Davis School District

Established 1911

INSURANCE BENEFITS GUIDE 2018

JANUARY –DECEMBER 2018

The Davis School District is pleased to offer you an excellent insurance benefit package. Eligible employees can elect participation in any or all of the following:

- Health Insurance
- Dental Insurance
- Basic Term Life Insurance
- Supplemental Term Life Insurance
- Short Term Disability Insurance
- Long Term Disability Insurance
- Vision Insurance
- Flexible Benefit Plan
- Catastrophic Sick Leave Bank

In this guide you will find a brief description of the options available, a comparison of basic plan coverages, and cost information. The guide was designed to help you make decisions about what coverage is best for you and your family's unique needs. Please take the time to carefully review this information and make thoughtful decisions about these valuable benefits.

Remember, this is summary information only and does not guarantee benefits. If you would like more information about any of the plans' specifics, don't hesitate to contact the insurance companies directly. Also remember that eligibility guidelines and benefits offered by the district are subject to negotiations with employee associations and may change at any time.

If you have questions about insurance choices, please contact the District Insurance Office at 801-402-5200. The District Insurance Office is committed as an employee advocate and liaison with the insurance carriers to assure that employees and their families receive prompt, appropriate, and courteous service.

If you have questions about the Flexible Benefit Plan, contact the Payroll Department at 801-402-5232. If you have questions about the Catastrophic Sick Leave Bank, contact the Human Resources Department at 801-402-5315.

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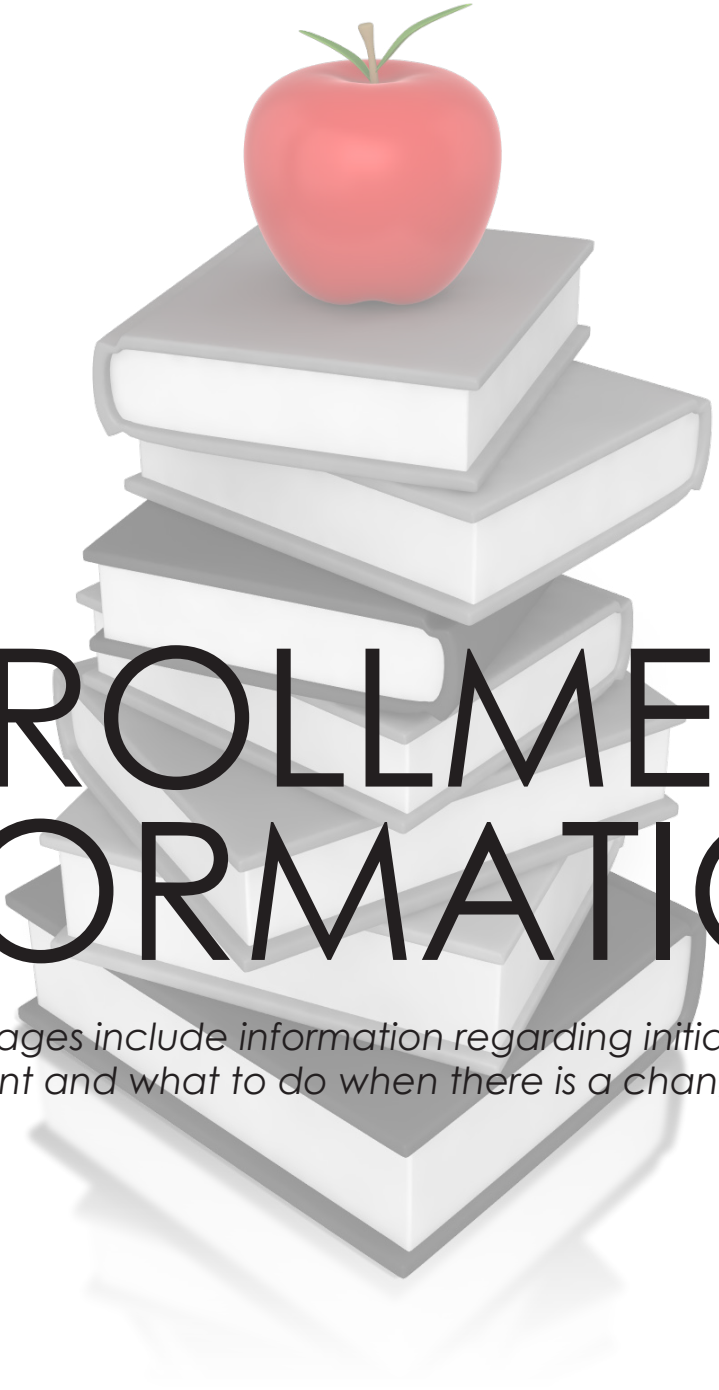
CREDITABLE COVERAGE NOTICE . . . . see page 80



ENROLLMENT INFORMATION

The following pages include information regarding initial enrollment, open enrollment and what to do when there is a change of status.

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Initial Enrollment

Newly hired or newly insurance eligible employees interested in district sponsored insurance plans are required to enroll for insurance through the District Insurance Office. These employees need to attend an Insurance Enrollment Meeting within 30 days of their insurance eligibility date. At this meeting, employees will receive information about insurance benefits, along with initial enrollment forms. These enrollment forms must be submitted to the District Insurance Office in a timely manner. Employees who fail to do so may be required to wait until the next insurance open enrollment period to enroll in district sponsored insurance plans. Additionally, employees who fail to enroll during their initial eligibility may be subject to benefit reductions and additional underwriting requirements when enrolling at a later date.

Open Enrollment

The district's "Insurance Open Enrollment" period is an annual opportunity for insurance eligible employees to enroll or make changes in their insurance coverage. The Open Enrollment period for the 2018 insurance plan year will begin on Monday, October 30, 2017, and continue through Friday, November 17, 2017. During this Open Enrollment period, employees have the opportunity to select their insurance coverage choices for the upcoming year. Selections or changes made during this Open Enrollment period will become effective January 1, 2018. Plans subject to underwriting may decline enrollment or have a delayed enrollment date based on underwriting approval.

Below is an explanation of the process you will need to follow to update or reconfirm your insurance coverage choices during the Open Enrollment period.

Active Employees

Complete the Open Enrollment process through the District's ENCORE system as follows:

Log onto ENCORE (Use Internet Explorer as your browser)

- Access the District Home Page (www.davis.k12.ut.us)
- Click on "Encore" under "Tools"
- Enter your "Encore" Username and Password

(If you do not have an Encore Username and Password use the following:)

Username: **ENROLLMENT**
Password: **ENROLLMENT**

↓

Select: *Financials*
↓
Insurance
↓
Open Enrollment Sign In Form

(Continued on next page)

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Enter your employee ID number, birthdate (DD-MON-YYYY), and the last 4 digits of your social security number to access the Open Enrollment options.

Continue through the Open Enrollment process as directed on the screens

PLEASE NOTE: You may access the Open Enrollment process as often as you would like during the Open Enrollment period. If you access the system more than once, you must re-enter your insurance selections. Remember, the last change you complete is the one that will be recorded and communicated as your enrollment choice.

Retired Employees

To complete Open Enrolllment and select your insurance coverage choices for 2018, you will need to complete the electronic Open Enrollment process by following the instructions on page 5 under "Active Employees". You will need to use the word "Enrollment" as both your Username and Password. Please remember that this enrollment process must be completed no later than Friday, November 17, 2017. If you do not complete the electronic Open Enrollment process by that date, your insurance coverage selection for 2018 will remain as it was during 2017.

COBRA Participants

Included with your Open Enrollment packet is an Enrollment Form. Complete the Enrollment Form and return it to the Human Resources Department no later than Friday, November 17, 2017. If the Human Resources Department does not receive your form by that date, your insurance coverage selection for 2018 will remain as it was during 2017.

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Spouses Working for the District

If spouses work for the district in insurance eligible positions, the district will cover a higher percentage of the health and dental premium contribution (up to 100% of the premium) than if only one worked for the district. Coverage is provided under one spouse only rather than coordinated coverage. In this situation, eligible children may be covered under only one district employed parent. In order to take advantage of this benefit, please be sure the District Insurance Division is notified if your spouse also works for the district.

SPECIAL ENROLLMENT EVENTS

Change Of Status

If you and/or your dependents experience a change of status such as:

- marriage;
- birth;
- adoption;
- addition of child(ren);
- deletion of child(ren) who lose dependent status;
- legal guardianship;
- divorce;
- loss of spouse's job; or
- death;

You must submit a written notice of the event to the District Insurance Division within 30 days of the effective date of the change. If notice is not submitted in a timely manner, coverage opportunities may be lost and/or delayed. *Failure to submit timely notice regarding a spouse and/or dependents losing eligibility may be considered insurance fraud and could subject employees to district disciplinary action.*

Change Of Authorized Hours

If you were a part-time insurance eligible employee who initially declined insurance coverage when first eligible, you have another enrollment opportunity if you are:

- in a licensed position and your authorized hours are increased to 35 hours per work week;
  or
- in a classified position and your authorized hours are increased to 37.5 hours per work week.

To take advantage of this new enrollment opportunity, you need to contact the District Insurance Division and attend a Benefits Meeting. You must enroll for coverage within 30 days of your new eligibility date (the effective date of the change in authorized hours). Otherwise, you will not be eligible to enroll until the next Open Enrollment period.

Late Enrollee

Late enrollees may be subject to benefit reductions, restrictions, and additional underwriting requirements. A late enrollee is an employee who:

- declines insurance enrollment when initially eligible and then elects to enroll at any time in the future;
  or
- cancels insurance coverage but continues working in an insurance eligible position and then elects to enroll at any time in the future.

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FLEXIBLE BENEFIT PLAN ENROLLMENT

For participation in the Flexible Benefit Plan from January 1, 2018, through December 31, 2018, you will need to complete enrollment through the Insurance Open Enrollment System anytime between Monday, October 30, 2017, and Friday November 17, 2017. (See instructions for Active Employee Open Enrollment on Page 5.) The Open Enrollment period is the only time you may elect to enroll in the Flexible Benefit Plan unless you are a new employee. Even if you were enrolled in the Flexible Benefit Plan during 2017, you must make a new election through Open Enrollment if you wish to continue your participation in the plan for 2018. Please refer to the Flexible Benefit Plan section of this booklet for additional information about the Flexible Benefit Plan. You may contact the Accounting Department at 801-402-5232 if you have additional questions or concerns.

CATASTROPHIC SICK LEAVE BANK ENROLLMENT

Employees desiring to participate in the Catastrophic Sick Leave Bank from January 1, 2018, through December 31, 2018, may enroll in the program by donating a day of sick leave to the bank through the Insurance Open Enrollment System anytime between Monday, October 30, 2017, and Friday, November 17, 2017. (See instructions for Active Employee Open Enrollment on page 5.) To learn more about the bank and determine whether this is a "contribution year", please review the Catastrophic Sick Leave Bank section on page 89 of this Benefits Guide.

If you do not elect to enroll in the bank during the Open Enrollment period, you will not have another opportunity to enroll until next year's Open Enrollment period. Employees hired after the Open Enrollment period will not be able to enroll in the bank until the following year.

Benefit plan enrollment for you and your dependents requires the collection of personal information. Failure to provide the necessary information could jeopardize enrollment in district sponsored insurance plans. Please note, private and controlled information is shared or received according to the requirements under the Government Records Access and Management Act (GRAMA) and Health Insurance Portability and Accountability Act (HIPAA).

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The following pages contain information on the health insurance plans offered by Davis School District. Isurance eligible employees may choose one of the following plans:

AETNA

Traditional Health Plan

High Deductible Health Plan

SELECTHEALTH

Traditional Health Plan

High Deductible Health Plan

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Traditional Health Plan Comparisons*

Benefits	SelectHealth Traditional Plan	Aetna Traditional Plan
Primary Care Physician Required	No	No
Specialist Referral Required	No	No
Deductible (PCY)**	$2000 for Individual / $4000 Family	$2000 Individual / $4000 Family
Out-of-Pocket Maximum (PCY)**	$2500 Individual / $5000 Family	$2500 Individual / $5000 Family
Annual/Lifetime Maxiumum	Unlimited	Unlimited
Pre-Existing Conditions	Covered	Covered
Prescriptions		
Prescription Drugs	$15 / $30 / $50 / $100	$15 / $30 / $50
Mail Order Prescription	$30 / $60 / $100 (90 day supply)	$30 / $60 / $100 (90 day supply)
Physicians Services		
Primary Care Provider (PCP)	$35 Copay per visit	$35 Copay per visit
Secondary Care Provider (SCP)	$45 Copay per visit	$45 Copay per visit
After-Hours Care / Urgent Care	$45 Copay at InstaCare/$35 at KidsCare	$45 Copay per visit
Maternity	80% Coverage after deductible	80% Coverage after deductible
Surgery	80% Coverage after deductible	80% Coverage after deductible
Anesthesiology/Pathology/Radiology	80% Coverage after deductible	80% Coverage after deductible
Physical Therapy	$45 Copay per visit after deductible (Limit 20 visits per year)	$45 Copay per visit (Limit 20 visits per year)
Chiropractic	Not covered	$45 Copay per visit (Limit 20 per year)
Preventative Health Services	Plan will cover many preventative services without charging a deductible, copay, or coinsurance. For specific information, please contact SelectHealth at (800) 538-5038	Plan will cover many preventative services without charging a deductible, copay, or coinsurance. For specific information, please contact Aetna at (866) 756-0376
Hospital Services		
Prior Authorization	Provider Responsibility	Provider Responsibility
Room & Board/Ancillary/Maternity	80% Coverage after deductible	80% Coverage after deductible
Outpatient Surgery	80% Coverage after deductible	80% Coverage after deductible
Major Diagnostic Test	80% Coverage after deductible	80% Coverage after deductible
Accidental/Emergency Care		
Emergency Room / Life Threatening	$200 Copay	$200 Copay
Emergency Room - Non Participating	$200 Copay	$200 Copay
Ambulance/Paramedic Services	80% Coverage after deductible	80% Coverage after deductible
Mental Health Services & Alcohol & Substance Abuse		
Pre-Notification	Call 1-800-538-5038	Participating Provider Responsibility
Office Visit	$35 Copay per visit	$45 Copay per visit
Outpatient Services	80% Coverage	$45 Copay per visit
Inpatient Services	80% Coverage after deductible	80% Coverage after deductible

*A Summary of Benefits and Coverage (SBC) for this plan can be found at www.davis.k12.ut.us/dsd/insurance.
**PCY means Per Calendar Year (January 1 through December 31)
This is an illustrative summary only and does not guarantee benefits. It is not meant to replace or fully interpret the contracts with the insurance carriers. Please refer to the specific contracts with the carriers for detailed explanation and coverage descriptions.

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High Deductible Health Plan (HDHP) Comparisons*

Benefits	SelectHealth High Deductible Health Plan	Aetna High Deductible Health Plan
Primary Care Physician Required	No	No
Specialist Referral Required	No	No
Deductible (PCY)**	$2000 for Individual coverage	$2000 for Individual coverage
	$4000 for 2 Party or Family coverage	$4000 for 2 Party or Family coverage
Out-of-Pocket Maximum (PCY)**	$2500 for Individual coverage	$2500 for Individual coverage
	$5000 for 2 Party or Family coverage	$5000 for 2 Party or Family coverage
Annual/Lifetime Maxiumum	Unlimited	Unlimited
Pre-Existing Conditions	Covered	Covered
Prescriptions		
Prescription Drugs	$7 /$21 / $42 / $100 -After deductible	$7 / $21 / $42 After deductible
Mail Order Prescription (90 Day Supply)	$7 /$42 /$126 -After deductible	$21 / $63 / $126 After Deductible
Physicians Services		
Primary Care Provider (PCP)	$15 Copay after deductible	80% Coverage after deductible
Secondary Care Provider (SCP)	$25 Copay after deductible	80% Coverage after deductible
After-Hours Care / Urgent Care	$35 Copay after deductible	80% Coverage after deductible
Maternity	80% Coverage after deductible	80% Coverage after deductible
Surgery	80% Coverage after deductible	80% Coverage after deductible
Anesthesiology/Pathology/Radiology	80% Coverage after deductible	80% Coverage after deductible
Physical Therapy	$25 Copay after deductible	80% Coverage after deductible
	(Limit 20 visits per year)	(Limit 20 visits per year)
Chiropractic	Not covered	80% Coverage after deductible (Limit 20 visits per year)
Preventative Health Services	Plan will cover many preventative services without charging a deductible, copay, or coinsurance. For specific information, please contact SelectHealth at (800) 538-5038	Plan will cover many preventative services without charging a deductible, copay, or coinsurance. For specific information, please contact Aetna at (866) 756-0376
Hospital Services		
Prior Authorization	Provider Responsibility	Provider Responsibility
Room & Board/Ancillary/Maternity	80% Coverage after deductible	80% Coverage after deductible
Outpatient Surgery	80% Coverage after deductible	80% Coverage after deductible
Major Diagnostic Test	80% Coverage after deductible	80% Coverage after deductible
Accidental/Emergency Care		
Emergency Room / Life Threatening	$75 Copay after deductible	80% Coverage after deductible
Emergency Room - Non Participating	$75 Copay after deductible	80% Coverage after deductible
Ambulance/Paramedic Services	80% Coverage after deductible	80% Coverage after deductible
Mental Health Services & Alcohol & Substance Abuse		
Pre-Notification	Call 1-800-538-5038	Participating Provider Responsibility
Office Visit	$15 Copay after deductible	80% Coverage after deductible
Outpatient Services	80% Coverage after deductible	80% Coverage after deductible
Inpatient Services	80% Coverage after deductible	80% Coverage after deductible

*A Summary of Benefits and Coverage (SBC) for each of these plans can be found at www.davis.k12.ut.us/dsd/insurance.
**PCY means Per Calendar Year (January 1 through December 31)
This is an illustrative summary only and does not guarantee benefits. It is not meant to replace or fully interpret the contracts with the insurance carriers. Please refer to the specific contracts with the carriers for detailed explanation and coverage descriptions.

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LEARN MORE ABOUT HOW YOU MIGHT BENEFIT FROM A "HIGH DEDUCTIBLE HEALTH PLAN" OPTION ALONG WITH A "HEALTH SAVINGS ACCOUNT"

Employees of Davis School District now have the option of enrolling in a "High Deductible Health Plan" (HDHP) as an alternative to the traditional health plans offered by the district. The two HDHPs offered by the district include "SelectHealth High Deductible" and "Aetna High Deductible".

Additionally, employees who select HDHP coverage will be eligible for a "Health Savings Account" (HSA) that may be used to pay qualified medical costs. These HSAs will be set up and administered through HealthEquity. Employees electing HDHP coverage will receive a monthly contribution from the district into their HSA. (See page 13) Additionally, employees may make contributions to their HSA on a pre-tax basis.

Please consider the following information in determining whether a "High Deductible Health Plan" is right for you.

How does a "High Deductible Health Plan" (HDHP) Work?

The HDHPs offered by the district have lower monthly premiums than the traditional health plans. (See premiums on pages 68-69.) Just like the name suggests, an HDHP has a high deductible which you must satisfy before any benefits will be paid by the insurance company.

For each of the HDHPs offered by the district, there is an annual deductible ($2,000 if you have individual coverage, and $4,000 if you have 2-party or family coverage.) Until this annual deductible is met, you would pay the entire cost of eligible medical expenses (i.e. doctor visits, prescriptions, diagnostic tests, surgeries, hospitalization, etc.) The amount you are billed will be the discounted rate which has been negotiated with the insurance carrier. (Please note, most preventive services are covered at 100% and are not subject to the deductible.)

Once you have satisfied the annual deductible, medical claims would be paid according to the plans' benefits schedule (see page 11). These benefits would apply until you have met the annual out-of-pocket maximum ($2,500 if you have individual coverage, and $5,000 if you have 2-party or family coverage.) Once you meet the out-of-pocket maximum, all eligible claims would be paid at 100%.

How does a "Health Savings Account (HSA) work in conjunction with HDHP coverage?

A "Health Savings Account" (HSA) is a tax-free savings account that works with a qualified HDHP to help you pay your insurance deductible and other qualified out-of-pocket medical expenses. In order to be eligible for an HSA, you must:

- -Be enrolled in a qualified high deductible health plan (HDHP);
- -Not be covered by another health plan that is not an HDHP;
- -Not be enrolled in Medicare;
- -Not be claimed as a dependent on anyone else's tax return.

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If you meet this criteria and choose one of the HDHPs offered by the district, you will be set up with an HSA which will be administered through HealthEquity. You will then be able to make tax-free contributions to your HSA that may be used to pay qualified medical expenses. Additionally, the district will make monthly contributions to your HSA. For 2018, the amount of the monthly district contribution will be based on the coverage you choose and your weekly authorized hours as follows:

	30 or more hours per week	Less than 30 hours per week
Family coverage	$160.00 per month	$ 80.00 per month
2-party coverage	$125.00 per month	$ 62.50 per month
Individual coverage	$ 65.00 per month	$ 32.50 per month

(Please note: Individuals continuing coverage through COBRA and retirees beyond the first three years of coverage under the early retirement incentive plan are not eligible for the monthly HSA contribution from the district.)

Contribution Limits

The total annual amount that may be contributed to your HSA is limited by the IRS. For 2018, the limit is $3,450 if you have individual coverage, and $6,900 if you have 2-party or family coverage. If you are over the age of 55, you can make an additional "catch-up" contribution of $1,000. Your own HSA contributions, combined with the monthly district contributions, cannot exceed these amounts. If you contribute too much, the IRS will impose a penalty on the excess amounts.

Tax Advantages

You can set-up a payroll deduction to have your own HSA contributions deducted from your paycheck on a pre-tax basis, or you can personally make contributions and write them off as a deduction on your federal and state tax returns. If you choose to make contributions to your HSA through payroll deductions, you may change the amount of your payroll deduction anytime during the year, as long as proper notification is given to the Payroll Department by the 15th day of the month for which you want the change effective.

