WASHINGTON COUNTY SCHOOL DISTRICT

August 1, 2017 - July 31,2018

Employee Benefit Guide

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Welcome

Welcome to the Washington County School District Benefit Guide for 2017-2018. Our objective is to help support your and your family's health and wellness needs, while reducing utilization costs.

The District fringe benefit package is an important part of your whole compensation. The District is pleased to offer you the opportunity to select from a variety of benefit options. Eligible employees can elect participation in any or all of the following:

- Medical (Choice of two plan options)
- Dental Insurance
- Life and Accidental Death and Dismemberment Insurance
- Optional AD&D Life Insurance
- Short-Term Disability
- Long-Term Disability
- Flexible Spending Account
- Health Savings Account
- Voluntary Vision Insurance
- Group Voluntary Accident
- Group Voluntary Critical Illness
- Group Voluntary Hospital Indemnity

This guide is designed to help you make decisions about what coverage is best for you and your family. Enclosed, you will find a brief description of the options available, a comparison of basic plan coverage and cost information.

This is a summary only. For more information about any of the plans, don't hesitate to contact the insurance companies directly. Provider listings can be found on the district website at **www.washk12.org**. Go to "Employees" click on "Human Resources," then click on "Benefits & Insurance," and then "Handbook." You will see vendor carrier information and carrier web addresses. **Also, insurance carrier's phone numbers and website addresses are listed on the back cover of this guide**.

Remember, this guide is a summary only. It is not meant to replace or fully interpret provisions of the negotiated agreements, FMLA, COBRA, Washington County School District Policy, or the insurance benefits.

Please take the time to carefully go through this guide and any other information required to make decisions about benefits offered by the district. Employees who make informed decisions about their benefit options, will have fewer questions and better access to benefits throughout the year.

Open Enrollment (OE)

Open Enrollment begins April 17, 2017 and ends April 28, 2017. This is the period of time when you, as an eligible employee, are able to enroll in insurance coverage or elect changes to your Medical, Dental, Optional Life Insurance, Vision, Short-Term Disability, Flex Spending, Voluntary Accident, Voluntary Critical Illness and Voluntary Hospital Indemnity. It is important to note that this is the only period of time that you can make changes to your benefit coverage (with the exception of changes necessary due to a change in family status or insurance eligibility status).

After you have reviewed all of this information carefully, if you decide to make a change to your insurance coverage for the 2017-2018 school year, you will need to complete the appropriate changes on the correct insurance enrollment forms by Friday, April 28, 2017.

Timeline and Events For Open Enrollment:

- Monday, April 17, 2017 – Open Enrollment Begins
- Wednesday, April 19, 2017 – Insurance Vendor Fair at the District Office Board Room 2–6 p.m.
- Friday, April 28, 2017 – Open Enrollment Ends
- Tuesday, August 1, 2017 – Changes made during open enrollment become effective.

If you have questions about insurance options, PLEASE contact your SCHOOL INSURANCE REPRESENTATIVE FIRST.

If additional assistance is needed, contact:

Tammara Robinson, WCSD Benefits Specialist
435.673.3553 ext. 5119 or tammara.robinson@washk12.org

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

It's important to review your enrollment options below, and learn for which benefits you are eligible. Be sure to take the time to review your current benefit options before deciding whether or not to make changes to your coverage during open enrollment.

New Hire Enrollment

If you are a newly hired or newly eligible employee, you will be *automatically enrolled in the "Qualified High Deductible Health Plan" medical plan as employee with SINGLE coverage effective the 1st of the month following your eligible contract. If you choose to change to the "traditional" health plan, add dental and all other supplemental insurance plans, or add your family, you are required to enroll within 30 days of hire or eligibility date. It is imperative that you complete the new hire orientation and benefits meeting in order to learn about the insurance benefits. if enrollment is not completed timely, this could result in benefits being delayed until the following month.

*REMINDER, AUTOMATIC ENROLLMENT IS MEDICAL SINGLE COVERAGE ON THE HIGH DEDUCTIBLE HEALTH PLAN. ATTEND NEW HIRE ORIENTATION FOR ADDITIONAL BENEFIT OPTIONS AND TO ADD FAMILY MEMBERS.

Enrollment Restrictions

Employees who do not apply for benefit coverage within 30 days of hire date or insurance eligibility will not be able to enroll in coverage until the next district open enrollment period. Employees who decline coverage, or fail to enroll for coverage, at their initial eligibility will be subject to insurance benefit restrictions as outlined in the insurance contracts.

Other Enrollment Events

(Other than open enrollment)

Change of Status:

» Marriage
» Birth
» Adoption
» Legal guardianship
» Divorce
» Death
» Addition of children
» Deletion of children who lose dependent status; and
» Loss of spouse's job or other insurance

You must complete the enrollment changes 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.

Change of Part-Time Hours

If you were eligible for benefits, as a part-time eligible employee who initially declined coverage at your first eligibility date but experienced a change in assignment or approved work hours, you may have another opportunity to enroll in benefit coverage.

To take advantage of this new enrollment opportunity, you will need to contact Tammara Robinson, extension 5119, at the District Office. You must enroll in benefit coverage within 30 days of your new eligibility date, or the date your authorized hour change is effective, or you will not be eligible to make an enrollment election until the next open enrollment period.

Section 125 Flexible Spending Benefit Plan Enrollment

For participation in the Section 125 Flexible Benefit Plan from August 1, 2017 through July 31, 2018, you must complete an enrollment form. To learn more about the National Benefit Services Cafeteria Plan, review the appropriate section in this booklet. The deadline for the flexible spending enrollment is Friday, April 28, 2017.

IMPORTANT NOTE: If you enroll in the Qualified High Deductible Health Plan (QHDHP) and Health Savings Account (HSA), you are not eligible to enroll in the Flex Plan for health/medical expenses. You may still participate in the Limited Purpose Flex Plan according to the Limited Purpose Guidelines (common dental, vision and post deductible medical expenses). This does not affect the Flex Plan for Dependent Child Care.

Medical Benefits

Administered by Regence BlueCross BlueShield (ValueCare Network)

Washington County School District offers a choice of two plan options so that you can decide which plan is the best fit for you and your family. We encourage you to consider the total cost of health care - deductibles, coinsurance and out-of-pocket maximums before you choose a medical plan option.

