Insurance Benefits Guide

2019

January through December

DSD

Davis School District

Includes a brief overview of District sponsored Insurance Plans, as well as information on the Catastrophic Sick Leave Bank and the Flexible Benefits Plan.

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

- Health Insurance
- Dental Insurance
- Basic Term Life Insurance
- Supplemental Life Insurance
- Accidental Death & Dismemberment
- 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 coverages is best for you and your family's unique needs. Please take 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.

TABLE OF CONTENTS

CREDITABLE COVERAGE NOTICE . . . . see page 96

ENROLLMENT INFORMATION

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

Back to Table of Contents

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 2019 insurance plan year will begin on Monday, October 29, 2018, and continue through Friday, November 16, 2018. 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, 2019. 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 "Quick Links"
- 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)

Back to Table of Contents

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 2019, 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 16, 2018. If you do not complete the electronic Open Enrollment process by that date, your insurance coverage selection for 2019 will remain as it was during 2018.

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 16, 2018. If the Human Resources Department does not receive your form by that date, your insurance coverage selection for 2019 will remain as it was during 2018.

Back to Table of Contents

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.

Back to Table of Contents

FLEXIBLE BENEFIT PLAN ENROLLMENT

For participation in the Flexible Benefit Plan from January 1, 2019, through December 31, 2019, you will need to complete enrollment through the Insurance Open Enrollment System anytime between Monday, October 29, 2018, and Friday November 16, 2018. (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 2018, you must make a new election through Open Enrollment if you wish to continue your participation in the plan for 2019. 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, 2019, through December 31, 2019, 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 29, 2018, and Friday, November 16, 2018. (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 104 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).

Back to Table of Contents

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

Back to Table of Contents

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 per Individual / $4000 Family	$2000 per Individual / $4000 Family
Prescription Deductible	$50 per individual; waived for Tier 1 drugs	$50 per individual; waived for Tier 1 drugs
Out-of-Pocket Maximum (PCY)**	$2500 per Individual / $5000 Family	$2500 per 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 (855) 339-9375
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/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.

Back to Table of Contents

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 (855) 339-9375
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/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.

Back to Table of Contents

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 84-85.) 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.

Back to Table of Contents

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 2019, 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 2019, the limit is $3,500 if you have individual coverage, and $7,000 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.

Back to Table of Contents

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 2019, 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/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.

It's all about choices

Just select what's right for you

Helping you reach your goals

Choosing a health plan and coverage is so important. But sometimes you or family members need something more — or different. That's why we designed special programs, services and tools to help during those times. You may never need them. But if you do, they're there for you.

Of course, we're always here to help you reach your health goals, large or small. So if you have questions, just call us at **866-756-0376**. **Monday - Friday 8 a.m. to 6 p.m. MST**

NOTE: Open Enrollment is October 29, 2018 to November 15, 2018

Why Aetna

Being healthy means having the freedom and choices to do what you want in life. To find and take opportunities that are right for you.

Everyone has different goals. That's why we'll put your individual needs at the center of a health plan. And then we'll give you the support, tools and programs to help you achieve these goals.

So whether you want to run a marathon or simply keep up with your grandkids, we'll be there to help along the way.

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Davis School District

Back to Table of Contents

aetna.com

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Open Access Aetna Select℠ health plan

This plan lets you visit any doctor in the Aetna network, without ever needing a referral. 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 and your medical history, and they can help guide you and direct your care. Plus, you may pay less out of pocket when you see your PCP. This plan has in-network benefits only.

Looking for a PCP or other network doctor? Use our online directory at **aetna.com**.

Informed Health® Line*

Sometimes, a phone call makes all the difference. You can talk to a registered nurse for information about tests, procedures and treatment options. 24 hours a day, 7 days a week. And the call is free. You can find the phone number on the back of your ID card. Or visit your members-only website at **aetna.com**.

*Informed Health Line nurses do not diagnose, prescribe or give members medical advice.

Teladoc® doctor access – by phone or video

Is it after hours? Or you can't get to the doctor's office? Teladoc gives you 24/7 access to quality care by board-certified doctors. They can treat many nonemergency medical issues by phone or video. Members can request a visit through the web, Teladoc app or by phone and speak to a licensed doctor in under ten minutes. And while urgent care centers and the emergency room can be costly and time consuming, Teladoc visits are never more than $40. Find out more and set up your Teladoc account at **teladoc.com/aetna**.

Get your medicine delivered—Aetna Rx Home Delivery® mail-order pharmacy

You can get medicine you take every day delivered right to your home. Or anywhere you choose. You can also usually get a larger supply of these types of drugs by mail. It's a simple way to help you stay on track with your medicine and be your healthiest you.

Delivery perks:

- Easy ordering. Easy renewal.
- Free shipping wherever you choose.
- Complete privacy. Your medicine will arrive in umarked, secure packaging.

Your safety comes first. Registered pharmacists check each and every order. And if you have an emergency, you can call them anytime. Sign in or register on your member website at **aetna.com** to learn more.

Aetna Concierge

Have questions about your plan? Our concierge is here to help.

Aetna concierge can help you with questions about a diagnosis, select a doctor, learn about your coverage or plan for upcoming treatment. Think of the concierge as your personal assistant for health care.

Your concierge will help find solutions that fit your needs, show you how to use our online tools, find network providers based on your medical needs and even help you schedule appointments.

Simply call the number on your ID card or log in to your member website at **aetna.com**.

Back to Table of Contents

Aetna Mobile app*

Find what you need – wherever, whenever. The Aetna Mobile app puts our most popular online features at your fingertips. It's available for AndroidTM and iPhone® mobile devices. Visit **aetna.com/mobile. Use a different smartphone or mobile device?** Instead of loading an app, just visit **aetna.com** and use the mobile web version of the site.

*Standard text messaging and other rates from your wireless carrier may apply.

Apple, the Apple logo and iPhone are trademarks of Apple Inc., registered in the U.S. and other countries. App Store is a service mark of Apple Inc. Android and Google Play are trademarks of Google Inc.

Online directory

Need a doctor? Use our online directory. You can find network doctors by specialty and location. You'll also find maps, directions and more. You can even look for doctors who speak your language. Visit **aetna.com** to get started.

Your member website

When you're an Aetna member, you get tools and resources to help manage your health and your benefits. All of your plan information and cost-savings tools are in one place – your member website. And with new enhancements, you'll enjoy a cleaner screen, simpler searches, uncomplicated claims and plenty of perks.

Sign up for this members-only website at **aetna.com**.

Aetna Discount Program

You get special discounts on gym memberships, weight-loss programs, vision services, hearing aids and more with any health plan. These built-in discounts aren't insurance. And there are no claims, referrals or limits on use. Just instant savings on your favorite healthy-living products and services. Start saving through the members-only website by logging in at **aetna.com**.

Discount offers provide access to discounted services and are not part of an insured plan or policy. Discount offers are rate-access offers and may be in addition to any plan benefits. Check any insurance benefits you have before using these discount offers, as those benefits may result in lower costs to you than using these discounts. Discount offers are not guaranteed and may be discontinued at any time. Aetna makes no payment to the discount vendor. You are responsible for the full cost of the discounted services.

Digital member ID card

You can now access your member ID card in various ways.

It's easy to get your ID card through your member website. And you can get it whichever way works better for you – paper or digital. All you do is sign up for the member website at **aetna.com**. Then when you log in from your computer or smartphone, search for "member ID card."

If you want even simpler steps, there's a link at the top page on the Aetna Navigator® member website for you to view ID cards on your desktop.

Remember, you can also easily view your ID card on Android and Apple devices. No Internet service? You can still access your ID card offline.

Back to Table of Contents

Making healthy simpler
Your member website

You've got healthy handled with aetna.com

Just sign up to manage your benefits — then log in often for so much more.

Clean, simple screen

Easy claims walk-through

Money-saving tools

Fitness and wellness perks

Back to Table of Contents

aetna®

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Features that get you where you need to go

Anytime, anywhere, any device

Find care

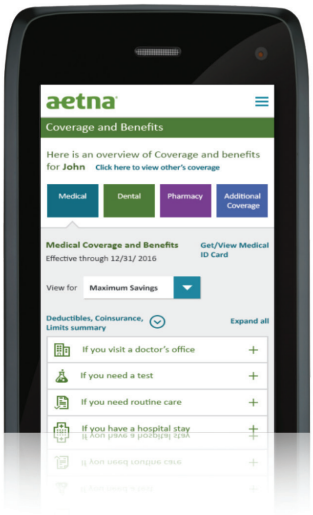
- Search network providers
- Find walk-in clinics
- Change your doctor
- See past activity

Manage claims

- See claims by date
- Pay your bill
- Get a bill breakdown

See coverage and costs

- Get coverage details
- See out-of-pocket costs
- Compare costs
- Read doctor reviews



Manage prescriptions

- Find a pharmacy
- Order medicine
- Price drugs to save
- Learn side effects
- Ask a pharmacist

Stay healthy

- Take a health assessment
- Try health coaching
- Start a wellness program
- Get treatment options
- Save on gyms, vision and more

Go healthy, and we'll go with you. Visit your member website at **aetna.com**.

In Idaho, health benefits and health insurance plans are offered and/or underwritten by Aetna Health of Utah Inc. and Aetna Life Insurance Company. For all other states, health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc., Aetna Health of California Inc., Aetna Health Insurance Company of New York, Aetna Health Insurance Company, HealthAssurance Pennsylvania Inc. and/or Aetna Life Insurance Company (Aetna). In Florida by Aetna Health Inc. and/or Aetna Life Insurance Company. In Utah and Wyoming by Aetna Health of Utah Inc. and Aetna Life Insurance Company. In Maryland by Aetna Health Inc., 151 Farmington Avenue, Hartford, CT 06156. Each insurer has sole financial responsibility for its own products.

This material is for information only. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Health benefits and health insurance plans contain exclusions and limitations. Estimated costs not available in all markets. The tool provides an estimate of what would be owed for a particular service based on the plan at that very point in time. Actual costs may differ from an estimate if, for example, claims for other services are processed after the estimate is provided but before the claim for this service is submitted. Or if the doctor or facility performs a different service at the time of the visit. Health maintenance organization (HMO) members can only look up estimated costs for doctor and outpatient facility services. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to a **aetna.com**.

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Back to Table of Contents

Open Access Aetna Select℠ plan

Your choice of network doctors without referrals

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42.02.301.1 L (8/17)

Back to Table of Contents

A plan that lets you choose from quality network doctors

This plan lets you visit any doctor in our 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 and 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? Let's walk through this plan and see what's covered.

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. It should be in your enrollment kit. If you do not have it, ask your employer.

Your options	Pick your doctor	How it works
PCP option	**Choose any PCP from our 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 ID card. Or do it online through your secure member website.	**Your PCP will:** • Give you checkups or treat you when you're sick or hurt • Get approval from us before giving you certain services • File claims for you **With this option, you may pay less out of pocket.** Your copay may be lower when you visit your PCP for care. A copay is a fixed 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 us 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.

Back to Table of Contents

You need to see network providers for this 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.

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

Tools to help you find network doctors and more

Find the right PCP or network doctor just for you

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 **aetna.com**.

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

It's your website, so be sure to sign up

When you're a member with us, 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 **aetna.com**.

You have our number — just call us

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 ID card.

Here's a way to estimate costs once you enroll

Our Member Payment Estimator tool 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 we will pay. To use the estimator tool, go to **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 **aetna.com/mobile**.

**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

made available through aetna®

TELADOC®

Getting started **with Teladoc**

Teladoc gives you access 24 hours, 7 days a week to a U.S. board-certified doctor through the convenience of phone, video or mobile app visits. Set up your account today so when you need care now, **a Teladoc doctor is just a call or click away.**

1

SET UP YOUR ACCOUNT

Set up your account by phone, web or mobile app.