Eligible Expenses

You may use your HSA funds to pay for qualified medical expenses for yourself, your spouse, and your children who are eligible to be claimed as dependents for income tax purposes. These include expenses that apply toward your HDHP annual deductible and out-of-pocket maximum, as well as other qualified medical expenses, including dental and vision expenses. (For a complete list of qualified expenses, see IRS Publication 502 at www.irs.gov.)

Savings Advantages

The HSA is your account. Any unused funds roll over every year and may be used for future medical expenses, even if you terminate your employment with the district, retire, or change health plans. Unlike a Flexible Spending Account (FSA), you don't lose the money left in your HSA at the end of the year. The money in your HSA earns interest and may also be invested in mutual funds once your balance reaches at least $2,000.

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Health Care Flexible Spending Account (FSA) not allowed with an HSA

If you elect HDHP coverage along with an HSA, you are not allowed to have a general purpose healthcare flexible spending account (FSA). You may, however, have a "limited-purpose" FSA along with your HSA. This limited purpose FSA may be used only for qualified dental and vision expenses.

If you currently have a healthcare FSA, it must have a zero balance before you can open an HSA. Therefore, if you choose to switch to HDHP coverage for 2018, you must have a zero balance in your healthcare FSA by December 31st in order to open an HSA and be eligible to receive the monthly district HSA contribution beginning in January.

Paying Claims and Medical Expenses

You may access your claims, pay bills, and request reimbursement from HealthEquity's on-line portal. Additionally, you will receive a HealthEquity Visa debit card that you can use to make payments for qualified medical expenses. You may also make payments by other methods and then request reimbursement from your account.

HealthEquity™

Health Equity will help you manage your Health Savings Account (HSA)

Through HealthEquity's on-line access, you will be able to see your HSA account balance, HSA debit card transactions, claims transactions, and other information about your account. You can also pay providers, request reimbursements, and manage your personal information. HealthEquity's Member Services is available to help you get the most from your HSA, find comparison pricing on prescriptions and medical services, research diseases, and more. HealthEquity's specialists are available 24 hours a day, 365 days a year, to assist you with questions about eligible expenses, contributions, and distributions.

For additional information and answers to frequently asked questions about HSAs, go to www.davis.k12.ut.us/dsd/insurance. There you will see a link to "Health Savings Accounts (HSAs) FAQs".

Additionally, information about HSAs is available directly from HealthEquity at: www.healthequity.com or by calling (866) 346-5800.

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Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

aetna®

Network doctors and no referrals

Open Access
Aetna Select℠ Plan

www.aetna.com

A health insurance plan designed to meet your needs

This plan lets you visit any doctor in the Aetna network. And you do not need a referral when you visit one.

You don't have to choose a **primary care physician (PCP)** either, but you may want to. That's because PCPs do more than give you a checkup. They know you, your medical history, and they can help guide you and direct your care.

This plan also gives you access to tools, tips, programs and services. They can help you find network doctors, estimate costs and more.

Looking for your exact copay amounts? Or what your plan covers and doesn't cover?

All employer health plans are different. This booklet gives a general idea of how the Open Access Aetna Select plan works and how to get the most out of it.

For details like copays and what's covered, check your Summary of Benefits and Coverage document.

Your options	Pick your doctor	How it works
Your network PCP	**Choose any PCP from Aetna's network.** Again, choosing one is not necessary, but you might find it helpful to have one. You can change your PCP anytime. Just call Member Services at the number on your Aetna ID card. Or do it online through your secure member website.	**Your PCP will:** • Give you checkups or treat you when you are sick or hurt • Get approval from us before giving you certain services • File claims for you **With this option, you typically pay less out of pocket.** Your copay may be lower when you visit your PCP for care. A copay is a fixed dollar amount you pay at the time of a visit.
Any network provider	**Visit any network doctor or specialist without a referral.** Network doctors contract with Aetna to offer rates that are often lower than their regular fees. A specialist is a doctor who focuses only on treating certain conditions or diseases. For example, a dermatologist treats skin conditions. A cardiologist treats heart problems.	**The network doctor or specialist will:** • Provide care • Get approval from us before giving you certain services • File claims for you **Visiting a network doctor may cost more than visiting your PCP.** And you may have a higher copay to visit specialists.

You need to see network providers for the plan to cover and help pay for care.* Providers are professionals and facilities that provide health care services. Doctors, hospitals and labs are examples of providers.

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*In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Health insurance plans are offered, underwritten and/or administered by Aetna Life Insurance Company (Aetna).

Tools to help you find network doctors and more

Finding a PCP or network doctor is easy

Use our online directory. You can find doctors by name, specialty and location. You'll also find maps, directions and more. You can even look for doctors who speak your language. Try it out at **www.aetna.com**.

Or get a printed directory. If you are already an Aetna member, call Member Services to get one. The toll-free number is on your Aetna ID card. If you're not an Aetna member yet — or haven't received your ID card — call **1-888-982-3862**.

Sign up for your members-only website

When you're an Aetna member, you get tools and resources to help you manage your health and your benefits. You'll find all your plan information and cost-saving tools in one place — your secure member website. You just need to sign up. Members can register at **www.aetna.com**.

Meet Ann, your virtual assistant

Ann can help you sign up for your secure member website. She can help you find a doctor, estimate the cost of health services, and even answer questions about claims, ID cards and more. She *never* sleeps — so chat with her anytime.

For help over the phone

You can speak to Member Services anytime during regular business hours. Our representatives are here to help answer any questions you have about your plan. Just call the toll-free number on your Aetna ID card.

Here's a way to estimate costs once you enroll

Our Member Payment Estimator lets you compare and estimate costs** for office visits, tests and surgeries. This online tool factors in any deductible, coinsurance and copays that are part of your plan, plus Aetna's contracted rates. You can see how much you'll have to pay and how much Aetna will pay. To use the estimator tool, go to **www.aetna.com** and log in to your secure member website.

The Aetna Mobile app puts our most popular online features at your fingertips. It's available for Android™ and iPhone® mobile devices. Visit **www.aetna.com/mobile**.

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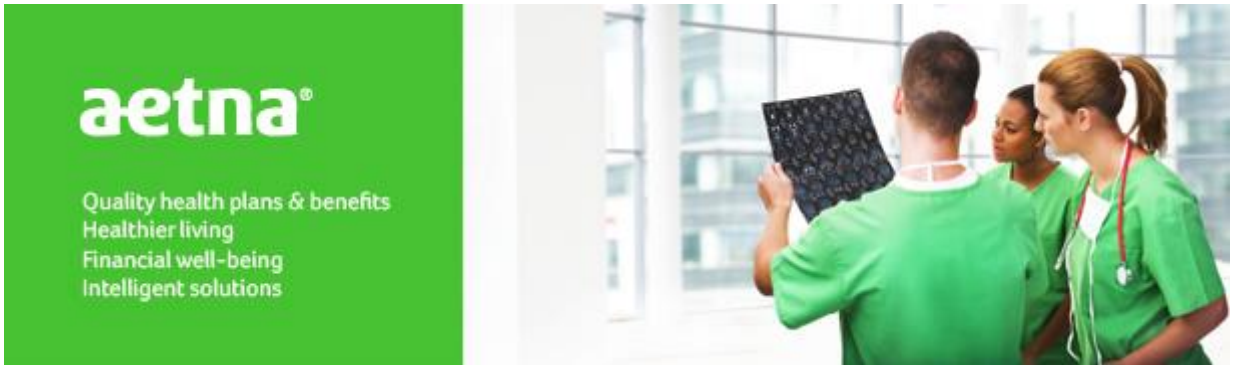
**Estimated costs not available in all markets. The tool gives you an estimate of what you would owe for a particular service based on your plan at that very point in time. Actual costs may differ from the estimate if, for example, claims for other services are processed after you get your estimate but before the claim for this service is submitted. Or, if the doctor or facility performs a different service at the time of your visit.



Searching our public provider directory

To locate a participating provider using the public Find a Doctor tool on www.aetna.com it is important that you choose the correct network for your plan. These step by step instructions will help you search our public directory with ease.

On the main page of www.aetna.com on the upper right side of the page click Find a Doctor. Do not use the one in the gray ribbon since that will direct to a page for existing members.

On the next page under Not a member yet?, which is on the right side of the page, click on *Plan from an employer >*

This will bring you to the Directory of Health Care Professionals page where you will type in a doctor's name or specialty type along with a city or zip code you wish to search. Once you hit the search button you will be asked to select a plan.

When asked to select your plan, scroll down the list until you find a bold header labeled **Aetna Open Access Plans** From there you will select Aetna Select(SM) (Open Access).

Once you have an Aetna member ID number it is important that you register with Aetna Navigator and search for a participating provider using your Aetna Navigator secure member site.

You can also call our Customer Care Team at 855-339-9375 to inquire about participating providers.

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aetna℠

Your Search Results

DocFind®

Health Plan: Aetna Select℠ Provider Type: Medical Hospitals

You searched by: State: UT Zip Code: 84025 Distance: 100
August 24, 2017

Provider ID #: 6550290
Bear River Valley Hospital
905 North 1000 West
Tremonton, UT 84337
(435) 207-4500

Provider ID #: 6550115
Brigham City Community Hospital
950 Medical Drive
Brigham City, UT 84302
(435) 734-9471

Provider ID #: 7356409
Cache Valley Hospital
2380 North 400 East
Logan, UT 84341
(435) 713-9700

Provider ID #: 5995441
Center For Change
1790 North State Street
Orem, UT 84057
(801) 224-8255

Provider ID #: 6550190
Central Valley Medical Center
48 West 1500 North
Nephi, UT 84648
(435) 623-3000

Provider ID #: 5282526
Copper Hills Youth Center
5899 West Rivendell Drive
West Jordan, UT 84081
(801) 561-3377

Provider ID #: 9007211
Cottonwood Treatment Center
1144 West 3300 South
Salt Lake City, UT 84119
(801) 443-2900

Provider ID #: 6550150
Davis Hospital and Medical Center
1600 West Antelope Drive
Layton, UT 84041
(801) 825-9561

Provider ID #: 4561692
Elevations Residential Treatment Center
2650 West 2700 South
Syracuse, UT 84075
(801) 773-0200

Provider ID #: 6610145
Evanston Regional Hospital
190 Arrowhead Drive
Evanston, WY 82930
(307) 789-3636

Provider ID #: 4188654
Healthsouth Rehab of UT
8074 South 1300 East
Sandy, UT 84094
(801) 561-3400

Provider ID #: 6550140
Heber Valley Hospital
1485 South Hwy. 40
Heber City, UT 84032
(435) 654-2500

Provider ID #: 6550365
Highland Ridge Hospital
7309 South 180 West
Midvale, UT 84047
(801) 569-2153

Provider ID #: 9183467
Huntsman Cancer Hospital
1950 Circle of Hope Drive
Salt Lake City, UT 84112
(801) 585-0100

Provider ID #: 9183467
Huntsman Cancer Hospital
50 North Medical Drive
Salt Lake City, UT 84132
(801) 581-2121

Provider ID #: 9183467
Huntsman Cancer Hospital
2000 Circle of Hope Drive
Salt Lake City, UT 84112
(801) 587-7000

Provider ID #: 9436108
Institute of Change, Inc.
958 East 11190 South
Sandy, UT 84094
(801) 487-0487

Provider ID #: 6550390
Jordan Valley Medical Center
3580 West 9000 South
West Jordan, UT 84088
(801) 561-8888

Provider ID #: 9830632
Jordan Valley Medical Center Dba Pioneer Valley Ho
3460 South Pioneer Pkwy.
West Valley City, UT 84120
(801) 964-3100

Provider ID #: 6550110
Lakeview Hospital
630 Medical Drive
Bountiful, UT 84010
(801) 299-2200

Provider ID #: 5463999
Landmark Hospital of Salt Lake City, LLC
4252 South Birkhill Blvd.
Murray, UT 84107
(801) 268-5400

Provider ID #: 6550155
Logan Regional Hospital
1400 North 500 East
Logan, UT 84341
(435) 716-1000

Provider ID #: 9620836
Lone Peak Hospital
11925 South State Street
Draper, UT 84020
(801) 545-8000

Provider ID #: 5529994
Mountain Point Medical Center
3000 Triumph Blvd.
Lehi, UT 84043
(385) 345-3000

Provider ID #: 6550205
Mountain View Hospital Utah
1000 East 100 North
Payson, UT 84651
(801) 465-7000

Provider ID #: 6550285
Mountain West Medical Center
2055 North Main Street
Tooele, UT 84074
(435) 843-3600

Provider ID #: 7714763
New Life Centers
1255 East 3900 South
Suite 300
Salt Lake City, UT 84124
(801) 281-3353

Provider ID #: 6550195
Ogden Regional Medical Center
5475 South 500 East
Ogden, UT 84405
(801) 479-2111

Provider ID #: 9944388
Park City Hospital
900 Round Valley Drive
Park City, UT 84060
(435) 658-7000

Provider ID #: 6550250
Primary Children's Hospital
100 Mario Capecchi Drive
Suite 2200
Salt Lake City, UT 84113
(801) 662-1000

Provider ID #: 7017730
Promise Specialty Hospital of Salt Lake
8th Avenue & C Street
Salt Lake City, UT 84143
(801) 408-7100

Provider ID #: 9340840
Provo Canyon Behavioral Hospital
1350 East 750 North
Orem, UT 84097
(801) 852-2273

Provider ID #: 4500384
Provo Canyon School-Boys Campus
4501 North University Avenue
Provo, UT 84604
(801) 420-6656

Provider ID #: 9087134
Provo Canyon School-Spingfield Girls Campus
763 North 1650 West
Springville, UT 84663
(801) 704-1369

Provider ID #: 9265631
Riverton Childrens Unit
3741 West 12600 South
4th Floor
Riverton, UT 84065
(801) 285-4000

Provider ID #: 9812631
Salt Lake Behavioral Health, LLC
3802 South 700 East
Salt Lake City, UT 84106
(801) 264-6034

Provider ID #: 6550245
Salt Lake Regional Medical Center
1050 East South Temple
Salt Lake City, UT 84102
(801) 350-4111

Provider ID #: 9261624
Shriners Hospitals for Children
East Fairfax Road And North Virginia Str
Salt Lake City, UT 84103
(801) 536-3500

Provider ID #: 6610170
South Lincoln Medical Center
711 Onyx Street
Kemmerer, WY 83101
(307) 877-4401

Provider ID #: 5082955
Specialty Hospital of Utah
401 South 400 East
Bountiful, UT 84010
(801) 295-2361

Provider ID #: 6550255
St. Mark's Hospital
1200 East 3900 South
Salt Lake City, UT 84124
(801) 268-7111

Provider ID #: 6550255
St. Mark's Hospital
2675 West Taylorsville Blvd.
Taylorsville, UT 84129
(801) 982-0050

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* This specialist has been designated for Aexcel®. If the specialist name is followed by a future effective or future end date, this indicates the date when the specialist Aexcel designation begins or ends.
** As of the date indicated, this provider has elected not to participate in Aexcel®.
# Provider may participate with Aetna through an agreement that Aetna has with a vendor. The provider may not be directly contracted with Aetna, and, consequently, not credentialed by Aetna. Providers available through these vendors are only subject to the credentialing requirements, if any, of the vendor.
If you should have any questions, contact Aetna Member Services via the member services phone number located on the back of your id card.
Please see DocFind online for additional information about these and other providers.

aetna℠

Your Search Results

DocFind®

Health Plan: Aetna Select℠ Provider Type: Medical Hospitals

You searched by: State: UT Zip Code: 84025 Distance: 100
August 24, 2017

Provider ID #: 9138499
St. Mark's Hospital Lone Peak Emergency Center
74 East Kimballs Lane
Suite 100
Draper, UT 84020
(801) 268-7111

Provider ID #: 5534617
Timpanogos Regional Medical Center
750 West 800 North
Orem, UT 84057
(801) 714-6000

Provider ID #: 6550275
University of Utah Hospital
50 North Medical Drive
Salt Lake City, UT 84132
(801) 581-2121

Provider ID #: 4851966
Utah Valley Childrens Unit
1034 North 500 West
4th Floor
Provo, UT 84604
(801) 373-7850

Provider ID #: 7970886
Utah Valley Specialty Hospital
306 River Bend Lane
Provo, UT 84604
(801) 226-8880

Provider ID #: 7302028
Youth Care
12595 South Minuteman Drive
Draper, UT 84020
(801) 572-6989

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** As of the date indicated, this provider has elected not to participate in Aexcel®.
# Provider may participate with Aetna through an agreement that Aetna has with a vendor. The provider may not be directly contracted with Aetna, and, consequently, not credentialed by Aetna. Providers available through these vendors are only subject to the credentialing requirements, if any, of the vendor.
If you should have any questions, contact Aetna Member Services via the member services phone number located on the back of your id card. Please see DocFind online for additional information about these and other providers.

Welcome to Aetna

Working together, we are building healthy communities with people like you at the center.

The real value of any health plan is how it works for you and your family. We're here to help you make the most of your health and wellness benefits. We have many tools and services that can help you get and stay well.

This guide covers important information you need as a new Aetna member.

- **ID cards**
- **Explanation of benefits (EOB)**
- **Secure member website, Aetna Navigator®**
- **Pharmacy information**
- **And more**

Explore your secure member website, Aetna Navigator®.
Go to
www.aetnanavigator.com
and click on "Take a Tour" or "Sign Up Now."

New member materials give you a good start

Now that you're an Aetna member, you'll get some new plan materials.

- **ID card —** In the past, you and your covered dependents each received a separate ID card. In most instances, you will now receive family ID cards. Your new family style ID card lists each family member (up to five per card) covered by your plan. If your household includes more than five plan members, a second ID card will be included that shows their names. When applicable, a duplicate ID card is included for another family member — such as a spouse — to carry.

  Take the new card with you when you visit the doctor, pharmacy or hospital. This will help us process your claims correctly. Your Aetna ID card shows your pharmacy information, so you have one ID card for all your needs.

  For additional or temporary ID cards: Visit your secure member website, Aetna Navigator®, through **www.aetnanavigator.com**. If you're on the go, you can access your card through Aetna's mobile app.

- **Privacy notice —** We will send this with your ID card. This notice tells you how Aetna, as well as doctors, hospitals and other providers, may use and share your personal health information. It also tells you how to get this information.

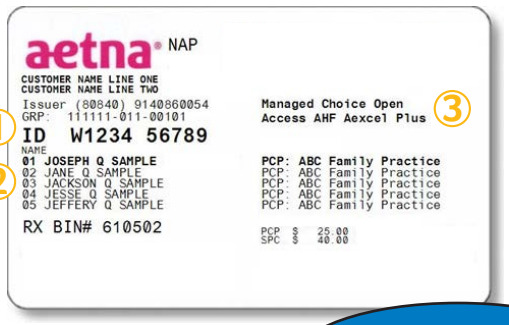
- **Plan documents —** Think of these as your owner's manual. They include a Summary of Benefits and a policy or Certificate of Coverage. They tell you what is covered and how benefits are paid.

Your ID card gives key information about your Aetna plan:

1. Your member ID and group number.
2. List of up to five family members.
3. Plan (this is the plan you choose when searching for a doctor, hospital or other providers).

On the back of the card:

- The toll-free number for member services to get answers to your questions.
- The claims address for paying claims.



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Aetna's family explanation of benefits (EOBs) makes tracking easy

Your Aetna family EOB will have a new look making it easier for you to understand your claims. Now, instead of an EOB for each dependent, you will get a single EOB for your family. This means there may be more than one claim shown on the EOB. Your EOB will:

1. Track your spending, savings and deductibles.
2. Include a list of some common EOB terms with definitions. After the definitions, it shows totals for charges.
3. Have helpful messages from Aetna or your employer.
4. Give a payment summary for the claims on the EOB.
5. Show detailed information for each claim processed on your EOB.

You can view, print or save your EOB and other documents anytime when you log in to your secure member website at **www.aetnanavigator.com**.

aetna℠ Aetna Life Insurance Company
P.O. BOX 981106
EL PASO, TX 79998-1106

Statement date: May 14, 2012
Member: MEMBER NAME
Member ID: XXXXXXXX
Group #: XXXXXXXX
Group name: TEST INC

QUESTIONS? Contact us at aetna.com
XXX-XXX-XXXX
Or write to the address shown above.

MEMBER NAME
111 AETNA STREET
HARTFORD CT 06156

THIS IS NOT A BILL
Keep this for your records

Explanation of benefits:

1

Track your health care costs

$25.24	$107.53	$0.00 (In-network)
Amount you owe or already paid	**Amount you saved**	**Amount you have left to meet deductible**
Amount billed $237.06	Going to a doctor or hospital in our network saves you money.	Annual deductible $1,000.00
Plan payments and discounts - $211.82	That's because we have arranged discounted rates with these providers.	Deductible used - $1,000.00
You owe $25.24	Our online provider directory can help you find a doctor or other health care professional. Just go to **www.aetna.com**.	Deductible remaining $0.00
$211.82 $25.24 $0 $237.06		$1,000.00 $0 $1,000.00

2

A guide to key terms

Term	This means	Your totals
Amount billed:	The amount your doctor or health care provider billed for services.	**$237.06**
Member rate:	The agreed upon amount your doctor or health care provider in our network accepts as their fee.	**$107.03**
Amount you saved:	The difference between the amount billed and the in-network arranged pricing.	**$107.53**
Pending or not payable:	A claim that needs more review by us or an amount we did not pay. You may or may not have to pay this. Read 'Your Claim Remarks' to learn more.	**$0.00**
Deductible:	The amount you pay before your health plan will pay benefits.	**$0.00**
Coinsurance:	When you pay part of the bill and we pay part of the bill. This is your out-of-pocket amount.	**$5.24**
Copay:	A fixed dollar amount you pay when you visit a doctor or other health care provider.	**$20.00**

3

A message from Aetna
Introducing your new Explanation of Benefits. It has a simpler look and feel, designed with you in mind.

