JORDAN SCHOOL DISTRICT

Benefit Enrollment Guide 2016 - 2017

PROVIDED FOR YOU BY
MORETON & COMPANY

Table of Contents

Notices

SOCIAL SECURITY NUMBERS

Federal law requires you to provide a valid Social Security number for each person to be covered by any medical plan sponsored by your employer (yourself, your spouse, and all dependent children).

MEDICARE PART D

If you have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. See Insurance Office for more information.

HIPAA PRIVACY NOTICE

The Health Insurance Portability and Accountability Act (HIPAA) requires employers to adhere to strict privacy guidelines and establishes employees' rights with regard to their personal health information. If you have any questions regarding this federal regulation, please speak with your Moreton & Company representative or contact Insurance Office.

IRS REGULATIONS

Failure to meet IRS deadlines will affect your insurance coverage! IRS regulations govern how and when an employee may make cafeteria plan elections and changes to those elections. These rules require that employers enforce firm deadlines with respect to employee benefit enrollment forms and the related cafeteria plan elections. This means that we cannot accept forms turned in after open enrollment ends. Furthermore, if you experience a qualifying event allowing you to add, drop, or modify your coverage and related cafeteria plan election mid-year, we must be notified of such event. The required forms generally must be completed within 30 days of such event, or you cannot make the change. In addition, please be aware that with the exception of the birth, adoption, or placement for adoption of a child, any cafeteria plan election changes can only be implemented prospectively, i.e., on the first paycheck or period of coverage following our receipt of the form. Therefore, if you are making a change based on a qualifying event other than a new child, and you want changes implemented as of the date of the event, you must inform us of the change and turn in your form in advance or as soon after the event as possible. ***If you do not enroll on time, you will not receive coverage or be able to change your elections mid-year unless you have a special enrollment opportunity.***

WORKSITE PRODUCTS

Worksite products are not sponsored or endorsed by your employer including for purposes of federal and state law, so federal ERISA law is inapplicable.

LEGAL DOCUMENTATION

Dependent verification may be required (i.e. marriage certificate, birth certificates, divorce decree, etc.)

Welcome To Your New Benefit Package!

This guide is an overview of the benefit options available to you and to help you make informed choices that best suit your needs.

Jordan School District offers six **Medical Plans:** Traditional Summit, Traditional Advantage, Value Summit, Value Advantage, STAR Summit (QHDHP) and STAR Advantage (QHDHP). When you review the side-by-side comparison chart on pages 8-10 for the Traditional plans, pages 11-13 for the Value plans and 14-16 STAR QHDHP plans, you will note that all plans have the same benefit. You will most likely want to select a plan according to the physicians and facilities you utilize (see page 5 for an outline of the contracted physicians and facilities for each plan), and the premiums, that best fit your needs. Premiums can be found on the District Insurance website.

There are multiple **Voluntary Dental** options available as well as **Voluntary Vision** coverage. Along with **Basic Life Insurance**, **Long Term Disability Insurance**, and an **Employee Assistance Program**, the District provides for you at no cost. **Voluntary Term Life / AD&D Insurance** is offered to you and your family at very competitive rates. Premiums are shown for 12-month deductions (September through August). If you have a 10-month contract (September through June), your deductions will be slightly higher to adjust for no payroll deduction in July and August.

These important benefit coverages provide a financial safety net for you and your family in the event of unexpected and potentially catastrophic events. Jordan School District's benefit programs are structured around the life events that trigger the need for coverage such as:

- Caring for your physical well-being and that of your dependents in case of illness or injury,
- Protecting your earnings in the event you are disabled, and
- Providing for your family in the event of your death.

The District's benefits package is designed to take advantage of IRS provisions under Section 125 that allows the portion of premiums you pay for medical, voluntary dental and voluntary vision to be deducted from your paycheck on a pretax basis. This saves you money! Premiums you pay for voluntary life and AD&D insurance, are deducted from your paycheck on an after tax basis.

In addition to the premiums you pay on a pretax basis, the District also offers a Flexible Spending Account which lets you set aside a certain amount of your paycheck into a Medical Reimbursement Account or Dependent Day Care Reimbursement Account before paying income taxes and Social Security. This can save you 20 to 30% on out-of-pocket costs, depending on your personal tax rate.

Please read all the information carefully and become familiar with your benefits; ask questions and become an active participant in the delivery of your benefits; review your benefit package with appropriate representatives and family members prior to making your selections. The choices you make will remain in force during the entire 2016 - 2017 plan year (unless there is an IRS approved qualifying event)**. Please carefully choose those options that best fit you and your family's unique needs!**

Jordan School District Enrollment Guidelines

NEW HIRES

Benefit eligible employees are required to submit your completed Benefit Election and Flexible Spending forms within 30 days of your employment start date. If you miss this deadline, you will not be able to enroll until next open enrollment period, unless you have a qualifying event. Insurance coverage will be effective on the first day of the month following your employment start date, provided enrollment forms are completed and filed in the District Insurance Office within 30 days of your employment start date.

PREMIUMS FOR EMPLOYEES ON 10-PAY CONTRACTS

Employees on 10-pay contracts (September through June) will be charged an adjusted premium to provide for no payroll deduction in July and August.

OPEN ENROLLMENT

Each June and July, Jordan School District conducts an annual Open Enrollment. During this enrollment period, eligible employees are invited to attend a meeting along with benefits representatives to review the upcoming benefits package in greater detail. This is an important time because it is the one time during the year you may change your benefit elections and/or add or delete family members from benefit coverages without documenting a qualifying event. **Benefit Change and Flexible Spending Election forms must be received in the District Insurance Office no later than July 31, 2016, for an effective date of September 1, 2016.**

When you have a qualifying event you have 30 days to complete and return a new change form or you will have to wait until the next Open Enrollment period.

QUALIFYING CHANGES (30 DAYS UNLESS OTHERWISE STATED BELOW)

- Marriage or change in number of dependents;
- Divorce or legal separation (60 days)
- Change in employment status of employee, spouse, or dependent that causes loss of eligibility;
- Dependent ceases to satisfy eligibility requirements; (60 days)
- Change in residence that causes loss of eligibility;
- Significant changes in company benefit plan(s) including cost change, significant coverage curtailment, additional or significant improvement of company offered benefits;
- Change in coverage under another employer plan (including mandatory or optional change initiated by your spouse's employer or a change initiated by your spouse);
- Loss of coverage from government plans / programs or educational institution;
- COBRA qualifying event (termination / reduction of hours, employee death, divorce / legal separation, ceasing to be a dependent);
- Other changes resulting from a judgment, decree, or order; Medicare or Medicaid entitlement; or FMLA leave of absence;
- Loss of CHIP or Medicaid eligibility; Gaining CHIP or Medicaid subsidy eligibility (60 Days).

DEPENDENTS

A dependent is defined as your legal spouse through marriage and legal dependent children (this includes children through adoption and step-children through marriage). Dependent children are eligible to age 26 (whether married or not) for the medical plan. For all other benefits they must not be married and they rely upon you for more than 50% of their support as defined in the IRS Code.

Handicapped children are eligible for continuous coverage when certification by PEHP has been approved.

Summit Network - PEHP

PEHP Summit is a network that offers excellent benefits and a comprehensive panel of Contracted Providers. **Those enrolled in this plan should only use the facilities and physicians panel contracted by the Summit Network**, generally non-IHC providers and rural IHC hospitals (e.g., University of Utah, St. Marks, Salt Lake Regional, Primary Children's, Jordan Valley, Huntsman Cancer Institute, and Pioneer Valley Hospitals, etc.). Check online at www.pehp.org for the most current list of physicians through the Summit Network.

PEHP Summit does not require you to select a Primary Care Provider (PCP) and you can self-refer to any contracted Summit specialist. However, some services do require pre-authorization or pre-notification (refer to page 7 in this enrollment guide for details). It is recommended you select a PCP to coordinate all your medical care. A PCP should practice one of the following disciplines: general practice, family medicine, internal medicine, obstetric / gynecology (OB / GYN), or pediatrics.

OUT OF AREA BENEFITS

Emergency and urgent care will be covered according to plan guidelines. Allowable fees for eligible benefits will be the PEHP Maximum Allowable Fee (MAF). PEHP contracts with MultiPlan to assist you with medical care while traveling or living outside the State of Utah (see page 6 of this guide for additional information).

IN THE SERVICE AREA, USING A NON-SUMMIT PROVIDER

Coverage for eligible medical services received at a non-contracted facility / provider will be covered according to plan guidelines. Allowable fees for eligible benefits will be up to the MAF. Any charges over the MAF, plus the applicable co-pay and deductible, will be the member's responsibility.

Advantage Network - PEHP

PEHP Advantage is a network that offers excellent benefits and a comprehensive panel of Contracted Providers.

PEHP Advantage uses providers largely around Intermountain Health Care (IHC) facilities. **Those enrolled in this plan should use the Advantage Network of facilities and physicians panel exclusively;** i.e. Intermountain Medical Center, LDS, Riverton, or Alta View, etc. Check online at www.pehp.org for the most current list of physicians through the Advantage Network.

Huntsman-Intermountain Care Centers are available at the Intermountain Medical Center, McKay Dee Hospital, Dixie Medical Center, American Fork Hospital, and the Valley View Medical Center - these hospitals all participate in PEHP Advantage.

PEHP Advantage does not require you to select a Primary Care Provider (PCP). However, it is recommended you select a PCP to coordinate all your medical care. A PCP should practice one of the following disciplines: general practice, family medicine, internal medicine, obstetric / gynecology (OB / GYN), or pediatrics. You may also self-refer to any contracted PEHP Advantage specialist.

OUT OF AREA BENEFITS

Emergency and urgent care will be covered according to plan guidelines. Allowable fees for eligible benefits will be the PEHP Maximum Allowable Fee (MAF). PEHP contracts with a MultiPlan to assist you with medical care while traveling or living outside the State of Utah (see page 6 of this guide for additional information).

IN THE SERVICE AREA, USING A NON-ADVANTAGE PROVIDER

Coverage for eligible medical services received at a non-contracted facility/provider will be covered according to plan guidelines. Allowable fees for eligible benefits will be up to the MAF. Any charges over the MAF, plus the applicable co-pay and deductible, will be the member's responsibility.

Out-of-State Network - PEHP

Members who are living outside the State of Utah MUST notify PEHP of their out of state address prior to receiving coverage. You can do this by contacting PEHP Customer Service at 801-366-7555 or 800-765-7347.

The Out of State Program is a value added addition to PEHP's Provider Network. Your card allows in-network Coverage for only the following PEHP Members: **1) Members who are living outside the State of Utah** (Members who are living outside the State of Utah MUST notify PEHP of their out of state address prior to receiving coverage)**; 2) Members traveling outside the State of Utah who are in need of urgent or life-threatening services while traveling** (Coverage is excluded for services outside the State of Utah when a Member is traveling for the purpose of seeking medical care or treatment)**; or 3) Members that require medical services that are not available in Utah and that have been Pre-authorized by PEHP.**

Participating providers can be found at www.multiplan.com or by calling 800-922-4362.

As a PEHP member, you can benefit from this program when you are out of state. Whether you are traveling or if you reside outside of the state the following rules apply:

INPATIENT / OUTPATIENT SURGERIES
Inpatient and outpatient surgeries will need to be pre-authorized by PEHP prior to the surgery in order to be covered.

ALL OTHER SERVICES
In order to have services covered, be sure to go to participating Multi-Plan providers.

To find a provider, log on to www.multiplan.com directly or you can click on the Out-of-State Network Provider List link at www.pehp.org. From the website you can download a list of participating providers and facilities in your area. You may also call Multi-Plan directly at 800-922-4362.

Keep in mind that this program is only available for services outside the state of Utah. It does not give you the opportunity to use in-state providers and facilities that are not a part of your network.

Value - Added Services Offered by PEHP

WeeCare is PEHP's prenatal and postpartum program. Members are given $50 cash incentive if you enroll at any time during your pregnancy through 12 weeks post-partum. By reaching the first trimester weight up to one year after the birth of your baby, an additional $50 rebate may be earned. In addition, all members who enroll will receive educational materials.

If you enroll with any PEHP plan, there is an available program established to promote good health and to provide discounts to members on services not normally covered. Vendor information can be found at www.pehp.org.

The following are value added benefits that are available:

- Gym
- Eyewear
- Lasik
- Hearing
- Fitness Classes
- Corporate Massage

Pre - Notification Program for Inpatient Hospital Admissions - PEHP

Advantage Plan (Advantage Network - IHC Facilities) **Summit Plan** (Mountain Star, University of Utah, and Iasis Networks)	
Procedure	**Required Date of Pre-Notification**
Elective Treatment	Call PEHP at least 5 working days before the admission date or surgery.
Urgent Treatment	Call PEHP at least 3 working days before the admission date or surgery.
Emergency Treatment	You do not have to call prior to admission. You or a responsible person must contact PEHP within 72 hours following admission or surgery (or if during a weekend, the first working day following treatment).
Maternity Cases	As soon as the estimated due date is known, call PEHP's WeeCare Program at 801-366-7400 or 855-366-7400
Mental Health and Drug / Alcohol Treatment	The Employee Assistance Program (EAP) through Blomquist Hale Employee Assistance coordinates all mental health and drug / alcohol treatment services for all of the Plans. To receive such benefits under the health plan, the Covered Person must obtain pre-authorization through an EAP counselor before seeking such counseling, by calling 801-262-9619 or 800-926-9619.

