2025 Benefit Guide

Helping you make informed choices
about your employee benefits.

CANYONS
SCHOOL DISTRICT

FREQUENTLY CALLED NUMBERS

Health and Pharmacy Insurance Plans

PEHP ..... www.pehp.org
801.366.7555
Pharmacy 801.366.7551

Employee Assistance Program

Blomquist Hale Consulting ..... www.blomquisthale.com
801.262.9619 or 800.926.9619

Life and Disability Insurance

Voya ..... https://presents.voya.com/EBRC/CanyonsSchoolDistrict
Group Basic Life / AD&D, Voluntary Life, and Voluntary AD&D.. 888.238.4840
Long-Term Disability 888.305.0602

Flexible Spending Account and Health Savings Account / COBRA

WEX ..... www.wexinc.com
866.451.3399

Dental Insurance

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

Vision Insurance

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

Voluntary Benefits

Voya ..... https://presents.voya.com/EBRC/CanyonsSchoolDistrict
888.238.4840

Canyons School District Insurance

Insurance Department 801.826.5428

Robert Reeder...Insurance Coordinator

Lisa Peterson...Insurance Specialist

Janet Ekenstam...Insurance Specialist

Sarah Hopkin...Insurance Specialist

Arthur J. Gallagher & Co. – Insurance Consultant

801.559.2929

IMPORTANT:

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. Please see page 41 for more details.

2025 MANDATORY BENEFIT CONFIRMATION

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

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Benefits Department.

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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 28, 2024 and Friday, November 8, 2024 at 5:00 pm.
- **SSN.** When enrolling, please remember to have social security numbers for you and your dependents.
- **Review.** Confirm and hit "agree" on the benefit summary.

*Per Health Care Reform, a full Summary of Benefits and Coverage (SBC) is located at **csd.employeenavigator.com**

WELCOME TO OPEN ENROLLMENT FOR 2025.

The Open Enrollment window is from October 28 to November 8. Your elections must be submitted by 5:00 pm on **November 8**. All changes will take effect January 1, 2025. Open Enrollment is mandatory. All benefit eligible employees, including new employees to the District this school year, must log in and confirm their elections for 2025. We're committed to reducing waste and have condensed the benefit materials to this booklet. This booklet contains the most requested benefits information. Digital versions of the benefit materials, including a full benefit book, are available online at **www.canyonsdistrict.org/open-enrollment**. A limited number of paper benefit booklets will be available upon request from the Insurance Department.

Update for 2025

There will be a small increase in the deductible on the high-deductible plan. This change was necessary because the IRS increased the required parameters for offering HSA plans. The District needed to comply with this increase to continue offering the HSA. As per negotiations the employee premiums will increase by approximately 6.5%. This constitutes ¼ of the total increase, the remaining ¾ of the increase will be covered by the District. All other deductibles, copays, and out-of-pocket maximums will remain the same for 2025 as will the District's contributions to the HSA. As a reminder, if you elect to participate in the FSA, HSA, Dependent Care FSA, or LFSA, the IRS requires you to make an election **every year**. If you do not make an active election for these benefits during Open Enrollment, you will not be enrolled in these benefits during the 2025 benefit year. Be aware that the District HSA contributions are contingent upon you entering an HSA election amount. If you do not make an HSA election, you will not receive any of the District's HSA contributions.

Please note that specific plan coverage parameters can change from year to year due to changes in administrative and compliance guidelines. If you have questions regarding specific coverage parameters you are encouraged to contact the carriers directly.

DEPENDENT ELIGIBILITY

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 until the end of the month in which they turn 26 regardless of financial or marital status. Handicapped children are eligible for continuous coverage once certified and approved by PEHP and/or EMI Health. Please review this list to be sure you do not have dependents enrolled who are not eligible. If you have enrolled ineligible dependents, you should remove them immediately. Be aware, intentionally enrolling individuals who don't meet eligibility requirements is a type of fraud and could result in disciplinary action up to and including termination. At the District's discretion, audits may be conducted periodically to validate eligibility of dependents.

What qualifies as an eligible dependent?

» Legal spouse through marriage (not common law)

» Legal dependent children (biological, adopted, stepchildren through marriage, children through legal guardianship)

» Legal dependent child until the end of the month they turn 26 years old

» Handicapped legal adult child once certified and approved by PEHP and EMI

WHEN CAN I CHANGE MY BENEFITS?

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 2025 are October 28, 2024 through November 8, 2024. It is your responsibility, through open enrollment, to verify coverage and print a copy of your benefit summary upon completion of enrollment.

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 the day they turn 26. Handicapped children are eligible for continuous coverage once certified and approved by PEHP.

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 the employee and two or more eligible dependents.

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 on the 1st of the month following your 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.

Benefits Offered: We offer medical, dental, vision, disability, and basic and voluntary life plans, provided your online benefits election is completed within 30 days of your position start date.

CANYONS SCHOOL DISTRICT ENROLLMENT GUIDELINES

Qualifying Life Events

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.employeenavigator.com.**

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 in writing.

- Marriage or change in number of dependents
- Change in employment status of employee, spouse or dependent that causes loss or gain 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 institutions
- 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 (60-day notification)

NAVIGATE MY BENEFITS

csd.employeenavigator.com

Navigate will be used for all employees to make benefit elections offered at Open Enrollment and for newly eligible employees. It will be available to use at anytime throughout the year to make changes due to qualifying events and to change personal information such as address and name changes due to marriage or divorce.

If you are NEW HIRE:

» **Step 1.** Go to **csd.employeenavigator.com** and click on 'New User Registration'.

» **Step 2.** Fill in the required fields. The company identifier is Canyons. Then click 'Next'.

» **Step 3.** Create a User Name and Password. Then check the 'I Agree with the Employee Navigator terms of use' before you Finish.

» **Step 4.** Once logged in, the system will direct you through your required tasks and enrollments.

If you are IN OPEN ENROLLMENT:

» **Step 1.** Login at **csd.employeenavigator.com** and begin the enrollment process.

» **Step 2.** Confirm all Personal Information is correct and click 'Save' to begin benefit elections.

» **Step 3.** Select all dependents you want to cover on each benefit and choose the plan you want. Complete this step for all benefits offered.

» **Step 4.** Complete your Open Enrollment by reviewing all benefits (enrolled or declined) and click 'Click to Sign' to finish.