SAMPLE

4

Your payment summary

		Your plan paid			You owe or already paid
Patient	**Provider**	**Amount**	**Sent to**	**Date**	**Amount**
Name (spouse)	Dr. Wellby	$60.84	Dr. Wellby	12/12/11	$20.00
Name (spouse)	Quest Diagnostics Incorpora	$20.95	Quest Diagnostics Incorporat	12/6/11	$5.24
Name (self)	Test, Inc.	$22.50	Test, Inc.	12/13/11	$0.00
Total:		$104.29			**$25.24**

5

Your claims up close

Claim for Amy (self)

Claim ID: EQ000006R00 Received on 12/12/11	Amount billed	Member rate	Pending or not payable (Remarks)	Applied to deductible	Your copay	Amount remaining	Plan pays	Your coinsurance	You owe C+D+E+H=I
FLU VIRUS VACC-SPLIT 3 YR & on 9/17/11 90658	12.50					12.50	12.50 (100%)		
ADMIN INFLUENZA VIRUS VAC on 9/17/11 G0008	10.00					10.00	10.00 (100%)		
Safeway Inc.									
Refer to Remarks Section			(1)						
Totals:	22.50					22.50	22.50		
	A	B	C	D	E	F	G	H	I

You can find all numbered claim remarks in 'Your Claim Remarks' section.

Claim for Roger (spouse)

Claim ID: E500000QK00 Received on 12/2/11	Amount billed	Member rate	Pending or not payable (Remarks)	Applied to deductible	Your copay	Amount remaining	Plan pays	Your coinsurance	You owe C+D+E+H=I
OFFICE VISIT on 11/29/11 99213	90.00	77.54			20.00	57.54	57.54 (100%)		20.00
COLLECTION OF VENOUS BLOOD on 11/29/11 36415	5.00	3.30				3.30	3.30 (100%)		
George M Markus									
Refer to Remarks Section			(1)						
Totals:	95.00	80.84			20.00	60.84	60.84		$20.00
	A	B	C	D	E	F	G	H	I

You can find all numbered claim remarks in 'Your Claim Remarks' section.

Continued on next page

SAMPLE

Go green with electronic EOBs

If you are registered for Aetna Navigator or have given us an e-mail address, we'll e-mail you when you have a new EOB. You can register for or log in to Navigator to view it.

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Aetna Navigator® gives you the information you need 24/7

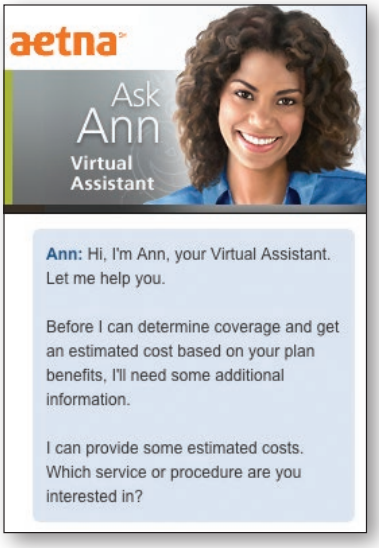
You can find information on your benefits and insurance plan plus cost-savings tools, all in one place — your Aetna Navigator secure member website at **www.aetnanavigator.com**.

By registering for Aetna Navigator, you can easily find almost everything about health and benefits:

- **How to use the member website — Ask Ann,** your online assistant, can help you sign up for your secure member website. She can even help you find a doctor, estimate the cost of services, answer questions about claims, ID cards and more. She *never* sleeps, so chat with her anytime.
- **Where to go — Our DocFind® search tool** identifies doctors, hospitals and other providers based on your health care needs and plan type.
- **What to pay — Aetna Member Payment Estimator** lets you estimate and compare costs for more than 650 non-emergency medical services at up to 10 providers at once.
- **What to do before receiving care — The iTriage® app** helps you answer the common medical questions: "What could be wrong?" and "Where can I go for care?" iTriage helps identify appropriate treatment options when, where, and how it's most convenient. Visit **www.itriagehealth.com** to download the free app.

Your online assistant, Ann, answers questions online

Ann can help you sign up for the member website, find a doctor, check the cost of services, answer questions about claims and more. Ann is on call 24/7, so chat with her anytime.



Important info about My Online Services℠

Your secure Coventry member website, My Online Services, will still be active for one more year. This means you'll be able to access past Coventry claims and other health care information until then.

This information won't be available on Aetna Navigator, so be sure to access the information before the year is over.

Finding a provider is simple

Choosing a doctor, hospital or other provider is a big decision. You want to do a little research first, right? That's why DocFind® is an important tool to know. With DocFind, you can:

- **Save money when you choose doctors, facilities and pharmacies in your network. We'll highlight them for you.**
- **See the latest information. Participating doctors and facilities are updated daily.**
- **Find doctors who have met extra care and cost standards.**
- **Get personalized results. Once you sign up for your Aetna Navigator member website, DocFind is tailored to your plan. This makes your search even easier.**

Back to Table of Contents

Pharmacy benefits and programs are included with your plan

Tools to compare costs, find pharmacies and more

Using Aetna Navigator, you can also find important pharmacy plan details, like your out-of-pocket costs and what's covered.

Look what you can do:

- **Estimate drug costs with the Price-A-Drug℠ tool.** You can find drug costs for your local pharmacy or mail order. You can also compare the costs of generic and brand-name drugs to see how much you can save.
- **Find a network pharmacy.** It's easy to find one in your neighborhood or while traveling.
- **Get help using medicine safely.** You can learn what a drug is used for and how it should be taken. Information about how to help prevent harmful drug interactions is available. You can also email a pharmacist with your questions.

Are you currently using a mail-order pharmacy? If so, you may be able to transfer your prescriptions with active refills to Aetna Rx Home Delivery. To learn more, call **888-RxAetna** (888-792-3862) or go online at **www.aetnanavigator.com.**

Skip the pharmacy line — get your medicine by mail

Mail order is quick and private. You choose where your medicine is delivered — your home, your doctor's office — wherever works for you. You get free standard shipping, too.

Enjoy two ways to get your medicine by mail:

Aetna Rx Home Delivery® mail-order pharmacy

Use this option if you take medicine on a regular basis for conditions like arthritis, asthma or diabetes.

- Get up to 90 days' worth of medicine, or the most allowed by your plan.
- Pay less for that larger supply, depending on your plan.

Get service and support from Aetna Specialty Pharmacy®

Use this option if you take specialty medicine for conditions like multiple sclerosis, rheumatoid arthritis or cancer.

- Medicine is packed safely and securely.
- You'll receive tips and training about medication use.

Additional tools and resources to help you

Check out discounts for your health, wellness and life

Want to save money on health and wellness products and services? Visit Aetna Navigator to check out these and other discounts:

- Gym memberships and weight loss programs.
- Acupuncture and massage therapy.
- Travel, electronics, home, auto, family care, wellness and more.

Best of all, there's no need for claims or referrals. You get on-the-spot savings for you and your family.

To get started:

1. Once you're an Aetna member, log in to your secure member website at **www.aetnanavigator.com**.
2. Choose "Health Programs," then "See the discounts."
3. Follow the steps for each discount you want to use.

Member Services is happy to help

No Internet? You can call Member Services with questions. The number is listed on the back of your Aetna ID card. Our voice prompt service offers a choice of options for everyday questions. In seconds, it will get you to the right person to help you.

Our phone service can help with:

- Answering eligibility and benefits coverage questions.
- Checking the status of a claim.
- Requesting a replacement ID card or claim form.

Reminder:

If you have questions about claims or services that you had before your effective date with Aetna, please contact Coventry Customer Service at the number on your Coventry ID card.

Start making your Aetna plan work for you.

Sign up for Aetna Navigator. Go to **www.aetnanavigator.com.**

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aetna®

made available through aetna®

Teladoc®

Talk to a  anytime

Teladoc® gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone or video consults. It's an affordable alternative to costly urgent care and ER visits when you need care now.

WHEN CAN I USE TELADOC?

Teladoc does not replace your primary care physician. It is a convenient and affordable option for quality care.

- When you need care now
- If you're considering the ER or urgent care center for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short-term prescription refills

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Respiratory infection
- Sinus problems
- And more!

MEET OUR DOCTORS

Teladoc is simply a new way to access qualified doctors. All Teladoc doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 15 years experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

With your consent, Teladoc is happy to provide information about your Teladoc consult to your primary care physician.

Talk to a doctor anytime for $40 or less

Less than an urgent care or ER visit, Teladoc's never more than a doctor visit.

Teladoc.com/Aetna

Facebook.com/Teladoc

1-855-Teladoc (835-2362)

Teladoc.com/mobile

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10E-100
0313

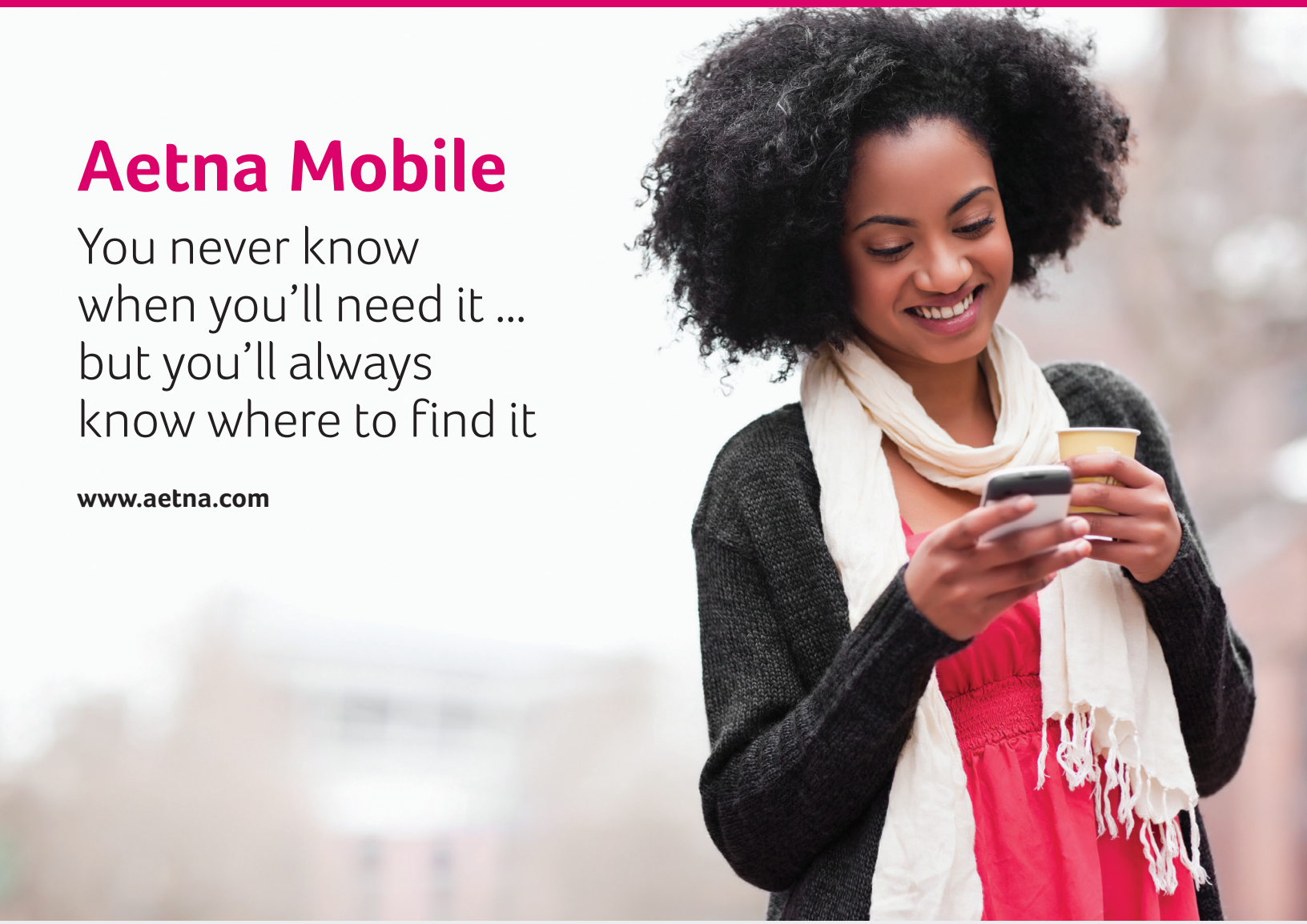
Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

aetna®

Aetna Mobile

You never know when you'll need it ... but you'll always know where to find it

www.aetna.com



Find what you need — wherever, whenever — with Aetna Mobile

That's why it's great to know you can use your cell phone with web access to view your health plan information — whenever you want, wherever you are. The Aetna Mobile app works with iPhone® mobile digital devices and Android™-powered phones.

Use a different smartphone or mobile device? Instead of loading an app, just visit **www.aetna.com**, and use the mobile web version of the site.

You're in your car, at the doctor's office ... anywhere. You need that ID number or claims record now. With Aetna Mobile, you'll get all the answers you need, instantly.

Features of Aetna Mobile

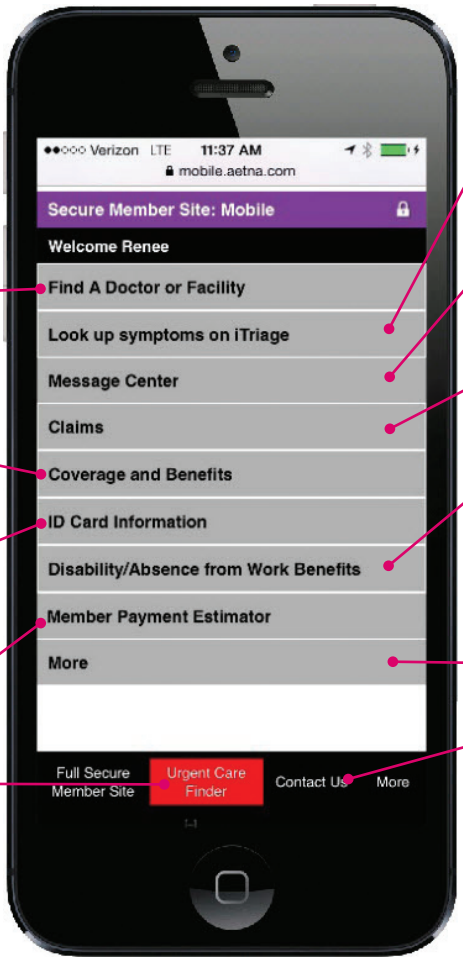
Find a doctor — it's easy to search for doctors, dentists and specialists in your area.

Check benefits and coverage information — just clear, accurate details when you click.

Pull up your medical and/or dental ID card information — if you left your ID card at home, it's no problem.

Member Payment Estimator — real-time estimates for out-of-pocket medical expenses based on your health plan.

Use the Urgent Care Finder — it's for immediate help in an emergency. Because every minute counts.



Look up symptoms on the iTriage® app — it's easy to search symptoms, conditions and medications.

Message Center — one location for all Aetna e-mail correspondence from Member Services.

Search claims — no more guesswork when you don't have the paperwork with you.

View your disability or leave information — reference your existing claims, leaves and payments while you're on the go.

More — for access to your personal health record.

Contact Us — for fast answers to your plan questions.

Two ways to download your FREE Aetna Mobile app:

- Text **Apps** to **23862** to download now*
- Scan the code with your mobile device

To learn more, visit us at **www.aetna.com/mobile**.

*Standard text messaging rates may apply.

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Your Benefits

DAVIS SCHOOL DISTRICT – 2018

LARGE EMPLOYER - UTAH

selecthealth

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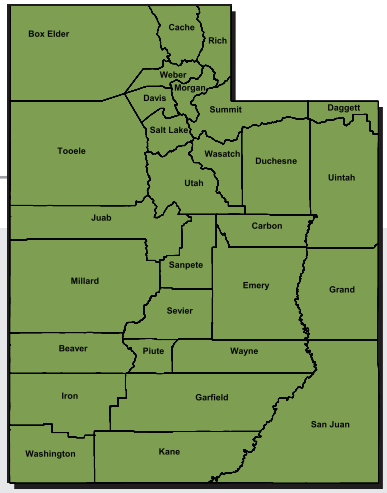
Select Med®

Select Med covers all of Utah and includes prominent hospitals like Primary Children's Hospital, Intermountain Medical Center and The Orthopedic Specialty Hospital (TOSH®). For cancer treatment, Select Med also includes the Huntsman Cancer Institute's clinics and hospital.

Use our provider search tool at **selecthealth.org/providers** to view doctors and facilities participating in the Select Med network.



select:med

Select Med Service Area

34 Participating Hospitals

Over 6,900 Participating Providers

Your network includes providers and facilities throughout Utah. Don't see your hospital? Visit **selecthealth.org/providers** to see all the hospitals included on Select Med.

- Alta View Hospital
- American Fork Hospital
- Cedar City Hospital
- Davis Hospital and Medical Center
- Dixie Regional Medical Center
- Heber Valley Hospital
- Huntsman Cancer Hospital (Cancer Treatment Only)
- Intermountain Medical Center
- LDS Hospital
- Logan Regional Hospital
- McKay-Dee Hospital
- Mountain West Medical Center
- Orem Community Hospital
- Park City Hospital
- Primary Children's Hospital
- Riverton Hospital
- TOSH - The Orthopedic Specialty Hospital
- Utah Valley Hospital

SELECTHEALTH ALSO INCLUDES:

INTERMOUNTAIN HEALTH ANSWERS℠

A 24/7 nurse line that allows you to speak to a registered nurse who will listen to your concerns, answer medical questions, and help you decide what course of action to take. All you need is your phone. Call **844.501.6600**.

Free!

INTERMOUNTAIN CONNECT CARE®

Use your computer, tablet, or phone to video connect with a doctor or nurse practitioner anytime (24/7 access). Visit **intermountainconnectcare.org** or download the app for Android or iOS.

Never more than $49 per visit. See your schedule of benefits for coverage information.

INTERMOUNTAIN INSTACARE®/KIDSCARE®

They're open late—and are a great choice for sore throats, broken bones, sprains, headaches, stomachaches, earaches, and other urgent medical conditions. With nearly 40 locations, there's a site near you. Use our app to reserve your spot in line!

Approximately doctor's office prices. Much cheaper than the ER!

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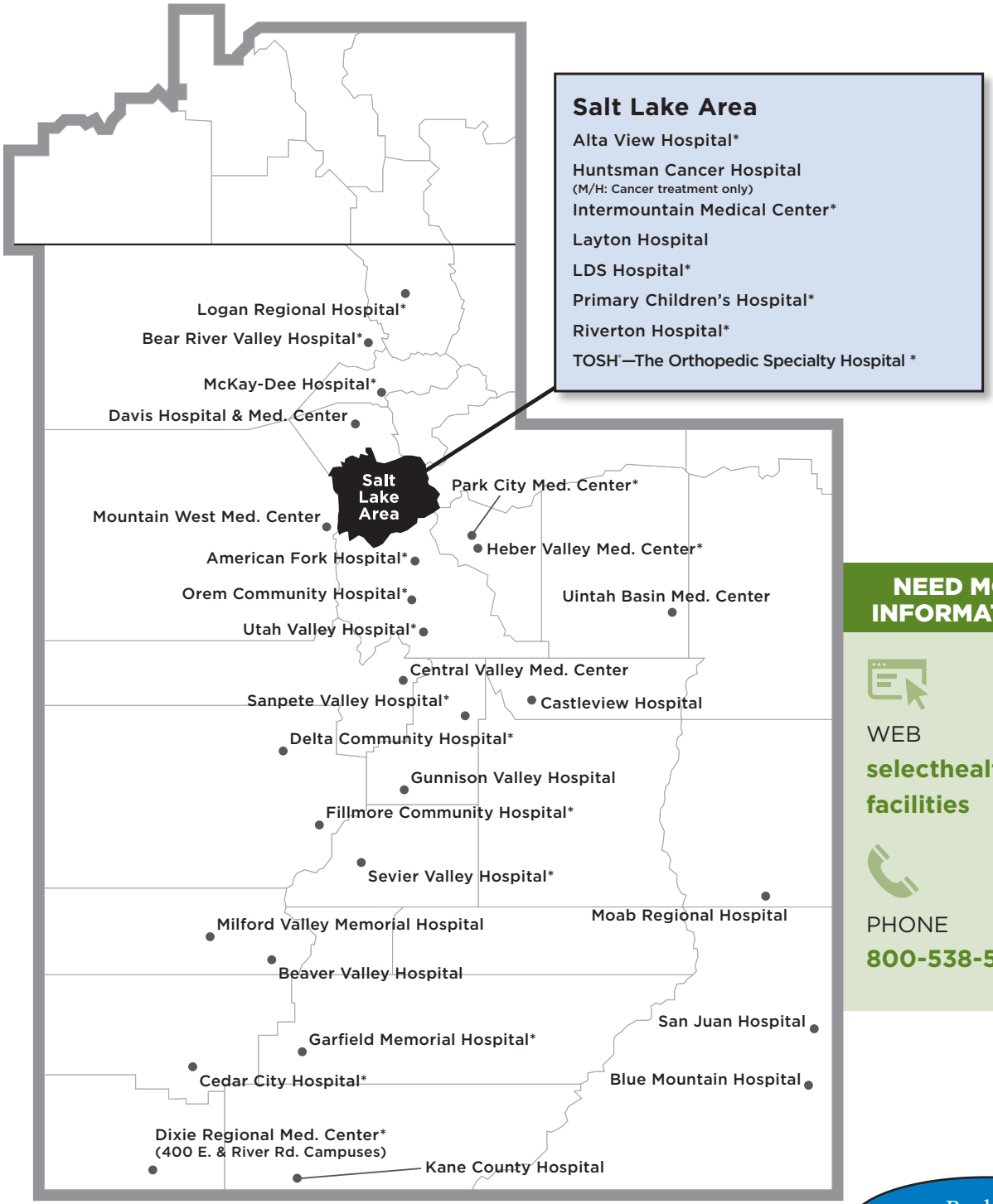
selecthealth

Select Med Facility Map

Use the map and key below to determine which hospitals are participating on your SelectHealth® plan.



NEED MORE INFORMATION?

WEB
selecthealth.org/facilities

PHONE
800-538-5038

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selecthealth.

Whenever and Wherever You Need It

CONVENIENT, HIGH-QUALITY CARE

A skilled clinician is just a swipe or click away. With Intermountain Connect Care®, you can use your smartphone, tablet, or computer to get basic healthcare. Just log in and speak face-to-face with an Intermountain caregiver through on-demand video.