PEHP Customer Service: **801-366-7555** or **800-765-7347**

Pre-Authorization for ALL Mental Health & Drug / Alcohol Treatment

Procedure	**Required Date of Pre-Notification**
Mental Health and Drug / Alcohol Treatment	The Employee Assistance Program (EAP) through Blomquist Hale Employee Assistance coordinates all mental health and drug / alcohol treatment services for all of the Plans. To receive such benefits under the health plan, the Covered Person must obtain pre-authorization through an EAP counselor before seeking such counseling, by calling 801-262-9619 or 800-926-9619.

Primary Care Physician Types

- Pediatrician
- OBGYN
- Certified Nurse Midwife (CNM)
- Internal Medicine
- Geriatrics
- Family Practice
- General Practice
- *All other provider types will be at the specialist co-pay.*

Traditional Health Benefit Comparison - PEHP

General Information	SUMMIT		ADVANTAGE	
	Network	Non-Network *	Network	Non- Network *
Dependent Age Limit	26		26	
First Dollar Deductible (PCY)	$500 Per Person / $1,500 Family	$1,000 Per Person / $3,000 Family	$500 Per Person / $1,500 Family	$1,000 Per Person / $3,000 Family
Out of Pocket Maximum (PCY)	$5,000 Per Person / $10,000 Family	$10,000 Per Person / $20,000 Family	$5,000 Per Person / $10,000 Family	$10,000 Per Person / $20,000 Family
Prescription Drug Benefits (Administered Through Express Scripts)	You Pay			
Participating Pharmacy (30 Day Supply)	$15 Generic / 35% Preferred Brand / 50% Non-Preferred Brand / 50% Specialty **The cost difference between the Generic and the Brand Name medication will be applied to the Generic Co-pay for those medications for which a Generic is available.**			
Non-Participating Pharmacy (30 Day Supply)	50% Generic / 50% Preferred Brand			
Prescriptions - Mail Order (90 Day Supply)	$30 Generic / 35% Preferred Brand / 50% Non-Preferred Brand / 50% Specialty			
Hospital / Facility Benefits	You Pay			
Medical / Surgical / Intensive Care / Maternity (Normal Delivery – 2 Days, C-Section – 4 Days) **Semi-Private Room**	20% AD	40% AD	20% AD	40% AD
Medical / Surgical / Intensive Care / Maternity (Ancillary)	20% AD	40% AD	20% AD	40% AD
Skilled Nursing Facility (60 Days PCY)	20% AD	40% AD	20% AD	40% AD
Medical / Surgical Care (Outpatient)	20% AD	40% AD	20% AD	40% AD
Emergency Room (ER)	$150 AD	$150 AD	$150 AD	$150 AD
Major Diagnostic Test, CT Scan, MRI (Per Test of $350 Or More)	20% AD	40% AD	20% AD	40% AD
Minor Diagnostic Test, X-Ray, Lab (Outpatient) (Per Test of $350 or Less)	Covered 100%	40% AD	Covered 100%	40% AD
Urgent Care Facility / Physician After Hours	$50	40% AD	$50	40% AD
Rehabilitation Therapy Benefit	You Pay			
Inpatient – Physical, Speech, Occupational, Cardiac, or Pulmonary (30 Days PCY)	Included with Regular Inpatient Stay AD	40% AD	Included with Regular Inpatient Stay AD	40% AD
Accident & Life Threatening Illness	You Pay			
Medical / Surgical / Physician / Facility	Covered as Any Other Condition AD	40% AD	Covered as Any Other Condition AD	40% AD
Ambulance Land / Air (Medical Emergency Only, Based On Final Diagnosis)	20% AD	Covered as In-Network	20% AD	Covered as In-Network
Orthodontic Injury Treatment	Not Covered	Not Covered	Not Covered	Not Covered
Dental Injury Treatment	20% AD	40% AD	20% AD	40% AD

AD - After Deductible

PCY - Per Contract Year

* You are responsible for the difference between the billed amount and the contracted amount.

Total ACA out of pocket limit (including deductibles, co-payments, coinsurance and similar charges) $6,350 / $12,700.

Traditional Health Benefit Comparison - PEHP *Continued*

General Information	SUMMIT		ADVANTAGE	
Physician and Professional Services	You Pay			
	Network	**Non-Network ***	**Network**	**Non- Network ***
Physician Office Visits - Primary Care	$30	40% AD	$30	40% AD
Physician Office Visits - Specialist	$40	40% AD	$40	40% AD
PEHP - Value Clinic	$10	Not Covered	$10	Not Covered
Amwell On-Demand Doctor Visit	$10	Not Covered	$10	Not Covered
Second Surgical Opinion	20% AD	40% AD	20% AD	40% AD
Physician Visits (Inpatient)	20% AD	40% AD	20% AD	40% AD
Physician Visits (Outpatient)	20% AD	40% AD	20% AD	40% AD
Major Diagnostic Test, CT Scan, MRI (Per Test of $350 or More)	20% AD	40% AD	20% AD	40% AD
Minor Diagnostic Test, X-ray, Lab (Office) (Per Test of Less Than $350)	Covered 100%	40% AD	Covered 100%	40% AD
Injections	20%	40% AD	20%	40% AD
Surgery (Office)	20%	40% AD	20%	40% AD
Surgery (Inpatient)	20% AD	40% AD	20% AD	40% AD
Surgery (Outpatient)	20% AD	40% AD	20% AD	40% AD
Anesthesiology (Inpatient)	20% AD	40% AD	20% AD	40% AD
Anesthesiology (Outpatient)	20% AD	40% AD	20% AD	40% AD
Routine Prenatal & Delivery	20% AD	40% AD	20% AD	40% AD
Home Health Care (In Lieu of Hospitalization)	20% AD	40% AD	20% AD	40% AD
Physical Therapy (Outpatient) (20 Visits PCY)	$40	40% AD	$40	40% AD
Outpatient Speech Therapy (Due to Accident or Illness) (20 Visits PCY)	$40	40% AD	$40	40% AD
Outpatient Occupational Therapy (20 Visits PCY)	$40	40% AD	$40	40% AD
Chiropractic Therapy (20 Visits PCY)	$40	Not Covered	$40	Not Covered
Pain Clinic (Inpatient / Outpatient)	Regular Inpatient and Outpatient Medical Benefits Apply AD	40% AD	Regular Inpatient and Outpatient Medical Benefits Apply AD	40% AD
Vision Exams (1 Routine Visit PCY)	$40	40% AD	$40	40% AD
Hearing Exams (1 Routine Visit PCY)	$40	40% AD	$40	40% AD
Preventive Services	You Pay			
Affordable Care Act Preventive Services (See master policy for complete list)	100% of MAF	Not Covered	100% of MAF	Not Covered

Note: If physical given by a Specialist, $40 Co-payment will apply

AD - After Deductible

PCY - Per Contract Year

***** You are responsible for the difference between the billed amount and the contracted amount.

Total ACA out of pocket limit (including deductibles, co-payments, coinsurance and similar charges) $6,350 / $12,700.

MAF - Maximum Allowable Fee (See page 10 for additional MAF information.)

Traditional Health Benefit Comparison - PEHP *Continued*

General Information	SUMMIT		ADVANTAGE	
Transplant Benefits	You Pay			
	Network	Non-Network *	Network	Non- Network *
Heart, Kidney, Lung, Liver, Pancreas, Cornea and Bone Marrow	20% AD	40% AD	20% AD	40% AD
Medical Supplies & Equipment	You Pay			
Medical Supplies	20% AD	40% AD	20% AD	40% AD
Medical Supplies (Office)	20%	40% AD	20%	40% AD
Durable Medical Equipment ‡	20% AD	40% AD	20% AD	40% AD
Orthotic Supplies	20% Up to $200 Maximum PCY	40% AD	20% Up to $200 Maximum PCY	40% AD
Mental Health & Substance Abuse Treatment	You Pay			
Non - Pre Authorization Penalty	**Failure to follow the Blomquist Hale pre-authorization procedure** (see page 7) **will result in the benefit being denied.**			
Mental Health - Inpatient Facility (Semi-Private Room) (21 Days PCY)	20% AD	50% AD	20% AD	50% AD
Mental Health - Inpatient Facility (Ancillary) (21 Days PCY)	20% AD	50% AD	20% AD	50% AD
Mental Health - Inpatient Facility (Physician Visits)	20% AD	50% AD	20% AD	50% AD
Substance Abuse - Inpatient Detox (7 Days PCY)	20% AD	50% AD	20% AD	50% AD
Substance Abuse - Intensive Outpatient (32 Days PCY)	20% AD	50% AD	20% AD	50% AD
Physician Office Visits (Limit 25 Combined Visits PCY, 1 Visit Per Day)		You Pay		
Psychologist / Clinical Social Worker / APRN	$40	50% AD	$40	50% AD
Psychiatrist	$40	50% AD	$40	50% AD
Other Limited Benefits	You Pay			
Adoption Indemnity	Plan pays a maximum of $2,500 toward adoption expenses per child		Plan pays a maximum of $2,500 toward adoption expenses per child	
Non-surgical TMJ Syndrome Treatment ($500 Per Lifetime)	50% AD	50% AD	50% AD	50% AD

AD - After Deductible

PCY - Per Contract Year

* You are responsible for the difference between the billed amount and the contracted amount.

‡ Durable medical equipment must be deemed medically necessary or payment will be denied.

PLEASE NOTE: This is a summary only and does not guarantee benefits. For detailed information, refer to your member handbook. All payments for benefits are subject to the plans Maximum Allowable Fee. When using Non-Contracted providers, you are responsible for all fees in excess of the PEHP Maximum Allowable Fee (MAF). If you receive service from both Contracted and Non-Contracted providers, the total day, visit, and dollar limits will be combined and will not exceed plan maximums. The Contracted and Non-Contracted options each have a separate co-insurance maximum and a separate first dollar deductible.

Value Health Benefit Comparison - PEHP

General Information	SUMMIT		ADVANTAGE	
	In-Network	Non-Network *	In-Network	Non- Network *
Dependent Age Limit	26		26	
First Dollar Deductible (PCY)	$1,250 Per Person / $3,750 Family	$2,500 Per Person / $7,500 Family	$1,250 Per Person / $3,750 Family	$2,500 Per Person / $7,500 Family
Out of Pocket Maximum (PCY)	$6,600 Per Person / $13,200 Family	$13,200 Per Person / $26,400 Family	$6,600 Per Person / $13,200 Family	$13,200 Per Person / $26,400 Family
Prescription Drug Benefits (Administered Through Express Scripts)	You Pay			
Pharmacy Deductible	$250 Per Person Per Year			
Participating Pharmacy (30 Day Supply)	$7 Generic / 20% Preferred Brand / 35% Non-Preferred Brand / 35% Specialty **The cost difference between the Generic and the Brand Name medication will be applied to the Generic Co-pay for those medications for which a Generic is available.**			
Non-Participating Pharmacy (30 Day Supply)	50% Generic / 50% Brand			
Prescriptions – Mail Order (90 Day Supply)	$15 Generic / 20% Up to $150 Maximum Preferred Brand / 35% Up to $175 Maximum Non-Preferred Brand / 35% Specialty			
Hospital / Facility Benefits	You Pay			
Medical / Surgical / Intensive Care / Maternity (Normal Delivery – 2 Days, C-Section – 4 Days) Semi-Private Room	20% AD	40% AD	20% AD	40% AD
Medical / Surgical / Intensive Care / Maternity (Ancillary)	20% AD	40% AD	20% AD	40% AD
Skilled Nursing Facility (60 Days PCY)	20% AD	40% AD	20% AD	40% AD
Medical / Surgical Care (Outpatient)	20% AD	40% AD	20% AD	40% AD
Emergency Room (ER)	20% AD	20% AD	20% AD	20% AD
Major Diagnostic Test, CT Scan, MRI (Per Test of $350 Or More)	20% AD	40% AD	20% AD	40% AD
Minor Diagnostic Test, X-Ray, Lab (Outpatient) (Per Test of $350 or Less)	20% AD	40% AD	20% AD	40% AD
Urgent Care Facility / Physician After Hours	$45	40% AD	$45	40% AD
Rehabilitation Therapy Benefit	You Pay			
Inpatient – Physical, Speech, Occupational, Cardiac, or Pulmonary (30 Days PCY)	Included with Regular Inpatient Stay AD	40% AD	Included with Regular Inpatient Stay AD	40% AD
Accident & Life Threatening Illness	You Pay			
Medical / Surgical / Physician / Facility	Covered as Any Other Condition AD	40% AD	Covered as Any Other Condition AD	40% AD
Ambulance Land / Air (Medical Emergency Only, Based On Final Diagnosis)	20% AD	Covered as In-Network	20% AD	Covered as In-Network
Orthodontic Injury Treatment	Not Covered	Not Covered	Not Covered	Not Covered
Dental Injury Treatment	20% AD	40% AD	20% AD	40% AD

AD - After Deductible

PCY - Per Contract Year

* You are responsible for the difference between the billed amount and the contracted amount. The difference does not apply to the Out of Pocket Maximum.