Online:
Go to Teladoc.com/Aetna and click **"set up account".**

Mobile app:
Download the app and click **"Activate account"**. Visit teladoc.com/mobile to download the app.

Call Teladoc:
Teladoc can help you register your account over the phone.

2

PROVIDE MEDICAL HISTORY

Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.

3

REQUEST A CONSULT

Once your account is set up, request a consult anytime you need care. And talk to a doctor by phone, web or mobile app.

Back to Table of Contents

Talk to a doctor anytime for **$40 or less!**

Teladoc.com/Aetna

1-855-Teladoc (835-2362)

Available on the iPhone App Store

ANDROID APP ON Google play

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Informed Health® Line

A 24-hour information line for your health questions

Talk to a registered nurse anytime

With the Informed Health Line, you can speak to a registered nurse about health issues that are on your mind — whenever you need to.*

Plus —

- It's toll-free.
- You can call as many times as you need — at no extra cost.
- Your covered family members can use it, too.

You could save time, money and a trip to the ER

You can turn to the Informed Health Line for helpful information — instead of an unneeded trip to the emergency room (ER). That can be a money-saver.

Plus, you'll be able to make smarter health decisions. You'll have reliable information you can trust — and it's only a phone call or click away.

*While only your doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide information on more than 5,000 health topics. Contact your doctor first with any questions or concerns regarding your health care needs.

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Back to Table of Contents

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33.03.300.1 L (8/17)

More reasons to use the Informed Health Line

You can:

- Get information on a wide range of health and wellness topics
- Make better health care decisions
- Find out more about a medical test or procedure
- Get help preparing for a visit to your doctor
- Receive emails with links to videos that relate to your question or topic

Your online source for health information

Prefer to go online for health information? Check out the Informed Health Line page on your secure member website.

Here's what you can do:

- Send us an email.
- Use our symptom checker.
- Learn about treatment options and health risks.
- Research a medicine, and more.

It explains things in terms that are easy to understand. And it's easy to get to — once you're a member, just log in at **aetna.com**.

Members like you get the information they need

We asked our members what they liked about Informed Health Line.[1] Here's what they said:

- 93 percent felt it helped them better manage their health.
- 96 percent said this program was an important part of their health plan benefits.

Two ways to get health information fast

1. Call a registered nurse anytime toll-free.
2. Visit your secure member website at **aetna.com**.

Get health information — when and where you need it. Put the Informed Health Line to work for you.

THIS IS NOT INSURANCE. THIS IS A PROGRAM AVAILABLE WITH THE MEDICAL PLAN.

[1]Informed Health Line Member Satisfaction Survey. October 2015.

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This material is for information only. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Health benefits and health insurance plans contain exclusions and limitations. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **aetna.com**.

Policy forms issued in Oklahoma include: HMO OK COC-5 09/07, HMO/OK GA-3 11/01, HMO OK POS RIDER 08/07, GR-23 and/or GR-29/GR-29N.

Policy forms issued in Idaho by Aetna Health of Utah Inc. include: HI HGrpAg 03, HI SG HGrpAg 02.

Policy forms issued in Idaho by Aetna Life Insurance Company (Aetna) include: GR-23, GR-29/GR-29N, GR-9/GR-9N, AL HGrpPol 03, AL SG HGrpPol 02.

Policy forms issued in Missouri include: AL HGrpPol 01R5, HI HGrpAg 01, HO HGrpPol 01.

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Back to Table of Contents

33.03.300.1 L (8/17)

Living your best

Aetna Health Connections℠ disease management program

A powerful step to be your healthiest, your way

Let's focus on you, not your condition

Maybe it's been a long road and you've been working with your doctor to manage a condition. Or you just received a diagnosis.

Either way, we're here to support you. We have a program to help you follow your doctor's treatment plan and do what's best for you — your way. You can try online coaching programs, group coaching* or get one-on-one nurse support when you need help the most.

You're in charge of your health care journey

How we support you is your choice, too. We can stay in touch by phone, email or chat. Whatever works best for you.

You'll also get healthy tips through our newsletter, sent straight to your mailbox, to help take better care of you.

*Group coaching is only available for certain conditions.

Support for more than 35 conditions

Our program supports conditions like diabetes, heart disease, asthma and low back pain. And many others. So it's likely we can help with your condition, too. To find out, just call us at **1-866-269-4500**.

Helping you stay safe

When you pick up a prescription or visit your doctor, we save that information in our system. And it helps us find ways to improve your care — from reminders to get preventive care to alerts for a possible drug interaction.

You may also get a letter or phone call from us, depending on your needs.

Let us be the coach in your corner.

Try online programs, group coaching or get one-on-one nurse support.

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Back to Table of Contents

Manage your health your way

Your condition may not be unique — but you sure are. So whether in a group or one-on-one, you have choices in how you manage it.

You can work one-on-one with a health coach

You choose why, when or how often to speak with your health coach. Your coach is not only a registered nurse, but also a personal support system for your health.

Your coach can help you:

- Understand your doctor's treatment plan
- Recognize any side effects of your medicine
- Work on your doctor's advice, like lowering your cholesterol
- Reach healthy steps, like getting active or making good food choices

Of course, only you and your doctor can decide on the best care for you. But your health coach is right by your side with a supportive ear and tips and ideas to help.

Need a little extra support? With our online coaching programs,* you choose your focus. And you set the pace.

We can work with you to:

- Quit smoking
- Eat healthier
- Manage asthma
- Stress less
- Ease back pain, and more

Each program is broken up into small steps, so you can choose what works best for you.

Three easy ways to get started

- You may get a call or letter from us to join the program.
- Your doctor or our care management nurses may alert us. Or we might figure it out from your pharmacy and medical claims.
- You can reach out to us directly.

Let us help you reach your health ambitions. To learn more or sign up, just call us at **1-866-269-4500**.

THIS IS NOT INSURANCE. THIS IS AN ADDITIONAL SERVICE AVAILABLE WITH THE MEDICAL PLAN.

*Check your health and benefits program. There may be certain restrictions.

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Policy forms issued in Idaho by Aetna Health of Utah Inc. include: HI HGrpAg 03, HI SG HGrpAg 02.

Policy forms issued in Missouri include: AL HGrpPol 01R5, HI HGrpAg 01, HO HGrpPol 01.

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Back to Table of Contents

45.02.300.1 J (8/17)

Preventive care covered with no cost sharing

Get checkups, screenings, vaccines, prenatal care, contraceptives and more with no out-of-pocket costs

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Back to Table of Contents

Coverage includes routine screenings and checkups.
It also includes counseling you get to prevent illness, disease or other health problems.

Many of these services are covered as part of physical exams. These include regular checkups, routine gynecological exams and wellness exams for children. You won't have to pay out of pocket for these preventive visits when they are provided in network.

But these services are generally not preventive if you get them as part of a visit to diagnose, monitor or treat an illness or injury. In these cases, copays, coinsurance and deductibles may apply.

Aetna follows the recommendations of national medical societies about how often children, men and women need these services. Be sure to talk with your doctor about which services are right for your age, gender and health status.

Covered preventive services for adults generally include:

Screenings for:
- Abdominal aortic aneurysm (one-time screening for men of specified ages who have ever smoked)
- Alcohol misuse
- High blood pressure screening
- Cholesterol (for adults of certain ages or at higher risk)
- Colorectal cancer (for adults over age 50)
- Depression
- Type 2 diabetes (for adults with high blood pressure)
- Human immunodeficiency virus (HIV)
- Obesity
- Prostate cancer (for men ages 40 and older)
- Tobacco use
- Lung cancer (for adults ages 55 and over with a history of smoking), effective on renewal on or after January 1, 2015
- Syphilis (for all adults at higher risk)

Medicine and supplements:
- Aspirin up to 81 mg for women up to the age of 45 at risk of preeclampsia and up to 81 mg for men and women from age 50 to 69 with certain cardiovascular risk factors
- Vitamin D supplements for adults ages 65 and older with certain conditions
- Tobacco-cessation medicine approved by the U.S. Food and Drug Administration (FDA), including over-the-counter medicine when prescribed by a health care provider and filled at a participating pharmacy
- Bowel preparation medication (for preventive colorectal cancer screening)
- Low dosage statins: simvastatin 10 mg and atorvastatin 5 mg/10 mg. Covered for members from age 40 to 75 with no history of cardiovascular disease (CVD), one or more CVD risk factors and a calculated ten-year CVD event risk of 10 percent or greater (effective November 1, 2017)

Counseling for:
- Alcohol misuse
- Domestic violence
- Nutritional diet (for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease)
- Obesity
- Sexually transmitted infection (STI) prevention (for adults at higher risk)
- Tobacco use (including programs to help you stop using tobacco)

Immunizations:

Doses, recommended ages and recommended populations vary.
- Tetanus, Diphtheria, pertussis (Tdap)
- Hepatitis A and B
- Herpes zoster
- Human papillomavirus (HPV)
- Influenza
- Measles, mumps, rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Varicella (chickenpox)

Back to Table of Contents

Covered preventive services for women

Screenings and counseling for:

- BRCA (counseling and genetic testing for women at high risk with no personal history of breast and/or ovarian cancer)
- Breast cancer chemoprevention (for women at higher risk)
- Breast cancer (mammography every one to two years for women over 40)
- Cervical cancer (for sexually active women)
- Chlamydia infection (for younger women and other women at higher risk)
- Gonorrhea (for all women at higher risk)
- Interpersonal or domestic violence
- Osteoporosis (for women over age 60 depending on risk factors)

Medicine and supplements:

- Folic acid supplements (for women of childbearing ages)
- Risk-reducing medicine such as tamoxifen and raloxifene for women ages 35 and older at increased risk for breast cancer, effective October 1, 2014

Contraceptive products and services*:

- Prescribed FDA-approved female over-the-counter or generic contraceptives** when filled at a network pharmacy
- Two visits a year for patient education and counseling on contraceptives
- Voluntary sterilization services

Covered preventive services for pregnant women

- Routine prenatal visits (you pay your normal cost share for delivery, postpartum care, ultrasounds or other maternity procedures, specialist visits and certain lab tests)
- Anemia screenings
- Diabetes screenings
- Bacteriuria urinary tract or other infection screenings
- Rh incompatibility screening, with follow-up testing for women at higher risk
- Hepatitis B counseling (at the first prenatal visit)
- Expanded counseling on tobacco use
- Breastfeeding interventions to support and promote breastfeeding after delivery, including up to six visits with a lactation consultant

Covered preventive supplies for pregnant women

- Certain standard electric breastfeeding pumps (nonhospital grade) anytime during pregnancy or while you are breastfeeding, once every three years
- Manual breast pump anytime during pregnancy or after delivery for the duration of breastfeeding
- Breast pump supplies if you get pregnant again before you are eligible for a new pump

For more information, go to **aetna.com** and search for "breast pumps." Or call Member Services for details on how to use this benefit.

Covered preventive services for children

Screenings and assessments for:

- Alcohol and drug use (for adolescents)
- Autism (for children at 18 and 24 months)
- Behavioral issues
- Cervical dysplasia (for sexually active females)
- Congenital hypothyroidism (for newborns)
- Development screening (for children under age 3, and surveillance throughout childhood)
- Hearing (for all newborns)
- Height, weight and body mass index
- Lipid disorders (dyslipidemia screening for children at higher risk)
- Hematocrit or hemoglobin
- Hemoglobinopathies or sickle cell (for newborns)
- Human immunodeficiency virus (HIV) (for adolescents at higher risk)
- Lead (for children at risk for exposure)
- Medical history
- Obesity
- Oral health (risk assessment for young children)
- Phenylketonuria (PKU) (for newborns)
- Tuberculin testing (for children at higher risk of tuberculosis)
- Vision

Back to Table of Contents

*Brand-name contraceptive drugs, methods or devices are only covered with no member cost sharing under certain limited circumstances, including when required by your doctor due to medical necessity.

