Employee Benefits

Everything you need to know about your employee benefits for the August 1, 2023-July 31, 2024 plan year

2022-2023 Employee Benefits

If you have questions regarding...	Contact	Call	Click
Medical Insurance	EMI Health	(800) 662-5851	www.emihealth.com
Telemedicine	EMI Health/Recuro	(855) 673-2876	www.emihealth.com
Dental Insurance	EMI Health	(800) 662-5851	www.emihealth.com
Vision Insurance	Opticare Vision	(800) 363-0950	www.opticarevisionservices.com
Health Savings Account	Health Equity	(866) 346-5800	www.healthequity.com
Flexible Spending Account	National Benefits Services	(800) 274-0503	www.nbsbenefits.com
Life & AD&D Insurance	USAble	(855) 207-2008	Custserv@usablelife.com www.USAblelife.com
Short-Term/Long-Term Disability	Lincoln Financial	(800) 423-2765 Customer Service	www.lfg.com
Voluntary Benefits	Voya	(877) 236-7564	https://presents.voya.com/EBRC/WashingtonCountySchoolDistrict
Employee Assistance Program (EAP)	Lincoln Financial	(866) 628-4824	www.guidanceresources.com
Tava		(877) 236-7564	https://care.tavahealth.com/signup
Chronic Health Condition Program	Kannact	(888) 828-7898	https://kannact.com/wcsd
Retirement Planning	Utah Retirement Systems (URS)	(800) 950-4877 (435) 673-6300	www.urs.org
Insurance Advisors	Group Benefits Services (GBS)	(435) 879-7889 Emilyann Peinamalie	Emilyann.peinamalie@gbsbenefits.com
COBRA Advisors	GBS Benefits Compliance Services	(801) 842-0148 Lorie Brown	lorie.brown@gbsbenefits.com
WCSD Human Resources & Payroll		(435) 673-3553 Phone (435) 673-3216 Fax	www.washk12.org
Benefit Coordinator		Tammara Robinson x5119	tammara.robinson@washk12.org
Benefit & Accounting		Marci Ware x5105	marci.ware@washk12.org
Wellness		Mitzi Lytle X5120	wcsd_wellness@washk12.org
Attendance & Medical Leave		Amanda Amaya x5116	amanda.amaya@washk12.org
Risk Management Specialist		Michael Lee x5110	michael.lee@washk12.org
Payroll		Tennille Mills certified x 5102 Misti Boulard classified x5118 Crystal Gorley classified x5120	tennille.mills@washk12.org Misti.boulard@washk12.org crystal.gorley@washk12.org

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What's Inside

This guide provides information for consideration when newly enrolling, changing your elections, or reenrolling in our benefit programs.

Important Information

Washington County School District

Washington County School District Benefits and You

Welcome

We are committed to providing our employees with quality benefit programs that are comprehensive, flexible and affordable. Giving our employees the best in benefit plans is one way we can show you that as an employee, YOU are our most important asset. Eligible employees have many benefit plans to choose from, so we ask that you read this benefits guide carefully to help you make the benefit elections that are the best fit for you and your family.

Know Your Benefits

Making wise decisions about your benefits requires planning. By selecting benefits that provide the best care and coverage, you can optimize their value and minimize the impact to your budget. The best thing you can do is "shop" for benefits carefully, using the same type of decision-making process you use for other major purchases.

› Take Advantage Of The Tools Available

That includes this guide, access to plan information, provider directories, and enrollment materials.

› Be a Smart Shopper

If you were buying a car or purchasing a home, you would do a lot of research beforehand. You should do the same for benefits.

› Don't Miss the Deadline and Keep Record of Your Enrollment

Pay attention to the enrollment deadline and be sure to provide us with your benefit elections in a timely manner. It is important to review your paycheck to ensure the accuracy of payroll deductions. Notify us immediately if there are any discrepancies. **Remember:** Once the enrollment period has ended, you may not make or change your benefit elections, unless you experience a qualified life event.

Summary of Benefits and Coverage (SBC) and Uniform Glossary

In addition to the plan information in this Benefits Guide, you can also review a Summary of Benefits and Coverage for each medical plan. This requirement of the ACA standardizes health plan information so that you can better understand and compare plan features. We will automatically provide you a copy of the SBC annually during open enrollment.

For the most up-to-date information regarding the ACA, please visit www.healthcare.gov.

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 Insurance
  Choose one of two plan options
- Health Savings Account
- Flexible Spending Account
- Dental Insurance
- Basic Group Term Life Insurance
- Optional AD&D life Insurance & Vol Optional Life
- Short Term Disability
- Long Term Disability
- Voluntary Vision Insurance
- Voluntary Insurance (Voya)

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 web-site 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 web-site addresses are listed on the back cover of this guide.

Keep in mind, learning module is available to access the carrier websites. Please go to https://courses.gbsbenefits.com/WCSD-OpenEnrollment-2023

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 2023 - April 28, 2023 New this year.*** Open Enrollment 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, and Flex Spending. 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 2023-2024 school years, you will need to complete the appropriate paper form by Friday, April 28, 2023.

Timeline & Events for Open Enrollment

- **Monday, April 17, 2023 - Open Enrollment Begins**
- **Friday, April 28, 2023- Open Enrollment Ends**
- **Monday, August 1, 2023 - Changes made during open enrollment become effective.**

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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

Who is Eligible?

If you are hired as a full-time employee working 30 or more hours per week, coverage will begin on the first day of the month following 30 days of qualified employment. You may also enroll your eligible dependents in the same plans you choose for yourself. Eligible dependents include your legal spouse and your natural, adopted or step-child(ren). The dependent age limit for children on your medical plan is age 26, but may vary for other benefits offered.

How We Define Medical Benefits Eligibility

We are a large employer according to the Employer Shared Responsibility provisions of the ACA. The enrollment guidelines listed in this guide may vary if you are hired to work less than 30 hours per week (130 hours per month) or your hours worked drop below the threshold. Please contact us for our complete policy on Measurement Methods to determine full-time benefits eligibility status under the Employer Shared Responsibility.

When to Enroll

You can enroll for coverage as a new hire, or during our annual open enrollment period. Outside of the annual open enrollment period, the only time you can change your coverage is if you experience a qualifying life event. Employees who decline coverage, or fail to enroll for coverage, at their initial eligibility shall be subject to insurance benefit restrictions as outlined in the insurance contracts.

How to Make Changes

Once you enroll in or decline benefits, you will not be able to make any changes to your elections until our next annual open enrollment period, unless you experience a qualified life event. Qualified life events include, but are not limited to:

- Change in your legal marital status
- Birth, adoption, placement for adoption or legal guardianship of a child
- Death of a dependent
- Change in child's dependent status
- You or your dependent(s) become eligible or lose eligibility for Medicaid or the Children's Health Insurance Program (CHIP)
- Change in your dependent's employment resulting in loss or gain of eligibility for employer coverage
- A court or administrative order

If your qualified life event is due to loss or gain of Medicaid or CHIP coverage, you have **60 days** to complete the necessary enrollment forms and return them to us. All other qualified life events must be reported to us within **30 days** of the event. It is your responsibility to notify us when you have a qualified life event and would like to make changes to your benefit elections. Please do not miss this important deadline!

When Coverage Ends

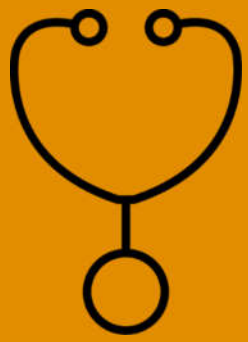
For most benefits, coverage will end on the last day of the month in which your regular work schedule is reduced to fewer than 30 hours per week, your employment ends, or you stop paying your share of the coverage. Your dependent(s) coverage ends when your coverage ends, or the last day of the month in which the dependent is no longer eligible. Certain benefits may terminate on the date of event.

Section 125 Flexible Spending Benefit Plan Enrollment:

For participation in the Section 125 Flexible Benefit Plan from August 1, 2023 through July 31, 2024, you **must complete** enrollment via Paper Application. 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, 2023.**

Limited-Purpose FSA: This type of FSA can be used in conjunction with a health savings account (HSA). A limited-purpose FSA (LPFSA) allows you to contribute pre-tax dollars to use for dental and/or vision expenses only. This allows you to maximize your pre-tax HSA contributions and contribute additional pre-tax dollars to an LPFSA.

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. This does not affect the Flex Plan for Dependent Child Care.



Medical

EMI - Care Plus Network
$1,500 Traditional Plan
Option 1

EMI HEALTH™

Administered by Educators Mutual Insurance Association
EMI Health Customer Service 801-262-7475 or 1-800-662-5851
Self Funded Employee Medical Benefit Plan

All services are subject to the EMI Health Maximum Allowable Charge. When using a Non-participating Provider, the Covered Person is responsible for all fees in excess of the Maximum Allowable Charge.

Washington County School District August 01, 2023 - July 31, 2024 Option 1	**Care Plus**	
	Participating Provider Option	**Non-Participating Provider Option**
GENERAL INFORMATION	**YOU PAY**	
Benefit Accumulator	Contract Year	
Dependent Age Limit	26	
Out-of-Pocket Maximum (Per Person/Family Per Year). Please note *	$5,000 / $10,000	$10,000 / $20,000
Medical Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Prescription Drug Deductible). Please note ♦	$1,500 / $3,000	$3,000 / $6,000
Non-Preauthorization Patient Penalty	Not Applicable	50% Reduction in Benefits
Non-Preauthorization Provider Sanction	50% Reduction in Payment	Not Applicable
PRESCRIPTION DRUG BENEFITS (If brand is purchased when generic is available, member pays the copay plus the difference between the generic and the brand price)	**YOU PAY**	
Prescription Drug Deductible (Per Person/Family Per Year - Separate from and not satisfied by the Medical Deductible). Please note ●	$100	
Participating Pharmacy (30 day supply)	Generic - $10 ●Preferred - $25 ●Non-Preferred - $45	
Non-Participating Pharmacy	Not Covered	
Mail Order (90 day supply)	Generic - $10 ●Preferred - $50 ●Non-Preferred - $135	
Specialty Pharmacy (90 day supply) All fills must be purchased through Express Scripts Specialty Pharmacy.	●$100	
Specialty Pharmacy SaveOnSP Program 1-800-683-1074 http://emihealth.com/pdf/saveon.pdf	Must enroll to receive: *$0 Copay	
PREVENTIVE SERVICES	**YOU PAY**	
Routine Physical Exam (1 visit per Year)	Covered 100%	Not Covered
Routine Gynecological Exam (1 visit per Year)	Covered 100%	Not Covered
Family History Exam (1 visit per Year)	Covered 100%	Not Covered
Routine Pap Smear & Mammogram (1 per Year)	Covered 100%	Not Covered
Routine Well-Baby Exams	Covered 100%	Not Covered
Covered Immunizations	Covered 100%	Not Covered
Routine Vision Exam (1 visit per Year)	Covered 100%	Not Covered
Routine Hearing Exam (1 visit per Year)	Covered 100%	Not Covered
PHYSICIAN & PROFESSIONAL SERVICES	**YOU PAY**	
Physician Office Visits (primary care)	$30	♦40%
Physician Office Visits (secondary care)	$60	♦40%
Physician Office Visits (after hours)	$60	♦40%
Physician Visits (Inpatient)	♦20%	♦40%
Physician Visits (Outpatient)	♦20%	♦40%
Major Diagnostic Test, CT Scan, MRI, NMR (office)	♦20%	♦40%
Minor Diagnostic Test, Radiology, Lab (office)	Covered 100%	♦40%
Minor Diagnostic Test, Radiology, Lab (Inpatient)	♦20%	♦40%
Minor Diagnostic Test, Radiology, Lab (Outpatient)	Covered 100%	♦40%
Minor Diagnostic Test, Radiology, Lab (Ambulatory Surgical Center)	♦5%	♦40%
Injections (office)	Covered 100%	♦40%
Surgery (office)	Covered 100%	♦40%
Surgery (Inpatient)	♦20%	♦40%
Surgery (Outpatient)	♦20%	♦40%
Surgery (Ambulatory Surgical Center)	♦5%	♦40%
Anesthesiology (office)	Covered 100%	♦40%
Anesthesiology (Inpatient)	♦20%	♦40%
Anesthesiology (Outpatient)	♦20%	♦40%
Anesthesiology (Ambulatory Surgical Center)	♦5%	♦40%
Routine Prenatal & Delivery (Dependent maternity included)	♦20%	♦40%
Home Health and Hospice Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	♦20%	♦40%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary - 60 visits per Year per injury/illness)	$60	♦40%
Neurodevelopmental Therapy (Outpatient physical, speech and occupational – Ages birth thru 6, limited to 40 visits per Year)	$60	♦40%
Chiropractic Therapy (15 visits per Year)	$60	♦40%
Allergy Testing	20%	♦40%

Washington County School District August 01, 2023 - July 31, 2024 Option 1	Care Plus	
	Participating Provider Option	Non-Participating Provider Option
Allergy Treatment/Serum	20%	♦40%
HOSPITAL/FACILITY BENEFITS (Physician & Professional Services are not included in this section.)	**YOU PAY**	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	♦20%	♦40%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	♦20%	♦40%
Skilled Nursing Facility (30 days per Year) (Admission must be within 5 days of discharge from Hospital Confinement)	♦20%	♦40%
Medical/Surgical Care (Outpatient)	♦20%	♦40%
Medical/Surgical Care (Ambulatory Surgical Center)	♦5%	♦40%
Emergency Room (ER)	$325	$325
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	♦20%	♦40%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦20%	♦40%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	Covered 100%	♦40%
Minor Diagnostic Test, X-ray, Lab (Ambulatory Surgical Center)	♦5%	♦40%
Newborn	20%	40%
InstaCare/Urgent Care Clinic	$60	♦40%
Eligible Preventive Services	Covered 100%	Not Covered
REHABILITATION THERAPY BENEFIT	**YOU PAY**	
Inpatient – physical, speech, occupational, cardiac, or pulmonary (40 days per person per Year)	♦20%	♦40%
ACCIDENT AND LIFE THREATENING CONDITION	**YOU PAY**	
Medical/Surgical – Physician/Facility/ER	Covered as any other condition	Covered as a Participating Benefit to the Maximum Allowable Charge
Ambulance Land/Air (Accident & Life-threatening)	♦20%	
Orthodontic Injury Treatment	♦50%	
Dental Injury Treatment	♦20%	
TRANSPLANT BENEFIT	**YOU PAY**	
Heart, Liver, Pancreas, Bone Marrow, Cornea, Lung, Kidney	Covered as any other condition	Not Covered
MEDICAL SUPPLIES & EQUIPMENT	**YOU PAY**	
Diabetic Testing Supplies (90 day supply)	$50	♦40%
Medical Supplies	♦20%	♦40%
Medical Supplies (office)	Covered 100%	♦40%
Durable Medical Equipment/Prosthetics/Orthotic Devices	♦20%	♦40%
Hearing Aids ($2,500 per Year)	♦20%	♦40%
Orthotic Supplies (foot inserts & arch supports)	♦20%	♦40%
Growth Hormone	♦20%	♦40%
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT	**YOU PAY**	
Inpatient Services (non-residential)	♦20%	♦40%
Residential Treatment (30 days per Year)	♦20%	♦40%
Outpatient Services	♦20%	♦40%
Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist	$30	♦40%
ADDITIONAL BENEFITS	**YOU PAY**	
Adoption Indemnity Benefit	The Plan pays a maximum of $4,000 towards adoption expenses.	
TMJ Syndrome diagnosis & non-surgical treatment (Limited to $2000 per person per lifetime)	♦20%	♦40%
Orthognathic/Mandibular Osteotomy	♦20%	♦40%
Total Parenteral Nutrition (TPN)	♦20%	♦40%
Initial assessment and diagnosis of Primary Infertility (Limited to $5000 per Year)	♦50%	Not Covered
Reduction Mammoplasty	♦20%	♦40%
Autism Applied Behavior Analysis	♦20%	♦40%
Nutritional Counseling (Limited to 3 visits per person per lifetime)	♦20%	♦40%

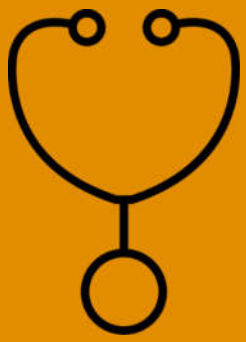
Services designated ● are subject to first dollar Prescription Drug Deductible.

Services designated ♦ are subject to first dollar Medical Deductible

Services designated *, premiums, balance-billed charges, charges for services this Plan doesn't cover, amounts in excess of benefit limits, and penalties for failure to obtain Preauthorization, do not accumulate toward your Out-of-pocket Maximum.

PROVIDER NETWORK	
Utah	EMI Health Care Plus
Outside of Utah	Cigna PPO

PLEASE NOTE: This is a summary only and does not guarantee benefits. All benefits are subject to the terms, limitations, and exclusions set forth in the Plan document and in the Summary Plan Description (SPD)/handbook of the Plan. Any discrepancies between this summary, the SPD/handbook, and the Plan document are resolved in favor of the Plan document. For more information, including Preauthorization, refer to the SPD/ handbook or the Plan document, or contact EMI Health Customer Service Department.