If you are MAKING A CHANGE DUE TO A QUALIFYING EVENT:

» **Step 1.** Login at **csd.employeenavigator.com**.

» **Step 2.** Click 'Change Benefits'.

» **Step 3.** Select the reason for your coverage change (i.e. Marriage, Newborn, etc.).

» **Step 4.** Enter the date of change and any other required information to make the change.

» **Step 5.** Once you have added a dependent you will have to make plan elections for the dependent to be enrolled.

» **Step 6.** Complete enrollment and 'Agree'.

If you are UPDATING PERSONAL INFORMATION:

» **Step 1.** Login at **csd.employeenavigator.com**.

» **Step 2.** Click 'Profile' or 'View Profile'.

» **Step 3.** Select 'Edit' next to the field you want to update. Make necessary change and 'Save'.

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
CommonSpirit Holy Cross Hospital - Davis	Davis	x	x
Common Spirit Holy Cross Hospital - Jordan Valley	Salt Lake		x
CommonSpirit Holy Cross Hospital - Jordan Valley West	Salt Lake		x
CommonSpirit Holy Cross Hospital - Mountain Point	Utah		x
CommonSpirit Holy Cross Hospital - Salt Lake	Salt Lake		x
Delta Community	Millard	x	x
Filmore	Millard	x	x
Garfield Memorial	Garfield	x	x
Gunnison Valley	Sanpete	x	x
Heber Valley	Wasatch		x
Huntsman Cancer Center	Salt Lake	x	x
IMC	Salt Lake	x	
Intermountain Health Primary Children's Hospital	Lehi	x	x
Kane County	Kane	x	x
Lakeview	Davis		x
Layton	Davis	x	
LDS	Salt Lake	x	
Logan Regional	Cache	x	
Lone Peak	Salt Lake		x
McKay-Dee	Weber	x	
Millford Valley	Beaver	x	x
Moab Regional	Grand	x	x
Mountain View	Utah		x
Mountain West	Tooele	x	x
Odgen Regional	Weber		x

Hospital	County	Network Options	
		Advantage	Summit
Orem Community	Utah	x	
Orthopedic Speciality (TOSH)	Salt Lake	x	
Park City Medical Center	Summit	x	x
Primary Children's	Salt Lake	x	x
Riverton	Salt Lake	x	
San Juan	San Juan	x	x
Sanpete Valley	Sanpete	x	x
Sevier Valley	Sevier	x	x
Spanish Fork Hospital	Utah	x	
St. George Regional	Washington	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: For emergent services in-state and out of state, members should go to the nearest hospital. Per the no surprise act, patients will receive in-network cost sharing and cannot be balance billed. For non life-threatening emergencies, when possible go to a contracted urgent care facility.
  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 provide PEHP with documentation to show that they have established residency.

- ### ARE YOU TRAVELING OUT OF STATE?
  Emergent / Urgent Care: For emergent services in-state and out of state, members should go to the nearest hospital. Per the no surprise act, patients will receive in-network cost sharing and cannot be balance billed. For non life-threatening emergencies, when possible go to a contracted urgent care facility.
  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 for a covered service not available in Utah. 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.

STEPS TO SELECTING THE RIGHT HEALTH COVERAGE

Canyons School District offers two medical plans in an effort to help you find the plan that best fits you and your family's needs. Use the following guide to help you decide which plan is best for you. There are three easy steps.

❒ STEP 1

Plan Design Selection: Traditional or High Deductible?

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

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

Full plan summaries are on pages 14-21. Premiums for the plans are listed on pages 22-23 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, Common Spirit and University of Utah network of hospitals. Please refer to pages 8–9 for a complete listing of the hospitals for each network. You can also go online at **www.pehp.org** to search for facilities and providers.

Network Options	
Advantage	**Summit**
Intermountain Healthcare Network	MountainStar, HCA, Common Spirit and University of Utah
❒ Intermountain Health	MountainStar Healthcare · CommonSpirit · HCA Healthcare · University of Utah Health

STEP 3

Base or Plus: 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 network or the Plus network. The Plus plan allows you to go out of network where the Base option is in-network only. The Base network of the PEHP plan (called Advantage and Summit) are in-network only.

Base Options	Plus Options
In-Network Benefits only	In- and Out-of-Network Benefits

DISTRICT PROVIDED BENEFITS

Medical	PEHP Health & Benefits
Dental, Vision	EMI HEALTH Smart Benefits
Life and Disability	VOYA FINANCIAL
Health Savings Account (HSA)	wex
Flexible Spending Accounts (FSA)	
Limited FSA	
Dependent Care FSA	
COBRA	
Employee Assistance Program: a free and confidential counseling service available to all employees and their families.	BLOMQUIST HALE CONSULTING
Voluntary Accident and Voluntary Critical Illness	VOYA FINANCIAL

PRESCRIPTION DRUG BENEFIT

The Traditional Plan and High Deductible Star Plan have similar prescription benefits. However, the High Deductible Star Plan is subject to the medical deductible, which must be met before copays or coinsurance take effect. Meaning you will pay the full negotiated cost of the prescription until you meet your deductible. (Deductible period is from January 1, 2025 – December 31, 2025.)

	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 **801.366.7551**.

90-Day Retail / Mail Order Benefit

As an added benefit, your plan allows for up to a 90-day (three-month) supply. The two ways of accessing this benefit are 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 a non-participating retail 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.

We have partnered with PEHP to provide enhancements to the Pharmacy program that include Paydhealth and pharmacy tourism.

You may be invited to participate in these programs. They are intended to save you and the district money.

Expanded Preventive **Medications**

The STAR HSA Plan

Expanded preventive drug coverage means that PEHP will pay a portion of the drug cost for some STAR HSA plans even before you meet your deductible. **Check your benefit summary for plan coverage details as not all STAR HSA plans include this benefit.** Make sure to visit an in-network pharmacy to receive this benefit.

