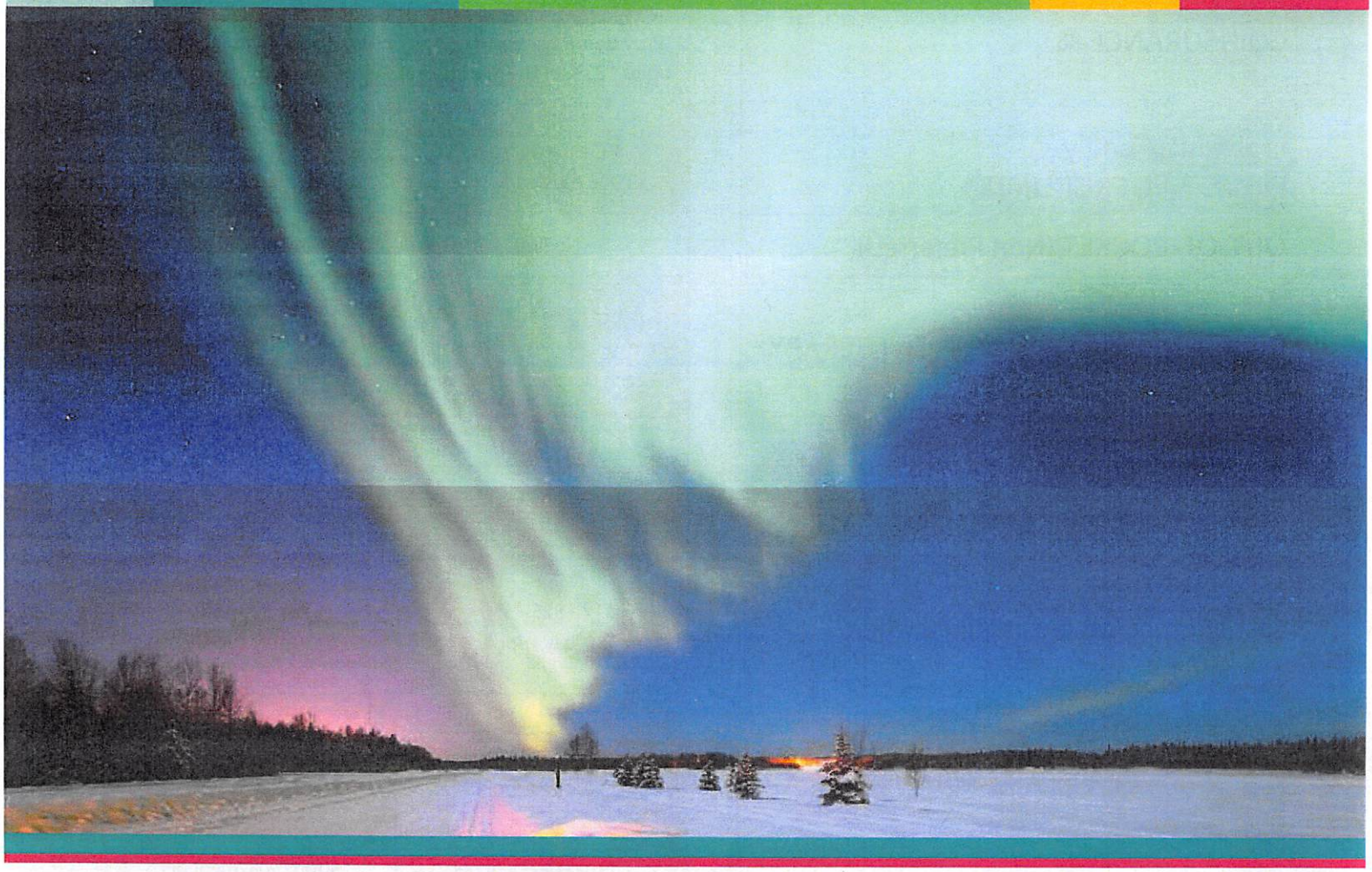


Public Education HEALTH TRUST

TRUST VISION STATEMENT

Maximize Member Benefits at the Least Cost.

We value fiscal integrity.
We value the highest standard of service.
We value open and honest communication.
We value mutual respect and building trust.
We value the greatest possible benefit for all.

	A	B
Individual/Family DEDUCTIBLE	$100 / $300	$250 / $750
COINSURANCE %	Preferred 80% to $5,000; Non-Preferred Facility and Providers Payable amount up to 125% of the Medicare equivalent rate	Preferred 80% to $10,000; Non-Preferred Facility and Providers Payable amount up to 125% of the Medicare equivalent rate
Individual/Family OUT-OF-POCKET LIMIT*	$1,000 plus deductible/ $3,000 plus deductible	$2,000 plus deductible/ $6,000 plus deductible
OUT-OF-POCKET (Non Preferred)	No limit	No limit
CHIROPRACTIC OR MASSAGE THERAPY	Subject to deductible and coinsurance; up to 20 visits each per calendar year	Subject to deductible and coinsurance; up to 20 visits each per calendar year
PRIMARY CARE OFFICE VISITS	N/A	N/A
SPECIALTY PROVIDER OFFICE VISITS	N/A	N/A
PRESCRIPTIONS - Retail (Generic medications required when available)	$12 / $25 / $50 - 30-day supply	$12 / $25 / $50 - 30-day supply
PRESCRIPTIONS - Mail Order (Generic medications required when available)	$24 / $50 / $100 - 90-day supply	$24 / $50 / $100 - 90-day supply
PRESCRIPTION SPECIALTY (Not including oncology medications)	50% co-payment per prescription with a per prescription maximum of $100 Value/$400 Formulary/$600 Non-Formulary	50% co-payment per prescription with a per prescription maximum of $100 Value/$400 Formulary/$600 Non-Formulary
PREVENTIVE CARE (Well baby and routine cancer screenings)	Paid at 100%	Paid at 100%
EMERGENCY ROOM DEDUCTIBLE (waived if admitted)	$500	$500
INPATIENT HOSPITAL CO-PAY	$500 per admission; capped two times per individual per year	$500 per admission; capped two times per individual per year
BridgeHealth or miChoice	100% no deductible	100% no deductible

* All plans that participate in the Trust are indexed each year to meet ACA required limitations for global out-of-pockets In network, out-of-pocket responsibilities include calendar year deductible, coinsurance, (office co-payment where applicable) inpatient hospital deductibles, emergency room deductibles, prescription co-payment, pediatric vision exam and pediatric material co-payment.

	C	E
Individual/Family DEDUCTIBLE	$500 / $1,500	$1,000 / $3,000
COINSURANCE %	Preferred 80% to $10,000; Non-Preferred Facility and Providers Payable amount up to 125% of the Medicare equivalent rate	Preferred 80% to $15,000; Non-Preferred Facility and Providers Payable amount up to 125% of the Medicare equivalent rate
Individual/Family OUT-OF-POCKET LIMIT*	$2,000 plus deductible / $6,000 plus deductible	$3,000 plus deductible / $9,000 plus deductible
OUT-OF-POCKET (Non Preferred)	No limit	No limit
CHIROPRACTIC OR MASSAGE THERAPY	Subject to deductible and coinsurance; up to 20 visits each per calendar year	Subject to deductible and coinsurance; up to 20 visits each per calendar year
PRIMARY CARE OFFICE VISITS	N/A	N/A
SPECIALTY PROVIDER OFFICE VISITS	N/A	N/A
PRESCRIPTIONS - Retail (Generic medications required when available)	$17 / $30 / $60 - 30-day supply	$17 / $30 / $60 - 30-day supply
PRESCRIPTIONS - Mail Order (Generic medications required when available)	$34 / $60 / $120 - 90-day supply	$34 / $60 / $120 - 90-day supply
PRESCRIPTION SPECIALTY (Not including oncology medications)	50% co-payment per prescription with a per prescription maximum of $100 Value/$400 Formulary/$600 Non-Formulary	50% co-payment per prescription with a per prescription maximum of $100 Value/$400 Formulary/$600 Non-Formulary
PREVENTIVE CARE (Well baby and routine cancer screenings)	Paid at 100%	Paid at 100%
EMERGENCY ROOM DEDUCTIBLE (waived if admitted)	$500	$500
INPATIENT HOSPITAL CO-PAY	$500 per admission; capped two times per individual per year	$500 per admission; capped two times per individual per year
BridgeHealth or miChoice	100% no deductible	100% no deductible

* All plans that participate in the Trust are indexed each year to meet ACA required limitations for global out-of-pockets. In network, out-of-pocket responsibilities include calendar year deductible, coinsurance, (office co-payment where applicable) inpatient hospital deductibles, emergency room deductibles, prescription co-payment, pediatric vision exam and pediatric material co-payment.

	F	G
Individual/Family DEDUCTIBLE	$1,500 / $3,000	$3,000 / $6,000
COINSURANCE %	Preferred 80% to $15,000; Non-Preferred Facility and Providers Payable amount up to 125% of the Medicare equivalent rate	Preferred 80% to $15,000; Non-Preferred Facility and Providers Payable amount up to 125% of the Medicare equivalent rate
Individual/Family OUT-OF-POCKET LIMIT*	$3,000 plus deductible / $6,000 plus deductible	$3,000 plus deductible / $6,000 plus deductible
OUT-OF-POCKET (Non Preferred)	No limit	No limit
CHIROPRACTIC OR MASSAGE THERAPY	Subject to PCP OVC or deductible/coinsurance; up to 20 visits each per calendar year.	Subject to PCP OVC or deductible/coinsurance; up to 20 visits each per calendar year.
PRIMARY CARE OFFICE VISITS (PCP OVC)	$25 (1st 6 visits per Calendar Year)	$30 (1st 6 visits per calendar year)
SPECIALTY PROVIDER OFFICE VISITS	Subject to deductible and coinsurance	Subject to deductible and coinsurance
PRESCRIPTIONS - Retail (Generic medications required when available)	$17 / $30 / $60 - 30-day supply	$17 / $30 / $60 - 30-day supply
PRESCRIPTIONS - Mail Order (Generic medications required when available)	$34 / $60 / $120 - 90-day supply	$34 / $60 / $120 - 90-day supply
PRESCRIPTION SPECIALTY (Not including oncology medications)	50% co-payment per prescription with a per prescription maximum of $100 Value/$400 Formulary/$600 Non-Formulary	50% co-payment per prescription with a per prescription maximum of $100 Value/$400 Formulary/$600 Non-Formulary
PREVENTIVE CARE (Well baby and routine cancer screenings)	Paid at 100%	Paid at 100%
EMERGENCY ROOM DEDUCTIBLE (waived if admitted)	$500	$500
INPATIENT HOSPITAL CO-PAY	$500 per admission; capped two times per individual per year	$500 per admission; capped two times per individual per year
BridgeHealth or miChoice	100% no deductible	100% no deductible

* All plans that participate in the Trust are indexed each year to meet ACA required limitations for global out-of-pockets. In network, out-of-pocket responsibilities include calendar year deductible, coinsurance, (office co-payment where applicable) inpatient hospital deductibles, emergency room deductibles, prescription co-payment, pediatric vision exam and pediatric material co-payment.