	High Deductible Health Plan		BluePoint Traditional	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (individual/family)	$2,000/$4,000	$2,250/$4,500	$1,500/$3,000	$3,000/$6,000
Annual Out-of-Pocket Maximum (individual/family)	$5,000*/$10,000	$6,500/$13,000	$5,000/$10,000	$10,000/$20,000
DOCTOR'S OFFICE				
Office Visits (PCP / SCP)	$20 copay AD	40% AD	$30 copay	40% AD
Specialist Office Visit	$30 copay AD	40% AD	$60 copay	40% AD
Preventative Care	Covered 100%	40% AD	Covered 100%	40% AD
PRESCRIPTION DRUGS				
Retail - 30-day supply				
RX Deductible	N/A		$100 per person/year for Tier 2-4	
Tier 1	$7 copay AD (Some generic preventative drugs available at $7 copay before deductible)		$10 copay	
Tier 2	$21 copay AD		$25 copay APD	
Tier 3	$42 copay AD		$45 copay APD	
Tier 4	$100 copay AD		$100 copay APD	
Mail Order - 90-day supply				
Tier 1	$7 copay AD		$10 copay	
Tier 2	$42 copay AD		$50 copay	
Tier 3	$126 copay AD		$135 copay	
HOSPITAL SERVICES				
Emergency Room	$75 copay AD	40% AD	$325 copay	40% AD
Urgent Care	$35 copay AD	40% AD	$60 copay	40% AD
Inpatient	20% AD	40% AD	20% AD	40% AD
Outpatient Surgery	20% AD	40% AD	20% AD	40% AD
Surgical Center Surgery	5% AD	40% AD	5% AD	40% AD
Ambulance Service	20% AD		20% AD	
Ambulatory Surgical Center	5% AD	40% AD	5% AD	40% AD
MENTAL HEALTH SERVICES				
Inpatient Services	20% AD	40% AD	20% AD	40% AD
Outpatient Services	$20 copay for therapy visits, other services 20% AD	40% AD	$30 copay for therapy visits, other services 20% AD	40% AD

	High Deductible Health Plan		BluePoint Traditional	
	In-Network	Out-of-Network	In-Network	Out-of-Network
SUBSTANCE ABUSE SERVICES				
Inpatient Services	20% AD	40% AD	20% AD	40% AD
Outpatient Services	$20 copay AD for therapy visits, other services 20% AD	40% AD	$30 copay for therapy visits, other services 20% AD	40% AD
VISION				
Annual Preventative Care Eye Exam (Limit 1 visit per year)	Covered 100%	Not Covered	Covered 100%	Not Covered
OTHER SERVICES				
Maternity Services	20% AD	40% AD	20% AD	40% AD
Hospice (up to 6 months in 3 years, requires preauthorization)	20% AD	40% AD	20% AD	40% AD
Rehabilitation Services—Inpatient (requires preauthorization, 40 days per year)	20% AD	40% AD	20% AD	40% AD
Skilled Nursing Facility (60 days per year, prior authorization required)	20% AD	40% AD	20% AD	40% AD
Chiropractic (Limit 15 visits per year)	Not Covered	Not Covered	$60 copay	40% AD

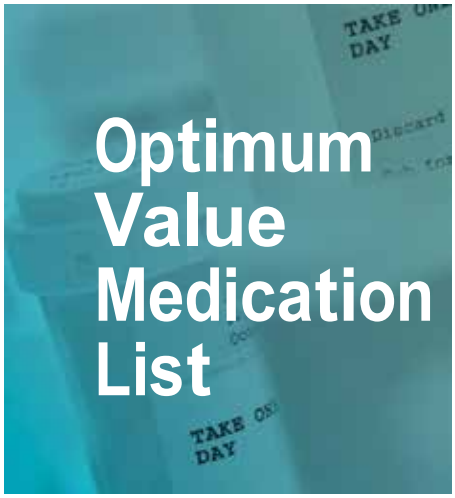
*Embedded Out-of-Pocket Maximum: Once one member in the family meets the individual Out-of-Pocket Maximum, that individuals In-network medical expenses are 100% covered for the remainder of the plan year.

AD= After Deductible
APD= After Pharmacy Deductible

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. Contact your claims payer or insurer for more information. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language.

This Pharmacy Benefit only applicable for HDHP

PHARMACY BENEFITS



SEE HOW YOUR BENEFITS CAN HELP YOU SAVE.

Find out if your medication is on the list

Are you on a medication to prevent or manage a condition? Looking for ways to save? Take a look at the value-based medications on this flyer. If you see your drug on the list, you can save.

Medications that offer the best value

In addition to leading a healthy lifestyle, the medications listed on this flyer can help prevent many illnesses and conditions for people who have risk factors.

Following your doctor's treatment plan – including taking prescribed medications as directed – can help you live a healthier life today and avoid serious illness and high health care costs down the road.

If your medication is on this list, your prescription medication benefit helps you save money and stay on your treatment plan. Under some plans, you may not need to pay a copay, coinsurance and/or deductible for the medications in this list.

Questions?
Call the Customer Service number on your member ID card.

OmedaRx®

This Pharmacy Benefit only applicable for HDHP

PHARMACY BENEFITS

2017 Optimum Value Medication List

Generics are cheaper than brand-names. So ask your doctor if it's okay for you to take a generic instead.

Drug Name	Brand or Generic?
DIABETES:	
Insulins	
Humalog® products*	Brand
Humulin® products*	Brand
Lantus® products*	Brand
Testing Supplies	
One Touch® Brand**	Brand
Sulfonylureas	
glimepiride	Generic
glipizide	Generic
glipizide ER	Generic
glyburide	Generic
glyburide micronized	Generic
tolazamide	Generic
Metformin Products	
glipizide-metformin	Generic
glyburide-metformin	Generic
metformin	Generic
metformin ER (non OSM, non MOD)	Generic
Miscellaneous	
pioglitazone	Generic
Glucose Rescue Products	
GlucaGen® HypoKit®	Brand
Glucagon®	Brand

*Includes vials, pens
**Includes test strips and other testing supplies

CARDIOVASCULAR:	
Beta Blockers	
acebutolol	Generic
atenolol	Generic
bisoprolol	Generic
carvedilol	Generic
labetalol	Generic
metoprolol succinate	Generic
metoprolol tartrate	Generic
propranolol solution	Generic
propranolol tablets	Generic
sotalol	Generic
timolol maleate tablets	Generic
Calcium Channel Blockers	
amlodipine	Generic
diltiazem	Generic
felodipine ER	Generic
isradipine	Generic
nifedipine capsules	Generic
nifedipine tablets ER	Generic
Renin/ Angiotensin System Antagonists (ACEI, ARB)	
benazepril	Generic
enalapril	Generic
eplerenone	Generic
fosinopril	Generic