Diabetes

GLUCOSE RESCUE PRODUCTS
GlucaGen HypoKit
Glucagon
METFORMIN PRODUCTS
glipizide-metformin
glyburide-metformin
metformin
metformin ER (non OSM, non MOD)
MISCELLANEOUS
pioglitazone
TESTING SUPPLIES
Freestyle test strips
SULFONYLUREAS
glimepiride
glipizide
glipizide ER
glyburide
glyburide micronized
tolazamide

Depression

citalopram
escitalopram
fluoxetine
sertraline

Cardiovascular

ANTICOAGULANTS/ ANTIPLATELETS
clopidogrel
dipyridamole
warfarin
BETA BLOCKERS
acebutolol
bisoprolol
carvedilol
labetalol
metoprolol succinate
metoprolol tartrate
propranolol solution
propranolol tablets
sotalol
timolol maleate tablets
CALCIUM CHANNEL BLOCKERS
amlodipine
diltiazem
felodipine ER
isradipine
nifedipine tablets ER
verapamil
COMBINATION PRODUCTS
amiloride & HCTZ
atenolol & chlorthalidone
bisoprolol & HCTZ
enalapril & HCTZ
irbesartan & HCTZ
lisinopril & HCTZ
losartan & HCTZ
metoprolol & HCTZ
nadolol & bendroflumethiazide
propranolol & HCTZ
triamterene & HCTZ

RENIN/ANGIOTENSIN SYSTEM ANTAGONIST (ACEI/ARB)
enalapril
fosinopril
irbesartan
lisinopril
losartan
quinapril
ramipril
trandolapril
DIURETICS
amiloride
bumetanide
chlorothiazide
chlorthalidone
furosemide solution
furosemide tablets
hydrochlorothiazide capsules
hydrochlorothiazide tablets
indapamide
methazolamide
methyclothiazide
spironolactone
torsemide
MISCELLANEOUS
prazosin
clonidine
digoxin
VASODILATORS
hydralazine
isosorbide

Respiratory

ANTICHOLENERGICS
ipratropium bromide solution
INHALED CORTICOSTEROIDS
QVAR inhaler
SABA/ ANTICHOLENERGICS
ipratropium-albuterol inhaler
ipratropium-albuterol nebulized
SHORT ACTING BETA AGONISTS
albuterol ER tablets
albuterol nebulized
albuterol syrup
albuterol tablets
ProAir HFA inhaler
ProAir RespiClick
Ventolin inhaler

Osteoporosis

alendronate

PEHP Health & Benefits

1-9-24

HIGH DEDUCTIBLE STAR PLAN DESIGN OPTION (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	 $1,650 $3,300 $3,300
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 and 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%
3D + 2D Mammogram Only	Covered 100% (40 years and over)

*Embedded out-of-pocket maximum. Each person has their own deductible but the family also has a maximum total deductible if multiple family members need medical care during the year.

	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 Office Visits 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	20% after deductible
Inpatient Physician Visits	20% after deductible
Outpatient	20% after deductible
Residential Treatment	Not covered
Injectable Drugs and Specialty Medications	20% after deductible
Prescription Drugs	
Annual Deductible	See Medical deductible
Preventive Drugs	Standard Copays before deductible
See page 12 for benefit details. For all questions regarding pharmacy tier classifications, coverages, and pricing, please call PEHP at 801.366.7551.	

HIGH DEDUCTIBLE PLUS STAR PLAN DESIGN OPTION (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 calendar year) Employee Employee + 1 Family	 $1,650 $3,300 $3,300	
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 and 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
3D + 2D Mammogram Only	Covered 100% (40 years and over)	
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

*Embedded out-of-pocket maximum

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.**
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
Injectable Drugs and Specialty Medications	20% after deductible	40% after deductible
Prescription Drugs		
Annual Deductible	See Medical Deductible	
Preventive Drugs	Standard Copays before deductible	

See page 12 for benefit details. **For all questions regarding pharmacy tier classifications, coverages, and pricing, please call PEHP at 801.366.7551.**

TRADITIONAL PLAN DESIGN
BASE OPTION NETWORK (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 Person/Family (per calendar year)	$900 / $2,700
Total Out-of-Pocket Maximum – Per Person / Family (per calendar year) (Includes Deductible, Copays, Prescriptions, and Coinsurance.)	$4,000 / $8,000
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 and 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%
3D + 2D Mammogram Only	Covered 100% (40 years and over)

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)**
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 Office Visits Psychiatrist, Psychologist / Licensed Clinical Social Worker / APRN combined	$30/visit for Psychiatrist, $20/visit for Psychologist / Licensed Clinical Social Worker / APRN
Inpatient	20% after deductible
Inpatient Physician Visits	20% after deductible
Outpatient	20% after deductible
Residential Treatment	Not covered
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 12 for benefit details. **For all questions regarding pharmacy tier classifications, coverages, and pricing, please call PEHP at 801.366.7551.**

TRADITIONAL PLUS PLAN DESIGN OPTION NETWORK (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)	$900 / $2,700	
Total Out-of-Pocket Max–Per Person / Family (per calendar year) (Includes Deductible, Copays, Prescriptions, and Coinsurance.)	$4,000 / $8,000	
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 and 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

	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.**
Wellchild Visits	Covered 100%	Not covered
3D + 2D Mammogram Only	Covered 100% (40 years and over)	
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 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
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 12 for benefit details. For all questions regarding pharmacy tier classifications, coverages, and pricing, please call PEHP at 801.366.7551.

HIGH DEDUCTIBLE STAR PLAN PREMIUMS

		FULL-TIME EMPLOYEE PORTION 30-40 hours per week .75 to 1.00 FTE day	District Semi-Monthly Portion	FULL PREMIUM (District + EE Portion)	
		Semi-Monthly	Semi-Monthly	Monthly	Annual
Certificated /Administrative	**Base Network Option: Advantage / Summit**				
	Single	$33.81	$260.64	$588.90	$7,066.80
	Employee + 1	$54.40	$419.50	$947.80	$11,343.60
	Family	$92.37	$712.33	$1,609.40	$19,312.80
	Plus Network Option: Advantage / Summit				
	Single	$61.03	$260.64	$643.34	$7,720.08
	Employee + 1	$98.22	$419.50	$1,035.42	$12,425.04
	Family	$166.77	$712.33	$1,758.20	$21,098.40
Educational Support Professionals	**Base Network Option: Advantage / Summit**				
	Single	$28.16	$266.29	$588.90	$7,066.80
	Employee + 1	$45.33	$428.57	$947.80	$11,373.60
	Family	$76.98	$727.72	$1,609.40	$19,312.80
	Plus Network Option: Advantage / Summit				
	Single	$55.38	$266.29	$643.34	$7,720.08
	Employee + 1	$89.14	$428.57	$1,035.42	$12,425.04
	Family	$151.38	$727.72	$1,758.20	$21,098.40

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

**As per District Policy, effective January 1, 2019 all employees have to be full-time (contracted to work 30 hours per week) in order to be benefit eligible.