Medical

EMI - Care Plus Network
HSA - $2,000 High Deductible Health Plan
Option 2

All services are subject to the EMI Health Maximum Allowable Charge. When using a Non-participating Provider, the Covered Person is responsible for all fees in excess of the Maximum Allowable Charge.

Washington County School District August 01, 2023 - July 31, 2024 Option 2 QHDHP	Care Plus	
	Participating Provider Option	Non-Participating Provider Option
GENERAL INFORMATION	**YOU PAY**	
Benefit Accumulator	Contract Year	
Dependent Age Limit	26	
Employee Only Coverage		
Out-of-Pocket Maximum (Per Year)	$5,000	$6,500
Medical Deductible (Per Year). Please note ♦	$2,000	$2,250
Two Party and Family Coverage		
Out-of-Pocket Maximum (Per Person/Family Per Year)	$5,000 / $10,000	$6,500 / $13,000
Medical Deductible (Per Year). Please note ♦	$4,000	$4,500
Non-Preauthorization Patient Penalty	Not Applicable	50% Reduction in Benefits
Non-Preauthorization Provider Sanction	50% Reduction in Payment	Not Applicable
PRESCRIPTION DRUG BENEFITS (If brand is purchased when generic is available, member pays the copay plus the difference between the generic and the brand price)	**YOU PAY**	
Participating Pharmacy (30 day supply) Deductible waived for medications on the Exclusive Maintenance Drug list found at http://emihealth.com/pdf/Exclusive.pdf	♦Generic - $7 ♦Preferred - $21 ♦Non-Preferred - $42	
Non-Participating Pharmacy	Not Covered	
Mail Order (90 day supply) Deductible waived for medications on the Exclusive Maintenance Drug list found at http://emihealth.com/pdf/Exclusive.pdf	♦Generic - $7 ♦Preferred - $42 ♦Non-Preferred - $126	
Specialty Pharmacy (90 day supply) All fills must be purchased through Express Scripts Specialty Pharmacy.	♦$100	
Specialty Pharmacy SaveOnSP Program 1-800-683-1074 http://emihealth.com/pdf/saveon.pdf	Must enroll to receive: *$0 Copay	
PREVENTIVE SERVICES	**YOU PAY**	
Routine Physical Exam (1 visit per Year)	Covered 100%	Not Covered
Routine Gynecological Exam (1 visit per Year)	Covered 100%	Not Covered
Family History Exam (1 visit per Year)	Covered 100%	Not Covered
Routine Pap Smear & Mammogram (1 per Year)	Covered 100%	Not Covered
Routine Well-Baby Exams	Covered 100%	Not Covered
Covered Immunizations	Covered 100%	Not Covered
Routine Vision Exam (1 visit per Year)	Covered 100%	Not Covered
Routine Hearing Exam (1 visit per Year)	Covered 100%	Not Covered
PHYSICIAN & PROFESSIONAL SERVICES	**YOU PAY**	
Physician Office Visits (primary care)	♦20%	♦40%
Physician Office Visits (secondary care)	♦20%	♦40%
Physician Office Visits (after hours)	♦20%	♦40%
Physician Visits (Inpatient)	♦20%	♦40%
Physician Visits (Outpatient)	♦20%	♦40%
Major Diagnostic Test, CT Scan, MRI, NMR (office)	♦20%	♦40%
Minor Diagnostic Test, Radiology, Lab (office)	♦20%	♦40%
Minor Diagnostic Test, Radiology, Lab (Inpatient)	♦20%	♦40%
Minor Diagnostic Test, Radiology, Lab (Outpatient)	♦20%	♦40%
Minor Diagnostic Test, Radiology, Lab (Ambulatory Surgical Center)	♦5%	♦40%
Injections (office)	♦20%	♦40%
Surgery (office)	♦20%	♦40%
Surgery (Inpatient)	♦20%	♦40%
Surgery (Outpatient)	♦20%	♦40%
Surgery (Ambulatory Surgical Center)	♦5%	♦40%
Anesthesiology (office)	♦20%	♦40%
Anesthesiology (Inpatient)	♦20%	♦40%
Anesthesiology (Outpatient)	♦20%	♦40%
Anesthesiology (Ambulatory Surgical Center)	♦5%	♦40%
Routine Prenatal & Delivery (Dependent maternity included)	♦20%	♦40%
Home Health and Hospice Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment)	♦20%	♦40%
Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary - 60 visits per Year per injury/illness)	♦20%	♦40%
Neurodevelopmental Therapy (Outpatient physical, speech and occupational – Ages birth thru 6, limited to 40 visits per Year)	♦20%	♦40%
Chiropractic Therapy (15 visits per Year)	♦20%	♦40%
Allergy Testing	♦20%	♦40%

Washington County School District August 01, 2023 - July 31, 2024 Option 2 QHDHP	Care Plus	
	Participating Provider Option	Non-Participating Provider Option
Allergy Treatment/Serum	♦20%	♦40%
HOSPITAL/FACILITY BENEFITS (Physician & Professional Services are not included in this section.)	**YOU PAY**	
Medical/Surgical/Maternity/Intensive Care (semi-private room)	♦20%	♦40%
Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary)	♦20%	♦40%
Skilled Nursing Facility (30 days per Year) (Admission must be within 5 days of discharge from Hospital Confinement)	♦20%	♦40%
Medical/Surgical Care (Outpatient)	♦20%	♦40%
Medical/Surgical Care (Ambulatory Surgical Center)	♦5%	♦40%
Emergency Room (ER)	♦20%	♦20%
Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient)	♦20%	♦40%
Minor Diagnostic Test, X-ray, Lab (Inpatient)	♦20%	♦40%
Minor Diagnostic Test, X-ray, Lab (Outpatient)	♦20%	♦40%
Minor Diagnostic Test, X-ray, Lab (Ambulatory Surgical Center)	♦5%	♦40%
Newborn	♦20%	♦40%
InstaCare/Urgent Care Clinic	♦20%	♦40%
Eligible Preventive Services	Covered 100%	Not Covered
REHABILITATION THERAPY BENEFIT	**YOU PAY**	
Inpatient – physical, speech, occupational, cardiac, or pulmonary (40 days per person per Year)	♦20%	♦40%
ACCIDENT AND LIFE THREATENING CONDITION	**YOU PAY**	
Medical/Surgical – Physician/Facility/ER	Covered as any other condition	Covered as a Participating Benefit to the Maximum Allowable Charge
Ambulance Land/Air (Accident & Life-threatening)	♦20%	
Orthodontic Injury Treatment	♦20%	
Dental Injury Treatment	♦20%	
TRANSPLANT BENEFIT	**YOU PAY**	
Heart, Liver, Pancreas, Bone Marrow, Cornea, Lung, Kidney	Covered as any other condition	Not Covered
MEDICAL SUPPLIES & EQUIPMENT	**YOU PAY**	
Diabetic Testing Supplies (90 day supply)	♦$42	♦40%
Medical Supplies	♦20%	♦40%
Medical Supplies (office)	♦20%	♦40%
Durable Medical Equipment/Prosthetics/Orthotic Devices	♦20%	♦40%
Hearing Aids ($2,500 per Year)	♦20%	♦40%
Orthotic Supplies (foot inserts & arch supports)	♦20%	♦40%
Growth Hormone	♦20%	♦40%
MENTAL HEALTH & DRUG/ALCOHOL TREATMENT	**YOU PAY**	
Inpatient Services (non-residential)	♦20%	♦40%
Residential Treatment (30 days per Year)	♦20%	♦40%
Outpatient Services	♦20%	♦40%
Physician Office Visits Psychologist / LCSW / APRN / Psychiatrist	♦20%	♦40%
ADDITIONAL BENEFITS	**YOU PAY**	
Adoption Indemnity Benefit	The Plan pays a maximum of $4,000 towards adoption expenses.	
TMJ Syndrome diagnosis & non-surgical treatment (Limited to $2000 per person per lifetime)	♦20%	♦40%
Orthognathic/Mandibular Osteotomy	♦20%	♦40%
Total Parenteral Nutrition (TPN)	♦20%	♦40%
Initial assessment and diagnosis of Primary Infertility (Limited to $5000 per Year)	♦50%	Not Covered
Reduction Mammoplasty	♦20%	♦40%
Autism Applied Behavior Analysis	♦20%	♦40%
Nutritional Counseling (Limited to 3 visits per person per lifetime)	♦20%	♦40%

Services designated ♦ are subject to first dollar Medical Deductible

Services designated *, premiums, balance-billed charges, charges for services this Plan doesn't cover, amounts in excess of benefit limits, and penalties for failure to obtain Preauthorization, do not accumulate toward your Out-of-pocket Maximum.

PROVIDER NETWORK	
Utah	EMI Health Care Plus
Outside of Utah	Cigna PPO

PLEASE NOTE: This is a summary only and does not guarantee benefits. All benefits are subject to the terms, limitations, and exclusions set forth in the Plan document and in the Summary Plan Description (SPD)/handbook of the Plan. Any discrepancies between this summary, the SPD/handbook, and the Plan document are resolved in favor of the Plan document. For more information, including Preauthorization, refer to the SPD/ handbook or the Plan document, or contact EMI Health Customer Service Department.

This represents a list of maintenance medications that are covered prior to having met the medical deductible for those enrolled in the Washington County School District High Deductible Health Plan (HDHP).

Exclusive Maintenance Drug List

ANTICONVULSANTS
Carbamazepine tablets, chewable tablets
Carbamazepine suspension
Divalproex capsules
Divalproex DR tablets
Divalproex ER tablets
Ethosuximide capsules, solution
Gabapentin capsules, tablets
Lamotrigine IR tablets, chewable tablets
Levetiracetam tablets, solution
Levetiracetam ER tablets
Lithium carbonate capsules, tablets
Lithium carbonate ER tablets
Oxcarbazepine tablets
Phenytoin sodium extended capsules
Primidone tablets
Topiramate tablets
Valproate sodium solution
Zonisamide capsules

CARDIOVASCULAR
Anticoagulants/ Antiplatelets
Cilostazol tablets
Clopidogrel tablets
Dipyridamole tablets
Prasugrel tablets
Warfarin tablets

Beta Blockers
Acebutolol capsules
Atenolol
Betaxolol tablets
Bisoprolol fumarate tablets
Carvedilol tablets
Labetalol tablets
Metoprolol succinate ER tablets
Metoprolol tartrate tablets (except 37.5mg and 75mg)
Propranolol tablets
Sotalol tablets
Sotatol AF tablets

Calcium Channel Blockers
Amlodipine tablets
Diltiazem ER capsules, tablets
Diltiazem IR capsules, tablets
Diltiazem SR capsules, tablets
Felodipine ER tablets
Isradipine capsules
Nifedipine capsules
Nifedipine ER tablets (osmotic release)

Cholesterol
Atorvastatin tablets
Lovastatin tablets
Pravastatin tablets
Rosuvastatin tablets
Simvastatin tablets

Combination products
Amiloride-HCTZ tablets
Amlodipine-benazepril capsules
Amlodipine-olmesartan medoxomil tablets
Amlodipine-valsartan tablets
Atenolol-chlorthalidone tablets
Benazepril-EICTZ tablets
Bisoprolol-HCTZ tablets
Enalapril-HCTZ tablets
Fosinopril sodium-HCTZ tablets
Irbesartan-HCTZ tablets
Lisinopril-HCTZ tablets
Losartan-HCTZ tablets
Metoprolol-HCTZ tablets
Moexipril-HCTZ tablets
Olmesartan-HCTZ tablets
Quinapril-HCTZ tablets
Spironolactone-HCTZ tablets
Triamterene-HCTZ capsules, tablets
Telmisartan-HCTZ tablets
Valsartan-HCTZ tablets

Diuretics
Acetazolamide tablets
Amiloride tablets
Bumetanide tablets
Chlorothiazide tablets
Chlorthalidone tablets
Furosemide tablets, solution
Hydrochlorothiazide capsules, tablets
Indapamide tablets
Spironolactone tablets
Torsemide tablets

Other
Clonidine patches
Digoxin tablets

Renin/ Angiotensin System Antagonists
Venazepril tablets
Enalapril tablets
Eplerenone tablets
Fosinopril tablets

Renin/ Angiotensin System Antagonists cont.
Irbesartan tablets
lisinopril tablets
Losartan tablets
Moexipril tablets
Olmesartan tablets
Erindopril erbumine tablets
Quinapril tablets
Ramipril tablets
Telmisartan tablets
Trandolapril tablets
Valsartan tablets
Verapamil tablets
Verapamil ER tablets

Vasodilators
Losartan tablets
Moexipril tablets
Olmesartan tablets
Erindopril erbumine tablets
Quinapril tablets
Ramipril tablets
Telmisartan tablets
Trandolapril tablets
Valsartan tablets
Verapamil tablets
Verapamil ER tablets

DIABETES
Glucose Rescue Products
GlucaGen® HypoKit®
Glucagon®

Insulins
Humalog® products
Humulin® products
generic Lantus® products (Semglee y/f)
Levemir® products
Toujeo® products
Tresiba ® products

Metformin products
Glipizide-metformin tablets
Glyburide-metformin tablets
Metformin tablets
Metformin ER tablets (non-osmotic, non-modified)

Other
Pioglitazone tablets

This represents a list of maintenance medications that are covered prior to having met the medical deductible for those enrolled in the Washington County School District High Deductible Health Plan (HDHP).

Exclusive Maintenance Drug List

Sulfonylureas
Glimepiride tablets
Glipizide tablets
Glipizide ER tablets
Glyburide tablets
Glyburide micronized tablets
Tolazamide tablets

Testing Strips
LifeScan OneTouch® products

MENTAL HEALTH
Amitriptyline tablets
Aripiprazole tablets (non-ODT)
Bupropion ER/SR tablets
Bupropion IR tablets
Bupropion XL tablets
Citalopram tablets, solution
Desvenlafaxine succinate SR tablets
Doxepin capsules, solution
Duloxetine capsules (except 40mg)
Escitalopram tablets, solution
Fluoxetine capsules, solution
Fluvoxamine IR tablets
Haloperidol tablets, oral concentrate
Loxapine succinate capsules
Mirtazapine tablets (non-ODT)
Nortriptyline capsules, solution
Olanzapine tablets (non-ODT)
Paroxetine tablets
Quetiapine IR tablets
Quetiapine SR tablets
Risperidone tablets (non-ODT
Sertraline tablets, solution
Thioridazine tablets
Venlafaxine ER capsules
Venlafaxine IR tablets
Ziprasidone capsules

OSTEOPOROSIS
Alendronate tablets (except 40mg)
Ibandronate tablets

RESPIRATORY

Anticho Iinergics
Ipratropium bromide solution

Inhaled Corticosteroids
Budesonide (inhalation) nebulized
QVAR® inhaler
QVAR® RediHaler™

Leukotriene Receptor Antagonists
Montelukast chewable tablets
Montelukast tablets

Methylxanthines
Theophylline elixir
Theophylline CR tablets
Theophylline solutionTheophylline ER tablets, 72 hour and 24 hour

Short Acting Beta Agonists (SABA)
Albuterol nebulized
Albuterol syrup
ProAir® HFA inhaler
ProAir® RespiClick®
Ventolin® HFA inhaler

SABA/ Anticholinergics
Ipratropium-albuterol inhaler
Ipratropium-albuterol nebulized

SaveOnSp Program

Ridiculous savings on specialty drugs

- Certain specialty drugs costs can be reduced to $0 member cost.
  - No accumulations will be applied to the deductible or Out-of-Pocket Maximum.
  - Outside of the program, the normal benefit is often a 25% coinsurance.
- Enrolled clients are seeing plan savings of over $1,300 per month per script
- Available for High Deductible and Traditional Plans.
- Specialty Drug spending as a percentage of overall Prescription drug costs have increased from 15% to over 45% in the past 10 years. The SaveOnSP program is a way to reduce costs for the member and plan.