**Certain eligible religious employers and organizations may choose not to cover contraceptive services as part of the group health coverage.

Medicine and supplements:

- Gonorrhea preventive medicine for the eyes of all newborns
- Oral fluoride for children 6 months through 11 years of age (prescription supplements for children without fluoride in their water source)
- Topical application of fluoride varnish by primary care providers

Counseling for:

- Obesity
- STI prevention (for adolescents at higher risk)

Immunizations:

From birth to age 18 — doses, recommended ages and recommended populations vary.

- Tdap/DTaP
- Haemophilus influenzae type B
- Hepatitis A and B
- HPV
- Inactivated poliovirus
- Influenza
- MMR
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Rotavirus
- Varicella (chickenpox)

Exclusions and limitations

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on the plan design or rider(s) purchased.

- All medical and hospital services not specifically covered in, or which are limited or excluded by, your plan documents, including costs of services before coverage begins and after coverage terminates
- Cosmetic surgery
- Custodial care
- Dental care and dental X-rays
- Donor egg retrieval
- Durable medical equipment
- Experimental and investigational procedures (except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial)
- Hearing aids
- Home births
- Immunizations for travel or work
- Implantable drugs and certain injectable drugs including injectable infertility drugs
- Infertility services including, but not limited to, artificial insemination and advanced reproductive technologies such as in vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), intracytoplasmic sperm injection (ICSI) and other related services unless specifically listed as covered in your plan documents
- Nonmedically necessary services or supplies
- Orthotics except diabetic orthotics
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medicine (except as provided in a hospital) and supplies
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies or counseling
- Special-duty nursing
- Therapy or rehabilitation other than what is listed as covered in the plan documents
- Weight-control services including surgical procedures, medical treatments, weight-control/loss programs, dietary regimens and supplements, appetite suppressants and other medicine, food or food supplements, exercise programs, exercise or other equipment, and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions

Back to Table of Contents

Aetna Discount Program

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Back to
Table of Contents

00.02.333.1 K (8/17)

Healthy vision

Savings on eyewear and exams

A fit, fabulous you

Savings on gyms and personal training

With EyeMed, you get:

Plenty of prescription savings

If your vision isn't 20/20, you'll love discounts on:

- Designer frames
- The latest in lens technology
- Non-disposable contact lenses
- Sunglasses, and more

Great rates on eye exams

Your eye exams are always discounted. So even if your plan covers your first exam, you can save on another one from any participating doctor.

Lots of locations

You can visit many doctors in private practice. Plus, national chains like JCPenney Optical, LensCrafters, Target Optical, Sears Optical and Pearle Vision.[1] You can find them all on your member website at **aetna.com**.

More eye-openers

- Savings on LASIK laser eye surgery
- Replacement contact lenses, delivered to your door

You can even save on eyeglass chains, lens cases and cleaners, and nonprescription sunglasses.

Built-in plan discounts with no referrals, claims or limits. Your family can use them, too.

Discounts on gym memberships

Get the lowest rates at your choice of over 10,000 gyms* (and growing) in the GlobalFit® network.

Plus, these sign-up perks:

- Flexible membership options
- Free guest pass (at most gyms)
- Easy billing
- Travel, transfer or freezing privileges at some gyms

Keep in mind these savings are for new gym members. You can find more details on **globalfit.com/fitness**.

A healthier you from home

If staying home is more your style, you have choices.

Health coaching
Get one-on-one support to quit smoking, ease stress, lose weight and more. On your schedule.

Personal training
With an On Demand** program, it's easy to get fit in private, at your pace. Your sessions air from any computer or mobile device. Just choose solo or group training.

At-home weight-loss program
Your body is your business. So you get weight-loss tips, menus and weigh-ins ... right in the privacy of your home.

Savings on home exercise equipment
Build your body — and your home gym — with discounts on home exercise helpers like Zumba® equipment.

*GlobalFit website. globalfit.com/fitness. March 2016.
**By Les Mills™ On Demand and Trainer On Demand, through GlobalFit.
[1]EyeMed Select Network and Provider List. January 1, 2016.

Back to Table of Contents

A natural health boost

Savings on massage and more

Hearing your world better

Savings on hearing aids and exams

Natural therapy services

You can try these services*** at a discount off the normal fee.

- Ease your stress and tension with **massage therapy**.
- Heal pain or stress points with **acupuncture**.
- Relieve neck and back pain with **chiropractic care**.
- Get advice from registered dietitians with **nutrition services**.

It's easy: You can find program professionals at **aetna.com**. Just bring your Aetna ID card to your visit.

Natural products, too

You can also order healthy items you use every day, like **over-the-counter vitamins** and **yoga equipment**.

Plus:

- Aromatherapy
- Natural body care products
- Herbal and nutritional supplements

Ready to browse and buy? Just log in to your member website at **aetna.com** for easy ordering instructions.

You have options

With Hearing Care Solutions, you get:

- **Discounts** on a large choice of hearing aids
- **A three-year supply of batteries**, then you can join a discount battery mail-order program
- **Free in-office service** of hearing aids for one year
- **Free routine cleanings** and battery door replacements for one year after purchase from the original provider

With Amplifon Hearing Health Care, you get:

- **Discounts** on many styles of hearing aids, including programmable and digital hearing aids from leading makers
- **Savings** on hearing exams and hearing aid repairs
- **Free follow-up services** for one full year
- **A two-year supply of batteries**

How to get started

Once you're an Aetna member, just log in to your member website at **aetna.com**. It's the place to take care of your benefits. Your place to save, too.

You can:

- Find a vision, hearing or natural therapy professional
- Start personal training
- Sign up for a weight loss program
- Buy health products
- Get a free gym trial, and more

Back to Table of Contents

***Through the ChooseHealthy® program, which is made available through American Specialty Health Administrators, Inc., a subsidiary of American Specialty Health Incorporated (ASH). ChooseHealthy is a federally registered trademark of ASH and used with permission herein.

A healthier body with a little help

Savings on weight-loss plans

Nutrisystem® discounts

You get plans to help you lose the weight and keep it off. That is, savings on any four-week Nutrisystem® Success™ weight-loss meal plan.* And a larger discount on auto-delivery.**

- Over 150 menu items
- Daily protein shakes packed with nutrition
- Online tools and coaching free
- Plans to help you lose the weight — and learn how to keep it off
- Unlimited counseling
- Free shipping

Jenny Craig® discounts

You get a free 3-month program + $50 in food savings*** **or** save 50 percent on our premium programs.† You also get:

- Unlimited consulting either in-center or via phone with your dedicated personal consultant
- Full menu selection
- Food you choose weekly, not monthly — no auto-ship
- No contract or cancellation penalties
- Free shipping on your first order (Jenny Craig Anywhere)

CalorieKing® discounts

With CalorieKing, you get a personalized food and exercise diary to help you understand and improve your eating behavior.

Join for free: Sign up for the yearly program at no cost.

You can enjoy:

- Personalized goals based on your body's needs
- A diary to track calories and physical activity
- A large food database with nutritional information
- Support through a social network

*The Aetna discount does not apply to any plan in which you are already enrolled. To receive the discounted rate, you must wait until your current plan ends. If you are enrolled in auto-delivery, you must cancel it and then re-enroll to receive the discounted rate.

**Offer good on new four-week auto-delivery programs only. With auto-delivery, you receive a discount off Nutrisystem's regular one-time rate with new four-week auto-delivery order. Free shipping to the continental U.S. only.

***Valid for 3-month trial membership. Cost of food ($15 – 23/day, CA$17 – 26/day) and shipping not included. $50 in food discounts to be used in $10 increments for each minimum weekly food purchase of $152/CA$173. Active program enrollment and program eligibility status required, which includes meeting with a consultant and adhering to the full Jenny Craig meal plan. Free shipping of first order requires purchase of 2-week full planned menu order (minimum purchase of $304) and valid for U.S. only. Offer valid at participating centers and Jenny Craig Anywhere. Not valid at jennycraig.com. New members only. No cash value. Not valid with any other offers or discounts. One offer per person. Restrictions apply.

†50 percent discount on enrollment fee for eligible premium programs. Plus the cost of food ($15 – 23/day, CA$17 – 26/day). Plus the cost of shipping, if applicable. Active program enrollment and program eligibility status required, which includes meeting with a consultant and adhering to the full Jenny Craig meal plan. Free shipping of first order requires purchase of 2-week full planned menu order (minimum purchase of $304) and valid for U.S. only. No cash value. Not valid with any other offer or discounts. Only available at participating locations and Jenny Craig Anywhere. Not valid at jennycraig.com. New members only. Restrictions apply.

If you require language assistance, please call the Member Services number on your Aetna ID card, and an Aetna representative will connect you with an interpreter. If you're deaf or hard of hearing, use your TTY and dial 711 for the Telecommunications Relay Service. Once connected, please enter or provide the Aetna telephone number you're calling.

Si usted necesita asistencia lingüística, por favor llame al número de Servicios al Miembro que figura en su tarjeta de identificación de Aetna, y un representante de Aetna le conectará con un intérprete. Si usted es sordo o tiene problemas de audición, use su TTY y marcar 711 para el Servicio de Retransmisión de Telecomunicaciones (TRS). Una vez conectado, por favor entrar o proporcionar el número de teléfono de Aetna que está llamando.

aetna®

aetna.com

Back to Table of Contents

Your Benefits

2019 DAVIS SCHOOL DISTRICT

LARGE EMPLOYER - UTAH

selecthealth

Back to
Table of Contents

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.

Back to Table of Contents

selecthealth.

SelectHealth Med℠

SelectHealth Med covers all of Utah. The Med network includes all Intermountain Healthcare® hospitals, facilities, and physicians, in addition to thousands of contracted doctors. This network also covers specialty care facilities like Primary Children's Hospital and Huntsman Cancer Hospital for cancer treatment. It includes about 2,000 more providers than the Value network.

Your Complete Care includes specialists, a free nurse line, telehealth access through Connect Care, and pharmacies nationwide.

Wondering whether your current doctor or neighborhood clinic participates with SelectHealth Med? To find out, visit **selecthealth.org/providers**. Remember to filter your results by choosing SelectHealth Med from the network drop-down menu.

NEED HELP?

Need help finding a doctor or making an appointment?

PHONE **800-515-2220**

PRIMARY CARE PROVIDERS

A Primary Care Provider (PCP) sees patients for common medical problems, performs routine exams, and helps prevent or treat illness. You can trust a PCP to know your health history, be your partner in preventive care, and help you find other doctors when you need them.

INTERMOUNTAIN CONNECT CARE®

Visit a provider 24/7 via live online video. Many plans cover this service for only $10, and you'll never pay more than $49 for the visit.

INTERMOUNTAIN INSTACARE®

What's open late and costs less than the ER? Our InstaCare℠ and KidsCare℠ clinics. If you need urgent care, these are great options.

HOSPITALS

Intermountain hospitals span the state of Utah, offering a variety of care and services. Think heart care, cancer treatment, transplant services, women and newborns, and much more—you name it, they can treat it.

SPECIALISTS

When you need more than your PCP, our network of specialists and surgeons can help—and there are thousands to choose from.

LOCAL CLINICS

Intermountain community clinics and contracted clinics are in your area, so you never have to drive far to get the care you need. Plus, some clinics have extended hours!

PHARMACIES

From major national chains to the corner drug store to convenient home delivery, you can get your prescriptions filled pretty much anywhere.

INTERMOUNTAIN HEALTH ANSWERS®

Our free nurse line is available 24/7. Call about any medical condition and we'll help ease your mind.

Back to Table of Contents

selecthealth.