Total ACA out of pocket limit (including deductibles, co-payments, coinsurance and similar charges) $6,350 / $12,700.

Value Health Benefit Comparison - PEHP *Continued*

General Information	SUMMIT		ADVANTAGE	
Physician and Professional Services	You Pay			
	Network	Non-Network *	Network	Non- Network *
Physician Office Visits - Primary Care	$25	40% AD	$25	40% AD
Physician Office Visits - Specialist	$35	40% AD	$35	40% AD
PEHP - Value Clinic	$10	Not Covered	$10	Not Covered
Amwell On-Demand Doctor Visit	$10	Not Covered	$10	Not Covered
Second Surgical Opinion	20% AD	40% AD	20% AD	40% AD
Physician Visits (Inpatient)	20% AD	40% AD	20% AD	40% AD
Physician Visits (Outpatient)	20% AD	40% AD	20% AD	40% AD
Major Diagnostic Test, CT Scan, MRI (Per Test of $350 or More)	20% AD	40% AD	20% AD	40% AD
Minor Diagnostic Test, X-ray, Lab (Office) (Per Test of Less Than $350)	20%	40% AD	20%	40% AD
Injections	20%	40% AD	20%	40% AD
Surgery (Office)	20% AD	40% AD	20% AD	40% AD
Surgery (Inpatient)	20% AD	40% AD	20% AD	40% AD
Surgery (Outpatient)	20% AD	40% AD	20% AD	40% AD
Anesthesiology (Inpatient)	20% AD	40% AD	20% AD	40% AD
Anesthesiology (Outpatient)	20% AD	40% AD	20% AD	40% AD
Routine Prenatal & Delivery	20% AD	40% AD	20% AD	40% AD
Home Health Care (In Lieu of Hospitalization)	20% AD	40% AD	20% AD	40% AD
Physical Therapy (Outpatient) (20 Visits PCY)	$35	40% AD	$35	40% AD
Outpatient Speech Therapy (Due to Accident or Illness) (20 Visits PCY)	$35	40% AD	$35	40% AD
Outpatient Occupational Therapy (20 Visits PCY)	$35	40% AD	$35	40% AD
Chiropractic Therapy (20 Visits PCY)	$35	Not Covered	$35	Not Covered
Pain Clinic (Inpatient / Outpatient)	Regular Inpatient and Outpatient Medical Benefits Apply AD	40% AD	Regular Inpatient and Outpatient Medical Benefits Apply AD	40% AD
Vision Exams (1 Routine Visit PCY)	$35	40% AD	$35	40% AD
Hearing Exams (1 Routine Visit PCY)	$35	40% AD	$35	40% AD
Preventive Services	You Pay			
Affordable Care Act Preventive Services (See master policy for complete list)	100% of MAF	Not Covered	100% of MAF	Not Covered
Transplant Benefits	You Pay			
Heart, Kidney, Lung, Liver, Pancreas, Cornea and Bone Marrow	20% AD	40% AD	20% AD	40% AD
Medical Supplies & Equipment	You Pay			
Medical Supplies	20% AD	40% AD	20% AD	40% AD
Medical Supplies (Office)	20%	40% AD	20%	40% AD
Durable Medical Equipment ‡	20% AD	40% AD	20% AD	40% AD
Orthotic Supplies	20% Up to $200 Maximum PCY	40% AD	20% Up to $200 Maximum PCY	40% AD

Note: If physical given by a Specialist, $40 Co-payment will apply

AD - After Deductible

PCY - Per Contract Year

MAF - Maximum Allowable Fee (See page 13 for additional MAF information.)

* You are responsible for the difference between the billed amount and the contracted amount.

‡ Durable medical equipment must be deemed medically necessary or payment will be denied.

Value Health Benefit Comparison - PEHP *Continued*

General Information	SUMMIT		ADVANTAGE	
Mental Health & Drug / Alcohol Treatment	You Pay			
	Network	Non-Network *	Network	Non- Network *
Non - Pre Authorization Penalty	**Failure to follow the Blomquist Hale pre-authorization procedure** (see page 7) **will result in the benefit being denied.**			
Mental Health Inpatient Facility (Semi-Private Room) (21 Days PCY)	20% AD	50% AD	20% AD	50% AD
Mental Health - Inpatient Facility (Ancillary) (21 Days PCY)	20% AD	50% AD	20% AD	50% AD
Mental Health - Inpatient Facility (Physician Visits)	20% AD	50% AD	20% AD	50% AD
Substance Abuse - Inpatient Detox (7 Days PCY)	20% AD	50% AD	20% AD	50% AD
Substance Abuse - Intensive Outpatient (32 Days PCY)	20% AD	50% AD	20% AD	50% AD
Physician Office Visits (Limit 25 Combined Visits PCY, 1 Visit Per Day)	You Pay			
Psychologist / Clinical Social Worker / APRN	$35	50% AD	$35	50% AD
Psychiatrist	$35	50% AD	$35	50% AD
Other Limited Benefits	You Pay			
Adoption Indemnity	Plan pays a maximum of $2,500 toward adoption expenses per child		Plan pays a maximum of $2,500 toward adoption expenses per child	
Non-surgical TMJ Syndrome Treatment ($500 Per Lifetime)	50% AD	50% AD	50% AD	50% AD

AD - After Deductible

PCY - Per Contract Year

* You are responsible for the difference between the billed amount and the contracted amount. The difference does not apply to the Out of Pocket Maximum.

PLEASE NOTE: This is a summary only and does not guarantee benefits. For detailed information, refer to your member handbook. All payments for benefits are subject to the plans Maximum Allowable Fee. When using Non-Contracted providers, you are responsible for all fees in excess of the Maximum Allowable Fee (MAF). If you receive service from both Contracted and Non-Contracted providers, the total day, visit, and dollar limits will be combined and will not exceed plan maximums. The Contracted and Non-Contracted options each have a separate co-insurance maximum and a separate first dollar deductible.

STAR (QHDHP) HEALTH BENEFIT COMPARISON - PEHP

General Information	SUMMIT		ADVANTAGE	
	In-Network	Non-Network *	In-Network	Non- Network *
Dependent Age Limit	26		26	
First Dollar Deductible (PCY)	$1,300 Per Person / $2,600 Family	$2,600 Per Person / $5,200 Family	$1,300 Per Person / $2,600 Family	$2,600 Per Person / $5,200 Family
Out of Pocket Maximum (PCY)	$5,000 Per Individual / $10,000 Family	$10,000 Per Person / $20,000 Family	$5,000 Per Individual / $10,000 Family	$10,000 Per Person / $20,000 Family
	If any family member reaches $5,000 of the out of pocket maximum then the out of pocket maximum is satisfied for that family member. If any combination of family members reach the family out of pocket maximum, then the out of pocket maximum is satisfied for the entire family.			
Prescription Drug Benefits (Administered Through Express Scripts)	You Pay			
Pharmacy Deductible	Subject to the Medical Deductible			
Participating Pharmacy (30 Day Supply)	20% AD Generic / 20% AD Preferred Brand / 20% AD Non-Preferred Brand / 20% AD Specialty			
Non-Participating Pharmacy (30 Day Supply)	50% AD Generic / 50% AD Preferred Brand / 50% AD Non-Preferred Brand / 50%AD Specialty			
Prescriptions – Mail Order (90 Day Supply)	20% AD Generic / 20% AD Preferred Brand / 20% AD Non-Preferred Brand / 20% AD Specialty			
Hospital / Facility Benefits	You Pay			
Medical / Surgical / Intensive Care / Maternity (Normal Delivery – 2 Days, C-Section – 4 Days) **Semi-Private Room**	20% AD	40% AD	20% AD	40% AD
Medical / Surgical / Intensive Care / Maternity (Ancillary)	20% AD	40% AD	20% AD	40% AD
Skilled Nursing Facility (60 Days PCY)	20% AD	40% AD	20% AD	40% AD
Medical / Surgical Care (Outpatient)	20% AD	40% AD	20% AD	40% AD
Emergency Room (ER)	20% AD	20% AD	20% AD	20% AD
Major Diagnostic Test, CT Scan, MRI (Per Test of $350 Or More)	20% AD	40% AD	20% AD	40% AD
Minor Diagnostic Test, X-Ray, Lab (Outpatient) (Per Test of $350 or Less)	20% AD	40% AD	20% AD	40% AD
Urgent Care Facility / Physician After Hours	20% AD	40% AD	20% AD	40% AD
Rehabilitation Therapy Benefit	You Pay			
Inpatient – Physical, Speech, Occupational, Cardiac, or Pulmonary (30 Days PCY)	Included with Regular Inpatient Stay AD	40% AD	Included with Regular Inpatient Stay AD	40% AD
Accident & Life Threatening Illness	You Pay			
Medical / Surgical / Physician / Facility	Covered as Any Other Condition AD	40% AD	Covered as Any Other Condition AD	40% AD
Ambulance Land / Air (Medical Emergency Only, Based On Final Diagnosis)	20% AD	Covered as In-Network	20% AD	Covered as In-Network
Orthodontic Injury Treatment	Not Covered	Not Covered	Not Covered	Not Covered
Dental Injury Treatment	20% AD	40% AD	20% AD	40% AD

AD - After Deductible

PCY - Per Contract Year

* You are responsible for the difference between the billed amount and the contracted amount. The difference does not apply to the Out of Pocket Maximum.

Total ACA out of pocket limit (including deductibles, co-payments, coinsurance and similar charges) $6,350 / $12,700.

STAR (QHDHP) HEALTH BENEFIT COMPARISON - PEHP

General Information	SUMMIT		ADVANTAGE	
Physician and Professional Services	You Pay			
	Network	Non-Network *	Network	Non- Network *
Physician Office Visits - Primary Care	20% AD	40% AD	20% AD	40% AD
Physician Office Visits - Specialist	20% AD	40% AD	20% AD	40% AD
PEHP - Value Clinic	20% AD	Not Covered	20% AD	Not Covered
Amwell On-Demand Doctor Visit	20% AD	Not Covered	20% AD	Not Covered
Second Surgical Opinion	20% AD	Not Covered	20% AD	Not Covered
Physician Visits (Inpatient)	20% AD	40% AD	20% AD	40% AD
Physician Visits (Outpatient)	20% AD	40% AD	20% AD	40% AD
Major Diagnostic Test, CT Scan, MRI (Per Test of $350 or More)	20% AD	40% AD	20% AD	40% AD
Minor Diagnostic Test, X-ray, Lab (Office) (Per Test of Less Than $350)	20% AD	40% AD	20% AD	40% AD
Injections	20% AD	40% AD	20% AD	40% AD
Surgery (Office)	20% AD	40% AD	20% AD	40% AD
Surgery (Inpatient)	20% AD	40% AD	20% AD	40% AD
Surgery (Outpatient)	20% AD	40% AD	20% AD	40% AD
Anesthesiology (Inpatient)	20% AD	40% AD	20% AD	40% AD
Anesthesiology (Outpatient)	20% AD	40% AD	20% AD	40% AD
Routine Prenatal & Delivery	20% AD	40% AD	20% AD	40% AD
Home Health Care (In Lieu of Hospitalization)	20% AD	40% AD	20% AD	40% AD
Physical Therapy (Outpatient) (20 Visits PCY)	20% AD	40% AD	20% AD	40% AD
Outpatient Speech Therapy (Due to Accident or Illness) (20 Visits PCY)	20% AD	40% AD	20% AD	40% AD
Outpatient Occupational Therapy (20 Visits PCY)	20% AD	40% AD	20% AD	40% AD
Chiropractic Therapy (20 Visits PCY)	20% AD	Not Covered	20% AD	Not Covered
Pain Clinic (Inpatient / Outpatient)	Regular Inpatient and Outpatient Medical Benefits Apply AD	40% AD	Regular Inpatient and Outpatient Medical Benefits Apply AD	40% AD
Vision Exams (1 Routine Visit PCY)	20% AD	40% AD	20% AD	40% AD
Hearing Exams (1 Routine Visit PCY)	20% AD	40% AD	20% AD	40% AD
Preventive Services	You Pay			
Affordable Care Act Preventive Services (See master policy for complete list)	100% of MAF	Not Covered	100% of MAF	Not Covered
Transplant Benefits	You Pay			
Heart, Kidney, Lung, Liver, Pancreas, Cornea and Bone Marrow	20% AD	40% AD	20% AD	40% AD
Medical Supplies & Equipment	You Pay			
Medical Supplies	20% AD	40% AD	20% AD	40% AD
Medical Supplies (Office)	20% AD	40% AD	20% AD	40% AD
Durable Medical Equipment ‡	20% AD	40% AD	20% AD	40% AD
Orthotic Supplies	20% AD Up to $200 Maximum PCY	40% AD	20% AD Up to $200 Maximum PCY	40% AD

AD - After Deductible

PCY - Per Contract Year

* You are responsible for the difference between the billed amount and the contracted amount.

‡ Durable medical equipment must be deemed medically necessary or payment will be denied.

MAF - Maximum Allowable Fee (See page 16 for additional MAF information.)

