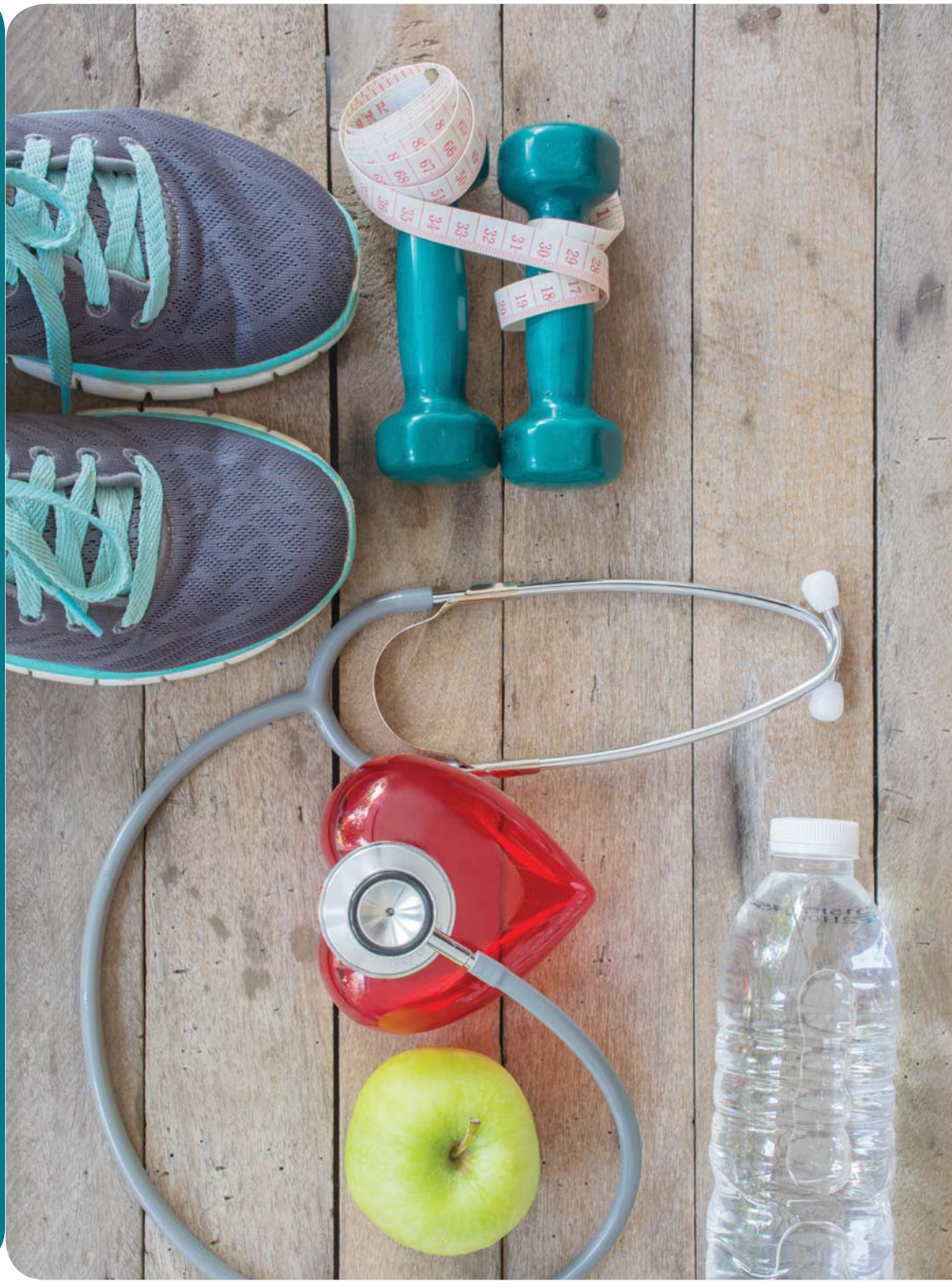
Canyons School District

2018 Employee Benefit Guide
January 1, 2018 – December 31, 2018

Mandatory Enrollment



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Open Enrollment Checklist

- ❑ **Review the booklet.** This benefit booklet includes all the plans available to you. Utilize this information to determine which plan best suits your needs.*
- ❑ **Assess upcoming life events.** Upcoming events like surgeries, weddings or births may affect your insurance choices.
- ❑ **Consider costs.** Review costs of premium, copays, deductibles and out-of-pocket maximums. Is a lower premium, higher deductible better for you, or is a higher premium, lower deductible better? Premiums are listed after each plan section throughout the booklet.
- ❑ **Enroll online.** Online benefit confirmation is **MANDATORY**. You must enroll or decline benefits between Monday, October 30, 2017, and 5:00 p.m., November 10, 2017.
- ❑ **SSN.** When enrolling, please remember to have social security numbers with you, for you and your dependents.
- ❑ **Review.** Confirm and hit "agree" on the benefit summary.

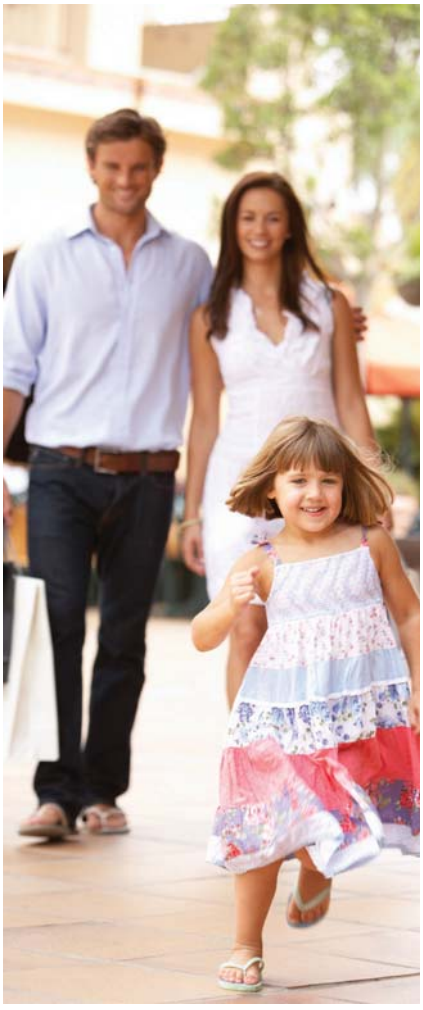
*Per Health Care Reform, a full Summary of Benefits & Coverage (SBC) is located at **https://canyonsschooldistrict.benefithub.com**

2018 MANDATORY BENEFIT CONFIRMATION

Due to Healthcare Reform requirements, all eligible employees must formally accept or decline Canyons School District medical benefits each year.

Welcome to Your 2018 Plan Year Benefit Package!

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



Benefits Overview

Canyons School District is proud to offer a comprehensive benefit package to eligible, full-time employees who work 30* hours or more per week. The complete benefits package is briefly summarized in this booklet.

Benefit Plans Offered

- Medical – Changed to PEHP
- Dental – Changed to EMI
- Vision
- Basic Life Insurance/Accidental Death and Dismemberment (AD&D) Insurance
- Voluntary Term Life/AD&D Insurance
- Long-Term Disability Insurance
- Flexible Spending Account/Dependent Care Account /Limited Flexible Savings Account (Eligibility depends on Health election and Federal Requirements)
- Health Savings Account
- Employee Assistance Program

Premiums are shown for employees with 12-month contracts. If you have a 10-month contract (September through June), your deductions will be slightly higher to adjust for no payroll deductions in July and August.

Benefits Tips

Please read all the information carefully and become familiar with your benefits. Ask questions so you can actively engage in your benefit elections. Review your benefit package with appropriate representatives and family members prior to making selections. The choices you make will remain in force during the entire plan year, January 1, 2018 – December 31, 2018, (unless there is an IRS-approved qualifying event). Please carefully choose those options that best fit your and your family's unique needs!

*If you are a contracted employee working 20 or more hours per week as of September 1, 2013, you can be grandfathered at 20 hours per week benefit eligibility. This policy is in place to benefit these employees by providing the security of insurance. Grandfathered status will sunset December 31, 2018. At which time, all part-time employees will no longer be eligible for benefits.

Summary of Benefits Coverage (SBCs) are available by request or on Canyons website, **www.canyonsdistrict.org**

Canyons School District Enrollment Guidelines

Qualifying Life Events

- Limited benefit changes are allowed due to select qualifying events. To make a change you must notify the insurance department within 30 days from the event, preferably in writing.
- Marriage or change in number of dependents
- Change in employment status of employee, spouse or dependent that causes loss of eligibility
- Change in coverage under another employer plan (including mandatory and optional change from your spouse's employer and change initiated by your spouse)
- Loss of coverage from government 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 and Medicaid entitlement or FMLA leave of absence
- Dependent satisfies (or ceases to satisfy) eligibility requirements (30-day notification)
- Divorce or legal separation (30-day notification)

Open Enrollment

Each year, Canyons School District conducts an annual Open Enrollment. 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 coverage without documenting a qualifying event. The annual open enrollment dates for 2018 are October 30, 2017 through November 10, 2017.

Dependents

A dependent is defined as your legal spouse through marriage and legal dependent children (this includes children through adoption and stepchildren through marriage). Dependent children remain eligible to age 26 for medical regardless of financial or marital status and 26 for all other lines. Handicapped children are eligible for continuous coverage when certification by PEHP has been approved.

Medical Coverage Tiers

Employee: Coverage for the employee only.

Employee + 1: Coverage for both the employee and one dependent, such as a child OR a spouse.

Family: Coverage for employee and anything above 1 dependent, such as a spouse and a child.

New Hires

When you are hired by Canyons School District to work 30* hours or more per week on a permanent basis, you are eligible for benefits and are required to complete the enrollment process within 30 days of your position start date. If you miss this deadline, you will not be able to enroll until the next open enrollment period, unless you have a qualifying event.

Certificated, Educational Support Professionals, and Administrative employees Medical, dental, vision, disability, and the basic and voluntary life plans will be effective the first day of the month following your position start date provided your online benefits election is completed within 30 days of your position start date.

Qualifying Events

When you have a qualifying event you have 30 days to notify the insurance department of the change and receive instructions on making the change in the online enrollment tool, or you will have to wait until the next Open Enrollment period. Please see the list of qualifying events on the left of this page.

*If you are a contracted employee working 20 or more hours per week as of September 1, 2013, you can be grandfathered at 20 hours per week benefit eligibility. This policy is in place to benefit these employees by providing the security of insurance. Grandfathered status will sunset December 31, 2018. At which time, all part-time employees will no longer be eligible for benefits.

30 days is the magic number. If you've had a life event (birth, marriage, divorce, death of subscriber, or an involuntary loss of coverage, which includes quitting your job) you have 30 days from the date of the event to make the changes on CSD's online tool.

Own Your Healthcare

Our health plan is counting on you.

As a self-funded plan we pay for our own claims. PEHP acts as our administrator while our health plan covers the costs. Being self-funded allows Canyons School District to maximize our healthcare dollars. While it has some risks involved, it is a proven and effective way for large groups to contain costs.*

The higher the claims, the higher the premium.

Because we are self-funded, all of us bear responsibility in the cost of our plan. We influence the cost of our premiums by the way we use the plan. If we use the insurance a lot and in expensive ways, the premium may have to go up in order to cover expenses. However, if we collectively engage in consumerism, we have the power to control our costs.