Effective January 1, 2022

A

Arcalyst
Actemra
Acthar
Adakveo
Adcetris
Adcirca
Advate
Adynovate
Afinitor
Afstyla
Aldurazyme
Alecensa
AlphaNine
Alprolix
Alunbrig*
Ampyra
Asceniv
Aubagio
Austedo
Avastin
Avonex
Avsola

B

Benefix
Benlysta
Beovu
Berinert
Blenrep*
Bosulif
Braftovi
Brukinsa*
Cablivi*
Cabometyx

C

Calquence*
Carbaglu
Cayston
Cerdelga
Cholbam*
Cimzia
Cinryze
Copaxone
Cosentyx
Crysvita
Cuvitru
Cyramza
Cystadrops*

D

Darzalex
Darzalex Faspro
Dojolvi
Doptelet
Dupixent

E

Elaprase
Elelyso
Eloctate
Empliciti
Enbrel
Enhertu
Erbitux
Erivedge
Erleada
Esperoct
Evenity
Evkeeza*
Exjade
Exondys 51*
Extavia
Eylea

F

Fabrazyme
Farydak
Fasenra
Feiba NF
Ferriprox*
Fintepla*
Firazyr
Firdapse*
Folotyn
Forteo
Fotivda*
Fulphila

G

Galafold
Gamifant*
Gammagard
Gattex
Gazyva
Gilenya
Gilotrif
Givlaari
glatiramer
Glatopa
Gleevec
Gocovri*
Granix

H

Haegarda
Hemlibra
Herceptin
Herceptin Hylecta
Herzuma
Hetlioz
Humate-P
Humira
Hyqvia

I

Ilbrance
Iclusig*
Idelvion
Ilumya
Imcivree*
Imfinzi
Increlex
Ingrezza*
Inlyta
Inqovi
Inrebic
Istodax
Ixempra
Ixinity

J

Jadenu
Jakafi
Jemperli
Jevtana
Jivi
Juxtapid
Jynarque*

K

Kadcyla
Kalbitor
Kalydeco
Kanjinti

**Indicated drug not dispensed by Accredo Pharmacy. Continue to fill through approved pharmacy.*

Kanuma
Kesimpta
Keveyis*
Kevzara
Kisqali
Kogenate FS
Koselugo*
Kovaltry
Krystexxa
Kuvan

L
Letairis
Leukine
Libtayo*
Lonsurf
Lorbrena
Lucentis
Lumakras
Lumizyme
Lumoxiti*
Lupkynis*
Luxturna
Lynparza

M
Makena
Margenza*
Mayzent
Mekinist
Mektovi
Mvasi
Myalept

N
Nerlynx
Neulasta
Neupogen
Nexavar
Nexviazyme
Ninlaro
Nityr
Nivestym
Northera
Novoeight
Novoseven RT
Nplate
Nubeqa
Nucala
Nulibry*
Nuplazid
Nuwiq
Nyvepria

O
Ocaliva
Ocrevus
Ogivri
Olumiant
Ontruzant*
Onureg
Opdivo
Opsumit
Orencia
Orenitram
Orfadin*
Orgovyx*
Orkambi
Orladeyo*
Otezla
Oxbryta
Oxervate
Oxlumo*

P
Padcev
Palynziq
Pemazyre*
Perjeta
Phesgo
Piqray
Plegridy
Polivy
Poteligeo*
Procysbi
Promacta
Pulmozyme

Q
Qinlock*

R
Radicava*
Ravicti
Rebif
Rebinyn
Recombinate
Remicade
Renflexis
Retevmo
Revcovi*
Riabni
Rinvoq
Rituxan
Rituxan Hycela
Rixubis
Ruxience
Rybrevant
Rydapt

S
Sandostatin Lar Depot
Saphnelo*
sapropterin
Sarclisa*
Serostim
Signifor*
Signifor LAR*
Siliq
Skyrizi
Soliris
Somatuline Depot
Somavert
Spinraza
Sprycel
Stelara
Stivarga
Strensiq*
Sublocade
Sutent

T
Tafinlar
Tagrisso
Takhzyro
Taltz
Talzenna
Tasigna
Tavalisse*
Tazverik*
Tecentriq
Tecfidera
Tegsedi
Thiola*
Tobi Podhaler
Tracleer
Trazimera
Tremfya
Treprostinil
Tretten
Trikafta
Triptodur*
Trodelvy*
Truseltiq*
Truxima
Tukysa*
Turalio*
Tysabri
Tyvaso

U
Udenyca
Ultomiris

V
Valchlor
Vectibix
Venclexta*
Verzenio
Viltepso*
Vistogard*
Vonvendi
Votrient
Vumerity
Vyleesi*
Vyndamax
Vyndaqel
Vyondys 53*
Vyxeos*

W
Wakix
Wilate

X
Xalkori
Xeljanz
Xembify
Xenazine
Xermelo*
Xgeva
Xolair
Xospata*
Xpovio*
Xtandi
Xyntha
Xyrem

Y
Yervoy

Z
Zarxio
Zejula*
Zelboraf
Ziextenzo
Zirabev
Zokinvy*
Zolgensma
Zytiga

To enroll, you just need to call 1-800-683-1074 and speak with SaveOnSP.

Enrollment in the SaveonSP program is voluntary; however, if you elect not to participate, you will be responsible for 100% of the SaveonSP Specialty copay. This copayment amount will not apply toward your out-of-pocket maximums. Participation may not disqualify an individual from being an eligible individual for HSA purposes. Material contained in this document does not constitute legal or tax advice and should not be construed as such. If you need legal advice upon which you can rely, you must seek a legal opinion from a competent attorney.

The SaveOnSP Drug List is subject to change at any time. The inclusion of a particular specialty prescription drugs within the SaveOnSP Program is subject to SaveOnSP Program design, as well as applicable laws or regulations. Prescription benefit plan terms will take precedence and determine access to all specialty prescription drugs on SaveOnSP Drug List; medical benefit drugs are excluded from the SaveOnSP Program.

Stretching Your Rx Dollar

GoodRx Comparison Tool

Stop paying too much for your prescriptions! With the GoodRx Comparison Tool, you can compare drug prices at over 70,000 pharmacies, and discover free coupons and savings tips.

Isn't health insurance all I need?

Your health insurance provides valuable prescription and other health benefits, but a smart consumer can save much more, especially for drugs that are not covered by health insurance (weight-loss medications, some antihistamines, etc.), drugs that have limited quantities, drugs that can be found for less than your copay, or drugs with a lower priced generic.

How can I find these savings?

The GoodRx Comparison Tool provides you with instant access to current prices on more than 6,000 drugs at virtually every pharmacy in America.

› **On the Web:** https://www.goodrx.com/
Instantly look up current drug prices at CVS, Walgreens, Walmart, Costco, and other local pharmacies.

Please Note:

- Prescription drug pricing displayed on the GoodRx Comparison Tool may be more or less than your insurance drug card.
- Please be sure to compare all discount pricing options before you purchase.
- Check your insurance carrier's pharmacy benefit before purchasing a 90-day supply.

› **On Your Phone**
Available on the App Store or with Android on Google play. Or, just go to m.goodrx.com from any mobile phone.

Generic Prescriptions

$4 30-Day Supply or a $10 90-Day Supply

These programs may assist you in paying a reduced amount for generic medications, as well as, reducing utilization of the medical prescription benefits.

Did You Know?

Even if the generic substitute for one of your prescription drugs is not on one of the $4 lists, generic drugs are often 80% less expensive than brand name drugs, so switching to a generic will have a large impact on your pocketbook whether you switch pharmacies or not. To see if you would benefit from a switch to a generic drug, do some comparison shopping. One of the better places to do this is at www.crbestbuydrugs.org, a Consumer Reports site.

Tips

- When you receive a prescription from your doctor, ask if a generic equivalent is available.
- The member must present the written prescription to the pharmacist and request the $4-Generic price.
- The member should not present the medical ID card. The pharmacy will not submit a claim to the insurance carrier.

How can I find out if my prescription is on the $4-Generic Drug List?

Most of the generic programs offer approximately 150 to 300 generic drugs at a discounted price. The generic drugs offered cover most diseases and most chronic conditions such as arthritis, heart disease, high blood pressure, depression and diabetes.
You may search for the generic medication on the pharmacy's website or contact the pharmacy to inquire if the generic medication the provider prescribed is on the pharmacy's $4-Generic Drug List.

TeleMedicine

$0 copay for all plans

Reach a doctor 24/7/365.

70% of doctor visits can be handled over the phone, and 40% of urgent care visits can be managed using TeleMedicine. Save time and money while still getting the treatment you need through EMI Health TeleMed offered through Recuro.

When to Use TeleMed

Recuro doctors diagnose acute, non-emergent medical conditions and prescribe medications when clinically appropriate.

Speak with a doctor anytime and pay no consultation fee rather than paying the high costs associated with office visits, urgent care visits, and emergency room visits.

Just call **855.6RECURO.**

Video consultations are available as well from 7 AM - 7 PM.

Common Conditions

- Acid Reflux
- Allergies
- Asthma
- Bladder Infection
- Bronchitis
- Cold & Flu
- Constipation
- Cough
- Ear Pain*
- Fever
- Gout
- Headache
- Hemorrhoids
- High Blood Pressure
- Joint Pain
- Nausea
- Pink Eye
- Rashes
- Sinus Conditions
- Sore Throat
- Stomach Virus
- Thyroid Conditions
- Urinary Tract Infections
- Yeast Infections

**In accordance with telemedicine guidelines, ear infections are only diagnosed for patients that are 18 years of age or older.*

Common Medications

- Albuterol
- Allegra
- Asthma
- Flonase
- Ibuprofen 800 mg
- Levaquin
- Lipitor
- Nasonex
- Many Others

RECURO HEALTH

855.6RECURO

Available on the App Store

ANDROID APP ON Google play

Download the Recuro mobile app

EMI.MKTG.TELEMEDANDMH.1119.1241

lyra

EMI HEALTH

OVERVIEW

Mental Health Made Easy

Educators Mutual Insurance Association (EMI) members have fast access to high-quality mental health care coaches and therapists in just a few clicks.

Therapy

Meet with a therapist for diagnosis and treatment of mental health conditions like depression, anxiety, substance use, and more.

Mental health coaching

Find care with a mental health coach to support you through managing stress, low confidence or self-doubt, relationship issues, and more via video.

Find care and get started

Getting started is easy

Share what you're experiencing, get care recommendations, and book an appointment immediately. With easy access to high-quality providers, Lyra members feel better faster.

High-quality care that works

Lyra is dedicated to offering the best care possible and supporting only treatments that are the most effective at relieving symptoms, typically within a short period of time.

The best coaches, therapists and physicians available nationwide

Our providers are ready to meet you where you are — via live video, live messaging, or even in-person. Many use digital lessons and exercises to enhance your care experience between sessions.

Who is eligible?

EMI members have access to Lyra Health's provider network of coaches and therapists. Sessions are billed through EMI and subject to in-network outpatient mental health cost-sharing, as defined under your health plan.

Learn more at emihealth.lyrahealth.com

(877) 299-4765 | care@lyrahealth.com

Communication to WCSD Employees and Students February 2, 2023

Family Healthcare provides medical visits for all Washington County School District Employees for $30. And ALL Washington County School District Students for $10.

Family Healthcare follows a healthcare model that provides the right care, at the right time, in the most cost-efficient way. The model emphasizes preventive care provided by a high quality consistent patient-centered healthcare team which includes a board certified licensed physician, nurse practitioner or physician assistant supported by a medical assistant, behavioral health provider, nurse, care coordinator, and clerical staff.

Services include, but are not limited to:

• Family health care • Teenage physicals • Scout physicals • Team physicals • Infant and child health care • Adolescent medicine	• Women's health care services • Sick visits • Management of acute and chronic problems • Preventative health care • Access to reduced cost prescriptions • Adult physicals and well care

Note: Bloodwork, as well as some immunizations and procedures may result in additional fees.

Two locations in Washington County:

Hurricane Clinic	Riverside Clinic St. George
Located on Hurricane Middle School Campus 391 North 200 West, Hurricane Medical & Behavioral: 435-986-2565 Hours: Monday 8 a.m. - 8 p.m. Wednesday 8 a.m. – 5 p.m. Thursday 8 a.m. – 8 p.m. Friday 8 a.m. – 5 p.m. Closed Tuesday, Saturday, Sunday **Closed for lunch 12-1**	2276 East Riverside Drive, St. George Medical & Behavioral: 435-986-2565 Dental: 435-359-2165 Pharmacy: 435-359-9899 Hours: Monday to Friday 8 a.m. - 8 p.m. Saturday 7 a.m. – 1 p.m. Closed Sunday
Pre-scheduled, Walk-in, Urgent Care, Same day, & Telehealth appointments available. Patients seen in Hurricane may also benefit from dental and pharmacy services at the St. George location.	

Health Savings Account

HealthEquity

Health Savings Account

About Health Savings Accounts

A Health Savings Account (HSA) is a tax advantaged savings account that you own and control. HSAs are similar to retirement accounts in that funds rollover year-to-year, it is portable if you move jobs or retire, the balance can be invested in mutual funds, and there are survivor benefits.

The HSA Advantage

- It's a Tax Saver
  - Contributions are excluded from federal income tax
  - Your money grows tax-free
  - Withdrawals used to pay for qualified health care expenses are also tax-free
- Ownership: The money in your HSA is always yours. Unspent balances simply roll over from year to year until spent.
- Flexibility: You decide when and how much to contribute to your account.
- Portable: Your money stays put even if you change health plans or employers, or if you retire.

Who is eligible?

You must be enrolled in our qualified high deductible health plan (HDHP) and meet the following requirements:

- Have no other health insurance coverage except what's permitted by the IRS
- Not be enrolled in Medicare
- Not be claimed as a dependent on someone else's tax return

How much can I contribute to my HSA?

Each year the IRS establishes the maximum contribution limits (see the table below). These limits are for the total funds contributed, including company contributions, your contributions and any other contributions. Please keep in mind you can change your HSA allocation at any time during the plan year.

	2023
Self-Only	$3,850
Family	$7,750

At age 55, an additional $1,000 contribution is allowed annually.

Determining Your Annual Contribution

Your allowed annual contribution is calculated based on the number of months covered by a qualified HDHP plan and your coverage type (self-only or family). For example, if you have self-only coverage 8 months of the year, your maximum contribution limit is $2,433. Formula: $2,433 = 8 x ($3,650 / 12)

Per the last-month rule (IRS Publication 969), if you are eligible on the 1st day of the last month of your tax year (usually December 1st), you are considered eligible for the entire year. You may contribute up to the annual maximum IRS limit, but only if you maintain qualified HDHP coverage for the entire following year.

Our Banking Partner

We have partnered with HealthEquity for HSA administration. For newly enrolled employees, your demographic data is transmitted to the bank upon electing our qualified HDHP. HealthEquity will mail you a welcome kit upon activating your account which will contain information about the bank and how to use the online banking features and your debit card. If you are an existing account holder, you will continue to use your same Health Savings Account which rolls over year after year. Please use the same debit card you currently have. The bank will automatically send you a new debit card approximately one month before your current card expires.

Health Savings Account

Qualified Health Care Expenses

You can use money in your HSA to pay for any qualified health care expenses you, your legal spouse and your tax dependents incur, even if they are not covered on your plan. Qualified health care expenses are designated by the IRS (Publication 502). They include medical, dental, vision and prescription expenses not covered by the insurance carrier.

Qualified expenses include, but are not limited to:

- Acupuncture
- Alcoholism (rehab)
- Ambulance
- Amounts not covered under another health plan
- Annual physical examination
- Artificial limbs
- Birth control pills/prescription contraceptives
- Body scans
- Post-mastectomy breast reconstruction surgery
- Chiropractor
- Contact lenses
- Crutches
- Dental treatments
- Eyeglasses/eye surgery
- Hearing aids
- Long-term care expenses
- Medicines (prescribed)
- Nursing home medical care
- Nursing services
- Optometrist
- Lasik surgery
- Orthodontia
- Oxygen
- Stop-smoking programs
- Surgery, other than unnecessary cosmetic surgery
- Telephone equipment for the hearing-impaired
- Therapy
- Transplants
- Weight-loss program (prescribed)
- Wheelchairs
- Wigs (prescribed)
- Over-the-counter drugs without a prescription

Non-qualified expenses include any expenses incurred before you establish your HSA.

Other non-qualified expenses include, but are not limited to:

- Concierge services
- Dancing lessons
- Diaper service
- Elective cosmetic surgery
- Electrolysis or hair removal
- Funeral Expenses
- Future medical care
- Hair transplants
- Health club dues
- Insurance premiums*
- Medicines and drugs from other countries
- Teeth whitening

The following insurance premiums may be reimbursed from your HSA:

- COBRA premiums
- Health insurance premiums while receiving unemployment benefits
- Qualified long-term care premiums
- Medicare premiums (Parts A, B, C, etc.)

> **Important**
> Any funds you withdraw for non-qualified expenses will be taxed at your income tax rate plus a 20% tax penalty if you're under age 65. After age 65, you pay taxes but no penalty.

Documentation is Key

An HSA can be used for a wide range of health care services within the limits established by law. Be sure you understand what expenses are HSA qualified, and be able to produce receipts for those items or services that you purchase with your HSA. You must keep records sufficient to show that:

- The distributions were exclusively to pay or reimburse qualified medical expenses,
- The qualified expenses had not been previously paid or reimbursed from another source, and
- The qualified expense had not been taken as an itemized deduction in any year.

Do not send these records with your tax return. Keep them with your tax records.

Flexible Spending Account

National Benefit Services

FLEXIBLE BENEFITS PLAN

Washington County School District

Employer ID NBS302966

PLAN HIGHLIGHTS

Login at: my.nbsbenefits.com

Congratulations! Washington County School District has established a "Flexible Benefits Plan" to help you pay for your out-of-pocket medical expenses. One of the most important features of the Plan is that the benefits being offered are paid for with a portion of your pay before Federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a Federal income tax credit or deduction on your return.