STAR (QHDHP) HEALTH BENEFIT COMPARISON - PEHP

General Information	SUMMIT		ADVANTAGE	
Mental Health & Drug / Alcohol Treatment	You Pay			
	Network	Non-Network *	Network	Non- Network *
Non - Pre Authorization Penalty	Failure to follow the Blomquist Hale pre-authorization procedure (see page 7) will result in the benefit being denied.			
Mental Health Inpatient Facility (Semi-Private Room) (21 Days PCY)	20% AD	50% AD	20% AD	50% AD
Mental Health - Inpatient Facility (Ancillary) (21 Days PCY)	20% AD	50% AD	20% AD	50% AD
Mental Health - Inpatient Facility (Physician Visits)	20% AD	50% AD	20% AD	50% AD
Substance Abuse - Inpatient Detox (7 Days PCY)	20% AD	50% AD	20% AD	50% AD
Substance Abuse - Intensive Outpatient (32 Days PCY)	20% AD	50% AD	20% AD	50% AD
Physician Office Visits (Limit 25 Combined Visits PCY, 1 Visit Per Day)	You Pay			
Psychologist / Clinical Social Worker / APRN	20% AD	50% AD	20% AD	50% AD
Psychiatrist	20% AD	50% AD	20% AD	50% AD
Other Limited Benefits	You Pay			
Adoption Indemnity	Plan pays a maximum of $2,500 toward adoption expenses per child		Plan pays a maximum of $2,500 toward adoption expenses per child	
Non-surgical TMJ Syndrome Treatment ($500 Per Lifetime)	50% AD	50% AD	50% AD	50% AD

AD - After Deductible

PCY - Per Contract Year

* You are responsible for the difference between the billed amount and the contracted amount. The difference does not apply to the Out of Pocket Maximum.

PLEASE NOTE: This is a summary only and does not guarantee benefits. For detailed information, refer to your member handbook. All payments for benefits are subject to the plans Maximum Allowable Fee. When using Non-Contracted providers, you are responsible for all fees in excess of the Maximum Allowable Fee (MAF). If you receive service from both Contracted and Non-Contracted providers, the total day, visit, and dollar limits will be combined and will not exceed plan maximums. The Contracted and Non-Contracted options each have a separate co-insurance maximum and a separate first dollar deductible.

Flexible Spending Account - PEHP

Sometimes referred to as a Cafeteria Plan, Flex Plan, or a Section 125 Plan, a Flexible Spending Account (FSA) lets you set aside a certain amount of your paycheck into a Medical Reimbursement Account or Dependent Day Care Reimbursement Account - before paying income taxes and Social Security. This can save you 20 - 30% on out-of-pocket costs, depending on your personal tax rate. **YOU MUST ELECT NEW AMOUNTS FOR YOUR FLEXIBLE SPENDING ACCOUNTS EACH YEAR.** Amounts set aside for the Medical Reimbursement Account should not include your portion of medical, dental, vision and cancer insurance premiums. These are withheld before tax automatically under a separate plan.

HOW REIMBURSEMENT ACCOUNTS WORK

During your annual enrollment or when you are first eligible for benefits, you decide how much you want to deposit into your reimbursement account(s). When you have determined how much expense you will have for the upcoming plan year, that amount is divided evenly over 10 or 12 pay periods depending upon your contract and is automatically deducted from your paycheck before taxes are taken out. For your medical FSA, you will receive a FLEX$ benefit card (you can request 1 additional dependent card at no charge). With your FLEX$ enrollment, your existing card will automatically start accessing your new annual election amount. So, keep your card, it is good for 3 years. **You will be asked to provide documentation with all manual claims submitted, and for card charges that cannot be independently verified. Keep receipts for all charges.** For items not charged on the card, you pay the bill, complete a claim form (available online at www.pehp.org), attach copies of your receipts and mail / fax to the address on the claim form. You will generally receive your reimbursement check or direct deposit within a week. It's that easy and you save money! Please be sure to keep copies of the claim form and receipt(s) for your records.

The Medical Reimbursement Account reimburses you for out-of-pocket medical expenses not paid by insurance. You may set aside up to $2,500, before taxes, through regular payroll deductions. During the year, the plan reimburses you directly from your account for any qualified healthcare expenses (except insurance premiums) you've paid that are not covered by insurance. Common expenses that qualify for reimbursement include:

- Doctor Visits
- Deductibles
- Co-payments
- Psychologist Fees
- Eye Surgery, Glasses, and Contacts
- Mental Health / Psychiatric Care
- Chiropractic Services
- Dental Services and Orthodontics
- Prescriptions and Medical Supplies
- Smoking Cessation Programs
- Weight-Loss Programs (if prescribed by a physician for a medical condition)

A detailed list of many eligible expenses can be found under FLEX$ at www.pehp.org.

The Dependent Day Care Reimbursement Account reimburses you for day care expenses for eligible children and adults to pay for eligible dependent care expenses in order for you and your spouse (if married), to work and/or go to school. Through regular payroll deductions, you may set aside up to $5,000 in pretax dollars for these expenses on a tax-free basis. To qualify, your dependent(s) must be:

- A child under the age of 13, or,
- A child, spouse, or other dependent that is physically or mentally incapable of self-care and spends at least 8 hours a day in your household.

Note: If your family's annual income is over $20,000, this reimbursement option will most likely save you more money than the dependent care tax credit you take on your tax return. You will also receive your tax savings in each paycheck, rather than once a year when you file your taxes.

Dependent Day Care Reimbursement is paid when you have received qualified dependent care with an accompanying paid receipt or invoice. PEHP provides an automatic reimbursement with direct deposit.

Here's an example of how a typical employee's take-home pay will increase as a result of participating in a Flexible Spending Account (FSA):

JOHN'S EXPENSES		JOHN'S SITUATION WITHOUT THE ACCOUNT		JOHN'S SITUATION WITH THE ACCOUNT	
LENSES & FRAMES	+ $280	JOHN'S ANNUAL EARNINGS	$30,000	JOHN'S ANNUAL EARNINGS	$30,000
ORTHODONTIA	+ $1,000	TAXES (25%)	- $7,500	EXPENSES (BEFORE TAXES)	- $2,500
CO-PAYS	+ $120	NET PAY	$22,500	TAXABLE PAY	$27,500
ANTICIPATED SURGERY	+ $1,100	EXPENSES (AFTER TAXES)	- $2,500	TAXES (25%)	- $6,875
TOTAL FOR THE YEAR	**= $2,500**	**TAKE HOME PAY**	**= $20,000**	**TAKE HOME PAY**	**= $20,625**
JOHN'S TAKE HOME PAY INCREASES $625 BY USING THE REIMBURSEMENT ACCOUNT					

Flexible Spending Account - PEHP - Frequently Asked Questions

What is a Flexible Reimbursement Account (FLEX$) **Program?**
The IRS allows FLEX$ participants to pay specific qualified health related expenses as well as dependent day care expenses with pretax dollars. This results in a reduction in your Federal, State, Social Security and Medicare taxes.

Where do I get Enrollment and Claim Forms for the FLEX$?
One is included in your enrollment packet or they are available at www.pehp.org. The forms are updated on a regular basis to meet the current Laws governing the FLEX$ plan. Please check the web site for the most current form and destroy the old forms you may have on file–each series is date stamped on the lower right hand corner. Turn the enrollment forms into the District Insurance office and claim forms into PEHP.

Can I change or cancel my FLEX$ contributions during the Plan Year?
Contributions cannot be changed or stopped during the Plan Year, unless a qualified change of status occurs. These are outlined in the FLEX$ Handbook (available at www.pehp.org), and a general listing is provided on the Enrollment form.

How do I use my FLEX$ money?
You have two ways of paying eligible expenses with your FLEX$ funds. You can use the PEHP FLEX$ Benefits Card, and the service provider is paid directly from your FLEX$ funds, or you can pay the provider out of your own pocket, and PEHP will reimburse you from your FLEX$ funds.

How do I submit a manual claim?
You can fax or mail your documents directly to PEHP. Make sure they are signed, legible, and include a daytime phone number, in case they need to contact you. Unsigned claims will not be processed.

How will I receive reimbursement for manual claims?
PEHP can set you up on a Direct Deposit account, so that funds are paid directly to your checking or savings account electronically. No more lost or stolen checks! Or PEHP can mail you a check.

Why use the PEHP FLEX$ Benefits Card?
You eliminate paying your claims with out-of pocket money. Using the card also reduces the amount of manual claims submitted for the year (PEHP will verify most claims electronically from your insurance files).

Does my PEHP FLEX$ Benefits Card work anywhere?
No. The FLEX$ Card only works at authorized vendors, i.e. physician's office, dentist, hospital or pharmacy. The FLEX$ Card is programmed to work solely for vendors who have appropriate merchant codes. Some general merchandise stores now identify most FLEX$ eligible items at the point of purchase. Use the benefits card first. The eligible amount will be charged to the card and a different form of payment will be requested for the other items purchased.

Can my PEHP FLEX$ Benefits Card distinguish whether or not the expense charge is eligible?
No. The PEHP FLEX$ Benefits Card can only recognize a valid merchant code and your eligible balance.

Do I need to keep my receipts?
YES. The IRS requires that every claim be documented either electronically or manually. If the PEHP FLEX$ staff cannot verify your claim electronically, you will need to provide documentation of your claim. **KEEP YOUR RECEIPTS.**

Do I have to wait for the money to be withheld from my paycheck before I can use the funds?
It depends on the benefit. With Medical Reimbursement, the entire annual election amount is available the day the Plan Year begins. For Dependent Day Care Reimbursement, only the funds you have had withheld from your paycheck will be available to you.

Does my PEHP FLEX$ Benefits Card work for Dependent Day Care?
No. But PEHP does offer Automatic Reimbursement of Dependent Day Care claims.

Can I transfer dollars between the Health Care and Dependent Day Dare accounts?
No. The dollars must be used in each account as specified on the enrollment form.

What is the current balance in my FLEX$ account?
Account balances can be obtained on-line or call the customer service line of the FLEX$ administrator.

How does my PEHP FLEX$ Benefits Card work if I only have $100.00 left in my account and I swipe it for $400.00? The system only approves claims that are equal to or under the current balance in the account. Tell the merchant to swipe the card for the $100.00 and pay the difference with non-FLEX$ money.

Flexible Spending Account - PEHP- Frequently Asked Questions *Continued*

What is Automatic Day Care Reimbursement?
At the beginning of the Plan Year you file one claim and funds are automatically paid to you when PEHP receives funds from your employer. You will be required to provide a statement from your day care provider at the end of the Plan Year documenting the actual costs incurred. This benefit is subject to the rules and limitations as outlined on the Automatic Reimbursement Claim Form. The Automatic Reimbursement Claim Form detailing this benefit is available at **www.pehp.org**.

Do I have to pay my doctor or day care provider before I submit a claim?
No. You just need to incur an expense by having a service provided for you. Keep in mind that the service must be provided during the Plan Year, regardless of when you are billed or pay for the expense.

Can I use my PEHP FLEX$ Benefits Card to purchase over-the-counter drugs? As of 2011 -"Under the new healthcare reform legislation, over-the-counter (OTC) drugs, medicines and biologicals will be eligible for reimbursement only if the request is accompanied by a doctor's prescription. This means items such as cough medicines, pain relievers, acid controllers, diaper rash ointment, to name a few, will no longer be reimbursed unless there is doctor's prescription submitted along with the reimbursement request. See "Eligible Expenses" at **www.pehp.org** for a more complete list of items.

Can I claim my over-the-counter vitamins?
Yes, vitamins are covered with a diagnosis and prescription from your provider. You will need to pay cash and submit a manual reimbursement form.

Can I claim expenses for teeth bleaching?
No. Teeth bleaching is considered a cosmetic procedure and is not reimbursable through the FLEX$ Plan.

Can I claim expenses for massage therapy?
Massages treating a specific injury or trauma are eligible. You must submit a Doctor's prescription with each claim you submit.

Can I claim expenses for LASIK surgery?
Yes. The cost of vision correction surgery to correct or promote the proper function of the eye is reimbursable.

Can I claim expenses for weight loss programs?
The cost of a weight loss program for general health is not reimbursable. However, a weight loss program to treat a specific illness such as heart disease, high blood pressure, etc. is reimbursable with a Doctor's prescription. Weight loss to treat obesity does not require a prescription, but obesity must be diagnosed.

What do I need to do if my claim is denied?
Follow the instructions in the denial letter. If you do not agree with the denial, you can appeal in writing to the PEHP FLEX$ Appeals Board at:

560 East 200 South, Ste 100 Salt Lake City, UT 84102

What do I need to do if I terminate employment?
Contact the PEHP FLEX$ department prior to your termination date for options. Your PEHP FLEX$ Benefits Card will only work after your termination date if you have funded a remaining balance and elected COBRA for the FLEX$ program. Otherwise, you will need to file manual claims for any expenses incurred before termination.

Flexible Spending Account - PEHP - Getting the Most Out of Your FSA

Remember: If you don't use all the pre-tax dollars you deposit to a reimbursement account(s) within the plan year and extension allowed by the IRS (September 1, 2016, through November 15, 2016), you will forfeit any balance in the account at the end of the plan year. It's a use it or lose it provision. You have until November 30, 2016, to submit qualifying receipts.

Once you have designated how much you want to contribute to one or both of your reimbursement accounts, you cannot stop or change your contributions unless you have a qualifying change in family status.