Tips to Keep Healthcare Costs Low

We know healthcare can be expensive, but by using the tips below, you can keep your costs lower.

GET CARE IN THE RIGHT PLACE

Make sure you choose the most appropriate place for your healthcare needs. This helps you not only save money, but also helps you stay healthy and safeguards your benefits. If you're not sure where to go, you can always give us a call at **800-515-2220**. And remember, save that trip to the emergency room for only true emergencies.

USE GENERIC DRUGS WHENEVER POSSIBLE

Talk to your doctor and pharmacist about options for using generic drugs—they can help you get effective medication at the best price.

STAY HEALTHY

The number one influence on your health is you. Take the time to take care of yourself and your family. Fact: The healthier you are, the less you spend on healthcare.

GET PREVENTIVE CARE

Preventive care is covered 100% by our plans when you use in-network providers. Preventive care can help you stay healthy in the long run.

SEE IN-NETWORK PROVIDERS

We've said it many times, but it's worth saying again. If you go to doctors and facilities in your network, your insurance will pay more and you will usually pay less for the care you receive. And if you go out-of-network, you will likely pay more out-of-pocket.

USE A FSA OR AN HSA

Sign up for a plan that pairs with a Federal Savings Accounts (FSA) or Healthcare Savings Account (HSA) to pay for your out-of-pocket health expenses. Remember only certain plans pair with these savings accounts.

MANAGE YOUR CHRONIC ILLNESS

The care management team at SelectHealth is available to help you manage your care. Current programs include asthma, cancer, COPD, diabetes, depression, heart disease, high-risk pregnancy, mental health concerns, and substance abuse. To speak with a care manager, call **800-442-5305**.

Back to Table of Contents

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. 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?

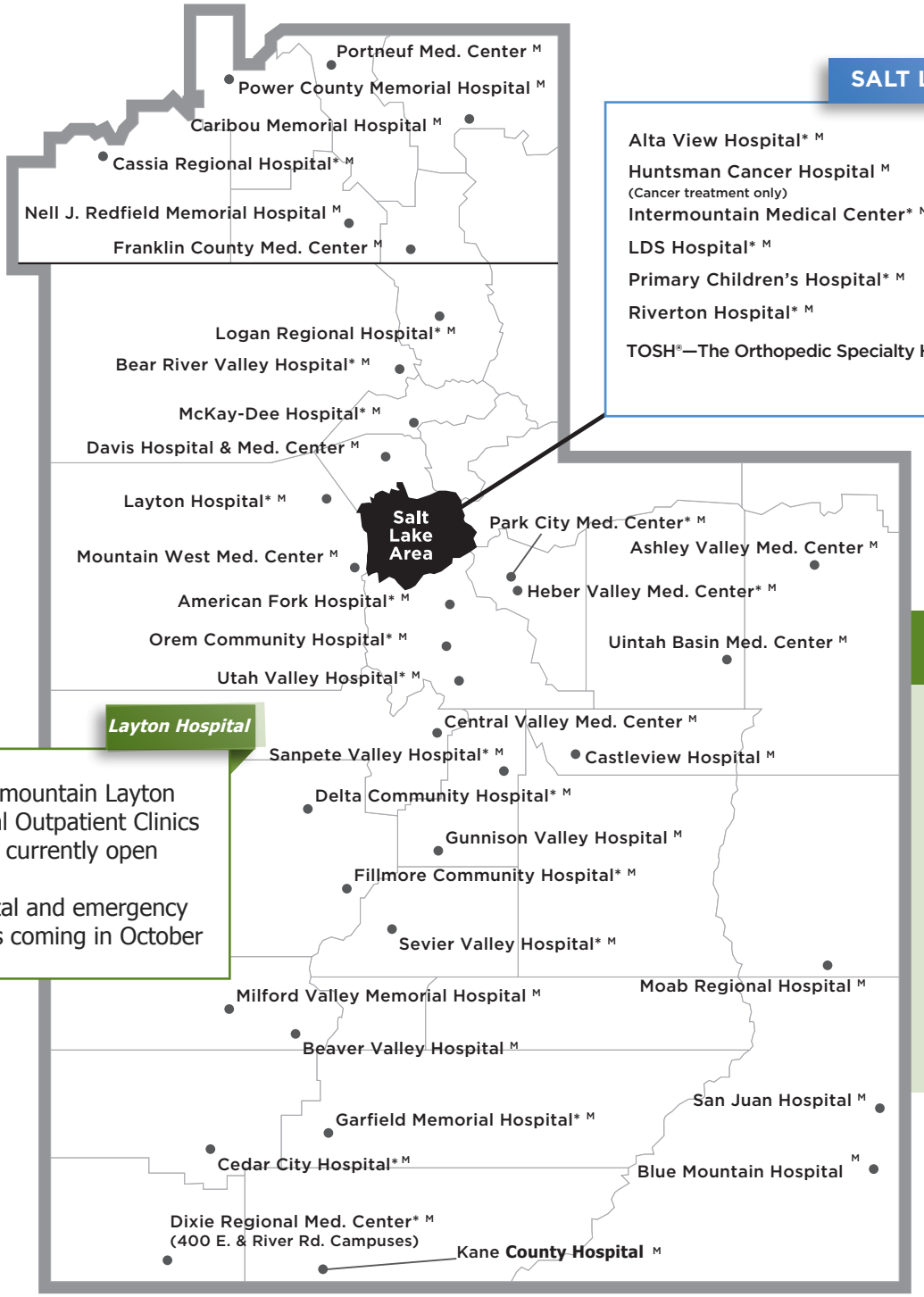
WEB
Download the app on Android or iOS, or visit
intermountainconnectcare.org
to register for free.

PHONE
800-538-5038

Back to Table of Contents

selecthealth

Facility Map



SALT LAKE AREA

Alta View Hospital* M

Huntsman Cancer Hospital M
(Cancer treatment only)

Intermountain Medical Center* M

LDS Hospital* M

Primary Children's Hospital* M

Riverton Hospital* M

TOSH®—The Orthopedic Specialty Hospital *M

Layton Hospital

Intermountain Layton Hospital Outpatient Clinics are currently open

Hospital and emergency services coming in October

NEED MORE INFORMATION?

WEB
selecthealth.org/facilities

PHONE
800-538-5038

Back to Table of Contents

selecthealth

On the Move?

OUTSIDE OF YOUR SERVICE AREA

In-network benefits apply when you receive services for urgent or emergency conditions, no matter where you are.

SAVE MONEY WHEN TRAVELING

To reduce your medical out-of-pocket expenses while traveling, our partner networks, MultiPlan and PHCS, are contracted to charge you a set amount for covered services. That means you will not be responsible for excess charges when using providers on these networks.

Remember: Always present your ID card when you visit a MultiPlan or PHCS provider or facility. The logos on the back of 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; selecthealth.org/providers

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

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**.

OUT-OF-AREA DEPENDENT CHILDREN

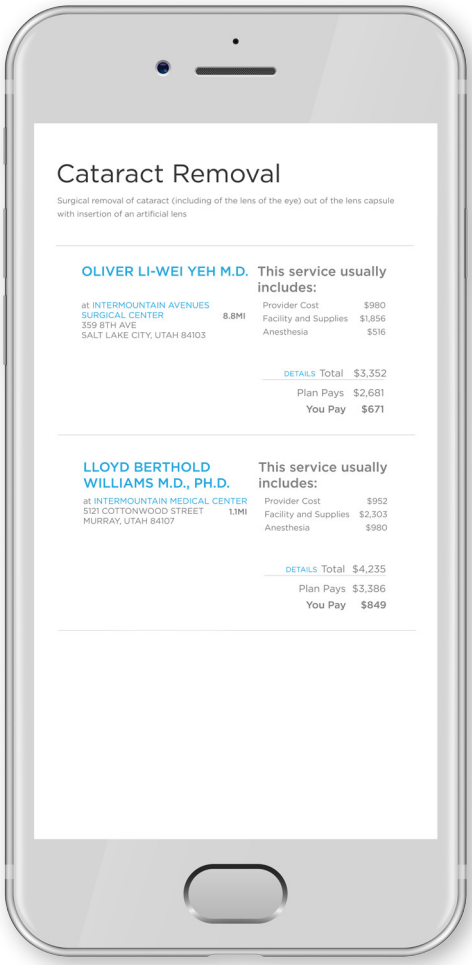
Enrolled dependent children who live outside of your service area (maybe they're going to college or living with another parent) can receive in-network benefits for covered services. To qualify for this coverage, you need to submit a *Dependent Address Change* form, which can be found at **selecthealth.org**.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

Back to Table of Contents

selecthealth

Online Tools

My Health can be accessed from your mobile device or computer by visiting **selecthealth.org**. Once you log in, click the SelectHealth® icon or link and enjoy being an informed healthcare consumer.



MEDICAL COST ESTIMATOR

We can use your benefits to estimate the cost of many healthcare services. For example, we can estimate the cost of cataract removal, including charges for the facility, provider, and anesthesiologist. Bundling these numbers together, we'll estimate how much your plan will cover and what you will pay.

ID CARDS

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

REQUEST A CALL

Use our call request feature to schedule a call back from our Member Services team at a set time that's convenient for you.

CHAT WITH US

No time for a phone call? Use our secure chat feature to talk with Member Services online. If you need to know if your medication will be covered or how much a doctor's bill was, chat can help.

HEALTHCARE INFORMATION

View your benefits, claims, and deductible levels. Also, many of our contracted providers and facilities can receive secure messages and will even upload lab results, imaging reports, and other health information right to your *My Health* account.

Back to Table of Contents

selecthealth

Know Before You Fill

COMPARE DRUG PRICES IN *MY HEALTH*

Log in to *My Health* to search for covered medications, compare drug prices, and see other information about your prescriptions and benefits. *My Health* also has information about any special requirements, like step therapy or preauthorization, which you and/or your doctor may need to complete before you can fill a prescription. If you ever have questions about drugs with special requirements, call Member Services at **800-538-5038**.

SAVE MONEY WITH LOWER-TIER DRUGS

The list of drugs covered by your plan will either be RxSelect® or RxCore®. Your member materials and ID card indicate which drug list you have, and searchable versions of these two drug lists are available on our website.

Your drug list will have three or four tiers of coverage and each tier corresponds to a copay or coinsurance amount (the amount you pay when you get drugs at the pharmacy). Look for generics and lower tier alternatives to pay less for effective medications.

> $ 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

NEED MORE INFORMATION?

WEB
selecthealth.org/pharmacyresources; intermountainrx.org

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

CONVENIENT PHARMACY ACCESS

INTERMOUNTAIN HOME DELIVERY PHARMACY

Get your prescriptions delivered for FREE. Register online at **intermountainrx.org** or call **855-779-3960**.

INTERMOUNTAIN SPECIALTY PHARMACY

If you take specialty drugs or self-injectables, the Specialty Pharmacy offers the convenience of FREE home delivery.

RETAIL 90®

Get a 90-day supply of your maintenance medications at a participating Retail 90 pharmacy—and pay less in most cases.

YOUR LOCAL PHARMACY

From major national chains to the corner drug store, you can get your prescriptions filled pretty much anywhere. Search for participating pharmacies at **selecthealth.org**.

Back to Table of Contents

selecthealth.

SelectHealth Healthy Beginnings®

A free program for moms-to-be? If you're expecting a new little bundle of joy, there's no reason not to sign up!

We want to help you get ready for the birth of your new baby. That's why we created Healthy Beginnings℠, a free program for moms-to-be. We work with your doctors to help you have a safe and healthy pregnancy, plus a few more perks to make it extra special.

As part of the program, you can earn a cash gift or gift card just for going to **both** of these exams:

1. **First prenatal exam** prior to the 14th week of your pregnancy.
2. **Postpartum exam** within 50 days of your delivery date.