What can you do to help?

Every member of the plan shares responsibility to manage our medical costs. Because of that shared responsibility, please see the suggestions below to improve consumerism:

USE THE PROPER FACILITY FOR CARE

- **Emergency room visits:** An average in-network visit to the emergency room can cost $1,500. Each time you go to the emergency room, your cost will involve your deductible and Canyons will cover the remaining amount. Don't use the emergency room as your doctor's office.
- **Telemedicine visits:** See a doctor for $10 (after deductible on the Star plan). PEHP e care visits are available via mobile or web 24 hours a day, every day and you don't need an appointment. Use PEHP e care for fevers, ear infections, cold, flu, allergies, migraines, pinkeye, stomach pain, and much more.
- **Urgent care visits:** If you have a non-life-threatening event and can't get into your doctor's office, the best option is to visit an urgent care facility. An in-network urgent care visit costs you $35 on the Traditional Plan and $35 after you have met the deductible on the Qualified High Deductible Plan. An average in-network visit to the urgent care will cost less than the average cost of the emergency room. Keep a list of in-network urgent care facilities in your vehicle.

LIVE A HEALTHY LIFESTYLE

- **Take proper care of yourself:** Good consumerism doesn't mean ignoring proper healthcare to save money. When issues arise take care of them promptly and completely.
- **Do your preventive screenings:** Preventive screenings are covered at 100%, as long as diagnostic issues (healthcare problems) are not included in the visit. Finding medical concerns early gives you the best chance of overcoming them.
- **Create and maintain an active lifestyle:** Take good care of yourself physically each day. Exercise, eat well, drink enough water, get plenty of sleep regularly, and minimize your stress. These efforts can prevent chronic and expensive conditions.
- **Read the blurbs in this booklet:** We've scattered helpful tidbits of information throughout this booklet. The apple icon is for healthy lifestyle tips, the chalkboard signals good consumer assignments, and the books are for informative details.

Most importantly, take good care of yourself and any conditions you may have. Here's to our health plan, your good health, and our success!

*Suitable precautions have been taken to protect the financial interests of Canyons School District against catastrophic claims.

Healthcare Reform Overview

What it means to you.

Please see below for a high level overview of what has been happening in Healthcare Reform since 2010.

Guarantee Issue: The individual market changes. No one can be denied for health conditions. The group market has been guarantee issue, the change is just in the individual market.

Preexisting Waiting Periods Waived For All. Insurance carriers can't deny services for specific conditions if members let their insurance lapse for more than 63 days.

Individual Mandate: Every citizen is required to carry medical insurance. If they fail to do so, the penalty in 2018 is $695 per adult in the household or 2.5% of applicable income.

Your Medical Plans Are Administered by PEHP

PEHP offers access to Intermountain Healthcare through the Advantage Network and Non Intermountain in the Summit Network. Each of these options offers both a traditional and a qualified high-deductible health benefit plan (Star), and each provides excellent benefits for you and your dependents.

If you want to change plan design or network, this must be done during open enrollment. Please review the steps on page 8 of this booklet to ensure your choice meets your family needs.

FAQ

- **Why do we have eight separate plans?**
  Canyons School District provides eight plans so you can enroll in the plan and network that best suits your needs.
- **What are the differences between the eight plans?**
  The eight plans fall into two categories; Traditional and Qualified High Deductible. The first set of four plans is a Traditional plan design. The plan design is identical for all four Traditional plans. The only difference between the plans is the network options. If you would like an in-network only plan, you can enroll in the Base plan with either the Advantage or Summit network. If you need a plan that has out-of-network benefits, you may enroll in the Buy-Up plan with either the Advantage or Summit network.

  The second category is Qualified High Deductible plans. The plan design is identical for all four Qualified High Deductible plans. The only difference between the plans is the network options. If you would like an in-network only plan, you can enroll in the Base plan with either the Advantage or Summit network. If you need a plan that has out-of-network benefits, you may enroll in the Buy-Up plan with either the Advantage or Summit network.
- **How do I know which network I need?**
  Pages 10-11 of the Benefit Booklet list Utah hospitals and provider numbers for each network. The Advantage network plans use the Intermountain Healthcare network of hospitals.* The link to find providers and facilities is **www.pehp.org.**

  The Summit network plans use the Mountain Star, HCA, Iasis and University of Utah network of hospitals. The link to find providers and facilities is **www.pehp.org.**
- **What is the difference between the Traditional and the Qualified High-Deductible Plan?**
  The difference between the two options, is the Traditional Plan has a lower deductible, lower out-of-pocket maximum, and a higher premium. The Qualified High-Deductible plan has a higher deductible, higher out-of-pocket maximum, and lower premiums. You have to meet your deductible before the plan will help cover any of your expenses. A District match into an HSA is available when enrolled in the QHDHP. A good rule of thumb to help you decide which plan is best for you, consider how often you go to the doctor, are you expecting any large procedures this year, and how much financial risk you are comfortable assuming. Remember, as long as you don't have major medical expenses, paying a lower premium is guaranteed money in your pocket.

Remember:

The Base plans offer in-network only benefits. If you need out-of-network benefits, you may want to elect Buy-Up option.

Your Health Savings Account can help. If you enroll in the Qualified High Deductible Health Plan and contribute to your Health Savings Account (HSA), Canyons School District will match your contributions, dollar for dollar, up to a yearly maximum. This is good news as the HSA can help cover your out-of-pocket costs on the Qualified High Deductible Health Plan.

The Benefit Structure Guide

Canyons School District offers eight medical plans in an effort to help you find the plan that best fits you and your family's needs. In case eight choices seem a bit overwhelming, please use the guide below to help simplify your medical decision. There are three easy steps.

❒ STEP 1

Plan Design Selection: Traditional or Qualified High Deductible?

There are only two types of plan designs: Traditional or Star (Qualified High Deductible Health Plan). Which plan better meets your and your family's needs? The primary difference between the two plans is highlighted below.

Plan Designs	
Traditional Health Plan	Star (Qualified High Deductible Health Plan)
Higher Monthly Premium	Lower Monthly Premium
Lower Deductible	Higher Deductible
Plan covers some benefits before deductible	Plan does not cover any expenses until after deductible
Preventive Care is covered 100% before deductible	Preventive Care is covered 100% before deductible
Lower out-of-pocket maximum	Higher out-of-pocket maximum
Standard FSA participation is available	**HSA** and **limited FSA** participation is available

Full plan summaries are on page 12-19. Premiums for the plans are listed on page 20-21 of the benefit booklet.

❒ STEP 2

Network Choice: Advantage or Summit

Now that you know the plan design you prefer, the next step is to decide which network is best for you. Advantage or Summit? Advantage offers the Intermountain Healthcare network. Summit includes the MountainStar, HCA, Iasis and University of Utah network of hospitals. Please refer to pages 10-11 for a complete listing of the hospitals and provider count for each network. You can also go online to **www.pehp.org** to search for facilities and providers.

Network Options	
Advantage	Summit
Intermountain Healthcare Network	MountainStar, HCA, Iasis and University of Utah

❒ STEP 3

Base or Buy-up: In-Network Only or In- and Out-of-Network?

Once you know which plan design and network you need, the final step is to determine if you need the base or buy-up network. The base network of the PEHP plan (called Advantage and Summit) are in-network only.

	PEHP
Base Options	In-Network Only
Buy-Up Options	In- and Out-of-Network Benefits

Prescription Drug Benefit

The Traditional and Star (Qualified High Deductible) Plans have similar prescription benefits. However, the Star (Qualified High Deductible Health) Plan is subject to the medical deductible, meaning you will pay the full negotiated cost of the prescription until you meet your deductible. (Deductible period is from January 1, 2018 – December 31, 2018)

	Participating Pharmacy	Non-Participating Pharmacy
Tier 1	$5 Copay	Plan pays up to the discounted cost, minus the preferred copay, if applicable. Member pays any balance
Tier 2	20% Coinsurance ($25 min/$75 max)	
Tier 3	35% Coinsurance ($50 min/$100 max)	
Specialty Medications, Retail Pharmacy	Tier A: 20%. No maximum copay Tier B: 30% No maximum copay	
Specialty Medications, office/outpatient	Tier A: 20% of In-Network Rate after deductible. No max copay Tier B: 30% of In-Network Rate after deductible. No max copay	Tier A: 40% of In-Network Rate after deductible. No max copay Tier B: 50% of In-Network Rate after deductible. No max copay
Specialty Medications, through specialty vendor Accredo	Tier A: 20%. $150 maximum copay Tier B: 30%. $225 maximum copay Tier C: 20%. No maximum copay	Not covered

For all questions regarding pharmacy tier classifications, coverages, and pricing, please call PEHP at 800.765.7347.

90-Day Retail/Mail Order Benefit

As an added benefit, your plan allows for up to a 90-day (three-month) supply. There are two ways of accessing this benefit listed below.

1) Participating 90-Day Retail Pharmacy

2) Mail Order Pharmacy

The same copay applies for each option:

	Participating Pharmacy	Non-Participating Pharmacy
Tier 1	$10 Copay	Not covered
Tier 2	20% Coinsurance ($50 min/$150 max)	Not covered
Tier 3	35% Coinsurance ($100 min/$200 max)	Not covered

In order to fill a 90-day supply, your prescriber must write your prescription for a 90-day supply. Prescriptions filled for less than a three-month supply (83 days) and more than a one-month supply (30 days) will not process at the pharmacy.

Use a Participating Pharmacy

Retail Pharmacy

Most retail pharmacies are contracted to allow you to fill a 30-day supply and up to a 90-day supply of maintenance medications.

Mail Order Pharmacy

PEHP offers the convenience of home delivery.

Hospital Comparison

Hospital	County	Network Options	
		Advantage	Summit
Alta View	Salt Lake	x	
American Fork	Utah	x	
Ashley Valley	Uintah	x	x
Bear River	Box Elder	x	x
Beaver Valley	Beaver	x	x
Blue Mountain	San Juan	x	x
Brigham City	Box Elder		x
Cache Valley Specialty	Cache	x	x
Castleview	Carbon	x	x
Cedar City	Iron	x	x
Central Valley	Juab	x	x
Davis	Davis	x	x
Delta Community	Millard	x	x
Dixie Regional	Washington	x	x
Filmore	Millard	x	x
Garfield Memorial	Garfield		x
Gunnison Valley	Sanpete	x	x
Heber Valley	Wasatch	x	x
Huntsman Cancer Center	Salt Lake		x
IMC	Salt Lake	x	
Jordan Valley	Salt Lake		x
Jordan Valley West	Salt Lake		x
Kane County	Kane	x	x
Lakeview	Davis		x
LDS	Salt Lake	x	
Logan Regional	Cache	x	
Lone Peak	Salt Lake		x
McKay-Dee	Weber	x	
Millford Valley	Beaver	x	x
Mountain Point Medical Center	Utah		x
Moab Regional	Grand	x	x
Mountain View	Utah		x
Mountain West	Tooele	x	x
Odgen Regional	Weber		x
Orem Community	Utah	x	
Orthopedic Speciality (TOSH)	Salt Lake	x	

Benefit Plan Scoop: Your deductible is built into your out-of-pocket maximum totals. That's good news because the out-of-pocket maximum starts getting paid with your first deductible dollar.