Drug Name	Brand or Generic?
irbesartan	Generic
lisinopril	Generic
losartan	Generic
quinapril	Generic
ramipril	Generic
trandolapril	Generic
verapamil	Generic
verapamil ER	Generic
Diuretics	
amiloride	Generic
bumetanide	Generic
chlorothiazide	Generic
chlorthalidone	Generic
furosemide solution	Generic
furosemide tablets	Generic
hydrochlorothiazide capsules	Generic
hydrochlorothiazide tablets	Generic
indapamide	Generic
methazolamide	Generic
methyclothiazide	Generic
spironolactone	Generic
torsemide	Generic
Combination Products	
amiloride & hydrochlorothiazide	Generic
atenolol & chlorthalidone	Generic
bisoprolol & hydrochlorothiazide	Generic
enalapril & hydrochlorothiazide	Generic
irbesartan & hydrochlorothiazide	Generic
lisinopril & hydrochlorothiazide	Generic
losartan & hydrochlorothiazide	Generic
metoprolol & hydrochlorothiazide	Generic
nadolol & bendroflumethiazide tab	Generic
propranolol & hydrochlorothiazide	Generic
triamterene & hydrochlorothiazide	Generic
Vasodilators	
hydralazine	Generic
isosorbide	Generic
nitroglycerin patch	Generic
Anticoagulants/ Antiplatelets	
clopidogrel	Generic
dipyridamole	Generic
warfarin	Generic
Miscellaneous	
prazosin	Generic
digoxin	Generic
Cholesterol	
atorvastatin	Generic
lovastatin	Generic
pravastatin	Generic
simvastatin	Generic
RESPIRATORY:	
Short Acting Beta Agonists (SABA)	

Drug Name	Brand or Generic?
albuterol ER tablets	Generic
albuterol nebulized	Generic
albuterol syrup	Generic
albuterol tablets	Generic
Anticholenergics	
ipratropium bromide solution	Generic
SABA/ Anticholenergics	
ipratropium-albuterol inhaler	Generic
ipratropium-albuterol nebulized	Generic
Inhaled Corticosteroids	
budesonide (inhalation) nebulized	Generic
ProAir® HFA inhaler	Brand
ProAir® RespiClick®	Brand
QVAR® inhaler	Brand
Ventolin® inhaler	Brand
Methylxanthines	
theophylline elixir	Generic
theophylline solution	Generic
theophylline tablets, 12 hour	Generic
theophylline tablets, 24 hour	Generic
Leukotriane Receptor Antagonists	
montelukast chewable tablets	Generic
montelukast tablets	Generic
URINARY:	
alfuzosin	Generic
doxazosin	Generic
finasteride 5mg	Generic
oxybutynin IR tablets	Generic
tamsulosin	Generic
terazosin	Generic
MENTAL HEALTH:	
amitriptyline	Generic
bupropion	Generic
bupropion ER/ SR	Generic
citalopram solution	Generic
citalopram tablets	Generic
doxepin capsules	Generic
doxepin solution	Generic
duloxetine	Generic
escitalopram	Generic
fluoxetine (PMDD) capsules	Generic
fluoxetine capsules	Generic
fluoxetine solution	Generic
fluoxetine tablets	Generic
fluvoxamine	Generic
mirtazapine	Generic
nortriptyline capsules	Generic
nortriptyline solution	Generic
olanzapine	Generic
paroxetine suspension	Generic
paroxetine tablets	Generic
quetiapine	Generic

Drug Name	Brand or Generic?
risperidone	Generic
sertraline solution	Generic
sertraline tablets	Generic
venlafaxine ER capsules	Generic
venlafaxine IR tablets	Generic
ziprasidone	Generic
ANTICONVULSANTS:	
carbamazepine chewable tablets	Generic
carbamazepine suspension	Generic
carbamazepine tablets	Generic
divalproex	Generic
gabapentin	Generic
lamotrigine chewable tablets	Generic
lamotrigine tablets	Generic
levetiracetam	Generic
lithium carbonate	Generic
oxcarbazepine	Generic
topiramate	Generic
valproate sodium	Generic
zonisamide	Generic
IMMUNOSUPPRESSANTS:	
azathioprine	Generic
methotrexate	Generic
sulfasalazine	Generic
OSTEOPOROSIS:	
alendronate	Generic

This list does not pertain to provisions of federal health care reform, the Affordable Care Act. It does not include all products available for treating the above stated medical conditions and is subject to change.

Brand-name medications may move from preferred to non-preferred status and in that case will be removed from this list.

OmedaRx®

Understanding a Health Savings Account (HSA)

Administered by Health Equity

What is a Health Savings Account (HSA)?

A Health Savings Account (HSA) is an account that can be funded by you with pre-tax dollars, by your employer, or both. The HSA helps pay for eligible medical expenses not covered by an insurance plan, including the deductible, coinsurance, and in some cases, health insurance premiums.

Who is eligible for a Health Savings Account?

Anyone who satisfies all of the following:

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

When do I use my HSA?

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

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

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

FSA vs. HSA

Questions	Health Savings Account (HSA)	Flexible Spending Account (FSA)	Dependent Care Account	Limited Purpose FSA
Am I Eligible?	Only if participating in the High Deductible Health Plan (HDHP)	Only if participating in the BluePoint Traditional Plan	Can be enrolled in either the Traditional or HDHP	Only if you enroll in the High Deductible Health Plan (HDHP) with an HSA
What Happens With Funds at the end of the Year?	Balance carries forward and portable	$500 Rollover	Use it or lose It	$500 Rollover
What are the Annual Contribution Limits?	$3,400 Self Only, $6,750 Family, +$1,000 Age 55+	$2,600 Max employee contribution	$5,000 Annual Max	$2,600 Max employee contribution
When can I change my Elections?	Elections can be changed anytime through the year	Election amount must be made at open enrollment	Election amount must be made at open enrollment	Election amount must be made at open enrollment
What can I use the Funds for?	Funds may be used for non-health expenses (but taxable + penalty)	Funds may only be used for health expenses (IRS rules)	Funds may only be used for qualified dependent care expenses (IRS rules)	Funds may be used for dental and vision expense. Can only be used for Medical expense after you have met your deductible on the High Deductible Health Plan (HDHP).