MOBILE APP OR WEB

With a smartphone or tablet, you can get access through the Connect Care mobile app. Use the app and start your visit in minutes. If you'd rather use a larger screen, you can access Connect Care using a video-capable computer at your home or office.

YOUR VISIT

Most visits take less than ten minutes. Your clinician will review your history, answer questions, diagnose, treat, and even prescribe medication.

COVERAGE

Connect Care visits are just $49 and the amount you pay may be less, depending on your SelectHealth® plan. For details, call Member Services at **800-538-5038**.

NEED MORE INFORMATION?

WEB
Download the app on Android or iOS, or visit **intermountainconnectcare.org** to register for free.

PHONE
800-538-5038

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We Can Help

Health insurance doesn't have to be complicated. We can help you with everything from understanding your benefits to finding the right doctor. Our customer service teams are dedicated to providing exceptional service.

MEMBER SERVICES

Superior service is at the heart of everything we do. Our Member Services team strives to answer your questions or resolve concerns the first time you call. Reach us by phone or secure email, or schedule a time for us to call you.

Member Services is available weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m.

CLICK-TO-CHAT

Don't have time for a phone call? Log in to *My Health* and reach out to us securely online with our new Click-to-Chat function. Click-to-chat is a great way to answer quick questions about your benefits.

SELECTHEALTH MEMBER ADVOCATES®

Whether you need help with mental or physical health, Member Advocates℠ can help you find the right doctor for your needs. They can also assist with the following:

- **Scheduling an appointment, including care for urgent conditions**
- **Finding the closest facility or doctor with the nearest available appointment**
- **Providing information about a doctor, such as age, training certifications, and languages spoken**
- **Helping you understand and maximize your benefits**

They are available weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m.

FIND A DOCTOR

To access the online provider directory, visit **selecthealth.org** and click on "Find Doctors & Facilities." You can search for providers by network, location, specialty, gender, and languages spoken.

CARE MANAGEMENT

Do you or one of your dependents have a chronic condition or need help recovering from a short-term illness or surgery? If so, give our care management team a call at **800-442-5305**. Our care managers are specially trained nurses who can help you find the right care and assist with your insurance benefits and claims. They specialize in helping with asthma, cancer, COPD, joint replace recovery, diabetes, heart disease, hemophilia, hepatitis c, high-risk pregnancies, HIV, and other surgery recoveries.

NEED MORE INFORMATION?

WEB
selecthealth.org/provider

PHONE
Member Services 800-538-5038
Member Advocates 800-515-2220

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selecthealth.

Online Tools

Whether you need to see how much a doctor billed, look up prescription costs, or learn more about your benefits, *My Health* is your source for personal plan information. *My Health* is available 24 hours a day, seven days a week through our mobile app or at **selecthealth.org**. After you log in, just click the "SelectHealth" icon to get started.

COVERAGE AND CLAIMS

View your plan information, claim details, Explanations of Benefits (EOBs), and sign up for paperless EOBs.

PHARMACY TOOLS

Access your pharmacy benefit information, claims, prescription history, and lower-cost drug alternative information.

ID CARDS

Lost your ID card? No worries—you can view and print copies of your card on *My Health*.

SEND SECURE MESSAGES

Send secure messages to SelectHealth® Member Services or your doctor. This is a confidential and convenient way to get your questions answered.

ACCESS MEDICAL RECORDS

Our integration with Intermountain Healthcare® gives you access to your medical records* through *My Health*. You can view lab results, medications, and imaging reports. You can also track your doctors' appointments and email questions to providers who participate in this program.

**May not be available for all providers and facilities.*

my health

NEED MORE INFORMATION?

WEB
selecthealth.org/myhealth

PHONE
800-538-5038

REQUEST A CALL

Use our call request feature to get in touch with Member Services. You can schedule an immediate call or set a time for us to call you back.

CLICK-TO-CHAT

Don't have time for a phone call? Log in to *My Health* and reach out to us securely online with our new Click-to-Chat function.

Click-to-chat is a great way to answer quick questions about your benefits, such as:

- How much of my deductible has been met?
- Has SelectHealth received a claim from my doctor?
- Can you tell me how to find a doctor near my home?

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selecthealth.

Access to Mobile Apps

THE SELECTHEALTH® MOBILE APP

With our mobile app, we'll be there wherever you need us—at home, work, or even the doctor's office.

ID Cards
> **View, email, and fax images of your ID Card**

Provider Search
> **Search for providers**

Claims
> **Access explanations of benefits and determine amounts owed**

Benefits and Coverage
> **Find out who's covered on your plan and view benefits**

Year-to-Date Totals
> **Look at medical and dental expenses, including your deductible and out-of-pocket max**

NEED MORE INFORMATION?

WEB

ANDROID APP ON Google play

Available on the App Store

PHONE

800-538-5038

THE INTERMOUNTAIN HEALTH HUB

As part of our integration with Intermountain Healthcare®, you can use your smart phone to view lab results, message doctors, and more.

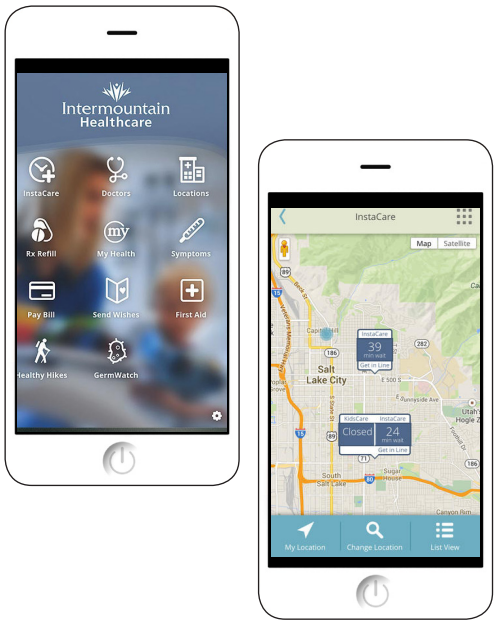
Intermountain Instacare®
> **Find wait times and save a place in line at InstaCare℠**

Prescriptions
> **Refill and check the status of prescriptions**

Locations
> **Find nearby Intermountain hospitals, clinics, and pharmacies**

Pay Bill
> **Pay Intermountain Healthcare bills by credit card or eCheck**

Healthy Hikes
> **Locate easy, moderate, and challenging hikes in your area**



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selecthealth.

On the Move?

OUTSIDE OF YOUR SERVICE AREA

If you have an emergency or need urgent care outside of your service area, participating benefits apply to services you receive in a doctor's office, urgent care facility, or emergency room.

In an effort to reduce your medical out-of-pocket expenses while traveling, SelectHealth® has an arrangement with the MultiPlan and PHCS networks. They accept an allowed amount for covered services, which means that you will not be responsible for excess charges when using these providers.

Always present your ID Card when visiting these providers or facilities. The logos on the card give you access to the networks.

To find MultiPlan and PHCS providers or facilities, call MultiPlan at **800-678-7427** or visit **multiplan.com/selecthealth**. For the greatest savings, search for PHCS providers first. You can also search for providers and facilities at **selecthealth.org/providers**.

MultiPlan PHCS

NEED MORE INFORMATION?

WEB
multiplan.com;
selecthealth.org/providers

PHONE
800-678-7427; 800-538-5038

OUTSIDE OF THE COUNTRY

If you are traveling outside of the country and need urgent or emergency care, visit the nearest doctor or hospital. You may need to pay for the treatment at the time of service. If you do, keep your receipt and submit it along with a Claim Reimbursement Form, which can be found on **selecthealth.org**.

DEPENDENT CHILDREN OUT OF AREA

Enrolled dependent children who live outside of your service area (maybe they're going to college or living with another parent) can receive participating benefits for covered services. To qualify for this coverage, you will need to submit a Dependent Address Change Form, which can be found at **selecthealth.org**. The form contains important instructions about which networks your enrolled dependent child can use when living outside your service area—please read it carefully.

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Preventive Care

Many of our plans cover preventive care 100 percent—that means no copay, coinsurance, or deductible.

For services to be covered as preventive, your doctor must submit claims with preventive codes. If a preventive service identifies a condition that needs further testing or treatment, regular copays, coinsurance, or deductibles may apply. Unless otherwise indicated, these services are generally covered once every 12 months. Additional limitations may apply.

This information is subject to change at any time and additional limitations may apply. To verify if your service or supply is considered preventive, call Member Services at **800-538-5038**

NEED MORE INFORMATION?

WEB
selecthealth.org/stayhealthy

PHONE
800-538-5038

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selecthealth.

Preventive Care Services

Adult Preventive Services (Ages 18 and older)

Laboratory Tests

- > Complete Blood Count (CBC)
- > Prostate Cancer Screening (PSA)
- > Diabetes Screening
- > Cholesterol Screening
- > Gonorrhea Screening
- > Human Papillomavirus (HPV) Testing (once every 3 years in women ages 30 and older)
- > Chlamydia Screening
- > Human Immunodeficiency Virus (HIV) Screening
- > Syphilis Screening
- > Tuberculosis (TB) Testing
- > Lead Screening
- > BRCA 1 & 2 Testing (covered once per lifetime for high-risk individuals who meet criteria)
- > Hepatitis B Virus (HBV) Screening (covered for high-risk individuals who meet criteria)
- > Hepatitis C Virus (HCV) Screening (ages 48 and older or high-risk individuals who meet criteria)

Procedures

- > Pap Test
- > Lung Cancer Screening (between ages 55 and 80)
- > Screening Mammogram
- > Colon Cancer Screening
- > Abdominal Aortic Aneurysm Screening (males only, once between ages 65 and 75)
- > Bone Density/DEXA (once every two years in women ages 60 and older)
- > Permanent Sterilization Procedures (such as tubal ligations/vasectomies)

Examinations/Counseling

- > Physical Exam
- > Tobacco Use Counseling
- > Alcohol Misuse Screening and Counseling
- > Hearing Screening (ages 65 and older)
- > Glaucoma Screening
- > Sexually Transmitted Infections Counseling
- > Dietary Counseling (only for certain diet-related chronic diseases)
- > Counseling for Intimate Partner Violence

Immunizations

- > Influenza
- > Tetanus or Tetanus, Diphtheria, and Pertussis (Td, Tdap)
- > Pneumococcal
- > Hepatitis A
- > Meningitis
- > Zoster (ages 60 and over)
- > Human Papillomavirus (HPV) (ages 9 to 26)

Contraception

Most contraceptives are covered as a preventive service under your pharmacy benefits.

- > Cervical Cap with Spermicide
- > Diaphragm with Spermicide
- > Emergency Contraception (Ella, Plan B)
- > Female Condom
- > Implantable Rod
- > IUDs
- > Generic Oral Contraceptives (Combined Pill, Progestin Only, or Extended/Continuous Use)
- > Patch
- > Shot/Injection (Depo Provera)
- > Spermicide
- > Sponge with Spermicide
- > Surgical Sterilization for Men (Vasectomy)
- > Surgical Sterilization for Women (Tubal Ligation)
- > Surgical Sterilization Implant for Women
- > Vaginal Contraceptive Ring

Pediatric Preventive Services (Younger than age 18)

Procedures/Counseling

- > Well-Child Visit (preventive when billed on the following schedule: birth; 2 to 4 days; 2 to 4 weeks; 2, 4, 6, 9, 12, 15, and 18 months; ages 2, $2^{1/2}$; once a year from ages 3 to 18)
- > Primary Care Tobacco Use Intervention
- > Eye Exam
- > Developmental Testing
- > Newborn Hearing Screening (younger than age 1)
- > Hearing Screening (ages 10 and younger)
- > Application of Fluoride Varnish (younger than age 5)

Laboratory Tests

- > Newborn Metabolic Screening (younger than age 1)
- > Human Immunodeficiency Virus (HIV) Screening
- > PKU Screening (younger than age 1)
- > Thyroid (younger than age 1)
- > Sickle Cell Disease Screening (younger than age 1)

Immunizations

(As recommended by the CDC/ACIP)

- > Measles, Mumps, Rubella (MMR)
- > Diphtheria, Tetanus, Pertussis (Dtap, DT, DTP)
- > Haemophilus Infuenzae Type B (Hib, DtaP-Hib-IPV, DTP-Hib, Dtap-Hib)
- > Hepatitis B (HepB)
- > Polio (OPV, IPV, DtaP-Hep-LPV)
- > Influenza
- > Pneumococcal
- > Hepatitis A
- > Hepatitis B
- > Meningitis
- > Varicella (including MMVR)
- > Rotavirus
- > Human Papillomavirus (HPV) (ages 9 to 26)

Obstetrical Preventive Services

These are specific to pregnant women. To determine which additional non-obstetrical services may be considered preventive, please refer to the Adult or Pediatric Preventive Services lists.

Laboratory Tests

- > Iron Deficiency Anemia Screening
- > Diabetes Screening
- > Urine Study to Detect Asymptomatic Bacteriuria (first prenatal visit or at 12 to 16 weeks gestation)
- > Rubella Screening
- > Rh(D) Incompatibility Screening
- > Hepatitis B Infection Screening (at first prenatal visit)
- > Gonorrhea Screening
- > Chlamydia Screening
- > Syphilis Screening

Breast-feeding supplies and support

- > Breast Pump, Electronic AC or DC (one per birth)
- > Lactation Class (one per birth at a SelectHealth-approved facility)

This information is subject to change at any time and additional limitations may apply. To verify if your service or supply is considered preventive, call Member Services at **800-538-5038**.

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selecthealth.

Prescription Drug Coverage

YOUR PHARMACY BENEFITS

Before you fill a prescription, it can be helpful to review the basics about how your coverage works.

PRESCRIPTION DRUGS

Coverage is divided into tiers. Your plan has three or four tiers. Each drug is covered under a specific tier that corresponds to a copay or coinsurance amount—this is the amount you pay.

- **Tier 1** – Lowest Cost (mostly generic drugs)
- **Tier 2** – Higher Cost (generic and brand-name drugs)
- **Tier 3** – Highest Cost (mostly brand-name drugs)
- **Tier 4** – Injectable Drugs and Specialty Medications

Drugs on lower tiers may provide the treatment you need at the best value.

PRESCRIPTION DRUG LIST (PDL)

Your member materials will indicate if you have RxSelect® or RxCore®. This is the list of prescription drugs covered by your plan. Search for your drug on our website to find the tier and any special requirements. You may have received a copy of the PDL with your member materials, but the online drug lookup is the most complete, current PDL.

ONLINE TOOLS

It's easy to view your family's prescription history or find out how much a drug will cost. Log in to *My Health* at **selecthealth.org** to access these useful pharmacy tools:

- **Use the search tool** to see what drugs are covered under your prescription drug list. You can use this feature even without a *My Health* account by going to the prescription drug list page under the pharmacy tab at **selecthealth.org**. Your prescription drug coverage is listed by tier for both 30-day (retail) and 90-day (maintenance) supplies.
- **View claims.** When you fill a prescription, the drug name, date filled, and total cost will be listed here.
- **Compare drug prices.** Use our drug lookup to find out how much your prescription will cost and to view lower-cost alternatives. This feature will also indicate if the drug has special requirements.
- **Find a pharmacy.** Search for a participating pharmacy by location. We are contracted with most major chains and many privately owned pharmacies.
- **Check for drug interactions.** Avoid the unwanted side effects or reduced effectiveness that can occur if two drugs you are taking interact with one another.

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SPECIAL REQUIREMENTS

Some drugs require step therapy or preauthorization before they will be covered.

- **Step Therapy** – If your drug requires step therapy, your doctor must first prescribe an alternative drug. These are generally more cost-effective and do not compromise clinical quality. Step therapy may be waived for medical necessity.
- **Preauthorization** – This means that your doctor must call us for approval before prescribing.
- **Nonformulary medications** – If you need to take a medication that is not on your formulary, your doctor can fax a request form stating why the drug is medically necessary for you.

INTERMOUNTAIN HOME DELIVERY

You can have many prescriptions delivered to your door by using the Intermountain Home Delivery Pharmacy. Register for this service online by visiting **intermountainrx.org** or call **855-779-3960** for more information.

INTERMOUNTAIN SPECIALTY PHARMACY

Home delivery is also available for specialty drugs and self-injectables. If you use the Intermountain Specialty Pharmacy a technician will call you when it is time to refill your prescription and will answer questions to ensure you have the tools you need to use your medication. Call **844-442-4600** for more information or to sign up.

RETAIL90®

Retail90 allows you to pick up a 90-day supply of maintenance medications at a participating Retail90 pharmacy for a more affordable copay/coinsurance amount. Go to **selecthealth.org** and click on "Maintenance Medications" under the pharmacy tab to search for participating Retail90 pharmacies. Retail90 may not be available with all plans.

NEED MORE INFORMATION?

WEB
selecthealth.org/pharmacyresources; intermountainrx.org

PHONE
800-538-5038; 855-779-3960

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Member Discounts

We know that embracing a healthy lifestyle is easier when it costs less. As a SelectHealth member, you have access to discounts on everyday products and services. Check out **discounts.selecthealth.org** for more information and to find participating businesses. Remember, some offers have exclusions or limitations.

NEED MORE INFORMATION?

WEB
selecthealth.org/discounts

PHONE
800-538-5038

ACUPUNCTURE

If you'd like to try acupuncture treatments, contact a SelectHealth Member Discounts provider.

CHILD SAFETY

You can save money on items like safety gates by using your discount at Safe Beginnings. Shop the Safe Beginnings website directly or order over the phone. Make sure to mention the code BAS.

COSMETIC DERMATOLOGY

SelectHealth Member Discounts offers deals on various procedures, including removing wrinkles and age spots, diminishing acne scars, collagen implants, and laser hair removal.

EYEWEAR

SelectHealth Member Discounts has savings on optical exams, frames, lenses, and contacts from providers you know and trust.

HEALTH CLUBS

Choose the participating SelectHealth Member Discounts facility that meets your lifestyle, personality, and fitness goals.

HEARING AIDS

You can enjoy cost savings and convenience by using one of the SelectHealth Member Discounts preferred hearing aid providers.

LASIK VISION SURGERY

Experience a world that is sharply in focus with LASIK vision surgery from a one of the quality SelectHealth Member Discounts providers in various locations.

MASSAGE THERAPY

SelectHealth Member Discounts vary by provider, but most offer $10 off each one-hour massage or $5 off each half-hour massage.

SUNGLASSES

SelectHealth Member Discounts offers healthy savings for top-quality sunglasses, both prescription and non-prescription.

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SelectHealth Healthy Beginnings®

Expecting? We want to help you get ready for the birth of your new baby. We encourage you to sign up for Healthy Beginnings℠, a program for moms-to-be. This program is free, and we work with your doctors to help you have a safe and healthy pregnancy.

By signing up for Healthy Beginnings, you become eligible for a cash gift or gift card when you see your doctor for each of these exams:

1. **The first prenatal exam prior to the 14th week of your pregnancy.**
2. **A postpartum exam within 50 days of your delivery date.**

Once enrolled in the program you will also have the support of a registered nurse or a high-risk prenatal nurse care manager who will be available to answer your questions, give referrals, and support you through your pregnancy. You will also get a welcome kit that includes these items:

- **> Great Expectations — A book about pregnancy.**
- **> Book Order Form — Choose a free book from our pregnancy and childcare library.**
- **> Community Resources — Information about childbirth and breast feeding classes and other helpful services.**
- **> Educational Materials — Helpful tips, pregnancy facts, the month-to-month growth of your baby, and more.**

To sign up for Healthy Beginnings, call **866-442-5052** weekdays, from 8:00 a.m. to 5:00 p.m.

When calling after hours, please leave a message with a phone number and the best time for us to reach you. A Healthy Beginnings representative will return your call.

NEED MORE INFORMATION?

WEB
selecthealth.org > Wellness Resources > Preventive Care

PHONE
866-442-5052

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selecthealth

Helping You Quit

TOBACCO CESSATION

Quit for Life® is a private program that patients follow at their pace from home. Participants receive a Quit Kit and access to a toll-free Quit Line. If you participate, a trained smoking cessation counselor will call you and provide one-on-one coaching and support over the phone for one year.

SelectHealth® members have 100 percent coverage for the Quit for Life program. No copay or coinsurance is required. Call **866-QUIT-4-LIFE** or visit **quitnow.net** for more information or to enroll.

The Quit For Life Program is brought to you by the American Cancer Society® and Optum. The two organizations have 35 years of combined experience in tobacco cessation coaching and have helped more than 1 million tobacco users. Together they will help millions more make a plan to quit, realizing the American Cancer Society's mission to save lives and create a world with more birthdays.

NICOTINE REPLACEMENT THERAPY

Most SelectHealth plans include 100 percent coverage for Nicotine Replacement Therapy (NRT), which includes prescription drugs or patches that can help curb nicotine cravings. Check your benefits to make sure you have coverage, but most of our plans allow you to get two, 90-day courses of nicotine-replacement medication each year. For more information about prescribed medication that may increase your chances to quit smoking, talk to your doctor.

NEED MORE INFORMATION?

WEB
quitnow.net

PHONE
866-QUIT-4-LIFE

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selecthealth.

Plan Information

CARE MANAGEMENT

SelectHealth works to manage costs while protecting the quality of care. We review things such as the appropriateness of the care setting, medical necessity, and appropriateness of hospital lengths of stay. This helps reduce unnecessary medical expenses and keeps premiums as low as possible. For more information about how we help manage healthcare, including information about services that require preauthorization or to know how to file an appeal, please visit **selecthealth.org/policy.**

PROTECTING YOUR PRIVACY

We understand the importance and sensitivity of your personal health information, and we have security in place to protect it. For more information about how we protect your privacy, including our complete Notice of Privacy Practices, please visit **selecthealth.org/policy**.

EXCLUSIONS AND LIMITATIONS

Unless otherwise noted on your Member Payment Summary, there are some healthcare services that SelectHealth does not cover. Please visit **selecthealth.org/policy** to learn more about some of the services that are not covered or have coverage limitations.