Hospital	County	Network Options	
		Advantage	Summit
Park City Medical Center	Summit	x	x
Primary Children's	Salt Lake	x	x
Riverton	Salt Lake	x	
Salt Lake Regional	Salt Lake		x
San Juan	San Juan	x	x
Sanpete Valley	Sanpete	x	x
Sevier Valley	Sevier	x	x
St. Mark's	Salt Lake		x
Timpanogos	Utah		x
Uintah Basin	Duchesne	x	x
University Medical Center	Salt Lake		x
University Orthopedic Center	Salt Lake		x
Utah Valley Regional	Utah	x	

Please note: This document is intended for information purposes only and is subject to change without notice.

Do You Need Out-of-State Coverage?

❑ IS A DEPENDENT LIVING OUT OF STATE?

Emergent/Urgent Care: PEHP will cover services at in-network levels, regardless of the facility or provider visited. If the provider is part of our MultiPlan Network and the member produces their PEHP ID card at the time of service, the facility or provider will not balance bill.

Routine Care: Members living outside the state of Utah must notify PEHP of their out-of-state address prior to receiving coverage. Members living out-of-state must use the MultiPlan Network to receive in-network benefits. Facilities and providers not on the MultiPlan Network will be considered out-of-network and be subject to their specific plan's out-of-network benefit.

*Dependents living out of state must show that they have established residency

❑ ARE YOU TRAVELING OUT OF STATE?

Emergent/Urgent Care: PEHP will cover services at in-network levels, regardless of the facility or provider visited. If the provider is part of our MultiPlan Network and the member produces their PEHP ID card at the time of service, the facility or provider will not balance bill.

Routine Care: Members residing in Utah may not travel to seek routine care from facilities or providers outside of the state without prior authorization from PEHP. Members who seek routine care out-of-state without prior authorization from PEHP will be denied coverage for those services.

❑ ARE YOU TRAVELING INTERNATIONALLY?

Emergent/Urgent Care: Eligible medical services received by a Member outside of the United States will be allowed by PEHP at billed charges if the Member provides PEHP with a copy of the original foreign claim and provides PEHP with acceptable documentation of the claim. PEHP will translate the claim into English and convert the charges to United States Currency.

Routine Care: Members traveling outside of the United States seeking coverage for any otherwise eligible medical service, medication, or device will be denied coverage for those services as well as any related complications resulting from the services provided.

Information about the MultiPlan Network can be found by logging on to pehp.org. More details about out-of-state coverage can be found in PEHP's Canyons School District Master Policy.

Traditional Plan Design
Base Option Networks (In-Network Only)

	PARTICIPATING (In-Network) When using participating providers, you are responsible to pay the amounts in this column. Services from nonparticipating providers are not covered (except emergencies)
Conditions and Limitations	
Lifetime Maximum Plan Payment (per person)	None
Benefit Accumulator Period	Calendar year
Medical Deductible and Medical Out-Of-Pocket	
Deductible–Per Person/Family (per calendar year)	$850/$2,550
Total Out-of-Pocket Maximum–Per Person/Family (per calendar year) (Includes Deductible, Copays, Prescriptions, and Coinsurance.)	$3,500/$7,000
Inpatient Services	
Medical and Surgical	20% after deductible
Skilled Nursing Facility Up to 60 Days (per calendar year)	20% after deductible
Inpatient Rehab Therapy Up to 45 days per plan year. Requires Authorization.	20% after deductible
Professional Services	
Office Visits & Minor Office Surgeries PEHP Value Clinics and PEHP e care Visits Primary Care Provider (PCP) Secondary Care Provider (SCP)	 $10 $30 $50
Allergy Tests	See Office Visits Above
Allergy Treatment	20%
Allergy Serum	$55
Major Office Surgery	20%
Physician's Fees Medical, Surgical, Maternity, Anesthesia	20% after deductible
Preventive Services as Outlined by the ACA	
Primary Care Provider (PCP)	Covered 100%
Secondary Care Provider (PCP)	Covered 100%
Adult and Pediatric Immunizations	Covered 100%
Elective Immunizations—herpes zoster (shingles), rotavirus	Covered 100%
Diagnostic Test: Minor	Covered 100%
Other Preventive Services	Covered 100%
Wellchild Visits	Covered 100%

Sign up for PEHP member online portals at www.PEHP.org where you can review claims, find providers, and review your benefits.

	PARTICIPATING (In-Network) When using participating providers, you are responsible to pay the amounts in this column. Services from nonparticipating providers are not covered (except emergencies)
Outpatient Services	
Outpatient Facility and Ambulatory Surgical	$50 after deductible
Ambulance (Air or Ground) Emergencies only	20% after deductible
Emergency Room Participating facility	$150 after deductible
Emergency Room Nonparticipating facility (plus any balance billing)	$150 after deductible
Urgent Care Facilities	$35
Chemotherapy, Radiation and Dialysis	20% after deductible
Diagnostic Tests Minor	Covered 100%
Diagnostic Tests Major	$30 after deductible
Home Health, Hospice, Outpatient Private Nurse	20% after deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational Up to 20 visits per calendar year for each therapy type	$30
Miscellaneous Services	
Durable Medical Equipment (DME)	20% after deductible
Miscellaneous Medical Supplies (MMS)	20% after deductible
Maternity	See Professional, Inpatient or Outpatient
Adoption	$2,500 benefit
Cochlear Implants	See Professional, Inpatient or Outpatient
Infertility–Selected Services Max Plan Payment $1,500 calendar year, $5,000 lifetime	50% after deductible
Donor Fees for Covered Organ Transplants	See inpatient medical and surgical benefit
TMJ (Temporomandibular Joint) Services Up to $2,000 lifetime	50% after deductible
Chiropractic–up to 20 visits per calendar year	$30
Other Benefits	
Mental Health and Chemical Dependency	
Mental Health Deductible Per Person/Family (per calendar year)	$300/$900
Mental Health Out-of-Pocket Maximum[1] (Includes Deductible, Out-of-Pocket Maximum, Copays, and Coinsurance)	$2,300/$4,900
Mental Health Office Visits Up to 25 visit per calendar year for Psychiatrist, Psychologist/Licensed Clinical Social Worker/APRN combined	$30/visit for Psychiatrist, $20/visit for Psychologist/Licensed Clinical Social Worker/APRN
Inpatient—Up to 21 days per calendar year	20% after deductible
Inpatient Physician Visits	20% after deductible
Outpatient	20% after deductible
Residential Treatment	Not covered
Dayspring	20% after deductible
Injectable Drugs and Specialty Medications	20% after deductible
Prescription Drugs*	
Participating Pharmacy (30-Day Supply)	Tier 1: $5/Tier 2: 20% ($25 min/$75 max)/Tier 3: 35% ($50 min/$100 max)
See page 9 for benefit details. For all questions regarding pharmacy tier classifications, coverages, and pricing, please call PEHP at 800.765.7347.	

Traditional Plan Design
Buy-up Option Networks (In- and Out-of-Network)

PEHP Health & Benefits

	PARTICIPATING (In-Network)	NON-PARTICIPATING (Out-of-Network)
	When using participating providers, you are responsible to pay the amounts in this column.	When using non-participating providers, you are responsible to pay the amounts in this column.
Conditions and Limitations		
Lifetime Maximum Plan Payment (per person)	None	
Benefit Accumulator Period	Calendar year	
Maximum Annual Out-of-Network Payment (per calendar year)	None	$2,000,000
Medical Deductible and Medical Out-Of-Pocket		
Deductible–Per Person/Family (per calendar year)	$850/$2,550	
Total Out-of-Pocket Max–Per Person/Family (per calendar year) (Includes Deductible, Copays, Prescriptions, and Coinsurance.)	$3,500/$7,000	
Out-of-Pocket Inpatient Services		
Medical and Surgical	20% after deductible	40% after deductible
Skilled Nursing Facility Up to 60 Days (per calendar year)	20% after deductible	40% after deductible
Inpatient Rehab Therapy Up to 45 days per plan year. Requires preauthorization.	20% after deductible	40% after deductible
Professional Services		
Office Visits & Minor Office Surgeries PEHP Value Clinics and PEHP e care Visits Primary Care Provider (PCP) Secondary Care Provider (SCP)	 $10 copay $30 copay $50 copay	40% after deductible
Allergy Tests	See Office Visits Above	40% after deductible
Allergy Treatment	20%	40% after deductible
Allergy Serum	$55 copay	40% after deductible
Major Office Surgery	20%	40% after deductible
Physician's Fees: Medical, Surgical, Maternity, Anesthesia	20% after deductible	40% after deductible
Preventive Services as Outlined by the ACA		
Primary Care Provider (PCP)	Covered 100%	Not covered
Secondary Care Provider (PCP)	Covered 100%	Not covered
Adult and Pediatric Immunizations	Covered 100%	Not covered
Elective Immunizations—herpes zoster (shingles), rotavirus	Covered 100%	Not covered
Diagnostic Test: Minor	Covered 100%	Not covered
Other Preventive Services	Covered 100%	Not covered
Wellchild Visits	Covered 100%	Not covered

Preventive medicine is the best kind. Be sure to get your annual preventive exams. If it is a strictly preventive visit, there is no cost to you. If you need diagnostic work done, schedule that for another appointment.

	PARTICIPATING (In-Network)	NON-PARTICIPATING (Out-of-Network)
	When using participating providers, you are responsible to pay the amounts in this column.	When using non-participating providers, you are responsible to pay the amounts in this column.
Outpatient Services		
Outpatient Facility and Ambulatory Surgical	$50 after deductible	40% after deductible
Ambulance (Air or Ground) Emergencies only	20% after deductible	See Participating Benefit
Emergency Room Participating facility	$150 after deductible	See Participating Benefit
Emergency Room Nonparticipating facility (plus any balance billing)	$150 after deductible	See Participating Benefit
Urgent Care Facilities	$35	40% after deductible
Chemotherapy, Radiation and Dialysis	20% after deductible	40% after deductible
Diagnostic Tests Minor	Covered 100%	40% after deductible
Diagnostic Tests Major	$30 after deductible	40% after deductible
Home Health, Hospice, Outpatient Private Nurse	20% after deductible	40% after deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational Up to 20 visits per calendar year for each therapy type	$30	40% after deductible
Miscellaneous Services		
Durable Medical Equipment (DME)	20% after deductible	40% after deductible
Miscellaneous Medical Supplies (MMS)	20% after deductible	40% after deductible
Maternity	See Professional, Inpatient or Outpatient	40% after deductible
Adoption	$2,500 Benefit	
Cochlear Implants	See Professional, Inpatient or Outpatient	40% after deductible
Infertility–Selected Services Max Plan Payment $1,500 calendar year, $5,000 lifetime	50% after deductible	Not covered
Donor Fees for Covered Organ Transplants	See inpatient medical and surgical benefit	40% after deductible
TMJ (Temporomandibular Joint) Services Up to $2,000 lifetime	50% after deductible	50% after deductible
Chiropractic–up to 20 visits per calendar year	$30	Not covered
Other Benefits		
Mental Health and Chemical Dependency		
Mental Health Deductible Per Person/Family (per calendar year)	$300/$900	
Mental Health Out-of-Pocket Maximum[1] (Includes Deductible, Out-of-Pocket Maximum, Copays, and Coinsurance)	$2,300/$4,900	
Mental Health Office Visits Up to 25 visit per calendar year for Psychiatrist, Psychologist/ Licensed Clinical Social Worker/APRN combined	$30/visit for Psychiatrist, $20/visit for Psychologist/Licensed Clinical Social Worker/APRN	50% after deductible
Inpatient—Up to 21 days per calendar year	20% after deductible	50% after deductible
Inpatient Physician Visits	20% after deductible	50% after deductible
Outpatient	20% after deductible	50% after deductible
Residential Treatment	Not covered	Not covered
Dayspring	20% after deductible	Not covered
Injectable Drugs and Specialty Medications	20% after deductible	40% after deductible
Prescription Drugs		
Participating Pharmacy (30-Day Supply)	Tier 1: $5/Tier 2: 20% ($25 min/$75 max)/Tier 3: 35% ($50 min/$100 max)	
See page 9 for benefit details. For all questions regarding pharmacy tier classifications, coverages, and pricing, please call PEHP at 800.765.7347.		