DETERMINING CONTRIBUTIONS

Before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year.

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections if you have a "change in status". Please refer to your Summary Plan Description for a change in status listing.

GENERAL PLAN INFORMATION

Plan Year End:…….....July 31st
Run-out Period:……..……...…90 Days
.
Maximum Medical Limit…….…...…Current IRS limit $3,050
…See Code Section 125(i)(2) or current enrollment information

Maximum Dependent Care Limit:……..……..……..$5,000

Health FSA Carryover…Up to $610 following the Plan run-out

WHEN AM I ELIGIBLE TO PARTICIPATE

If you work 30 hours or more each week for the company, you will be eligible to join the Plan following your date of employment.

You will enter the Plan on the first day of the month following the day in which you meet the above eligibility requirements.

WHAT TYPE OF BENEFITS ARE AVAILABLE

Under our Plan, you can choose the following benefits. Each benefit allows you to save taxes at the same time because the amount you elect is set aside on a pre-tax basis.

Health Flexible Spending Account:
The Health Flexible Spending Account (FSA) enables you to pay for expenses allowed under Section 105 and 213(d) of the Internal Revenue Code which are not covered by our insured medical plan. The most that you can contribute to your Health FSA each Plan Year is set by the IRS. This amount can be adjusted for increases in cost-of-living in accordance with Code Section 125(i)(2).

Please note: If you participate in a Health Savings Account (HSA) benefit because you are enrolled in a HDHP, you **cannot** participate in the Full Health Flexible Spending Account benefit, but you **can** participate in the Limited Health Flexible Spending Account Benefit.

Health Savings Account:
A Health Savings Account allows participants insured by a Qualified High Deductible Health Plan to save for deductibles and other expenses not covered under the Plan. If you participate in this benefit you **cannot** participate in the Health Flexible Spending Account benefit, only a Limited FSA.

Limited Health Flexible Spending Account:
If you participate in an HSA you may also participate in a Limited Health Flexible Spending Account and be reimbursed for out-of-pocket dental and/or vision expenses incurred by you and your dependents. Once you satisfy the statutory deductible you may be reimbursed for medical expenses that are allowed under Section 105 and 213(d) of the Internal Revenue Code which are not covered by our insured medical Plan. Please refer to your SPD for the current statutory amount. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses.

NBS Welfare Benefit Service Center
P.O. Box 6980
West Jordan, UT 84084
801-532-4000 or 1-800- 274-0503
Fax: 1-800-478-1528

nbs national benefit services

Washington County School District Cafeteria Plan
Washington County School District

Plan Contact Person:
Tammara Robinson
121 West Tabernacle
St. George, Utah 84770
(435) 673-3553

Flexible Benefits Plan
Highlights Continued

Dependent Care Flexible Spending Account:
The Dependent Care Flexible Spending Account (DCAP) enables you to pay for out-of-pocket, work-related dependent day-care cost. Please see the Summary Plan Description for the definition of eligible dependent. The law places limits on the amount of money that can be paid to you in a calendar year. Generally, your reimbursement may not exceed the lesser of: (a) $5,000 (if you are married filing a joint return or you are head of a household) or $2,500 (if you are married filing separate returns; (b) your taxable compensation; (c) your spouse's actual or deemed earned income. Also, in order to have the reimbursements made to you and be excluded from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider, as well as the amount of such expense and proof that the expense has been incurred.

Premium Expense Plan:
A Premium Expense portion of the Plan allows you to use pre-tax dollars to pay for specific premiums under various insurance programs that we offer you.

Please note: Policies other than company sponsored policies (i.e. spouse's or dependents' individual policies etc.) may not be paid through the Flexible Benefits Plan. Furthermore, qualified long-term care insurance plans may not be paid through the Flexible Benefits Plan.

HOW DO I RECEIVE REIMBURSEMENTS
During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. You can get a claim form at www.NBSbenefits.com.

Claim forms must be submitted no later than 90 days after the end of the Plan Year for the Health Flexible Spending Account and the Dependent Care Flexible Spending Account. Any contributions remaining at the end of the Plan Year will be forfeited. However, if you have unused contributions in your Health Flexible Spending Account following the Plan run-out period, you may roll up to $610 to the new plan year. If you move to a HDHP and HSA, any remaining balance up to $610 in your Health Flexible Spending Account will be moved into a Limited Health Flexible Spending Account due to eligibility in an HSA. Funds can be used as indicated under Limited Health Flexible Spending Account above. Any amount above $500 in your Health FSA at the end of the Plan run-out period will be forfeited.

NBS Flexcard – FSA Pre-paid MasterCard
Your employer may sponsor the use of the NBS Flexcard, making access to your flex dollars easier than ever. You may use the card to pay merchants or service providers that accept credit cards, so there is no need to pay cash up front then wait for reimbursement.

Orthodontic expenses that are paid fully up-front at the time of banding are reimbursable in full after the initial service has been performed and payment has been made. Ongoing orthodontia payments are reimbursable only as they are paid.

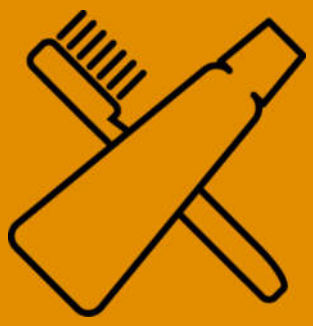
WHO ARE HIGHLY COMPENSATED & KEY EMPLOYEES
Under the Internal Revenue Code, "highly compensated employees" and "key employees" generally are Participants who are officers, shareholders or highly paid.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Please refer to your Summary Plan Description for more information. You will be notified of these limitations if you are affected.

Updated: 11/4/2022

NBS Welfare Benefit Service Center
P.O. Box 6980
West Jordan, UT 84084
801-532-4000 or 1-800- 274-0503
Fax: 1-800-478-1528

Washington County School District Cafeteria Plan
Washington County School District
Plan Contact Person:
Tammara Robinson
121 West Tabernacle
St. George, Utah 84770
(435) 673-3553



Dental

EMI Health

Corporate (801)262-7475
Customer Service (800)662-5851
EMIHealth.com

DENTAL COVERAGE
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL DENTAL EXPENSES
OUTLINE OF COVERAGE

Read Your Policy Carefully-This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Group:	**Washington County School District (Plan #0832)**
Plan:	**Choice PPO**
Administered by:	**Educators Mutual Insurance Association, a Utah Company**
Effective Date:	**8/1/2023**
Benefit Year:	**Contract**
Plan Type:	**Contributory / Self Funded**

	In-Network (Advantage *Plus* Network)	In-Network (Premier Network)	Out-of-Network
Type 1 - Preventive Oral Exams, Cleanings, X-rays, Fluoride	**100%**	**100%**	**70% up to MAC***
Type 2 - Basic Fillings, Oral Surgery	**80%**	**80%**	**70% up to MAC***
Type 3 - Major Crowns, Bridges, Prosthodontics	**50%**	**50%**	**40% up to MAC***
Type 4 - Orthodontics Dependent children ages 7 through 18	**50%**	**50%**	**50%**
Adults	Discount Only	Discount Only	No Coverage
Endodontics	Type 2 - Basic	Type 2 - Basic	Type 2 - Basic
Periodontics	Type 2 - Basic	Type 2 - Basic	Type 2 - Basic
Sealants	Type 3 - Major	Type 3 - Major	Type 3 - Major
Space Maintainers	Type 2 - Basic	Type 2 - Basic	Type 2 - Basic
Waiting periods			
Type 2 - Basic	None		
Type 3 - Major Type 4 - Orthodontics	Failure to enroll at first opportunity results in a 12 month waiting period		
Deductible	In and Out of Network Deductibles are Combined		
Per Person	$50.00	$50.00	$50.00
Family Max	$150.00	$150.00	$150.00
Deductible Applies To	Type 2 & Type 3	Type 2 & Type 3	Type 1, Type 2 & Type 3
Annual Maximum Per Person	$2,000.00	$1,500.00	
	All maximums are combined up to limits above		
Orthodontic Lifetime Maximum	$1,000.00		
Network / Reimbursement Schedule	Advantage Plus	Premier	Premier

Provisions / Limitations / Exclusions	
Exams (including Periodontal), Cleanings and Fluoride	2 per year
Fluoride	Any age
Sealants	Dependent children only
Space Maintainers	Up to age 17
Bitewing X-Rays	2 per year
Periapical X-Rays	Covered in Type 1
Panoramic X-Ray	1 every 3 years
Impacted Teeth	Covered in Type 2 - Basic
Anesthesia - (Age 8 and over for the extraction of impacted teeth only)	Covered in Type 2 - Basic**
Anesthesia - (For children age 7 and under, once per year)	Covered in Type 2 - Basic **
Implants / Implant Abutments	Covered in Type 3 - Major
Crowns, Pontics, Abutments, Onlays and Dentures	1 every 5 years per tooth
Fillings on the same surface	1 every 18 months

* All Services are subject to EMI Health Maximum Allowable Charge (MAC). When using a Non-participating Provider, the insured is responsible for all fees in excess of the Maximum Allowable Charge (MAC).

** Anesthesia is not subject to waiting periods.

The EMI Health Mobile App

Your benefits. Anytime. Anywhere.

Provider Search

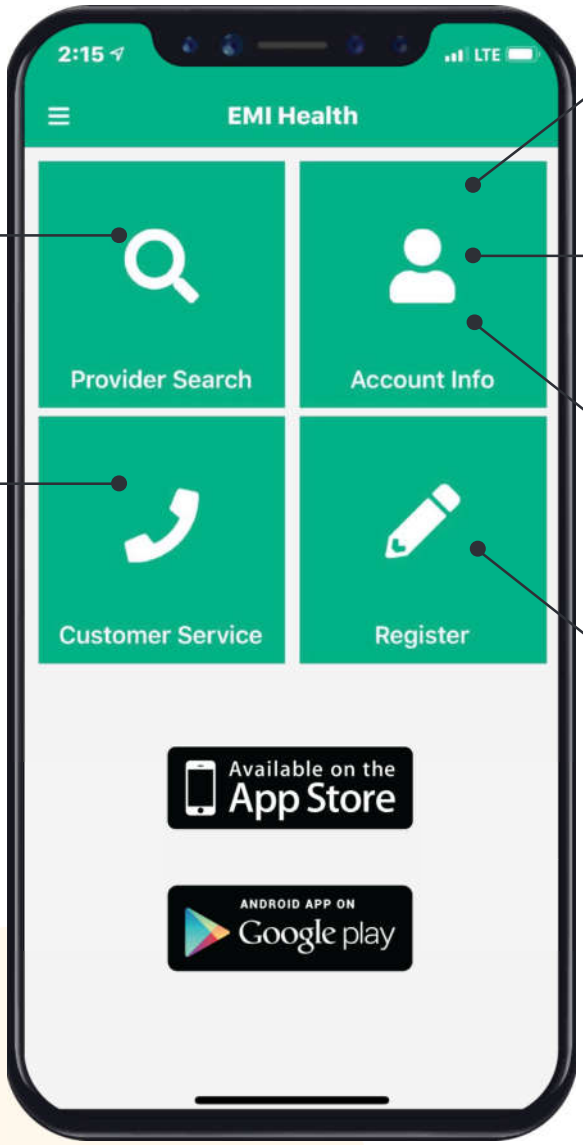
Find in-network providers and facilities.

Customer Service

Need to talk to a person? No problem.
Call us from the app.

Other Features

- Access current and past issues of the Hope Health newsletter.
- Update your profile information like email address, password, or security questions.



ID Card

Access your ID Card from anywhere at any time.

EOBs

View your EOBs and search by person, service, date, and more.

Plan Information

View and download your plan grids so you always know the benefits you have.

Log in/Register

Download the app and log in using your My EMI Health username and password.

If you haven't registered your account, you can do so in the app or online at emihealth.com.

Scan this QR code with your phone to download.

Life and AD&D & Travel Assistance

LifeMap

USAble Life

EMPLOYEE BENEFITS SUMMARY | **50052021**
WASHINGTON COUNTY SCHOOL DISTRICT

FOR ALL OTHER FULL TIME ACTIVE EMPLOYEES ELIGIBLE FOR THE ER-SPONSORED MEDICAL PLAN

GROUP TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT	**EMPLOYER CONTRIBUTION: 100%**

AMOUNT OF COVERAGE: Pays a benefit of $25,000 without evidence of insurability.

Benefits reduce, based on your age, to 65% at age 65, to 50% at age 70, and to 35% at age 75, and then terminate when you are no longer eligible or your retirement, whichever occurs first. Reductions occur at the Policy Anniversary.

GROUP TERM LIFE insurance is designed to provide benefits to your designated beneficiary for loss of life.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) is payable, if within 365 days of a covered accident, you suffer loss of life or dismemberment. AD&D provides protection for losses occurring on or off the job.

GROUP TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT ALSO INCLUDES THE FOLLOWING:

- Accelerated Benefit
- Extended Life Insurance Benefit (Waiver of Premium)
- Portability
- Coma Benefit
- Exposure & Disappearance Benefit
- Repatriation Benefit
- Child Care Center Benefit
- Felonious Assault Benefit
- Restoration Benefit
- Special Education Benefit
- Spouse Training Benefit
- Safety Equipment Benefit
- Total Loss of Use Benefit
- Travel Assistance
- Dignity Planner

DEPENDENT LIFE	**EMPLOYER CONTRIBUTION: 100%**

Spouse: Pays a benefit to your eligible spouse in the amount of $2,420.

Children: Pays a benefit to your eligible children between the ages of 6 months and 26 years in the amount of $2,420. Benefits are $2,420 for children from Live Birth to 6 Months.

Benefits terminate when you are no longer eligible or your retirement, whichever occurs first.

VOLUNTARY GROUP TERM LIFE	**EMPLOYER CONTRIBUTION: 0%**

Employee: If you are age 69 or younger, you may purchase coverage in units of $5,000 to a maximum of $450,000 through age 69, and $0 after reaching age 70 without evidence of insurability. Coverage over these amounts to a maximum of $500,000 is available with evidence of insurability.

Benefits reduce, based on your age, to 65% at age 65, to 50% at age 70, and to 35% at age 75, and then terminate when you are no longer eligible or your retirement, whichever occurs first. Reductions occur at the Policy Anniversary.

Spouse: If you have purchased Voluntary GTL for yourself, you may purchase coverage for your eligible spouse, age 69 or younger, in units of $5,000 to a maximum of $50,000 through age 69, and $0 after reaching age 70 without evidence of insurability. Coverage over these amounts to a maximum of $300,000 is available with evidence of insurability. Coverage cannot exceed 100% of your benefit.

Benefits reduce, based on your age, to 65% at age 65, to 50% at age 70, and to 35% at age 75, and then terminate when you are no longer eligible or your retirement, whichever occurs first. Reductions occur at the Policy Anniversary.

Child: If you have purchased Voluntary GTL for yourself, you may purchase coverage for your eligible children between the ages of Live Birth and 26 years from $2,500 to $10,000 in increments of $2,500.

Benefits terminate when they are no longer eligible, or at the termination of your eligibility, whichever occurs first.

VOLUNTARY GROUP TERM LIFE (VGTL) If you need additional term life protection for you and your eligible family members, think about USAble Life's low cost VGTL coverage. You select the benefit amounts to suit your specific situation and premium payments are made through payroll deduction.

VOLUNTARY GROUP TERM LIFE ALSO INCLUDES THE FOLLOWING:

- Accelerated Benefit
- Dignity Planner
- Portability
- Extended Life Insurance Benefit (Waiver of Premium)

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT	EMPLOYER CONTRIBUTION: 0%

Employee: You may purchase coverage in units of $5,000 to a maximum of $500,000.

Benefits reduce, based on your age, to 65% at age 65, to 50% at age 70, and to 35% at age 75, and then terminate when you are no longer eligible or your retirement, whichever occurs first. Reductions occur at the Policy Anniversary.

Spouse: If you have purchased Voluntary AD&D for yourself, you may purchase coverage for your eligible spouse in units of $5,000 to a maximum of $250,000. Coverage cannot exceed 50% of your Benefit.

Benefits reduce, based on your age, to 65% at age 65, to 50% at age 70, and to 35% at age 75, and then terminate when you are no longer eligible or your retirement, whichever occurs first. Reductions occur at the Policy Anniversary.

Child: If you have purchased Voluntary AD&D for yourself, you may purchase coverage for your eligible children between the ages of Live Birth and 26 years from $5,000 to $25,000 in increments of $5,000.

Benefits terminate when they are no longer eligible, or at the termination of your eligibility, whichever occurs first.

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (VAD&D) coverage allows you to purchase benefits to provide protection in the event of an unexpected loss of accidental death or dismemberment. Protection is issued on a 24-hour basis for you and your eligible family members and covers you as the result of a covered accident anywhere in the world.