	HDHP	SGOOP
Individual/Family DEDUCTIBLE	$1,500 / $3,000	$6,650 / $13,300
COINSURANCE %	Preferred 80% to $17,500; Non-Preferred Facility and Providers Payable amount up to 125% of the Medicare equivalent rate	Preferred: Paid at 100% Non Preferred Facility & Providers: up to 125% of Medicare equivalent rate
Individual/Family OUT-OF-POCKET LIMIT*	$3,500 plus deductible / $7,000 plus deductible	$6,650 / $13,300
OUT-OF-POCKET (Non Preferred)	No limit	No Limit
CHIROPRACTIC OR MASSAGE THERAPY	Subject to deductible and coinsurance; up to 20 visits each per calendar year	Subject to deductible; up to 20 visits each per calendar year
PRIMARY CARE OFFICE VISITS	N/A	N/A
SPECIALTY PROVIDER OFFICE VISITS	N/A	N/A
PRESCRIPTIONS - Retail (Generic medications required when available)	Prescriptions are subject to deductible and coinsurance. Some preventive drugs will be covered with deductible waived.	Prescriptions are subject to deductible. Some preventive drugs will be covered with deductible waived.
PRESCRIPTIONS - Mail Order (Generic medications required when available)	Prescriptions are subject to deductible and coinsurance. Some preventive drugs will be covered with deductible waived.	Prescriptions are subject to deductible. Some preventive drugs will be covered with deductible waived.
PRESCRIPTION SPECIALTY (Not including oncology medications)	50% co-payment per prescription with a per prescription maximum of $100 Value/$400 Formulary/$600 Non-Formulary	Prescriptions are subject to deductible
PREVENTIVE CARE (Well baby and routine cancer screenings)	Paid at 100%	Paid at 100%
EMERGENCY ROOM DEDUCTIBLE (waived if admitted)	$500	N/A
INPATIENT HOSPITAL CO-PAY	$200 per admission; capped two times per individual per year; applies to out-of-pocket	N/A
BridgeHealth or miChoice	100% after deductible	100% after deductible

* All plans that participate in the Trust are indexed each year to meet ACA required limitations for global out-of-pockets. In network, out-of-pocket responsibilities include calendar year deductible, coinsurance, (office co-payment where applicable) inpatient hospital deductibles, emergency room deductibles, prescription co-payment, pediatric vision exam and pediatric material co-payment.

Your Dental Benefit Options

Dental Plan A

Deductible	$50 per person or $150 per family
Maximum (per calendar year)	$2000
Preventive Care	100% up to Usual and Customary (two visits per person per year)
Basic	80% subject to deductible and up to Usual and Customary
Major	50% subject to deductible and up to Usual and Customary

Dental Plan B

Deductible	$75 per person or $225 per family
Maximum (per calendar year)	$3000 per person
Preventive Care	100% up to Usual and Customary (two visits per person per year)
Basic	80% subject to deductible and up to Usual and Customary
Major	50% subject to deductible and up to Usual and Customary

Dental Plan - Value

Deductible	$50 per person or $150 per family
Maximum (per calendar year)	$500 per person
Preventive Care	100% up to the UCR (two visits per person per year) – after dental deductible
Basic	None
Major	None

Orthodontia

Orthodontia (per lifetime)	50% up to $2000 per person

Members are encouraged to use Aetna Dental Administrators **ASAlookup.AetnaSignatureAdministrators.com** when available for additional Plan discounts.

Your Health Benefit Plan ebms

Public Education Health Trust (PEHT), has contracted with Employee Benefit Management Services, LLC (EBMS), a family-owned, nationally recognized third party administrator of group health benefit plans, for the administration of your benefits, including claims processing, access to Aetna Signature Administrator's national provider network, call center and online customer support and Carelink's medical management services. EBMS' dedicated team of health, legal and business strategists work collaboratively with PEHT administration and your member organizations to help maximize health and financial outcomes for the Trust and the members they serve.

EBMS has devoted a team of highly trained professionals available to help members navigate the complicated healthcare and insurance system. These member advocates will help explain the member's summary of benefits, review benefit programs offered by the member's health plan, assist with billing questions, and/or help the member resolve outstanding claims issues. This service is designed for members who are experiencing complex health issues or are having difficulty resolving their claims and benefits questions.

EBMS also provides real time access through our web based benefit administration resource, miBenefits. Allowing 24/7 online access to all benefits, claims, healthcare resources and general information, miBenefits allows you to check claims status and Explanation of Benefits (EOB) forms, view plan documents and provider directories. To access this web based portal, visit www.ebms.com.

Your VSP Vision Benefits

VSP is the largest not-for-profit vision care company in the U.S. today. They've worked exclusively with private-practice doctors to provide Public Education Health Trust members with the best eye care possible. With more than 67 million members nationwide, 49,000 clients, 54,000 access points of care and 31,000 doctors in their network, one in five people in the U.S. rely on VSP for quality eye coverage.

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

Co-pay	Examination - $25; Materials - $25
Annual Exam	Paid-in-Full every calendar year (after co-payment)
Lenses (single vision, lined bifocal, lined trifocal, and Lenticular Lenses)	Paid-in-Full every calendar year (after co-payment). Anti-reflective coating covered in full.
Frames	Paid-in-Full up to $195 every calendar year (after co-payment) OR 2 pairs of frames every other calendar year (after co-payment).
Contact Lenses (instead of spectacle lenses and frame)	Necessary - Paid-in-Full (after co-payment); Specific benefit criteria must be met for Necessary Contact Lenses. Eligibility is determined by the VSP doctor at the time of service. Elective - paid up to $130 . Contact lens fitting and evaluation exam is covered after a $60 copay.

**The above table is not applicable to the HDHP. Please see routine care services listed in the medical benefit booklet.*

Pharmacy Benefit Management

As your pharmacy benefits manager, Optum wants to help you get the most value from your prescription benefits. We are committed to giving you the information you need to make the best decisions regarding the prescriptions you take!

YOUR HEALTH IS IN YOUR HANDS

Visit Optumrx.com/myoptumrx or get the Optum Mobile App for iPhone or Android to locate a nearby pharmacy, find your copay, review your benefit documents, order mail order refills, and more. Most national chains and many local pharmacies are included in the Optum network. Save the most money by choosing generic medications when possible.

HOME DELIVERY

Members who take long-term maintenance medications will save money using this service. Medications are delivered right to your door, and you can order refills quickly and easily online or by phone.

CUSTOMER SERVICE

We are here to assist you day and night! Call the phone number on your member ID card or visit Optumrx.com/myoptumrx.

Member Assistance Program

The SupportLinc Member Assistance Program (MAP) is designed to help you manage life's daily challenges. We can refer you to professional counselors and services that can help you and your eligible family members resolve a broad range of personal concerns, such as:

- Marriage and Relationship Issues
- Stress and Anxiety
- Depression
- Substance Abuse
- Anger Management
- Family Problems
- Grief and Loss
- Legal and Financial Services
- Dependent Care

Visit www.supportlinc.com to find out more information!

SUPPORT LINC
EMPLOYEE ASSISTANCE PROGRAMS

Go365

Getting motivated to get healthier just got a little easier. In October, PEHT partnered with Go365, a wellness rewards program, to provide members with resources to help make better lifestyle choices. Members who participate in Go365 earn points – which translate into dollars – by tracking healthy activities.

POINTS AND BUCKS | Points are earned with activities, such as logging physical activity in a fitness app or device, keeping a sleep diary, tracking food intake, getting a flu shot, going to the dentist, donating blood, participating in online health coaching, using the online Go365 health calculators, and more.

Points earned through the designated activities translate into "bucks" that can be redeemed at Go365's online mall to purchase e-gift cards to Amazon, Target, movie theaters, Lowe's, and other retailers. The bucks can also be used to purchase fitness trackers and other items.

LEVELS | All participants start in the Blue status and begin to work their way up by earning points. To move to Bronze, members can complete their health assessment and/or their biometric screening or log a verified workout. After achieving Bronze status, participants work toward Silver, Gold, and Platinum. Participants become eligible for Bonus Bucks, surprise rewards, and monthly jackpot drawings, as they progress.

CONDITIONS | All members participating in the medical plan and their enrolled dependents are eligible to take part in this program. Every member 18 years or older can register and create their own account. The points and bucks earned through the program will track toward the family's account. NEXT STEPS | All members receive an ID card in the mail from Go365. You can use your Member ID number, found on your card, to register at www.Go365.com. Then, you can sign into your account at any time to view a personalized dashboard, connect a compatible fitness device or tracking app, track points, unlock activities, contact a health coach, participate in challenges with coworkers, and more.

QUESTIONS?
Please contact Go365 or visit the Go365 community page.

Teladoc

TELADOC.

Public Education Health Trust has contracted with Teladoc to provide 24/7 Physician Consultations for you and your Dependents.

Teladoc offers 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, treatment recommendations and can even prescribe medications over the phone.

Call: 1-800-Teladoc or www.Teladoc.com.

BridgeHealth

BridgeHealth

BridgeHealth is a surgery benefit program that is offered to you through PEHT. The suite of tools, services and dedicated Care Coordinators are available to help you when considering a planned surgery. Then, if surgery is right for you, this program may actually lower your out-of-pocket costs while improving the quality of care and the entire experience.

BRIDGEHEALTH IS OFFERED TO YOU AT NO EXTRA COST – YOU'RE ALREADY ENROLLED!!

> ***Gain access to decision support:*** If you are considering surgery, that's when to contact BridgeHealth. It's at this important juncture that you can start off with less anxiety and focus more fully on your options. No worries. That's the BridgeHealth way.

>***Get top-quality care:*** If you decide to have surgery, you want the best care. BridgeHealth's stringent standards in selecting providers, verified by external data, deliver top-tier options.

>***Save Money:*** BridgeHealth has pre-negotiated agreements with care providers that lower your plan sponsor's healthcare costs as well as those of the actual surgery. These savings, which can be significant, are passed on to you.

>***Let your Care Coordinators help:*** BridgeHealth provides you with dedicated Care Coordinators who will guide you toward your most informed decision.