Star (Qualified High Deductible) Plan Design
Base Option Networks (In-Network Only)

PEHP Health & Benefits	PARTICIPATING (In-Network) When using participating providers, you are responsible to pay the amounts in this column. Services from nonparticipating providers are not covered (except emergencies)
Conditions and Limitations	
Lifetime Maximum Plan Payment (per person)	None
Benefit Accumulator Period	Calendar year
Medical Deductible and Medical Out-Of-Pocket	
Deductible–(per calendar year) Employee Employee + 1 Family	 $1,500 $3,000 $3,000
Total Out-of-Pocket Maximum–Per Person/Family (per calendar year) (Includes Deductible, Copays, Prescriptions, and Coinsurance.)	$5,000/$10,000*
Inpatient Services	
Medical and Surgical	20% after deductible
Skilled Nursing Facility Up to 60 Days (per calendar year)	20% after deductible
Inpatient Rehab Therapy Up to 45 days per plan year. Requires preauthorization.	20% after deductible
Professional Services	
Office Visits & Minor Office Surgeries PEHP e care Visits PEHP Value Clinics Primary Care Provider (PCP) Secondary Care Provider (SCP)	 $10 after deductible 20% after deductible $20 after deductible $35 after deductible
Allergy Tests	See Office Visits Above
Allergy Treatment and Serum	20% after deductible
Major Office Surgery	20% after deductible
Physician's Fees Medical, Surgical, Maternity, Anesthesia	20% after deductible
Preventive Services as Outlined by the ACA	
Primary Care Provider (PCP)	Covered 100%
Secondary Care Provider (PCP)	Covered 100%
Adult and Pediatric Immunizations	Covered 100%
Elective Immunizations—herpes zoster (shingles), rotavirus	Covered 100%
Diagnostic Test: Minor	Covered 100%
Other Preventive Services	Covered 100%
Wellchild Visits	Covered 100%

*Embedded out-of-pocket maximum.

Take Note! The High Deductible Health Plan has changed to a Qualified High Deductible Health Plan. This means all of your health care expenses, including prescriptions, are subject to the deductible. You will not have any copays for doctors visits or prescriptions until you meet the deductible.

	PARTICIPATING (In-Network) When using participating providers, you are responsible to pay the amounts in this column. Services from nonparticipating providers are not covered (except emergencies)
Outpatient Services	
Outpatient Facility and Ambulatory Surgical	$50 after deductible
Ambulance (Air or Ground) Emergencies only	20% after deductible
Emergency Room Participating facility	20% after deductible
Emergency Room Nonparticipating facility	20% after deductible
Urgent Care Facilities	$35 after deductible
Chemotherapy, Radiation and Dialysis	20% after deductible
Diagnostic Tests Minor	Covered 100% after deductible
Diagnostic Tests Major	20% after deductible
Home Health, Hospice, Outpatient Private Nurse	20% after deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational Up to 20 visits per calendar year for each therapy type	$20 after deductible
Miscellaneous Services	
Durable Medical Equipment (DME)	20% after deductible
Miscellaneous Medical Supplies (MMS)	20% after deductible
Maternity	See Professional, Inpatient or Outpatient
Adoption	20% after deductible; $2,500 benefit
Cochlear Implants	See Professional, Inpatient or Outpatient
Infertility–Selected Services Max Plan Payment $1,500 calendar year, $5,000 lifetime	50% after deductible
Donor Fees for Covered Organ Transplants	See inpatient medical and surgical benefit
TMJ (Temporomandibular Joint) Services Up to $2,000 lifetime	50% after deductible
Chiropractic–up to 20 visits per calendar year	$20 after deductible
Other Benefits	
Mental Health and Chemical Dependency	
Mental Health Deductible Per Person/Family (per calendar year)	Included in Medical Deductible
Mental Health Out-of-Pocket Maximum Per Person/Family (per calendar year)	Included in Medical Out-Of-Pocket Maximum
Mental Health Office Visits Up to 25 visit per calendar year for Psychiatrist, Psychologist/Licensed Clinical Social Worker/APRN combined	$30 after deductible/visit for Psychiatrist, $20 after deductible/visit for Psychologist/ Licensed Clinical Social Worker/APRN
Inpatient—Up to 21 days per calendar year	20% after deductible
Inpatient Physician Visits	20% after deductible
Outpatient	20% after deductible
Residential Treatment	Not covered
Dayspring	20% after deductible
Injectable Drugs and Specialty Medications	20% after deductible
Prescription Drugs	
Annual Deductible	See Medical Deductible
See page 9 for benefit details. For all questions regarding pharmacy tier classifications, coverages, and pricing, please call PEHP at 800.765.7347.	

Star (Qualified High Deductible) Plan Design
Buy-up Option Networks (In- and Out-of-Network)

PEHP Health & Benefits

	PARTICIPATING (In-Network) When using participating providers, you are responsible to pay the amounts in this column.	NON-PARTICIPATING (Out-of-Network) When using non-participating providers, you are responsible to pay the amounts in this column.
Conditions and Limitations		
Lifetime Maximum Plan Payment (per person)	None	
Benefit Accumulator Period	Calendar year	
Maximum Annual Out-of-Network Payment (per calendar year)	None	$2,000,000
Medical Deductible and Medical Out-Of-Pocket		
Deductible–(per calendar year) Employee Employee + 1 Family	 $1,500 $3,000 $3,000	
Total Out-of-Pocket Maximum–Per Person/Family (per calendar year) (Includes Deductible, Copays, Prescriptions, and Coinsurance.)	$5,000/$10,000*	
Inpatient Services		
Medical and Surgical	20% after deductible	40% after deductible
Skilled Nursing Facility Up To 60 Days (per calendar year)	20% after deductible	40% after deductible
Inpatient Rehab Therapy Up to 45 days per plan year. Requires preauthorization.	20% after deductible	40% after deductible
Professional Services		
Office Visits & Minor Office Surgeries PEHP e care Visits PEHP Value Clinics Primary Care Provider (PCP) Secondary Care Provider (SCP)	 $10 after deductible 20% after deductible $20 after deductible $35 after deductible	40% after deductible
Allergy Tests	See Office Visits Above	40% after deductible
Allergy Treatment and Serum	20% after deductible	40% after deductible
Major Office Surgery	20% after deductible	40% after deductible
Physician's Fees Medical, Surgical, Maternity, Anesthesia	20% after deductible	40% after deductible
Preventive Services as Outlined by the ACA		
Primary Care Provider (PCP)	Covered 100%	Not covered
Secondary Care Provider (PCP)	Covered 100%	Not covered
Adult and Pediatric Immunizations	Covered 100%	Not covered
Elective Immunizations—herpes zoster (shingles), rotavirus	Covered 100%	Not covered
Diagnostic Test: Minor	Covered 100%	Not covered
Other Preventive Services	Covered 100%	Not covered
Wellchild Visits	Covered 100%	Not covered

* Embedded out-of-pocket maximum

PEHP Health & Benefits	PARTICIPATING (In-Network) When using participating providers, you are responsible to pay the amounts in this column.	NON-PARTICIPATING (Out-of-Network) When using non-participating providers, you are responsible to pay the amounts in this column.
Outpatient Services		
Outpatient Facility and Ambulatory Surgical	$50 after deductible	40% after deductible
Ambulance (Air or Ground) Emergencies only	20% after deductible	See Participating Benefit
Emergency Room Participating facility	20% after deductible	See Participating Benefit
Emergency Room Nonparticipating facility	20% after deductible	See Participating Benefit
Urgent Care Facilities	$35 after deductible	40% after deductible
Chemotherapy, Radiation and Dialysis	20% after deductible	40% after deductible
Diagnostic Tests Minor	Covered 100% after deductible	40% after deductible
Diagnostic Tests Major	20% after deductible	40% after deductible
Home Health, Hospice, Outpatient Private Nurse	20% after deductible	40% after deductible
Outpatient Rehab Therapy: Physical, Speech, Occupational Up to 20 visits per calendar year for each therapy type	$20 after deductible	40% after deductible
Miscellaneous Services		
Durable Medical Equipment (DME)	20% after deductible	40% after deductible
Miscellaneous Medical Supplies (MMS)	20% after deductible	40% after deductible
Maternity	See Professional, Inpatient or Outpatient	40% after deductible
Adoption	20% after deductible; $2,500 benefit	
Cochlear Implants	See Professional, Inpatient or Outpatient	40% after deductible
Infertility–Selected Services Max Plan Payment $1,500 calendar year, $5,000 lifetime	50% after deductible	Not covered
Donor Fees for Covered Organ Transplants	See inpatient medical and surgical benefit	40% after deductible
TMJ (Temporomandibular Joint) Services Up to $2,000 lifetime	50% after deductible	50% after deductible
Chiropractic–up to 20 visits per calendar year	$20 after deductible	Not covered
Other Benefits		
Mental Health and Chemical Dependency		
Mental Health Deductible Per Person/Family (per calendar year)	Included in Medical Deductible	Included in Medical Deductible
Mental Health Out-of-Pocket Maximum Per Person/Family (per calendar year)	Included in Medical Out-Of-Pocket Maximum	Included in Medical Out-Of-Pocket Maximum
Mental Health Office Visits Up to 25 visit per calendar year for Psychiatrist, Psychologist/Licensed Clinical Social Worker/APRN combined	$30 after deductible/visit for Psychiatrist, $20 after deductible/visit for Psychologist/Licensed Clinical Social Worker/APRN	50% after deductible
Inpatient—Up to 21 days per calendar year	20% after deductible	50% after deductible
Inpatient Physician Visits	20% after deductible	50% after deductible
Outpatient	20% after deductible	50% after deductible
Residential Treatment	Not covered	Not covered
Dayspring	20% after deductible	Not covered
Injectable Drugs and Specialty Medications	20% after deductible	40% after deductible
Prescription Drugs		
Annual Deductible	See Medical Deductible	
See page 9 for benefit details. For all questions regarding pharmacy tier classifications, coverages, and pricing, please call PEHP at 800.765.7347.		