How much can be contributed to an HSA?

As noted by federal law, the Annual Contribution limits are:

Type of Coverage	2017 Maximum Annual Contribution	2017 Employer Annual Contribution
Individual	$3,400*	$950
Family	$6,750*	$950
*A $1,000 additional catch up contribution is allowed for account holders age 55+		

	HSA Fees	FSA Fees Full and Limited Purpose
Setup	Free	Free
Monthly Maintenance	$2.70/month (with balance under $2,000)	$0/month
Monthly Paper Statement	$1.00/month **No** monthly fee for electronic statements	N/A
Debit Card	First 3 free, $5.00 for each additional card	$18/year

Flexible Spending Accounts (FSAs)

Administered by National Benefit Services

A Flexible Spending Account (FSA) provides you the opportunity to pay for health care and dependent care expenses on a pre-tax basis. By anticipating your family's health care and dependent care costs for the next plan year, you can lower your taxable income.

Flexible Spending Accounts are convenient and easy to use. With a little up-front planning, you can enjoy significant tax savings, while paying for a wide assortment of out-of-pocket health care and dependent care expenses.

How it Works

Each plan year you designate an annual election to be deposited into your health care and/or dependent care accounts. Your annual election will be divided by the number of pay periods in the plan year and deducted equally from each paycheck on a pre-tax basis. For health care expenses, you have immediate access to the total amount you elected to contribute for the plan year. With the dependent care, you have access to the amount at the time you request reimbursement.

$500 Rollover!

FSA rules now allow for a $500 Rollover at the end of the year. This means instead of loosing all remaining funds in your FSA, you can roll over up to $500 to use in the upcoming plan year.

Things to Consider

- Be conservative when estimating your annual election amount. The IRS has a strict "use it or lose it" rule. If there is a balance in your account after the $500 rollover you will forfeit any funds left in your account after the end of the plan year
- Your 2017 contributions must be used for expenses you incur August 1, 2017 to July 31, 2018.
- There is a 90 day run-out period that allows you to submit claims for your FSA after the plan year ends on 7/31/2017.
- The health care and dependent care FSA's are two separate accounts and funds cannot be transferred between accounts.
- The Dependent Care FSA cannot be used for dependent's medical expenses.

- You cannot stop or change your FSA contribution amount during the year unless you have a qualified change in family status.
- Expenses reimbursed through an FSA cannot be used as a deduction or credit on your federal income taxes .
- You cannot be enrolled in an HSA and a full FSA during the same tax year, this includes a spouse's FSA and or HSA.

FSA Reimbursement Options

To receive reimbursement from your FSA, you can submit a claim online, complete a paper claim form or use your FSA debit card. It is important to save your receipts. National Benefit Services may ask you to provide a copy to substantiate a claim.

Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account enables you to pay for work-related dependent day care costs with pre-tax dollars. Available regardless of enrollment in the FSA or HSA.

Limited Purpose FSA

If you enroll in the High Deductible Health Plan (HDHP) with an HSA you are eligible to enroll in a Limited Purpose FSA and will only be able to use these funds for qualified dental and vision expenses. Common examples of dental and vision expense are: dental deductibles, orthodontics and coinsurance. Vision expenses include things such as exams, frames, lenses, contacts and Lasik.

Flexible Spending Account Options			
	Health Care FSA	Dependent Care FSA	Limited Purpose FSA
Maximum Plan Year Contribution Amount	Up to $2,600	Up to $5,000 ($2,600 if married and filing separate income tax returns)	Up to $2,600
Examples of Eligible Expenses	Medical, RX, and Dental expenses. Hearing care and Prescription Eye Care	Cost of child care for children under age 13	Dental and Vision expenses. Can only be used for Medical expense after you have met the deductible on the High Deductible Health Plan (HDHP)

Dental Benefits

Administered by EMI Health

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Washington County School District dental benefit plan.

EMI Health	In-Network Advantage Plus Network	In-Network Premier Network	Out-of-Network
Annual Deductible	$50 / $150		
Annual Benefit Maximum	$2,000	$1,500	
Preventive Dental Services (cleanings, exams, x-rays)	80% (Deductible waived)	80% (Deductible waived)	70% (Deductible waived)
Basic Dental Services (fillings, root canal therapy, oral surgery)	80%	80%	70%
Major Dental Services (extractions, crowns, inlays, onlays,bridges, dentures, repairs)	50%	50%	40%
Orthodontia Services (Dependent children up to age 19)	50%	50%	50%
Orthodontia Maximum	$1,000		

Provisions / Limitations / Exclusions	
Exams (cleanings and fluoride: 2 per year)	Anesthesia: Covered in Basic (age 8 and over for the extractions of impacted teeth only) (For children age 7 and under, once per year)
Fluoride: Any Age	Panoramic X-Ray: 1 every 3 years
Sealants: Dependent Children Only	Implants: Covered in Major Dental Services (limited to $225)
Space Maintainers: Up to Age 17	Onlays and Dentures: 1 every 5 years per tooth
Bitewing X-Rays: 2 Per Year	Crowns, Pontics and Abutments: 1 every 5 years per tooth
Periapical X-Ray: Covered in Preventive	Fillings on the same surface: 1 every 18 months
Waiting Periods	
Basic Services	None
Major/Ortho	Failure to enroll in Out-of-Network opportunity, results in a 12-month waiting period

Voluntary Vision Benefits

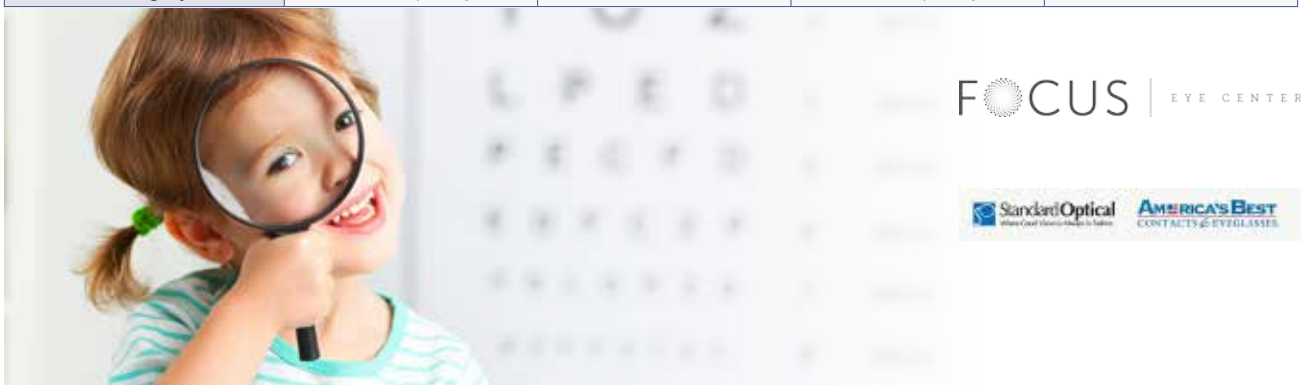
Administered by Opticare of Utah

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

Basic Eye Exams are covered under the medical plan. This vision plan includes benefits for eye glasses and contact lenses.