Please consult your tax advisor regarding the specific tax advantages a reimbursement account has to you.

The administration fee for both the Health Care and Dependent Care expenses will be $2.75 per pay period ($33.00 per year). If your flexible spending election is at least $1,200 per year the district will pay your monthly administration fee.

Flexible Spending - PEHP - Estimated Health Care Expenses Worksheet

Refer to your summary plan description for specific plan benefits. This worksheet is intended only to help you determine Flex Spending expenses.

Service / Procedure	Plan Co-pay x	Estimated Use = (Number of Visits or RX Co-pay)	Estimated Expenses
Office Co-pay			
Prescriptions			+
Deductible			+
Maternity			+
Emergency Room			+
Vision			+
Dental Deductible			+
Dental Expenses			+
Orthodontic Expenses			+
Acupuncture			+
Mental Health			+
Other			+
Total Estimated Expenses			=
Total Estimated Expenses Divided by 10 or 12 Pay Periods *(Depending on Contract)*			÷
Monthly Amount to Contribute to Account			=

PEHP FLEX$ forms and information are available at *www.pehp.org* or call 801-366-7503 or 800-753-7703.

Understanding An Health Savings Account (HSA)

What is a Health Savings Account (HSA)**?**
A Health Savings Account (HSA) is a tax advantaged account that can be used to pay eligible medical expenses not covered by an insurance plan including deductibles and coinsurance.

1. You can fund your HSA with pre-tax dollars through payroll deduction.
2. You can fund your HSA with after tax dollars and receive an above the line deduction on your tax return.

Who is eligible for a Health Savings Account?
Anyone who satisfies all of the following:

- Covered by a Qualified High Deductible Health Plan (QHDHP);
- Employee cannot be covered under another medical plan;
- Not enrolled in Medicare A or Medicare B benefits; and,
- Not eligible to be claimed on another person's tax return.

What is a deductible?
It is a set dollar amount, determined by your plan that you must pay out-of-pocket or from your HSA account before insurance coverage for medical expenses can begin.

What is the difference between an HSA & Flexible Spending Account (FSA)**?**

- An HSA can roll-over unused funds from year to year, indefinitely.
- FSA contribution limits are lower than for HSAs. In addition, JSD's FSA does not roll-over the unused funds.

How does a Health Savings Account Work?

Part 1: Qualifying High Deductible Health Insurance Plan	Part 2: Health Savings Account
Intended to cover serious illness or injury after the deductible is met	Pays for out-of-pocket qualifying medical expenses incurred before the deductible is met

How is an HSA used to pay for medical care?

1. Employee funds an HSA account.
2. Employee seeks medical services and presents Medical ID card.
3. A bill for medical services is submitted as a claim to your insurance carrier and paid in part according to your HDHP, subject to a deductible and coinsurance.*
4. Employee can pay the remaining amount with a debit card or check from their HSA account.
5. This process is repeated until the out-of-pocket maximum is reached, after which the employee generally should be covered for almost all in-network eligible expenses.

* Subject to plan design, check your Benefits Summary.
Preventive care may be covered at 100%.

When do I use my HSA?
After visiting a physician, facility, or pharmacy, request that they submit your claim to your Medical Carrier for payment. You should make sure that your provider has your most up-to-date insurance information. Once the claim has been processed, any out-of-pocket expenses will be billed. At this time you may choose the following options:

- Use your HSA debit card or HSA check to pay for any out-of-pocket expenses.
- You may choose to write a personal check, receiving reimbursement at a later date.
- You can choose to save your HSA dollars for future medical expenses.

You should always ask that your claim be submitted to the health plan before you seek reimbursement from your HSA. This procedure will ensure that provider discounts are applied. **Also, remember to keep all medical receipts and Explanation of Benefits** (EOBs) **to support your personal tax record. You should keep these records for at least four years.**

How much can be contributed to an HSA?
As noted by federal law, the Annual Contribution limits are:

TYPE OF COVERAGE	**2016 MAXIMUM** ANNUAL CONTRIBUTION
INDIVIDUAL	$3,350
TWO PARTY	$6,750
FAMILY	$6,750
Individuals age 55 or older may be eligible to make a catch up contribution of $1,000 in 2016.	

Understanding An Health Savings Account (HSA) *Continued*

Can I contribute to both an HSA and FSA in the same year?
You **may not** contribute to or use a general purpose health FSA and an HSA. However, contributions to a Limited Purpose FSA, which only allows reimbursement of certain expenses that are not eligible for payment under the High Deductible Health Plan (HDHP), are permissible. The Limited Purpose FSA allows HSA covered employees to pay for dental and vision expenses that are not covered by insurance, however, it **does not** allow you to pay for other medical expenses. Your employer **HAS NOT** established a limited FSA to allow employees to contribute pre-tax dollars to an account.

What if I am a new hire or have a special enrollment and enroll in an HSA in the middle of a year?
If you enroll in an HSA and corresponding HDHP at any time other than the start of the calendar year, so long as you enroll by December 1, you may still contribute the maximum amount allowed for the calendar year. (See the chart on the previous page.) However, the IRS requires you to participate in the HDHP during a subsequent testing period (generally through the end of the following year). Failure to do so will result in adverse tax consequences.

Why should I elect an HSA?

1. Cost Savings

- Tax benefits:
  - HSA contributions are excluded from federal income tax.
  - Interest earnings may be tax free.
  - Withdrawals for eligible expenses are exempt from federal income tax.
- You pay a reduced medical plan premium contribution.
- Unused money is held in interest-bearing savings or investment accounts from year to year.

Note: Many states have passed legislation to provide favorable state tax treatment for HSAs. However, in a small number of states, amounts contributed to HSAs and interest earned on HSA accounts could be included in the employee's compensation for state income tax purposes.

2. Long-Term Financial Benefits

- Save for future medical expenses, including retiree medical
- Funds roll over year to year
- This is your account - you take it with you. If you leave your employer you can do the following:
  - Leave your funds in your current HSA account;
  - Transfer your funds to an HSA with your new employer; or
  - Transfer your funds to another qualifying account within 60 days.

3. Choice

- You control and manage your health care expenses.
- You choose when to use your HSA dollars to pay your health care expenses.
- You choose when to save your HSA dollars and pay health care expenses out-of-pocket.
- You can choose to increase or decrease your election during the year (as allowed by your employer).

Frequently Asked Questions -

Can I use my HSA dollars for non-eligible expenses?
Money withdrawn from an HSA account to reimburse non-eligible expenses is taxable income to the account holder and is subject to a tax penalty. If the account holder is over age 65 OR disabled, the distribution amount (if for a non-eligible expense) IS still considered taxable income; however, the tax penalty IS waived.

When can I start using my HSA dollars?
You can use your HSA dollars immediately following your HSA account activation and once contributions have been made.

Can my HSA dollars be used for retirement health care costs?
Yes, for expenses eligible for reimbursement, and Medicare and other health coverage premiums after age 65.

Can I use the money in my account to pay for my dependents' medical expenses?
Yes, you can use the money in the account to pay for medical expenses of yourself, your spouse, or your dependent children. You can pay for expenses of your spouse and dependent children even if they are not covered by your HDHP.

Prescription Drug Benefit Program - Express Scripts

Jordan School District provides a prescription drug program for covered persons in differing plans. This program consists of a four-tier drug program. The plan covers the cost of certain generic, Preferred Brand, Non-Preferred Brand and Specialty Brand medications after you pay the applicable Co-payment.

SUMMARY OF YOUR PHARMACY BENEFIT CO-PAYMENT

- The cost difference between the Generic and the Brand Name medication will be applied to the Generic Co-pay for those medications for which a Generic is available.
- Value Plan members have an annual $250 deductible.

DRUG FORMULARY

The amount you pay for each prescription is based on the drug formulary. The four tiers below are covered by this program:

- **Generic Drugs -** When patents expire on a brand-name. is a list of commonly prescribed medications that have been elected for their clinical effectiveness, safety and cost.
- **Non-Preferred Brand -** A listing of brand name and generic prescription drugs that is covered, but not on the preferred drug list.
- **Specialty Brand -** A listing of brand-name and generic drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis.

You can determine your medication's drug classification by logging on to **Express Scripts'** web site: **www.expressscripts.com**.

TRADITIONAL HEALTH PLAN				
Purchased at	**Generic Drugs**	**Preferred**	**Non-Preferred**	**Specialty Drugs**
Participating Pharmacies (30 Day Supply)	$15 Co-pay *	35% *	50% *	50% *
Non-Participating Pharmacies (30 Day Supply)	50% *	50% *	50% *	50% *
Mail Order Drugs (90 Day Supply)	$30 Co-pay *	35% *	50% *	50% *

VALUE HEALTH PLAN				
Purchased at	**Generic Drugs**	**Preferred**	**Non-Preferred**	**Specialty Drugs**
Participating Pharmacies (30 Day Supply)	$7 Co-pay *	20% *	35% *	35% *
Non-Participating Pharmacies (30 Day Supply)	50% *	50% *	50% *	50% *
Mail Order Drugs (90 Day Supply)	$15 Co-pay *	20% * ($150 Max)	35% * ($175 Max)	35% *

STAR HEALTH PLAN (QHDHP)				
Purchased at	**Generic Drugs**	**Preferred**	**Non-Preferred**	**Specialty Drugs**
Participating Pharmacies (30 Day Supply)	20% AD *	20% AD *	20% AD *	20% AD *
Non-Participating Pharmacies (30 Day Supply)	50% AD *	50% AD *	50% AD *	50% AD *
Mail Order Drugs (90 Day Supply)	20% AD *	20% AD *	20% AD *	20% AD *

* Per Prescription

PRESCRIPTION REQUIREMENTS AND EDITS

- **Dispense As Written Requirements -** For brand-name medications that have a generic alternative available, you will be responsible for the difference in cost between the brand and the generic, plus the generic Co-payment.
- **Prior Authorization Requirements -** Some specialty and non-specialty medications may require prior authorization from your prescription drug benefit manager.
- **Preferred Drug Step Therapy Edits -** Some medications (such as generics, nonprescription, and less expensive brand-name drugs) may be preferred over non-preferred, more expensive brand-name medications. Coverage for non-preferred medications will require prior authorization from your prescription drug benefit manager. You will receive communications from **Express Scripts** concerning which medications are affected.
- **Quantity / Dose Duration Edits -** Some medications may contain quantity and duration limitations.

RETAIL PHARMACY OPTION

Participating pharmacies have contracted with the plan to charge reduced fees for covered prescription drugs. The prescription drug vendor is **Express Scripts**. The retail pharmacy program should be used when you need a prescription on a short-term basis—for example, an antibiotic to treat a sinus infection. Pharmacy prescriptions are usually for those medications that require up to a 30-day supply. You can find a list of participating pharmacies on **Express Scripts'** website at **www.expressscripts.com**.

ORDERING NEW PRESCRIPTIONS

If you are filling your prescription at a participating pharmacy, show your prescription drug identification card to the pharmacist each time you order a new prescription or refill. Pay the required Co-payment when you pick up your medication.

If you are filling your prescription at a non-participating pharmacy, you must pay 100% of the prescription price when you receive your medication and submit a claim to **Express Scripts**. You will be reimbursed the amount that would have been charged by a participating pharmacy, less your required Co-payment.

Prescription Drug Benefit Program - Express Scripts *Continued*

REFILLS

To refill your medications, have your member ID and prescription numbers ready when you order refills from your pharmacy. If you are using a participating pharmacy, you must pay the required co-payment when you receive your medication. At non-participating pharmacies, you will need to pay in full and submit a claim to **Express Scripts.**

EXPRESS SCRIPTS BY MAIL (Mail Service Pharmacy Program)

The mail-order program is specifically for maintenance medications (those taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma). Because of volume buying, the mail order pharmacy is able to offer significant savings on prescriptions. Mail order is economic and convenient to use.

ORDERING NEW PRESCRIPTIONS

The first time you are prescribed a medication, ask your doctor for two prescriptions: the first for up to a 14-day supply to be filled at a participating retail pharmacy; the second for the balance, up to a 90-day supply, to be filled through the mail service pharmacy. The co-payment is applied to each covered mail order prescription charge. You may order your mail order prescription in one of the following ways:

- **By fax from your doctor -** Give your member ID number to your doctor and have your doctor call 888-327-9791 to obtain fax instructions.
- **By Mail -** Mail your prescription and required co-payment along with an order form in the envelope provided.

REFILLS

You may order your mail order prescription refills in one of the following ways:

- **On the Internet** www.express-scripts.com
- **By Phone** Call 800-818-6632. Have your member ID, prescription numbers, and credit card ready.

VERIFYING COVERAGE OF YOUR MEDICATION

You may verify coverage of your medication in one of the following ways:

- **On the Internet** www.expressscripts.com
- **By Phone** Call 800-818-6632. Have your member ID ready

DELIVERY OF YOUR MEDICATION

Prescription orders receive prompt attention and, after processing, are usually sent to you in about a week. Your enclosed medication will include instructions for refills, if applicable. Your package may also include information about the purpose of the medication, correct dosages, and other important details.

PRIOR AUTHORIZATION

Your prescription drug program provides coverage for some drugs only if they are prescribed for certain uses. For this reason, some medications must receive prior authorization before they can be covered under your benefit plan. If you need one of these medications (which are covered under the plan for specific conditions), your physician should call **Express Scripts** at **800-458-8001** to request prior authorization.