Traditional Plan Premiums

		Full-Time Employee Portion 30-40 hours per week .75 to 1.00 FTE day	Grandfathered** Part-Time Employee Portion 20-30 hours per week .50 to .74 FTE (4 to 5.99 hours per day)	Full Premium (District + EE Portion)	
		Semi-Monthly	Semi-Monthly	Monthly	Annual
Certificated	**Base Network Option: Advantage/Summit**				
	Single	$92.95	$206.58	$640.44	$7,685.28
	Employee + 1	$149.59	$332.47	$1,030.72	$12,368.64
	Family	$254.02	$564.57	$1,750.26	$21,003.12
	Buy-up Network Option: Advantage/Summit				
	Single	$124.96	$238.59	$704.46	$8,453.52
	Employee + 1	$201.12	$384.00	$1,133.78	$13,605.36
	Family	$341.52	$652.07	$1,925.25	$23,103.00
Educational Support Professionals	**Base Network Option: Advantage/Summit**				
	Single	$80.55	$200.38	$640.44	$7,685.28
	Employee + 1	$129.65	$322.50	$1,030.72	$12,368.64
	Family	$220.17	$547.65	$1,750.26	$21,003.12
	Buy-up Network Option: Advantage/Summit				
	Single	$112.56	$214.23	$704.46	$8,453.52
	Employee + 1	$181.18	$344.80	$1,133.78	$13,605.36
	Family	$307.66	$585.50	$1,925.25	$23,103.00
Administrative	**Base Network Option: Advantage/Summit**				
	Single	$92.95	$206.58	$640.44	$7,685.28
	Employee + 1	$149.59	$332.47	$1,030.72	$12,368.64
	Family	$254.02	$564.57	$1,750.26	$21,003.12
	Buy-up Network Option: Advantage/Summit				
	Single	$124.96	$238.59	$704.46	$8,453.52
	Employee + 1	$201.12	$384.00	$1,133.78	$13,605.36
	Family	$341.52	$652.07	$1,925.25	$23,103.00

*Spouses who are both employed with the District are allowed to have dual coverage as long as they are both enrolled on the traditional plan and one employee enrolls in family/couple coverage and the other elects single coverage.

**Per District policy, employees are benefit eligible at 20 hour per week as of September 1, 2013. Part-time employees hired after September 1, 2013, will not be benefit eligible. Grandfathered status will sunset December 31, 2018. At which time, all part-time employees will no longer be eligible for benefits.

January 1, 2018 – December 31, 2018 COBRA Rates
Traditional PPO Medical Plan – COBRA Premiums 102%

Base Option: Advantage/Summit		
	Monthly	Annual
Single	$653.25	$7,838.99
Employee + 1	$1,051.33	$12,616.01
Family	$1,785.27	$21,423.18

Buy-up Option: Advantage/Summit		
	Monthly	Annual
Single	$718.55	$8,622.59
Employee + 1	$1,156.46	$13,877.47
Family	$1,963.76	$23,565.06

Star (Qualified High Deductible) Plan Premiums

		Full-Time Employee Portion 30-40 hours per week .75 to 1.00 FTE day	Grandfathered** Part-Time Employee Portion 20-30 hours per week .50 to .74 FTE (4 to 5.99 hours per day)	Full Premium (District + EE Portion)	
		Semi-Monthly	Semi-Monthly	Monthly	Annual
Certificated	**Base Network Option: Advantage/Summit**				
	Single	$45.31	$152.28	$518.50	$6,222.00
	Employee + 1	$72.91	$245.07	$834.47	$10,013.64
	Family	$123.81	$416.15	$1,416.99	$17,003.88
	Buy-Up Network Option: Advantage/Summit				
	Single	$71.23	$178.20	$570.34	$6,844.08
	Employee + 1	$114.63	$286.79	$917.91	$11,014.92
	Family	$194.65	$486.99	$1,558.68	$18,704.16
Educational Support Professionals	**Base Network Option: Advantage/Summit**				
	Single	$41.67	$150.46	$518.50	$6,222.00
	Employee + 1	$67.07	$242.15	$834.47	$10,013.64
	Family	$113.88	$411.19	$1,416.99	$17,003.88
	Buy-Up Network Option: Advantage/Summit				
	Single	$67.59	$176.38	$570.34	$6,844.08
	Employee + 1	$108.79	$283.87	$917.91	$11,014.92
	Family	$184.72	$482.03	$1,558.68	$18,704.16
Administrative	**Base Network Option: Advantage/Summit**				
	Single	$45.31	$152.28	$518.50	$6,222.00
	Employee + 1	$72.91	$245.07	$834.47	$10,013.64
	Family	$123.81	$416.15	$1,416.99	$17,003.88
	Buy Up Network Option: Advantage/Summit				
	Single	$71.23	$178.20	$570.34	$6,844.08
	Employee + 1	$114.63	$286.79	$917.91	$11,014.92
	Family	$194.65	$486.99	$1,558.68	$18,704.16

Please Note: Dual coverage is not compatible with the Qualified High Deductible Health Plan

**Per District policy, employees are benefit eligible at 20 hour per week as of September 1, 2013. Part-time employees hired after September 1, 2013, will not be benefit eligible. Grandfathered status will sunset December 31, 2018. At which time, all part-time employees will no longer be eligible for benefits.

January 1, 2018–December 31, 2018 COBRA Rates Star (Qualified Health Deductible) plan – COBRA Premiums 102%

Base Option: Advantage/Summit		
	Monthly	Annual
Single	$528.87	$6,346.44
Employee + 1	$851.16	$10,213.91
Family	$1,445.33	$17,343.96

Buy-up Option: Advantage/Summit		
	Monthly	Annual
Single	$581.75	$6,980.96
Employee + 1	$936.27	$11,235.22
Family	$1,589.85	$19,078.24

Dental

Canyons School District is partnering with EMI Health as our sole dental carrier. EMI Health is one of the premier dental carriers in Utah and will offer four options. The dental plan details are on page 23, but as a simple tool for your decision-making, please see the diagram below detailing the differences in the four plans.

Dental Plan Highlights

Value Plan

- 1546 Providers
- **This is a discount only plan. It is not a full dental benefit plan** so your benefit will be the least rich of the four plans when you receive services.
- This is an in-network only plan
- It provides the least expensive premiums
- No waiting periods

Warning: You will be responsible for the full cost of services. This plan will provide a discount only.

Advantage Copay Plan

- 2144 Providers
- This is a copay only plan. You will pay according to a fee schedule which will be a less rich benefit than the PPO plans.
- Benefits for a general dentist are in-and out-of-network. Out-of-network they are balance billed.
- There is not an annual maximum
- No waiting periods
- 20% discount Specialist-in network only.

Choice PPO Plan

- 2733 Providers in the Premier Network and 2144 in the Advantage Network
- Less out-of-pocket expense for dental services than the discount plan.
- This is an in- and out-of-network plan
- The out-of-network option is significantly more expensive than the in-network option
- There is a waiting period for Basic and Major Services
- **$2,000** annual maximum benefit if you see a provider in the Advantage Plus Network, **$1,500** for all others
- Ortho benefit is $1,000 lifetime maximum. There is a 12-month waiting period.

Choice Indemnity Plan

- 2733 Providers in the Premier Network and 2144 in the Advantage Network
- Less out-of-pocket expense for dental services than the discount plan.
- This is an in- and out-of-network plan
- If you need to see dentists out-of-network, this is the best plan for you. It has the richest out-of-network option.
- There is a waiting period for Basic and Major Services
- **$2,500** annual maximum benefit if you see a provider in the Advantage Plus Network, **$2,000** for all others
- Ortho benefit is $1,000 lifetime maximum. There is a 12-month waiting period.

Did you know that good oral care can protect your overall health? Without proper dental care, the bacteria naturally present in your mouth can affect or contribute to various diseases, including endocarditis, cardiovascular disease, diabetes, Alzheimer's, osteoporosis, and others. Go get your cleanings done.

—Mayo Clinic

Dental Plan Summaries

	Value Plan	Advantage Copay Plan	Choice PPO Plan		Choice Indemnity Classic	
	In-Network Only (Value Network)	In-Network Only	In-Network (Advantage and Premier Network)	Out-of-Network	In-Network (Advantage and Premier Network)	Out-of-Network
Deductible	$0	$0	$50/$150**	$50/$150	$50/$150**	$50/$150
Deductible Waived for Preventive Care	Yes	Yes	Yes	Yes	Yes	Yes
Preventive (Routine Exams, Cleanings, Topical Fluoride, X-Rays)	Up to 70% Fee Reduction	100%	100%—No Waiting Period	80% of FS	100%	100% of R&C
Basic (Fillings, Extractions, Oral Surgery)	Up to 60% Fee Reduction	Fixed copays, refer to schedule of copayments	80% AD[1] 3-Month Waiting Period*	70% of FS[2] 3-Month Waiting Period*	80% AD[1] 3-Month Waiting Period*	80% of R&C[3] 3-Month Waiting Period*
Major (Crowns, Bridges, Dentures, Periodontics, Endodontics)	Up to 50% Fee Reduction	Fixed copays, refer to schedule of copayments	50% AD[1] 12-month Waiting Period*	30% of FS 12-Month Waiting Period*	50% AD[1] 12-Month Waiting Period*	50% of R&C[3] 12-Month Waiting Period*
Annual Maximum	No Maximum	None	$1,500 per participant ($2,000 max if you use an Advantage Plus Provider)		$2,000 per participant ($2,500 max if you use an Advantage Plus Provider)	
Ortho Deductible	N/A	N/A	N/A	N/A	N/A	N/A
Orthodontics (Children under 19)	25% Discount	25% Discount	50%—12-Month Waiting Period* 25% discount in addition to the benefit		50%—12-Month Waiting Period* 25% discount in addition to the benefit	
Orthodontics (Adult)	25% Discount	25% Discount	50% — 12-Month Waiting Period* 25% discount in addition to the benefit		50%—12-Month Waiting Period* 25% discount in addition to the benefit	
Orthodontics (Lifetime Maximum)	No Maximum	None	$1,000 per participant		$1,000 per participant	

Plan Name	Status	Employee Semi-Monthly Contribution	Full Premium Monthly
Value Plan	Employee	$0.50	$1.00
	Employee + 1	$1.00	$2.00
	Family	$1.50	$3.00
Advantage Copay Plan	Employee	$8.55	$17.10
	Employee + 1	$15.55	$31.10
	Family	$24.35	$48.70
Choice PPO Plan	Employee	$15.95	$31.90
	Employee + 1	$29.00	$58.00
	Family	$45.40	$90.80
Choice Indemnity Plan	Employee	$17.90	$35.80
	Employee + 1	$32.65	$65.30
	Family	$51.10	$102.20

[1]AD = after deductible. You first pay $50 per single for a max of $150 per family.

[2]FS = fee schedule. This is an amount set by EMI Health.

[3]RC = reasonable and customary. This amount is an average amount dentists charge in an area. It is the most generous out-of-network benefit for members.

* = Time spent on the Advantage plan will be credited towards waiting periods on the Choice PPO and Choice Indemnity plans.

** = Deductible does not apply to dentists in the Advantage Network.

It you are a new hire coming on the dental plan and can provide proof of prior dental coverage, EMI Health will give credit towards the waiting period. The only employees who will have the waiting period will be new hires who come on after the initial open enrollment who do not have current dental coverage.

Don't scrimp on your sleep. Some people think you can make up for sleep deprivation incurred during the week by sleeping in on the weekends. But your body needs consistent sleep in order to ward off problems associated with sleep deprivation including memory loss, weight gain, mood inconsistencies, and reduced immune function.

—Harvard Medical School

Vision

Canyons School District's vision carrier is EMI Health. EMI Health partners with VSP Vision to offer enhanced vision benefits. There is a large access to care, both nationally and in Utah, including Walmart, Sam's Club, Costco, Shopko, Vision Works, and community-based providers. Canyons School District offers two options for an employee's choice on their vision plan. 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.

EMI Health				
	VSP Plus 10-130		VSP Plus 10-100	
	In-Network	Out-of-Network Reimbursement	In-Network	Out-of-Network Reimbursement
Benefit Frequency	Every Calendar Year		Every Calendar Year	
Exam Copay	$10 copay	Up to $65	$10 copay	Up to $65
Eye Glass Lenses				
- Single Vision	$10 copay per pair	Up to $30	$10 copay	Up to $30
- Bifocal	$10 copay per pair	Up to $50	$10 copay	Up to $50
- Trifocal	$10 copay per pair	Up to $65	$10 copay	Up to $65
Standard Progressive Lenses	$55 copay per pair	Up to $50 (in lieu of Lined Bifocal reimbursement)	$55 copay	Up to $50 (in lieu of Lined Bifocal reimbursement)
Polycarbonate Lenses	$0-Child $31 SV/$35 Multifocal—Adults	NA	$0-Child $31 SV/$35 Multifocal—Adults	NA
Scratch Coating	$17 copay	NA	$17 copay	NA
UV Protection	$16 copay	NA	$16 copay	NA
Frame Allowance	$130 Allowance at any VSP doctor or $70 at Costco, Sam's Club or Walmart	Up to $80	$100 Allowance at any VSP doctor or $55 at Costco, Sam's Club or Walmart	Up to $70
Contact Lens Allowance	In lieu of frames & lenses		In lieu of frames & lenses	
- Elective	$130 Allowance	Up to $115	$100 Allowance	Up to $85
Lasik Surgery	Up to $500 in savings	NA	Up to $500 in savings	NA

Vision Rates				
	Semi-Monthly Rates		Full Month Premium	
	VSP Plus 10-130	VSP Plus 10-100	VSP Plus 10-130	VSP Plus 10-100
Employee	$3.05	$2.60	$6.10	$5.20
Employee+ 1	$5.65	$5.20	$11.30	$10.40
Family	$9.40	$8.20	$18.80	$16.40

Using Your VSP Benefit is Easy

- **Register at vsp.com.** Review your benefit information and access personalized eligibility and plan coverage details.
- **Find an eye care provider who's right for you.** The decision is yours to make– choose a VSP provider, participating retail chain, or any out-of-network provider. Visit **vsp.com** or call **801.262.7476** to find a provider near you.
- **Select your network.** You will select VSP Choice Plus network when searching online or if you call VSP, let them know you have the VSP Choice Plus Network.
- **At your appointment.** Tell them you have VSP. Make sure to give them your ID card for proof of coverage.
- **Claim forms.** There are no claim forms to complete when you see a VSP Provider.

Long-Term Disability Benefits

RELIANCE STANDARD

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. Canyons 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 within a 40-mile radius from home. 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	Canyons School District pays 100% of the premium
Benefit Percentage	66 ⅔% of gross monthly earnings
Maximum Monthly Benefit	$5,000
Minimum Monthly Benefit	$100 or 10% per month
Benefit Waiting Period	180 days
Maximum Benefit Period	To age 65 or your Social Security Retirement Age
Own Occupation Period	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	Workers Compensation, Retirement, Social Security and other income (please see your certificate).
Survivor Benefit	A lump sum equal to 3 times your gross monthly benefit
Limitations	Mental and Nervous: 24 months; 3 months prior/12 months insured preexisting condition.
Exclusions	Act of war, self-inflicted injury, attempted suicide, violent or criminal conduct, or incarceration.

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 the employee is actively at work.

The employee should apply for Social Security Disability benefits promptly, as Reliance Standard 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 summary represents highlights for information purposes only. Please refer to your certificate for complete details. The Master Contract contains all of the controlling provisions of this coverage.

Life Insurance Benefits

RELIANCE STANDARD

Life Insurance – Basic and Voluntary

Canyons 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. Eligible active employees are covered for $32,000.

Along with your basic life insurance benefit, the District also provides an Accidental Death & Dismemberment policy. Eligible active employees are covered for $32,000.

The basic life insurance provided by Canyons School District also includes coverage for every eligible active employee's spouse and children. The District provides $3,000 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. Contact the District Insurance Office for further information regarding this program.

You may also purchase additional life insurance for your spouse and children. Spouse coverage is available in increments of $5,000 up to $250,000. If you enroll your spouse when initially eligible, you can elect up to $50,000 of insurance without medical underwriting.

Dependent Coverage is available from live birth to age 26 as long as they are **financially dependent,** for $2,500, $5,000, $7,500 or $10,000. This covers all eligible children without medical underwriting for him or her.

If you and your spouse do not enroll during this enrollment, 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 guarantee issue, and are not medically underwritten. You are eligible for a minimum of $10,000, in $10,000 increments, up to a maximum of $500,000 (amount elected over $250,000 is subject to 10 times annual salary). Your family is also eligible for a benefit of a maximum of $300,000 spouse/$25,000 child(ren). 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.

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.

If multiple employees are employed, benefits will only pay on one policy.

How Much Does Voluntary Term Life Insurance Cost?

RELIANCE STANDARD

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

Voluntary Life	
Age	**Semi-Monthly Rates per $1,000**
For Employees and Spouse	
Under 30	$.030
30-34	$.030
35-39	$.040
40-44	$.050
45-49	$.08
50-54	$.11
55-59	$.185
60-64	$.22
65-69	$.36
70-74	$.675
75-79	$1.175
(Initial rates based on age as of effective date of your coverage. Rates will change based on the above age schedule.)	

Voluntary Life	
Coverage	**Semi-Monthly Rate**
For Children - Choose one of the following	
$2,500	$.30
$5,000	$.60
$7,500	$.90
$10,000	$1.20

Voluntary AD&D	
Covered Party	**Semi-Monthly Rates per $1,000**
Choose one of the following	
Employee Only	$.0125
Employee & Family	$.019

Steps to Determine Your Semi-Monthly Cost for Life Insurance

1. Select your desired amount of coverage $_____

2. Locate your age from the table and note the corresponding rate. The Semi-Monthly 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 semi-monthly cost of insurance.

   $_____ (Employee Coverage Amount) divided by $1,000 = $_____

   x _____ (Rate Factor)

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

   (Example: $100,000 coverage/$1,000 = $100 x .040 (age 35) = $4.00 semi-monthly)

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

   $_____ (Spouse Coverage Amount) divided by $1,000 = $_____

   x _____ (Rate Factor)

   = $_____ (Total Semi-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 semi-monthly rate. (Please note that this is a flat rate that is not dependent upon the number of children covered.)

   = $_____ (Desired Coverage Amount) $_____ (Semi-Monthly Cost of Insurance)

Steps to Determine Your Semi-Monthly Cost for AD&D 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 Semi-Monthly 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 choice. The answer is your semi-monthly cost of insurance.

   $_____ (Desired Coverage Amount) divided by $1,000 = $_____

   x _____ (Rate Factor)

   = $_____ (Total Semi-Monthly Cost of AD &D Insurance)

(Employee-Only: $300,000 coverage/$1,000 = $300 x .0125 = $3.75 semi-monthly)
(Employee & Family - $300,000 coverage/$1,000 = $300 x .019 = $5.70 semi-monthly)

Flexible Spending Account

Dependent Care Flex Plan

You can pay for daycare expenses pretax under the Dependent Care Plan. You can sign up for this benefit if:

1. You and your spouse both work
2. You are single filing "head of household"
3. The care is for children under the age of 13.

Important Notice

Your Flexible Spending Account elections should be for qualified medical and dependent daycare expenses you expect to **incur from January 1, 2018 – December 31, 2018**. Remember, all amounts you do not use in this time frame (plus the 2.5 month grace period) will be forfeited. This is called the "Use it or Lose it" rule.

This year, Canyons School District has added a Limited Flexible Spending Account option. A Limited FSA is different than a Traditional FSA in that you can only use it for qualified vision and dental expenses. This account is a good option if you enroll in the Qualified High Deductible Plan and have a Health Savings Account (HSA). If you have an HSA, you cannot enroll in the Traditional FSA under IRS guidelines.

Sometimes referred to as a Cafeteria Plan, Flex Plan, or a Section 125 Plan, a Flexible Spending Account (FSA) allows you to set aside a certain amount of your paycheck into a Medical Reimbursement Account or Dependent Day Care Reimbursement Account—before paying income and FICA taxes. This can save you 26%-36% on out-of-pocket costs, depending on your tax rate. Amounts set aside for the Flexible Spending Account should not include your portion of medical, dental, vision and cancer insurance premiums. These are withheld before tax automatically under a separate plan. Also, elections cannot be changed during the year unless you experience a life event (birth, death, divorce, adoption, marriage.)

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). Your annual election will be deducted from your paycheck in even contributions during the year, before taxes are taken out. For an annual fee of $18.00 you can receive a debit card which can be used nationwide wherever Visa is accepted. For most qualified medical expenses additional substantiation will not be required when using your debit card. But keep track of your receipts in the event that APA Benefits needs to review them to process your claim. You will also want to save them for your personal tax records.

We all have medical expenses and by enrolling in the FSA and/or dependent care plans you can pay for those expenses tax free!

Take special note. If you will have a Health Savings Account (HSA) on January 1, 2018 and you have funds left in your Traditional FSA account after 12/31/2017, your remaining balance will roll into a Limited FSA account. You will have the 2.5 month grace period to use the funds on dental and vision expenses.

APA Benefits Inc.

Qualified FSA Expenses

- Office Copays
- Prescription Copays
- Deductibles
- Mental Health/Psychiatric Care
- Chiropractic Services
- Dental Treatment
- Eyeglasses
- LASIK
- Orthodontia
- X-Rays
- And more!

Qualified Limited FSA Expenses (When paired with an HSA)

- Vision Expenses
- Eyeglasses
- LASIK
- Dental Expenses
- Orthodontia

Check your balance or file a claim online at **www.apabenefits.com**

First Time Login:

User ID – Participants SSN#

Password – Last 4 digits of participant's SSN#

Annual Limits

FSA	$2,600*
Limited FSA	$1,000
Dependent Care	$5,000

APA Benefits
8899 S. 700 E., Suite 225
Sandy, Utah 84070
801.561.4980
www.apabenefits.com

*Federal Health Care Reform requires Canyons School District limit FSA elections to $2,600.

Note: All services for reimbursement must be rendered while employed by Canyons School District, unless the employee elects to extend Flexible Spending Coverage through COBRA.

Health Savings Account (HSA)

When you enroll in the Qualified High Deductible Health Plan, you are allowed to open a Health Savings Account (HSA). This allows you to put money away tax-free through payroll deductions, let it accrue interest tax-free, and then use it for qualified medical, dental and vision expenses tax-free.

What is an HSA?