In addition, a registered nurse or a high-risk prenatal nurse care manager will be available to answer your questions, give referrals, and help you through your pregnancy.

You also get a **welcome kit** that includes:

> **Great Expectations** — A book about pregnancy.

> **Book Order Form** — Another free book of your choice 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

Back to Table of Contents

selecthealth

Helping You Quit

TOBACCO CESSATION

If you smoke, Quit for Life® can help. It's a private program that you follow at your own pace from home. You 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.

The Quit for Life program is covered 100%—no copay or coinsurance 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.

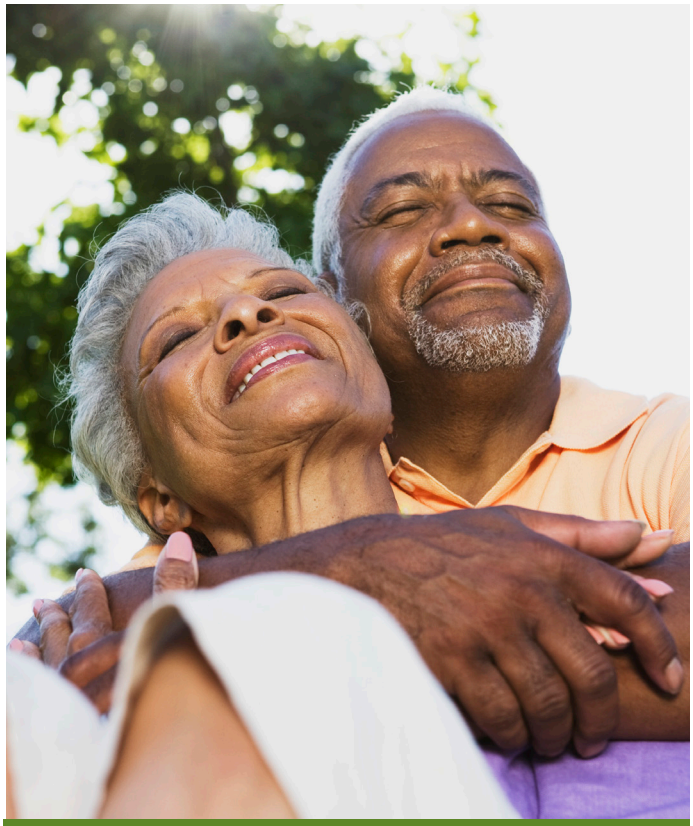
NICOTINE REPLACEMENT THERAPY

Most SelectHealth plans include 100% 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 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



Back to Table of Contents

selecthealth.

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/wellness-resources

PHONE
800-538-5038

Back to Table of Contents

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)

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**.

Back to Table of Contents

selecthealth

Helping You Manage Your Health

Care managers are specially trained registered nurses who assist patients with long-term chronic diseases and help them recover from surgeries and short-term illnesses. They have years of healthcare experience, with extensive knowledge about facilities, providers, and services. If you qualify for care management, a care manager will work with you and your doctor to make sure you get the most appropriate care and receive help with your benefits and claims.

In addition to one-on-one support, we provide educational materials and follow-up phone calls to help you manage your condition. Care management is available for members with the conditions, surgeries, or illnesses listed here. Please call us to learn more.

- **Asthma**
- **Cancer**
- **Chronic Obstructive Pulmonary Disease (COPD)**
- **Complex joint replacements**
- **Diabetes**
- **Heart disease**
- **Hemophilia**
- **Hepatitis C**
- **High-risk pregnancy**
- **HIV**
- **Some surgeries**

NEED MORE INFORMATION?

WEB
selecthealth.org/caremanagement

PHONE
800-442-5305

Back to Table of Contents

selecthealth.

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 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.

Back to Table of Contents

selecthealth.

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

Back to Table of Contents

DENTAL PLANS COMPARISON

JANUARY 1, 2019 THROUGH DECEMBER 31, 2019

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.

Back to Table of Contents

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

Back to Table of Contents

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

Back to Table of Contents

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).

Back to Table of Contents

VISION INSURANCE PLAN

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

Back to Table of Contents

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.

Back to Table of Contents

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

Back to Table of Contents

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

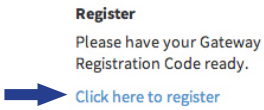
1b Click the "MEMBERS" link in the left navigation

1c Click the "MANAGE YOUR ACCOUNT" banner

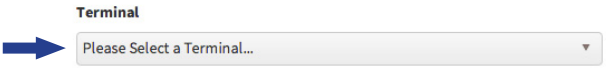
2 Register as a new user

*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)*

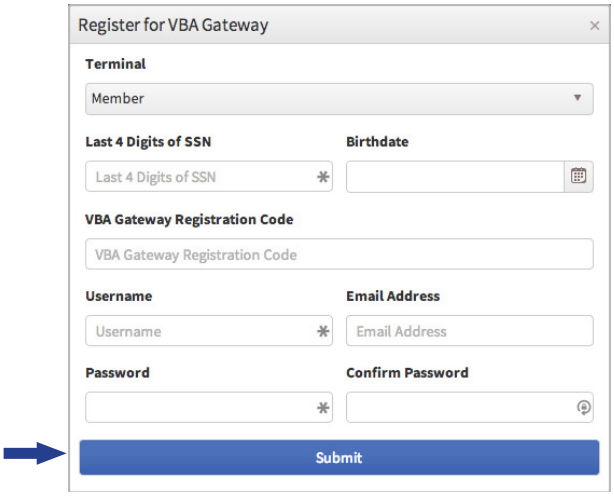
2a Click on "Click here to register"



2b Click the drop down menu, select "Member"

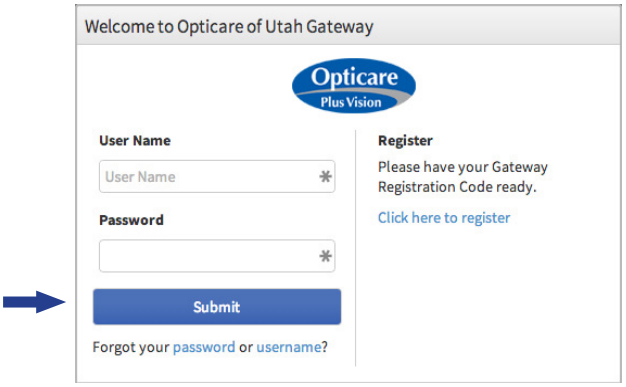


2c Fill out the form with the necessary details, then click the "Submit" button

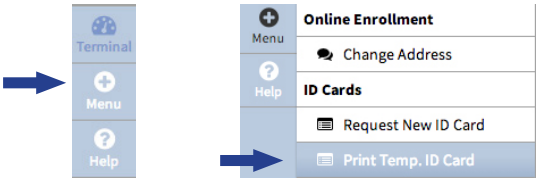


3 Obtain ID Cards

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

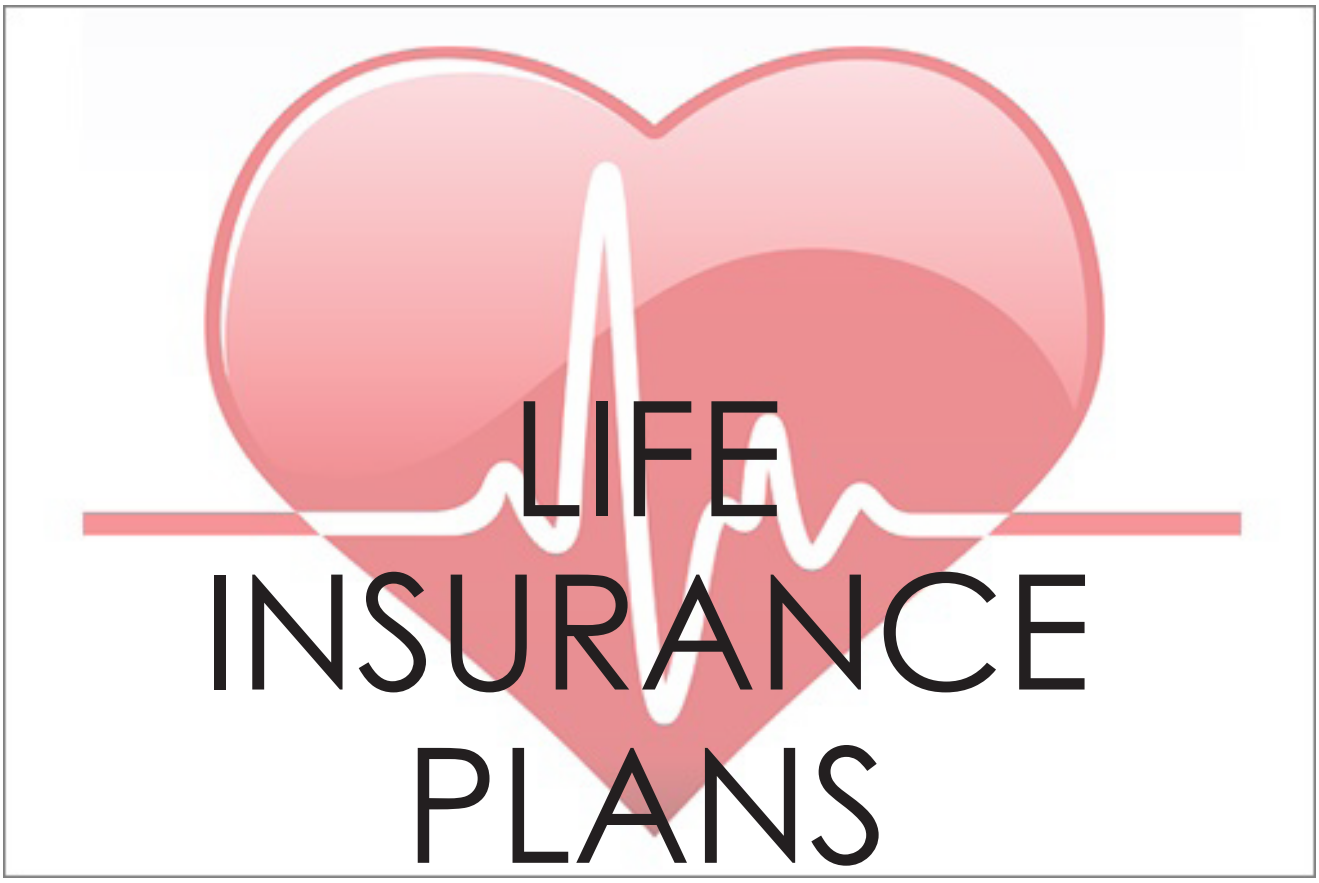
SHOPKO eyecare center

AMERICA'S BEST CONTACTS & EYEGLASSES

INDEPENDENT OPTOMETRY NETWORK

FirstLook Vision Network

Back to Table of Contents



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, and Accidental Death and Dismemberment Insurance for themselves.

HARTFORD BASIC LIFE

HARTFORD SUPPLEMENTAL LIFE

HARTFORD ACCIDENTAL DEATH & DISMEMBERMENT

Back to Table of Contents

BASIC GROUP TERM LIFE INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

Approximately 50 million households recognize they need more life insurance (40 percent of households).[1]

Davis County School District

The group term life insurance available through your employer gives extra protection that you and your family may need. Life insurance offers financial protection by providing you coverage in case of an untimely death. Life insurance is disbursed to your beneficiaries in a lump sum in the event of your death.

To learn more about Life insurance, visit thehartford.com/employee-benefits

COVERAGE INFORMATION

APPLICANT	LIFE COVERAGE
Employee	Benefit[2]: 1 times earnings Maximum: $150,000
Spouse	Benefit[2]: $3,000
Child(ren)	Benefit: $3,000

ASKED & ANSWERED

WHO IS ELIGIBLE?

Insurance eligible employees of Davis County School District.