MEMBER RIGHTS AND RESPONSIBILITIES

We want you to be an active part of your healthcare. Visit **selecthealth.org/policy** to view your member rights and responsibilities.

PRINTED VERSIONS AVAILABLE

If you would like to request a printed copy of any or all of these notices, call Member Services at **800-538-5038** weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m.

NEED MORE INFORMATION?

WEB
selecthealth.org/policy

PHONE
800-538-5038

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DENTAL INSURANCE PLANS

The following pages contain information on the two dental insurance plans offered by Davis School District. Insurance eligible employees may choose one of the following two plans:

DELTA DENTAL BASIC PPO

DELTA DENTAL PREMIER + PPO

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DENTAL PLANS COMPARISON

JANUARY 1, 2018 THROUGH DECEMBER 31, 2018

BENEFITS	DELTA DENTAL BASIC PPO		DELTA DENTAL PREMIER + PPO	
	PPO Dentists	Premier Dentists & Non-Delta Dentists*	Premier Dentists & Non-Delta Dentists*	PPO Dentists
Deductible Per Calendar Year	$50 Per Member for Basic and Major Services ($150 Per Family)		None	
Calendar Year Maximum Benefit Per Person	$1,000		$1,500	
Lifetime Orthodontic Maximum Per Member	$1,000		$1,500	
Preventive and Diagnostic Benefits (Cleaning and X-rays)	100% PPO fee schedule	80% PPO fee schedule	80% of UCR (Usual, Customary and Reasonable)	80% PPO fee schedule
Basic Benefits (Restoration and Denture Repair)	80% PPO fee schedule	60% PPO fee schedule	80 % of UCR (Usual, Customary and Reasonable)	80% PPO fee schedule
Major Benefits (Crowns, and Prosthodontics) **	50% PPO fee schedule	40% PPO fee schedule	50% of UCR (Usual, Customary, and Reasonable)	50% PPO fee schedule
Orthodontic Benefits**	50% PPO fee schedule	40% PPO fee schedule	50% Benefit up to $1,500 Life Time Maximum	

*You pay balance of billed charge when services are received from a Non-Delta Dentist.
**One year waiting period for these services if you enroll later than the date you were initially eligible for coverage.

This is an illustrative summary only.
It is not meant to replace or fully interpret your summary plan description (SPD).
Refer to your SPD for detailed explanations and coverage descriptions.

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BASIC PPO

The following is a brief summary of benefits and description of the Delta Dental Basic PPO program. The Summary Plan Description contains complete details of benefits, limitations, exclusions, grievance procedures and binding arbitration for disputes.

BENEFITS	PPO Dentists	PREMIER AND NON-DELTA DENTISTS*
Deductible Per Calendar Year	$50 Per Member for Basic and Major Services ($150 Per Family Unit)	
Calendar Year Maximum Benefit Per Member	$1,000	
Orthodontic Life Time Maximum Per Member	$1,000	
Preventive and Diagnostic Benefits (Cleaning and X-rays)	100% of PPO fee schedule	80% of PPO fee schedule
Basic Benefits (Restoration and Denture Repair)	80% of PPO fee schedule After Deductible	60% of PPO fee schedule After Deductible
Major Benefits (Crowns, and Prosthodontics) **	50% of PPO fee schedule After Deductible	40% of PPO fee schedule After Deductible
Orthodontic Benefits**	50% of PPO fee schedule	40% of PPO fee schedule

*You pay balance of billed charge when services are received from a Non-Delta Dentist.
**One year waiting period for these services if you enroll later than the date you were initially eligible for coverage.

Using a PPO Dentist will maximize your benefits. Benefits for services received from a PPO Dentist are paid at a higher percentage than if you had benefits paid for services received from a Premier or Non-Delta Dentist. Benefits are based on the PPO fee schedule, which is typically less than the UCR fee schedule. PPO participating dentists have agreed not to charge above the PPO fee schedule.

Using a Premier Dentist or Non-Delta Dentist means benefits for services are paid at a lower percentage than if you use a PPO Dentist. Benefits will be based on the PPO fee schedule. In addition to your coinsurance percentage you would be responsible for any balance between Delta Dental Plan expenses and charges billed by the provider.

When you receive services from a Non-Delta Dentist, you are required to submit your claims to Delta Dental for reimbursement. Benefit payments will be made directly to you and you will be responsible for paying the Non-Delta Dentists for eligible services. Claim forms are available on our web site at www. deltadentalins.com.

ELIGIBILITY / CLAIMS CONTACT INFORMATION
Delta Dental Insurance Company
P. O. Box 1809
Alpharetta, GA 30023-1809
(800) 521-2651

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PREMIER+PPO

The following provides a brief summary of benefits and a description of the Delta Dental Insurance Company (Delta Dental) Premier + PPO Plan. The Summary Plan Description contains complete details of benefits, limitations, exclusions, grievance procedures and binding arbitration for disputes.

BENEFITS	PREMIER DENTISTS & NON-DELTA DENTISTS*	PPO DENTISTS
Deductible Per Calendar Year	NONE	
Calendar Year Maximum Benefit Per Member	$1,500	
Orthodontic Life Time Maximum Per Member	$1,500	
Preventive and Diagnostic Benefits (Cleaning and X-rays)	80% of UCR (Usual, Customary and Reasonable)	80% of PPO fee schedule
Basic Benefits Restoration and Denture Repair)	80% of UCR (Usual, Customary and Reasonable)	80% of PPO fee schedule
Major Benefits (Crowns, and Prosthodontics) **	50% of UCR (Usual, Customary and Reasonable)	50% of PPO fee schedule
Orthodontic Benefits**	50% Benefit up to $1,500 Life Time Maximum	

*You pay balance of billed charge when services are received from a Non-Delta Dentist.

**One year waiting period for these services if you enroll later than the date you were initially eligible for coverage.

If you are enrolled on the Delta Dental Premier + PPO Plan you have the option to visit a ***Premier***, ***PPO***, or ***Non-Delta Dentist***.

Using a ***Premier Dentist*** your benefits will pay for services based on a UCR (Usual, Customary and Reasonable) fee schedule. You will be responsible for your coninsurance percentage. Participating providers agree not to charge more than the contracted UCR fees.

Using a ***PPO Dentist*** will maximize your benefits. Charges are based on the PPO fee schedule which is typically less than the UCR fee schedule. Therefore, you would have lower coinsurance costs and participating providers have agreed not to charge more for services than allowed by the PPO fee schedule.

Using a ***Non-Delta Dentist*** means higher out-of-pocket costs. Services are based on the UCR fee schedule and the dentist may bill you for the costs above the Delta Dental Plan eligible expenses in addition to your coinsurance. Benefit payments might be paid directly to you and you would be responsible for paying the Non-Delta Dental Dentist for covered services. To receive benefit payments for covered services provided by Non-Delta Dental Dentists, you may need to submit your own claim. In that case, you will need to obtain an itemized statement from the dentist, attach it to a claim form and send it to the claims address indicated below. Be sure to include your name, age, gender, contract ID number and any other information requested by Delta Dental.

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809
(800) 521-2651

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DELTA DENTAL

Verify Provider Participation

We recommend you verify your dentist's participating status before *each* dental visit. Make sure you specifically ask if the dentist "participates" in the Delta Dental Premier or PPO networks.

Delta Dental's Web-site

Delta Dental's website is a one-stop-shop for plan and oral health care information. You can make the most of your plan by following these easy steps on the website located at www.deltadentalins.com.

1. ***Find a Delta Dental PPO or Delta Dental Premier Dentist near you.*** Keep your dental expenses as low as possible by staying in your plan's network. For a listing of dentists in your area, visit the website and click on "Find a Dentist" on the right hand side of the home page. You will need to select either the PPO or Premier network for a current listing. If you have a long standing relationship with a dentist who does not participate in a Delta Dental network and don't want to change providers, we invite you to go to a link called "What if your dentist isn't a Delta Dental Dentist". It will take you to this page: https://www.deltadentalins.com/individuals/guidance/recommend-your-dentist.html.
2. ***Check Eligibility and Benefit Details.*** You will be able to access personalized information once you register for Online Services, including covered procedures and the family members included on your plan.
3. ***Access your Delta Dental ID Card.*** Everyone receives an ID card initially. However, you do not need an ID card to obtain services. You can view or print an ID card from the website. Go mobile on your smartphone to access mobile-optimized Online Services, or download the Delta Dental app, available through the App Store or Google Play, to access your plan information and view your ID card.
4. ***View online statements.*** Check your electronic statement to see what you owe your dentist, if anything. You will be able to browse previous statements and download them for your records.

COORDINATION OF BENEFITS (COB)

Are you covered under another dental plan as well? Payments for covered services will be determined by coordinating the benefits of the two programs. The primary carrier pays the full benefits covered in its program and the secondary carrier is responsible for payment of the balance of covered expenses not to exceed the carrier's maximum payment level. In no event will payment be made in excess of expenses incurred. A dental program covering a person under state or federal continuation (i.e., COBRA) will always be a secondary carrier. Primary responsibility is determined by COB rules (refer to the Summary Plan description for COB rules).

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DELTA DENTAL Value Added Vision Care Discount Plan. Delta Dental members simply visit www.eyemedvisioncare.com/deltadental to view plan details, locate a provider and print out a vision care ID card. For further information visit the website or call 1-866-246-9041.

VISION INSURANCE PLAN

The following pages contain information on the voluntary vision insurance plan available to insurance eligible employees through Opticare of Utah

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Attention Davis School District Employees:

Approximately 50% of the U.S. population (80% of those over the age of 45) requires corrective vision. Vision insurance is a vehicle to help fund the cost of these expenses. Opticare of Utah is happy to announce a partnership with Davis School District offers a VOLUNTARY Vision plan for you and your family members. Keep in mind, the employee must enroll in order to enroll any dependents on this benefit, however, if you have a family with multiple dependents but only one dependent needs the vision benefit, the employee will only have to elect coverage for themselves and the dependent (i.e. 2-party coverage rather than family coverage) in order to have this vision benefit.

Opticare of Utah is Utah's largest and fastest growing managed-vision care provider. With your **120B** plan you will receive a benefit every plan year; there are low co-pays and no waiting periods or deductibles to meet. Please note, vision exams are not covered under this plan, but are covered under the district's healthcare plans.

Opticare of Utah has over 150 contracted eye care facilities in Utah and over 20,000 Nationwide. You have TWO networks to utilize the best way that fits your individual needs:

1. **In Network**: If you visit any of our participating providers you will receive your benefit at the time of service. Some of our contracted providers are: Standard Optical, Visionworks, Shopko, America's Best, as well as many independent optometrists. Please refer to our website www.opticareofutah.com for a complete provider listing.

2. **Out of Network:** This includes any provider not listed in our directory. You can go anywhere you want and still have access to great benefits; you will just need to pay up front and submit to us for reimbursement.

The following pages include; A summary of benefits including rates; Provider Search page with instructions on how to locate a provider; Instruction on how to register on line to print id cards and have access to your information online via smart phone. Please feel free to call Opticare of Utah 801-869-2020 or 800-363-0950 for any additional questions.

Eye care is a critical part of overall health care; an eye exam is more than just a means to prescription eyewear. Regular comprehensive eye exams can give early detection to many eye and systemic diseases such as: diabetes, multiple sclerosis, and high blood pressure, among others, which can help lower overall healthcare costs.

We look forward to keeping a good eye on you and your families.

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Opticare Plan: 120B

	Voluntary
Single	$ 4.11
Two Party	$ 7.97
Family	$10.46

Davis County School District	**In Network**	**Out-of-network**
Eye Exam		
No Eye Examination Benefit		
Standard Plastic Lenses		
Single Vision	$10 Co-pay	♦$85 Allowance for lenses, options, and coatings
Bifocal (FT 28)	$10 Co-pay	
Trifocal (FT 7x28)	$10 Co-pay	
Lens Options		
Progressive *(Standard plastic no-line)*	$50 Co-pay	
Premium Progressive Options	$100 Co-pay	
Ultra Premium Progressive Options	Up to 20% Discount	
Polycarbonate	25% Discount	
High Index	25% Discount	
Coatings		
Scratch Resistant Coating	$10 Co-pay	
Ultra Violet protection	$10 Co-pay	
Other Options *A/R, edge polish, tints, mirrors, etc.*	Up to 25% Discount	
Frames		
*Allowance Based on Retail Pricing	$120 Allowance	♦$80 Allowance
Additional Eyewear		
****Additional Pairs of Glasses Throughout the Year**	Up to 50% Off Retail	
Contacts		
Contact benefits is in lieu Of lens and frame benefit.	$120 Allowance	♦$80 Allowance
Additional contact purchases:		
***Conventional	Up to 20% Discount	
***Disposables	Up to 10% Discount	
Frequency		
Exams, Lenses, Frames, Contacts	Every 12 months	Every 12 months
Refractive Surgery		
LASIK	$250 Off Per Eye	Not Covered

Discounts

Any item listed as a discount is a merchandise discount only and not an insured benefit. Discounts vary by providers, see provider for details

**Up to 20% Discount off balance above Frame Allowance*

*** 50% discount varies by provider, ask provider for details.*

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

****** LASIK (Refractive surgery) Standard Optical Locations ONLY.** *LASIK services are not an insured benefit – this is a discount only. All pre & post operative care is provided by Standard Optical only and is based on Standard Optical retail fees.*

♦***Out of Network*** *– Out of Network benefit may not be combined with promotional items. Online purchases at approved providers only.*

For more Information please visit www.opticareofutah.com or call 800-363-0950

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Register and **Print Member ID Cards Online**

Printing member ID cards is simple! This guide will walk you through each step of the process.

1 Access the member portal

1a Go to www.opticareofutah.com

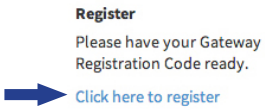
1b Click the “MEMBERS” link in the left navigation

1c Click the “MANAGE YOUR ACCOUNT” banner

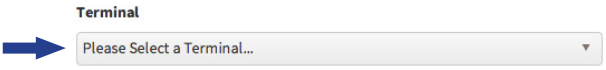
2 Register as a new user

*If you have already registered, skip to step 3.
*Have your gateway registration code ready. *(This is your subscriber ID # found on your insurance card plus “01” to identify as the employee. If you do not have or know your subscriber ID # Please contact us at - 1-800-363-0950)*

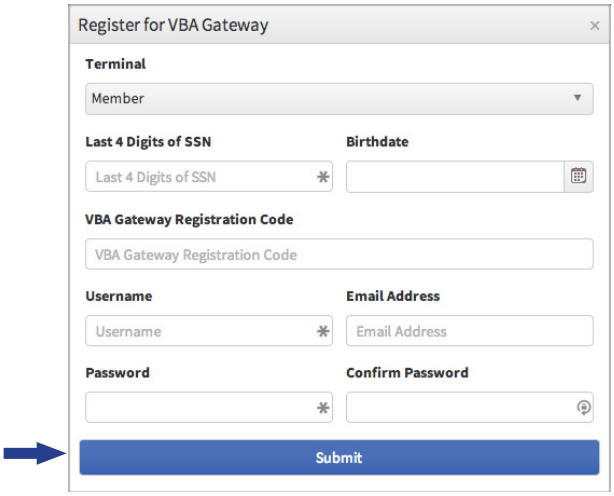
2a Click on “Click here to register”



2b Click the drop down menu, select “Member”

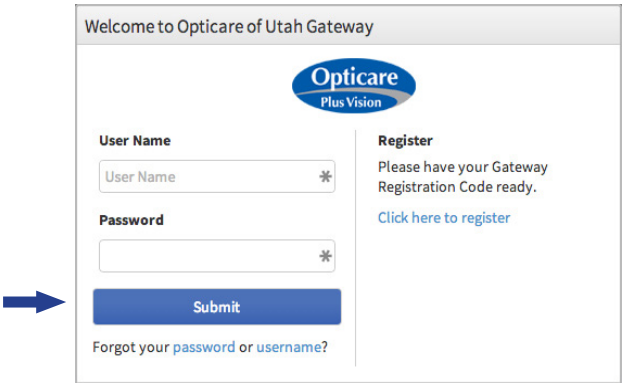


2c Fill out the form with the necessary details, then click the “Submit” button

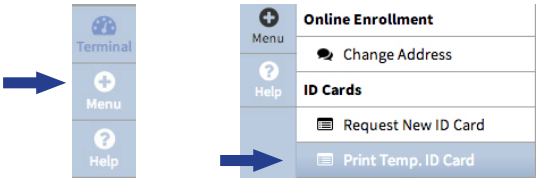


3 Obtain ID Cards

3a Log into your account



3b Hover over the menu icon, select “Print Temp. ID Card”



3c Print Temporary ID Card. Scroll down and click “Print”

Visit Our Providers

Want to visit an Opticare of Utah participating preferred provider?

We have over 150 providers located in the State of Utah and over 20,000 nationwide.

To locate a provider in your area view our website:

www.opticareofutah.com

From the home page, click FIND an Opticare Provider and search by network choice.

In Network will allow you to locate providers in your area by zip code in the state of Utah.

Out of State will allow you to search our Nationwide Network to find a provider 0ut side of the state of Utah by zip code.

You will find a selection of Local Chains, Nationwide Chains as well as Independent Private Practice offices in your area.

Need help or have questions?

(801) 869-2020 or (800) 363-0950

service@opticareofutah.com

Standard Optical
Where Good Vision is Always in Fashion.

Visionworks

SHOPKO eyecare center

AMERICA'S BEST CONTACTS & EYEGLASSES

INDEPENDENT OPTOMETRY NETWORK

FirstLook Vision Network

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LIFE INSURANCE PLANS

The following pages contain information on both the Basic Life Insurance and Supplemental Life Insurance plans available to insurance eligible employees through The Hartford

Davis School District offers Basic Life Insurance to insurance eligible employees and their dependents at no cost to the employee. Employees may also purchase Supplemental Life Insurance for themselves and their dependents.

HARTFORD BASIC LIFE

HARTFORD SUPPLEMENTAL LIFE

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Group Benefits from The Hartford

Basic Life and Accidental Death and Dismemberment (AD&D) and Supplemental Life Insurance

Benefit Highlights

Davis School District

What is Basic and Supplemental life insurance?	Your employer provides, at no cost to you, Basic Life and AD&D Insurance in an amount equal to 1 times your annual Salary, rounded to the next higher $1,000, to a maximum of $150,000. Supplemental Life Insurance is coverage that you pay for. Life Insurance pays your *beneficiary* (please see below) a benefit if you die while you are covered. This highlight sheet is an overview of your Basic Life and AD&D Insurance and Supplemental Life Insurance. Once a group policy is issued to your employer, a certificate of Insurance will be available to explain your coverage in detail.
Am I eligible?	You are eligible if you are an active full time Employee or Retiree.
How much Supplemental Life Insurance can I purchase?	You can purchase Supplemental Life Insurance in increments of $10,000. The maximum amount you can purchase cannot be more than $500,000, the minimum amount you can purchase cannot be less than $20,000.
Basic AD&D Coverage	AD&D provides benefits due to certain injuries or death from an accident. The covered injuries or death can occur up to 365 days after that accident. The insurance pays: • 100% of the amount of coverage you purchase in the event of accidental loss of life, two limbs, the sight of both eyes, one limb and the sight of one eye, or speech and hearing in both ears or quadriplegia. • 75% for paraplegia or triplegia (paralysis of three limbs). • One-half (50%) for accidental loss of one limb, sight of one eye, or speech or hearing in both ears or hemiplegia. • One-quarter (25%) for accidental loss of thumb and index finger of the same hand or uniplegia. Your total benefit for all losses due to the same accident will not be more than 100% of the amount of coverage you purchase.
Am I guaranteed coverage?	The guaranteed issue amount is the amount of Insurance that you may elect without providing evidence of insurability. You are eligible to enroll for coverage up to the guaranteed issue amount of $400,000, if enrolled within 31 days of eligibility *no medical information is required*. You must provide evidence of insurability and be approved by The Hartford to receive coverage above the guaranteed issue amount. You may need to complete a Personal Health Application. These are available from The Hartford or your employer.
Are there other limitations to enrollment?	If you do not enroll in Supplemental Life within 31 days of your first day of eligibility, you will be considered a “late entrant.” Typically, late entrants must show evidence of insurability and may be responsible for the cost of physical exams or other associated costs if they are required.
Spouse Supplemental Life Insurance	If you elect Supplemental Life Insurance for yourself, you may choose to purchase Spouse Supplemental Life Insurance in increments of $10,000 to a maximum of $200,000. Coverage cannot exceed 100% of the amount of your Employee Supplemental Life Insurance coverage. You may not elect coverage for your Spouse if they are an active member of the armed forces of any country or international authority, or is already covered as an Employee under this policy. Spouse premium rates based on Spouse's age. If your Spouse is confined in a hospital or elsewhere because of disability on the date his or her Insurance would normally have become effective, coverage (or an increase in coverage) will be deferred until that dependent is no longer confined and has performed all the normal activities of a healthy person of the same age for at least 15 consecutive days. Your Spouse is guaranteed coverage of up to $50,000, if enrolled within 31 days of eligibility. Your Spouse must provide evidence of insurability and be approved by The Hartford to receive coverage above the guaranteed issue amount. Your Spouse may need to complete a *Personal Health Application*. These are available from The Hartford or your employer.