With an HSA you own the account and it is fully portable. Balances roll over year after year, growing tax-free. You never lose your contributions to your HSA, unlike other health accounts, such as a flexible spending account (FSA). Even if you change jobs, health plans, or retire, you keep your HSA. If enrolled in the Qualified High Deductible Health Plan, you are eligible to contribute to an HSA as long as you don't have non-high deductible health plan coverage elsewhere and cannot be claimed as a dependent on someone else's tax return.

HSA's can be used to pay for eligible medical, dental and vision expenses for you, your spouse, and any family member who qualifies as a tax dependent. (See IRS Publications 969 for a list of eligible expenses). This includes things like pre-deductible medical expenses and prescription costs.

Yearly HSA Contribution Limit

Individual HSA: $3,450* for 2018

Family HSA: $6,900* for 2018

*A $1,000 additional catch up contribution is allowed for account holders age 55+

Check your balance or file a claim online at **www.apabenefits.com**

First Time Login:

User ID—Participants SSN#

Password—Last 4 digits of participants SSN#

APA Benefits
8899 S. 700 E. Suite 225
Sandy, Utah 84070
801.561.4980
www.apabenefits.com

Benefits of an HSA

- Pay for qualified medical, dental and vision expenses with tax-free dollars.
- Lower health insurance premiums than the Traditional Medical Plan.
- Keep your contributions year after year and watch your balance grow. There is no "use it or lose it." It's yours.
- Invest your balance over the threshold amount to grow your HSA further.
- If you participate in the Qualified High Deductible Health Plan, and contribute to your HSA, you are eligible for an employer contribution. Canyons School District will match the amount you contribute to your HSA, on a prorated basis per pay period, up to the yearly maximum shown in the table below.
- The Employer Match Contribution will be matched dollar for dollar. Maximum amounts are listed below.

Employer Match Contribution	
Employee	$500
Employee + 1	$800
Family	$1,200

You are ineligible to open a Health Savings Account:

» *When you are not enrolled in a QHDHP*
» *If you are covered by other Health Insurance*
» *If you are enrolled in Medicare*
» *If you are claimed as a dependent on someone else's tax return*

Here's How an HSA Works

1. You decide the annual amount you want to contribute to your HSA; not to exceed the yearly IRS limits. Please note: any amount your employer contributes to the HSA counts towards the IRS maximum; thus reducing the amount you can contribute.

2. Your contributions are deducted from each paycheck pretax, and deposited into your HSA.

3. You can pay for eligible medical, dental and vision expenses with your HSA debit card, or if you pay the provider with another form of payment, you can log into your HSA Online bank account and request reimbursement. You do not have to send in receipts but it is encouraged you save all of your medical receipts in the event the IRS requests them.

Employee Assistance Program

There is no more valuable asset to Canyons School District than you, the employee. That is one reason why we provide you and your family access to an Employee Assistance Program. The Canyons 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 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. Blomquist Hale provides the counseling services in collaboration with your health care provider.

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 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
- Child/Elder Care
- Depression
- Parenting
- Workplace
- Relationships
- Aging
- Abuse
- Legal
- Grief
- Alcohol/Drugs
- Family
- Finances
- Marriage

Remember!

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

BLOMQUIST HALE CONSULTING

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, 7 days a week at **801.262.9619** or **800.926.9619**.

Voluntary Benefits

Administered by Aflac

Accident Insurance

An accidental injury can be costly, especially if you are financially unprepared. Your current medical coverage will help pay for expenses associated with an injury, but won't cover all of the out-of-pocket expenses you may face. Don't wait until you are rushed to the emergency room to realize you need more protection. With accident insurance, you will receive additional coverage that your medical insurance may not cover.

The plan has limitations and exclusions that may affect benefits payable. Refer to your certificate for complete details, definitions, limitations, and exclusions.

Benefits Summary	Employee	Spouse	Child
Hospital Benefits			
Hospital Admission	$1,000	$1,000	$1,000
Hospital Confinement (per day)	$200	$200	$200
Hospital Intensive Care (per day)	$400	$400	$400
Medical Fees (for each accident)	$125	$125	$125
PARALYSIS (lasting 90 days or more and diagnosed by a physician within 90 days)			
Quadriplegia	$10,000	$10,000	$10,000
Paraplegia	$5,000	$5,000	$5,000
Accidental Death and Dismemberment (within 90 days)			
Accidental Death	$50,000	$10,000	$5,000
Accidental Common Carrier Death (plane, train, boat or ship)	$100,000	$50,000	$15,000
Single Dismemberment	$6,250	$2,500	$1,250
Double Dismemberment	$25,000	$10,000	$5,000
Loss of One or More Fingers or Toes	$1,250	$500	$250
Partial Amputation of Fingers or Toes (including at least one joint)	$100	$100	$100
Major Injuries (diagnosis and treatment within 90 days)			
FRACTURES (closed reduction)			
Hip/Thigh	$4,500	$4,000	
Vertebrae (except processes)	$4,050	$3,600	
Pelvis	$3,600	$3,200	
Skull (depressed)	$3,375	$3,000	
Leg	$2,700	$2,400	
Forearm/Hand/Wrist	$2,250	$2,000	
Foot/Ankle/Knee Cap	$2,250	$2,000	
Shoulder Blade/Collar Bone	$1,800	$1,600	
Lower Jaw (mandible)	$1,800	$1,600	
Skull (simple)	$1,575	$1,400	
Upper Arm/Upper Jaw	$1,575	$1,400	
Facial Bones (except teeth)	$1,350	$1,200	
Vertebral Processes	$900	$800	
Coccyx/Rib/Finger/Toe	$360	$320	
DISLOCATIONS (closed reduction)			
Hip	$3,600	$2,700	
Knee (not knee cap)	$2,600	$1,950	
Shoulder	$2,000	$1,500	
Foot/Ankle	$1,600	$1,200	
Hand	$1,400	$1,050	
Lower Jaw	$1,200	$900	
Wrist	$1,000	$750	
Elbow	$800	$600	
Finger/Toe	$320	$240	

- Open reduction is paid at 150% of closed reduction.
- Multiple fractures and dislocations are paid at 150% of the benefit amount for open or closed reduction.
- Chip fractures are paid at 10% of the fracture benefit.

Critical Illness

No one knows what lies ahead on the road through life. Will you have to undergo a major organ transplant or a coronary artery bypass procedure? Will you suffer a stroke or a heart attack? The signs pointing to a critical illness are not always clear and may not be preventable, but our coverage can help offer financial protection in the event you are diagnosed. Critical illness coverage can help offer peace of mind when a critical illness diagnosis occurs.

The plan has limitations and exclusions that may affect benefits payable. Refer to your certificate for complete details, definitions, limitations, pre-existing conditions and exclusions.

Covered Critical Illnesses	
Cancer (Internal or Invasive)	100%
Heart Attack (Myocardial Infarction)	100%
Stroke (Apoplexy or Cerebral Vascular Accident)	100%
Major Organ Transplant	100%
Renal Failure (End-Stage)	100%
Carcinoma In Situ	25%
Coronary Artery Bypass Surgery	25%

First-Occurrence Benefit

After the waiting period, a lump sum benefit is payable upon initial diagnosis of a covered critical illness. Employee benefit amounts are available from $5,000 to $50,000. Spouse coverage is also available in benefit amounts up to $25,000. If you are deemed ineligible due to a previous medical condition, you still retain the ability to purchase Spouse coverage.

Additional Occurrence Benefit

If an insured collects full benefits for a critical illness under the plan and later has one of the remaining covered critical illnesses, then we will pay the full benefit amount for each additional illness. Occurrences must be separated by at least six months.

Re-Occurrence Benefit

If an insured collects full benefits for a covered condition and is later diagnosed with the same condition, we will pay the full benefit again. The two dates of diagnosis must be separated by at least 12 months, or for cancer, 12 months treatment free. Cancer that has spread (metastasized) even though there is a new tumor, will not be considered an additional occurrence unless the Insured has gone treatment free for 12 months.

Child Coverage at No Additional Cost

Each Dependent Child is covered at 25 percent of the primary insured amount at no additional charge.

Hospital Indemnity

A stay in the hospital for an accident or procedure can be costly, especially if you are financially unprepared. Your current medical coverage will help pay for expenses associated with an injury or procedure, but won't cover all of the out-of-pocket expenses you may face. Don't wait until you are rushed to the emergency room or go in for a procedure to realize you need more protection. With hospital indemnity, you will receive additional coverage that your medical insurance may not cover.

The plan has limitations and exclusions that may affect benefits payable. Refer to your certificate for complete details, definitions, limitations, and exclusions.

Benefit Summary	
Hospital Admission (Per Confinement)	$1,500
Hospital Confinement (Per Day)	$200
Hospital Intensive Care (Per Day)	$200

Semi-Monthly Rates

Critical Illness

Employee NON-TOBACCO Premium										
	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18–29	$2.25	$3.63	$5.00	$6.38	$7.75	$9.13	$10.50	$11.88	$13.25	$14.63
30–39	$3.10	$5.33	$7.55	$9.78	$12.00	$14.23	$16.45	$18.68	$20.90	$23.13
40–49	$5.55	$10.23	$14.90	$19.58	$24.25	$28.93	$33.60	$38.28	$42.95	$47.63
50–59	$8.71	$16.54	$24.38	$32.36	$40.04	$47.88	$55.71	$63.54	$71.38	$79.21
60–69	$13.38	$25.88	$38.38	$50.88	$63.38	$75.88	$88.38	$100.88	$113.38	$125.88

Spouse NON-TOBACCO Premium (Spouse is eligible for 50% of employee election)									
	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18–29	$2.25	$2.94	$3.63	$4.32	$5.00	$5.69	$6.38	$7.07	$7.75
30–39	$3.10	$4.22	$5.33	$6.44	$7.55	$8.67	$9.78	$10.89	$12.00
40–49	$5.55	$7.89	$10.23	$12.57	$14.90	$17.24	$19.58	$21.92	$24.25
50–59	$8.71	$12.63	$16.54	$20.46	$24.38	$28.29	$32.36	$36.13	$40.04
60–69	$13.38	$19.63	$25.88	$32.13	$38.38	$44.63	$50.88	$57.13	$63.38

Employee TOBACCO Premium										
	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18–29	$3.05	$5.23	$7.40	$9.58	$11.75	$13.93	$16.10	$18.28	$20.45	$22.63
30–39	$4.60	$8.33	$12.05	$15.78	$19.50	$23.23	$26.95	$30.68	$34.40	$38.13
40–49	$10.53	$20.18	$29.83	$39.48	$49.13	$58.78	$68.43	$78.08	$87.73	$97.38
50–59	$16.33	$31.78	$47.23	$62.68	$78.13	$93.58	$109.03	$124.48	$139.93	$155.38
60–69	$25.55	$50.23	$74.90	$99.58	$124.25	$148.93	$173.60	$198.28	$222.95	$247.63

Spouse TOBACCO Premium (Spouse is eligible for 50% of employee election)									
	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18–29	$3.05	$4.14	$5.23	$6.32	$7.40	$8.49	$9.58	$10.67	$11.75
30–39	$4.60	$6.47	$8.33	$10.19	$12.05	$13.92	$15.78	$17.64	$19.50
40–49	$10.53	$15.35	$20.18	$25.00	$29.83	$34.65	$39.48	$44.30	$49.13
50–59	$16.33	$24.05	$31.78	$39.50	$47.23	$54.95	$62.68	$70.40	$78.13
60–69	$25.55	$37.89	$50.23	$62.57	$74.90	$87.24	$99.58	$111.92	$124.25

Accident Illness

24-Hour High Accident Coverage	Semi-Monthly Rates
Employee	$8.10
Employee & Spouse	$11.58
Employee & Dependent Children	$15.95
Family	$18.93

Hospital Indemnity

Semi-Monthly Rates	
Employee	$11.64
Employee & Spouse	$22.88
Employee & Dependent Children	$16.31
Family	$27.55

Frequently Called Numbers

Health and Pharmacy Insurance Plans

PEHP ..... www.PEHP.org
800.765.7347

Employee Assistance Program

Blomquist Hale Associates ..... www.bha.com
801.262.9619 or 800.926.9619

Disability Insurance

Reliance Standard ..... www.reliancestandard.com
Long-Term Disability 800.351.7500

Life Insurance

Reliance Standard ..... www.reliancestandard.com
Group Basic Life/AD&D, Voluntary Life, Voluntary AD&D 800.351.7500

Flexible Spending Account and Health Savings Account/ COBRA

APA Benefits ..... www.apabenefits.com
801.561.4980

Dental Insurance

EMI Health ..... www.emihealth.com
800.662.5850

Vision Insurance

EMI Health ..... www.emihealth.com
EMI Health: 800.662.5850

Canyons School District Insurance

Robert Reeder 801.826.5448

Insurance Department .. 801.826.5428

Arthur J. Gallagher & Co. – Insurance Consultant

801.559.2929

Aflac

Lee Harmer 801.716.0084

RE: Mental Health Parity Exemption Notice.