***These rates are based on a 12-month contract. Rates may vary if employed on a 10-month contract.

January 1, 2025–December 31, 2025 COBRA Rates
High Deductible Star – COBRA Premiums 102%

Base Option: Advantage / Summit		
	Monthly	Annual
Single	$600.68	$7,208.16
Employee + 1	$966.76	$11,601.12
Family	$1,641.59	$19,699.08

Plus Option: Advantage / Summit		
	Monthly	Annual
Single	$656.21	$7,874.52
Employee + 1	$1,056.13	$12,673.56
Family	$1,793.36	$21,520.32

TRADITIONAL PLAN PREMIUMS

	FULL-TIME EMPLOYEE PORTION 30-40 hours per week .75 to 1.00 FTE day	District Semi-Monthly Portion	FULL PREMIUM (District + EE Portion)	
	Semi-Monthly	Semi-Monthly	Monthly	Annual
Certificated /Administrative				
Base Network Option: Advantage / Summit				
Single	$87.43	$277.73	$730.32	$8,763.84
Employee + 1	$140.70	$446.98	$1,175.36	$14,104.32
Family	$238.90	$759.00	$1,995.80	$23,949.60
Plus Network Option: Advantage / Summit				
Single	$121.54	$277.73	$798.54	$9,582.48
Employee + 1	$196.42	$446.98	$1,286.80	$15,441.60
Family	$333.56	$759.00	$2,185.12	$26,221.44
Educational Support Professionals				
Base Network Option: Advantage / Summit				
Single	$73.44	$291.72	$730.32	$8,763.84
Employee + 1	$118.19	$469.49	$1,175.36	$14,104.32
Family	$200.69	$797.21	$1,995.80	$23,949.60
Plus Network Option: Advantage / Summit				
Single	$107.55	$291.72	$798.54	$9,582.48
Employee + 1	$173.91	$469.49	$1,286.80	$15,441.60
Family	$295.35	$797.21	$2,185.12	$26,221.44

*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.

**As per District Policy, effective January 1, 2019 all employees must be full-time (contracted to work at least 30 hours per week) in order to be benefit eligible.

*** These rates are based on a 12 month contract. Rates may vary if employed on a 10 month contract.

January 1, 2025 – December 31, 2025 COBRA Rates
Traditional PPO Medical Plan – COBRA Premiums 102%

Base Option: Advantage / Summit		
	Monthly	Annual
Single	$744.93	$8,939.16
Employee + 1	$1,198.87	$14,386.44
Family	$2,035.72	$24,428.64

Buy-up Option: Advantage / Summit		
	Monthly	Annual
Single	$814.50	$9,774.00
Employee + 1	$1,312.54	$15,750.48
Family	$2,228.82	$26,745.84

DENTAL

Canyons School District has partnered 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 25, but as a simple tool for decision-making, please see the diagram below detailing the differences in the four plans.

Dental Plan Highlights

Value Plan

- 2,179 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

- 3,183 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

- 3,937 Providers in the Premier Network and 3,183 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

- 3,937 Providers in the Premier Network and 3,183 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.

If 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.

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% Savings	100%	100%—No Waiting Period	80% of MAC	100%	100% of R&C
Basic (Fillings, Extractions, Oral Surgery)	Up to 60% Savings	Fixed copays, refer to schedule of copayments	80% AD[1] 3-Month Waiting Period*	70% of MAC 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% Savings	Fixed copays, refer to schedule of copayments	50% AD[1] 12-month Waiting Period*	30% of MAC 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 Only	25% Discount Only	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 Only	25% Discount Only	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	$10.45	$20.90
	Employee + 1	$18.90	$37.80
	Family	$29.65	$59.30
Choice PPO Plan	Employee	$19.35	$38.70
	Employee + 1	$35.30	$70.60
	Family	$55.25	$110.50
Choice Indemnity Plan	Employee	$22.40	$44.80
	Employee + 1	$40.90	$81.80
	Family	$63.95	$127.90

[1]AD After Deductible. You first pay $50 per single for a max of $150 per family.

MAC Maximum Allowable Charge.

[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.

EMI HEALTH Smart Benefits

VISION

Canyons School District's vision carrier is EMI Health. EMI Health partners with VSP Vision to offer enhanced vision benefits. There is considerable access to care, nationally and in Utah, including Walmart, Sam's Club, Costco, Shopko Optical, 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 12 months		Every 12 months	
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 and lenses		In lieu of frames and 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

Plan Name	Status	Semi-Monthly Rates	Full Month Premium
VSP Plus 10-100	**Employee**	$3.20	$6.40
	Employee + 1	$6.45	$12.90
	Family	$10.15	$20.30
VSP Plus 10-130	**Employee**	$3.80	$7.60
	Employee + 1	$7.00	$14.00
	Family	$11.70	$23.40

Using Your VSP Benefit is Easy

1. Register at **vsp.com**. Review your benefit information and access personalized eligibility and plan coverage details.
2. Find an eye care provider who's right for you. Visit vsp.com or call **801.262.7476** to find a provider near you. The decision is yours to make – choose a VSP provider, participating retail chain, or any out-of-network provider.
3. 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.
4. At your appointment. Tell them you have VSP. Make sure to give them your ID card for proof of coverage.
5. Claim forms. There are no claim forms to complete when you see a VSP Provider.

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

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

WHICH IS BETTER FOR ME? HSA VS. FSA

	HSA	Standard Health Care FSA	Limited Purpose FSA	Dependent Care FSA
Eligibility is based on your medical plan option enrollment	High Deductible Star	Traditional	High Deductible Star	High Deductible Star or Traditional
Your account is opened automatically for you	Yes			
You can make contributions	Yes, you contribute pre-tax money up to the annual IRS limits for 2025: *4,300 for you only *8,550 if you cover dependents *An additional $1,000 if you're age 55 or older as of your birthday	Yes, you can contribute pre-tax money up to $3,300	Yes, you can contribute pre-tax money up to $1,000	Yes, you can contribute pre-tax money up to $5,000
How you can use your spending account	Eligible medical expenses like your annual deductible, prescription drugs, or coinsurance, as well as dental and vision expenses	Eligible medical expenses like your annual deductible, prescription drugs, or coinsurance, as well as dental and vision expenses	Eligible dental and vision expenses	Eligible expenses for dependent children under the age of 13 or disabled adult day care
Your account balance rolls over from year to year	Yes	No, you must use and submit your claims for any money you contribute to your 2025 account by March 15, 2026. Unused funds will be forfeited.		
You can roll over your unused balance and take it with you	Yes, you own the balance in your account and take it with you even if you leave Canyons School District.	No, your FSA balance is use-it-or-lose-it and you must use it in full each calendar year or by the end of the grace period. Funds set aside in an FSA don't roll over to the next year.		
You can invest your account balance	Yes, once your HSA balance reaches $2,000.	No		
Tax savings benefits	There's no tax when your contributions go in, no tax as your HSA money grows with interest, and no tax when you spend it on eligible medical, prescription drug, dental, or vision expenses.	There's no tax when your contributions go in and no tax when you spend your FSA money on eligible medical, prescription drug, dental, vision, or child and elder care expenses (depending on the type of FSA you choose).		