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Child(ren) Supplemental Life Insurance	If you elect Supplemental Life Insurance for yourself, you may choose to purchase Child(ren) Supplemental Life Insurance coverage in the amount(s) of $5,000 or $10,000 for each child – no medical information is required. You may not elect coverage for your Child if your Child is an active member of the armed forces of any country or international authority. • If your dependent child is confined in a hospital or elsewhere because of disability on the date his or her insurance would normally have become effective, coverage (or an increase in coverage) will be deferred until that dependent is no longer confined and has performed all the normal activities of a healthy person of the same age for at least 15 consecutive days. • Your child(ren) must be from live birth but not yet age 26 to be covered. • Child(ren) age 26 or older may be covered if they were disabled prior to attaining age 26.
Spouse Basic Life Insurance	Your employer provides, at no cost to you, Spouse Basic Life Insurance in an amount equal to $3,000.
Child(ren) Basic Life Insurance	Your employer provides, at no cost to you, Child(ren) Basic Life Insurance in an amount equal to $3,000 for each child–*no medical information is required.* Children are covered from 1 Day to 26 years old.
Does my coverage reduce as I get older?	Your benefit will be reduced to 65% at age 65 and to 40% of the reduced amount at age 80.
Can I keep my Life Coverage if I leave my employer?	Yes, subject to the contract, you have the option of: • Converting your group life coverage to your own individual policy (policies). • If you leave your employer, portability is an option that allows you to continue your Supplemental Life Insurance coverage. To be eligible, you must terminate your employment prior to Social Security normal retirement age. This option allows you to continue all or a portion of your Supplemental Life Insurance coverage under a separate portability term policy. Portability is subject to a minimum of $5,000 and a maximum of $250,000 and does include coverage for your spouse and child(ren). To elect portability, you must apply and pay the premium within 31 days of the termination of your life insurance. Evidence of insurability will not be required. Dependent spouse portability is subject to a maximum of $50,000. Dependent child(ren) portability is subject to a maximum of $10,000.
What is the Living Benefits Option?	If you are diagnosed as terminally ill with a 12 month life expectancy, you may be eligible to receive payment of a portion of your life insurance. The remaining amount of your life insurance would be paid to your beneficiary when you die.
Do I still pay my Life Insurance premiums if I become disabled?	If you become totally disabled before age 60 and your disability lasts for at least 6 months, your Supplemental Life Insurance premium may be waived. The premium for your dependent's coverage will also be waived if you are disabled and approved for waiver of premium.
What is Life Conversations?	Life Conversations is a comprehensive life planning program with tools, information and services you need to begin difficult life conversations with your family. Life conversations Includes Funeral Planning and Concierge Services, Estate Guidance, Beneficiary Assist and Travel Assistance. For more information visit www.hartfordlifeconversations.com. These value added services are available at no additional cost.

Important Details

As is standard with most term life insurance, this insurance coverage includes certain limitations and exclusions:

- the amount of your coverage may be reduced when you reach certain ages.
- death by suicide (two years).

AD&D insurance does not cover losses caused by or contributed by:

• sickness; disease; or any treatment for either;	• injury sustained while in the armed forces of any country or international authority;
• any infection, except certain ones caused by an accidental cut or wound;	• taking prescription or illegal drugs unless prescribed for or administered by a licensed physician;
• intentionally self-inflicted injury, suicide or suicide attempt;	• injury sustained while committing or attempting to commit a felony;
• war or act of war, whether declared or not;	• the injured person's intoxication.

Other exclusions may apply depending upon your coverage. Once a group policy is issued to your employer, a certificate of insurance will be available to explain your coverage in detail.

This benefit highlights sheet is an overview of the insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the benefit highlights sheet and the insurance policy, the terms of the insurance policy apply.

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MORE BENEFITS THAN YOU MIGHT EXPECT.

DAVIS SCHOOL DISTRICT

Take advantage of additional services that come with your insurance plan.

Your Life insurance from The Hartford can help you protect the financial future of your loved ones. But did you know about the other services that come with them? They can provide valuable services to you and your family when you need them most. Here's a quick summary.

FUNERAL PLANNING & CONCIERGE SERVICES[1]

Helps provide peace of mind when it's needed the most.

The Hartford offers a funeral planning and concierge service provided by Everest. It provides a suite of online tools to guide you through key decisions before a loss, including help comparing funeral-related costs. After a loss, this service includes family advocacy and professional negotiation of funeral prices with local providers – often resulting in significant financial savings.

Find out more: **1-866-854-5429**. Or visit **WWW.EVERESTFUNERAL.COM/HARTFORD** and use this code: **HFEVLC**

BENEFICIARY ASSIST® COUNSELING SERVICES[2]

Getting through a loss is hard. Getting support to help cope doesn't have to be.

The Hartford offers you Beneficiary Assist counseling services provided by ComPsych®. Compassionate professionals can help you or your beneficiaries (named in your policy) cope with emotional, financial and legal issues that arise after a loss. Includes unlimited phone contact with a counselor, attorney or financial planner for up to a year, and five face-to-face sessions.

Find out more: **1-800-411-7239**.

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continued

THE HARTFORD

ESTATEGUIDANCE® WILL SERVICES[3]

Create a simple will from the convenience of your desktop.

Whether your assets are few or many, it's important to have a will. Through The Hartford you have access to EstateGuidance® Will Services, provided by ComPsych. It helps you protect your family's future by creating a will online – backed by online support from licensed attorneys. Your will is customized and legally binding.

Visit **WWW.ESTATEGUIDANCE.COM/WILLS** today and use this code: **WILLHLF**

TRAVEL ASSISTANCE SERVICES WITH ID THEFT PROTECTION AND ASSISTANCE[4]

Even the best planned trips can be full of surprises.

Travel Assistance Services with ID Theft Protection and Assistance include pre-trip information to help you feel more secure while traveling. It can also help you access medical professionals across the globe for medical assistance when traveling 100+ miles away from home for 90 days or less when unexpected detours arise. The ID theft services are available to you and your family at home or when you travel.

For more information on Travel Assistance Services or ID Theft Services, call **1-800-243-6108** or collect from other locations: **202-828-5885**.
Fax: **202-331-1528**
or email **IDTHEFT@EUROPASSISTANCE-USA.COM**.
Please provide your employer's name, a phone number where you can be reached, nature of the problem, Travel Assistance Identification Number **GLD-09012**, and your company policy number **220069**.

Prepare. Protect. Prevail.®

Visit **THEHARTFORD.COM/EMPLOYEEBENEFITS**

THE HARTFORD

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Home office is Hartford, CT.

[1] Funeral Concierge Services are offered through Everest Funeral Package, LLC (Everest). Everest and the Everest logo are service marks of Everest Funeral Package, LLC. Everest is not affiliated with The Hartford and is not a provider of insurance services. Everest and its affiliates have no affiliation with Everest ReGroup, Ltd., Everest Reinsurance Company or any of their affiliates.

[2] Beneficiary Assist® is offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services.

[3] EstateGuidance® services are provided through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. A simple will does not cover credit shelter trust, printing or certain other features. These features are available at an additional cost to you.

[4] Travel Assistance and ID Theft Protection and Assistance are provided by Europ Assistance USA. Europ Assistance USA is not affiliated with The Hartford and is not a provider of insurance services. The Hartford's Privacy Policy is available at: http://thehartford.com/online-privacy-policy.

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DISABILITY INSURANCE PLANS

SHORT-TERM DISABILITY INCOME PROTECTION

LONG-TERM DISABILITY INCOME PROTECTION

The following pages include information on both Short-Term Disability and Long-Term Disabilty plans available to eligible employees through UNUM.

Short-term and Long-term disability insurance provides income protection by paying a percentage of your monthly income if you become disabled and unable to work. If you elect long-term disability coverage, the district pays a portion of the cost of the monthly premium.

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Short Term Disability Income Protection insurance plan highlights
Policy number #537234

How many weeks can you afford to be without a paycheck? With Short Term Disability Insurance, you won't have to miss several weeks of pay if you are unable to work because of a non-work related injury or illness.

This voluntary STD plan pays a percentage of your weekly salary for up to 22 weeks if you meet the definition of disability defined in the plan. Premiums are payroll deducted on a post-tax basis, so any benefits paid to you are not subject to state or federal income tax.

Your Plan

Benefit Amount	66 2/3% of your base weekly earnings (as defined by your employer) to a maximum of $1,385 per week. (Employees currently enrolled in plans with benefit percentages of 33%, 50%, or 66% have the option of remaining in their current plan. However, all other UnumProvident plan provisions will apply.) Your STD benefits may be reduced by the amount of other income replacement benefits you receive for the same disability, such as benefits from state-mandated disability plans or Worker's Compensation, etc. However, the minimum weekly benefit is $25.
Guarantee Issue	You will not have to answer medical questions if you enroll before or on the date you become initially eligible, or within the 30 days following the date you become initially eligible for coverage. You will be required to provide evidence of insurability if you enroll following these enrollment periods or if you voluntarily cancel your coverage and are reapplying. Please see your Plan Administrator for your eligibility date.
Definition of Disability	You are disabled when Unum determines that due to your sickness or injury: • you are unable to perform the material and substantial duties of your regular occupation; and • you are not working in any occupation.
Elimination Period	The Elimination Period is the length of time of continuous disability which must be satisfied before you are eligible to receive benefits. If your disability is the result of an injury that occurs while you are covered under the plan, your Elimination Period is 30 days. If your disability is due to a sickness, your Elimination Period is 30 days.
Benefit Duration	If you meet the definition of disability you may receive a benefit for 22 weeks.

Limitations/Exclusions/ Termination of Coverage

Pre-existing Condition Exclusion	You have a pre-existing condition if: • you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and • the disability begins in the 12 months after your effective date of coverage.
Instances When Benefits Would Not Be Paid	Benefits would not be paid for loss resulting from: • war, declared or undeclared, or any act of war; • active participation in a riot; • intentionally self-inflicted injuries; • loss of a professional license, occupational license or certification; • commission of a crime for which you have been convicted under state or federal law; • any period of disability during which you are incarcerated; • an **occupational injury or sickness**,(*this will not apply to a partner or sole proprietor who cannot be covered by law under Workers' Compensation or any similar law);* • pre-existing condition.
Termination of Coverage	Your coverage under the policy ends on the earliest of the following: • The date the policy or plan is cancelled; • The date you no longer are in an eligible group; • The date your eligible group is no longer covered; • The last day of the period for which you made any required contributions; • The last day you are in active employment except as provided under the covered layoff or leave of absence provision. Please see your Plan Administrator for further information on these provisions. Unum will provide coverage for a payable claim which occurs while you are covered under the policy or plan.
Delayed Effective Date of Coverage	Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.
Questions on Claims or Benefits?	Call Unum's Customer Service Center at 800-421-0344.

This plan highlight is a summary provided to help you understand your insurance coverage from Unum. Details may differ from state to state. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Underwritten by:

Unum Life Insurance Company of America
2211 Congress Street, Portland, Maine 04122
www.unum.com

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Long Term Disability Income Protections insurance plan highlights 537234

This voluntary LTD plan pays a percentage of your monthly salary if you meet the definition of disability defined in the plan. The maximum period of payment is based on your age at disability. Your employer pays for half the cost (or a prorated portion if you are not a full time employee). Your half (or prorated portion) of the premiums are payroll deducted on a post tax basis, so that portion of your benefit is not subject to state or federal income tax.

Your Plan

Benefit Amount	60% of your base monthly earnings (as defined by your employer) to a maximum of $6,000 per month. Your LTD benefits may be reduced by the amount of other income replacement benefits you receive for the same disability, such as benefits from Social Security or Worker's Compensation, etc.
Guarantee Issue	You will not have to answer medical questions if you enroll before or on the date you become initially eligible, or within the 30 days following the date you become initially eligible for coverage. You will be required to provide evidence of insurability if you enroll following these enrollment periods or if you voluntarily cancel your coverage and are reapplying. Please see your Plan Administrator for your eligibility date.
Definition of Disability	You are disabled when Unum determines that: • you are limited from performing the material and substantial duties of your regular occupation; and • you have a 20% or more loss in indexed monthly earnings due to the same sickness or injury. • After benefits have been paid for 24 months, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience

Elimination Period	The Elimination Period is the length of time of continuous disability which must be satisfied before you are eligible to receive benefits. LTD benefits would begin after 180 consecutive days of disability, as described in the definition above.
Benefit Duration	Your duration of benefits is based on your age when the disability occurs. Your LTD benefits are payable for the period during which you continue to meet the definition of disability. If your disability occurs before age 60, benefits will be payable until age 65. If your disability occurs at or after age 60, benefits would be paid according to a benefit duration schedule.
Cost of Living Adjustment	Unum will make a Cost of Living Adjustment (COLA) after you have received 1 full year(s) of payments for your disability. Your payments will increase by 2% beginning on the first anniversary of payments and each following anniversary while you continue to receive payments for your disability.

Additional Benefits

Rehabilitation and Return to Work Assistance	Unum has a vocational rehabilitation program available to assist you to return to work. This program is offered as a service, and is voluntary on your part and on Unum's part. Unum may elect to offer you a return-to-work program including, but not limited to, the following services: • coordination with your Employer to assist you to return to work; • evaluation of adaptive equipment to allow you to work; • vocational evaluation to determine how your disability may impact your employment options; • job placement services; • resume preparation; • job seeking skills training; or • retraining for a new occupation.
Waiver of Premium	You will not be required to pay LTD premiums as long as you are receiving LTD benefits.
Conversion	If you are covered under your group's LTD plan for 12 consecutive months and you choose to leave you may convert your LTD coverage to coverage under a group trust contract. There are certain times that you may not convert your coverage. Please see your certificate booklet for details.

Work/Life Balance Employee Assistance Program	Unum's work/life balance employee assistance program is a comprehensive resource designed to provide fast and convenient answers and advice on a wide variety of topics ranging from severe to everyday problems. Available to you and your family members, Unum's work/life balance employee assistance program provides 24 hour access to professional advice - even face to face sessions when needed. Every inquiry is answered by an experienced, masters-level consultant, who can help in a variety of ways including: telephone consultations, personalized searches and referrals, educational materials, Tips-on-Tape™, and online resources. Some of the topics addressed are parenting and childcare, older adults, legal and financial issues, emotional well-being and education. And if you should become disabled and be on claim, the new On Claim Support service can help you handle everyday concerns, the kinds of things that used to be easy to do. A consultant and a researcher can help find solutions to problems such as finding child care, setting up appointments and arranging transportation.
Universal Access Card	The Universal Access card puts you in touch with some of Unum's support services that enhance your coverage and help you deal with concerns both in and out of the workplace.
Worldwide Emergency Travel Assistance Services	A 24-hour network of emergency medical and legal resources offers valuable protection for you and your family when traveling more than 100 miles from home. With just one call, you have access to a global network of highly qualified professionals trained to manage any travel emergency. (Note that spouses traveling on business are not eligible.)
Survivor Benefit	Unum will pay your eligible survivor a lump sum benefit equal to 3 months of your gross disability payment. This benefit will be paid if, on the date of your death, your disability had continued for 180 or more consecutive days, and you were receiving or were entitled to receive payments under the plan. If you have no eligible survivors, payment will be made to your estate, unless there is none. In this case, no payment will be made. However, we will first apply the survivor benefit to any overpayment which may exist on your claim.

Limitations/Exclusions/ Termination of Coverage

Pre-existing Condition Exclusion	You have a pre-existing condition if: • you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 12 months just prior to your effective date of coverage; and • the disability begins in the first 12 months after your effective date of coverage.

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Instances When Benefits Would Not Be Paid	Benefits would not be paid for disabilities caused by, contributed to by, or resulting from: • intentionally self-inflicted injuries; • active participation in a riot; • war, declared or undeclared, or any act of war; • conviction of a crime under state or federal law; • loss of professional license, occupational license or certification; • pre-existing conditions (see definition). Unum will not pay a benefit for any period of disability during which you are incarcerated.
Mental and Nervous	Disabilities due to a sickness or injury which are primarily based on self-reported symptoms and disabilities due to mental illness have a limited payment period of 24 months per lifetime. Mental and nervous benefits would continue beyond 24 months only if you are institutionalized or hospitalized as a result of the disability.
Termination of Coverage	Your coverage under the policy ends on the earliest of the following: • The date the policy or plan is cancelled; • The date you no longer are in an eligible group; • The date your eligible group is no longer covered; • The last day of the period for which you made any required contributions; • The last day you are in active employment except as provided under the covered layoff or leave of absence provision. Unum will provide coverage for a payable claim which occurs while you are covered under the policy or plan.
Questions on Claims or Benefits?	Call Unum's Customer Service Center at 800-421-0344.

This plan highlight is a summary provided to help you understand your insurance coverage from Unum. Details may differ from state to state. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

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Underwritten by:
Unum Life Insurance Company of America
2211 Congress Street, Portland, Maine 04122
www.unum.com

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PREMIUM SCHEDULES

The following pages include the premium schedules listed below.

ACTIVE EMPLOYEE

Includes premiums for Health, Dental, and Long-Term Disability

SHORT-TERM DISABILITY

SUPPLEMENTAL TERM LIFE

VISION INSURANCE

COBRA PARTICIPANTS

Includes premiums for Health and Dental

RETIREE PARTICIPANTS

Includes premiums for Health and Dental

When reviewing premium schedules, remember that for active employees:

District pays full premium cost of:
Basic Term Life Insurance

District contributes to the premium cost of:
Health Insurance
Dental Insurance
Long-Term Disability Insurance

Employee pays full premium cost of:
Supplemental Term Life Insurance
Short-Term Disability Insurance
Vision Insurance

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Based on 12 checks*

Plans and Coverage	Monthly Premium Cost	Annual Cost Total	Eligible Hours Per Week: 35 + Hours per week — District Monthly Cost	35 + Hours per week — Employee Monthly Cost**	32.5 + Hours per week — District Monthly Cost	32.5 + Hours per week — Employee Monthly Cost**	30 + Hours per week — District Monthly Cost	30 + Hours per week — Employee Monthly Cost**
HEALTH PLANS								
AETNA (Traditional)								
Employee + 2 or more	1,614.40	19,372.80	1,400.98	213.42	1,214.18	400.22	1,120.78	493.62
Employee + 1	1,198.30	14,379.60	1,055.62	142.68	914.87	283.43	844.50	353.80
Employee Only	554.80	6,657.60	521.51	33.29	451.98	102.82	417.21	137.59
SELECTHEALTH (Traditional)								
Employee + 2 or more	1,627.50	19,530.00	1,412.32	215.18	1,224.01	403.49	1,129.86	497.64
Employee + 1	1,207.80	14,493.60	1,063.97	143.83	922.11	285.69	851.18	356.62
Employee Only	559.10	6,709.20	525.55	33.55	455.48	103.62	420.44	138.66
AETNA (High Deductible)								
Employee + 2 or more	1,441.50	17,298.00	1,250.93	190.57	1,084.14	357.36	1,000.74	440.76
Employee + 1	1,070.00	12,840.00	942.58	127.42	816.90	253.10	754.06	315.94
Employee Only	495.30	5,943.60	465.58	29.72	403.50	91.80	372.46	122.84
SELECTHEALTH (High Deductible)								
Employee + 2 or more	1,455.40	17,464.80	1,262.98	192.42	1,094.58	360.82	1,010.38	445.02
Employee + 1	1,080.10	12,961.20	951.48	128.62	824.62	255.48	761.18	318.92
Employee Only	500.00	6,000.00	470.00	30.00	407.33	92.67	376.00	124.00
LONG TERM DISABILITY								
UNUM								
Employee Only	20.59	247.08	10.30	10.29	8.93	11.66	8.24	12.35
DENTAL PLANS								
DELTA BASIC PPO								
Employee + 2 or more	88.19	1,058.28	79.09	9.10	68.54	19.65	63.27	24.92
Employee + 1	59.93	719.16	57.69	2.24	50.00	9.93	46.15	13.78
Employee Only	29.97	359.64	29.97	0.00	25.97	4.00	23.98	5.99
DELTA PREMIER + PPO								
Employee + 2 or more	118.32	1,419.84	79.09	39.23	68.54	49.78	63.27	55.05
Employee + 1	75.52	906.24	57.69	17.83	50.00	25.52	46.15	29.37
Employee Only	44.28	531.36	42.07	2.21	36.46	7.82	33.66	10.62

Premium schedule continued on next page

*Employees who receive 10 checks a year rather than 12 will prepay a protion of the annual premium. Therefore, the monthly amount deducted from an employee's paycheck will exceed the Employee Monthly Cost amount.

**Employees enrolled in District health insurance will also be subject to a monthly wellness premium in the amount of $6.25.

NOTE: Premiums listed for less than 30 hours per work week are applicable to employees who meet the eligibility criteria requirements of an employment start date and insurance eligibility date of June 30, 2004, or earlier.

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Active Employee Premium Schedules

January 1 through December 31, 2018

Based on 12 checks*

Plans and Coverage	Monthly Premium Cost	Annual Cost Total	Eligible Hours Per Week: 27.5 + Hours per week		25 + Hours per week		22.5 + Hours per week		20 + Hours per week	
			District Monthly Cost	Employee Monthly Cost**	District Monthly Cost	Employee Monthly Cost**	District Monthly Cost	Employee Monthly Cost**	District Monthly Cost	Employee Monthly Cost**
HEALTH PLANS										
AETNA (Traditional)										
Employee + 2 or more	1,614.40	19,372.80	1,027.39	587.01	933.99	680.41	840.59	773.81	747.19	867.21
Employee + 1	1,198.30	14,379.60	774.12	424.18	703.75	494.55	633.37	564.93	563.00	635.30
Employee Only	554.80	6,657.60	382.44	172.36	347.67	207.13	312.91	241.89	278.14	276.66
SELECTHEALTH (Traditional)										
Employee + 2 or more	1,627.50	19,530.00	1,035.70	591.80	941.55	685.95	847.39	780.11	753.24	874.26
Employee + 1	1,207.80	14,493.60	780.24	427.56	709.31	498.49	638.38	569.42	567.45	640.35
Employee Only	559.10	6,709.20	385.40	173.70	350.37	208.73	315.33	243.77	280.29	278.81
AETNA (High Deductible)										
Employee + 2 or more	1,441.50	17,298.00	917.35	524.15	833.95	607.55	750.56	690.94	667.16	774.34
Employee + 1	1,070.00	12,840.00	691.23	378.77	628.39	441.61	565.55	504.45	502.71	567.29
Employee Only	495.30	5,943.60	341.43	153.87	310.39	184.91	279.35	215.95	248.31	246.99
SELECTHEALTH (High Deductible)										
Employee + 2 or more	1,455.40	17,464.80	926.19	529.21	841.99	613.41	757.79	697.61	673.59	781.81
Employee + 1	1,080.10	12,961.20	697.75	382.35	634.32	445.78	570.89	509.21	507.46	572.64
Employee Only	500.00	6,000.00	344.67	155.33	313.33	186.67	282.00	218.00	250.67	249.33
LONG TERM DISABILITY										
UNUM										
Employee Only	20.59	247.08	7.55	13.04	6.87	13.72	6.18	14.41	5.49	15.10
DENTAL PLANS										
DELTA BASIC PPO										
Employee + 2 or more	88.19	1,058.28	58.00	30.19	52.73	35.46	47.45	40.74	42.18	46.01
Employee + 1	59.93	719.16	42.31	17.62	38.46	21.47	34.61	25.32	30.77	29.16
Employee Only	29.97	359.64	21.98	7.99	19.98	9.99	17.98	11.99	15.98	13.99
DELTA PREMIER + PPO										
Employee + 2 or more	118.32	1,419.84	58.00	60.32	52.73	65.59	47.45	70.87	42.18	76.14
Employee + 1	75.52	906.24	42.31	33.21	38.46	37.06	34.61	40.91	30.77	44.75
Employee Only	44.28	531.36	30.85	13.43	28.05	16.23	25.24	19.04	22.44	21.84

*Employees who receive 10 checks a year rather than 12 will prepay a protion of the annual premium. Therefore, the monthly amount deducted from an employee's paycheck will exceed the Employee Monthly Cost amount.