Your spouse and child(ren) are also eligible for coverage. Any child(ren) must be under age 26.

AM I GUARANTEED COVERAGE?

This insurance is guaranteed issue coverage - it is available without having to provide information about your family's health. If you are a late entrant, evidence of insurability is required for the full coverage amount.

WHEN CAN I ENROLL?

Your employer will automatically enroll you and your dependent(s) for this coverage. If you have not already done so, you must designate a beneficiary.

WHEN DOES THIS INSURANCE BEGIN?

This insurance will become effective for you and your dependents on the date you become eligible.

You must be actively at work with your employer on the day your coverage takes effect. Your spouse and child(ren) must be performing normal activities and not be confined (at home or in a hospital/care facility), unless already insured with the prior carrier.

WHEN DOES THIS INSURANCE END?

This insurance will end when you (or your dependent(s)) no longer satisfy the applicable eligibility conditions, premium is unpaid, you are no longer are actively working, you leave your employer, or the coverage is no longer offered.

Back to Table of Contents

[2]Your benefits will reduce by 35% at age 65 and 60% at age 80. Reductions will be based on original amount.

CAN I KEEP THIS INSURANCE IF I LEAVE MY EMPLOYER OR AM NO LONGER A MEMBER OF THIS GROUP?
Yes, you can take this life coverage with you. Coverage may be continued for you and your dependent(s) under an individual conversion life certificate. Your spouse may also continue insurance in certain circumstances. The specific terms and qualifying events for conversion are described in the certificate.

[1]LIMRA, Facts About Life 2016. Web. 30 June 2017. <https://www.limra.com/uploadedFiles/limra.com/LIMRA_Root/Posts/PR/_Media/PDFs/Facts-of-Life-2016.pdf>

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This Benefit Highlights document explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this document and the policy, the terms of the policy apply. **Benefits are subject to state availability. Policy terms and conditions vary by state.** Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder. The Hartford compensates both internal and external producers, as well as others, for the sale and service of our products. For additional information regarding Hartford's compensation practices, please review our website http://thehartford.com/group-benefits-producer-compensation. Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

Back to Table of Contents

SUPPLEMENTAL GROUP TERM LIFE INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

Approximately 50 million households recognize they need more life insurance (40 percent of households).[1]

Davis County School District

The group term life insurance available through your employer is a smart, affordable way to purchase the extra protection that you and your family may need. Life insurance offers financial protection by providing you coverage in case of an untimely death. Life insurance is disbursed to your beneficiaries in a lump sum in the event of your death.

To learn more about Life insurance, visit thehartford.com/employeebenefits

COVERAGE INFORMATION

APPLICANT	LIFE COVERAGE
Employee	Benefit[2]: Increments of $10,000 Maximum: $500,000
Spouse	Benefit[2]: Increments of $10,000. Maximum: the lesser of 100% of your supplemental coverage or $200,000
Child(ren)	Benefit: Increments of $5,000 Maximum: $10,000

ASKED & ANSWERED

WHO IS ELIGIBLE?

Insurance eligible employees of Davis County School District.

Your spouse and child(ren) are also eligible for coverage. Any child(ren) must be under age 26.

AM I GUARANTEED COVERAGE?

This coverage is offered without requiring you to provide evidence of insurability.

For your spouse's coverage, if you enroll during your annual enrollment period or are newly eligible and elect an amount that exceeds the guaranteed issue amount of $50,000, your spouse will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective. If you enroll after your annual or initial enrollment period, evidence of insurability will be required for all coverage amounts.

Your child(ren)'s coverage is guaranteed issue coverage – it is available without having to provide information about your child(ren)'s health.

WHEN CAN I ENROLL?

You may enroll during any scheduled enrollment period, within 31 days of the date you have a change in family status, or within 31 days of the completion of any eligibility waiting period established by your employer.

WHEN DOES THIS INSURANCE BEGIN?

Subject to any eligibility waiting period established by your employer, insurance will become effective in accordance with the terms of the certificate (usually the first day of the month following the date you elect coverage).

You must be actively at work with your employer on the day your coverage takes effect.

Your spouse and child(ren) must be performing normal activities and not be confined (at home or in a hospital/care facility), unless already insured with the prior carrier.

[2]Your benefits will reduce by 35% at age 65 and 60% at age 80. Reductions will be based on original amount.

Back to Table of Contents

WHEN DOES THIS INSURANCE END?

This insurance will end when you (or your dependent(s)) no longer satisfy the applicable eligibility conditions, premium is unpaid, or the coverage is no longer offered.

CAN I KEEP THIS INSURANCE IF I LEAVE MY EMPLOYER OR AM NO LONGER A MEMBER OF THIS GROUP?

Yes, you can take this life coverage with you. Coverage may be continued for you and your dependent(s) under a group portability certificate or an individual conversion life certificate. Your spouse may also continue insurance in certain circumstances. The specific terms and qualifying events for conversion and portability are described in the certificate.

[2]LIMRA, Facts About Life 2016. Web. 30 June 2017. <https://www.limra.com/uploadedFiles/limra.com/LIMRA_Root/Posts/PR/_Media/PDFs/Facts-of-Life-2016.pdf>

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GROUP VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

In the U.S., a disabling injury occurs every second, and an accidental death occurs every 4 minutes.[1]

Davis County School District

Group Voluntary Accidental Death & Dismemberment (AD&D) insurance pays your beneficiary a death benefit if you die due to a covered accident or pays you if you are unexpectedly injured in a covered accident. The benefits are paid in lump sum amounts to you (or your beneficiary), and can be used to pay for health care expenses not covered by your major medical insurance, help replace income lost while not working, funeral expenses, or however you choose. Accidental death benefits are paid in addition to any life insurance.

To learn more about AD&D insurance, visit thehartford.com/employeebenefits

COVERAGE INFORMATION

You (the primary insured) may enroll for the following AD&D coverage amount[2]. The maximum amount you can elect is $500,000.

AD&D BENEFITS – PERCENT OF COVERAGE AMOUNT PER ACCIDENT	
Covered accidents or death can occur up to 365 days after the accident. The total benefit for all losses due to the same accident will not exceed 100% of your coverage amount.	
LOSS FROM ACCIDENT	**COVERAGE AMOUNT**
Life	100%
Both Hands or Both Feet or Sight of Both Eyes	100%
One Hand and One Foot	100%
Speech and Hearing in Both Ears	100%
Either Hand or Foot and Sight of One Eye	100%
Movement of Both Upper and Lower Limbs (Quadriplegia)	100%
Movement of Both Lower Limbs (Paraplegia)	75%
Movement of Three Limbs (Triplegia)	75%
Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia)	50%
Either Hand or Foot	50%
Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
Movement of One Limb (Uniplegia)	25%
Thumb and Index Finger of Either Hand	25%

ASKED & ANSWERED

WHO IS ELIGIBLE?

Insurance eligible employees of Davis County School District.

AM I GUARANTEED COVERAGE?

This insurance is guaranteed issue coverage – it is available without having to provide information about your health.

[2]Your benefit will be reduced by 35% at age 65 and 60% at age 80. Reductions will be applied to the original amount.

Back to Table of Contents

WHEN CAN I ENROLL?

You may enroll during any scheduled enrollment period, within 31 days of the date you have a change in family status, or within 31 days of the completion of any eligibility waiting period established by your employer.

WHEN DOES THIS INSURANCE BEGIN?

Subject to any eligibility waiting period established by your employer, Insurance will become effective in accordance with the terms of the certificate (usually the first day of the month following the date you elect coverage).

You must be actively at work with your employer on the day your coverage takes effect. .

WHEN DOES THIS INSURANCE END?

This insurance will end when you no longer satisfy the applicable eligibility conditions, premium is unpaid, you are no longer are actively working, you leave your employer, or the coverage is no longer offered.

CAN I KEEP THIS INSURANCE IF I LEAVE MY EMPLOYER OR AM NO LONGER A MEMBER OF THIS GROUP?

Yes, you can take this coverage with you. Coverage may be continued for you under an individual conversion certificate. The specific terms and qualifying events for conversion are described in the certificate.

[1]Injury Facts. National Safety Council. 2015 Edition. P. 37. Web. 30 June 2017.

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This Benefit Highlights document explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this document and the policy, the terms of the policy apply. **Benefits are subject to state availability. Policy terms and conditions vary by state.** Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder. The Hartford compensates both internal and external producers, as well as others, for the sale and service of our products. For additional information regarding Hartford's compensation practices, please review our website http://thehartford.com/group-benefits-producer-compensation. Accidental Death & Dismemberment Form Series includes GBD-1000, GBD-1300, or state equivalent.

Back to Table of Contents

LIMITATIONS & EXCLUSIONS

This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

GROUP LIFE INSURANCE

GENERAL LIMITATIONS AND EXCLUSIONS

- Your benefits will reduce by 35% at age 65 and 60% at age 80. Reductions will be applied to the original amount.
- A benefit will not be paid if death occurs by suicide within two years (or as allowed by state law) of purchasing this coverage.
- You and your dependent(s) must be citizens or legal residents of the United States, its territories and protectorates.

DEPENDENT LIMITATIONS AND EXCLUSIONS

- Coverage may only be elected for dependents when you elect and are approved for coverage for yourself.
- Coverage may not be elected for a dependent who has employee coverage under this certificate.
- Coverage may not be elected for a dependent who is in active full-time military service.
- Child(ren) may only be covered as a dependent of one employee.
- Infants may receive a reduced benefit prior to the age of six months.

GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

GENERAL LIMITATIONS AND EXCLUSIONS

- Your benefit will be reduced by 35% at age 65 and 60% at age 80. Reductions will be applied to the original amount.
- This insurance does not cover losses caused by:
  - Sickness; disease; or any treatment for either
  - Any infection, except certain ones caused by an accidental cut or wound
  - Intentionally self-inflicted injury, suicide or suicide attempt
  - War or act of war, whether declared or not
  - Injury sustained while in the armed forces of any country or international authority
  - Injury sustained on aircraft in certain circumstances
  - Taking prescription or illegal drugs unless prescribed by or administered by a licensed physician
  - Injury sustained while riding, driving, or testing any motor vehicle for racing
  - Injury sustained while committing or attempting to commit a felony
  - Injury sustained while driving while intoxicated
- You must be a citizen or legal resident of the United States, its territories and protectorates.

DEFINITIONS

- Loss means, with regard to hands and feet, actual severance through or above wrist or ankle joints; with regard to sight, speech or hearing, entire and irrecoverable loss thereof; with regard to thumb and index finger, actual severance through or above the metacarpophalangeal joints; with regard to movement, complete and irreversible paralysis of such limbs.
- Injury means bodily injury resulting directly from an accident, independent of all other causes, which occurs while you or your dependent(s) have coverage.

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Back to Table of Contents

ADDITIONAL SERVICES

Davis County School District

If you are enrolled in insurance coverage with The Hartford, you may also be eligible to receive additional services at no cost to you. These services help with challenges that come before and after a claim. Be sure to read the information provided below; The Hartford wants to be there when you need us.

SERVICES AVAILABLE

COVERAGE ENROLLED IN	ADDITIONAL SERVICES AVAILABLE
Accidental Death and Dismemberment	Beneficiary Assist Counseling Services Travel Assistance Services with ID Theft Protection and Assistance
Life	Beneficiary Assist Counseling Services EstateGuidance Will Services Funeral Planning and Concierge Services Travel Assistance Services with ID Theft Protection and Assistance Parent Conversations

ASKED & ANSWERED

WHAT IS BENEFICIARY ASSIST COUNSELING SERVICES?

Beneficiary Assist®[2] Counseling Services offers compassionate expertise to help you or your beneficiaries (those you name 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.
For more information on Beneficiary Assist® Counseling Services, call 1-800-411-7239.

WHAT IS ESTATEGUIDANCE WILL SERVICES?