FEEL NO PAIN IN YOUR WALLET!!

How? BridgeHealth pre-negotiates rates for a wide variety of surgical procedures with top tier providers across the nation. These rates translate to lower costs for you. More reasons to take advantage of BridgeHealth include: You'll know about any costs upfront — no surprises after surgery! Your health plan offers the BridgeHealth surgical benefit to deliver more value, quality and cost savings to you.

Refer to your PEHT Plan Benefits Booklet to learn more about your BridgeHealth Surgery Benefit or call the BridgeHealth Staff at 855.265.2874 with any questions.

miChoice

miChoice

If your elective surgery is not eligible through the BridgeHealth Surgery Option, you can use the EBMS miChoice program.

A friendly and knowledgeable miChoice concierge will help find a provider who can perform a high-quality, low-cost procedure.

The concierge will explore options across your area and the U.S. to ensure you receive the high-quality healthcare you deserve. This means you could receive compensation for you and your companion, if travel is required for your procedure.

In addition, our team will coordinate with your providers' offices for you.

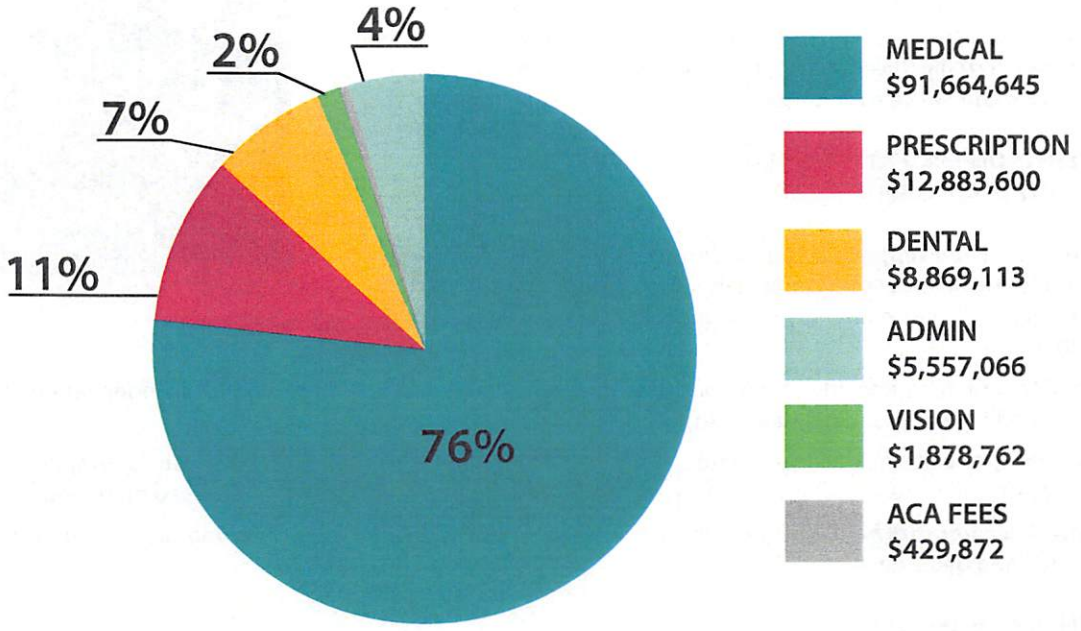
Plus, you'll experience personalized support from one of our clinical nurses.

Your health plan may also have financial incentives within your benefits to reward you for being an informed healthcare consumer.

The miChoice concierge team analyzes reports of facilities, based on both cost and quality. miChoice also allows a member to see how many times facilities have performed their specific surgery and what the success rate was nationally and compared to others in the area. This information helps the concierge team determine the best medical provider.

If you would like more information on miChoice and what it can do, call a miChoice advocate toll-free at 866.677.8745.

Public Education Health Trust
FY 2017 Dollar Spend



The Public Education Health Trust was established on July 1, 1996.
As of January 1, 2018, the following associations/employer groups participate in the Trust:

Alaska Gateway School District
Anchorage Education Association
Bristol Bay Borough School District
Chatham School District
Classified Employee Association
Copper River School District
Cordova School District
Craig City School District
Delta Greely School District
Denali Borough School District
Haines School District
Hoonah School District
Hydaburg City School District
Juneau Administrators
Juneau Exempt
Juneau Education Association
Kake School District
Kashunamiut School Board
Kashunamiut School District
Klawock School District
Mat-Su Borough School Board
Mat-Su Borough School District
Mat-Su Education Association
Nenana School District
NEA Alaska - Staff
NEA Alaska - Management
Petersburg School District
Pribilof School District
Public Education Health Trust Office
Southeast Island School District
Tanana School District
Wrangell School District

Contact the Health Plan by Mail:
Public Education Health Trust
4003 Iowa Drive; Anchorage, Alaska 99517

Contact the Health Plan by Phone:
in Anchorage: 907-274-7526
outside of Anchorage: 1-888-685-7526

Contact the Health Plan by Fax:
907-222-2556

Public Education HEALTH TRUST

Rates for Plan Year FY 2019
Effective January 1, 2019

Group:	Kenai Peninsula Borough School District

Please complete the following steps:

- ✓ Indicate which medical plan or plans you will offer by checking the appropriate green box(s)
- ✓ Indicate the dental plan that will go with the medical plan(s) offered by checking the corresponding orange box(s)
- ✓ If orthodontia is included under the plan indicate by checking the corresponding purple box

Review your current enrollment provided within the rate exhibit below. The enrollment by plan and rate tier is listed under the Tiered Rates section.

Initial, sign and date the bottom of the rate sheet

Return this form to the Trust no later than November 2, 2018

	Medical Plan Choices	TIERED RATES Employee	Employee + Spouse	Employee + Child(ren)	Employee + Spouse + Child(ren)	Dental Plan Choices (rates illustrated below medical rates) A	B	V	Ortho
	Enrollment Assumption	209	209	107	559				
☐	Plan A Medical	$1,202.00	$2,523.00	$2,332.00	$3,653.00	☐	☐	☐	☐
☐	Plan B Medical	$1,156.00	$2,426.00	$2,242.00	$3,512.00	☐	☐	☐	☐
☐	Plan C Medical	$1,140.00	$2,393.00	$2,211.00	$3,464.00	☐	☐	☐	☐
☐	Plan E Medical	$1,053.00	$2,211.00	$2,042.00	$3,200.00	☐	☐	☐	☐
☐	Plan F Medical	$1,034.00	$2,172.00	$2,005.00	$3,143.00	☐	☐	☐	☐
☐	Plan G Medical	$954.00	$2,004.00	$1,850.00	$2,900.00	☐	☐	☐	☐
☐	HDHP	$960.00	$2,016.00	$1,862.00	$2,918.00	☐	☐	☐	☐
☐	SHDHP	$877.00	$1,843.00	$1,704.00	$2,670.00	☐	☐	☐	☐
	Plan Dental A	$57.70	$121.30	$129.90	$193.50				
	Plan Dental B	$54.90	$115.30	$123.50	$183.90				
	Plan Dental Value (V)	$25.30	$53.10	$56.90	$84.70				
	Orthodontia Rider	$9.60	$20.10	$21.60	$32.10				

	Initial
Group has selected to offer Medical Plan(s) indicated above	_____
Group has selected to offer Dental Plan(s) indicated above	_____
Group has selected to offer Orthodontia, if indicated above	_____
Group will offer coverage to Domestic Partners	_____

_____ Signature _____ Title _____ Date

Proposal Assumptions

Rates assume a January 1, 2019 effective date and are guaranteed through June 30, 2019
Rates will only cover claims incurred and paid effective January 1, 2019 and after
Employee must work a minimum of 15 hours on average per work week to be eligible for coverage
Our rates assume the PEHT plans are the only benefits offered to employees. If other plans are made available, the Trust must be notified and have an opportunity to review
PEHT reserves the right to change rates if enrollment changes by 10% or more
Plan deductibles and out of pocket maximums are accumulated on a calendar year basis
For mid-year enrollment of new groups, plan deductibles can be credited for prior coverage, provided EOB information is submitted to the Plan Administrator
Rates include broker payment of 2.75% of premium to a maximum of $15,000 annually for a fiscal year, payable to Marsh & McLennan Agency.
Rates include a new group load, which will be reviewed annually for up to three plan years starting at the July 1, 2019 renewal
A group participation agreement must be signed and returned no later than December 1, 2018
Completed enrollment applications must be submitted by December 1, 2018
Proof of dependent eligibility documents must be submitted by January 31, 2019

		Plan A	Plan B	Plan C	Plan E	Plan F	Plan G	HDHP	SHDHP
Individual/Family Deductible		$100/$300	$250/$750	$500/$1500	$1000/$3000	$1500/$3000	$3000/$6000	$1500/$300	$6500/$13300
In-network co-insurance		80%							100%
Out-of-network co-insureance		125% of medicare							
Individual/Family Out of Pocket		$1100/$3300	$2250/$6750	$2500/$7500	$4000/$12000	$4500/$9000	$6000/$12000	$5000/$10000	$6500/$13300
EE	209	$1,202.00	$1,156.00	$1,140.00	$1,053.00	$1,034.00	$954.00	$960.00	$877.00
ES	209	$2,523.00	$2,426.00	$2,393.00	$2,211.00	$2,172.00	$2,004.00	$2,016.00	$1,843.00
EC	107	$2,332.00	$2,242.00	$2,211.00	$2,042.00	$2,005.00	$1,850.00	$1,862.00	$1,704.00
ESC	559	$3,653.00	$3,512.00	$3,464.00	$3,200.00	$3,143.00	$2,900.00	$2,918.00	$2,670.00
Monthly	1084	$3,070,076.00	$2,951,740.00	$2,911,350.00	$2,689,470.00	$2,641,526.00	$2,437,272.00	$2,452,380.00	$2,243,338.00
Composite		$2,832.17	$2,723.01	$2,685.75	$2,481.06	$2,436.83	$2,248.41	$2,262.34	$2,069.50

		Dental A	Dental B	Ortho
Deductible		$50/$150	$75/$225	
Co-insurance		100%/80%/50%		50%
Annual Max		$3,000	$2,000	$2000 lifetime max
EE	209	$57.70	$54.90	$9.60
ES	209	$121.30	$115.30	$20.10
EC	107	$129.90	$123.50	$21.60
ESC	559	$193.50	$183.90	$32.10
	1084	$159,476.80	$151,586.40	$26,462.40
		$147.12	$139.84	$24.41

PEHT Proposal

Medical Plan	Monthly Premium		Dental Plan	Monthly Premium		Total Monthly Premium				Difference
A	$ 2,832.17	+	B	$ 139.84	=	$ 2,972.01	$ 2,421.49	KPBSD Traditional	$	550.52
B	$ 2,723.01	+	B	$ 139.84	=	$ 2,862.85				12
C	$ 2,685.75	+	B	$ 139.84	=	$ 2,825.59			$	6,606.24
E	$ 2,481.06	+	B	$ 139.84	=	$ 2,620.90				
F	$ 2,436.83	+	B	$ 139.84	=	$ 2,576.67				
G	$ 2,248.41	+	B	$ 139.84	=	$ 2,388.25				
HDHP	$ 2,262.34	+	B	$ 139.84	=	$ 2,402.18	$ 2,078.47	KPBSD HDHP	$	323.71
										12
									$	3,884.52

Stacey Cockroft

To: Health Committee Members
Subject: Specific Stop Loss 10/31/2018

Good Morning,

Below is the Specific Stop loss Report through 10/31/2018.

Subscriber	Total Amt	Amt over Spec	Amt Requested	Amt Reimbursed	Non Reimbursed Expenses	Amt Open
1	$1,429,844.37	$ 1,209,844.37	$1,067,686.35	$1,066,042.93	$ 1,643.42	$ 143,801.44
2	$1,387,258.62	$ 1,167,258.62	$1,028,188.74	$1,028,188.74		$ 139,069.88
3	$ 281,276.74	$ 61,276.74	$ 59,912.76	$ 59,912.76		$ 1,363.98
5	$ 317,188.91	$ 97,188.91	$ 65,994.04	$ 65,994.04		$ 31,194.87
5	$ 315,064.08	$ 95,064.08	$ 12,461.45	$ 12,461.45		$ 82,602.63
6	$ 294,376.42	$ 74,376.42	$ 14,590.24	$ 18,204.03		$ 56,172.39
	$4,025,009.14	**$ 2,705,009.14**	**$2,248,833.58**	**$2,250,803.95**	**$ 1,643.42**	**$ 454,205.19**

Thanks,

Stacey Cockroft
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Kenai Peninsula Borough School District

Health Care Committee Monthly recap
as of October 31, 2018

Reserve Account	As of 6-30-17	As of 6-30-18
Employee Share	701,399.69	471,065.27
Employer Share	1,353,713.48	1,572,408.17

FY18 Monthly Contribution - Traditional	
Employee Share *	498.00
Employer Share	1,923.49
	2,421.49

FY18 Monthly Contribution - HDHP	
Employee Share *	308.00
Employer Share	1,770.47
	2,078.47

This document is provided to the Health Care Committee as a work paper to recap the contributions to and expenditures from the Health Care Plan each month. It is to be used primarily as an aid in estimating costs of the plan to determine if changes should be made in employee contribution amounts. Every effort is made to provide current and accurate information, but this information is not audited until after the end of the fiscal year.

	Number of Employees	YTD Employees		Current Month Obligations	YTD Obligations	Contributions Current Month Collected	Contributions YTD Collected
Employees							
KPEA Employees	300	1,641		149,400.00	817,218.00	197,133.92	416,045.25
KPEA Employees - HDHP	311	752		95,788.00	231,616.00	138,105.39	246,304.98
KPEA Repay EE Reserve						16,944.54	33,775.23
KPESA Employees	186	1,080		92,628.00	537,840.00	123,727.15	278,810.68
KPESA Employees - HDHP	202	489		62,216.00	150,612.00	90,850.02	162,575.99
KPESA Repay EE Reserve						10,905.00	21,761.70
Administrators	21	144		10,458.00	71,712.00	13,332.15	36,834.20
Administrators - HDHP	37	85		11,396.00	26,180.00	15,848.04	28,367.60
Admin Repay EE Reserve						1,600.80	3,201.60
Board Members	2	11		996.00	5,478.00	275.00	4,245.48
Board Members - HDHP	4	10		1,232.00	3,080.00	2,198.87	2,978.39
Board Repay EE Reserve						448.50	476.10
Exempt Employees	8	57		3,984.00	28,386.00	4,103.28	24,699.42
Exempt Employees - HDHP	17	41		5,236.00	12,628.00	5,764.56	11,446.81
Exempt Repay EE Reserve						690.00	1,352.40
Affordable Care Act **	-	-		0.00	0.00		
ACA Empl Repay EE Reserve							
Total Employees on Payroll	**1,088**	**4,310**		**433,334.00**	**1,884,750.00**	**621,927.22**	**1,272,875.83**
COBRA Payers (FY19 = $2215.88)	2	8		4,431.76	17,727.04	2,215.88	15,511.16
COBRA HD Payers (FY19 = $1960.28)	1	4		1,960.28	7,841.12	3,920.56	9,801.40
Total Employees	**1,091**	**4,322**	**Total**	**439,726.04**	* **1,910,318.16**	**628,063.66**	**1,298,188.39**

* Current month employee obligations are a calculation of "Number of Employees" eligible for health care coverage during that month times the "Employee Share" (shown in the upper right corner of the sheet).

** Affordable Care Act (ACA) coverage is offered to employees once eligibility is determined. Eligiblity is based on number of hours worked during the measurement period.

Employer						
Employer share	519	2,937	998,291.31	5,649,290.13	1,321,216.72	2,875,345.95
Employer share - HDHP	572	1,379	1,012,708.84	2,441,478.13	1,338,637.12	2,587,681.82
Total			**2,450,726.19**	**10,001,086.42**	**3,287,917.50**	**6,761,216.16**

+ Employee Share Split	**FY19 Contribution Traditional**	**498.00**	**Subtotal**	338,571.50	760,635.03
	Cobra	**2,215.88**	**Subtotal**	2,215.88	15,511.16
				340,787.38	776,146.19
	FY19 Contribution HDHP	**308.00**	**Subtotal**	252,766.88	451,673.77
	Cobra HD	**1,960.28**	**Subtotal**	3,920.56	9,801.40
				256,687.44	461,475.17
	Prior Year Reserve Repayment	**20.70**	**Subtotal**	30,588.84	60,567.03

Expenditures

Since the health care plan is self-funded, both employee and employer contributions are collected and bills are paid from the accumulated funds.

	TRADITIONAL		HDHP	
Claims	**Current Month**	**Year-To-Date**	**Current Month**	**Year-To-Date**
Health Care Claims paid by TPA (Rehn)	1,349,873.05	5,927,611.14	326,705.54	533,408.57
Prescription Claims paid by Caremark	435,775.84	1,725,139.79	80,708.94	121,925.96
HRA	-	-	26,126.29	41,674.31
Total Claims Paid	1,785,648.89	7,652,750.93	433,540.77	697,008.84
Administration				
TPA (Rehn) fees and costs	9,724.71	102,696.34	-	-
TPA (Rehn) HRA fees and costs	-	-	12,080.94	34,756.31
Aetna Administration Fees	9,986.29	55,456.49	11,006.09	26,464.05
Consultant Fees	2,346.84	9,379.56	2,586.49	10,353.76
Stop Loss Premiums	100,970.49	562,826.56	111,281.55	272,186.96
Affordable Care Act Fee	-	32,010.59	-	4,297.02
Total Administration	123,028.33	762,369.54	136,955.07	348,058.10
Total Claims plus Administration	1,908,677.22	8,415,120.47	570,495.84	1,045,066.94
Adjustments				
Stop Loss reimbursements	(641,601.12)	(1,567,125.97)	-	-
Prescription Rebates	-	(55,739.69)	-	-
Health Care Claims refund	-	-	-	-
Claims reimbursements	(1,000.00)	(1,000.00)	-	-
Other adjustments	-	(24.83)	-	-
Total Adjustments	(642,601.12)	(1,623,890.49)	-	-
Total Expenditures	**1,266,076.10**	**6,791,229.98**	**570,495.84**	**1,045,066.94**

Obligations/Contributions

Health care obligations and contributions provide employee and employer amounts of health care contributions using different calculation methods.

Obligations are estimates of funds that employees and the district will be obligated to contribute, based on the plan year (July through June).

Returning employees are covered by the health care plan for the entire plan year, meaning the 12 month period July through June; both employee and employer are obligated to pay for 12 months of coverage. New employees pay for coverage from date of hire through June, the end of the plan year. If an employee works at all during a month, both employee and employer pay for the entire month of coverage.

Actual Contributions made by employees and benefits paid by the employer during the payroll process are shown on the sheet in the columns labeled "Collected." The division of payments is governed by the Collective Bargaining Agreements and Memorandums of Understanding between the district and the employee groups.

Employee-paid contributions are deductions from payroll checks. Employees who work 12 months make contributions each pay period. Many school district employees do not work 12 months, so contributions are collected for those employees during the 9 month period from September through May.

For this reason, contributions are generally larger than obligations for September through May and contributions are generally smaller than obligations for June, July and August.

The "Collected" columns show what is actually available for paying health care costs. The "Obligations" show what is estimated to be available by month, based on number of employees at the current rate of contributions.

Kenai Peninsula Borough School District
Healthcare Expenditures Split
as of October 31, 2018

Traditional Plan	
YTD Participants	2,937
Net Expenditures	6,820,237.53
ER - Employer Cap $1731.45	5,085,268.65
EE - Employee Cap $305.55	897,400.35
Total Cap Expenditure EE/ER	5,982,669.00
Expenditures over Cap	837,568.53
50/50 Split of Expenditures over Cap	418,784.27
ER Expenditures Up To Cap	781,608.35
ER Expenditures Above Cap	418,784.27
Total ER Expenditures	1,200,392.62
EE Expenditures Up To Cap	137,930.89
EE Expenditures Above Cap	418,784.27
Total EE Expenditures	556,715.16
Total ER & EE Expenditures	1,757,107.77

HDHP	
YTD Participants	1,379
Net Expenditures	1,015,366.17
ER - Employer Cap $1645.61	2,269,296.19
EE - Employee Cap $182.85	252,150.15
Total Cap Expenditure EE/ER	2,521,446.34
Expenditures over Cap	-
50/50 Split of Expenditures over Cap	-
ER Expenditures Up To Cap	913,829.55
ER Expenditures Above Cap	-
Total ER Expenditures	913,829.55
EE Expenditures Up To Cap	101,536.62
EE Expenditures Above Cap	-
Total EE Expenditures	101,536.62
Total ER & EE Expenditures	1,015,366.17

Traditional Summary

Through August 2018	YTD EXP	YTD REV	REV Less EXP
Employer	5,382,589.13	2,875,345.95	(2,507,243.18)
Employee	1,437,648.40	776,146.19	(661,502.21)
Totals	6,820,237.53	3,651,492.14	(3,168,745.39)

Obligation per Employee FY19		Year-to-date
498.00 EE/1923.49 ER Split	2,421.49	2,421.49
Monthly Cost per Employee - ER		1832.68
Monthly Cost per Employee - EE + Cobra		489.50
		2322.18
Current Variance		**99.31**

HDHP Summary

Through August 2018	YTD EXP	YTD REV	REV Less EXP
Employer	913,829.55	2,587,681.65	1,673,852.10
Employee	101,536.62	461,475.17	359,938.55
Totals	1,015,366.17	3,049,156.82	2,033,790.65

Obligation per Employee FY19		Year-to-date
308.00 EE/1770.47 ER Split	2,078.47	2,078.47
Monthly Cost per Employee - ER		662.68
Monthly Cost per Employee - EE + Cobra		73.63
		736.31
Current Variance		**1,342.16**

Obligations indicate the funds that will be accumulated per employee per month. Expenditures are amounts that have been paid through the plan.

A positive number for "current variance" represents the amount per employee per month that is estimated to be collected above the amount spent year-to-date. A negative number represents the amount of expenditures (per employee per month) that are more than what is estimated to be collected for payment of those expenditures.

KPBSD Plan Review by MMA

Health Insurance Committee – Cost Saving Considerations

November 28, 2018

Comments on Cost Containment measures currently in place:

BridgeHealth

This program may continue to provide valuable savings for non-emergent surgeries. Continued promotion and utilization of BridgeHealth will save the plan claims dollars.

Teledoc

Teledoc provides a low cost and convenient alternative by offering virtual care to KPBSD's membership.

Dialysis Program

The dialysis program is effective to reduce claims cost when it comes to expensive dialysis treatments by establishing usual and customary levels.

Other areas to consider:

Deductibles

The deductible on the Traditional plan and High deductibles could be increased in an effort to achieve some cost savings, and push closer to national averages.

Out-of-Pocket Maximum

Out-of-pocket maximums are lower than the national average for both types of plans.

High Deductible Health Plan

A Health Savings Account compatible HDHP could be introduced. This would allow some flexibility to the employee and additional consumerism through the use of a tax-free HSA plan. Prescription drugs would be subject to the deductible, and family out-of-pocket maximum may need to be on an aggregate basis.

Prescription Drug

Implement a coinsurance percentage for specialty medications. A common plan provision is 30% up to certain amount per script.

Steerage for specialty pharmacy would also help generate cost savings. For example, if a member receives a specialty drug from an in-network pharmacy, then the plan provides more coverage than non-network pharmacy.

4th Quarter Deductible Carry-Over

Remove this benefit since most plans no longer allow.

Accident Expenses

Remove this benefit since most plans do not offer.

Dental – Basic Care Benefit

Currently covered at 100% and we normally see this at 80%, or sometimes 90%.

Vision

Annual maximum for specialty contacts of $600 (2 pair).

Other Considerations:

Effective Date of Coverage

Consider 1st of the month following date of eligibility, and if eligibility is on the 1st then coverage will begin on the first day.

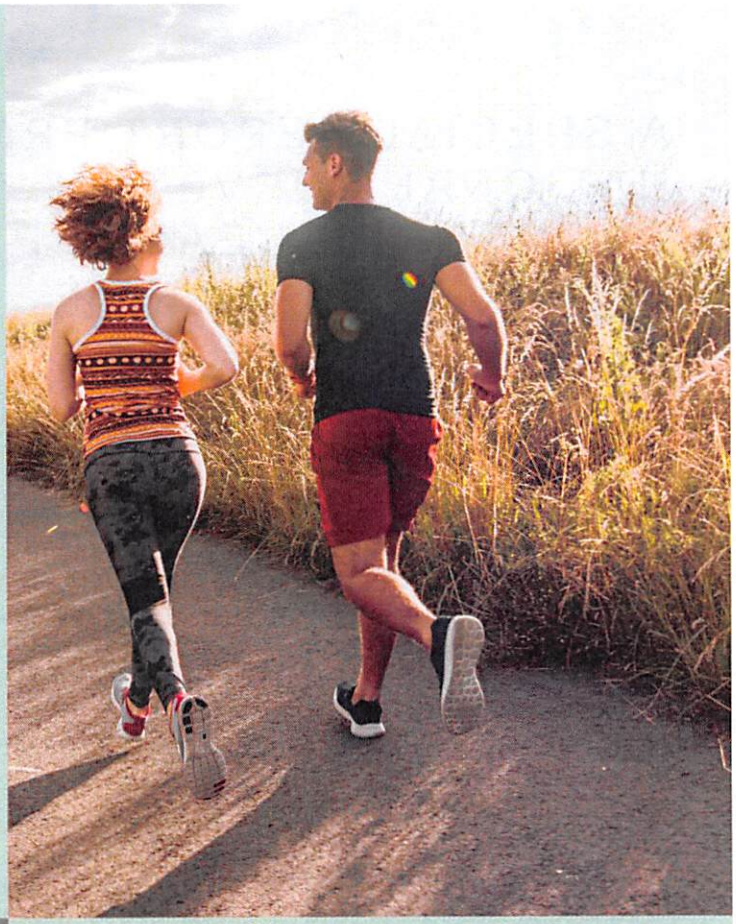
Multi-Tier Rates

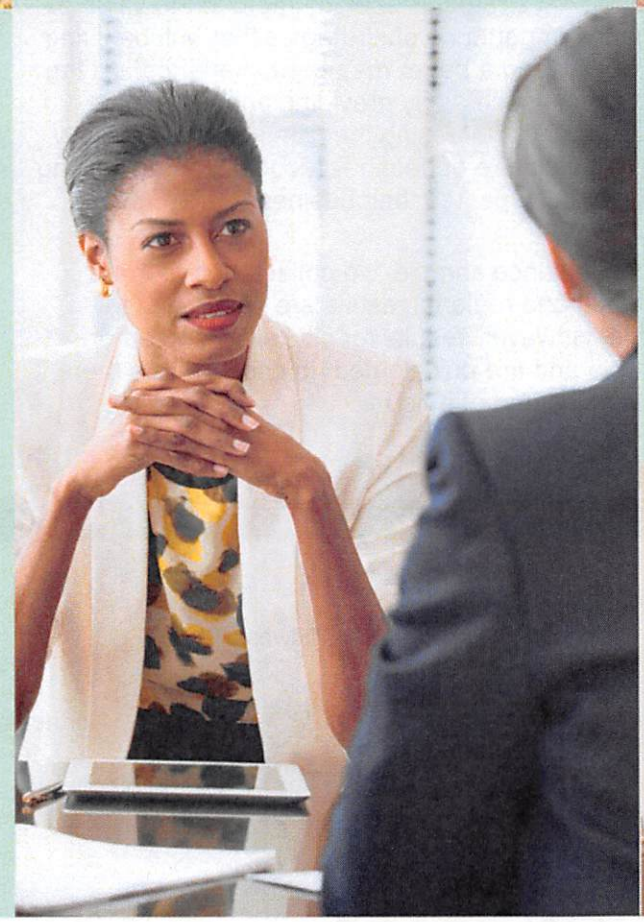
Move from a composite rate structure to a multi-tier rate structure.

HEALTH WEALTH CAREER

NATIONAL SURVEY

OF EMPLOYER-SPONSORED HEALTH PLANS





A special report for

KENAI PENINSULA BOROUGH SCHOOL DISTRICT

MAKE TOMORROW, TODAY MERCER

A SPECIAL REPORT FROM THE 2017 NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS

In contrast to the turmoil in the individual health plan market, employer health plan sponsors extended their run of low annual cost increases in 2017, as average total health benefit cost per employee rose by just 2.6%. Employers expect cost to rise by 4.2% in 2018, reflecting changes made to hold down cost; if they made no changes, they projected cost would rise by an average of 6.5%. Despite relatively moderate cost growth, health coverage represents an enormous expense. Total health benefits cost averaged $12,229 per employee in 2017. Even among smaller employers (those with 10-499 employees), where benefits are typically less generous, per-employee cost averages $11,527.

One of the key strategies for slowing cost growth has been consumerism: making employees responsible for a greater share of their healthcare expenses and providing resources to help them spend more carefully. Resources such as transparency tools, telemedicine and voluntary benefit options like hospital indemnity plans can make choosing a high-deductible plan a more comfortable choice. Nearly two-thirds of all large employers (those with 500 or more employees) now offer a high-deductible consumer-directed health plan (CDHP), most often as a choice rather than as a full replacement. However, after years of steady growth, enrollment in CDHPs among large employers slowed nearly to a halt in 2017, rising only from 33% to 34% of covered employees.

While consumerism has an important role in cost management, it can't solve for all of the inefficiencies in the healthcare market. The next wave of cost management strategies seek to improve the value of the care provided. The survey asked employers to rate the importance of strategies they will be using over the next five years to achieve lower cost, higher quality and a better member experience. At the top of the list was taking action to manage high-cost claims – such as by providing enhanced care management or a "high-touch" advocacy program, followed by addressing the rising cost of specialty drugs. The third priority -- a focused strategy for creating a culture of health -- recognizes that helping employees thrive has a measurable impact on virtually every aspect of their business.

Using a scientific random sample and supplemental convenience sample, we collected data from 2,481 employers with 10 or more employees. The national and regional results are based on the random sample only and are weighted to be projectable. However, results for city, state and other special employer groups include the convenience sample and are unweighted. In cases where there are too few data to report, "ID" (insufficient data) appears instead of a figure.

NUMBER OF PARTICIPANTS

School Boards and Other Institutions 500+	64
Employers 500+ with at least 65% union	118
County Governments 500+	91
West 500+	271

GEOGRAPHIC REGIONS USED IN THIS SURVEY

EMPLOYER PROFILE

Demographics

	School Boards and Other Institutions 500+	Employers 500+ with at least 65% union	County Governments 500+	West 500+
Average employee age	42	44	45	42
Average % of female employees	72%	51%	52%	49%
Average % of union employees	49%	81%	35%	16%

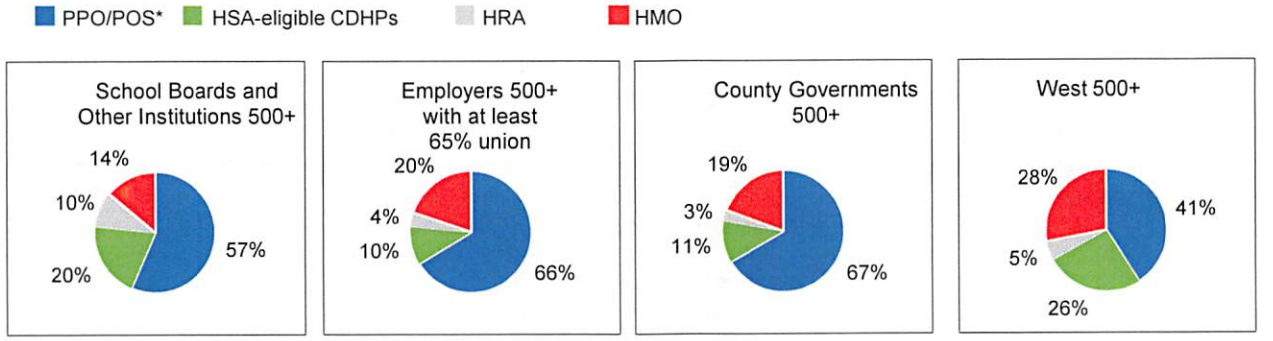
MEDICAL PLAN PREVALENCE AND ENROLLMENT

Prevalence and enrollment, by medical plan type

Percent of employers offering each type of medical plan:

	School Boards and Other Institutions 500+	Employers 500+ with at least 65% union	County Governments 500+	West 500+
PPO/POS*	75%	91%	92%	86%
HSA-eligible CDHP	56%	36%	31%	60%
HRA-based CDHP	20%	14%	9%	6%
Either type of CDHP	66%	42%	37%	64%
HMO	27%	41%	31%	43%

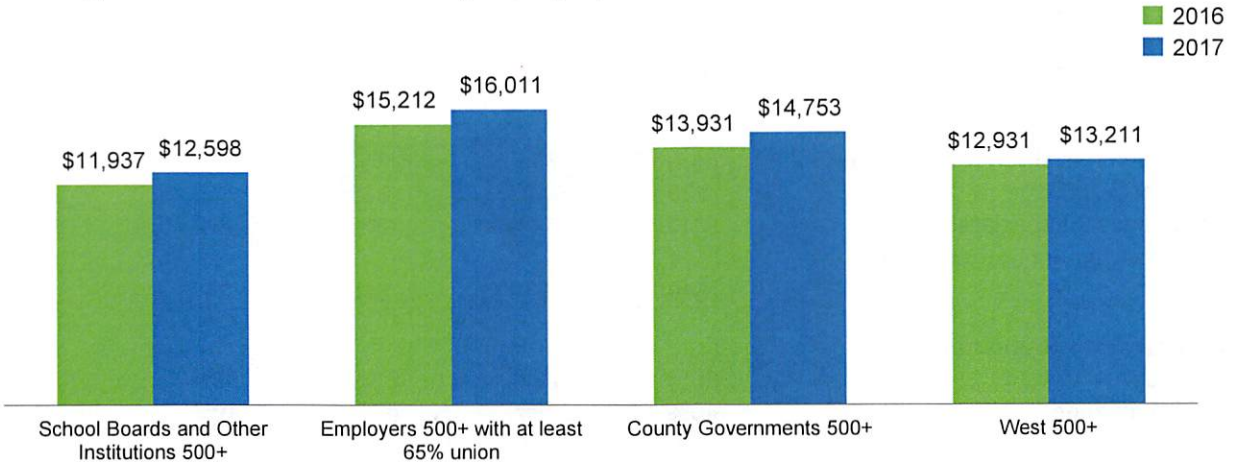
Percent of all covered employees enrolled in each type of medical plan



*includes traditional indemnity plans

TOTAL HEALTH BENEFIT COST

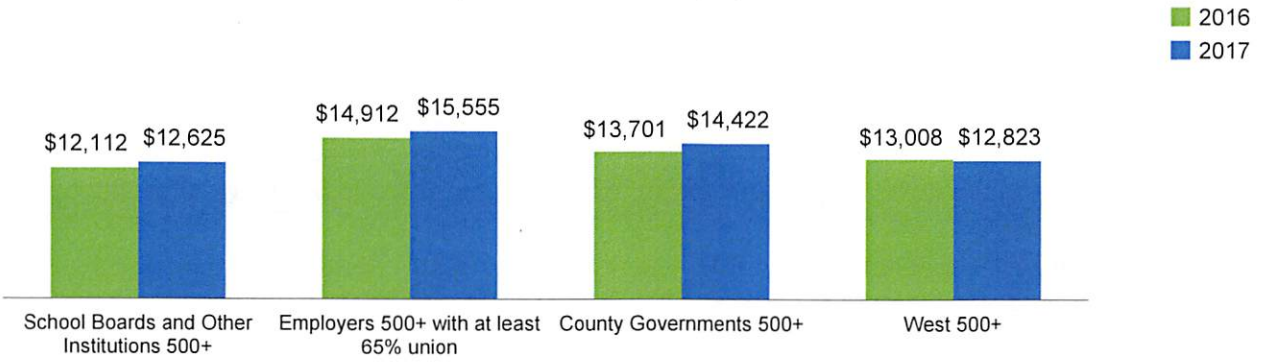
Average total health benefit cost* per employee



*Total health benefit cost includes medical, dental, Rx, vision and hearing benefits

PREFERRED PROVIDER ORGANIZATION (PPO) / POINT-OF-SERVICE PLANS (POS)

Average PPO / POS* cost per employee, for active employees



*includes traditional indemnity

Employee contributions

	School Boards and Other Institutions 500+	Employers 500+ with at least 65% union	County Governments 500+	West 500+
Employee-only coverage				
% requiring a contribution	80%	83%	91%	87%
Average contribution as a percent of premium	15%	15%	15%	22%
Average monthly contribution amount	$140	$107	$97	$129
Family coverage				
% requiring a contribution	86%	89%	95%	93%
Average contribution as a percent of premium	31%	22%	21%	32%
Average monthly contribution amount	$585	$376	$348	$456

PPO / POS cost sharing

	School Boards and Other Institutions 500+	Employers 500+ with at least 65% union	County Governments 500+	West 500+
Median actuarial value[1]	88%	89%	88%	87%
Deductible for in-network services				
Median individual deductible amount	$500	$500	$500	$600
Median family deductible amount	$1,200	$1,000	$1,450	$1,500
Deductible for out-of-network services				
Median individual deductible amount	$1,000	$750	$1,000	$1,000
Median family deductible amount	$2,625	$1,550	$2,000	$2,250
In-network physician visit				
% requiring primary care physician (PCP) copay	84%	78%	85%	82%
Median PCP copay amount	$25	$20	$20	$25
% requiring higher copay for specialist	51%	34%	48%	49%
Median specialist copay amount, when higher than PCP	$40	$40	$40	$40
Out-of-network primary care physician visit				
% requiring coinsurance	80%	86%	82%	89%
Median coinsurance amount	40%	38%	40%	40%

[1]Calculated using plan design information supplied by the respondent, modeled through Mercer's MedPrice tool. AVs represent the ratio of paid claims divided by covered health care claims and exclude the impact of employee payroll contributions.

PREFERRED PROVIDER ORGANIZATION (PPO) / POINT-OF-SERVICE PLANS (POS), CONTINUED

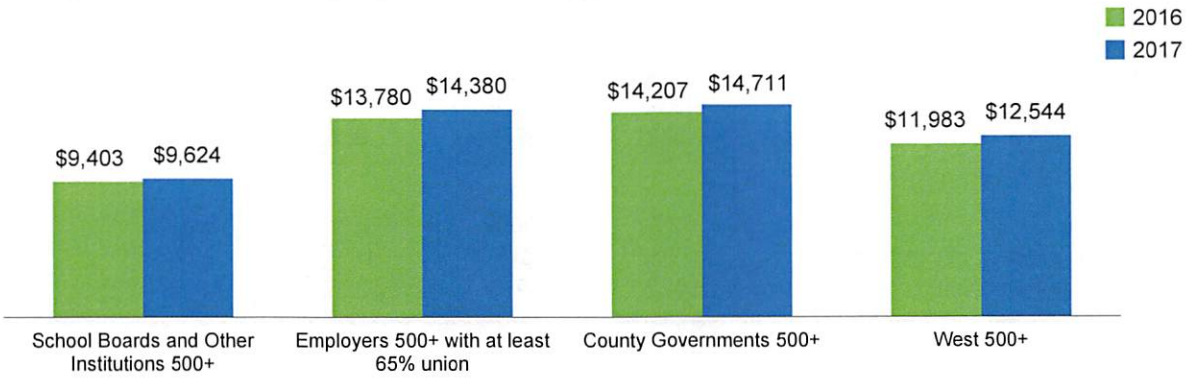
Out-of-pocket maximums

	School Boards and Other Institutions 500+	Employers 500+ with at least 65% union	County Governments 500+	West 500+
Out-of-pocket maximum for in-network services*				
Median individual out-of-pocket maximum	$3,000	$2,500	$2,800	$3,300
Median family out-of-pocket maximum	$5,000	$5,000	$6,000	$7,000
Out-of-pocket maximum for out-of-network services*				
Median individual out-of-pocket maximum	$5,400	$3,225	$4,025	$6,000
Median family out-of-pocket maximum	$10,000	$7,000	$8,750	$13,000

*Includes deductible

HEALTH MAINTENANCE ORGANIZATION (HMO)

Average HMO cost per employee, for active employees



Employee contributions

	School Boards and Other Institutions 500+	Employers 500+ with at least 65% union	County Governments 500+	West 500+
Employee-only coverage				
% requiring a contribution	69%	77%	85%	75%
Average contribution as a percent of premium	21%	12%	9%	21%
Average monthly contribution amount	$133	$89	$62	$118
Family coverage				
% requiring a contribution	81%	84%	92%	84%
Average contribution as a percent of premium	52%	18%	15%	32%
Average monthly contribution amount	$732	$311	$331	$473

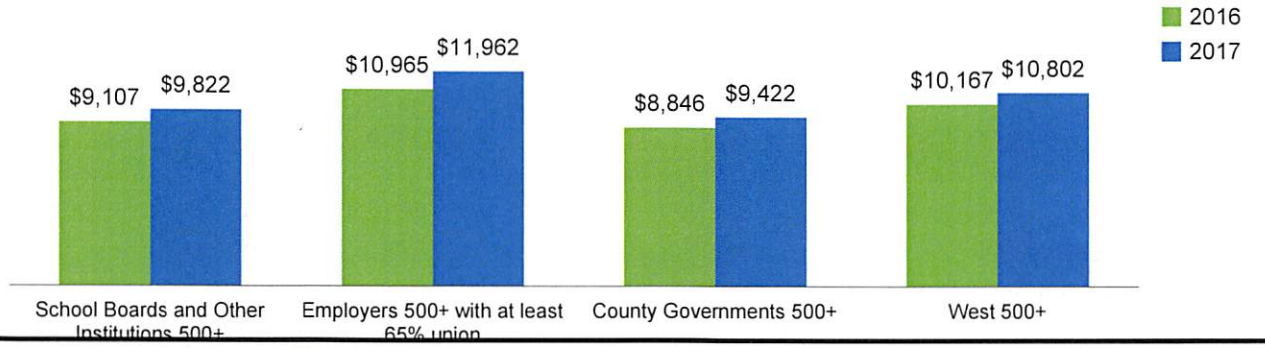
HMO cost sharing

	School Boards and Other Institutions 500+	Employers 500+ with at least 65% union	County Governments 500+	West 500+
Average actuarial value[1]	93%	94%	94%	94%
Deductible required	33%	24%	26%	44%
Physician visit copays (median)				
Primary care physician (PCP) copay	$25	$20	$20	$20
Specialist copay, when higher than PCP	$45	$30	$35	$30
Inpatient hospital deductible (median)	$375	$225	$250	$250
Emergency room copay (median)	$150	$100	$100	$100

[1]Calculated using plan design information supplied by the respondent, modeled through Mercer's MedPrice tool. AVs represent the ratio of paid claims divided by covered health care claims and exclude the impact of employee payroll contributions.

HSA-ELIGIBLE CONSUMER-DIRECTED HEALTH PLANS (CDHP)

Average HSA-eligible CDHP cost per employee, for active employees



Employee contributions

	School Boards and Other Institutions 500+	Employers 500+ with at least 65% union	County Governments 500+	West 500+
Employee-only coverage				
% requiring a contribution	58%	85%	70%	79%
Average contribution as a percent of premium	15%	15%	9%	15%
Average monthly contribution amount	$79	$79	$55	$62
Family coverage				
% requiring a contribution	82%	90%	85%	88%
Average contribution as a percent of premium	37%	21%	18%	28%
Average monthly contribution amount	$422	$279	$236	$323

HSA cost sharing

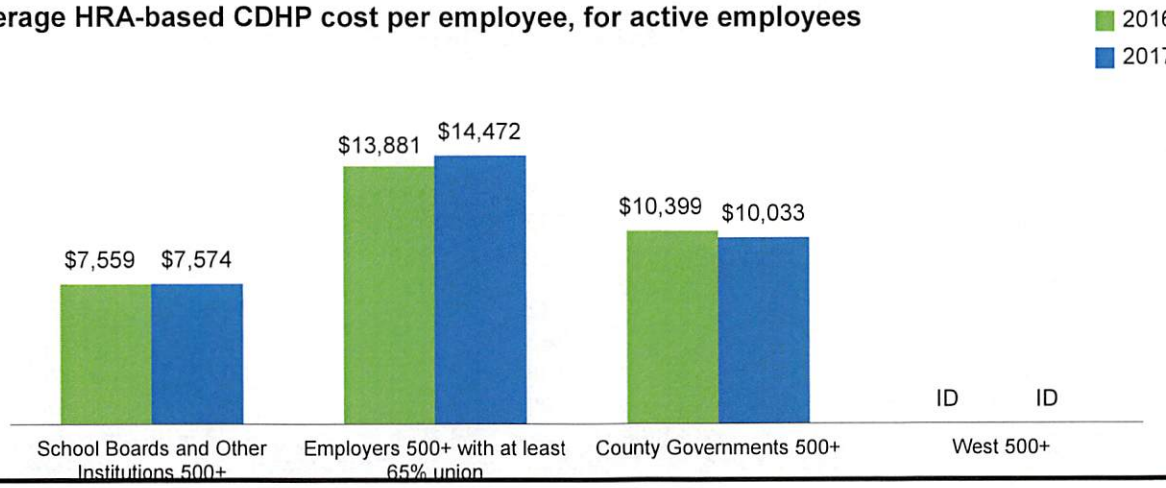
	School Boards and Other Institutions 500+	Employers 500+ with at least 65% union	County Governments 500+	West 500+
Average actuarial value[1]	84%	85%	82%	83%
Percent of employers making an account contribution	79%	85%	82%	77%
Employee-only coverage				
Median employer contribution to account*	$1,000	$750	$750	$675
Median in-network deductible	$2,600	$1,500	$1,800	$1,500
Median in-network out-of-pocket maximum	$3,500	$3,000	$3,413	$3,400
Family coverage				
Median employer contribution to account*	$1,500	$1,500	$1,170	$1,008
Median in-network deductible	$4,800	$3,000	$3,600	$3,250
Median in-network out-of-pocket maximum	$6,850	$6,000	$6,000	$6,800
Type of employer account contribution*				
Matching contributions	4%	10%	11%	8%
Incentive-based contributions	16%	27%	11%	14%
Cost-sharing for in-network physician visit				
% requiring coinsurance	38%	64%	68%	80%
Median coinsurance amount	20%	20%	20%	20%

*Among employers contributing to employee accounts

[1]Calculated using plan design information supplied by the respondent, modeled through Mercer's MedPrice tool. AVs represent the ratio of paid claims divided by covered health care claims and exclude the impact of employee payroll contributions.

HRA-BASED CONSUMER-DIRECTED HEALTH PLANS (CDHP)

Average HRA-based CDHP cost per employee, for active employees



Employee contributions

	School Boards and Other Institutions 500+	Employers 500+ with at least 65% union	County Governments 500+	West 500+
Employee-only coverage				
% requiring a contribution	40%	79%	86%	ID
Average contribution as a percent of premium	28%	15%	11%	ID
Average monthly contribution amount	$137	$84	$59	ID
Family coverage				
% requiring a contribution	78%	79%	100%	ID
Average contribution as a percent of premium	75%	17%	15%	ID
Average monthly contribution amount	$906	$249	$274	ID

HRA plan design

	School Boards and Other Institutions 500+	Employers 500+ with at least 65% union	County Governments 500+	West 500+
Employee-only coverage				
Median employer contribution to account	$600	$600	$750	ID
Median in-network deductible	$1,750	$1,200	$1,500	ID
Median in-network out-of-pocket maximum	$4,000	$3,000	$3,000	ID
Family coverage				
Median employer contribution to account	$1,150	$1,500	$1,500	ID
Median in-network deductible	$3,500	$2,500	$3,000	ID
Median in-network out-of-pocket maximum	$8,000	$4,800	$6,000	ID
Cost-sharing for in-network physician visit				
% requiring coinsurance	50%	58%	83%	ID
Median coinsurance amount	20%	20%	20%	ID

PRESCRIPTION DRUG (RX) BENEFITS[1]

Average copayments in prescription drug plans

Retail	School Boards and Other Institutions 500+	Employers 500+ with at least 65% union	County Governments 500+	West 500+
Generic	$11	$10	$11	$11
Brand-name formulary	$30	$27	$32	$32
Brand-name non-formulary	$49	$44	$51	$55
Specialty or biotech drugs (when separate)	$96	$79	$123	$112
Mail-order (for 90-day supply)				
Generic	$22	$18	$19	$22
Brand-name formulary	$65	$48	$58	$66
Brand-name non-formulary	$105	$79	$92	$112
Specialty or biotech drugs (when separate)	$188	$130	$226	ID

HEALTH AND WELL-BEING PROGRAMS[1]

Steps taken to build a "culture of health"

	School Boards and Other Institutions 500+	Employers 500+ with at least 65% union	County Governments 500+	West 500+
Vision / mission statement supports a culture of health	11%	19%	29%	25%
Offer onsite fitness facility	20%	34%	26%	40%
Work environment modified to promote physical activity	18%	22%	18%	23%
Have policies to promote healthy work / life balance	41%	43%	38%	40%
Healthy food choices in cafeteria, meetings / events	48%	44%	29%	55%
No smoking anywhere on campus	79%	63%	40%	51%

Health and well-being incentives / penalties

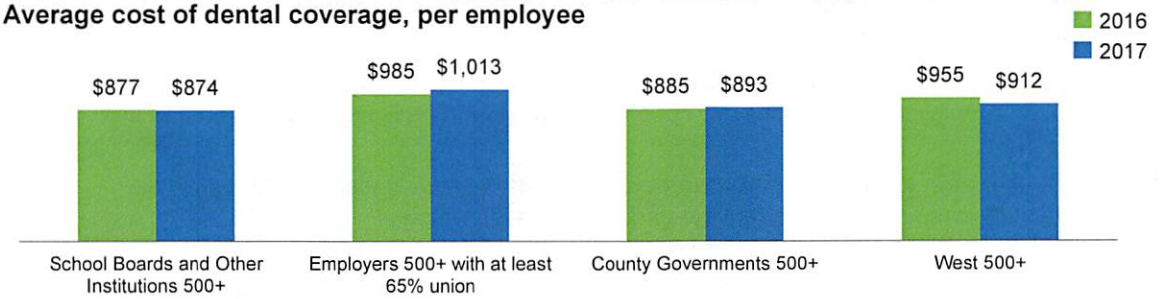
Use incentives in connection with health and well-being program	School Boards and Other Institutions 500+	Employers 500+ with at least 65% union	County Governments 500+	West 500+
Financial rewards	42%	54%	61%	56%
Financial penalties	11%	14%	16%	10%
Charitable contributions	0%	0%	1%	2%
Non-financial rewards	34%	31%	32%	30%
Do not use any incentives	34%	29%	21%	29%
Incentives for participating in health and well-being programs[2]				
Provide participation incentives	62%	63%	72%	64%
Maximum annual value of incentive* (median)	$500	$250	$245	$300
Outcomes-based incentives[2]				
Provide outcomes-based incentives	14%	23%	19%	17%
Maximum annual value of incentive* (median)	$413	$500	$600	ID
Program participation rates[2]				
Health assessment (% of eligible employees)	29%	34%	48%	32%
Validated biometric screening (% of eligible employees)	30%	31%	47%	36%
Provide incentive for non-tobacco users				
Lower premium contribution	9%	12%	13%	10%
Other incentive	2%	8%	13%	8%

*Among employers that offer financial incentives

[1]Offered to employees enrolled in the largest medical plan of any type
[2]Based on employers with 500 or more employees

DENTAL BENEFITS

Average cost of dental coverage, per employee



Employee contributions

	School Boards and Other Institutions 500+	Employers 500+ with at least 65% union	County Governments 500+	West 500+
Employee-only coverage				
Average monthly contribution amount	$20	$15	$18	$16
Average contribution as a percent of premium	59%	37%	56%	39%
Family coverage				
Average monthly contribution amount	$58	$50	$59	$65
Average contribution as a percent of premium	64%	43%	59%	50%