**Employees enrolled in District health insurance will also be subject to a monthly wellness premium in the amount of $6.25.

NOTE: Premiums listed for less than 30 hours per work week are applicable to employees who meet the eligibility criteria requirements of an employment start date and insurance eligibility date of June 30, 2004, or earlier.

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SHORT-TERM DISABILITY RATES

Premium Rates per $10 of Base Salary		
Age	**Male**	**Female**
29 and under	.04	.08
30-39	.06	.10
40-49	.09	.16
50-59	.13	.22
60 and over	.18	.26

Sample Premium Calculation: Yearly base salary ($26,696) divide by 52 weeks = $513; weekly salary $513 x 66.6667% of benefit = $342.00 (round to nearest $10) = $340 divide by 10 = $34 x .18 (rate) = $6.12 monthly premium.

SUPPLEMENTAL LIFE RATES

Monthly Rates per $1,000 of Coverage

Attained Age	Employee & Spouse Rates
34 and under	$ .06
35 to 39	.09
40 to 44	.11
45 to 49	.17
50 to 54	.23
55 to 59	.39
60 to 64	.47
65 to 69	.76
70 to 74	1.43
75 to 79	2.49

Child(ren)		
	Coverage for $ 5,000	$ .78
	Coverage for $10,000	1.56

Calculate your total monthly premium here

	Desired No. of Thousands		Premium Per $1,000		Total Premium
Employee	_____	X	_____	=	_____
Spouse	_____	X	_____	=	_____
Child(ren)	$5,000 (.78)		$10,000 ($1.56)	=	_____
			Total Monthly Premium	=	_____

(Employee's who receive 10 checks a year rather than 12 will prepay a portion of the annual premium)

VISION MONTHLY RATES

Employee Only	$ 4.11
Employee + 1	$ 7.97
Employee + 2 or more	$10.46

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COBRA PREMIUMS

Qualified beneficiaries who continue coverage under COBRA, the federal health care continuation law, pay 102% of the premium cost. Premiums are remitted directly to the district's COBRA Administrator.

January 1, 2018 through December 31, 2018

Health Plans — Monthly Premiums

AETNA (Traditional Health Plan)

Family	$1,646.69
2-Party	1,222.27
Single	565.90

SELECTHEALTH (Traditional Health Plan)

Family	$1,660.05
2-Party	1,231.96
Single	570.28

AETNA (High Deductible Health Plan)

Family	$1,470.33
2-Party	1,091.40
Single	505.21

SELECTHEALTH (High Deductible Health Plan)

Family	$1,484.51
2-Party	1,101.70
Single	510.00

Dental Plans — Monthly Premiums

DELTA BASIC PPO

Family	$ 89.95
2-Party	61.13
Single	30.57

DELTA PREMIER + PPO

Family	$120.69
2-Party	77.03
Single	45.17

Vision — Monthly Premiums

OPTICARE OF UTAH

Family	$ 10.67
2-Party	8.13
Single	4.19

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RETIREE PREMIUMS

As defined in the Davis School District Negotiated Agreements, employees who retire under the Davis School District Early Retirement Incentive Medical and Dental Plan (ERP) may continue to be enrolled in group medical and dental programs until they become eligible for medicare, or for ten consecutive years following retirement, whichever occurs first. Special provisions apply to retirees who return to active employment with the district. (Dependents may have limited continuation of coverage in cases where they would otherwise lose coverage - see ERP document.)

Retired Employees in **first three years** of plan participation–

- Refer to the Active Employee Premium Schedule.

Retired Employees **beyond the first three years** of plan participation–

- Refer to the schedule below.

January 1, 2018 through December 31, 2018

Health Plans	Monthly Premiums
AETNA (Traditional Health Plan)	
Family	$1,646.69
2-Party	1,222.27
Single	565.90
SELECTHEALTH (Traditional Health Plan)	
Family	$1,660.05
2-Party	1,231.96
Single	570.28
AETNA (High Deductible Health Plan)	
Family	$1,470.33
2-Party	1,091.40
Single	505.21
SELECTHEALTH (High Deductible Health Plan)	
Family	$1,484.51
2-Party	1,101.70
Single	510.00

Dental Plans	Monthly Premiums
DELTA BASIC PPO	
Family	$ 89.95
2-Party	61.13
Single	30.57
DELTA PREMIER + PPO	
Family	$120.69
2-Party	77.03
Single	45.17

Vision	Monthly Premiums
OPTICARE OF UTAH	
Family	$ 10.67
2-Party	8.13
Single	4.19

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IMPORTANT INSURANCE NOTES

The following pages include important information regarding miscellaneous insurance issues.

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ADDITIONAL DISTRICT BENEFITS

In addition to insurance coverage, the district offers a significant number of valuable benefits to eligible employees. These benefits include, but are not limited to, the following: vacation leave, personal leave, sick leave, catastrophic sick leave bank, workers compensation coverage, early retirement plan, contribution to a tax-deferred annuity plan, participation in the Utah State Retirement System, and flexible benefit plan.

For more information about these benefits, review the current Educators or Classified Negotiated Agreements available on the district website at: www.davis.k12.ut.us or contact the District Payroll or Human Resources Departments.

BENEFICIARY CHANGES

Employees may change beneficiary designation for basic and supplemental life insurance coverage at any time. Change forms are available from the District Insurance Office.

BENEFIT PLAN INFORMATION

Information about district benefit plans can be found on the district website (www.davis.k12.ut.us). From the homepage, select "Departments" then "Insurance" for the "Davis School District Benefits Guide," insurance change forms, insurance company website links, Medicare notice, privacy practices notice, etc.

CANCELLATION OF COVERAGE

Employees who wish to cancel insurance coverage do not need to wait for an open enrollment period. Any policy may be canceled by submitting a **written request** to the District Insurance Division. Coverage will be terminated the end of the month in which the request is received.

CHANGE OF ADDRESS

Employees who have a change of address need to notify the Payroll Office at 801-402-5236. Correct address information helps assure that information mailed from the insurance companies (e.g. membership cards, updated policy information, Explanation of Benefits, etc.) is received in a timely manner.

CHANGE OF NAME

By law, the district must use the name on an employee's social security card for payroll purposes. This assures that social security contributions are credited appropriately. The district also uses the name on the social security card for insurance identification purposes. Therefore, it is important that the same name is used when accessing health care services to avoid unnecessary claim denial. Employees should contact the Social Security Administration to make a name change on their card. The new social security card must be taken to the Payroll Department to update district records.

CHANGE OF STATUS

Employees who experience a change of status (marriage, birth, adoption, divorce, death, addition of children, deletion of children who lose dependent status, loss of spouse's job) must submit written notice of same to the District Insurance Division within 30 days of the effective date of the event. If notice is not submitted in a timely manner, coverage opportunities may be lost and/or delayed. **Failure to submit timely notice regarding spouse and/or dependents losing eligibility status may be considered insurance fraud and subject employees to district disciplinary action.**

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CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) NOTICE

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

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Meidicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in Utah, you can contact the Utah Medicaid office at http://health.utah.gov/upp or 1-866-435-7414 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, you can contact the Utah Medicaid office as indicated above, or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, **and you must request coverage within 60 days of being determined eligible for premium assistance.**

CONTINUATION OF COVERAGE UNDER COBRA

"COBRA" stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA is the federal health care continuation law that allows a "qualified beneficiary" who loses employer-provided coverage due to a "triggering event" to continue coverage. COBRA coverage has limited duration. In most cases, the maximum COBRA period from the date of the qualifying event is 18 months for employees and 18 to 36 months for dependents. In cases of disability, COBRA coverage may be continued for up to 29 months. If you divorce, are legally separated, or your child loses dependent status, be sure to submit written notice to the District Insurance Division within 30 days of the event.

COORDINATION OF BENEFITS

Employees covered under more than one group medical and/or dental plan have primary coverage through the plan where they are an active employee. Claims are processed first by the **primary plan**. The Explanation of Benefits (EOB) received from your primary plan should be subsequently submitted to your other coverage, or **secondary plan**, for consideration.

As a general rule, when a child is covered as a dependent of both parents, under two separate plans, the primary plan is the plan carried by the parent whose birthday falls earliest in the calendar year. If both parents have the same birthday, the plan that has been in effect for the longest period of time is the primary plan. If an employee and his/her spouse both work for the District, refer to the Eligibility note in this section for coordination information.

In order to assure the appropriate processing of claims, you are required to provide information to all insurance companies regarding other coverage. Failure to provide requested information may result in a delay of processing or denial of claims.

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EARLY RETIREMENT PLAN (ERP)

- **Eligibility** - To be eligible for the ERP, employees must have ten years of salary schedule service credit (including five years current service in the district) and meet the eligibility requirements for and be receiving Utah State Retirement System benefits within 90 calendar days following retirement. Employees with at least five but fewer than ten years of salary service credit who meet the above criteria may also apply for these benefits on a pro rated basis. Employees and/or their dependents who are eligible for Medicare are not eligible to continue participation in the district's Early Retirement Plan (See "Medicare and Medigap Plans" in this section for more information.)

- **Enrollment** - Enrollment in the ERP is contingent upon the retiree completing an enrollment form and contributing the same premium for all coverage as required of active employees for the first three years and the full premium, as determined by the District Insurance Committee, for the following seven years. At time of retirement, employees may choose to take a credit of 21.5 percent of the value of their accumulated sick leave to be applied toward the payment of ERP insurance premiums during retirement.

- **Period of Coverage** - Employees who retire under the Early Retirement Incentive Program may continue to be enrolled in group medical and dental programs under the ERP until they become eligible for medicare, or for the ten consecutive years following retirement, whichever occurs first. By electing participation in this plan, employees and their dependents are electing an alternative to COBRA participation.

- **Life Insurance** - Participants in the ERP may also continue to carry life insurance during the first three years of retirement or until they become eligible for medicare, whichever occurs first. Employees who continue supplemental term life insurance coverage will be responsible for direct payment of premiums or for establishing a direct payment plan from their bank account. The initial premium must be paid within 30 days of the date of retirement. Additional premium payments are due the first of each month to the Davis School District Accounting Department, P. O. Box 588, Farmington, UT 84025-0588. If premiums are not paid on a timely basis, coverage will terminate at the end of the month for which premiums have been paid.

- **Dependent Coverage** - Special provisions apply for dependent coverage continuation in the ERP in cases where the retiree loses coverage eligibility. See the District Insurance Office for details. Please note, dependents eligible for medicare are ineligible for coverage under the ERP.

- **Return to Active Employment** - Special provisions apply to retired employees who receive Davis School District retirement incentives and subsequently return to employment with the Davis School District. See the District Insurance Office for details.

- **Additional Information** - For more information on the ERP, refer to the Educators or Classified Negotiated Agreements or call the Insurance Division at 801-402-5636.

EFFECTIVE DATE/TERMINATION DATE

The effective date of coverage for an insurance eligible employee is the first day of the month following 30 calendar days after his/her start date. An employee who loses insurance eligibility because of a break in service with the district does not have a 30-calendar day waiting period before the insurance effective date if the employee begins coverage, or is hired into an insurance eligible position, or combination of positions, by the district within 12 months of losing coverage eligibility.

When dependent eligibility occurs subsequent to the employee's initial eligibility (e.g. marriage, birth, adoption) coverage will be effective the date of the event. Coverage that requires underwriting will not be effective until underwriting approval is completed. **Remember, no coverage will be effective without completion of appropriate Insurance Enrollment Forms and appropriate documentation.**

If an employee terminates employment or when coverage eligibility is lost, insurance coverage shall terminate the last day of the month in which eligibility was lost. However, if an employee working in a licensed position loses eligibility after the end of the school year, coverage may continue through: August 31 for employees working on a traditional schedule or retiring from district employment; July 31 for employees working on a year round schedule. If a dependent loses eligibility status unrelated to the termination of the employee (e.g. marriage, divorce, death, or child reaches age 26) insurance coverage shall terminate the last day of the month in which eligibility was lost.

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ELIGIBILITY

- **Employees Eligible to Participate in District Group Insurance Plans Include:**
  Employees with an employment start date July 1, 2004, or later, working in a position that is: authorized for an average of thirty (30) or more hours per work week and authorized for at least 168 days each fiscal year; OR, authorized for an average of thirty (30) or more hours per work week and authorized for a total of at least 1,008 hours each fiscal year.

  Employees with an employment start date and insurance eligibility date June 30, 2004, or earlier, working in a position that is: authorized for an average of twenty (20) or more hours per work week and authorized for at least 168 days each fiscal year; **OR**, authorized for an average of twenty (20) or more hours per work week and authorized for a total of at least 704 hours each fiscal year.

  Employees with an employment start date June 30, 2004, or earlier, but not eligible for insurance July 1, 2004, working in a position that is: authorized for an average of thirty (30) or more hours per work week and authorized for at least 168 days each fiscal year; **OR**, authorized for an average of thirty (30) or more hours per work week and authorized for a total of at least 1,008 hours each fiscal year.

  Employees working in a combination of positions that are: authorized for an average of thirty (30) or more hours per work week and authorized for at least 168 days each fiscal year; **OR**, authorized for an average of thirty (30) or more hours per work week and authorized for a total of at least 1,008 hours each fiscal year.

- **Retired Employees**
  A retired employee who has retired under the district incentive program and elected the Early Retirement Incentive Medical and Dental Plan (ERP) is eligible to participate as specified in the ERP.

- **Change in Work Hours**
  An eligible part-time employee who declined coverage when first eligible, but later experiences a change in approved work hours may apply to enroll if done so within 30 days of the change in hours. The change must be to a total of 35 hours or more per work week for licensed positions and 37.5 hours or more per work week for classified positions. The employee is responsible for contacting the Insurance Division to request and complete enrollment.

- **Married Couple Working for the District**
  If an employee and his/her spouse work for the District, both employees shall be eligible for coverage if they meet other eligibility guidelines. Dental coverage shall be provided under the name of one spouse only, with the other spouse as a dependent, rather than as coordinated coverage for both. Each spouse may elect to carry medical coverage, in which case they may include each other as a dependent on their coverage. Alternatively, they may elect to carry medical coverage under the name of one spouse only, with the other spouse as a dependent on that coverage, in which case the employee portion of the premium may be waived.

- **Eligible Dependents**
  - •Employee's spouse.
  - •Employee's children under the age of 26.
  - •Employee's children with disabilities age 26 and older (as specifically approved by the insurance carrier).

ENROLLMENT RESTRICTIONS

Employees who decline coverage or who do not apply for benefit coverage within 30 days of insurance eligibility date or change of status date shall not be able to enroll in coverage until the next district open enrollment period. In these cases, coverage is subject to insurance benefit restrictions as outlined in the insurance contracts.

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LEAVE OF ABSENCE

Employees anticipating or experiencing an absence exceeding ten consecutive work days shall submit a written request for a leave of absence to the Human Resources Department (regardless of accumulated paid leave). During a leave of absence, insurance coverage eligibility is lost at the end of the month in which an employee:

- not eligible for family and medical leave (FMLA) exhausts approved paid leave (or has no available paid leave for the position). If the employee is insurance eligible as a result of combined positions he/she loses insurance eligibility if paid leave is exhausted in a position that is needed to meet the insurance eligibility threshold.

or

- eligible for family and medical leave (FMLA) exhausts or approved paid leave and is beyond the FMLA period. If the employee is insurance eligible as a result of combined positions, he/she loses insurance eligibility if paid leave is exhausted in a position that is needed to meet the insurance eligibility threshold and he/she is beyond the FMLA period.

Catastrophic sick leave and/or advanced paid leave approval provides paid leave only and does not provide for continuation of insurance eligibility.

MEDICARE "CREDITABLE COVERAGE NOTICE"

The "Creditable Coverage Notice" for Medicare eligible employees and dependents is included on page 80 of this Benefits Guide. This notice contains important information about the prescription drug coverage provided by the health insurance plans offered by Davis School District.

PREMIUM PAYMENT

- **Payroll Deductions**
  Insurance premiums shall be payroll deducted where possible. Deductions taken from an employee's payroll check at the end of the month are payment for that month's insurance coverage.

- **Schedule (Costs)**
  Where the district participates in the cost of insurance premiums, the contribution is prorated based on authorized average hours per work week for the position or combination of positions. Premium schedules are listed in this booklet and on the district web page.

- **Payment Adjustments**
  Employees are financially responsible for their portion of insurance premiums. When an employee does not receive a payroll check or receives a payroll check with an incorrect or insufficient insurance premium deduction, an adjustment will be made as soon as possible on a succeeding payroll check. Adjustments may consist of a refund or an additional premium deduction. In some cases, the employee may be asked to directly pay any amount owing.

- **Part-Time Employees**
  Employees who are scheduled to receive less than 12 checks per year will prepay a portion of the annual premium. Part-time employees working less than 225 days who are paid in 10 checks rather than 12 will have their annual insurance premium deducted over 9 payroll checks. If coverage eligibility is lost, any prepaid premium amount shall be refunded.

- **Married Couple Working for the District**
  If an employee and his/her spouse both work for the District in insurance eligible positions, the District shall pay up to 100% of the premium cost for one of the employed spouses for medical and dental coverage, provided that coverage is elected for that spouse only, with the other spouse being included as a dependent on that coverage. Eligible, enrolled spouses employed in positions authorized for 32.5 or less hours per work week shall receive a prorated premium contribution reflecting the higher contribution level.

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SUMMARY OF BENEFITS AND COVERAGE (SBC) INFORMATON

A summary of Benefits and Coverage (SBC) for each of the health insurance plans offered by the District may be found at www.davis.k12.ut.us/dsd/insurance.

WEB SITE INFORMATION

Information regarding insurance benefits, leaves of absence, family leave, retirement incentives and the catastrophic sick leave bank can be found on the district web site at: www.davis.k12.ut.us. Web site addresses for the different insurance carriers are listed at the end of this guide.

By using the district computer system you can:

- learn more about your current insurance enrollments.
- review the current Benefits Guide,
- review and/or print documents related to your coverage,
- link to company web sites.

To review your current insurance coverage, log on to the district's ENCORE System.

1. Click on your name (upper right)
2. Select MyEncore
3. Select Personnel Master
4. Enter your Employee ID #
5. Select Blue Insurance Tab
6. Select Insurance Summary

To review other insurance information go to www.davis.k12.ut.us.

1. Select Departments
2. Select Insurance
3. Select Specific Plan Information

This is summary information only.
It is not meant to replace or fully interpret provisions of the negotiated agreements, FMLA, COBRA, district policy or your insurance benefits.

Benefits, eligibility guidelines and premium contributions are subject to change at any time.

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Davis School District

Important Notice from Davis 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 Davis 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. Davis School District has determined that the prescription drug coverage offered by the Davis School District Employee Benefit 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 Davis School District coverage will not be affected. If you do decide to join a Medicare drug plan and drop your Davis School District coverage, be aware that you and your dependents will be able to get this coverage back if you continue to meet Davis School District's insurance eligibility guidelines.

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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 Davis 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 Davis School District Insurance Office at 801-402-5200 for further information or call Aetna at 855-339-9375 or SelectHealth at 800-538-5038. NOTE: This notice will be provided each year. You will also get it before the next period you can enroll in a Medicare drug plan, and if this coverage through Davis School District changes. You may also 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 prescription 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 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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 1-800-772-1213 (TTY 1-800-325-0778).

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:	September 1, 2017
Name of Entity:	Davis School District
Contact Office:	District Insurance Office
Address:	45 E. State Street, Farmington, UT 84025
Phone Number:	(801) 402-5200

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Davis School District

Davis School District 2017-2018

Davis Moves

Employee Wellness Program

Davis School District values the health of our employees. We are excited for employees and their spouses to participate in our confidential health and wellness program, ***Davis Moves***. The goal of ***Davis Moves*** is to provide a means for our employees to become more aware of their own health and health risks as well as reduce insurance and health care costs.

Employees who carry health insurance with Select Health or Aetna will have a $6.25 wellness premium deducted monthly from ten paychecks beginning with the September 30th paycheck. (No wellness premium is deducted from the July 31st or August 31st paychecks.) For the 2017-2018 school year, insured employees will have a total of $62.50 deducted.

Insured employees who pay the monthly wellness premium will be eligible to receive a $60.00 incentive by completing the following two steps:

1. Complete a biometric screening at one of the designated Davis School District health fairs. This will require a blood draw, as well as a measurement of his or her blood pressure, height, and weight. Employees not completing this requirement at the Davis District health fairs also have the option of having the screening done through their own physician. A form is available online under the Davis Moves link on the Davis School District home page that the employee can have their physician fill out and sign.
2. Complete an online Health Risk Assessment through the MountainStar Wellness portal. Instructions for completing the assessment are included under the Davis Moves link on the Davis School District home page.

When the insured employee completes these two steps, he or she will be eligible for the $60.00 wellness incentive. **Incentives will be distributed each month starting in November,** after our annual health fair and screenings.

Take a few minutes and invest in your health and your future!