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT ALSO INCLUDES THE FOLLOWING:

- Coma Benefit
- Exposure & Disappearance Benefit
- Repatriation Benefit
- Child Care Center Benefit
- Felonious Assault Benefit
- Restoration Benefit
- Special Education Benefit
- Spouse Training Benefit
- Safety Equipment Benefit
- Total Loss of Use Benefit

Important Note

If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, the coverage or increase in coverage will take effect on the day you return to active work. This benefit summary provides a very brief description of USAble Life's insurance products. This is not an insurance policy and only the actual provisions of an issued policy control. USAble Life's policies set forth the rights and obligations of covered persons and USAble Life. Please be aware that certain participation requirements, limitations, or exclusions may apply, and certain coverage may reduce or terminate due to age or lack of eligibility. If you enroll and are approved for coverage, you will be furnished with a certificate of insurance. Please read your insurance documents carefully.

This benefit summary was generated by USAble Life on 1/11/2023 at 11:12 AM and may not reflect changes recently submitted to USAble Life.

USAble Life

WASHINGTON COUNTY SCHOOL DISTRICT | VGTL + VADD

PREMIUMS BASED ON 12 PAYROLL DEDUCTIONS PER YEAR
Applying for coverage over Guaranteed Issue will require evidence of medical insurability
Employee's Guaranteed Issue is $450,000 through age 69.
Spouse's Guaranteed Issue is $50,000 through age 69. Spouse Premiums are determined by Employee's age
The maximum spouse benefit is $300,000

VGTL PREMIUMS FOR CHILD	$2,500	$0.23	VADD RATE FOR EMPLOYEE, SPOUSE, & CHILD PER $1,000	$0.02
	$5,000	$0.45		
	$7,500	$0.68		
	$10,000	$0.90		

Benefit Units	Voluntary GTL									
	UNDER 35	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$5,000	$0.300	$0.400	$0.500	$0.800	$1.100	$1.850	$2.200	$3.600	$6.750	$11.750
$10,000	$0.600	$0.800	$1.000	$1.600	$2.200	$3.700	$4.400	$7.200	$13.500	$23.500
$15,000	$0.900	$1.200	$1.500	$2.400	$3.300	$5.550	$6.600	$10.800	$20.250	$35.250
$20,000	$1.200	$1.600	$2.000	$3.200	$4.400	$7.400	$8.800	$14.400	$27.000	$47.000
$25,000	$1.500	$2.000	$2.500	$4.000	$5.500	$9.250	$11.000	$18.000	$33.750	$58.750
$30,000	$1.800	$2.400	$3.000	$4.800	$6.600	$11.100	$13.200	$21.600	$40.500	$70.500
$35,000	$2.100	$2.800	$3.500	$5.600	$7.700	$12.950	$15.400	$25.200	$47.250	$82.250
$40,000	$2.400	$3.200	$4.000	$6.400	$8.800	$14.800	$17.600	$28.800	$54.000	$94.000
$45,000	$2.700	$3.600	$4.500	$7.200	$9.900	$16.650	$19.800	$32.400	$60.750	$105.750
$50,000	$3.000	$4.000	$5.000	$8.000	$11.000	$18.500	$22.000	$36.000	$67.500	$117.500
$55,000	$3.300	$4.400	$5.500	$8.800	$12.100	$20.350	$24.200	$39.600	$74.250	$129.250
$60,000	$3.600	$4.800	$6.000	$9.600	$13.200	$22.200	$26.400	$43.200	$81.000	$141.000
$65,000	$3.900	$5.200	$6.500	$10.400	$14.300	$24.050	$28.600	$46.800	$87.750	$152.750
$70,000	$4.200	$5.600	$7.000	$11.200	$15.400	$25.900	$30.800	$50.400	$94.500	$164.500
$75,000	$4.500	$6.000	$7.500	$12.000	$16.500	$27.750	$33.000	$54.000	$101.250	$176.250
$80,000	$4.800	$6.400	$8.000	$12.800	$17.600	$29.600	$35.200	$57.600	$108.000	$188.000
$85,000	$5.100	$6.800	$8.500	$13.600	$18.700	$31.450	$37.400	$61.200	$114.750	$199.750
$90,000	$5.400	$7.200	$9.000	$14.400	$19.800	$33.300	$39.600	$64.800	$121.500	$211.500
$95,000	$5.700	$7.600	$9.500	$15.200	$20.900	$35.150	$41.800	$68.400	$128.250	$223.250
$100,000	$6.000	$8.000	$10.000	$16.000	$22.000	$37.000	$44.000	$72.000	$135.000	$235.000

$105,000	$6.300	$8.400	$10.500	$16.800	$23.100	$38.850	$46.200	$75.600	$141.750	$246.750
$110,000	$6.600	$8.800	$11.000	$17.600	$24.200	$40.700	$48.400	$79.200	$148.500	$258.500
$115,000	$6.900	$9.200	$11.500	$18.400	$25.300	$42.550	$50.600	$82.800	$155.250	$270.250
$120,000	$7.200	$9.600	$12.000	$19.200	$26.400	$44.400	$52.800	$86.400	$162.000	$282.000
$125,000	$7.500	$10.000	$12.500	$20.000	$27.500	$46.250	$55.000	$90.000	$168.750	$293.750
$130,000	$7.800	$10.400	$13.000	$20.800	$28.600	$48.100	$57.200	$93.600	$175.500	$305.500
$135,000	$8.100	$10.800	$13.500	$21.600	$29.700	$49.950	$59.400	$97.200	$182.250	$317.250
$140,000	$8.400	$11.200	$14.000	$22.400	$30.800	$51.800	$61.600	$100.800	$189.000	$329.000
$145,000	$8.700	$11.600	$14.500	$23.200	$31.900	$53.650	$63.800	$104.400	$195.750	$340.750
$150,000	$9.000	$12.000	$15.000	$24.000	$33.000	$55.500	$66.000	$108.000	$202.500	$352.500
$155,000	$9.300	$12.400	$15.500	$24.800	$34.100	$57.350	$68.200	$111.600	$209.250	$364.250
$160,000	$9.600	$12.800	$16.000	$25.600	$35.200	$59.200	$70.400	$115.200	$216.000	$376.000
$165,000	$9.900	$13.200	$16.500	$26.400	$36.300	$61.050	$72.600	$118.800	$222.750	$387.750
$170,000	$10.200	$13.600	$17.000	$27.200	$37.400	$62.900	$74.800	$122.400	$229.500	$399.500
$175,000	$10.500	$14.000	$17.500	$28.000	$38.500	$64.750	$77.000	$126.000	$236.250	$411.250
$180,000	$10.800	$14.400	$18.000	$28.800	$39.600	$66.600	$79.200	$129.600	$243.000	$423.000
$185,000	$11.100	$14.800	$18.500	$29.600	$40.700	$68.450	$81.400	$133.200	$249.750	$434.750
$190,000	$11.400	$15.200	$19.000	$30.400	$41.800	$70.300	$83.600	$136.800	$256.500	$446.500
$195,000	$11.700	$15.600	$19.500	$31.200	$42.900	$72.150	$85.800	$140.400	$263.250	$458.250
$200,000	$12.000	$16.000	$20.000	$32.000	$44.000	$74.000	$88.000	$144.000	$270.000	$470.000
$205,000	$12.300	$16.400	$20.500	$32.800	$45.100	$75.850	$90.200	$147.600	$276.750	$481.750
$210,000	$12.600	$16.800	$21.000	$33.600	$46.200	$77.700	$92.400	$151.200	$283.500	$493.500
$215,000	$12.900	$17.200	$21.500	$34.400	$47.300	$79.550	$94.600	$154.800	$290.250	$505.250
$220,000	$13.200	$17.600	$22.000	$35.200	$48.400	$81.400	$96.800	$158.400	$297.000	$517.000
$225,000	$13.500	$18.000	$22.500	$36.000	$49.500	$83.250	$99.000	$162.000	$303.750	$528.750
$230,000	$13.800	$18.400	$23.000	$36.800	$50.600	$85.100	$101.200	$165.600	$310.500	$540.500
$235,000	$14.100	$18.800	$23.500	$37.600	$51.700	$86.950	$103.400	$169.200	$317.250	$552.250
$240,000	$14.400	$19.200	$24.000	$38.400	$52.800	$88.800	$105.600	$172.800	$324.000	$564.000
$245,000	$14.700	$19.600	$24.500	$39.200	$53.900	$90.650	$107.800	$176.400	$330.750	$575.750
$250,000	$15.000	$20.000	$25.000	$40.000	$55.000	$92.500	$110.000	$180.000	$337.500	$587.500
$255,000	$15.300	$20.400	$25.500	$40.800	$56.100	$94.350	$112.200	$183.600	$344.250	$599.250
$260,000	$15.600	$20.800	$26.000	$41.600	$57.200	$96.200	$114.400	$187.200	$351.000	$611.000
$265,000	$15.900	$21.200	$26.500	$42.400	$58.300	$98.050	$116.600	$190.800	$357.750	$622.750

$270,000	$16.200	$21.600	$27.000	$43.200	$59.400	$99.900	$118.800	$194.400	$364.500	$634.500
$275,000	$16.500	$22.000	$27.500	$44.000	$60.500	$101.750	$121.000	$198.000	$371.250	$646.250
$280,000	$16.800	$22.400	$28.000	$44.800	$61.600	$103.600	$123.200	$201.600	$378.000	$658.000
$285,000	$17.100	$22.800	$28.500	$45.600	$62.700	$105.450	$125.400	$205.200	$384.750	$669.750
$290,000	$17.400	$23.200	$29.000	$46.400	$63.800	$107.300	$127.600	$208.800	$391.500	$681.500
$295,000	$17.700	$23.600	$29.500	$47.200	$64.900	$109.150	$129.800	$212.400	$398.250	$693.250
$300,000	$18.000	$24.000	$30.000	$48.000	$66.000	$111.000	$132.000	$216.000	$405.000	$705.000
$305,000	$18.300	$24.400	$30.500	$48.800	$67.100	$112.850	$134.200	$219.600	$411.750	$716.750
$310,000	$18.600	$24.800	$31.000	$49.600	$68.200	$114.700	$136.400	$223.200	$418.500	$728.500
$315,000	$18.900	$25.200	$31.500	$50.400	$69.300	$116.550	$138.600	$226.800	$425.250	$740.250
$320,000	$19.200	$25.600	$32.000	$51.200	$70.400	$118.400	$140.800	$230.400	$432.000	$752.000
$325,000	$19.500	$26.000	$32.500	$52.000	$71.500	$120.250	$143.000	$234.000	$438.750	$763.750
$330,000	$19.800	$26.400	$33.000	$52.800	$72.600	$122.100	$145.200	$237.600	$445.500	$775.500
$335,000	$20.100	$26.800	$33.500	$53.600	$73.700	$123.950	$147.400	$241.200	$452.250	$787.250
$340,000	$20.400	$27.200	$34.000	$54.400	$74.800	$125.800	$149.600	$244.800	$459.000	$799.000
$345,000	$20.700	$27.600	$34.500	$55.200	$75.900	$127.650	$151.800	$248.400	$465.750	$810.750
$350,000	$21.000	$28.000	$35.000	$56.000	$77.000	$129.500	$154.000	$252.000	$472.500	$822.500
$355,000	$21.300	$28.400	$35.500	$56.800	$78.100	$131.350	$156.200	$255.600	$479.250	$834.250
$360,000	$21.600	$28.800	$36.000	$57.600	$79.200	$133.200	$158.400	$259.200	$486.000	$846.000
$365,000	$21.900	$29.200	$36.500	$58.400	$80.300	$135.050	$160.600	$262.800	$492.750	$857.750
$370,000	$22.200	$29.600	$37.000	$59.200	$81.400	$136.900	$162.800	$266.400	$499.500	$869.500
$375,000	$22.500	$30.000	$37.500	$60.000	$82.500	$138.750	$165.000	$270.000	$506.250	$881.250
$380,000	$22.800	$30.400	$38.000	$60.800	$83.600	$140.600	$167.200	$273.600	$513.000	$893.000
$385,000	$23.100	$30.800	$38.500	$61.600	$84.700	$142.450	$169.400	$277.200	$519.750	$904.750
$390,000	$23.400	$31.200	$39.000	$62.400	$85.800	$144.300	$171.600	$280.800	$526.500	$916.500
$395,000	$23.700	$31.600	$39.500	$63.200	$86.900	$146.150	$173.800	$284.400	$533.250	$928.250
$400,000	$24.000	$32.000	$40.000	$64.000	$88.000	$148.000	$176.000	$288.000	$540.000	$940.000
$405,000	$24.300	$32.400	$40.500	$64.800	$89.100	$149.850	$178.200	$291.600	$546.750	$951.750
$410,000	$24.600	$32.800	$41.000	$65.600	$90.200	$151.700	$180.400	$295.200	$553.500	$963.500
$415,000	$24.900	$33.200	$41.500	$66.400	$91.300	$153.550	$182.600	$298.800	$560.250	$975.250
$420,000	$25.200	$33.600	$42.000	$67.200	$92.400	$155.400	$184.800	$302.400	$567.000	$987.000
$425,000	$25.500	$34.000	$42.500	$68.000	$93.500	$157.250	$187.000	$306.000	$573.750	$998.750
$430,000	$25.800	$34.400	$43.000	$68.800	$94.600	$159.100	$189.200	$309.600	$580.500	$1,010.500

$435,000	$26.100	$34.800	$43.500	$69.600	$95.700	$160.950	$191.400	$313.200	$587.250	$1,022.250
$440,000	$26.400	$35.200	$44.000	$70.400	$96.800	$162.800	$193.600	$316.800	$594.000	$1,034.000
$445,000	$26.700	$35.600	$44.500	$71.200	$97.900	$164.650	$195.800	$320.400	$600.750	$1,045.750
$450,000	$27.000	$36.000	$45.000	$72.000	$99.000	$166.500	$198.000	$324.000	$607.500	$1,057.500
$455,000	$27.300	$36.400	$45.500	$72.800	$100.100	$168.350	$200.200	$327.600	$614.250	$1,069.250
$460,000	$27.600	$36.800	$46.000	$73.600	$101.200	$170.200	$202.400	$331.200	$621.000	$1,081.000
$465,000	$27.900	$37.200	$46.500	$74.400	$102.300	$172.050	$204.600	$334.800	$627.750	$1,092.750
$470,000	$28.200	$37.600	$47.000	$75.200	$103.400	$173.900	$206.800	$338.400	$634.500	$1,104.500
$475,000	$28.500	$38.000	$47.500	$76.000	$104.500	$175.750	$209.000	$342.000	$641.250	$1,116.250
$480,000	$28.800	$38.400	$48.000	$76.800	$105.600	$177.600	$211.200	$345.600	$648.000	$1,128.000
$485,000	$29.100	$38.800	$48.500	$77.600	$106.700	$179.450	$213.400	$349.200	$654.750	$1,139.750
$490,000	$29.400	$39.200	$49.000	$78.400	$107.800	$181.300	$215.600	$352.800	$661.500	$1,151.500
$495,000	$29.700	$39.600	$49.500	$79.200	$108.900	$183.150	$217.800	$356.400	$668.250	$1,163.250
$500,000	$30.000	$40.000	$50.000	$80.000	$110.000	$185.000	$220.000	$360.000	$675.000	$1,175.000

Important Note: The above rates are subject to change. The rates shown here are meant as an illustration for you to determine the approximate deduction you may expect to see each paycheck. Due to the rounding of rates, these deductions will vary, though differences should be slight. This is not part of an insurance policy and only the actual provisions of an issued policy control. USAble Life's policies set forth the rights and obligations of covered persons and USAble Life. Please be aware that certain limitations and exclusions apply and that benefits may reduce or terminate. If you enroll for coverage, you will be provided with a certificate of insurance. Please read your certificate carefully.

TRAVEL ASSISTANCE SERVICES

Frequently asked questions

What is travel assistance?

USAble Life has partnered with AXA Assistance USA Inc.* to offer travel assistance, which is a valuable program that provides travel and medical support services 24 hours a day, 365 days a year. If you become sick or injured or require travel services while traveling, help is a phone call away with our global response center.

Who can use the travel assistance services?

You and your eligible dependents — spouse, domestic partner, and children under the age of 26 — traveling 100 miles or more away from home for business or pleasure have access to this program. Services are also available to dependents traveling with or without you.

When do my travel assistance services become effective?

The program provides services to support you before, during, and after your trip. Eligibility for medical transportation services requires that you are 100 miles or more from your home residence for up to 120 days.

What if my dependents or I need medical assistance?

Medical assistance is as simple as a phone call. AXA will collect the following to begin assisting: patient's name, member's name, employer, current location, phone number, hospital details if admitted, and medical symptoms/diagnosis.

AXA's medical team will contact the medical facility to obtain current medical information and assess if appropriate care is being received. If AXA's medical staff, along with the local attending physician, determine that transportation to another facility is medically necessary, AXA will coordinate and provide transportation to the closest medical facility capable of offering adequate treatment. AXA will remain in contact with the patient, member's family, and treating facility until discharged and/or medical repatriation can be provided.

How will my dependents get home if I am medically evacuated?