IMPORTANT!

STAR High Deductible Plan Prescription Enhancement

For those enrolled in the High Deductible Health Plan – Expanded preventive drug coverage means that PEHP will pay a portion of the drug cost for certain qualified medications for the STAR High Deductible Health plans even before you meet your deductible. Please check the Canyons open enrollment website or page 13 of this guide for details for which Rx are included in this program. Make sure to visit an in-network pharmacy to receive this benefit. Covered conditions include diabetes, cardiovascular, respiratory, and osteoporosis.

HEALTH SAVINGS ACCOUNT (HSA)

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

What is an HSA?

An HSA is a savings account that you own 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 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: $4,300* for 2025

Family HSA: $8,550* for 2025

*A $1,000 additional catch up contribution is allowed if employee is age 55 or older.

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

866.451.3399

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 High Deductible Health Plan. Canyons School District will match the amount you contribute to your HSA, up to the yearly maximum based on your enrollments. Maximum amounts are listed on page 30.

» You are also eligible for an employer contribution, on a prorated basis, per pay period.

How an HSA Works

See page 30 for breakdown of contributions

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. Alternatively, 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 that you save all of your medical receipts in the event the IRS requests them.

You are not eligible to open a Health Savings Account if:

» ***You are not enrolled in a High Deductible Health Plan***
» ***You are covered by other Health Insurance***
» ***You are enrolled in Medicare***
» ***You are claimed as a dependent on someone else's tax return***

DISTRICT HSA CONTRIBUTION

In addition to the District's dollar for dollar match contribution, the District will also provide a direct HSA contribution that doesn't require a match contribution from the employee. Please see chart for details.

District HSA Contribution				
	District Direct Contribution	District $ for $ Match Contribution	Total Available District Contribution	Annual Limit
Single	$400	$400	$800	$4,300
Employee + 1	$600	$600	$1,200	$8,550
Family	$800	$800	$1,600	$8,550

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

In 2025, there could potentially be three contributions to an HSA: the District's direct contribution, the District's dollar for dollar match, and the employee's contribution.

Please Note: Due to the complexity of the District's HSA contributions the administration system has limited capabilities in managing the HSA dollar for dollar match contribution. Employees who don't elect to contribute enough to receive the full dollar for dollar match may notice an inaccuracy in the total election amounts. This inaccuracy is the result of the system limitation and will be corrected manually post enrollment.

Example 1: An employee with family coverage wants to receive the full $1,600 HSA contribution from the District. They will need to elect at least $800 for the employee portion on the HSA election. The District will provide the direct contribution of $800, which will be allocated incrementally in equal amounts over the entire year. The District will also match the Employee contribution up to $800. The match contribution will depend on the amount of the employee contribution. The combined total contribution will be $2,400.

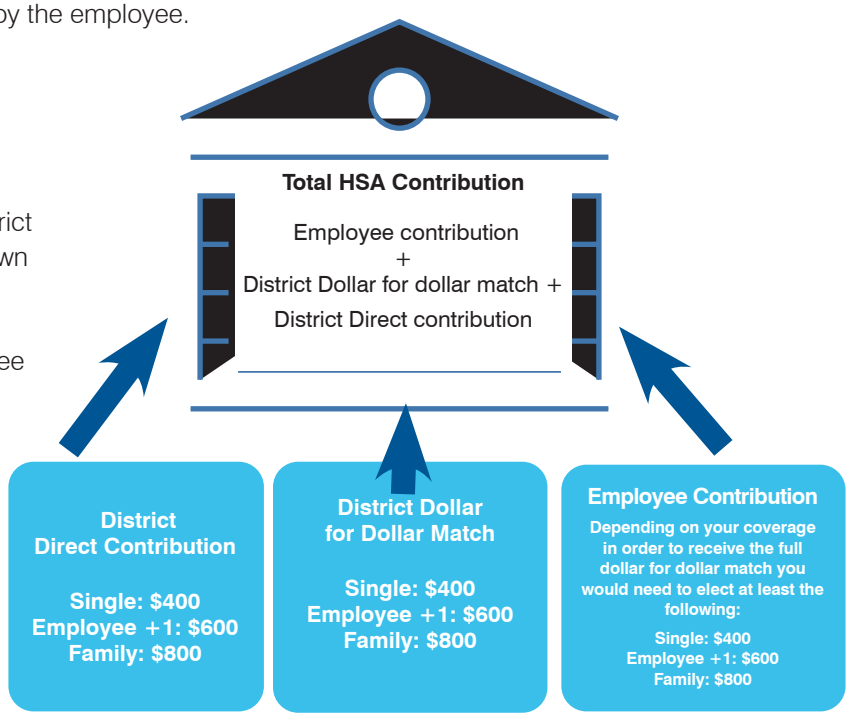
Employee Election	$800
District Match Contribution	$800
District Direct Contribution	$800
Total HSA Contribution	$2,400

Example 2: An Employee with Employee +1 coverage wants to maximize their savings in the HSA. They elect $7,350 for the year. The $600 direct contribution would be funded incrementally over the entire year. A dollar for dollar contribution of $600 would be funded incrementally based on the first $600 of the employee's contribution. At that point the dollar for dollar match would end. The remaining $7,350 would be contributed by the employee.

Employee Election	$7,350
District Match Contribution	$600
District Direct Contribution	$600
Total HSA Contribution	$8,550

Example 3: A single employee wants to receive the District Direct Contribution but doesn't want to contribute their own funds to the HSA. They would elect $0 for the employee contribution. The District would provide the incremental contribution of $400 to the HSA but because the employee isn't contributing their own funds, there wouldn't be any match contribution from the District.