Your results are 100% confidential!

If you have questions regarding our Davis Moves program, please contact Kim Johnson at kimjohnson@dsdmail.net or (801)402-5294.

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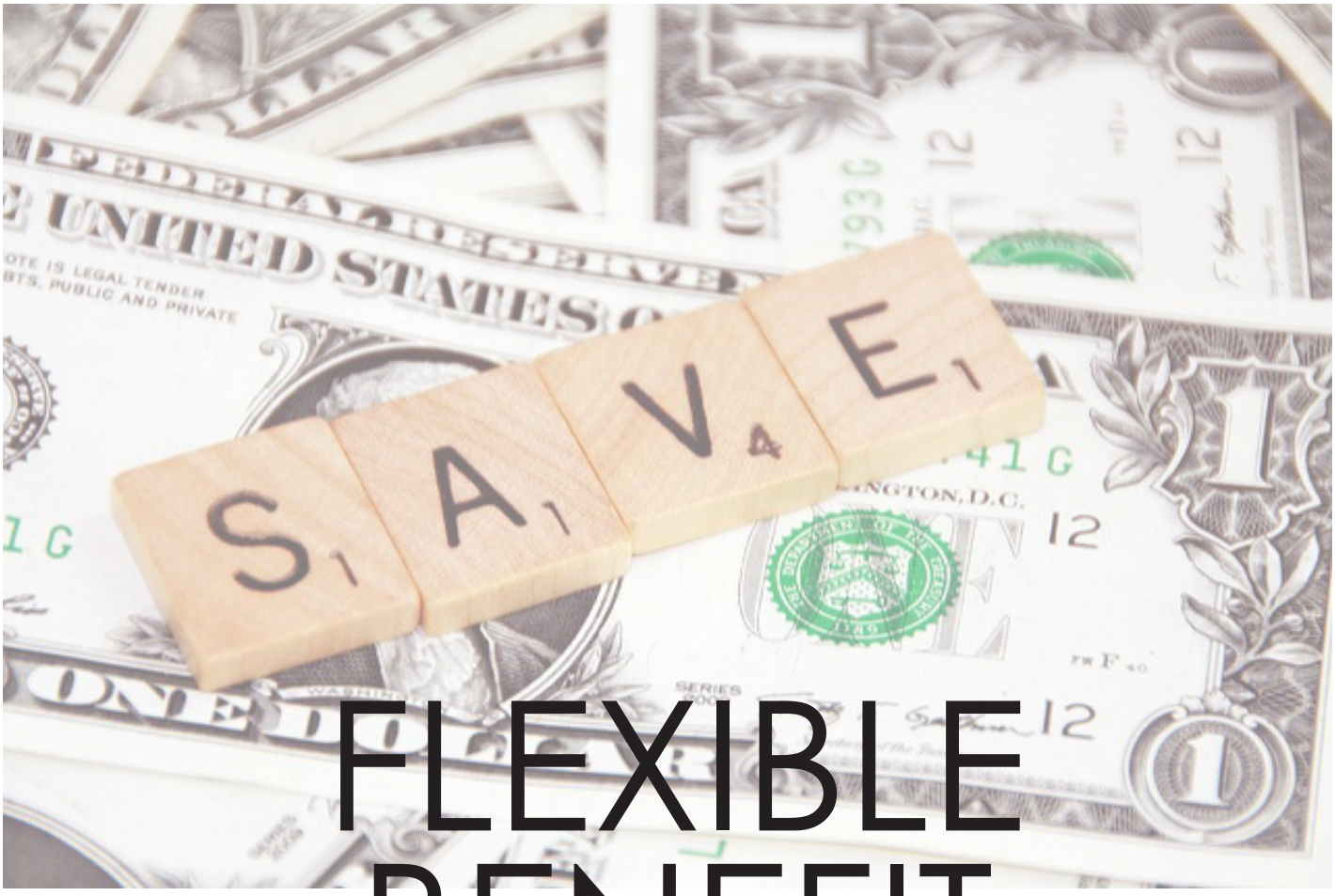

FLEXIBLE BENEFIT PLAN

The following pages include information on how you can save on medical, dental etc. costs and how it works. Money taken out is on a pretax basis which can save around 30% in taxes!

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WHAT IS A FLEXIBLE BENEFIT PLAN?

The flexible benefit plan allows you to elect an amount for the year that you plan to spend on out-of-pocket health care and day care expenses. The money is then taken out of your paycheck on a pretax basis, which means you can save around 30% in taxes!

You Save:

7.65% FICA
7.1% State
15% + Federal
30% + Savings

For example: If you pay $100/month for braces with this plan, you could save $360/year in taxes!

HOW DOES IT WORK?

You deposit money into your account through pre-tax payroll deductions. Once eligible expenses are incurred, you simply file a request to receive reimbursement from your account. These expenses can be incurred by yourself, your spouse or any of your dependants. NBS processes claims daily so you will receive your reimbursement funds quickly!

HOW DO I GET REIMBURSED?

You can pay for expenses out of pocket, and then send in your receipt with the reimbursement claim form to NBS, or you can choose to get the NBS Benefits Prepaid MasterCard. For more information about this card, see page 90.

ARE THERE MAXIMUM AMOUNTS I CAN CONTRIBUTE?

The maximum annual election for a health care expense account is $2,600. The maximum allowable election for a dependent care account is $5,000 per family for a married couple filing jointly (or a single parent) and $2,500 for a married person filing separately.

CAN I CHANGE THE AMOUNT I CONTRIBUTE DURING THE YEAR?

Yes, you can change your contribution amount during the year, but only if you have a qualifying life event occur during the year. These events include: a birth or death in the family, adoption, no longer dependent, marriage or divorce, employment change, and spousal employment change.

DO I NEED TO SPEND ALL OF THE MONEY THIS PLAN YEAR?

Careful planning is important. For an expense to be eligible it must be incurred in the plan year. The Internal Revenue Code does not allow the plan to return your unused payroll deductions to you. There is, however, a claims grace period through March 15th following the plan year during which expenses for reimbursement under your account can continue to be incurred. Reimbursement requests will be paid out from any funds left over from the previous plan year first. All requests for reimbursement for the plan year and the grace period must be submitted by March 31st following the plan year.

SPECIAL NOTE FOR EMPLOYEES ELECTING "HIGH DEDUCTIBLE HEALTH PLAN" INSURANCE COVERAGE:

If you elect one of the High Deductible Health Plan insurance options along with a Health Saving Account, you will not be eligible for a regular health care flexible spending account. You do, however, have the option of enrolling in a "limited purpose" flexible spending account. This limited purpose flexible spending account may be used only for qualified vision and dental expenses. The maximum annual election for this type of account is $2,600.

HOW DO I SIGN UP?

Use the District's electronic open enrollment system .

The District's insurance open enrollment period is the only time you may elect to enroll in the plan unless you are a new employee.

You must make a new election each year during open enrollment if you wish to continue your participation in the Flexible Benefit Plan.

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FLEXIBLE BENEFIT PLAN EXAMPLE

	Without 125 Plan	With 125 Plan
Gross Pay	**$1,500.00**	**$1,500.00**
Amount Withheld for Flexible Benefit Plan	0.00	-200.00
Taxable Earnings	**$1,500.00**	**$1,300.00**
Minus:		
Federal Income Tax (15%)	-225.00	-195.00
State Income Tax (7.2%)	-108.00	-93.60
FICA (7.65%)	-114.75	-99.45
Same expenses paid After Taxes . . .	-200.00	0.00
Take Home Pay	852.25	911.95
	Monthly Savings	**$59.70**
	Annual Savings	**$716.40**

www.nbsbenefits.com

On our website you can:

Access your account balance 24 hours per day
Get all forms including reimbursement forms
Calculate projected savings and expenses
Find many other useful forms and financial planning tools

NATIONAL BENEFIT SERVICES, LLC
Customer Care • Knowledge and Expertise • Organizational Excellence

8523 REDWOOD ROAD • WEST JORDAN, UTAH • 84088 • (800) 274-0503

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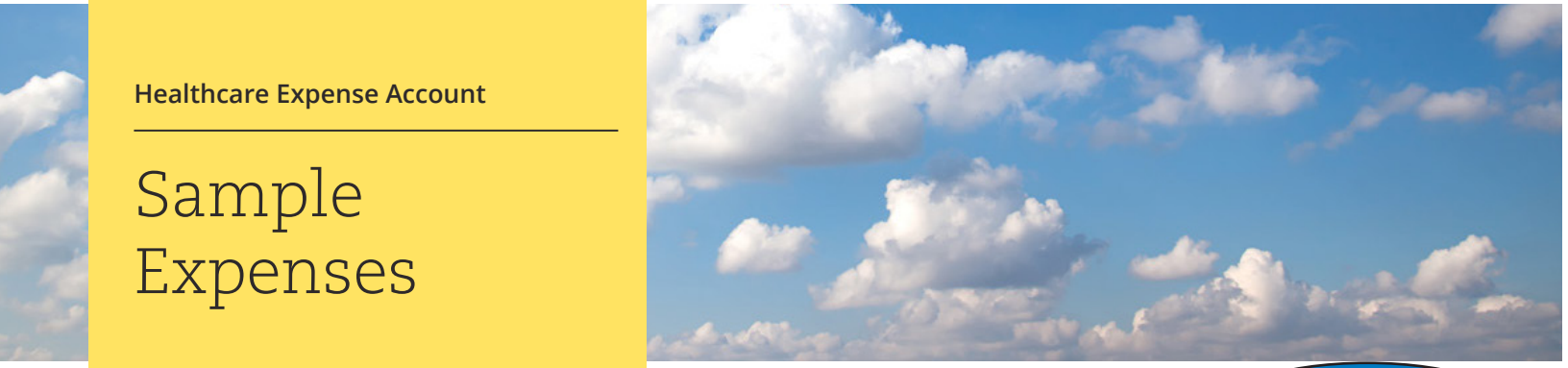
Healthcare Expense Account

Sample Expenses



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Medical expenses

- Acupuncture
- Addicition programs
- Adoption (medical expenses for baby birth)
- Alternative healer fees
- Ambulance
- Body scans
- Breast pumps
- Care for mentally handicapped
- Chiropractor
- Copayments
- Crutches
- Diabetes (insulin, glucose monitor)
- Eye patches
- Fertility treatment
- First aid (i.e. bandages, gauze)
- Hearing aids & batteries
- Hypnosis (for treatment of illness)
- Incontinence products (i.e. Depends, Serene)
- Joint support bandages and hosiery
- Lab fees
- Monitoring device (blood pressure, cholesterol)
- Physical exams
- Pregnancy tests
- Prescription drugs
- Psychiatrist/psychologist (for mental illness)
- Physical therapy
- Speech therapy
- Vaccinations
- Vaporizers or humidifiers
- Weight loss program fees (if prescribed by physician)
- Wheelchair

Dental expenses

- Artificial teeth
- Copayments
- Deductible
- Dental work
- Dentures
- Orthodontia expenses
- Preventative care at dentist office
- Bridges, crowns, etc.

Vision expenses

- Braille - books & magazines
- Contact lenses
- Contact lens solutions
- Eye exams
- Eye glasses
- Laser surgery
- Office fees
- Guide dog and upkeep/other animal aid

Items that generally do not qualify for reimbursement

- Personal hygiene (deodorant, soap, body powder, sanitary products)
- Addiction products
- Allergy relief (oral meds, nasal spray)
- Antacids and heartburn relief
- Anti-itch and hydrocortisone creams
- Athlete's foot treatment
- Arthritis pain relieving creams
- Cold medicines (i.e. syrups, drops, tablets)
- Cosmetic surgery
- Cosmetics (i.e. makeup, lipstick, cotton swabs, cotton balls, baby oil)
- Counseling (i.e. marriage/family)
- Dental care - routine (i.e. toothpaste, toothbrushes, dental floss, anti-bacterial mouthwashes, fluoride rinses, teeth whitening/bleaching)
- Exercise equipment
- Fever & pain reducers (i.e. Aspirin, Tylenol)
- Hair care (i.e. hair color, shampoo, conditioner, brushes, hair loss products)
- Health club or fitness program fees
- Homeopathic supplement or herbs
- Household or domestic help
- Laser hair removal
- Laxatives
- Massage therapy
- Motion sickness medication
- Nutritional and dietary supplements (i.e. bars, milkshakes, power drinks, Pedialyte)
- Skin care (i.e. sun block, moisturizing lotion, lip balm)
- Sleep aids (ie.e oral meds, snoring strips)
- Smoking cessation relief (i.e. patches, gum)
- Stomach & digestive relief (i.e. Pepto-Bismol, Imodium)
- Tooth and mouth pain relief (Orajel, Anbesol)
- Vitamins
- Wart removal medication
- Weight reduction aids (i.e. Slimfast, appetite suppresant

These expenses may be eligible if they are prescribed by a physician (if medically necessary for a specific condition).

nbs national benefit services

NBS Benefits Prepaid MasterCard®

The Smart Way to Pay for the Things You Need

The NBS Benefits® Prepaid MasterCard®
As part of your flexible benefit plan, you can receive your own NBS Benefits card that makes using your flex dollars easier than ever. As long as the merchant or service provider accepts MasterCard, there's no need to pay cash upfront and then wait for reimbursement.

HERE'S HOW IT WORKS . . .

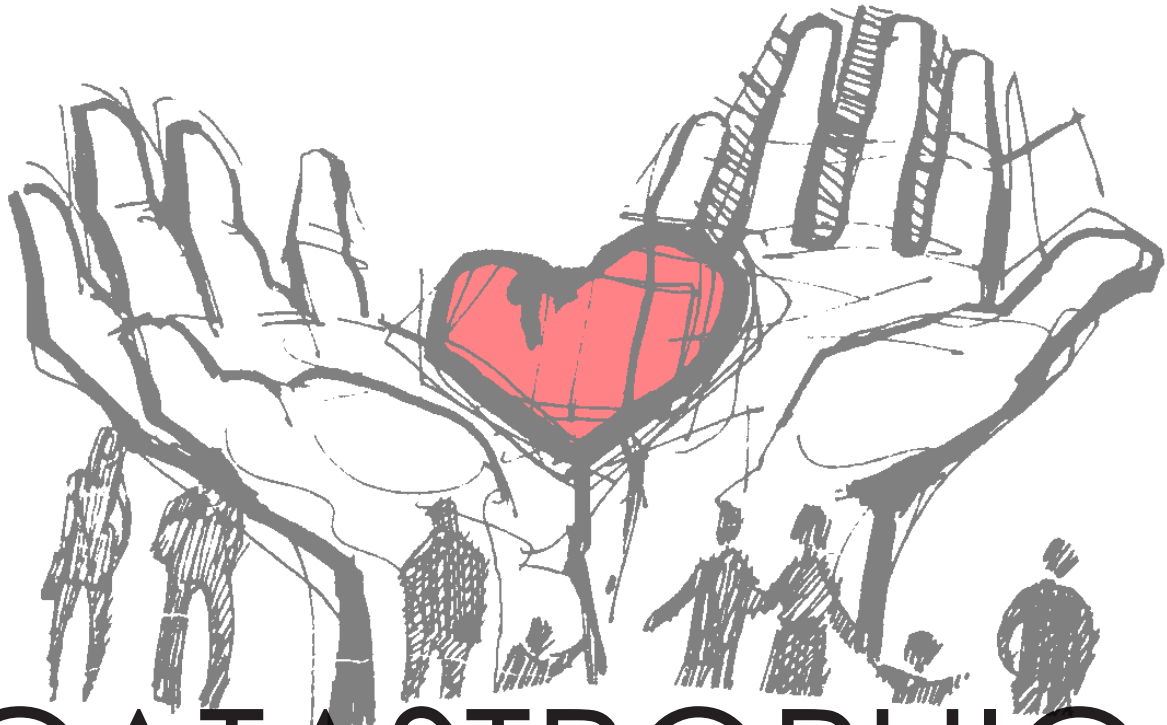
1. Enroll in the flexible benefit plan and select an annual contribution amount.
2. Pre-tax funds are loaded into your account via payroll deduction.
3. You receive your NBS Benefits card in the mail, and can use it immediately for qualified expenses. Funds are deducted directly from your flex account. Purchases that exceed the available funds are declined, and you'll have to use another form of payment and submit a claim for reimbursement.
4. An NBS Benefits card is similar to a credit card in that you always select "Credit" and sign for purchases. Your card does not require a PIN and you cannot withdraw cash. If the merchant or service provider does not accept MasterCard, you'll need to use another form of payment and submit a claim for reimbursement. To see a list of stores that accept the card see http://sig-is.org/card-holder/store-locator.
5. If you already have an NBS Benefits card, please retain the card as it will be reloaded with your new plan year's election amount.

Sign up for the flexible benefit plan today, and keep those hard earned dollars in your wallet.

Please note, the NBS Benefits Card is optional and costs $18 per year. The cost will be subtracted up front from your first check of the year, tax-free. You will be sent one card automatically when you enroll for the card. You can request additional cards at https://nbsbenefits.com/ordernew-cards. You can get a second card at no additional cost, then for each card after there is a $5 card fee. Enrollment is for the plan year and is not reversible. **If you have any questions about the plan, call the District Payroll Department at 801-402-5232 or NBS at 800-274-0503.**

KEEP YOUR NBS BENEFITS CARD FOR 2018

To re-activate your NBS Benefits card and/or re-enroll, employees must access the open enrollment system to make those elections. When you elect or re-activate the NBS Benefits card, the administrative fee will be a one time deduction from your January payroll check, and your elected amount is loaded to your card for the 2018 plan year.
Some of your cards will be expiring during the 2018 plan year. You can check your expiration date on your card. Most cards are good for three years. If your card is expiring in 2018, you will receive a new card at no additional cost in your name one month prior to the expiration date. Please watch for these to come in the mail to your home.



CATASTROPHIC SICK LEAVE BANK

The following page includes important information on how you can qualify to receive additional sick leave if you or a family member experience a severe, extended illness or a catastrophic medical problem.

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WHAT IS THE CATASTROPHIC SICK LEAVE BANK?

Upon the recommendation of the Davis Education Association and the Davis Educational Support Professionals, the district has established a Catastrophic Sick Leave Bank from which participating employees may receive additional sick leave when they or an immediate family member experience a severe, extended illness or a catastrophic medical problem.

Who is qualified for the benefit?

Only employees who have contributed to the bank as required and who have depleted all available sick leave and personal/vacation leave shall be eligible to receive consideration for sick leave from the bank.

Only severe, extended illness and catastrophic medical problems of an employee or immediate family member will be considered for leave withdrawals from the bank. Illness or medical problems of a short-term nature shall not be considered. Life-threatening illness and severe accidents requiring extended recovery periods will be given first priority.

How to apply for the benefit.

Requests to use leave from the Catastrophic Sick Leave Bank must be in writing and addressed to the Human Resources Director. The request must include:

- reason for the request,
- written verification from attending physician (indicating nature, severity of illness or health problem,and projected recovery date).

The district reserves the right to approve requests, deny requests, or to approve only a portion of the days requested.

HOW TO ENROLL IN THE CATASTROPHIC SICK LEAVE BANK

To participate in the Catastrophic Sick Leave Bank program, an employee must contribute one day of his or her sick leave to the bank. This contribution must be made during the district's insurance open enrollment period. The contribution is made by following the instructions on the district's automated open enrollment system.

Who should contribute?

Due to the fact that the Catastrophic Sick Leave Bank still has a substantial balance of hours remaining, employees who contributed to the bank during any of the five previous years' open enrollment periods do not need to contribute again this year in order to remain eligible for the program's benefits during the upcoming year. (The district's automated open enrollment system will let you know if you contributed to the bank during the previous five years.)

Employees who did not contribute a day of sick leave during any of the previous five years but wish to participate in the Catastrophic Sick Leave Bank program will need to contribute one day of sick leave to the bank prior to the end of this year's open enrollment period. Employees who contribute during the open enrollment period will be eligible to apply for benefits from the Catastrophic Sick Leave Bank beginning January 1, 2018.

Specific provisions governing the Catastrophic Sick Leave Bank may be found in the current Classified Agreement and Educators' Agreement.

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Contact Information

aetna

Customer Service	855-339-9375
RX Member Services	800-238-6279
www.aetna.com	

selecthealth

Customer Service	800-538-5038
Local	801-442-5038
Member Advocates	801-442-4993
Mail Order RX	800-875-3146
Mental Health	800-515-2220
www.selecthealth.org	

DELTA DENTAL

Customer Service	800-521-2651
www.deltadentalins.com	

Opticare of Utah

Customer Service	800-363-0950
www.opticareofutah.com	

unum

Customer Service	800-421-0344
www.unum.com	

The Hartford

Customer Service	800-523-2233 Group # 220069
www.groupbenefits.thehartford.com	

HealthEquity

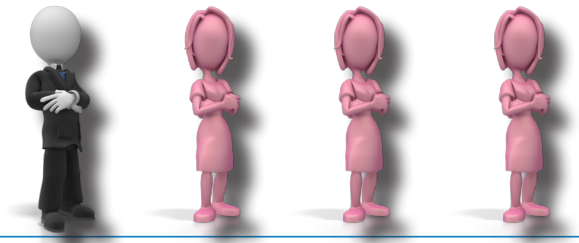
Customer Service	866-346-5800
www.healthequity.com	

National Benefit Services, LLC

Customer Care • Knowledge and Expertise • Organizational Excellence

Customer Service	800-274-0503
Local	801-532-4000
Fax	800-478-1528
www.nbsbenefits.com	

Davis School District Payroll Department	
Flexible Benefits Questions	801-402-5232



Davis School District Insurance Division	
Nyoka Egan-Insurance Technician	801-402-5200
Email: negan@dsdmail.net	
Denise Robins Insurance Specialist	801-402-5139
Email: drobins@dsdmail.net	
Rose Bassett -Insurance Technician	801-402-5636
Email: rbassett@dsdmail.net	
Steven Baker-HR Associate Director	801-402-5315
Email: stbaker@dsdmail.net	

URS Utah Retirement Systems

Toll Free	800-688-401k
Local	801-366-7770
www.urs.org	

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