Opticare Plan: 70WSD		Opticare Plan: 120WSD	
Single	$3.44	Single	$6.40
Two-Party	$6.69	Two-Party	$11.59
Family	$8.99	Family	$16.85

	Opticare Plan: 70WSD		Opticare Plan: 120 WSD	
	In-Network (Member Pays)	Out-of-Network (Reimbursement)	In-Network (Member Pays)	Out-of-Network (Reimbursement)
Eye Exam	Not covered		Not covered	
Frames				
Any available frame at provider location.	$70 Allowance	$60 Allowance	$120 Allowance	$100 Allowance
Lenses				
Single Vision Lenses	100% Covered	$85 Allowance	100% Covered	$100 Allowance
Bifocal Lenses	100% Covered	$85 Allowance	100% Covered	$100 Allowance
Trifocal Lenses	100% Covered	$85 Allowance	100% Covered	$100 Allowance
Lens Options				
Progressive	$50 copay	N/A	$30 copay	N/A
Premium Progressive	20% Discount	N/A	20% Discount	N/A
Glass Lenses	15% Discount	N/A	15% Discount	N/A
Standard Polycarbonate	$40 copay	N/A	$40 copay	N/A
High Index	$80 copay	N/A	$80 copay	N/A
Contacts				
Conventional	$70 Allowance	$60 Allowance	$120 Allowance	$100 Allowance
Disposable	$70 Allowance	$60 Allowance	$120 Allowance	$100 Allowance
Frequency				
Examination	Not covered		Not covered	
Frames	Once Every 12 months		Once Every 12 months	
Lenses or Contact Lenses	Once Every 12 months		Once Every 12 months	
Refractive Surgery - Lasik	$250 off per Eye	Not covered	$250 off per Eye	Not covered



Life and Accidental Death & Dismemberment

Administered by LifeMap

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

Washington County School District provides full-time eligible employees with basic group life insurance and accidental death & dismemberment coverage at no cost to you. Basic dependent group life insurance is also provided at no cost to you.

Voluntary Life and AD&D Insurance

You also have the option to purchase additional life insurance coverage for yourself, your spouse and your unmarried dependent children to age 26. However, you may only elect coverage for your dependents if you elect additional coverage for yourself. You pay for the cost of additional coverage through payroll deductions on a post-tax basis.

Beneficiary Designation

We recommend you designate a beneficiary for your life insurance policy(ies). A beneficiary is the person(or people, estate, trust, etc.) to whom benefits will be paid in the event of your death. You may change your beneficiary at any time during the plan year.

Basic Life and AD&D		
Plan Features	Basic Life	AD&D
Employee Benefit	$25,000	$25,000
Spouse & Child(ren) Benefit	$2,420	N/A

Voluntary Life and AD&D			
Plan Features	Employee	Spouse	Child(ren)
Maximum Amount	5x Annual earnings to a max of $500,000	$300,000	$2,500 to a max of $10,000
Board Members are limited to $100,000			
Guarantee Issue	$400,000	$30,000	$10,000
Guarantee Issue is only if you apply for coverage within 31 days of your initial eligibility. Coverage applied for outside of your initial 31 day window will require Evidence of Insurability.			
Age Reductions	65% at age 65 50% at age 70 35% at age 75	65% at age 65 50% at age 70 35% at age 75	N/A
Employee and Spouse Voluntary Life Monthly Rate per $1,000 of Coverage			
Under 25	$0.06	50 – 54	$0.22
25 – 29	$0.06	55 – 59	$0.37
30 – 34	$0.06	60 – 64	$0.44
35 – 39	$0.08	65 – 69	$0.72
40 – 44	$0.10	70 – 74	$1.35
45 – 49	$0.16	75+	$2.35
Child(ren): $0.225 per $2,500 increments regardless of the number of covered children			
Employee or Employee + Family Voluntary AD&D Monthly Rate Per $1,000 of Coverage			
Employee Only	$0.02	Example: $100,000 $0.02 x 100 = $2.00 per month	
Employee + Family	$0.02		

Monthly Premium Calculator							
$	/		x		=		
Benefit		$1,000		Rate			

Voluntary Short-Term Disability (STD)

Administered by Lincoln Financial Group

Short-Term Disability (STD) insurance provides income if you become disabled due to an injury or illness. Benefits begin on the fifteenth day of any injury, hospitalization or illness and can continue for up to 26 weeks.

Eligibility— All full-time employees and employees in an **eligible class** are eligible to enroll in Voluntary Short-Term Disability.

Total Disability— You are considered totally disabled if, due to an injury or illness, you are unable to perform each of the main duties of your regular occupation.

Partial Disability—You are considered partially disabled if you are unable, due to an injury or illness, to perform the main duties of your regular occupation on a full-time basis. Partial Disability benefits may be payable if you are earning at least 20% of the income you earned prior to becoming disabled, but not more then 99%. Partial Disability benefits allow you to work and earn income from your employer as well as continue to receive benefits, which may enable you to receive 100% of your income during your time of disability.

Attained Age	Monthly Rate (per $10 of covered benefit)
<30	$.324
30 – 34	$.314
35 – 39	$.293
40 – 44	$.293
45 – 49	$.324
50 – 54	$.366
55 – 59	$.439
60 – 64	$.523
65 – 69	$.607
70 – 74	$.669
75 – 99	$.711

Voluntary Short-Term Disability Benefits	
Weekly Benefit	66.67% of weekly salary
Maximum Weekly Benefit	$1,000 per week
Elimination Period	15th day for accident & illness
Maximum Benefit Duration	26 weeks
Pre-Existing Condition	12 months look-back / 12 not covered

Monthly Premium Calculator
Weekly salary x .667 x Monthly Rate ÷ 10 = Your monthly cost

Maximum covered payroll is $1,499 weekly. This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Long-Term Disability (LTD)

Administered by LifeMap

Long-Term Disability is intended to protect your income for a long duration after you have depleted Short-Term Disability or any sick leave your company may offer. Washington County School District provides Long-Term Disability Insurance (LTD) coverage for you at no cost.