Employee Election	$0
District Match Contribution	$0
District Direct Contribution	$400
Total HSA Contribution	$400



FLEXIBLE SPENDING ACCOUNT

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 deductions 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.)

1. 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. For most qualified medical expenses additional substantiation will not be required when using your debit card. Keep track of your receipts in the event that WEX, needs to review them to process your claim. You will also want to save them for your personal tax records.

2. Important Notice

Your Flexible Spending Account elections should be used for qualified medical and dependent daycare expenses you expect to **incur from January 1, 2025 – December 31, 2025**. 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. All claims for reimbursement must be submitted by March 31, 2026.

If you elect less then $1,200 then you will be subject to an Admin fee. If you elect more than $1,200 that fee will be waived. Be aware that if you terminate from the district, all services for reimbursement from the FSA must be received prior to termination to be eligible for reimbursement.

3. 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.

4. Limited Purpose FSA

Canyons School District has 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 High Deductible Plan **and max out your HSA**. If you have an HSA, you cannot enroll in the Traditional FSA under IRS guidelines.

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

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.wexinc.com**

First Time Login:

See page 32 for directions on how to log in for the first time.

Annual Limits

FSA	$3,200*
Limited FSA	$1,000
Dependent Care	$5,000

*Federal Health Care Reform requires Canyons School District limit FSA elections to $3,200.

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.

Benefits Technology & Resources

Benefits debit card

The benefits debit card is the fastest and most convenient way to pay for eligible expenses. Just one debit card is all you need for your benefits regardless of how many plans you have with us.

Benefits eligible expenses

There are thousands of eligible procedures, items and expenses based on your plan. View our interactive list of eligible expenses a **www.wexinc.com/insights/benefits-toolkit/eligible-expenses/**.

Knowledgebase

Once you're enrolled, check out the knowledgebase to quickly search for answers to your questions. The knowledgebase boasts millions of views of our microvideos, articles and step-by-step how-tos empowering you to get the most out of your benefits. Have a question? Visit any time of day or night by logging in to your online account on **www.wexinc.com**.

Benefits mobile app & participant portal

Access your benefits 24/7 with the WEX mobile app. Our app is free, convenient and offers real-time access to all your benefits accounts. With our benefits mobile app you can:

» Get instant updates on the status of your claims.

» File a claim and upload documentation in seconds using your phone's camera.

» Scan an item's bar code to determine if it's an IRS Code Section 213(d) eligible expense.

» Report a card as lost or stolen, which cancels the card and ships you a new one.

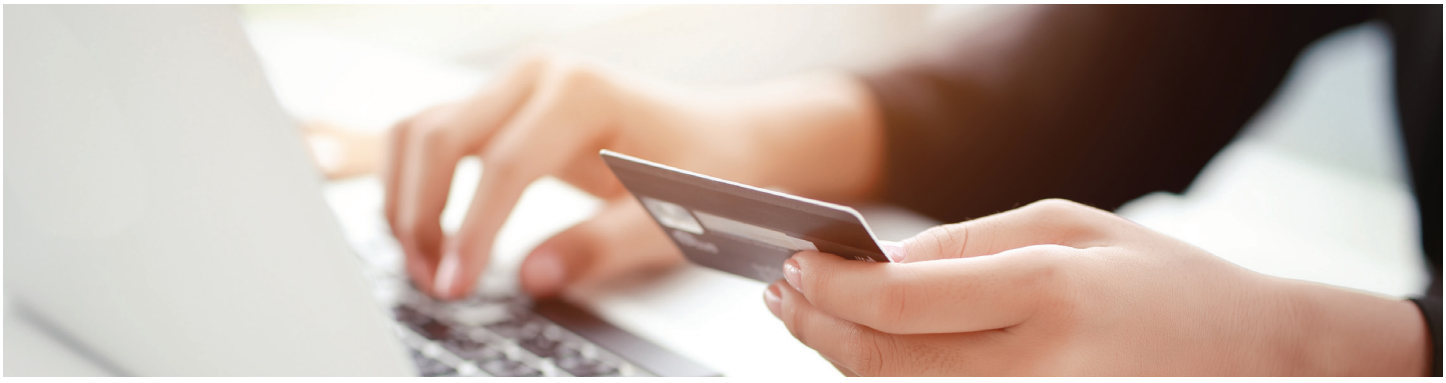
» Log in through face recognition or fingerprint (depending on your phone).

» Check your balance and view account activity.

» Reset login credentials.

Don't have a smartphone?

Go to **www.wexinc.com**, hover over Solutions and select Participants/ Employees. This page provides login buttons for accessing your online account, along with helpful resources like a benefits knowledge base, a link to current eligible expenses, and chat.



Have questions?

Our Participant Services team is available Monday - Friday 6:00 a.m. to 9:00 p.m. Central time.

Questions when enrolled: 1.866.451.3399
Questions before you enroll: 1.844.561.1337
Email a question: customerservice@wexhealth.com
Submit a form: forms@wexhealth.com
Live chat: go to **www.wexinc.com**, hover over Solutions and select Participants/Employees.

LIFE INSURANCE BENEFITS

Life Insurance – Basic and Voluntary

Canyons School District provides Basic Life, Accidental Death & Dismemberment (AD&D) and Dependent Life insurance at no cost to you. Voluntary Life and Accidental Death & 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 the employee is 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 younger than 26 years of age and they qualify as dependents under IRS Code 152, 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 the 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. This allows you to elect up to the Guaranteed Issue amount of $200,000 without underwriting requirements. 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 $200,000 of insurance without medical underwriting. Contact the District Insurance Office for 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 the lesser of 100% of your election amount or $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 them.

If you and your spouse do not enroll during initial eligibility, you may apply, but you will be subjected 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 & Dismemberment policy is available to you. All amounts are guaranteed 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 subjected to 10 times annual salary). Your family benefit is based on the following criteria at time of accident: 50% 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 individuals in a family are employed and insured, benefits will only pay on one policy.

LONG-TERM DISABILITY BENEFITS

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 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 benefit eligibility.