APPEAL PROCESS

When a request for a medication requiring prior approval is denied, you and / or your prescribing physician have the opportunity to appeal the decision. The physician must provide the Managed Prior Authorization Unit with additional information required to support the use of the drug for the patient. The **Express Scripts** Managed Prior Authorization pharmacist evaluates the information to determine if the drug use is medically appropriate. The patient and physician are advised of the appeal decision. If approval is granted, benefits are authorized for the proposed drug therapy. If the drug is deemed medically inappropriate, the request for the appeal is denied. You and/or the physician then have the opportunity to appeal the decision using the Plan's second-level claim appeal procedures.

MEMBER SERVICES

If you have questions you may call **Express Scripts Member Services** 24 hours a day, seven days a week. Call toll-free **800-818-6632**. If necessary, a registered pharmacist is available for emergency consultations.

EXPRESS SCRIPTS ON THE INTERNET

Visit the **Express Scripts** website (www.expressscripts.com) for patient education and medication safety tips. You can also obtain up to 18 months history of mail-order pharmacy service and 12 months of retail prescription history. In addition, you can use their automated pharmacy locator, order mail-order refills, and check the status of your mail-order prescriptions.

Jordan School District Prescription Drug Benefit Program is administered by Express Scripts.

Getting the Most Out of Your - Medical Plan

COMMON QUESTIONS AND ANSWERS

What is a deductible?
A deductible is an annual first dollar out-of-pocket amount that needs to be satisfied. Once the amount is satisfied, contracted benefits are paid at plan reimbursement levels; non-contracted benefits will be subject to a reduction or denial of benefits. Once three members of your family have satisfied his / her deductible for the plan year, no other member is required to meet the plan year deductible. For example, the Traditional Plan deductible for a network provider benefit is $500 per plan year up to three family members ($1,500). Please Note that the deductible does apply toward the coinsurance maximum.

What is a Co-payment?
A Co-payment is a fixed dollar amount that applies to select services. Co-payments are due to your provider at the time you or a family member receives services. For example, when you receive services from a contracted provider for an office visit, your co-payment for a Primary Care Provider is $25 on the Value Plan or $30 on Traditional Plan. Your co-payment for a Specialists is $35 on Value Plan or $40 on Traditional Plan for each visit. Co-payments do not apply toward satisfying your deductible.

What is coinsurance?
Coinsurance is the percentage amount you owe once the health benefits plan has reimbursed at its percentage payment level for a covered service. For example, after the benefits plan has paid 80% for services received from a network provider, you are responsible for the 20% coinsurance amount.

What is my coinsurance maximum?
Jordan School District's health benefits plan is designed to protect you and your family from financial devastation should you experience catastrophic medical expenses. An annual coinsurance maximum acts as a financial ceiling for your out-of-pocket medical expenses. What that means is that in each plan year, your maximum out of pocket for coinsurance and co-pay expenses for one member on the Traditional Plan, is $5,000 and $10,000 for two family members who have received services from network providers. Once those amounts have been reached, your benefit plan pays 100% for eligible health benefits. Expenses over and above the eligible amounts do not apply to these maximums. Please keep in mind that non-contracted providers can bill you over and above the eligible amounts for services.

CONTRACTED vs. NON-CONTRACTED – The Choice is Yours

NETWORK BENEFITS

When you choose a contracted provider for your health care, the PPO plan will pay a greater percentage of your medical bills. When you use a network provider, there are no claim forms. Your PPO provider will file the claims directly with the claims administrator. Pre-notification and Pre-authorization is the responsibility of the member.

NON-CONTRACTED BENEFITS

If you choose to receive care from a non-contracted provider, the PPO plan will pay a lower percentage of your medical bills requiring you to pay the greater portion of out-of-pocket expense. Your non-contracted provider may also require you to pay the balance billed besides your coinsurance. Pre-authorization is required for any hospital admission.

ASK YOUR DOCTOR QUESTIONS

Amazingly, many patients do not ask their doctor basic questions. How much will my treatment cost? Can I be treated another way? What are the risks? What are the side effects?

Having a dialogue with your physician can help you better understand how his or her care decisions affect your health plan costs. It will also help your doctor get to know you better and consequently prescribe treatment that is more effective.

MAKE CAREFUL DECISIONS ABOUT PRESCRIPTION DRUGS

Many people incorrectly think there is a difference between generic and brand name prescriptions. Actually, with few exceptions, a generic drug is the same as a brand name drug. The next time your doctor writes you a prescription, ask if a generic equivalent is available.

In addition to generic drugs being less expensive than brand name drugs, you should also know that in most cases less expensive and more effective alternatives to some well-known drugs exist. Because of the surge in direct-to-consumer marketing of prescription drugs, patients become more familiar with certain drugs and often believe that these high profile, high cost drugs are automatically the best option for treating their condition.

HERE ARE SOME THINGS THAT YOU CAN DO TO KEEP HEALTH CARE COSTS DOWN:

- Take care of yourself first. Live an active and healthy lifestyle. Watch your weight.
- Eat healthy foods. Exercise regularly. Get plenty of rest.
- When you need care, ask questions. Read and study. Participate in the process.
- If you need to take a medication, ask your doctor for a sample prior to filling the prescription to make sure it will work for you. Ask for generic substitutions.
- Use the mail order program for maintenance medications.
- If you have a serious medical condition, contact the case manager of your plan to help you oversee your care.
- Remember, you have access to an Employee Assistance Program when you need to talk with someone in strictest confidence regarding a family or work related problem. Each member of your family is eligible to receive unlimited telephonic counseling sessions each year.

Needless to say, everyone is concerned about rising health care costs. However, when you or family members are sick or injured, it's the financial protection we all need.

Employee Assistance Program (EAP) - Blomquist Hale

There is no more valuable asset to Jordan School District than you, the employee. That is one reason why we provide you and your family access to an Employee Assistance Program. The Jordan School District Employee Assistance Program provides you with confidential and professional resources designed to help individuals cope with a variety of personal and job-related issues.

Being healthy goes beyond physical exercise and eating right. Emotional wellness, strong personal relationships, and positive attitudes are important building blocks of health that need to be maintained. Yet, there are times when we may feel unable to resolve all the decisions, personal problems, family issues or job difficulties we face. In those times, it's a relief to have somewhere to turn. The Blomquist Hale Employee Assistance Program fills this need.

WHAT IS AN EAP?

An Employee Assistance Program (EAP) provides short-term, confidential counseling for you and your household at no out-of-pocket expense to you.

IS IT CONFIDENTIAL?

Yes, all discussions between you and the EAP counselor are confidential. Personal information is never shared with anyone, including your employer, at any time without your direct knowledge and approval (exceptions are made only in cases governed by law to protect individuals threatened by violence).

WHY USE AN EAP?

At times, we can all use help with a personal problem or issue that is interfering with our life or work. Most people experience personal or family challenges in the course of their lives. Seeking help early minimizes the chance of problems escalating and requiring more extensive and expensive services. Often a few visits with a counselor are all that are needed to gain perspective on a problem and regain a sense of control in one's life. An EAP counselor can assist with issues related to:

- Stress / Anxiety
- Parenting
- Aging
- Grief
- Finances
- Senior Care
- Abuse
- Alcohol / Drugs
- Marriage
- Depression
- Relationships
- Legal
- Family

The EAP counselors are available around the clock for emergency and crisis situations.

Call for confidential assistance with personal or work issues. Crisis services are available 24 hours a day, seven days a week at:
801-262-9619 or **800-926-9619.**

The EAP is your gateway into the mental health portion of your medical plan.
All mental health services must be pre-approved through Blomquist Hale.

Getting the Most from Your - Voluntary Dental Plan

Jordan School District is happy to make available three different dental carriers for your voluntary dental benefit. Employees and dependents may receive services through Dental Select, EMI Health, or Total Dental Administrators (TDA). There are several benefit options available within each network. Below is a brief explanation of each network, followed by a side-by-side comparison of each of the available dental plans on page 21.

Note: Changes in dental coverage may only be made during an open enrollment period or if you have a qualifying event (See page 4).

Voluntary Dental Plan - Dental Select

DISCOUNT PLAN (Silver)

With this plan, you don't have to worry about waiting periods, deductibles, or annual maximums. You receive the services you want, when you want them. You and your family can now receive quality care at reduced prices, saving you up to 90% for preventive. Plan features include:

- Very Low Rates
- Large Quality Network Of General Dentists
- No Deductibles
- No Waiting Periods
- No Age Limits
- No Annual Maximums
- Over 900 Contracted Providers
- Receive Dental Discounts The Day You Enroll
- Includes Adult And Child Orthodontics (Discount)
- Includes Teeth Bleaching And Veneers (Discount)
- Fee For Service Discount Program, Not An Insured Product

THE CO-PAY GOLD PLAN

The Co-pay Gold Plan makes dental insurance easy. There are no annual maximums to track. You know your Co-payment before you even schedule your appointment. For quality care, excellent benefits, and low Co-payments, the Co-pay Gold Plan is a great option. Plan features include:

- No Waiting Periods
- No Deductible
- No Annual Maximum
- Large, Quality Network Of Dentists
- Fixed Low Co-payments
- Over 1,500 Contracted Providers
- Covers Preventive Care At 100% (In Network)
- Includes Adult And Child Orthodontics (Discount)
- Includes Discount On Teeth Bleaching & Veneers

Note: In-Network General Dentists – Providers accept combination of co-pay and insurance payment. In-Network Specialists-Member receives 20% off the Specialists fee for covered services. Pediatric Specialists In-Network-refer to co-pay. Out of Network-No benefit.

PPO INDEMNITY PLAN (Platinum)

Choice is key to the PPO Indemnity Plan. You can choose any dentist, but have the advantage of out-of-pocket savings when you visit any Platinum in-network provider. Plan features include:

- Excellent Benefits
- Freedom To Choose Any Dentist
- Includes Child Orthodontic Benefit And Adult Orthodontic Discount (In-Network)
- Lower Out-Of-Pocket Costs When Receiving Care From Any Of Over 2,000 Platinum Network Providers

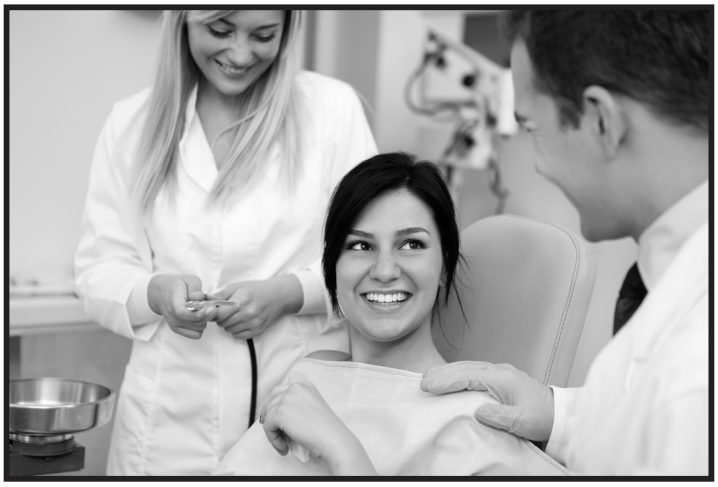
Note: In-Network General Dentist & Specialist - all payments made by the plan are based on the Platinum fee schedule. In-Network General Dentists accept the Platinum fee schedule as payment in full. For services from all out-of-Network Dentists, you are responsible for charges exceeding R&C (Reasonable & Customary Fees).

In-Network Specialist – Plan payment is based on the General Dentist fees. You are responsible for the difference between the plan payment and the discounted Specialist's fee. For services from all Out-of-Network Specialists, you are responsible for charges exceeding the plan payment.

* Please visit our website www.dentalselect.com for a current listing of providers.