Eligibility

All full-time employees in an **eligible class** are automatically enrolled in Long-Term Disability. At will employees are not eligible.

Group Long-Term Disability	
Weekly Benefit	66.67% of salary
Maximum Monthly Benefit	$10,000 per month
Elimination Period	180 days
Maximum Benefit Period	Later of age 65 or social security normal retirement age
Own Occupation Period	24 months
Pre-Existing Condition Limitation	3 months look-back / 12 not covered

Understanding Your Benefits

Own Occupation— The occupation, trade or profession you were employed in prior to your disability as defined by the US DOL Dictionary of Occupational Titles.

Total Disability— You are considered totally disabled if, due to an injury or illness, you are unable to perform each of the main duties of your own occupation. Your "own" occupation is covered for a specific period of time. Following this, the definition of total disability becomes the inability to perform any occupation for which you are reasonably suited based on your experience, education or training.

Partial Disability— You are considered partially disabled if you are unable, due to an injury or illness, to perform the main duties of your regular occupation on a full-time basis. Partial Disability benefits may be payable if you are earning at least 20% of the income you earned prior to becoming disabled, but not more than 99%. Partial disability benefits all you work and earn in income from your employer as well as continue to receive benefits, which may enable you to receive 100% of your income during your time of disability.

Pre-Existing Condition— Any sickness or injury for which you have received medical treatment, consultation, care, or services (including diagnostic measures or the taking of prescribed medications) during the specified months prior to the coverage effective date. A disability arising from any sickness or injury will be covered only if it begins after you have performed your regular occupation on a full-time basis for the specified months following the coverage effective date.

Benefit Exclusions

You will not receive benefits in the following circumstances:

- Your disability is the result of a self-inflicted injury
- You are not under the regular care of a doctor when requesting disability benefits
- You were involved in a felony commission, act of war, or participation in a riot
- You were residing outside of the U.S. or Canada for more than 12 consecutive months for purposes other than employment with your Employer.

Group Voluntary Accident (off the job)

Administered by Aflac

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

The plan has limitations and exclusions that may affect benefits payable. Below is for illustrative purposes only and is not a complete list of benefits payable. Refer to your certificate for complete details, definitions, limitations, and exclusions.

Monthly Premium			
Employee Only	Employee & Spouse	Employee & Child(ren)	Family
$12.61	$18.46	$25.87	$31.72

Group Voluntary Critical Illness

Administered by Aflac

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

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

Monthly Premium

Employee Amounts				
	Non-Tobacco		Tobacco	
Ages	$15,000	$30,000	$15,000	$30,000
18-29	$7.30	$12.85	$11.05	$20.35
30-39	$11.95	$22.15	$19.30	$36.85
40-49	$22.45	$43.15	$45.25	$88.75
50-59	$39.15	$76.55	$76.75	$151.75
60-69	$61.75	$121.75	$121.75	$241.75

Spouse Amounts				
	Non-Tobacco		Tobacco	
Ages	$15,000	$30,000	$15,000	$30,000
18-29	$4.53	$7.30	$6.40	$11.05
30-39	$6.85	$11.94	$10.53	$19.30
40-49	$12.10	$22.45	$23.50	$45.25
50-59	$20.45	$39.15	$39.25	$76.75
60-69	$31.75	$61.75	$61.75	$121.75

Group Voluntary Hospital Indemnity Plan

Administered by Aflac

The Aflac Group Hospital Indemnity plan provides financial assistance to enhance your current coverage. This plan may help you avoid dipping into your savings or having to borrow to address out-of-pocket expenses major medical insurance was never intended to cover; like transportation and meals for family members, help with child care, or time away from work.

The Aflac Group Hospital Indemnity Plan benefits include the following:

» Hospital confinement benefit

» Hospital admission benefit

» Hospital intensive care benefit

» Intermediate intensive care step-down unit

Monthly Premium			
Employee Only	Employee & Spouse	Employee & Child(ren)	Family
$33.14	$67.97	$57.52	$92.35

Insurance Eligibility

Health Insurance benefits are offered to all employees, as described in District Policy 1200, section 3.2.7. "All full-time employees who are eligible for health insurance coverage under the Patient Protection and Affordable Care Act will be enrolled. Eligible employees who work 30 hours or more, but less than full-time, must pay a portion of the premium consistent with the fractional amount of their part-time FTE or part-time hours worked. Variable hour employees whose service cannot be determined to work on average at least 30 hours per week will be subject to completion of a 12 month look-back measure period for enrollment to determine whether the employee is reasonably expected to work on average at least 30 hours or more per week." See premium schedule (see chart below) or access the benefit calculator at: http://timekeeping.admin.washk12.org/insurancecalc.html.

In the event the District employs two members of a single family who meet all eligibility requirements for insurance coverage, the family will be eligible to apply for a District-established insurance supplement. The Health Reimbursement Account is designed to reimburse up to a total of $1,200 per insurance contract year for copays or deductibles not covered under the primary insurance policy, based on District Policy 1200.

Monthly Rates for Benefits

Without the wellness Premiums

Benefit Plan	Total Premium	Employee Contribution 40 hrs/1FTE	Employee Contribution 35 hrs/.875FTE	Employee Contribution 30 hrs/.7143FTE	COBRA
Medical – HSA Health Plan					
Employee	$376.10	$0.00	$0.00	$0.00	$383.62
Two-Party	$844.80	$0.00	$105.60	$211.20	$861.70
Family	$1,197.10	$0.00	$149.64	$299.27	$1,221.04
HSA Employer Contribution		$950*	$950*	$950*	
Medical – BluePoint Traditional Health Plan					
Employee	$438.10	$29.90	$80.92	$131.95	$446.86
Two-Party	$984.00	$69.70	$183.99	$298.27	$1,003.68
Family	$1,394.50	$99.00	$260.94	$422.88	$1,422.39
Dental					
Employee	$27.10	$0.00	$3.39	$6.78	$27.64
Two-Party	$50.90	$0.00	$6.36	$12.72	$51.92
Family	$94.90	$0.00	$11.86	$23.73	$96.80
Basic Life Plan					
Single	$2.33	$0.00	$0.29	$0.58	Portable
Family	$0.61	$0.00	$0.37	$0.73	Portable

*HSA Employer Contribution amount will be pro-rated based upon hire date.