AXA will arrange return transportation for a travel companion or unattended minor if an accident or illness results in a medical evacuation or repatriation. If a child is left unattended, AXA will arrange for an escort to accompany the child to ensure a safe return home.

Are reimbursements accepted?

No, reimbursements are not accepted.

Is payment for medical expenses included in the program?

No, medical expenses are not included. AXA recommends that you contact your primary health insurance carrier before traveling for consideration of coverage for medical expenses while abroad.

What is the claims process?

All services must be authorized and arranged by AXA's designated personnel to relieve travelers from the burden of paying out-of-pocket expenses.

Are there any exclusions to the benefits?

Services will not be provided for any loss or injury that is caused by or the result of:

- Normal childbirth, normal pregnancy (except complications of pregnancy), or voluntary-induced abortion
- A mental or nervous condition, unless hospitalized
- Traveling against the advice of a medical professional
- Traveling for medical treatment
- Traveling over 120 days
- Traveling within 100 miles of the member's place of residence

Are any countries excluded from the program?

AXA's global presence allows us access and the ability to assist in many parts of the world, including some of the most remote locations; however, AXA cannot provide direct assistance in countries sanctioned by the U.S. Department of the Treasury. All services are provided as permitted under applicable law. No services will be available in any country or territory where the existing infrastructure is deemed inadequate by AXA to guarantee service.

How else can this program help while traveling abroad?

Having access to the AXA Travel Assistance Program helps provide peace of mind while abroad. You can rely on medical and dental referrals to pre-selected providers, emergency cash advance services, prescription transfer, lost document and lost luggage assistance, valuable destination country information prior to travel, and much more.

How can we help?

If you have any questions or require assistance, please contact AXA Assistance USA Inc. at 866-384-2786 or 630-616-4536 (collect) or email medassist-usa@axa-assistance.us.

**USAble Life has contracted with AXA Assistance USA Inc. to offer the service to our Group Term Life policyholders. Travel Assistance services are not insurance.*

USAble Life℠

22L-USAL-0162

TRAVEL ASSISTANCE SERVICES

AXA Assistance USA Inc.
Travel Assistance Program

866-384-2786
630-616-4536 collect

Carry this card with you when you travel. Assistance is available 24 hours a day, seven days a week, 365 days a year.

AXA USAble Life℠

Travel assistance helps when unexpected events happen while traveling

Live life. You're covered.®

USAble Life understands that unexpected events can occur whether your employees are traveling for business or pleasure. That's why we've partnered with AXA Assistance USA Inc.[1] to provide global emergency response and everyday travel assistance to our members, their spouses, and dependent children at no additional cost.

This program offers you a broad range of valuable travel and medical support services 24 hours a day, seven days a week, 365 days a year. With one simple phone call to our response center, you will be connected to a global network of providers to assist you when you travel 100 miles or more from home.

Travel Eye information portal

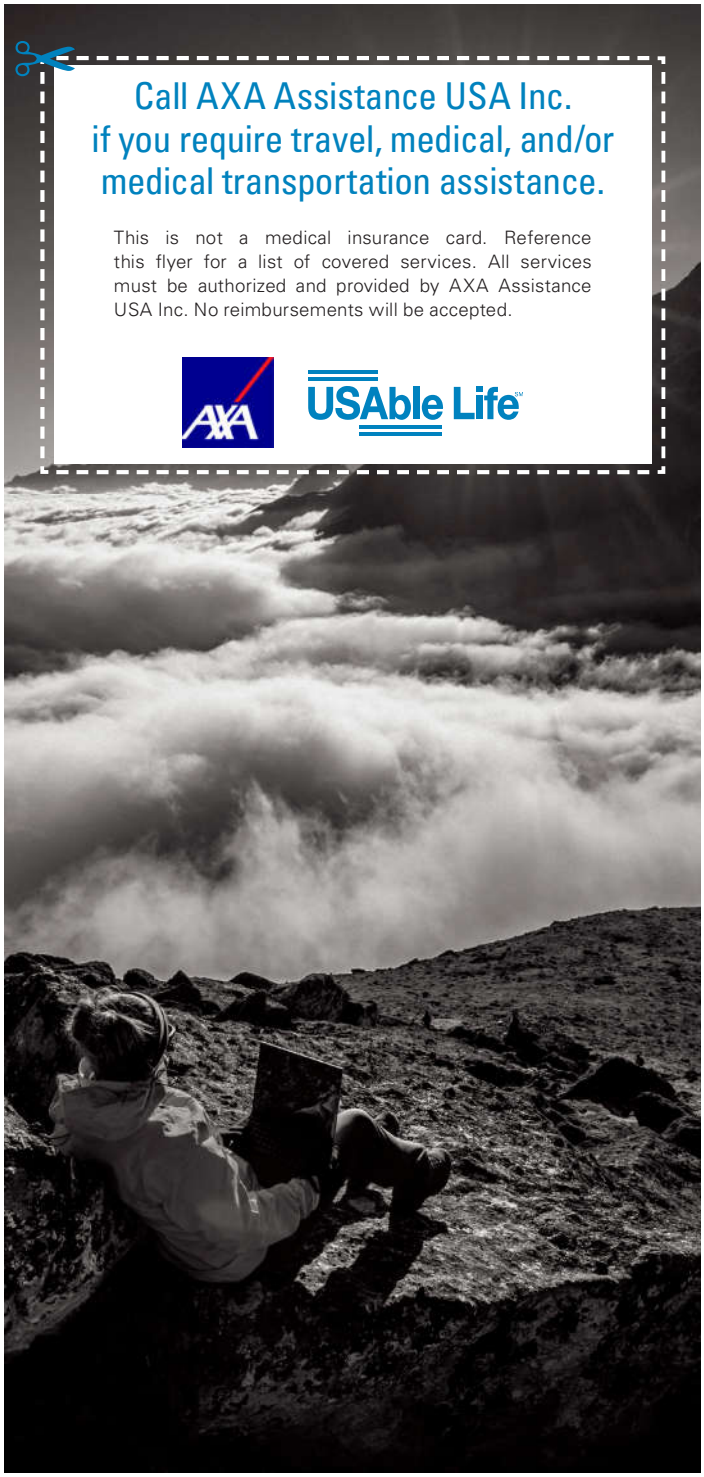
Travel Eye offers useful intelligence designed to provide necessary knowledge throughout the life cycle of your trip. Through this dedicated information portal, you have access to the most accurate, real-time information on global events, security and medical risks per country, as well as access to AXA's global medical network.

Register by visiting: accounts.travel-eye-axa.com/en/registration/usa_life_emp

PRODUCT HIGHLIGHTS

- *Assistance is just a phone call away — travel information and medical assistance services can be accessed worldwide 24 hours a day, seven days a week, 365 days a year*
- *Travel Eye information portal provides access to the most accurate, real-time information on global events, security, and medical risks per country, as well as access to AXA's global medical network*
- *Put the attached member card in your wallet and take it with you when you travel*

USAble Life℠



Program guidelines and services

Travel services

- *Lost document and luggage assistance*
- *Emergency cash/bail assistance*
- *Emergency message transmission*
- *Telephone interpretation*
- *Legal referrals*
- *Pre-trip and cultural information*
- *Vaccination recommendations*
- *General travel information*
- *Vehicle return*[2]

Medical transportation services

- *Emergency medical evacuation*[2]
- *Medical repatriation*[2]
- *Return of mortal remains*[2]
- *Return of traveling companion*[2]
- *Visit of a family member or friend*[2]
- *Return of minor children*[2]
- *Dispatch of physician*[2]

Medical assistance services

- *Medical and dental referrals*
- *Coordination of hospital admission*
- *Critical care monitoring*
- *Dispatch of prescription medication*

Services will not be provided or available for any loss or injury that is caused by, or a result of a mental nervous condition or diagnosis, traveling against the advice of a physician, traveling for medical treatment, pregnancy *(except complications of pregnancy)* and childbirth, or voluntary-induced abortion.

How can we help?

If you have any questions about the services or require assistance, please contact AXA Assistance USA Inc. at 866-384-2786 or 630-616-4536 (collect), or email medassist-usa@axa-assistance.us.

[1]*USAble Life has contracted with AXA Assistance USA Inc. to offer the service to our Group Term Life policyholders.*

[2]*Program Terms: When traveling 100 miles or more away from home for up to 120 days, medical emergency transportation services include the arrangement and payment for any reasonable and customary charges determined by AXA Assistance USA Inc. Vehicle return service is applicable upon activation of medical emergency transportation. No reimbursements for out-of-pocket expenses will be accepted. All additional costs are the responsibility of the member. Services will be provided as permitted under applicable law. Services must be authorized and arranged by AXA Assistance. Travel assistance services are not insurance.*

A.M. BEST
Consecutively ranked "A" (excellent) by A.M. Best

WARD'S 50 SAFETY · CONSISTENCY · PERFORMANCE
Recognized as one of the "Ward's 50" L&H Top Performers

USAble Life℠

21L-USAL-0822

Disability

Lincoln Financial Group

Lincoln Financial Group®

Full-Time Employees of Washington County School District

Benefits At-A-Glance

Voluntary Short-term Disability Insurance

The Lincoln Short-term Disability Insurance Plan:

- Provides a cash benefit when you are out of work for up to 26 weeks due to injury, illness, surgery, or recovery from childbirth
- Provides a partial cash benefit if you can only do part of your job or work part time
- Features group rates for Washington County School District employees
- Offers a fast, no-hassle claims process

Short-term Disability	
Weekly benefit amount	66.67% of your weekly salary, limited to $1,500 per week
Sickness elimination period	14 days
Accident elimination period	14 days
Maximum coverage period	26 weeks

Sickness Elimination Period

- You must be out of work for 14 days due to an illness before you can collect disability benefits. You can begin collecting benefits on day 15.

Accident Elimination Period

- You must be out of work for 14 days due to an accidental injury before you can collect disability benefits. You can begin collecting benefits on day 15.

Pre-existing Condition

- If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the 3 months leading up to your coverage start date, you may not be eligible for benefits for that condition until you have been covered by the plan for 12 months.

No Benefits Reduction

- Your short-term disability benefits can coordinate with income from other sources, such as any state disability benefits, continued income or sick pay from your employer, or Workers' Compensation, during your disability—your benefit will not be reduced by this other income.

Open Enrollment

- When you are first offered this coverage (and during approved open enrollment periods), you can take advantage of this important coverage.
- If you decline this coverage now and wish to enroll later, a health examination may be required.

Benefit Exclusions & Reductions

Like any insurance, this short-term disability insurance policy does have some exclusions. You will not receive benefits if:

- Your disability is the result of a self-inflicted injury or act of war
- You are not under the regular care of a doctor when you request disability benefits

A complete list of benefit exclusions and reductions is included in the policy. State restrictions may apply to this plan.

Questions? Call 800-423-2765 and mention Group ID: WASHINGSD.

This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the contract, the contract will govern.

Insurance products (policy series GL1101) are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. Product availability and/or features may vary by state. Limitations and exclusions apply.

Lincoln Financial Group®

Voluntary Short-term Disability Premium
Here's how little you pay with group rates.

Your estimated monthly premium is determined by multiplying your weekly salary amount (up to $2,250) by your age-range premium factor. If your weekly salary exceeds $2,250, multiply $2,250 by your premium factor.

$ _____
weekly salary

X _____
premium factor

=$ _____
monthly premium

Age Range	Premium Factor
25 - 29	0.02160
30 - 34	0.02093
35 - 39	0.01953
40 - 44	0.01953
45 - 49	0.02160
50 - 54	0.02440
55 - 59	0.02927
60 - 64	0.03487
65 - 69	0.04047
70 - 74	0.04460
75 - 99	0.04740

The Lincoln National Life Insurance Company

Please see prior page for product information.

Voluntary Short-term Disability Insurance Premium Calculation

STD-ENRO-BRC001-UT

Lincoln Financial Group®

Washington County School District provides this valuable benefit at no cost to you.

All Full-Time Provisional and Career Employees

Long-term Disability Insurance

Keep getting a check when you're hurt or sick.

You always have bills to pay, even when you can't get to work due to injury, illness, or surgery. Long-term disability insurance helps you make ends meet during this difficult time.

AT A GLANCE:

- A cash benefit of 66.67% of your monthly salary (up to $10,000) starting 180 days after you are out of work and continuing up to age 65 or Social Security Normal Retirement Age (SSNRA), whichever is later
- *EmployeeConnect*℠ services, which give you and your family confidential access to counselors as well as personal, legal, and financial assistance.
    - Program Services include:
    - Unlimited, 24/7 access to information and referrals
    - In-person help for short-term issues; up to five sessions with a counselor per person, per issue, per year.
    - One free consultation with a network attorney (with subsequent meetings at a reduced fee)
    - Online tools, tutorials, videos and much more

ADDITIONAL DETAILS

Coverage Period for Your Occupation: 24 months. After this initial period, you may be eligible to continue receiving benefits if your disability prohibits you from performing any employment for which you are reasonably suited through your training, education, and experience. In this case, your benefits may be extended through the end of your maximum coverage period (benefit duration).

Pre-existing Condition: If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the 3 months leading up to your coverage start date, you may not be eligible for benefits for that condition until you have been covered by the plan for 12 months.

For complete benefit descriptions, limitations, and exclusions, refer to the certificate of coverage.

Vision

Opticare Vision Services

OpticareVision services

Employee Only	$3.44
Two Party	$6.69
Family	$8.99

OPTICARE PLAN:

70SD

Products/Services	In-Network	Out-Of-Network
Standard Plastic Lenses		
Single Vision	100% Covered	$85 Allowance for lenses, options, and coatings
Bifocal (FT 28)	100% Covered	$85 Allowance for lenses, options, and coatings
Trifocal (FT 7x28)	100% Covered	$85 Allowance for lenses, options, and coatings
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	$40 Co-pay	
High Index	$80 Co-pay	
Coatings		
Scratch Resistant Coating	100% Covered	
Ultra Violet protection	100% Covered	
Other Options	Up to 25% Discount	
A/R, edge polish, tints, mirrors, etc.		
Frames		
Allowance Based on Retail Pricing	$70 Allowance	$60 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.	$70 Allowance	$60 Allowance
Additional contact purchases:		
Conventional	Up to 20% Discount	
Disposables	Up to 10% Discount	
Frequency		
Lenses, Frames, Contacts	Every 12 months	Every 12 months
Refractive Surgery		
LASIK	$250 Off Per Eye	Not Covered

OpticareVision services

Employee	$6.40
Two-Party	$11.59
Family	$16.85

OPTICARE PLAN:

120SD

Products/Services	In-Network	Out-Of-Network
Standard Plastic Lenses		
Single Vision	100% Covered	$100 Allowance for lenses, options, and coatings
Bifocal (FT 28)	100% Covered	$100 Allowance for lenses, options, and coatings
Trifocal (FT 7x28)	100% Covered	$100 Allowance for lenses, options, and coatings
Lens Options		
Progressive (Standard plastic no-line)	$30 Co-pay	
Premium Progressive Options	$80 Co-pay	
Ultra-Premium Progressive Options	Up to 20% Discount	
Polycarbonate	$40 Co-pay	
High Index	$80 Co-pay	
Coatings		
Scratch Resistant Coating	$10 Co-pay	
Ultra Violet protection	$10 Co-pay	
Other Options	Up to 25% Discount	
A/R, edge polish, tints, mirrors, etc.		
Frames		
Allowance Based on Retail Pricing	$120 Allowance	$100 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	$100 Allowance
Additional contact purchases:		
Conventional	Up to 20% Discount	
Disposables	Up to 10% Discount	
Frequency		
Lenses, Frames, Contacts	Every 12 months	Every 12 months
Refractive Surgery		
LASIK	$250 Off Per Eye	Not Covered

Voluntary Benefits

Voya

Accident, Critical Illness & Hospital Indemnity

Voluntary Accident

Voya

Group Accident Insurance (off-the-job)

Accident insurance can help provide you with a cushion to help cover expenses and living costs when you get hurt unexpectedly. While you can count on health insurance to cover medical expenses, it doesn't usually cover indirect costs that can arise with a serious or even not-so-serious injury. You may end up paying out of your own pocket for things like transportation, over-the-counter medicine, day care or sitters and extra help around the house. With accident insurance, the benefits you receive can help take care of these extra expenses and anything else that comes up.

With Voya Group Accident Insurance, you can have peace of mind knowing -

- Coverage is guaranteed issue
- Benefits are paid directly to you unless assigned to someone else.
- Benefits are paid in addition to any other coverage.

Plan Features	Benefit Amounts
Accident Physician Treatment	$90
X-ray	$75
Ambulance	$360 Ground / $1,500 Air
ER Service/Urgent Care	$225
Dislocation/Fracture Benefit	Up to $10,000
Hospital Confinement/Daily Benefit	$1,250 Admission / $275 Daily
Accident Follow-Up Visits	$90
Lacerations	Up to $480
Burns *(Depends on severity)*	Up to $15,000
AD&D	Up to $50,000
Wellness Benefit	$75 Employee and Spouse $37.50 for up to 4 Children

Group Accident Monthly Premiums

Employee Only	$9.97
Employee & Spouse	$15.98
Employee & Child(ren)	$22.15
Family	$26.96

**This is not a complete description of benefits. For a complete description of benefits and policy requirements, please refer to the brochures and certificates of coverage.*
https://presents.voya.com/EBRC/WashingtonCountySchoolDistrict

Voluntary Critical Illness

Voya

Group Critical Illness Insurance

Critical Illness insurance provides a lump sum benefit to help you cover the out-of-pocket expenses associated with a critical illness diagnosis. **With Voya Group Critical Illness Insurance, you can have peace of mind knowing you're covered in the event of:**

Covered Illness / Condition	Benefit
Heart Attack	100%
Cancer	100%
Stroke	100%
Major Organ Transplant	100%
Type 1 Diabetes	100%
Severe Burns	100%
Benign Brain Tumor	100%
Permanent Paralysis	50%
Loss of Sight, Hearing or Speech	50%
Advanced Dementia (including Alzheimer's)	50%
Coma	50%
Coronary Artery Bypass Surgery	25%
Carcinoma In-Situ	25%
Open Heart Surgery/Valve Replacement	25%

Covered Illness / Condition	Benefit
ICD Placement	25%
Bone Marrow Transplant	25%
Stem Cell Transplant	25%
Multiple Sclerosis	25%
ALS	25%
Parkinson's Disease	25%
Infectious Disease	25%
Transient Ischemic Attacks	10%
Ruptured or Dissecting Aneurysm	10%
Abdominal/Thoracic Aortic Aneurysm	10%
Coronary Angioplasty	10%
Pacemaker Placement	10%
Transcatheter Heart Valve Replacement or Repair	10%
Skin Cancer	10%

Plan Features	Employee	Spouse	Dependent
Coverage	$15,000 or $30,000	50% of Employee's Elected Benefit	50% of Employee's Elected Benefit
Guarantee Issue	$30,000	$15,000	$15,000
Pre-Existing	None	None	None
Wellness Benefit *Must complete a health screening*	$50	$50	$25 per child *Up to four children*

**This is not a complete description of benefits or rates. For a complete description of benefits, rates and policy requirements, please refer to the brochures and certificates of coverage.*

https://presents.voya.com/EBRC/WashingtonCountySchoolDistrict

Worksite Voluntary Benefits

Voya

Critical Illness Coverage Rates

EE: $15,000 SP: $7,500 Children: $7,500

	Non-Tobacco User				Tobacco User			
Age	EE Only	EE+SP	EE+CH	Family	EE Only	EE+SP	EE+CH	Family
<30	$4.05	$6.08	$4.05	$6.08	$6.45	$9.68	$6.45	$9.68
30-39	$7.05	$10.58	$7.05	$10.58	$11.85	$17.78	$11.85	$17.78
40-49	$13.80	$20.70	$13.80	$20.70	$28.35	$42.53	$28.35	$42.53
50-59	$24.45	$36.68	$24.45	$36.68	$48.60	$72.90	$48.60	$72.90
60+	$39.00	$58.50	$39.00	$58.50	$77.40	$116.10	$77.40	$116.10

EE: $30,000 SP: $15,000 Children: $15,000

	Non-Tobacco User				Tobacco User			
Age	EE Only	EE+SP	EE+CH	Family	EE Only	EE+SP	EE+CH	Family
<30	$8.10	$12.15	$8.10	$12.15	$12.90	$19.35	$12.90	$19.35
30-39	$14.10	$21.15	$14.10	$21.15	$23.70	$35.55	$23.70	$35.55
40-49	$27.60	$41.40	$27.60	$41.40	$56.70	$85.05	$56.70	$85.05
50-59	$48.90	$73.35	$48.90	$73.35	$97.20	$145.80	$97.20	$145.80
60+	$78.00	$117.00	$78.00	$117.00	$154.80	$232.20	$154.80	$232.20

Spouse age and tobacco status are based of the employee age and tobacco state.
Child Embedded in Employee Rate
https://presents.voya.com/EBRC/WashingtonCountySchoolDistrict

Voluntary Hospital

Voya

Group Hospital Indemnity Insurance

An inpatient stay in the hospital is expensive, and there may be additional costs unrelated to your stay such as having a baby or missing work. Hospital Confinement coverage pays a cash benefit when you are admitted "inpatient" for a minimum of 20 or more hours. You can use the monies to pay for medical bills not covered by insurance, or in any way you see fit.

With Voya Group Hospital Indemnity Insurance, you can have peace of mind knowing:

Benefits from a Hospital Indemnity plan can be used to assist you in paying deductibles, coinsurance, out-of-network costs, daily living expenses, etc.

Benefits are paid regardless of other coverage and is Health Savings Account compatible.

Benefits Include:

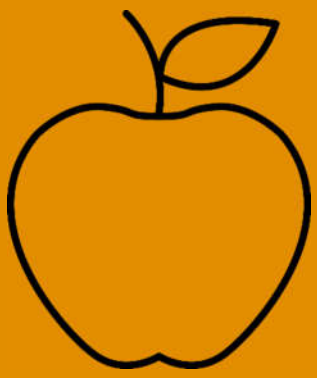
Guarantee Issue	Yes
Pre-Existing	None
Maternity Waiting Period	None
First Day Hospital Confinement	$1,200
Daily Hospital Benefit *Up to 31 Days*	$200 per day
Intensive Care *Up to 31 days*	$400 per day
Rehabilitation Unit *Up to 31 days*	$100 per day
Wellness	$50 Employee and Spouse $25 per child up to 4 children

Hospital Indemnity Monthly Premiums

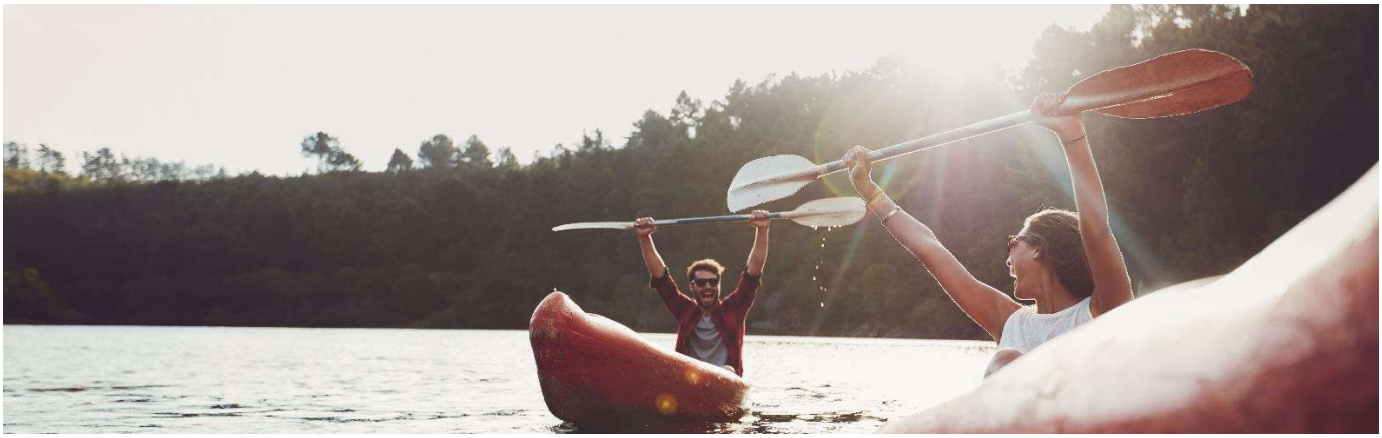
Employee Only	$24.86
Employee & Spouse	$50.98
Employee & Child(ren)	$43.14
Family	$69.26

**This is not a complete description of benefits. For a complete description of benefits and policy requirements, please refer to the brochures and certificates of coverage.*

https://presents.voya.com/EBRC/WashingtonCountySchoolDistrict



Wellness



Washington County School District Wellness Program

Did you know that about 70% of costs in medical care in the US are attributed to chronic disease? The good news is that healthy lifestyle choices are highly associated with reduced risk of developing chronic conditions such as heart disease, diabetes, metabolic syndrome, and more.

The District believes our employees and associates are our greatest asset. We also believe the greatest asset any individual can have is their health. We value your health and strive to continue identifying programs and tools that can assist you in managing your overall well-being.

What does our wellness program offer?

Our wellness program is a participatory-based program that offers a connection of paths, knowledge, and action to help provide the tools for you to take steps towards better health, all while offering choice and diversity, healthcare community support, incentive prizes, personalization, preventive care, social networking, and spotlights.

- **Monthly Wellness Theme:** We currently distribute weekly materials on our Wellness Wednesdays based on a wellness-related theme each month. These include preventive care, physical health, emotional well-being, financial wellness, stress management, healthcare community support, and more.
- **Monthly Initiative:** We aim to get active, seek balance, fuel your health, and work together! We have established weekly initiatives through mini-challenges to help maintain and improve well-being. We offer mini-challenge opportunities in various formats, such as wellness recordings, newsletters, flyers, health-related quizzes, in-person events, and more.

Rewards

Employees and their spouses who participate and complete mini-challenge requirements will be eligible for our monthly prize drawings. Don't miss out on the opportunity to improve your well-being while being rewarded!

The resources you need to meet life's challenges

*EmployeeConnect*SM offers professional, confidential services to help you and your loved ones improve your quality of life.

In-person guidance

Some matters are best resolved by meeting with a professional in person. With *EmployeeConnect*SM, you and your family get:

- In-person help for short-term issues (up to five sessions with a counselor per person, per issue, per year)
- In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and **25% off** subsequent meetings

Unlimited 24/7 assistance

You and your family can access the following services anytime — online, on the mobile app or with a toll-free call:

- Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning and more
- Legal information and referrals for family law, estate planning, consumer and civil law
- Financial guidance on household budgeting and short- and long-term planning

Online resources

*EmployeeConnect*SM offers a wide range of information and resources you can research and access on your own. Expert advice and support tools are just a click away when you visit GuidanceResources.com or download the GuidanceNow℠ mobile app. You'll find:

- Articles and tutorials
- Videos
- Interactive tools, including financial calculators, budgeting worksheets and more

*EmployeeConnect*SM

EMPLOYEE ASSISTANCE PROGRAM SERVICES

Confidential help 24 hours a day, seven days a week for employees and their family members. Get help with:

- Family
- Parenting
- Addictions
- Emotional
- Legal
- Financial
- Relationships
- Stress

We partner with your employer to offer this service at no additional cost to you!

*EmployeeConnect*SM counselors are experienced and credentialed.

When you call the toll-free line, you'll talk to an experienced professional who will provide counseling, work-life advice and referrals. All counselors hold master's degrees, with broad-based clinical skills and at least three years of experience in counseling on a variety of issues. For face-to-face sessions, you'll meet with a credentialed, state-licensed counselor.

You'll receive customized information for each work-life service you use.

To take advantage of the *EmployeeConnect*SM program or for more information: Visit GuidanceResources.com (username: LFGSupport, password: LFGSupport1), download the GuidanceNowSM mobile app or call 888-628-4824.

LincolnFinancial.com

LCN-2836182-112019
MAP 12/19 **Z01**
Order code: LTD-EAPEE-FLI001

Lincoln Financial Group®

*EmployeeConnect*SM

EMPLOYEE ASSISTANCE PROGRAM SERVICES

To find out more:

- Visit GuidanceResources.com
  (username: LFGSupport ■ password: LFGSupport1)
- Download the GuidanceNowSM mobile app
- Call 888-628-4824

Lincoln Financial Group®

ComPsych® GuidanceResources® Worldwide

Get started with your free online mental health benefit

Get back to feeling like you! Your psychological well-being can affect your physical health, relationships, and work performance. Tava's network of vetted therapists helps you step out of the fog, and get back to a happier, more fulfilled you.

Tava Health is a free, confidential mental health benefit available to all WCSD employees (full-time and part-time) and on-call/substitute contract workers. The benefit provides up to 8 free sessions anually with licensed therapists through Tava's secure, web-based technology platform. All you need for a session is reliable internet access and a connected device with a camera (smartphone, computer, or tablet).

Free to Use
No claims, no co-pays, no deductibles. You'll have 8 sessions completely covered.

Convenient
Self-scheduled online video therapy gives you therapy when it works for you, days, nights or weekends.

Confidential
We don't tell your employer who used the service. Your identity and anything you discuss is confidential.

Top Quality
Quality therapy from quality therapists. Tava's clinicians are licensed, vetted, and use evidence-based treatments.

Whether you're feeling stressed, stuck, or burdened with something else, Tava can help. Support is available for a range of issues such as:

Addiction
Anxiety
Depression
Eating disorders
Family issues
Grief and loss
LGBTQ+ issues
Life changes
Postpartum issues
PTSD
Trauma
Relationship issues
Work pressure
Stress
and more...

Schedule your first appointment today at
care.tavahealth.com

FAQ

Frequently Asked Questions

Is this service really free?
Yes! The costs of your first 8 sessions will be completely covered by your employer. Once you have used your free sessions, you can continue therapy by paying for it out of pocket at a rate of $91.80 per session (rate effective through May 31, 2023).

Do I need to file a claim with my insurance?
No. Payment has been taken care of by your employer, so you don't have to do anything. No claims, no copays, and no deductibles. In other words, no hassle.

Does this count toward my deductible?
No. Tava sessions do not impact your deductible.

Who is eligible to use this service?
Tava is a benefit available to all full-time and part-time employees of Washington County School District. It also includes "on-call" or "substitutes" that have contracts with the district.

Is this service confidential?
Yes. Written records of all services are kept private and are unavailable to employers or others without the written consent of the identified patient (or legal guardian) unless disclosure of information is required by law or court order.

Will my employer know that I am using Tava?
No. Your employer will not know that you are using this service unless you tell your employer or you tell someone who tells your employer. Tava will never give your employer data which could identify you in statistical reports; any data shared with employers is always de-identified and aggregated, protecting the identities of our individual patients.

Will my personal information be kept safely?
Yes. All personally identifiable information is stored in a secure, HIPAA-compliant database and will never be sold, shared, or transmitted for any reason. The video used for your visit is also encrypted and HIPAA compliant.

Is this service available after business hours?
Yes. Tava's therapists have availability that extends beyond normal business hours. For current appointment availability, please visit care.tavahealth.com.

What if I need help immediately?
If you have an emergency or urgent matter, call the suicide hotline at 1-800-273-8255, go to www.suicidepreventionlifeline.org, visit your nearest emergency room, or call 911.

How long does a therapy session last?
All therapy appointments are 50 minutes.

How will I talk with my clinician?
Sessions are delivered via video chat through Tava's online portal. All you need is a connected device with a camera (e.g., computer, smartphone, tablet). We recommend choosing a quiet, private location with reliable, high-speed Wi-Fi for your visits.

What are the qualifications of my therapist?
Therapy sessions are provided by licensed masters-level or doctoral-level mental health professionals. Licensure requirements and specific titles vary by state. We verify each clinician's credentials and require their licensure be maintained in good standing.

What kind of therapy does Tava provide?
Tava's therapists provide talk therapy (i.e. psychotherapy) to help you identify ways to understand, manage, and resolve problems, including unhealthy thought patterns and behaviors. Therapists cannot prescribe medications.