Dear Colleagues:

This document is for notification purposes only; no action is required on your part. The district qualifies for an exemption from certain provisions of the Public Health Service Act, and has elected to file an exception for these provisions. We are required to notify participants of these exemptions.

Notice to Enrollees in a Self-Funded Nonfederal Governmental Group Health Plan

For Plan Years Beginning On or After September 23, 2010

Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. Canyons School District has elected to exempt Canyons School District's health plans from the following requirements

- Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.

The exemption from these Federal requirements will be in effect for the 2018 plan year beginning January 1, 2018, ending December 31, 2018. The election may be renewed for subsequent plan years.

If you have any questions concerning this notification, contact the District insurance office at 801.826.5428.

Sincerely,

Robert Reeder
Insurance Coordinator

Important Notices & Disclosures

This information provides an informal explanation of the statutes as mandated by the Federal Government. Please note that this information is presented as general guidance and should not be considered legal advice.

If you have questions about these notices, please contact Human Resources or contact the Employee Benefits Security Administration (EBSA) regional office nearest you. A list of these offices is on the agency's Website at **www.dol.gov/ebsa.**

Women's Cancer Right Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998. For individuals receiving mastectomy–related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

All stages of reconstruction of the breast on which the mastectomy has been performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and Treatment of physical complications of all stages of mastectomy, including lymph edema.

Benefits for the above coverage are payable on the same basis as any other physical condition covered under the plan, including any applicable deductible and/or copays and coinsurance amounts.

If you would like more information on WHCRA benefits, please contact Human Resources.

Newborns' Act Disclosure

Group health plans and health insurance issuers generally may not under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Family & Medical Leave Act (FMLA)

FMLA is designed to help employees balance their work and family responsibilities by allowing them to take reasonable unpaid leave for certain family and medical reasons. It also seeks to accommodate the legitimate interests of employers and promote equal employment opportunity for men and women.

FMLA applies to all public agencies, all public and private elementary and secondary schools, and companies with 50 or more employees.

There may be times when you need an extended leave of absence. The company has a Family and Medical Leave Policy that is in compliance with The Family and Medical Leave Act of 1993 (FMLA), as amended. FMLA provides an entitlement of up to 12 weeks, which protects employees' jobs and benefits in the event of a medical or family circumstance, which requires the employee to take time off from work **without pay.** In general, the employee must have worked for at least 12 months and at least, 1,250 hours within the last 12 months immediately prior to the first day of leave.

Circumstances Permitting Family and Medical Leave

- Birth of an employee's child (within 12 months after birth)
- Adoption of a child by an employee (within 12 months after placement)
- Placement of a child with the employee for foster care (within 12 months after placement)
- Care of a child, spouse or parent having a serious health condition
- Incapacity of the employee due to a serious health condition
- Military Leave

Additional leave laws may apply to you depending upon your specific state and if you or a dependent or a military member. Whenever possible leave must be requested in advance. If you have questions about FMLA or any leave requests, please contact Human Resources.

Continuation of Coverage during an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be determined by your Employer.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources.

Qualified Medical Child Support Orders

Coverage will be provided to any of your dependent child(ren) if a Qualified Medical Child Support Order (QMCSO) is issued, regardless of whether the child(ren) currently reside with you. A QMSCO may be issued by a court of law or issued by a state agency as a National Medical Support Notice (NMSN), which is treated as a QMSCO. If a QMSCO is issued, the child or children shall become an alternate recipient treated as covered under the Plan and are subject to the limitations, restrictions, provisions and procedures as all other plan participants.

Michelle's Law Legislation

On October 9, 2008, President Bush signed into federal law a new statute known as "Michelle's Law" (H.R. 2851). The law amends ERISA, the Public Health Service Act, and the Internal Revenue Code. Michelle's law generally requires group health plans, which provide coverage for dependent children who are postsecondary school students, to continue such coverage if the student loses the required student status because he or she must take a leave of absence from studies due to a serious illness or injury. The law applies to fully insured and self funded group health plans and will be effective for an employer's plan on the first plan year on or after October 9, 2009.

- For research purposes limited information may be disclosed as permitted by law
- To workers' compensation or similar programs for the payment of benefits for work-related injuries
- To coroners, medical examiners and funeral directors to identify a deceased person, determine cause of death, or to carry out duties
- To comply with court orders, judicial proceedings, or other legal processes related to law enforcement, custody of inmates, legal and administrative actions, and criminal activity
- For U.S. military and veteran reporting regarding members and veterans of the armed forces of U.S. or foreign military
- For national security and intelligence activities such as protective services for the President and other authorized persons

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **877.KIDS.NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **866.444.EBSA (3272).**

You may be eligible for assistance paying your employer health plan premiums. The following is current as of August 10, 2017. Contact State of Utah for more information on eligibility.

UTAH – Medicaid and CHIP
Medicaid: **https://medicaid.utah.gov**
CHIP: **http://health.utah.gov/chip**
877.543.7669

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents. At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage.

If any coverage your Employer allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date.

If this Plan provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under this Plan will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under this Plan only if and when this Plan gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.

Employee Retirement Income Security Act of 1974 (ERISA)

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and updated summary plan description. The administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this Notice, please contact Human Resources.

Introduction

The Company along with its corporate affiliates and divisions sponsor a variety of health benefit programs. For the purposes of this Notice, we refer to these health benefit programs collectively as the **"Benefit Plan."**

For example, the Benefit Plan includes medical, dental, vision, prescription drug benefits, and flexible spending accounts. In most cases, these programs are administered through arrangements with health insurance companies, HMOs, and third party administrators. The Benefit Plan does not include worker's compensation, life insurance, disability benefits, medical leaves, pre-employment physicals, or drug testing.

The Benefit Plan is subject to a federal law called the Health Insurance Portability and Accountability Act of 1996, also known as "HIPAA." HIPAA sets standards to protect the privacy of medical information. We are required by HIPAA to:

Make sure that medical information that identifies you is kept private; Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and follow the terms of the Notice that is currently in effect.

Our Pledge Regarding Medical Information

The Benefit Plan is committed to protecting medical information about you. This Notice describes the Benefit Plan's privacy practices and that of all its employees and staff. This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

In addition to HIPAA, the Benefit Plan uses and discloses medical information in compliance with all other applicable state and federal laws.

How We May Use and Disclose Medical Information about You

The following categories describe different ways that the Benefit Plan uses and discloses medical information.

For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

The Benefit Plan has delegated some plan administration activities to its Business Associates, such as third party administrators, who also may use and disclose your medical information to perform services and functions on behalf of the Benefit Plan.

For Treatment. The Benefit Plan may use and disclose medical information about you to provide you with medical treatment or services. For example, if your health care needs to be coordinated, we may give information to your primary care physician or specialist.

For Payment. The Benefit Plan may use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be made to the health care providers that provided care to you. For example, we may need to give your medical information to a third party administrator so that they will pay claims for your care.

For Health Care Operations. The Benefit Plan may use and disclose medical information about you for Benefit Plan operations. These uses and disclosures are necessary to run the Benefit Plan and make sure that our members receive quality services. For example, we may use medical information to review our coverage options and services and to evaluate the performance of our plan.

Treatment Alternatives. The Benefit Plan may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. The Benefit Plan may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. The Benefit Plan may disclose medical information about you to a close personal friend or family member who is involved in your medical care or payment for your care if you have signed an authorization. Please note that our health insurance companies, HMOs and third party administrators may impose different protections when disclosing medical information to individuals involved in your care or payment for your care.

For Special Purposes. The Benefit Plan may disclose medical information about you as for special purposes as permitted or required by law, including the following:

- To avert a serious threat to health or safety against you, the public or another person
- For public health and administrative oversight activities such as disease control, abuse or neglect reporting, health and vital statistics, audits, investigations, and licensure reviews
- For organ and tissue donation and transplant to facilitate organ or tissue donation and transplant

Your Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of certain disclosures we made of medical information about you. Your request must state a time period. We may limit the time period to 6 years and to disclosures made on or after April 14, 2003. The first list you request within a 12-month period is free. For additional lists, we may charge you for the costs of providing the list.

Your Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you. **We are not required by law to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Your Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. We will accommodate all reasonable requests.

Right to File a Complaint If you believe your privacy rights have been violated, you may file a complaint with the Benefit Plan. You may also file a complaint directly with the Secretary of the Department of Health and Human Services. **You will not be penalized in any way for filing a complaint.**

Other Uses & Disclosures of Your Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us an authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by the written authorization.

You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provide to you.

Changes to This Notice

The Benefit Plan reserves the right to change this Notice. The Benefit Plan reserves the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future.

Your Rights Regarding Medical Information About You. You have many rights with regard to your medical information. If you wish to exercise any of these rights, please submit your request in writing to Canyons School District, HIPAA Privacy Officer.

Your Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

Your Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the Information. You have the right to add a statement. You must provide a reason that supports your request for an amendment.

Prescription Drug Coverage and Medicare

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Canyons School District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join. For more information about this notice or your current prescription drug coverage, please contact Human Resources.

Note: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Canyons School District changes. You also may request a copy of this notice at any time.

For More Information about Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

Visit **www.medicare.gov.**

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.

Call **800.MEDICARE (800.633.4227).** TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov,** or call them at **800.772.1213** (TTY 800.325.0778).

Important Notice from Canyons School District About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with ***Canyons School District*** *and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.*

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- **Canyons School District** has determined that the prescription drug coverage offered by the carrier is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current **Canyons School District** coverage will be affected. **If you do decide to enroll in a Medicare prescription drug plan and drop your Canyons School District prescription drug coverage, be aware that you may not be able to get this coverage back.**

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. In addition, your current coverage pays other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

Notes

CANYONS
School District

This benefit summary prepared by

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