Voluntary Dental Plan - EMI Health

Our plans make dental insurance easy and convenient. You don't have to worry about deductibles, preexisting conditions, or waiting periods. Also, you have the convenience of having over 2,100 participating dental providers in our **Premier Network**. Best of all, you know your Co-payments before you even schedule your appointment so you aren't surprised at the dentist's office. Our comprehensive plans enable you to receive high quality care while enjoying the following features and benefits:



FEATURES

- No deductible
- No preexisting condition waiting period
- Low Co-payments
- Access to over 2,100 participating providers statewide
- Plan year maximum of $1,500 per person
- Child and adult orthodontic discount

PREVENTIVE AND DIAGNOSTIC BENEFITS

- Oral examinations
- X-rays - Full mouth, supplementary bitewings, supplementary periapical
- Space maintainers for children up to the 16th birthday
- Sealants for children up to the 16th birthday
- Cleaning and scaling teeth
- Application of fluoride in conjunction with cleaning up to the 16th birthday

BASIC BENEFITS

- Extractions and other oral surgery for extractions of erupted teeth
- Treatment of gum and mouth tissue disease
- Restoration of decayed teeth with amalgam, synthetics, or plastic

MAJOR BENEFITS

- Crowns
- Initial installation of a removable or fixed partial or complete denture
- Laboratory reline of denture
- Replacement of missing teeth with complete or partial dentures or fixed bridges
- Replacement of a denture that is no longer serviceable
- Endodontic treatment, including root canal therapy

* Please visit our website **www.emihealth.com** for a current listing of our dental providers

Voluntary Dental Plan - Total Dental Administrators, Inc. (TDA)

DENTAL ECLIPSE PLAN

This plan is a discount plan which gives you significant savings on quality dental health care. TDA has contracted with established members of the dental profession to deliver quality dental care services in accordance with the Schedule of Covered Services and Co-payments. Plan features include:

- Large Provider Network (Over 1,000 providers to choose from)
- No Annual Maximums or Deductibles
- Preventative / Diagnostic Service - Up to 75% off
- Significantly Reduced Fees for All Other Services
- Cosmetic Dentistry Covered
- Child Orthodontics Discount
- Adult Orthodontics Discount
- Covers Pre-existing Conditions
- No Waiting Periods

TOTAL CARE EXECUTIVE PLUS DHMO (Formerly Total Care Plan TC6000-DHMO)

This plan is designed to give you significant savings on quality health care. TDA has contracted with established members of the dental profession to deliver quality dental care services in accordance with the Schedule of Covered Services and Co-Payments. Specialists and General Dentists honor Co-payments. You will need to select a Primary Care Dentist. Plan features include:

- Pre-Existing Conditions Covered
- No Maximums or Deductibles
- Rich Specialty Care Benefit Performed by Specialists
- Child Orthodontics Discount
- Adult Orthodontics Discount
- Several Cosmetic Procedures Covered
- Preventative Care at 100% after $10 Co-pay

TDA PPO PLAN

This plan is designed to give you the freedom to use the dentist of your choice. There are no network restrictions of any kind. Plan features include:

- Employees can receive services from any dentist they choose
- High Yearly Maximum
- Lifetime Deductible per Family Member
- Preventative and Basic Services at 100% coverage

* Please visit our website **www.tdadental.com** for a current listing of providers.

Voluntary Dental Plan Comparison - Dental Select, EMI, & TDA

Dental Plan Options	**Dental Select ****					**EMI Health**		**Total Dental Administrators** (TDA)		
	Silver Discount Plan	**Co-pay Gold Plan**		**Platinum PPO Indemnity Plan**		**OPTION 1** Premier Co-pay	**OPTION 2** Premier Co-pay	**Dental Eclipse**	**Total Care Executive Plus DHMO**	**PPO**
	Discount	**Network**	**Non Network**	**Network**	**Non Network**	**PPO**	**Discount**	**Discount**	**DHMO**	**Indemnity ***
Deductible	$0	$0	$0	$50 / $150	$50 / $150	$0	$0	$0	$0	$100 Per Person (Lifetime)
Deductible Waived for Preventive Care	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Preventive (Routine Exams, Cleanings **§**, Topical Fluoride, X-Rays)	Up to 90% Fee Reduction	100%	See Out of Network Payment	80%	80% *	Covered 100%	Refer to Co-pay [1] Schedule	Refer to Fee Schedule Approximately 75% Discount	Covered 100% after $10 Co-pay	100% AD
Basic (Fillings, Extractions, Oral Surgery)	Up to 60% Fee Reduction	Fixed Co-pays; refer to schedule of Co-payments [1]		80% AD 3 Month Waiting Period	60% AD * 3 Month Waiting Period	Refer to Co-pay [1] Schedule	Refer to Co-pay [1] Schedule	Refer to Fee Schedule Approximately 40% Discount	Refer to Fee Schedule Approximately 80% Discount	100% AD
Major (Crowns, Bridges, Dentures, Periodontics, Endodontics)	Up to 50% Fee Reduction	Fixed Co-pays; refer to schedule of Co-payments [1]		50% AD 12 Month Waiting Period	40% AD * 12 Month Waiting Period	Refer to Co-pay [1] Schedule	Refer to Co-pay [1] Schedule	Refer to Fee Schedule Approximately 30% Discount	Refer to Fee Schedule Approximately 55% Discount	50% AD; 12 Months Waiting Period Without Prior Coverage
Annual Maximum	None	None	None	$1,000	$1,000	$1,500	$1,500	None	None	$1,200
Ortho Deductible	N / A	N / A	N / A	N / A	N / A	N / A	N / A	N / A	N / A	N / A
Orthodontics (Children Under 19)	20% Discount	20% Discount	No Coverage	50% 12 Month Waiting Period	50% 12 Month Waiting Period	25% Discount	25% Discount	15-25% Discount	15-25% Discount	50% AD; 12 Months Waiting Period Without Prior Coverage
Orthodontics (Adult)	20% Discount	20% Discount	No Coverage	20% Discount No Waiting Period No Max.	No Coverage	25% Discount	25% Discount	15-25% Discount	15-25% Discount	15-25% Discount In Network
Orthodontics Lifetime Maximum	None	None	None	$1,000 *(Child)*	$1,000 (*Child*)	None	None	None	None	$1,000

AD - After Deductible

PCY - Per Contract Year

* For service from all Non-Network Dentists, you are responsible for charges exceeding Reasonable and Customary fees for the state of Utah.

** Refer to notes located on page 18 of the Plan Comparison

§ Customer is allowed 2 PCY

[1] Co-pays are valid through December 31, 2016

Monthly Rates (12 Pay)	**Dental Select ****			**EMI Health**		**Total Dental Administrators** (TDA)		
Plan	**Silver Discount Plan**	**Co-pay Gold Plan**	**Platinum PPO Indemnity Plan**	**OPTION 1** Premier Co-pay	**OPTION 2** Premier Co-pay	**Dental Eclipse**	**Total Care Executive Plus DHMO**	**PPO**
Employee	$1.00	$18.92	$34.82	$26.10	$6.70	$1.00	$13.86	$38.44
Two Party	$3.00	$34.40	$63.43	$47.60	$14.50	$2.00	$27.72	$80.80
Family	$4.00	$53.85	$99.33	$98.70	$23.20	$2.00	$45.83	$117.24

Voluntary Vision Plan - Opticare

Jordan School District has made available a voluntary vision plan for the upcoming plan year through Opticare of Utah. Opticare is committed to making sure you are pleased with your experience and find solid value in the benefits. The following are summaries of services offered to assist you in making your selection. Changes in vision coverage may only be made during an open enrollment period.

OPTICARE PLANS	10-120 PLAN			10-70 PLAN		
	SELECT NETWORK	BROAD NETWORK	OUT OF NETWORK	SELECT NETWORK	BROAD NETWORK	OUT OF NETWORK
Eye Exam [1]						
Eyeglass / Contact Exam	$10 Co-pay	$15 Co-pay	$50 Allowance	$10 Co-pay	$20 Co-pay	$40 Allowance
Dilation, Contact Fitting	Covered 100%	Retail	Included Above †	Covered 100%	Retail	Included Above †
Lenses [1]						
Plastic Single Vision / Bifocal / Trifocal	Covered 100%	$10 Co-pay	$100 Allowance for Lenses, Options and Coatings †	Covered 100%	$20 Co-pay	$75 Allowance for Lenses, Options and Coatings †
Progressive Lenses (Standard No-Line)	$30 Co-pay	$50 Co-pay		$50 Co-pay	$75 Co-pay	
Premium Progressive Options	20% Discount	20% Discount		20% Discount	20% Discount	
Glass Lenses	15% Discount	15% Discount		15% Discount	15% Discount	
Polycarbonate	$40 Co-pay	25% Discount		$40 Co-pay	25% Discount	
High Index	$80 Co-pay	25% Discount		$80 Co-pay	25% Discount	
Coatings						
Scratch Resistant Coating	Covered 100%	$10 Co-pay		Covered 100%	$10 Co-pay	
Ultraviolet Filter	Covered 100%	$10 Co-pay		Covered 100%	$10 Co-pay	
Other Options: Anti-Reflective, Edge Polish, Tints, Mirrors, etc.	Up to 25% Discount	Up to 25% Discount		Up to 25% Discount	Up to 25% Discount	
Frames [1]						
Allowance based on retail pricing	$120 Allowance	$100 Allowance	$100 Allowance †	$70 Allowance	$60 Allowance	$50 Allowance †
Back-Up or Multiple Pairs *	Up to 50% Discount	Up to 25% Discount		Up to 50% Discount	Up to 25% Discount	
Contacts (In Lieu of Glasses) [1]						
Benefit Allowance	$120 Allowance	$100 Allowance	$100 Allowance †	$70 Allowance	$60 Allowance	$50 Allowance †
Additional Contact Purchases:						
Conventional **	Up to 20% off	Retail		Up to 20% off	Retail	
Disposable **	Up to 10% off	Retail		Up to 10% off	Retail	
Monthly Rates (12 Pay)	10-120 PLAN			10-70 PLAN		
Employee	$6.38			$4.31		
Two Party	$10.50			$6.73		
Family	$19.85			$13.54		

Refractive Surgery (LASIK) **- Discount $250 off per eye -** LASIK services are not an insured benefit - this is a discount only. All pre & post operative care is provided by Standard Optical Only and is based on Standard Optical retail fees.

Discounts - Any item listed as a discount in the benefit outline is a merchandise discount only and not an insured benefit. Providers may offer additional discounts.

* 50% Discount varies by provider. Refer to provider for details.

** Must purchase full year supply to receive discounts on select brands. See provider for details.

† Out of Network - Out of Network benefit may not be combined with promotional items. Online purchases at approved providers only.

For a complete description of benefits, limitations, and exclusions, consult your Summary Plan Description available from Insurance Office.
You may contact Opticare of Utah online www.opticareofutah.com, call 1-800-363-0950 or email service@opticareofutah.com.

Finding a Vision Provider

Over 150 providers located in the state of Utah and over 20,000 nationwide! To find providers in your area please visit: www.opticareofutah.com or call 800-363-0950.

INDEPENDENT OPTOMETRY NETWORK

Visionworks

SHOPKO®

Standard Optical

AMERICA'S BEST CONTACTS & EYEGLASSES

FIRSTLOOK Vision Network

Register and Print Member ID Cards Online

1. **Access the member portal -** Go to **www.opticareofutah.com**
   a. Click the "**MEMBERS**" link in the left navigation
   b. Click the "**MANAGE YOUR ACCOUNT**" banner

2. **Register as a new user -** ***If you have already registered, skip to step 3. Or have your gateway registration code ready.*** *(This is your subscriber ID number that can be found on your insurance card plus "01" to identify as the employee. If you do not have or know your subscriber ID # Please contact us at - 1-800-363-0950)*
   a. Click on "**Click here to register**"
   b. Click the drop down menu, select "**Member**"
   c. Fill out the form with the necessary details, then click the "**Submit**" button

3. **Obtain ID Cards**
   a. Log into your account
   b. Hover over the menu icon, select "**Print Temp. ID Card**"
   c. Print Temporary ID Card. Scroll down and click "**Print**"

Life Insurance Benefits - Cigna

BASIC AND VOLUNTARY LIFE INSURANCE

Jordan School District provides Basic Life, Accidental Death and Dismemberment (AD&D) and Dependent Life insurance at no cost to you. Supplemental Life and Accidental Death and Dismemberment (AD&D) insurance is offered through the group on a voluntary basis, and is at your cost.

BASIC LIFE / AD&D INSURANCE - 100% Employer Paid

Basic life insurance provides a death benefit payable to the insured person's named beneficiary if death occurs while you, the employee, are insured under this plan. All active, eligible employees working a minimum of 20 hours receive a life benefit of $50,000. All eligible employees will also be covered for an additional $50,000 for Accidental Death & Dismemberment.

The basic life insurance provided by Jordan School District also includes coverage for all eligible active employee's spouse and children. The District provides $2,000 of life insurance coverage on your spouse and each dependent child from birth to age 26. Your dependents are eligible if less than 26 years of age and they qualify as dependents under IRS Code, which states that they rely upon you for more than 50% of their support. (You must have legal guardianship and/or be a legal spouse to qualify as a dependent under IRS Code.)

VOLUNTARY TERM LIFE / AD&D INSURANCE - 100% Employee Paid

As an eligible active employee, you have the opportunity to purchase Voluntary Life Insurance. This insurance is not sponsored or paid by the District, but it is available at affordable group rates. Voluntary Group Life Insurance is available in increments of $10,000, up to the lesser of $500,000 or 5 times your annual earnings. If you enroll when you are first eligible, you may purchase up to $150,000 of insurance without medical underwriting. Retirees are not eligible for the voluntary group plan but can enroll in an individual plan if already enrolled at the time of retirement. Contact the District Insurance Office for further information regarding this program.

If you elect voluntary term life for yourself, you may also purchase additional life insurance for your spouse and children. Spouse coverage is available in increments of $5,000 up to the lesser of 50% of your election or $250,000. If you enroll your spouse when he / she is initially eligible and you are enrolled for at least $100,000, you may elect spouse coverage up to $50,000 without medical underwriting.

Dependent Coverage is available from live birth to age 26 **for children who are financially dependent upon you**. You may purchase $2,500, $5,000, $7,500 or $10,000 for your child(ren). This covers all eligible children without medical underwriting.

If you and your spouse do not enroll when you are first eligible, you may apply, but you will be subject to medical examination, medical underwriting, and you may be denied coverage. Evidence of Insurability Forms are available at the District Insurance Office.