Type of dental plan offered

	School Boards and Other Institutions 500+	Employers 500+ with at least 65% union	County Governments 500+	West 500+
Active PPO	50%	57%	55%	56%
Passive PPO	47%	35%	42%	41%
Dental HMO	22%	19%	18%	16%
No provider network	3%	8%	5%	5%

Dental plan design

	School Boards and Other Institutions 500+	Employers 500+ with at least 65% union	County Governments 500+	West 500+
Deductible for restorative services				
% requiring individual deductible	74%	66%	76%	81%
Median individual deductible	$50	$50	$50	$50
% requiring family deductible	75%	67%	75%	82%
Median family deductible	$100	$100	$150	$150
Annual maximum benefit (median)	$1,500	$1,500	$1,500	$1,500
Lifetime maximum orthodontic benefit (median)	$1,500	$1,500	$1,500	$1,500

OTHER BENEFITS

Voluntary insurance benefits offered

	School Boards and Other Institutions 500+	Employers 500+ with at least 65% union	County Governments 500+	West 500+
Accident	61%	56%	64%	66%
Cancer / critical illness	61%	53%	60%	47%
Individual disability insurance	58%	46%	49%	47%
Whole / universal life	56%	44%	53%	40%
Hospital indemnity	40%	28%	18%	26%
Long-term care	35%	31%	20%	33%
Auto / homeowners	11%	16%	10%	12%
ID theft	21%	25%	31%	25%
Legal benefit	28%	31%	38%	43%
Investment advisory	33%	24%	19%	27%
Discount purchase program	11%	19%	23%	32%
Pet insurance	5%	8%	6%	17%
None of the above voluntary programs offered	14%	14%	14%	13%

DEFINITIONS

HEALTH PLAN PREVALENCE AND ENROLLMENT

A **consumer-directed health plan eligible for a Health Savings Account** is a high-deductible health plan with an employee-controlled account. Employer contributions are optional. Account funds roll over at year end and are portable.

A **consumer-directed health plan with a Health Reimbursement Account** is a health plan with an employer-funded spending account. Account funds may roll over at year end, but are not portable.

HEALTH PLAN COST

Total health benefit cost is the total gross cost for all medical, dental, prescription drug, MH / SA, vision and hearing benefits for all covered active employees and their dependents divided by the number of enrolled employees. Total gross annual cost includes employee contributions but not employee out-of-pocket expenses.

Medical plan cost is the total gross cost for medical and prescription drug benefits divided by the number of enrolled employees. Mental health, vision and hearing benefits for all active employees and their covered dependents are included if part of the plan. Dental benefits, even if a part of the plan, are not included in these costs. CDHP cost includes any employer account contribution.

EMPLOYEE CONTRIBUTIONS, PPO/POS, HMO, CDHP, DENTAL

Unless otherwise noted, employers with multiple plans of the same type were asked to respond for the **largest plan of each type** (i.e., the one with the largest enrollment).

Family coverage is the coverage level for an employee, spouse and two children.

STRATEGIC PLANNING

A **bundled solution** (which includes private exchanges) is where a single vendor provides consulting, administration and a high-tech platform designed to deliver an enhanced consumer experience. Typically, these solutions offer a wide range of health plan choices.

EMPLOYEE WELL-BEING

A **health advocacy** program is a "high-touch" telephonic program with *integrated* customer service and clinical teams.

"ID" = Insufficient data.

Kenai Peninsula Borough School District

Stop Loss Marketing Analysis - $220,000 Individual Stop Loss Deductible
Effective January 1, 2019

FIXED COSTS	Enrollment	Voya Current	FIRM Voya Renewal	Illustrative Sun Life
PREMIUM				
Individual Stop Loss (ISL) Coverage		$220,000	$220,000	$220,000
Coverage Basis		Incurred in 48 months / Paid in 12 months	Incurred in 48 months / Paid in 12 months	Incurred in 24 months / Paid in 12 months
Benefits Covered		Medical/Rx	Medical/Rx	Medical/Rx
	Total			
Employee	212	$191.77	$278.07	$94.32
Employee/Spouse	214	$191.77	$278.07	$222.61
Employee/Child	108	$191.77	$278.07	$190.81
Employee/Family	566	$191.77	$278.07	$328.62
Composite	1,100	$191.77	$278.07	$249.31
Annual Cost		$2,531,364	$3,670,524	$3,290,889
Aggregate Stop Loss Coverage ($1,000,000 Loss Limit)				
Level		125%	125%	125%
Coverage Basis		Incurred in 48 months / Paid in 12 months	Incurred in 48 months / Paid in 12 months	Incurred in 24 months / Paid in 12 months
Benefits Covered		Medical/Rx/Vision/Dental	Medical/Rx/Vision/Dental	Medical/Rx
Composite	1,100	$2.60	$4.00	$2.14
Annual Cost		$34,320	$52,800	$28,248
Total Fixed Costs				
Composite		**$194.37**	**$282.07**	**$251.45**
Total Annual Cost		**$2,565,684**	**$3,723,324**	**$3,319,137**
Percentage Change from Current			**45.1%**	**29.4%**

CLAIM LIABILITY					
Expected Claim Liability	Total				
Employee	212	$2,207.41	$2,263.45		$876.14
Employee/Spouse	214	$2,207.41	$2,263.45	*Medical/Rx*	$1,839.88
Employee/Child	108	$2,207.41	$2,263.45	*only*	$1,577.05
Employee/Family	566	$2,207.41	$2,263.45		$2,716.02
Composite - Medical/Rx/Vision/Dental	1,100	**$2,207.41**	**$2,263.45**		**$2,079.15**
Expected Vision Claims[2]		Included	Included		$39.91
Expected Dental Claims[2]		Included	Included		$160.61
Composite Total	1,100	**$2,207.41**	**$2,263.45**		**$2,279.67**
Annual Expected Claim Liability - Estimated		$29,137,786	$29,877,514		$30,091,600
Maximum Claim Liability	Total				
Employee	212	$2,759.26	$2,829.31		$1,095.17
Employee/Spouse	214	$2,759.26	$2,829.31	*Medical/Rx*	$2,299.85
Employee/Child	108	$2,759.26	$2,829.31	*only*	$1,971.31
Employee/Family	566	$2,759.26	$2,829.31		$3,395.03
Composite - Medical/Rx/Vision/Dental	1,100	**$2,759.26**	**$2,829.31**		**$2,598.94**
Expected Vision Claims[2]		Included	Included		$39.91
Expected Dental Claims[2]		Included	Included		$160.61
Composite Total	1,100	**$2,759.26**	**$2,829.31**		**$2,799.45**
Annual Maximum Claim Liability - Estimated		**$36,422,232**	**$37,346,892**		**$36,952,798**
Percentage Change from Current			**2.5%**		**1.5%**

FIXED COST and CLAIM LIABILITY			
Fixed Cost and Expected Claim Liability			
Composite	$2,401.78	$2,545.52	$2,531.12
Total Annual Liability - Estimated	$31,703,470	$33,600,838	$33,410,738
Fixed Cost and Maximum Claim Liability			
Composite	$2,953.63	$3,111.38	$3,050.90
Total Annual Liability - Estimated	$38,987,916	$41,070,216	$40,271,935
Additional Laser Liability[1]	N/A	N/A	TBD
Total Annual Liability with Laser - Estimated	$38,987,916	$41,070,216	$40,271,935
Percentage Change from Current		5.3%	3.3%
Network Assumption	Aetna	Aetna	Aetna

Notes:

1) Please refer to the Contingencies page for information on lasers.
2) This is a brief summary for comparison purposes only and is not considered a contract; refer to proposals/contracts for details. If any provision is inconsistent with the administrative agreement or stop loss contract, the carrier documents will govern.
3) All estimates are based upon the information available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Marsh & McLennan Agency. Marsh & McLennan Agency is not responsible for the consequences of any unauthorized use.

Kenai Peninsula Borough School District

Contingencies Applicable to $220,000 Individual Stop Loss Level and Incurred in 48 months / Paid in 12 months Contract with Current Plan of Benefits
Effective January 1, 2019

CONTINGENCY	DESCRIPTION
Minimum Aggregate Deductible	
Voya	◆ The estimated annual minimum aggregate deductible is $31,744,858 (85%).
Sun Life	◆ The estimated annual minimum aggregate deductible is $30,875,390 (90%).
Right to Recalculate Rates & Factors	
Voya	◆ Review of paid claims, enrollment and shock loss information for at least 9 months in the most recent experience period. Enrollment varies by more than 15% of the quoting assumption.
Sun Life	◆ Review of paid claims, enrollment and shock loss information through the 10/31/2018. Enrollment varies by more than 15% of the quoting assumption.
Disclosure Requirements	
All Carriers	◆ Disclosure information will be required and will vary slightly depending upon the carrier. Disclosure might include, but is not limited to: serious medical conditions based on diagnosis and claims that have exceeded a certain amount. Disclosure information is typically due no earlier than 15 to 30 days prior to the effective date.
Other Limitations	
Voya	◆ **Proposal is firm if accepted by 11/30/2018. Page 2 of the proposal must be signed and returned to Voya.** ◆ Proposal includes a load to the rates for the Renewal Rate Cap of 45%, which applies to the ISL rates. ◆ Quote assumes the current plan design, contribution levels, use of Rehn as the TPA and use of the Aetna PPO network. The plan must have medical case management and utilization review. ◆ Coverage Period: Paid in 12 months and incurred January 1, 2015 or after.
Sun Life	◆ **Proposal is illustrative; additional information is required on high claimants. Individual lasers may be applied.** ◆ Proposal includes a load to the rates for the No New Laser at Renewal option and a Renewal Rate Cap of 50%. The Renewal Rate Cap applies to the ISL rates and assumes there are no material changes to the policyholder's plan, the Stop Loss policy or the group being covered. ◆ Quote includes a managed care discount for precertification, utilization review and medical case management. Additional discounts on the ISL rates have been applied for pregnancy management and disease management; if these programs are not in place by the effective date, rates will increase 2% for each program. ◆ Quote assumes the current plan design, use of Rehn as the TPA and use of the Aetna PPO network. A Dialysis Cost Containment program must be in place on the effective date.
Retirees	
All Carriers	◆ Quote assumes that retirees are not covered.

Notes:

1) This is a brief summary for comparison purposes only and is not considered a contract; refer to proposals/contracts for details. If any provision is inconsistent with the administrative agreement or stop loss contract, the carrier documents will govern.
2) All estimates are based upon the information available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Marsh & McLennan Agency. Marsh & McLennan Agency is not responsible for the consequences of any unauthorized use.