EstateGuidance®[2] Will Services 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.
For more information on EstateGuidance® Will Services:
www.estateguidance.com/wills Use Code: **WILLHLF**

WHAT IS FUNERAL PLANNING AND CONCIERGE SERVICES?

Funeral Planning and Concierge Services [1] 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.
For more information on Funeral Planning and Concierge Services:
Call 1-866-854-5429 or visit www.everestfuneral.com/hartford Use Code: **HFEVLC**

WHAT IS PARENT CONVERSATIONS?

Parent Conversations: The Estate Guidance®[2] Will Services and Funeral Planning and Concierge Services[1] may be used with your parents, step-parents, and parents-in-law. Parent Conversations can be a crucial benefit. There are many reasons to consider it:

- It helps clarify and document your parents' end-of-life decisions
- Eases the stress involved in caring for aging parents
- Places a sensitive subject within the positive context of a benefit
- Provides you with support at a time of transition and loss

For more information on Funeral Planning and Concierge Services:
Call 1-866-854-5429 or visit www.everestfuneral.com/hartford Use Code: **HFEVLC**
For more information on EstateGuidance® Will Services:
Visit www.estateguidance.com/wills Use Code: **WILLHLF**

WHAT IS TRAVEL ASSISTANCE SERVICES WITH ID THEFT PROTECTION AND ASSISTANCE?

Travel Assistance Services with ID Theft Protection and Assistance[3] includes 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 from United States: 1-800-243-6108
Call collect from other locations: 202-828-5885
Fax: 202-331-1528
Email: idtheft@europassistance-usa.com

Travel Assistance Identification Number: **GLD-09012**

Back to Table of Contents

You'll be asked to provide your employer's name, a phone number where you can be reached, nature of the problem, Travel Assistance Identification Number, and your company policy number which can be obtained through your Human Resources/Personnel department.

If you have a serious medical emergency, please obtain emergency medical services first, and then contact Europ Assistance USA for follow-up.

[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 affliated with The Hartford and is not a provider of insurance services. Everest and its affliates have no affliation with Everest ReGroup, Ltd., Everest Reinsurance Company or any of their affliates.
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Prepare. Protect. Prevail. With The Hartford.®

Back to Table of Contents

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.

Back to Table of Contents

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:

Back to Table of Contents

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

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

Back to Table of Contents

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.

Back to Table of Contents

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.

Back to Table of Contents

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

Back to Table of Contents

Better benefits at work.

Don't forget this travel essential!

Pack your worldwide emergency travel assistance phone number and leave travel worries at home

Whether traveling for business or pleasure, one phone call connects you to:

- Multi-lingual, medically certified crisis management professionals
- A state-of-the-art global response operations center
- Qualified medical providers around the world

With the Assist America Mobile App, you can:

- Call Assist America's Operation Center from anywhere in the world with the touch of a button
- Access pre-trip information and country guides
- Search for local pharmacies (U.S. only)
- Download a membership card
- View a list of services
- Search for the nearest U.S. embassy
- Read Assist Alerts

Download and activate the app today from the Apple App Store or Google Play.

Reference Number:
01-AA-UN-762490

If you experienced a medical emergency while traveling, would you know who to call?

Whenever you travel 100 miles or more from home — to another country or just another city — be sure to pack your worldwide emergency travel assistance phone number! Travel assistance speaks your language, helping you locate hospitals, embassies and other "unexpected" travel destinations. Add the number to your cell phone contacts, so it's always close at hand! Just one phone call connects you and your family to medical and other important services 24 hours a day.

Use your travel assistance phone number to access:

- Hospital admission assistance*
- Emergency medical evacuation
- Prescription replacement assistance
- Transportation for a friend or family member to join a hospitalized patient
- Care and transport of unattended minor children
- Assistance with the return of a vehicle
- Emergency message services
- Critical care monitoring
- Emergency trauma counseling
- Referrals to Western-trained, English-speaking medical providers
- Legal and interpreter referrals
- Passport replacement assistance

24/7 services anywhere in the world

Unum's travel assistance services are provided by Assist America, Inc., a leading provider of global emergency assistance services through employee benefit plans. Assist America's medically certified personnel are ready to help 24 hours a day, 365 days a year, and can connect you with pre-qualified, English-speaking and Western-trained medical providers anywhere in the world.

MORE You can access travel assistance services through the **phone number on your travel assistance wallet card.** If you have misplaced your card, contact your human resources department and ask for a replacement.


If you need travel assistance anywhere in the world, contact us day or night:

- **Within the U.S.:** 1-800-872-1414
- **Outside the U.S.:** (U.S. access code) +609-986-1234
- **Via e-mail:** medservices@assistamerica.com

Reference number: 01-AA-UN-762490

Employer's name (please write above)

unum Better benefits at work.

For reference only. Not actual card.

Travel assistance FAQs

Q. Which countries can I travel to?

A. Assist America's services have no geographical exclusions. Its worldwide network stands ready to help wherever your travels take you.

Q. Is my family covered?

A. Your spouse and dependent children up to age 19 (or the age specified by your medical plan) are covered. Spouses and children traveling on business for their employers are not eligible to access these services during those trips.

Q. Are pre-existing conditions excluded?

A. No. Whether your medical emergency is the result of a new or pre-existing condition, Assist America's trained representatives will help you find qualified medical care and facilities.

Q. What about sports-related injuries?

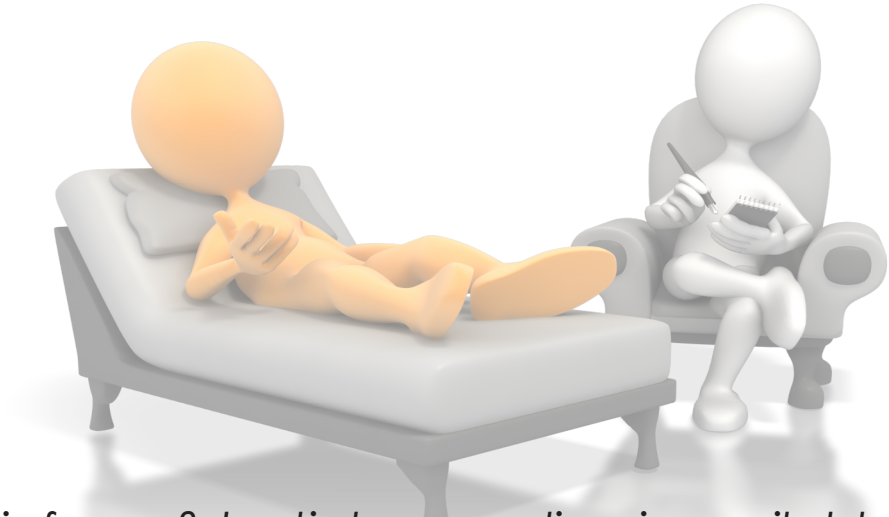
A. Whether you've been involved in recreational or extreme sporting, worldwide emergency travel assistance will provide support for all your medical needs.

Q. Who pays for the services I use if I have a travel emergency?

A. Assist America arranges and pays for 100% of the services the company provides, with no caps or charge-backs to either you or your employer. But you must call Assist America first — you can't be reimbursed for services you arrange on your own.

* Hospital admission is coordinated by Assist America, Inc. It may require a validation of your medical insurance or an advance of funds to the foreign medical facility. You must repay any expenses related to emergency hospital admissions to Assist America, Inc. within 45 days. Worldwide emergency travel assistance services, provided by Assist America, Inc., are available with select Unum insurance offerings. Terms and availability of service are subject to change and prior notification requirements. Services are not valid after coverage terminates. Please contact your Unum representative for details. All emergency travel assistance must be arranged by Assist America, which pays for all services it provides. Medical expenses such as prescriptions or physician, lab or medical facility fees are paid by the employee or the employee's health insurance.

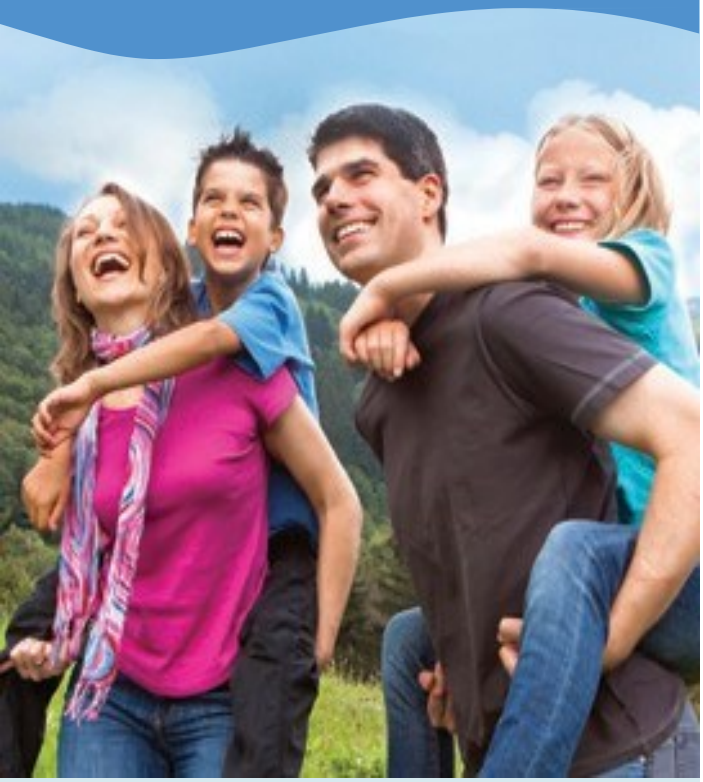
LIVE WELL EMPLOYEE ASSISTANCE PROGRAM



Free, brief, confidential counseling is available to insurance eligible employees, their spouses, and dependent children by a staff of licensed mental health professionals.

Back to Table of Contents

LiVe Well



Your LiVe Well Partner

Offering free, confidential, and brief counseling to employees and their family members.

The LiVe Well Employee Assistance Program is your partner in living a life filled with energy, strength, and vitality. Taking care of your mental health is as essential to your well-being as taking care of your physi-cal health. Rewarding relationships at home and work, effective stress management skills, and learning to thrive with life changes all improve your ability to LiVe Well.

Intermountain®
LiVe Well
Employee Assistance Program

"Thank you for providing this service. It has really helped ease my burdens and made my life better, including my worklife!"
~ EAP CLIENT

EAP SERVICES

Counseling: Free, brief counseling for life problems such as conflict at work or with a family member, depression, anxiety, and life stress. Services are available to employees, spouses or partners, and dependent children (under 26 years old.)

Help for Caregivers: Information, resources, and coaching for employees who are providing assistance to a spouse or relative who is ill, disabled, or needs help with basic activities of daily living. Caregiver services can help identify medical, legal, and financial resources, as well as provide support for the emotional issues of caregiving.

Crisis Services: 24/7 telephone crisis services with a licensed mental health professional.

Website: Valuable resources for employees and family members including Quick Tips on common life problems, resources such as "Our Favorite Books," and a sign up for bi-monthly LiVe Well E-Tips. You will also find details about our office locations and staff biographies. **www. intermountainhealthcare.org/eap**

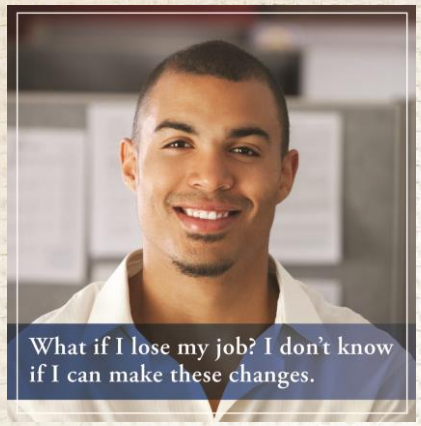
Back to Table of Contents

CONTACT US

Call 801.442.3509 or 800.832.7733 from 8:00 a.m. – 5:00 p.m. (MST) to schedule an appointment. A crisis counselor is available by phone 24/7 at the same number.

You can also e-mail us at eap@imail.org with non-urgent questions or feedback.

Intermountain®
LiVe Well
Employee Assistance Program



Seeking counseling can help us improve the quality of our lives and our relationships.

For more information or free counseling call Intermountain EAP at 1.800.832.7733.

Visit our website at intermountainhealthcare.org/eap

Me? See a Counselor?

Life presents many challenges and sometimes talking to a counselor who is a neutral party can be helpful.

The counselor will carefully listen to you and help you use your strengths to solve problems and learn new skills. It isn't a sign of weakness or craziness to see a counselor. It's a sign that you are willing to look for solutions. Everyone will confront a problem in their life when the solution is not obvious. Talking with a non-judgmental listener helps you sort out your thoughts and feelings and this can lead to personal insight and answers. Typically, a lot of progress can be made in just a few sessions.

To make an appointment with an EAP counselor, call 1.800.832.7733. This service is completely confidential and free. No information is ever released without your written permission unless there is a report of abuse.

How will I know if the counseling is helping?

Here are some questions to help you decide:

- Am I comfortable with my counselor and treatment?
- Do I feel understood?
- Are my needs being addressed?
- Have the counselor and I agreed upon the goals of my counseling?
- Can I alter my goals at any time?
- Am I making progress toward my goals?
- Do I trust my counselor?
- Does my counselor behave professionally?

You should be able to answer yes to all of these questions. If you have any concerns, discuss them with your counselor or ask to see another counselor.

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
Employee Assistance Program (EAP) Counseling Services

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
Accidental Death & Dismemberment Insurance
Short-Term Disability Insurance
Vision Insurance

Back to Table of Contents

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	1,727.40	20,728.80	1,499.03	228.37	1,299.16	428.24	1,199.22	528.18
Employee + 1	1,282.20	15,386.40	1,129.52	152.68	978.92	303.28	903.62	378.58.
Employee Only	593.60	7,123.20	557.98	35.62	483.58	110.02	446.38	147.22
SELECTHEALTH (Traditional)								
Employee + 2 or more	1,741.40	20,896.80	1,511.17	230.23	1,309.68	431.72	1,208.94	532.46
Employee + 1	1,292.30	15,507.60	1,138.41	153.89	986.62	305.68	910.73	381.57
Employee Only	598.20	7,178.40	562.31	35.89	487.34	110.86	449.85	148.35
AETNA (High Deductible)								
Employee + 2 or more	1,542.40	18,508.80	1,338.49	203.91	1,160.02	382.38	1,070.79	471.61
Employee + 1	1,144.90	13,738.80	1,008.57	136.33	874.09	270.81	806.86	338.04
Employee Only	530.00	6,360.00	498.20	31.80	431.77	98.23	398.56	131.44
SELECTHEALTH (High Deductible)								
Employee + 2 or more	1,557.30	18,687.60	1,351.41	205.89	1,171.22	386.08	1,081.13	476.17
Employee + 1	1,155.70	13,868.40	1,018.08	137.62	882.34	273.36	814.46	341.24
Employee Only	535.00	6,420.00	502.90	32.10	435.85	99.15	402.32	132.68
LONG TERM DISABILITY								
UNUM								
Employee Only	19.05	228.60	9.53	9.52	8.26	10.79	7.62	11.43
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.

Back to Table of Contents

Active Employee Premium Schedules

January 1 through December 31, 2019

Based on 12 checks*

Eligible Hours Per Week

Plans and Coverage	Monthly Premium Cost	Annual Cost Total	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	1,727.40	20,728.80	1,099.29	628.11	999.35	728.05	899.42	827.98	799.48	927.92
Employee + 1	1,282.20	15,386.40	828.31	453.89	753.01	529.19	677.71	604.49	602.41	679.79
Employee Only	593.60	7,123.20	409.19	184.41	371.99	221.61	334.79	258.81	297.59	296.01
SELECTHEALTH (Traditional)										
Employee + 2 or more	1,741.40	20,896.80	1,108.19	633.21	1,007.45	733.95	906.70	834.70	805.96	935.44
Employee + 1	1,292.30	15,507.60	834.83	457.47	758.94	533.36	683.05	609.25	607.15	685.15
Employee Only	598.20	7,178.40	412.36	185.84	374.87	223.33	337.39	260.81	299.90	298.30
AETNA (High Deductible)										
Employee + 2 or more	1,542.40	18,508.80	981.56	560.84	892.33	650.07	803.09	739.31	713.86	828.54
Employee + 1	1,144.90	13,738.80	739.62	405.28	672.38	472.52	605.14	539.76	537.90	607.00
Employee	530.00	6,360.00	365.35	164.65	332.13	197.87	298.92	231.08	265.71	264.29
SELECTHEALTH (High Deductible)										
Employee + 2 or more	1,557.30	18,687.60	991.03	566.27	900.94	656.36	810.85	746.45	720.75	836.55
Employee + 1	1,155.70	13,868.40	746.59	409.11	678.72	476.98	610.85	544.85	542.98	612.72
Employee Only	535.00	6,420.00	368.79	166.21	335.27	199.73	301.74	233.26	268.21	266.79
LONG TERM DISABILITY										
UNUM										
Employee Only	19.05	228.60	6.99	12.06	6.35	12.70	5.72	13.33	5.08	13.97
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.

Back to Table of Contents

SHORT-TERM DISABILITY RATES

Premium Rates per $10 of Base Salary		
Age	**Male**	**Female**
29 and under	.03	.06
30-39	.05	.08
40-49	.07	.13
50-59	.10	.18
60 and over	.14	.21

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)	or	$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)

ACCIDENTAL DEATH & DISMEMBERMENT

Monthly Rate $ .02 per $1,000 of Coverage

Calculate your total monthly premium here

Desired No.of Thousands			Total Monthly Premium
_____	X	$ .02	= _____
(up to 500)			

(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

Back to Table of Contents

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, 2019 through December 31, 2019

Health Plans — Monthly Premiums

AETNA (Traditional Health Plan)

Family	$1,761.95
2-Party	1,307.84
Single	605.47

SELECTHEALTH (Traditional Health Plan)

Family	$1,776.23
2-Party	1,318.15
Single	610.16

AETNA (High Deductible Health Plan)

Family	$1,573.25
2-Party	1,167.80
Single	540.60

SELECTHEALTH (High Deductible Health Plan)

Family	$1,588.45
2-Party	1,178.81
Single	545.70

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

Back to Table of Contents

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, 2019 through December 31, 2019

Health Plans	Monthly Premiums
AETNA (Traditional Health Plan)	
Family	$1,761.95
2-Party	1,307.84
Single	605.47
SELECTHEALTH (Traditional Health Plan)	
Family	$1,776.23
2-Party	1,318.15
Single	610.16
AETNA (High Deductible Health Plan)	
Family	$1,573.25
2-Party	1,167.80
Single	540.60
SELECTHEALTH (High Deductible Health Plan)	
Family	$1,588.45
2-Party	1,178.81
Single	545.70

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

Back to Table of Contents

IMPORTANT INSURANCE NOTES

The following pages include important information regarding miscellaneous insurance issues.

Back to Table of Contents

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 Insurance Department at 801-402-5200, or 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.**

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 but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in Utah, you can contact the Utah Medicaid office at http://health.utah.gov/chip or 1-877-543-7669 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.

Back to
Table of Contents

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.

Back to Table of Contents

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.

Back to Table of Contents

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 96 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.

Back to Table of Contents

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/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:
https://www.davis.k12.ut.us/insurance
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.

Back to Table of Contents

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.

Back to Table of Contents

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 866-756-0376 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, 2018
Name of Entity:	Davis School District
Contact Office:	District Insurance Office
Address:	45 E. State Street, Farmington, UT 84025
Phone Number:	(801) 402-5200

Back to Table of Contents

Davis School District

Davis School District 2018-2019

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 automatically 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 2018-2019 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. 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, they 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.

Back to Table of Contents

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!

Back to Table of Contents

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 $2,650. 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 $2,650.

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.

Back to Table of Contents

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

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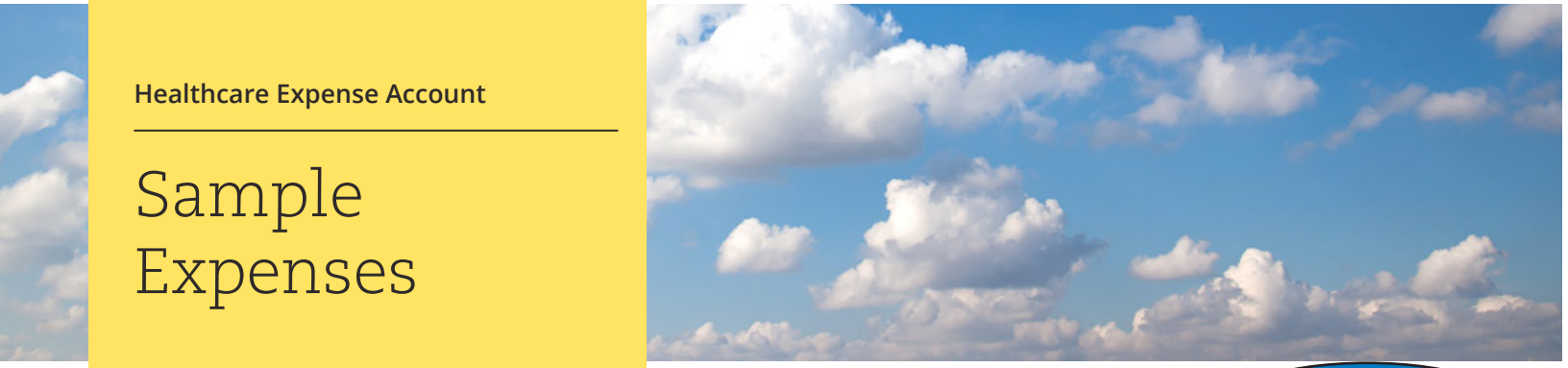
Back to Table of Contents

Healthcare Expense Account

Sample Expenses



Back to Table of Contents

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 by calling **NBS at 800-274-0503**. 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.**

EEP YOUR NBS BENEFITS CARD FOR 2019

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 2019 plan year.

Some of your cards will be expiring during the 2019 plan year. You can check your expiration date on your card. Most cards are good for three years. If your card is expiring in 2019, 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.

Back to Table of Contents

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?
This year, all district employees who are eligible for sick leave and wish to participate in the Catastrophic Sick Leave Bank program for 2019 will need to contribute one day of sick leave to the bank during the open enrollment period, regardless of past participation and contributions. Employees who contribute during the open enrollment period will be eligible to apply for benefits from the Catastrophic Sick Leave Bank beginning January 1, 2019.

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

Back to Table of Contents

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	

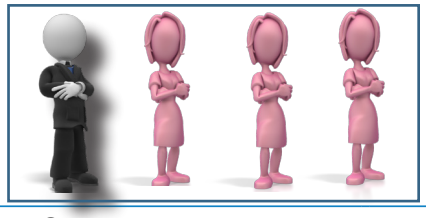
The Hartford	
Customer Service	800-523-2233 Group # 220069
https://www.thehartford.com/employee-benefits	

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

NATIONAL BENEFIT SERVICES, LLC	
Customer Service	800-274-0503
Local	801-532-4000
Fax	800-478-1528
www.nbsbenefits.com	

Intermountain LiVe Well Employee Assistance Program	
Customer Service	800-832-7733
Local	801-442-3509
Email:	eap@imail.org
www.intermountainhealthcare.org/eap	

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	

Back to Table of Contents