Insurance rate information is estimation only. Employee premiums will be pro-rated based on the fractional amount for certified teachers based on the hourly amount for classified employees. See District Policy 1200, section 3.2.7

Meets ACA Affordability Safe Harbor with Minimum Essential Coverage and Minimum Value.

» If you work different hours than what is listed above, please use the District's Insurance Plan Calculator to calculate your exact monthly premium. **https://employeeonline.washk12.org/insurancecalc/index.html**

Important Notices and Disclosures

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan.

If you would like more information on WHCRA benefits, please contact your plan administrator.

Newborn's Act Disclosure

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

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

HIPAA Special Enrollment Rights

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

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

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

Qualified Medical Child Support Orders

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

CHIPRA State Premium Assistance

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, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid 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 a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1.877.KIDS NOW or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or by call toll free 1.866.444.EBSA (3272).

UTAH – Medicaid and CHIP

Websites:

Medicaid: http://health.utah.gov/medicaid

CHIP: http://health.utah.gov/chip

Phone: 866.435.7414

To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/ebsa

866.444.EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

877.267.2323, Menu Option 4, Ext. 61565

Employee Retirement Income Security Act of 1974 (ERISA)

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

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

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

HIPAA Privacy Notice

This notice describes how medical information about you may be used and disclosed by the employer and its affiliates, if any, and how you can get access to this information as mandated for health plans that are subject to HIPAA. Please review it carefully.

The Health Insurance and Portability and Accountability Act of 1996 (HIPAA) requires certain health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information (45 Code of Federal Regulations parts 160 and 164). Where HIPAA applies to a health plan sponsored by the Employer, this document is intended to satisfy HIPAA's notice requirement for all health information created, received, or maintained by the Employer-sponsored health plans (the plans). The regulations will supersede any discrepancy between the information in this notice and the regulations.

The plans need to create, receive, and maintain records that contain health information about you to administer the plans and provide you with health care benefits. This notice describes the plans' health information privacy policy for your health care, dental, personal spending account and flexible reimbursement account benefits. The notice tells you the ways the plans may use and disclose health information about you, describes your rights, and the obligations the plans have regarding the use and disclosure of your health information. It does not address the health information policies or practices of your health care providers.

Our Commitment Regarding Health Information Privacy

The privacy policy and practices of the plans protect confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information' (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by Federal and State health information privacy laws.

Privacy Obligations of the Plans

The plans are required by law to: (a) make sure that health information that identifies you is kept private; (b) give you this notice of the plans' legal duties and privacy practices for health information about you; and (c) follow the terms of the notice that is currently in effect.

How the Plans May Use and Disclose Health Information about You

The following are the different ways the plans may use and disclose your PHI without your written authorization:

For Treatment. The plans may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the plans may advise an emergency room physician about the types of prescription drugs you currently take.

For Payment. The plans may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the terms of the plans. For example, the plans may receive and maintain information about surgery you received to enable the plans to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.

For Health Care Operations. The plans may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the plans' participants receive their health benefits. For example, the plans may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the plans may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The plans may also combine health information about many plan participants and disclose it to the Employer and its affiliates, if any, in summary fashion so it can decide what coverages the plans should provide. The plans may remove information that identifies you from health information disclosed so it may be used without the Employer's learning who the specific participants are.

To the Employer. The plans may disclose your PHI to designated Employer personnel so they can carry out their plan-related administrative functions, including the uses and disclosures descried in this notice. Such disclosures will be made only to the Employer's Privacy Officer and

personnel under the Privacy Officer's supervision. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: 1) may not be disclosed by the plans to any other employee and 2) will not be used by the Employer for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the Employer.

To a Business Associate. Certain services are provided to the plans by third-party administrators known as "business associates." For example, the plans may input information about your health care treatment into an electronic claim processing system maintained by the business associate so your claim may be paid. In so doing, the plans will disclose your PHI to its business associate so it can perform its claims payment function. However, the plans will require its business associates, through contract, to appropriately safeguard your health information.

Treatment Alternatives. The plans may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. The plans may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Individual Involved in Your Care or Payment of Your Care. The plans may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The plans may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.

As Required by Law. The plans will disclose your PHI when required to do so by Federal, State, or local law, including those that require the reporting of certain types of wounds or physical injuries.

To the Secretary of the Department of Health and Human Services (HHS). The plans may disclose your PHI to HHS for the investigation or determination of compliance with privacy regulations.

Special use and Disclosure Situations

The plans may also use or disclose your PHI under the following circumstances:

Lawsuits and Disputes. If you become involved in a lawsuit or other legal action, the plans may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

Law Enforcement. The plans may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims. or the identity, description, or location of the person who committed the crime.

Worker's Compensation. The plans may disclose your PHI to the extent authorized by and to the extent necessary to comply with worker's compensation laws and other similar programs.

Military and Veterans. If you are or become a member of the U.S. armed forces, the plans may release medical information about you as deemed necessary by military command authorities.

To Avert Serious Threat to Health or Safety. The plans may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

Public Health Risks. The plans may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.

Health Oversight Activities. The plans may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.

Research. Under certain circumstances, the plans may use and disclose your PHI for medical research purposes.

National Security, Intelligence Activities, and Protective Services. The plans may release your PHI to authorized Federal officials: 1) for intelligence, counterintelligence, and other national security activities authorized by law and 2) to enable them to provide protection to the members of the U. S. government or foreign heads of state, or to conduct special investigations.

Organ and Tissue Donation. If you are an organ donor, the plans may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Coroners, Medical Examiners, and Funeral Directors. The plans may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The plans may also release your PHI to a funeral director, as necessary, to carry out his or her duty.

Your Rights Regarding Health Information About You

Your rights regarding the health information the plans maintain about are as follows:

Right to Inspect and Copy. You have the right to inspect and copy your PHI. This includes information about your plan eligibility, claim and appeal records, and billing

records, but does not include psychotherapy notes. To inspect and copy health information maintained by the plans, submit your request in writing to the Privacy Officer. The plans may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the plans may deny your request to inspect and coy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

Right to Amend. If you feel that health information the plans have about you is incorrect or incomplete, you may ask to amend it. You have the right to request an amendment for as long as the information is kept by or for the plans. To request an amendment, send a detailed request in writing to the Privacy Officer. You must provide the reason(s) to support your request. The plans may deny your request if you ask to amend health information that was: accurate and complete, not created by the plans; not part of the health information kept by or for the plans; or not information that you would be permitted to inspect or copy.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures". This is a list of disclosures of your PHI that the plans have made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; disclosures made prior to this effective date at the end of this notice; or in certain other situations. To request an accounting of disclosures, submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six years prior to the date the account was requested.

Right to Request Restrictions. You have the right to request a restriction on the health information the plans use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the plans disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. For example, you could ask that the plans not use or disclose information about a surgery you had. To request restrictions, make your request in writing to the Privacy Officer. You must advise us: 1) what information you want to limit; 2) whether you want to limit the plans' use, disclosure, or both; and 3) to whom you want the limit(s) to apply. Note: The plans are not required to agree to your request.

Right to Request Confidential Communications. You have the right to request that the plans communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the plans send you explanation of benefits (EOB) forms about your benefit claims to a specified address. To request confidential communications, make your request in writing to the Privacy Officer. The plans will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

A Note About Personal Representatives

You may exercise your rights through a personal authorized representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The plans retain discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Change to this Notice

The plans reserve the right to change this notice at any time and to make the revised or changed notice effective for health information the plans already have about you, as well as any information the plans receive in the future. The plans will post a copy of the current notice in the Employer's office. All individuals covered under the Plan will receive a revised notice within 60 days of a material revision to the notice.

Notice of Breach of PHI

You have a right to receive a notice when there is a breach of your unsecured PHI.

Complaints

If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Privacy Officer at the address listed below. Alternatively, you may file a complaint with the Secretary of the U. S. Department of Health and Human Services (Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington D.C. 20201), generally within 180 days of when the act or omission complained of occurred. Note: The plans, the Employer, and nay of its affiliates will not retaliate against you for filing a complaint.

Other Uses and Disclosures of Health Information

A plan must obtain your written authorization to use or disclose psychotherapy notes, to use PHI for marketing purposes, or to sell PHI. An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use and disclosure of psychotherapy notes.

Plans (excluding long-term care plans) are prohibited from using or disclosing PHI that is genetic information for underwriting purposes.

Other uses and disclosures of health information not covered by this notice or by the laws that apply to the plans will be made only with your written authorization. If you authorize the plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you authorize the plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the plans will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the plans will not reverse any uses or disclosures already made.

Contact Information: If you have any questions about this notice, please contact the Privacy Officer at the Employer, Attention: Privacy Officer.

Updated and effective March 26, 2013

Prescription Drug Coverage and Medicare

Date of this Notice: October 2016

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

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

» Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

» Washington County School District has determined that the prescription drug coverage offered by Washington County School District 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 (penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-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 Washington County School District coverage will be affected. If you do decide to enroll in a Medicare prescription drug plan and drop your Washington County School District prescription drug coverage, be aware that you may not be able to get this coverage back.

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

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 Washington County School District and do not 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, please contact Human Resources.

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 and You handbook. You will receive a copy of the handbook in the

mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

» Visit www.medicare.gov.

» Call your State Health Insurance Assistance Program (see inside back cover of your copy of the Medicare and 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.

Remember to 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).

Mental Health Parity Notice

The Mental Health Parity Act (MHPA) provides for parity in the application of aggregate lifetime and annual dollar limits on mental health benefits with dollar limits on medical/surgical benefits. In general, group health plans offering mental health benefits cannot set annual or lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical/surgical benefits.

A plan that does not impose an annual or lifetime dollar limit on medical/surgical benefits may not impose such a dollar limit on mental health benefits under the plan. MHPA's provisions, however, do not apply to benefits for substance abuse or chemical dependency.

For more information about mental health coverage under your plan, please refer to the plan's Summary Plan Description (SPD). You may obtain a copy of the SPD by contacting Human Resources.

Family & Medical Leave Act (FMLA)

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

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

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

Circumstances Permitting Family and Medical Leave

» Birth of an employee's child (within 12 months after birth)

» Adoption of a child by an employee (within 12 months after placement)

» Placement of a child with the employee for foster care (within 12 months after placement)

» Care of a child, spouse or parent having a serious health condition

» Incapacity of the employee due to a serious health condition.

» Military Leave

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

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

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

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Contact Information

If you have specific questions about any of the benefit plans, please contact the administrator listed below, or your local human resources department.

Benefit	Administrator	Phone	Website
Medical	Regence BlueCross BlueShield	866.240.9580	www.regence.com
Dental	EMI Health	800.662.5851	www.emihealth.com
Life and AD&D Insurance	LifeMap	800.286.1129	www.lifemapco.com
Long-Term Disability	LifeMap	800.286.1129	www.lifemapco.com
Voluntary Vision	Opticare of Utah	800.363.0950	www.opticareofutah.com
Voluntary Life and AD&D Insurance	LifeMap	800.286.1129	www.lifemapco.com
Voluntary Short-Term Disability	Lincoln Financial Group	800.423.2765	www.lfg.com
Flexible Spending Account	National Benefit Services	800.274.0503	www.nbsbenefits.com
Health Savings Account	Health Equity	866.346.5800	www.healthequity.com
Accident, Critical Illness & Hospital Indemnity	AFLAC	800.433.3036	www.aflacgroupinsurance.com
Arthur J. Gallagher & Co. – Advisors	Leah Dunn	801.559.2929	leah_dunn@ajg.com
APA Benefits	COBRA	801.561.4980	info@apabenefits.com
Retirement Planning	Utah Retirement Services (URS)	800.950.4877 435.673.6300	www.urs.org

WCSD Human Resources & Payroll	Contact
WCSD	435.673.3553 Phone 435.673.3216 Fax
Benefits Specialist & Wellness	Tammara Robinson x5119
Attendance & Medical Leave	Amanda Amaya x5116
Fingerprinting & Background Check	Heather Wade x5115
Elementary Secretary	Mandi Peck x5122
Secondary Secretary	Denise Thompson x5121
Risk Management Specialist	Michael Lee x5110
Position Specialist	Kesha Schultz x5117
Licensing & Extra Duty	Terri Hendrix x5114
Payroll	Laurie Rich x5103 for certified Kathy Adams x5118 for classified
Business Plus Employee On-line	Tennille Mills x5102

This benefit summary prepared by

Arthur J. Gallagher & Co.