A Voluntary Accidental Death and Dismemberment policy is available to you. All amounts are available without medical underwriting. You are eligible for coverage, in $10,000 increments, up to a maximum of $500,000 (amount elected over $250,000 is subject to 10 × annual salary). You may elect Employee Only, or Family coverage. If you elect Family coverage, your family benefit is based on the following criteria at time of accident:

- 60% for spouse if no children;
- 50% for spouse if eligible children;
- 10% for children if eligible spouse; and 15% for children if no spouse

The maximum coverages are $300,000 for your spouse and $25,000 for your child(ren).

For coverage for your spouse and/or children to be effective, they must not be hospitalized, confined at home, under the care of a doctor, or unable to perform the normal daily activities of a person of the same age or sex. See the District Insurance Office for information regarding conversion / portability eligibility. You, your spouse, and your dependents are NOT covered until your application(s) have been approved by the life insurance carrier.

How Much Does Voluntary Term Life Insurance Cost?

Follow this worksheet to determine your monthly costs for Voluntary Term Life and AD&D insurance.

VOLUNTARY LIFE
Employee & Spouse
(12 Month Rates)

AGE	Per $1,000
Under 30	$0.06
30 - 34	$0.06
35 - 39	$0.08
40 - 44	$0.10
45 - 49	$0.16
50 - 54	$0.22
55 - 59	$0.37
60 - 64	$0.44
65 - 69	$0.72
70 - 74	$1.35
75 - 79	$2.35

(Initial rates based on age as of effective date of your coverage. Rates will change based on the above age schedule.)

VOLUNTARY LIFE
Child(ren) (12 Month Rates)
(Choose one of the following)

COVERAGE	Per $1,000
$2,500	$0.50
$5,000	$1.00
$7,500	$1.50
$10,000	$2.00

STEPS TO DETERMINE YOUR MONTHLY COST OF LIFE INSURANCE

1. Select your desired amount of coverage: $ _____

2. Locate your age from the table and note the corresponding rate. The 12 month rate per $1,000 for my age range is:

   $ _____

3. Divide your desired amount of coverage by $1,000. Then multiply the result by the rate factor for your age. The answer is your monthly cost of insurance.

   $_____ ÷ $1,000 = _____
   (Employee Coverage Amount)

   × _____
   (Rate Factor)

   = $ _____
   (Total Monthly Cost of Insurance for Employee)

   Example: $100,000 (Coverage) ÷ $1,000 = $100 × 0.080 (Rate Age 35) = $8.00 (Per Month)

4. Repeat this process for your desired amount of coverage for your spouse.

   $_____ ÷ $1,000 = _____
   (Spouse Coverage Amount)

   × _____
   (Rate Factor)

   = $ _____
   (Total Monthly Cost of Insurance for Spouse)

5. Select the amount of voluntary life insurance you would desire for your dependents (you may choose among $2,500, $5,000, $7,500, or $10,000 of coverage). **Then look to see the corresponding monthly rate.** (Please note that this is a flat rate that is not dependent upon the number of children covered.)

   $_____ = _____
   (Desired coverage amount) (Monthly Cost of Insurance)

VOLUNTARY AD&D
(12 Month Rates)
(Choose one of the following)

COVERAGE	Per $1,000
Employee (EE)	$0.025
EE + Family	$0.038

STEPS TO DETERMINE YOUR MONTHLY COST OF LIFE INSURANCE

1. Select your desired amount of coverage: $ _____

2. Determine whether you would like coverage only for yourself, or if you would like to have coverage for yourself and your family. Note the corresponding rate. The 12 month rate per $1,000 for my choice is:

   $ _____

3. Divide your desired amount of coverage by $1,000. Then multiply the result by the rate factor for your age. The answer is your monthly cost of insurance.

   $_____ ÷ $1,000 = _____
   (Desired coverage amount)

   × _____
   (Rate Factor)

   = $ _____
   (Total Monthly Cost of AD&D for Employee)

Long Term Disability Benefits - Cigna

Long Term Disability coverage replaces a percentage of your income on a monthly basis in the event you are unable to work due to an accident or illness. Jordan School District pays the entire premium for Long Term Disability Insurance. If approved, the coverage guarantees income replacement up to 66 2/3 percent of gross monthly earnings to a maximum of $5,000 per month for up to two years or longer if determined to be unable to work at any profession as defined in the contract. There is a 180-day waiting period after the disabling event, before benefits can be received.

DESCRIPTION OF LONG TERM DISABILITY BENEFITS	
Definition of Disability	Unable to perform your occupational duties and 20% earnings loss.
Eligible Employees	Those employees who are regularly working at least 20 hours per week.
Employer Premium Contribution	Jordan School District pays 100% of the premium.
Benefit Percentage	66 2/3% of gross monthly earnings.
Maximum Monthly Benefit	$5,000
Minimum Monthly Benefit	$100 or 10% per month whichever is greater.
Benefit Waiting Period	180 days
Maximum Benefit Period	To age 65 or according to the schedule in your certificate.
Own Occupation Period	The first 24 months that disability benefits are payable. The period of time that an insured employee is eligible for LTD benefit payments under the policy if he / she is unable to perform the duties of his/her own occupation due to a disability.
Social Security Offset	Primary and Family
Deductible Income	Worker's Comp., Retirement, Social Security and other income (Please see your Certificate of Coverage).
Survivor Benefit	A lump sum equal to 3 times your gross monthly benefit.
Limitations	**Mental and Nervous:** 24 months **Pre-existing Condition:** Benefits are not payable for the first 12 months of coverage for any Injury or Sickness from the 3 months before coverage began.
Exclusions	Act of war, self-inflicted injury, attempted suicide, violent or criminal conduct, or incarceration.

The application process begins with a telephone call, which should take place one month after the last day actively at work. A GROUP LONG TERM DISABILITY CLAIM FORM must be completed for every claim. The employee, the employee's attending physician and the policyholder should complete their applicable portion of the form within three months of the last day actively at work.

The employee should apply for Social Security Disability benefits promptly, as Cigna will estimate the amount of these benefits after five full months of disability. A copy of the "Social Security Award" notice should be forwarded to the claims office.

Please contact the District Insurance Office to obtain information regarding the Long Term Disability policy.

Note: This represents highlights for information purposes only. Please refer to your certificate for complete details. The Master Contract located under Insurance Services on Jordan School District's website at www.jordandistrict.org contains all of the controlling provisions of this coverage.

Worksite Products - Aflac

ACCIDENT INSURANCE

Accidents are unexpected. How you care for them shouldn't be.

The following is an example of the premium rates per month for off-the-job Aflac **Accident** coverage:			
Individual	Couple	One-Parent Family	Two-Parent Family
$12.61	$18.46	$25.87	$31.72

Benefits include:

- Cash paid to you for the care and treatment of a covered accidental injury.
- Benefits are paid regardless of any other insurance you have with other insurance companies.
- Your coverage is portable; as long as your employer continues to offer these products at Jordan School District, you can take the coverage with you even if you change jobs.

CRITICAL ILLNESS INSURANCE

No one plans on it. But statistics show you or someone you love may suffer from a heart attack, stroke, cancer or some form of critical illness in your lifetime. In fact, according to the American Cancer Society, one in every two men now living and one in every three women now living will develop some form of cancer. Critical Illness insurance from Aflac can help provide the protection you need when you need it most.

The following gives examples of the non-tobacco premium rates per month for Aflac **Critical Illness** coverage at $10,000 for the insured and $5,000 for the spouse:				
AGE	Individual	Couple	One-Parent Family	Two-Parent Family
18 - 29	$5.45	$9.05	$5.45	$9.05
30 - 39	$8.55	$13.70	$8.55	$13.70
40 - 49	$15.55	$24.20	$15.55	$24.20
50 - 59	$26.68	$40.90	$26.68	$40.90
60 - 69	$41.75	$63.50	$41.75	$63.50

Benefits include:

- Cash paid to you to assist with some of the direct and indirect costs related to critical illness diagnosis and treatment.
- Helps fill in the gaps for deductibles and coinsurance and complements the health insurance you may already have in place.
- Dependent children are covered at no additional cost.
- Your coverage is portable; as long as your employer continues to offer these products at Jordan School District, you can take the coverage with you if you change jobs or retire.

CANCER INSURANCE

Despite the best efforts of doctors, researchers, and countless organizations, Cancer remains a concern for many individuals and families. People from all walks of life are at risk, regardless of age, gender, or ethnic background. Aflac's cancer insurance helps you focus on getting well instead of being distracted by the stress and cost of medical and personal bills.

The following is an example of the premium rates per month for Aflac **Cancer** coverage:			
Individual	Couple	One-Parent Family	Two-Parent Family
$31.72	$53.95	$31.72	$53.95

Benefits include:

- Cash paid to you for the care and treatment of Cancer.
- Benefits are paid regardless of any other insurance you have with other insurance companies.
- Your coverage is portable; as long as your employer continues to offer these products at Jordan School District, you can take the coverage with you even if you change jobs.

HOSPITAL ADVANTAGE

Every year millions of people are admitted to a hospital. Aflac can help with the out of pocket expenses, charges or other financial challenges through the benefits provided on its Hospital Intensive Care Protection policy.

The following is an example of the premium rates per month for Aflac **Hospital Advantage** coverage:			
Individual	Couple	One-Parent Family	Two-Parent Family
$18.72	$26.52	$24.96	$29.77

Benefits cover hospital stays and ER visits. Optional riders are available to cover physician visits, daily confinement, ICU and surgical procedures.

Benefits include:

- Pays $500 per Hospital Confinement
- $50 per day in a rehabilitation facility
- $50 per ER visit (2× per year)
- Cash benefits are paid directly to policyholders

Aflac Representative: Lee Harmer

Phone: 801-716-0084 ***Claims:*** 801-942-0143 ***Email Address:*** karen_harmer@us.aflac.com

Checklist and Reminders

CHECKLIST

☐ **Review "Enrollment Guide"** and make benefit elections.

☐ **Complete "Employee Benefit Change Form"** ONLY if you are making changes **or** the **"Employee Benefit Election Form"** if you are enrolling for the first time.

☐ **Current Employees - Return "Employee Benefit Change Form"** to the District Insurance Office prior to July 31, 2016.

☐ **New Hires or Newly Benefit Eligible Employees – Return "Employee Benefit Election Form"** to the District Insurance Office within 30 days of contract start date or benefit eligibility date. If you miss this deadline, you will not be able to enroll until the next open enrollment period, or if you have a qualifying event.

☐ **Current Employees - Complete the Flexible Spending election form** and return to the District Insurance Office prior to July 31, 2016 . New Hires or Newly Benefit Eligible Employees - Return Flexible Spending election form and return to the District Insurance Office within 30 days of contract start date or benefit eligibility date. Forms may be mailed, faxed, emailed or hand delivered to the JSD Insurance Office.

REMINDERS

- **After the enrollment deadline**, benefit elections cannot be changed until the next open enrollment period unless a qualifying event occurs.
- **Licensed New Hires -** you will not receive insurance benefits unless your Benefits Election form is completed and received in the District Insurance Department within 30 days of your contract start date.
- **Classified and Administrative New Hires -** you will not receive insurance benefits unless your Benefits Election form is completed and received in the District Insurance Department within 30 days of your contract start date.

Your Notes

Benefits 2016 - 2017

Frequently Called Numbers

HEALTH INSURANCE PLANS - PEHP (Advantage, Summit Plans)
801-366-7555 or 800-765-7347 **www.pehp.org**

SECTION 125 / FLEXIBLE SPENDING ACCOUNT - PEHP
801-366-7503 or 800-753-7703 **www.pehp.org**

PRESCRIPTION SERVICES - EXPRESS SCRIPTS
800-818-6632 Mail Order Prescriptions: **www.express-scripts.com**

EMPLOYEE ASSISTANCE PROGRAM - BLOMQUIST HALE
801-262-9619 or 800-926-9619 **www.blomquisthale.com**

VOLUNTARY DENTAL INSURANCE - DENTAL SELECT, EMI HEALTH & TDA
Dental Select
801-495-3000 **www.dentalselect.com**

EMI Health
801-262-7475 **www.emihealth.com**

Total Dental Administrators
801-268-9740 **www.tdadental.com**

VOLUNTARY VISION INSURANCE - OPTICARE OF UTAH
801-869-2020 or 800-363-0950 **www.opticareofutah.com**
Email: **service@opticareofutah.com**

LIFE INSURANCE - CIGNA (Group Basic Life / AD&D, Vol. Life, Vol. AD&D)
800-732-1603 **www.cigna.com**

LONG TERM DISABILITY INSURANCE - CIGNA
800-732-1603 **www.cigna.com**

WORKSITE PRODUCTS - AFLAC
800-433-3036 **www.aflac.com**

Enrollment: **Lee Harmer**
Phone: 801-716-0084 **karen_harmer@us.aflac.com**
Claims: 801-942-0143

JORDAN SCHOOL DISTRICT INSURANCE OFFICE

Employee Last Names A - G	Employee Last Names H - S	Employee Last Names T - Z
Victoria Foy	**Jeanne Ince**	**Kathryn Brinton**
801-567-8146	801-567-8341	801-567-8255
victoria.foy@jordandistrict.org	jeanne.ince@jordandistrict.org	kathryn.brinton@jordandistrict.org

Fax: 801-567-8070