Description of Long-Term Disability Benefits	
Definition of Disability	Due to Sickness, or as a direct result of accidental injury: The Employee is receiving Appropriate Care and Treatment and complying with the requirements of such treatment, and During the elimination period and the next 24 months is unable to perform each of the material duties of their Own Occupation; After such period, is unable to perform the duties of any gainful occupation for which they are reasonably qualified taking into account their training, education and experience.
Eligible Employees	Those employees who are regularly working at least 30 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	The later of your Normal Retirement Age as defined by Social Security of the period shown below: **Age on Date of your Disability** — **Benefit Duration** Less than 60 — to age 65 60 — 60 months 61 — 48 months 62 — 42 months 63 — 36 months 64 — 30 months 65 — 24 months 66 — 21 months 67 — 18 months 68 — 15 months 69 and over — 12 months
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	Lesser of 24 months; or The Maximum Benefit Period
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 was actively at work.

Once you are approved for Disability benefits, Voya can help you obtain Social Security Disability benefits. Our specialists can guide you through the initial application and appeals processes. The specialists may also help you access assistance from attorneys or vendors to pursue Social Security benefits. 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.

VOLUNTARY BENEFITS

Administered by Voya

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. Get a $75 wellness benefit per person per year if you complete an approved wellness screening.

Benefits Summary	Employee	Spouse	Child
Hospital Benefits			
Hospital Admission	$1,500	$1,500	$1,500
Hospital Confinement (per day)	$300	$300	$300
Hospital Intensive Care (per day)	$600	$600	$600
Emergency Room Treatment	$250	$250	$250
Paralysis (lasting 90 days or more and diagnosed by a physician within 90 days)			
Quadriplegia	$20,000	$20,000	$20,000
Paraplegia	$13,500	$13,500	$13,500
Accidental Death & Dismemberment (within 90 days)			
Accidental Death	$50,000	$25,000	$10,000
Accidental Common Carrier Death (plane, train, boat or ship)	$150,000	$50,000	$25,000
Single Dismemberment	$12,500	$12,500	$12,500
Double Dismemberment	$22,000	$22,000	$22,000
Loss of One Finger or Toe	$1,250	$1,250	$1,250
Loss of Two of More Fingers or Toes	$1,800	$1,800	$1,800
Major Injuries (diagnosis and treatment within 90 days)			
FRACTURES (closed reduction)			
Hip/Thigh	$5,000	$5,000	
Vertebrae (except processes)	$4,050	$4,050	
Pelvis	$3,600	$3,600	
Skull (depressed)	$4,000	$4,000	
Leg	$2,700	$2,700	
Forearm/Hand/Wrist	$2,250	$2,250	
Foot / Ankle / Knee Cap	$2,250	$2,250	
Shoulder Blade	$2,250	$2,250	
Lower Jaw (mandible)	$1,800	$1,800	
Collarbone	$1,800	$1,800	
Upper Arm	$2,400	$2,400	
Facial Bones (except nose)	$1,350	$1,350	
Vertebral Processes	$1,750	$1,750	
Finger / Toe	$360	$360	
DISLOCATIONS (closed reduction)			
Hip	$3,850	$3,850	
Knee	$2,400	$2,400	
Shoulder	$1,600	$1,600	
Foot / Ankle	$1,500	$1,500	
Hand	$1,100	$1,100	
Lower Jaw	$1,100	$1,100	
Wrist	$1,100	$1,100	
Elbow	$1,100	$1,100	
Finger / Toe	$275	$275	

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. Get a $50 wellness benefit per person per year if you complete an approved wellness screening.

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	100%

Covered Benefit Amount

Employees can choose coverage amounts of $5,000 to $40,000 in $5,000 increments.

If you choose to elect coverage for a Spouse or Child it is 50% of the employee elected benefit.

Diagnosis Separation Periods

The plan will pay for diagnosis of the same critical illnesses if a certain amount of time has passed. For a critical illness other than cancer or carcinoma in stu or skin cancer it is three months. For cancer or carcinoma in situ or skin cancer it is 12 months.

Hospital Indemnity

A stay in the hospital for an accident or illness 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)	$400

SEMI-MONTHLY RATES

Critical Illness

Employee NON-TOBACCO Semi-Monthly Premium								
	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000
Under 25	$0.93	$1.85	$2.78	$3.70	$4.63	$5.55	$6.48	$7.40
25-29	$1.23	$2.45	$3.68	$4.90	$6.13	$7.35	$8.58	$9.80
30-34	$1.58	$3.15	$4.73	$6.30	$7.88	$9.45	$11.03	$12.60
35-39	$1.95	$3.90	$5.85	$7.80	$9.75	$11.70	$13.65	$15.60
40-44	$2.58	$5.15	$7.73	$10.30	$12.88	$15.45	$18.03	$20.60
45-49	$3.23	$6.45	$9.68	$12.90	$16.13	$19.35	$22.58	$25.80
50-54	$3.90	$7.80	$11.70	$15.60	$19.50	$23.40	$27.30	$31.20
55-59	$4.50	$9.00	$13.50	$18.00	$22.50	$27.00	$31.50	$36.00
60-64	$6.13	$12.25	$18.38	$24.50	$30.63	$36.75	$42.88	$49.00
65-69	$7.75	$15.50	$23.25	$31.00	$38.75	$46.50	$54.25	$62.00
70+	$10.78	$21.55	$32.33	$43.10	$53.88	$64.65	$75.43	$86.20

Spouse NON-TOBACCO Semi-Monthly Premium (Spouse is eligible for 50% of employee election)								
	$2,500	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000
Under 25	$0.34	$0.68	$1.01	$1.35	$1.69	$2.03	$2.36	$2.70
25-29	$0.44	$0.88	$1.31	$1.75	$2.19	$2.63	$3.06	$3.50
30-34	$0.65	$1.30	$1.95	$2.60	$3.25	$3.90	$4.55	$5.20
35-39	$0.89	$1.78	$2.66	$3.55	$4.44	$5.33	$6.21	$7.10
40-44	$1.33	$2.65	$3.98	$5.30	$6.63	$7.95	$9.28	$10.60
45-49	$1.85	$3.70	$5.55	$7.40	$9.25	$11.10	$12.95	$14.80
50-54	$2.41	$4.83	$7.24	$9.65	$12.06	$14.48	$16.89	$19.30
55-59	$2.99	$5.98	$8.96	$11.95	$14.94	$17.93	$20.91	$23.90
60-64	$3.89	$7.78	$11.66	$15.55	$19.44	$23.33	$27.21	$31.10
65-69	$4.21	$8.43	$12.64	$16.85	$21.06	$25.28	$29.49	$33.70
70+	$5.06	$10.13	$15.19	$20.25	$25.31	$30.38	$35.44	$40.50

Accident Illness

24-Hour High Accident Coverage	Semi-Monthly Rates
Employee	$3.99
Employee & Spouse	$7.98
Employee & Dependent Children	$8.58
Family	$12.56

Hospital Indemnity

Semi-Monthly Rates	
Employee	$10.95
Employee & Spouse	$19.85
Employee & Dependent Children	$19.06
Family	$27.96

KEY TERMS

Brand Name Prescription Drug

A prescription drug that is sold under a trademarked name. An equivalent generic drug may or may not be available at lower cost, depending on whether the patent on the brand name drug has expired.