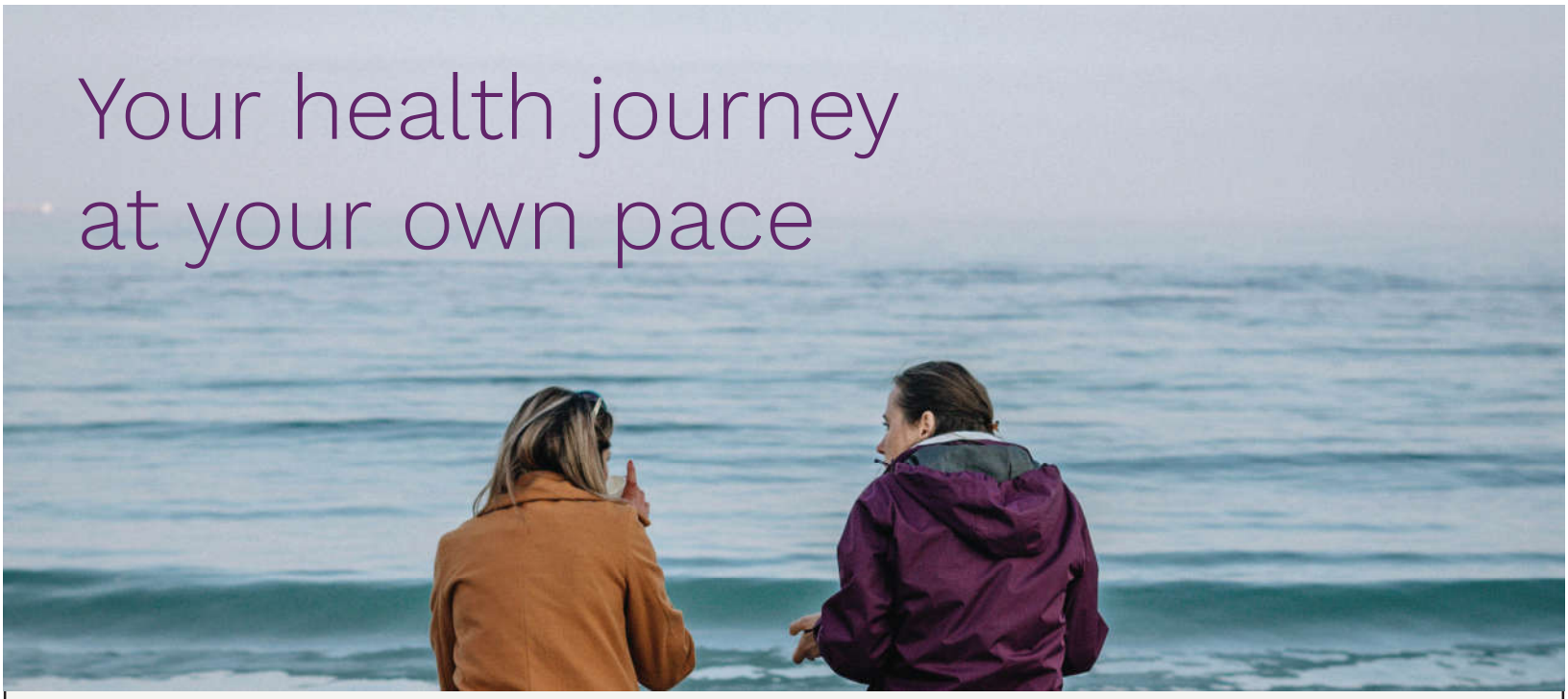
What issues does Tava help resolve?
Tava has therapists who understand and treat many types of issues. See a comprehensive list of issues our therapists often address on the previous page of this document. If you are wondering whether Tava can help you, schedule a free, initial consultation at care.tavahealth.com.

Will my therapist and I be a good match?
Before your first visit, you will fill out a questionnaire that will help Tava suggest therapists for you. If at any time you feel your therapist is not a great fit, it's easy to change therapists. This relationship is a key determinant to the success of therapy.

Is online, video-based therapy effective?
Yes. Research has shown that online, video-based therapy is equivalent to in-person care in diagnostic accuracy, treatment effectiveness, quality of care, and patient satisfaction. In 2018, the American Psychiatric Association issued the following statement in support of telemental health: "Telemedicine in psychiatry, using video conferencing, is a validated and effective practice of medicine that increases access to care. The American Psychiatric Association supports the use of telemedicine as a legitimate component of a mental health delivery system to the extent that its use is for the benefit of the patient, protects patient autonomy, confidentiality, and privacy; and when used consistent with APA policies on medical ethics and applicable governing law."

Schedule your first appointment today at
care.tavahealth.com

Your health journey at your own pace



Many of us have experienced going to the doctor and getting told: “You should eat less, exercise more, take your medicine and come back in three months.”

But how do we execute this plan once we leave the doctor’s office?

This is where Kannact’s one-on-one health coaching comes in.

A free health benefit provided by WCSD

Kannact’s coaches help each individual identify steps that they can take in their daily life to improve the outlook of their chronic condition. Coaching sessions take place via phone call or text message at least once a month depending on each individual’s schedule and needs.

Schedule a call today:

kannact.com/wcsd
1.888.828.7898

Supported Conditions

- Diabetes
- Hyperlipidemia
- Cardiovascular Disease
- Hypertension

How it works

1. Schedule a irst call with your health coach.
2. Commit 15 minutes each month to talk with your coach.
3. Receive free medical devices to monitor your condition.
4. Set goals with your coach and achieve them over time.

Kannact

Additional Information

Important Notices & Disclosures

Washington County School District

Group Health Plan Notices

Annual Required Legal Notices and Disclosures for Plan Participants

The following notices provide important information about your employer provided group health plan. Please read the notices carefully and keep a copy for your records. If you have any questions regarding these notices, please contact Human Resources or the plan administrator at marci.ware@washk12.org or 435-673-3533 x5105.

Medicare Part D Notice

Important Notice About Your Creditable Prescription Drug Coverage and Medicare

If you or any of your eligible dependents are eligible for Medicare, or will soon become eligible for Medicare, please read this notice. If not, you can disregard this notice.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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 prescription 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. Your employer has determined that the prescription drug coverage offered is expected to pay, on average, 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 prescription drug plan.

Please contact Human Resources for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area. Your medical benefits brochure contains a description of your current prescription drug benefits. If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer's group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with your employer and don't join a Medicare prescription 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 Human Resources for further information.

NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage…

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

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 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 the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA 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 prescription 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).**

Women's Health and Cancer Rights Act Notice

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

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

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

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

The Newborns' and Mothers' Health Protection Act (NMHPA) requires that group health plans and health insurance issuers who offer childbirth coverage 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or contact your plan administrator.

For additional information about NMHPA provisions and how Self-funded non Federal governmental plans may opt-out of the NMHPA requirements, visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html.

HIPAA Non-Discrimination Requirements

The Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance
issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in
individual premium or contribution rates based on health factors.
These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as
motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities),
and disability.

Notice of HIPAA Special Enrollment Rights

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

Special Enrollment Provisions

Loss of Other Coverage (Except Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Eligibility Under Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in

effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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

Other mid-year election changes may be permitted under your plan (refer to "Permitted Midyear Election Changes" section below).

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

Permitted Midyear Election Changes

Due to Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election generally must be irrevocable for the entire plan year (with the exception of HSA benefit elections, for which prospective election changes generally are allowed). As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will generally remain in place until the next open enrollment period, unless you have an approved election change event and certain other conditions are met as outlined in IRS Code Section 125. See your Section 125 premium conversion plan summary plan description (SPD) for further details and a complete listing of permitted change in election events.

Examples of permitted change in election events include:

- Change in legal marital status (e.g., marriage, divorce, annulment, or legal separation)
- Change in number of dependents (e.g., birth, adoption, or death)
- Change in your employment status or your spouse's or covered child's change in employment (e.g., reduction in hours affecting eligibility or change in employment)
- Your child satisfies or ceases to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance as provided in the plan under which you receive coverage
- You and/or your spouse or covered child has a change of residence
- Your spouse or covered child makes an election change during an open enrollment period under his or her employer's cafeteria plan, but only if the change under this Plan is consistent with and on account of your spouse's or covered child's change.
- Enrollment in state-based insurance Exchange
- Medicare Part A or B enrollment

These are just some examples of permitted mid-year change in election events. Consult with Human Resources for other circumstances that may be permissible mid-year change in election events.

You must notify Human Resources within 30 days of the above change in status, with the exception of the loss of eligibility or enrollment in Medicaid or state health insurance programs - which requires notice within 60 days.

HIPAA Privacy Notice Notice of Health Information

Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). One of its primary purposes is to make certain that information about your health is handled with special respect for your privacy. HIPAA includes numerous provisions designed to maintain the privacy and confidentiality of your protected health information (PHI). PHI is health information that contains identifiers, such as your name, address, social security number, or other information that identifies you.

How the Health Plan Uses and Discloses Protected Health Information

Under HIPAA, we may use or disclose protected health information (PHI) under certain circumstances without your permission, provided that the legal requirements applicable to the use or disclosure are followed. The following categories describe the different ways that we may use and disclose your PHI. Not every use or disclosure in a category will be listed. However, all the ways permitted to use and disclose information will fall within one of the categories. Most of the time we will use, disclose, and request only the minimum information necessary for these purposes.

For treatment. The plan may use or disclose PHI to facilitate medical treatment or services by health providers. The Health Plan may disclose health information about you to health care providers, including doctors, nurses, technicians, or hospital personnel who need the information to take care of you. For example, the plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription conflicts with your current prescriptions.

For payment. The plan may use or disclose PHI to make payments to health care providers who are taking care of you. The plan may also use and disclose PHI to determine your eligibility for plan benefits, to evaluate the plan's benefit responsibility, and to coordinate plan coverage with other coverage you may have. For example, the plan may share information with health care providers to determine whether the plan will cover a particular treatment. The plan may also share your PHI with another organization to assist with financial recoveries from responsible third parties

For health care operations. The plan may use and disclose PHI to run the plan. For example, the plan may use PHI in connection with quality assessment and improvement activities; care coordination and case management; underwriting, premium rating, and other activities relating to plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general plan administrative activities. However, the plan will not use genetic information for underwriting purposes.

To Business Associates. The plan may contract with third parties, known as "Business Associates," to perform various functions or provide various services on behalf of the plan. To perform these functions or to provide these services, Business Associates may receive, create, maintain, transmit, use, and disclose protected health information, but only after they agree in writing to safeguard PHI and respect your HIPAA rights. For example, the plan may disclose PHI to a third-party administrator to process claims for plan benefits.

As required by law. We will disclose health information about you when required to do so by federal,
state or local law.

To prevent a serious threat to health or safety. The plan may use and disclose PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

To the employer. The plan may disclose PHI to certain employees of the Employer who are involved with plan administration. These employees are permitted to use or disclose PHI only to perform plan administration functions or as otherwise permitted or required by HIPAA, unless you have authorized further disclosures. PHI cannot be used for employment purposes without your specific authorization.

Workers' compensation. The plan may disclose PHI for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public health. The plan may disclose PHI for public health activities, including, for example, to prevent or control disease, injury, or disability; or to report child abuse or neglect.

Health oversight. The plan may disclose PHI to a health oversight agency for activities authorized by law, including, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and disputes. The plan may disclose PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.

Law enforcement. The plan may disclose PHI if asked to do so by a law-enforcement official in certain limited circumstances.

Family members. The plan may disclose PHI to a family member or close personal friend who is involved in your care or payment for your care or for notification purposes. Generally, you will have an opportunity to object to these disclosures. With only limited exceptions, all mail regarding the plan will be sent to the employee unless we have agreed otherwise. This includes mail relating to participation of the employee's spouse and other family members in the plan, such as availability of plan benefits and information on the processing of any plan benefits (including explanations of benefits (EOBs)).

Coroners, medical examiners, and funeral directors. The plan may disclose PHI to a coroner, medical examiner, or funeral director, as necessary for them to carry out their duties.

National security and intelligence activities. The plan may disclose PHI to authorized federal officials for national security activities authorized by law.

Military. The plan may disclose PHI as required by military and veterans authorities if you are or were a member of the uniformed services.

Research. In very limited situations, the plan may disclose protected health information to researchers; however, usually we will need to get your authorization.

Compliance with HIPAA. The plan is required to disclose PHI to the United States Department of Health and Human Services when requested to determine compliance with HIPAA.

Authorizations. Other uses or disclosures of PHI not described above will be made only with your written authorization. For example, the plan generally needs your authorization to disclose psychiatric notes about you; to use or disclose PHI for marketing; or to sell PHI. You may revoke your authorizations at any time, so long as the revocation is in writing. However, the revocation will not be effective for any uses or disclosures made in reliance upon the authorization.

Your Rights

You have the rights described below with respect to PHI about you, subject to certain conditions and exceptions.

Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the

date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting Human Resources. You can file a complaint with the U.S. Department of Health and Human
Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to: (1) Share information with your family, close friends, or others involved in payment for your care. (2) Share information in a disaster relief situation. (3) Contact you for fundraising efforts. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission: (1) Marketing purposes. (2) Sale of your information.

The Plan's Responsibilities

The plan is required to:

- Maintain the privacy and security of your PHI.
- Let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- Will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

More Information

- If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact Human Resources and the plan privacy officer. All requests must be submitted in writing.
- If you believe your privacy rights have been violated, you can file a formal complaint with the plan privacy officer, or with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.
- The plan reserves the right to change the terms of this notice and to make new provisions effective for all PHI that the plan maintains, including PHI created or received prior to any revision. If significant changes are made, the plan will furnish you with a revised copy.

Important Information on How Health Care Reform Impacts Your Plan

Primary Care Provider Designations

For plans and issuers that require or allow for the designation of primary care providers by participants or
beneficiaries:

- Your plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Human Resources office.

For plans and issuers that require or allow for the designation of a primary care provider for a child:

- For children, you may designate a pediatrician as the primary care provider. For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:
- You do not need prior authorization from your insurance provider or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Human Resources office.

Grandfathered Plans

If your group health plan is grandfathered, then the following will apply. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Human Resources.

Prohibition on Excess Waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the
period that must pass before coverage for an eligible employee or his or her dependent becomes effective
under the Plan.

Prohibition on Preexisting Condition Exclusions

Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A preexisting condition includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information. When key parts of the health care law took effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace? The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October for coverage starting as early as January.

Can I Save Money on my Health Insurance Premiums in the Marketplace? You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information? For more information about your coverage offered by your employer, please check your summary plan description or contact the plan administrator. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Employee Rights & Responsibilities under the Family Medical Leave Act (FMLA)

The FMLA only applies to employers that meet certain criteria. A covered employer is a:

- ***Private-sector employer with 50 or more employees in 20 or more workweeks in the current or preceding calendar year (including a joint employer or successor in interest).***
- ***Public agency (including a local, state, or Federal government agency) regardless of number of employees.***
- ***Public or private elementary or secondary school, regardless of number of employees.***

Leave Entitlement

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job
protected leave in a 12-month period to eligible employees for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;

- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.
An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.
Employees do not have to share a medical diagnosis but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.
Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.
Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.
The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.
For additional information or to file a complaint:
(866) 4US-WAGE ((866) 487-9243) TYY: (877) 889-5627
www.wagehour.dol.gov

Notice of Right to Continued Coverage under Uniformed Services Employment & Reemployment Rights Act (USERRA)

Right to Continue Coverage

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
USERRA continuation group health plan coverage is considered alternative group health plan coverage for purposes of COBRA. Therefore, if a you elect USERRA continuation coverage, COBRA continuation group health plan coverage will not be available.
Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

How to Continue Coverage

If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens if You Do Not Elect to Continue Coverage?

If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.
If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage

The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for more details.

Medicare and Health Savings Accounts (HSAs)

If you are approaching Medicare eligibility and you currently contribute to a Health Savings Account (HSA) that is integrated with a High Deduction Health Plan (HDHP), it is important to understand how HSA eligibility rules and Medicare enrollment interact.
An individual is not eligible to make HSA contributions (nor eligible to have employer contributions made to their HSA) if the individual has other coverage including being enrolled in Medicare. An individual who is enrolled in Medicare is not eligible for continued HSA contributions, however, funds that existed in the HSA prior to Medicare enrollment may continue to be used for ongoing medical expenses.
It is important to be aware that Medicare enrollment based on age or disability cannot be waived by individuals who are receiving Social Security benefits. However, Medicare enrollment may be delayed by delaying the receipt of Social Security benefits. For those that delay applying for Medicare, enrollment is generally retroactive for up to six months (that is, Medicare coverage will begin up to six months prior to the month in which they applied). Because the first month of Medicare enrollment will be retroactive for individuals who delay applying for Medicare, those individuals should use extra care when determining the amount of their HSA contributions to avoid excess contributions and possible adverse tax consequences.

Premiums

Premiums

August 1, 2023 - July 31, 2024

Medical

EMI

Traditional Plan - Option 1					
Status	Total Premium Per Month	Employee Contribution 40hrs/1FTE	Employee Contribution 35 hrs/.875FTE	Employee Contribution 30hrs/.7143FTE	COBRA
Single	$635.00	83.00	152.00	241.00	648.00
Two-Party	$1,426.00	185.00	340.00	540.00	1455.00
Family	$2,019.00	262.00	482.00	764.00	2060.00

QHDHP with HSA Plan - Option 2					
Status	Total Premium Per Month	Employee Contribution 40hrs/1FTE	Employee Contribution 35hrs/.875FTE	Employee Contribution 30hrs/.7143FTE	COBRA
Employee	$545.00	19.00	19.00	19.00	556.00
Two-Party	$1,223.00	42.00	189.00	379.00	1248.00
Family	$1,733.00	59.00	268.00	537.00	1768.00
HSA Employer Contribution of $80 and WCSD will match employee contributions of $20 each month	$80+20(match) = $100	$80+20(match) = $100	$80+20(match) = $100	$80+20(match) = $100	N/A

Dental

EMI

Choice PPO					
Status	Total Premium Per Month	Employee Contribution 40hrs/1FTE	Employee Contribution 35hrs/.875FTE	Employee Contribution 30hrs/.7143FTE	COBRA
Single	28.00	0.00	4.00	8.00	29.00
Two-Party	52.00	0.00	7.00	15.00	53.00
Family	97.00	0.00	13.00	28.00	99.00

Basic Life Plan

LifeMap

Status	Total Premium Per Month	Employee Contribution 40hrs/1FTE	Employee Contribution 35hrs/.875FTE	Employee Contribution 30hrs/.7143FTE	COBRA
Employee	2.33	0.00	.30	.59	Portable
Family	.61	0.00	.08	.16	Portable

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

Insurance rate information is estimation only. Employee premiums will be pro-rated based on the fractional amount for certified teachers and 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.


GBS
A Leavitt Group Company