Copay

A flat dollar amount you pay for a medical service. On the following plans, the copay does not apply to the deductible; however, it does apply to the out-of-pocket maximum:

» Traditional Plan Base Option

» Traditional Plan Buy-Up Option

Coinsurance

The percentage of the charges you are responsible for paying.

Deductible

This is the amount you pay before your plan begins covering expenses not subject to a copay.

Explanation of Benefits

The statement you receive from your insurance company detailing how much the provider billed, how much (if any) the plan paid, and the amount that you owe the provider (if any).

Generic Prescription Drug

A prescription drug made and distributed after the brand name drug patent has expired, and available at a lower cost than brand name prescriptions.

Out-of-Pocket (OOP) Maximum

The most you pay in a calendar year for covered medical services. Once the OOP maximum is met, the plan will pay 100% of the allowed amount for the remainder of the calendar year for covered services.

In-Network

Services from a provider or facility that is contracted with the insurance company. In-network providers agree to accept set fees for covered medical services and not bill you for any amounts over those fees. In-network providers also agree to bill the insurance company directly, so you will not have to pay up front and submit your own claims to the insurance company.

Out-Of-Network

Services from a provider or facility that is not contracted with the insurance company. Not all plans provide coverage for out of network expenses. If you receive services out-of-network, then you will typically have a higher coinsurance and you will be responsible for the difference between the provider's billed charge and the allowable charge.

Preventive Care

Measures taken to prevent diseases. This includes routine cancer screenings, exams and certain drugs and immunizations. Most preventive care is covered-in-full by the plan, with no cost to you.

IMPORTANT NOTICES AND DISCLOSURES

Women's Health & Cancer Rights Act

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 ("WHCRA"). 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 was performed;

» Surgery and reconstruction of the other breast to produce a symmetrical appearance;

» Prostheses; and

» Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. If you would like more information on WHCRA benefits, contact the insurance department.

Newborns' and Mothers' Health Protection 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

ACA DISCLAIMER

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible, you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.12% of your modified adjusted household income.

Michelle's Law

Michelle's Law requires group health plans to provide continued coverage for a dependent child covered under the plan if the child loses eligibility under the Canyons School District Welfare Benefits Plan because of the loss of student status resulting from a medically necessary leave of absence from a post-secondary educational institution. If your child is covered under the Canyons School District Welfare Benefits Plan, but will lose eligibility because of a loss of student status caused by a medically necessary leave of absence, your child may be able to continue coverage under our plan for up to one year during the medically necessary leave of absence. This coverage continuation may be available if on the day before the medically necessary leave of absence begins your child is covered under the Canyons School District Welfare Benefits Plan and was enrolled as a student at a post-secondary educational institution.

A "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution (or change in enrollment status in that institution) that: (1) begins while the child is suffering from a serious illness or injury, (2) is medically necessary, and (3) causes the child to lose student status as defined under our plan.

The coverage continuation is available for up to one year after the first day of the medically necessary leave of absence and is the same coverage your child would have had if your child had continued to be a covered student and not needed to take a medical leave of absence. Coverage continuation may end before the end of one year if your child would otherwise lose eligibility under the plan – for example, by reaching age 26.

If your child is eligible for this coverage continuation and loses coverage under the plan at the end of the continuation period, COBRA continuation may be available at the end of the Michelle's Law coverage continuation period.

If you have any questions concerning this notice or your child's right to continued coverage under Michelle's law, please contact the Insurance Department.

HIPAA Notice Of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

Canyons School District is committed to the privacy of your health information. The administrators of the Canyons School District Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Robert Reeder at 801-826-5448.

HIPAA Special Enrollment Rights

Canyons School District Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Canyons School District Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Rober Reeder, **801.826.5448**.

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:

1. **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.**
2. **Canyons School District has determined that the prescription drug coverage offered by the medical plan 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 15th to December 7th.

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 may be affected.

If you do decide to join a Medicare drug plan and drop your current Canyons School District coverage, be aware that you and your dependents may be able to get this coverage back.

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 October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage:

Contact the person listed below for further information. **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**).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2025
Name of Entity/Sender:	Canyons School District
Contact:	Robert Reeder
Address:	9361 S. 300 East Sandy, Utah 84070
Phone Number:	801.826.5448

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).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Fax: 916.440.5676| Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.mycohibi.com/ HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/ health-insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/ childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program Family and Social Services Administration http://www.in.gov/fssa/dfr/ | 800.403.0864 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://hhs.iowa.gov/programs/welcome-iowa-medicaid 800.338.8366 Hawki: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/ hawki 800.257.8563 HIPP: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884 | HIPP Phone: 800.967.4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kynect.ky.gov | 877.524.4718 Medicaid: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/ applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800.862.4840 | TTY: 711| Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
https://mn.gov/dhs/health-care-coverage/ 800.657.3672

MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084 | Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 15218 | Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 800.356.1561 CHIP: http://www.njfamilycare.org/index.html 800.701.0710 (TTY: 711) | Premium Assistance: 609.631.2392
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov 919.855.4100
NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid and CHIP
http://healthcare.oregon.gov/Pages/index.aspx 800.699.9075
PENNSYLVANIA – Medicaid and CHIP
https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 800.692.7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program 800.440.0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) https://medicaid.utah.gov/upp/ | Email: upp@utah.gov | 888.222.2542 Adult Expansion: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program: https://medicaid.utah.gov/buyout-program/ CHIP: https://chip.utah.gov/
VERMONT – Medicaid
https://dvha.vermont.gov/members/medicaid/hipp-program 800.250.8427
VIRGINIA – Medicaid and CHIP
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid and CHIP
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2026)

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This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting