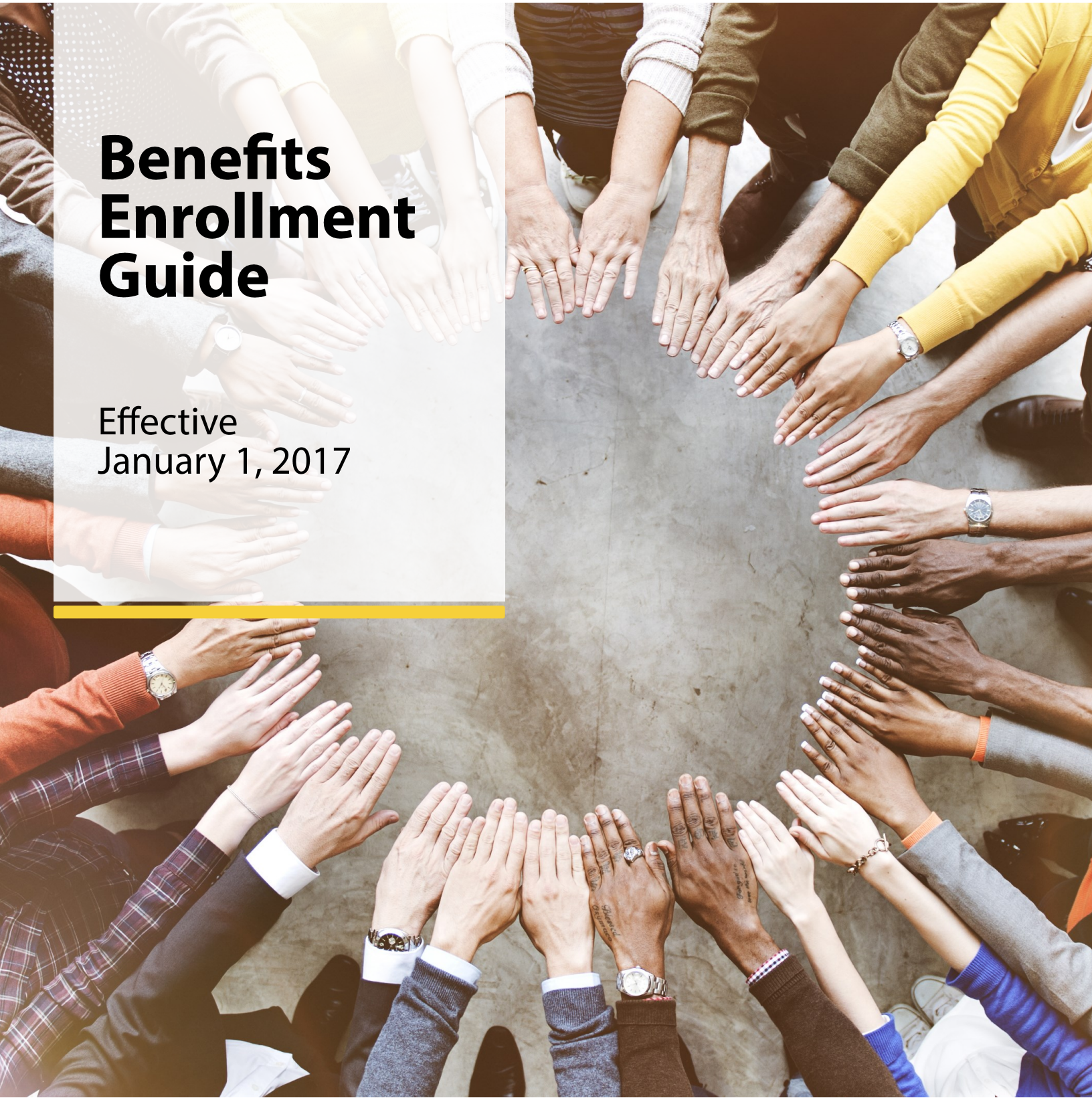
Benefits Enrollment Guide

Effective
January 1, 2017



Utah County
HEART of UTAH

BENEFIT PROGRAM INFORMATION

YOUR BENEFITS

The benefits provided by Utah County are an important part of your compensation package. These benefits provide ongoing health care, tax-deferred savings, and an important financial safety net in case you can no longer provide an income for yourself and/or your family. Please be advised, the purpose of this guide is to provide an overview of your benefit programs. If there is any discrepancy between the insurance carrier's certificate of coverage and this guide, the insurance carrier's certificate of coverage is the prevailing document.

ELIGIBILITY

Coverage begins for enrolled eligible employees on the first of the month following 30 days of employment. To obtain benefits, you must satisfy the following:

- You must be a career-service employee* working 20 hours or more per week
- If eligible, you may enroll your spouse and dependent children on the offered benefit plans
- Dependent children are eligible if less than 26 years of age

OPEN ENROLLMENT

The medical and dental plan year is from Jan. 1, 2017, through Dec. 31, 2017. The next open enrollment period will be held in November.

During open enrollment, you may enroll in or make changes to your benefit programs. Open enrollment is the only time that you may add or change benefits during the year unless you have a qualifying life event. Make sure that you understand the offerings and enroll yourself and your eligible dependents in the programs that you would like for the upcoming plan year.

QUALIFYING CHANGES

The following events allow you a **30-day** special enrollment period to complete and submit a change request to update your benefits outside of the open enrollment period:

- You get married, divorced, or legally separated
- You add a child through birth, adoption, or change in custody
- Your spouse or child dies
- Your spouse or child(ren) lose eligibility for coverage

The following events allow you a **60-day** special enrollment period to complete and submit a change request to update your benefits outside the open enrollment period:

- You, your spouse, or child loses coverage under either a Medicaid plan under Title XIX or under a state child health plan (CHIP) under Title XXI of the Social Security Act due to a loss of eligibility for that program's coverage
- You, your spouse, or child becomes eligible for premium assistance with respect to the cost of coverage under our group health plan through either a Medicaid plan under Title XIX (such as Utah's Premium Partnership) or under a state child heath plan (CHIP) under Title XXI of the Social Security Act (see enclosed disclosure)

*Eligible employees include appointed, elected, and retained by election.

BENEFIT PROGRAM INFORMATION

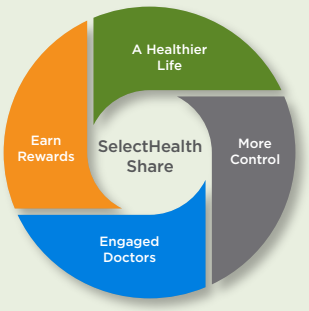
For information about…	Go to…
Your Benefits	Benefits Administration Utah County HR Kellie Manning or Cammie Taylor 801.851.8162 801.851.8161
Customer Service Support	NFP Client Services Libby Deliote, CSR 800.553.3903 libby.deliote@nfp.com
Medical Plan	SelectHealth 800.538.5038 www.selecthealth.org
Dental Plan	Dental Select 800.999.9789 www.dentalselect.com
Vision Plan	EyeMed Vision 866.939.3633 www.eyemedvisioncare.com
Health Savings Account	HealthEquity 866.346.5800 www.healthequity.com
Flexible Spending Accounts	American Benefits Group 800.499.3539 www.amben.com
Life & Disability	CIGNA 800.362.4462 www.cigna.com
Voluntary Benefits	Colonial - Eli Swenson 801.592.0771 www.coloniallife.com
Retirement Plan/401(k)	Prudential Retirement 800.992.4472 www.prudential.com
Employee Assistance Program (EAP)	Intermountain Healthcare 800.832.7733 www.intermountainhealthcare.org/eap

SelectHealth Share℠

Welcome to SelectHealth Share. We want to help you live healthy and give you more control over your healthcare.

Each of the four participants in SelectHealth Share—the health plan, the doctor, the employer, and the employee—plays a role in reducing costs. As a SelectHealth Share member you will be engaged in your healthcare, and we will work with your employer to keep premiums as low as possible. Here's what you need to do to be a fully-engaged SelectHealth Share member:

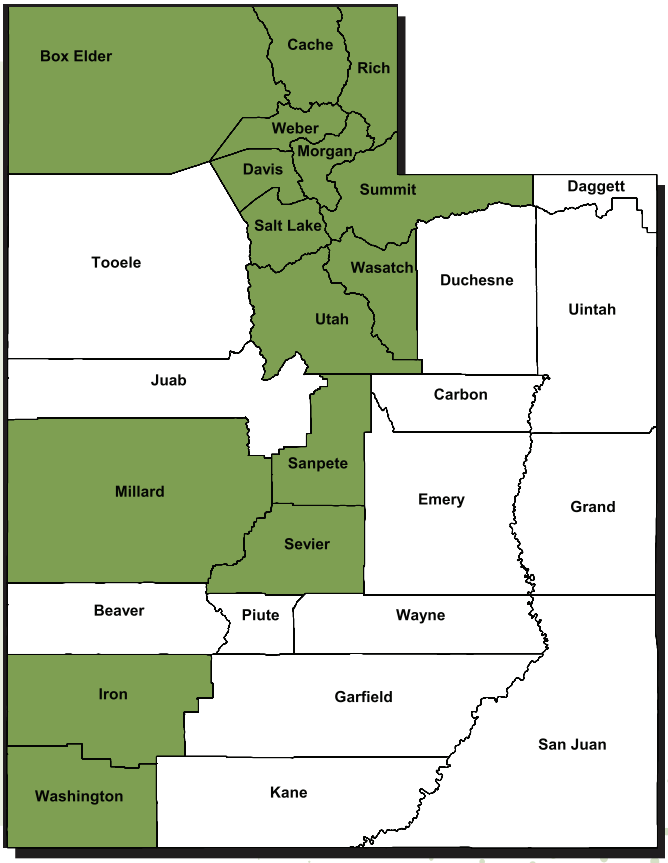
1. If you don't already have a *My Health* account visit **selecthealth.org** and create one from the home page. If you're a mobile user, you can download the SelectHealth app and start a *My Health* account there.
2. Access your Healthy Living account through *My Health* by clicking the "Health and Wellness" button.
3. Take your health assessment on the Healthy Living website. You'll need to complete the assessment as part of your SelectHealth Share commitment .
4. After completing your assessment, you'll get an email inviting you to participate in digital health coaching. Access your digital coaching module(s) from the Healthy Living home page. Be sure to complete at least one of the available modules, as this is a SelectHealth Share commitment.
5. Complete a health screening. This checkup measures things such as blood pressure, waist circumference, and weight. If your employer schedules a health fair with our Healthy Living team you can complete your required health screening at the fair. If not, you can complete your screening at your doctor's office.
6. Complete at least two of the six core challenges or employer-promoted activity campaigns to meet your SelectHealth Share commitment. These campaigns run quarterly and can be accessed from the Healthy Living wellness activities page.



SelectHealth Share Network and Service Area

2,200+ Participating Providers
20 Hospitals

As a SelectHealth Share member, you have access to many Intermountain Medical Group® physicians and more than 1,000 affiliated providers. Additionally, you can use 20 Intermountain Healthcare hospitals in Utah, including recognized facilities such as Primary Children's Hospital, Intermountain Medical Center®, The Orthopedic Specialty Hospital (TOSH®), Utah Valley Regional Medical Center, McKay-Dee Hospital, and Dixie Regional Medical Center.



7. When you're ready to see a doctor, make sure you choose a doctor on the SelectHealth Share network. Visit **selecthealth.org/providers** and choose the SelectHealth Share network. You'll see more than 2,200 providers to choose from—pick the one that meets your needs. Tell us who you've chosen by selecting "Update Primary Care Physician" under the Insurance tab in *My Health*. Or call Member Services and tell a customer service representative. During your first appointment, let the doctor know you are participating in SelectHealth Share. Also, talk to your doctor about the preventive care you need. It could be time for a colonoscopy, mammogram, or routine physical. Completing preventive screenings as prescribed by your doctor is part of your SelectHealth Share commitment. The good news? Many of these services may be free to you. See the rest of your Member Materials for more information about preventive care.
8. If you choose the SelectHealth Share High Deductible Health Plan (HDHP) you will need to create a Health Savings Account (HSA). We recommend working with HealthEquity®. They make it simple to create an account by visiting **healthequity.com** or by calling **866-346-5800**. Once your account is set up, you will need to make a deposit. Your employer offers some matching dollars, and you may be able to work with your payroll department to deposit a portion of your pre-tax wages into your account. If a payroll deposit is not available, you can make deposits into your HSA directly from your personal checking account. When you sign up, you'll get a HealthEquity Visa Card® that you can use for eligible healthcare expenses.
9. Do you have temporary or ongoing health issues—like diabetes, tobacco use, pregnancy, or obesity? If so, part of your SelectHealth Share commitment is to participate in programs designed to help you live healthy. The good news is that when you participate in some of these programs, like care management, you'll earn financial rewards (pre-loaded onto a Healthy Rewards Visa) that you can use to pay for healthcare expenses. Keep in mind that there may be financial penalties (in the form of higher premiums) if you don't participate.

You may receive an invitation to:

- Enroll in Weigh to Health® (for weight loss).
- Work with one of our care managers if you have asthma, diabetes, chronic obstructive pulmonary disease, congestive heart failure, or other complex health conditions. Our care managers can help you schedule appointments and make sure you get the care you need.
- Participate in the SelectHealth Healthy Beginnings® maternity program, when pregnant.
- Complete the educational portion of a tobacco cessation program, like Quit For Life® (for tobacco users).
- Use Shared Decision Making modules, as prescribed by a physician and when appropriate (financial incentives for certain procedure modules will be available).

We look forward to building strong relationships with our SelectHealth Share members. If you have questions, call Member Services at **800-538-5038**. Identify yourself as a SelectHealth Share member and you will be connected to our dedicated SelectHealth Share service team.

SHARE CHECKLIST:

- ❑ Create a *My Health* account on **selecthealth.org**
- ❑ From *My Health*, access a Healthy Living account
- ❑ Take your annual health assessment on the Healthy Living website
- ❑ Participate in at least one digital coaching module (you will get an email invitation to participate)
- ❑ Complete a health screening at a health fair or with your doctor
- ❑ Finish at least two of the six core challenges or participate in employer-promoted activity campaigns
- ❑ When you're ready to see a doctor choose one on the SelectHealth Share network And have your annual preventative exam
- ❑ Tell us the name of your doctor through My Health or by calling Member Services
- ❑ If you choose the High Deductible Health Plan, set up a Health Savings Account and make deposits to fund the account.
- ❑ Participate in care management or other programs if necessary

NEED MORE INFORMATION?

WEB
selecthealthshare.org

PHONE
800-538-5038

SelectHealth Share-HSA Qualified High Deductible Health Plan	
	In-Network
Preventive Care Services Primary Care Provider Specialist Physician Diagnostic Tests (Lab, X-Ray)	Covered 100%
Deductible (Single/Family)	You Pay $2,000/$4,000
Out of Pocket Maximum (Single/Family) Includes Copays, Coinsurance & Deductibles	$3,000/$6,000
Office Visits	You Pay
Primary Care Provider	$15 AD
Specialist Physician	$25 AD
Urgent Care	$35 AD
Prescriptions	Tier 1 / Tier 2 / Tier 3 / Tier 4
30 Day Supply	$7 AD / $21 AD / $42 AD / $100 AD
Mail Order- 90 Day Supply	$7 AD / $42 AD / $126 AD
Diagnostic Lab/X-Ray Services	You Pay
Minor	Covered 100% AD
Major	20% AD
Hospital Services*	You Pay
Outpatient	20% AD
Inpatient	20% AD
Maternity	20% AD
Durable Medical Equipment*	20% AD
Emergency Room	$75 AD (Participating and Non-Participating Facility)
Mental Health Services*	You Pay
Outpatient	20% AD
Inpatient	20% AD

AD: After Deductible

*Pre-service notification may be required.

This plan only offers in-network benefits except on emergency care. To receive the maximum benefits from the plan you should always use participating providers. To find a provider, use the respective contact information shown on the first page in this guide.

SelectHealth Share-HSA QHDHP Employee Cost Per Pay Period (24)			
	Full Time	**3/4 Time**	**1/2 Time**
Employee Only	$0.00	$0.00	$131.25
Employee + Spouse	$0.00	$0.00	$265.83
Family	$0.00	$0.00	$356.15

HEALTH SAVINGS ACCOUNT

What is a Health Savings Account (HSA)?

A qualified high deductible health plan with a Health Savings Account is an alternative to traditional health insurance plans. The HSA is a savings product that offers a different way for consumers to pay for their health care costs. HSAs enable you to pay for current, qualified expenses and save for future medical and retiree health expenses on a tax-free basis.

You must be covered by a Qualified High Deductible Health Plan (QHDHP) to be able to contribute to an HSA. You own and control the money in your HSA. As your account balances grow, you may also decide what types of investments to make with your HSA money.

You and/or your employer may contribute to your HSA, up to the legal maximum. **In 2017, the maximum annual contribution for single enrollee set by the IRS is $3,400, and the maximum family contribution is $6,750.** A catch-up contribution, up to an additional $1,000, is allowed for individuals who are 55 years or older. Please see the contribution chart below to determine the amount contributed to your HSA by your employer.

What you can do with your HSA

- Pay qualified health care expenses: Use the HealthEquity online PayChoice payment platform at www.MyHealthEquity.com to pay for qualified health care expenses. You can use your debit card, request a check by phone or online, or transfer funds online
- Save money for future medical expenses: You may not have significant health care expenses every year, but saving the maximum amount every year helps you build a sizeable savings for when you are faced with larger medical expenses
- Save for post-retirement expenses: Once you reach age 65, you can use your HSA funds to pay for anything you wish. Qualified medical expenses are still not taxed; any other expenses are subject to tax but not penalties

Your HSA is *your* money. Whatever you do not spend in a given year rolls over to the next. If you change jobs or retire, your HSA balance goes with you.

HSA/HDHP Annual Limits		
	Single Coverage	**Family Coverage**
2017 Maximum Contribution to HSA	$3,400	$6,750
Catch-up Contribution (age 55 & older)	$1,000	$1,000

Share HSA Incentive	
2017 Incentive Contribution to HSA	
up to Single: $400	Receive: • $100 per core challenge, up to two per year. • $100 for Annual Health Assessment and health screening within 90 days. • $100 Preventive Exam.
up to 2-Party/Family: $800	Receive: • $200 per core challenge, up to two per year. • $200 for Annual Health Assessment and health screening within 90 days. • $200 Preventive Exam.

Annual HSA Matching Contribution
With the Share Program, Utah County will contribute to your Health Savings Account on a 1:1 match.
Single $400 1:1 2-Party/Family $800 1:1
Participants are also eligible for additional incentive dollars. See the chart to the left for details.

This outline is for plan comparison purposes only. Refer to plan certificate(s) for additional details– 2017

SelectHealth Share Signature Plan	
	In-Network
Preventive Care Services Primary Care Provider Specialist Physician Diagnostic Tests (Lab, X-Ray)	Covered 100%
Office Visits	You Pay
Primary Care Provider	$25
Specialist Physician	$40
Urgent Care	$40
Prescriptions	Tier 1 / Tier 2 / Tier 3 / Tier 4
Deductible	$100 Per Person
30 Day Supply	$15 / $30 APD/ $50 APD / $100 APD
Mail Order- 90 Day Supply	$15 / $60 APD/ $150 APD / NA
Deductible (Single/Family)	You Pay $1,000/$2,000
Out of Pocket Maximum (Single/Family) Includes Copays, Coinsurance & Deductibles	$3,000/$6,000
Diagnostic Lab/X-Ray Services*	You Pay
Minor	Covered 100%
Major	20% AD
Hospital Services*	You Pay
Outpatient	20% AD
Inpatient	20% AD
Maternity	20% AD
Durable Medical Equipment*	20% AD
Emergency Room	$250 AD (Participating and Non-Participating Facility)
Mental Health Services*	You Pay
Outpatient	20%
Inpatient	20% AD
Chiropractic (15 Visits Per Year)	$20

AD: After Deductible; APD: After Prescription Deductible

*Pre-service notification may be required.

This plan only offers in-network benefits except on emergency care. To receive the maximum benefits from the plan you should always use participating providers. To find a provider, use the respective contact information shown on the first page in this guide.

SelectHealth Share Signature Plan Employee Cost Per Pay Period (24)			
	Full Time	**3/4 Time**	**1/2 Time**
Employee Only	$42.40	$42.40	$173.65
Employee + Spouse	$85.80	$85.80	$351.63
Family	$114.95	$114.95	$471.10

Medical Rates

Career Service Employee* Status Definition	
Full-Time	Regularly scheduled 40 hours per week
3/4 Time	Regularly scheduled 30 - 39.5 hours per week
1/2 Time	Regularly scheduled 20 - 25 hours per week

SelectHealth Share-HSA QHDHP Employee Cost Per Pay Period (24)			
	Full Time	3/4 Time	1/2 Time
Employee Only	$0.00	$0.00	$131.25
Employee + Spouse	$0.00	$0.00	$265.83
Family	$0.00	$0.00	$356.15

SelectHealth Share Signature-Plan Traditional Employee Cost Per Pay Period (24)			
	Full Time	3/4 Time	1/2 Time
Employee Only	$42.40	$42.40	$173.65
Employee + Spouse	$85.80	$85.80	$351.63
Family	$114.95	$114.95	$471.10

Share Signature-Plan Cash (taxable) incentive available for Share engagement	
up to Single: $400	Receive: • $100 per core challenge, up to two per year. • $100 for Annual Health Assessment and health screening within 90 days. • $100 Preventive Exam.
up to 2-Party/Family: $400	Receive: • $200 per core challenge, up to two per year. • $200 for Annual Health Assessment and health screening within 90 days. • $200 Preventive Exam.

Waiver Incentive Utah County Contribution to Employee's PaycheckPer Pay Period (24)			
	Full Time	3/4 Time	1/2 Time
Employee Only	$40.00	$30.00	$20.00
Employee + Spouse	$80.00	$60.00	$40.00
Family	$80.00	$60.00	$40.00

*Eligible employees include appointed, elected, and retained by election.

SelectHealth Healthy Living®

2017 CHALLENGE CALENDAR

2017 CHALLENGE I
Scale the Summits

Registration Start: 1/3/17

Challenge Start: 1/23/17

Challenge End: 2/19/17

2017 CHALLENGE II
American Adventure

Registration Start: 2/22/17

Challenge Start: 3/6/17

Challenge End: 4/2/17

2017 CHALLENGE III
The Outback

Registration Start: 4/19/17

Challenge Start: 5/1/17

Challenge End: 5/28/17

2017 CHALLENGE IV
US National Parks

Registration Start: 6/21/17

Challenge Start: 7/3/17

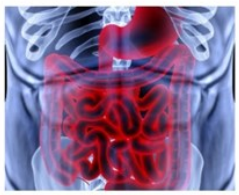
Challenge End: 7/30/17

2017 CHALLENGE V
European Expedition

Registration Start: 8/23/17

Challenge Start: 9/4/17

Challenge End: 10/1/17



2017 CHALLENGE VI
The Human Body

Registration Start: 10/18/17

Challenge Start: 10/30/17

Challenge End: 11/26/17

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Questions??
Contact Selecthealth Member Services
1-800-442-5260
or
Your on-site wellness coordinator
Kari Schmidt
801-851-7098
karis@utahcounty.gov

DENTAL

Dental Select - Gold Plan	
	In-Network Benefits Only
	You Pay
Deductible (Individual/Family) [Calendar Year]	No Deductible
Preventive Services Routine Exams, Cleanings, Topical Fluoride, X-rays	Covered 100%
Basic Services Fillings, Periodontics, Oral Surgery	Up to 70% Coverage*
Major Services Crowns, Bridges, Dentures, Endodontics	Up to 50% Coverage*
Calendar Year Maximum	No Maximum
Orthodontia- Children & Adults	20% Discount
Orthodontia Lifetime Maximum	No Maximum
Specialists Endodontists, Oral Surgeons, Orthodontists, Periodontists, Prosthodontists, Pediatric Specialists	20% Discount

There is no Out-of-Network Benefit.

*Fixed Copays. Refer to Patient Copay Schedule.

In-Network General Dentists: Providers accept combination of fixed copay and insurance payment

In-Network Specialists: You receive 20% off the specialists' fee for covered services.

Discount Only: No benefit will be paid.

This plan offers only in-network benefits. To find a provider, use the respective contact information shown on the first page in this guide.

Dental Select Gold Plan	Employee Cost Per Pay Period (24) (Full Time, 3/4 Time, 1/2 Time)
Employee Only	$0.00
Two-Party	$1.87
Family	$10.55

DENTAL

Dental Select - Platinum Plan		
	In-Network	Out-of-Network*
	You Pay	
Deductible (Individual/Family) [Calendar Year]	$50/$150	
Preventive Services Routine Exams, Cleanings, Topical Fluoride, X-rays	Covered 100%	20% UCR
Basic Services Fillings, Routine Extractions, Oral Surgery, Root Canal, Endodontics	20%	40% UCR
Major Services Crowns, Bridges, Dentures, Periodontics	50%	60% UCR
Calendar Year Maximum	$1,500 per person per year	
Orthodontia- Children under 19	50%	
Lifetime Maximum Per Child	$1,500	
Adults 19 and Older	20% Discount	No Discount
Specialists Endodontists, Oral Surgeons, Orthodontists, Periodontists, Prosthodontists, Pediatric Specialists	*See Below	Reimbursed same as General Dentists

UCR: Usual, Customary, and Reasonable Fees for Utah. You pay any balance billing.

* 1) You receive a 20% discount off the Specialist's fee.
2) After discount, plan pays according to the General Dentist's Schedule of Fees

This plan may offer in-network and out-of-network benefits. However, to receive the maximum benefits from the plan you should always use participating providers. To find a provider, use the respective contact information shown on the first page in this guide.

Dental Select Platinum Plan	Employee Cost Per Pay Period (24) (Full Time, 3/4 Time, 1/2 Time)
Employee Only	$0.81
Two-Party	$23.30
Family	$39.62

VISION

EyeMed Vision - Base Plan		
	In-Network	**Out-of-Network**
Lenses or Contact Lenses	Once Every 12 Months	
Frames	Once Every 24 Months	
Frames, Lens & Options Any frame, lens, and lens options at provider location	$100 Allowance for frame, lens, and lens options 20% off balance over $100	Up to $50
Contact Lens (Materials Only) Conventional Contacts Disposable Contacts	$0 Copay, $100 Retail Allowance, 15% Discount off Balance over $100	Up to $80
Medically Necessary Contacts	$0 Copay, Paid in Full	Up to $200
Additional Eyewear Purchases	40% off Additional Pairs of Glasses and 15% off Conventional contact lenses Purchased Within the Same Plan Year, Once the Benefit Above has Been Utilized	N/A

Be sure to choose a provider from the Access Network.

This plan may offer in-network and out-of-network-benefits. However, to receive the maximum benefits from the plan you should always use participating providers. To find a provider, use the respective contact information shown on the first page in this guide.

EyeMed Vision Base Plan	Employee Cost Per Pay Period (24) (Full Time, 3/4 Time, 1/2
Employee Only	$2.36
Two-Party	$4.43
Family	$6.48

VISION

EyeMed Vision High Plan		
	In-Network	**Out-of-Network**
Examinations	Once Every 12 Months	
Lenses or Contact Lenses	Once Every 12 Months	
Frames	Once Every 24 Months	
Exam w/Dilation as Necessary	$20 Copay	Up to $35
Frames -Allows ANY Frame at Provider Location to be Chosen	$0 Copay; $100 Retail Allowance, 20% Discount Over $100	Up to $45
Standard Plastic Lenses		
Single Vision	$20 Copay	Up to $25
Bifocal	$20 Copay	Up to $40
Trifocal	$20 Copay	Up to $55
Lens Options - Contracted Fees		
Tint (Solid & Gradient)	$15 Contracted Fee	Non-Contracted (Provider Discretion)
UV Coating	$15 Contracted Fee	
Standard Scratch Resistance	$15 Contracted Fee	
Standard Polycarbonate	$40 Contracted Fee	
Standard Anti-Reflective	$45 Contracted Fee	
Standard Progressive (Add-on Bifocal)	$65 Contracted Fee	
Other Add-Ons and Services	20% Off Retail Price	
Contact Lens Exam Options		
Standard Contact Lens Fit & Follow Up	Up to $55	N/A
Premium Contact Lens Fit & Follow Up	10% Off Retail Price	N/A
Contact Lens - Materials		
Conventional Contacts (in Lieu of Lenses)	$0 Copay, $115 Retail Allowance, 15% Discount off Balance Over $115	Up to $92
Disposable Contacts (in Lieu of Lenses)		
Medically Necessary Contacts	$0 Copay, Paid in Full	Up to $200
Additional Eyewear Purchases	40% off Additional Pairs of Glasses and 15% off Conventional contact lenses Purchased Within the Same Plan Year, Once the Benefit Above has Been Utilized	N/A
Lasik and PRK Vision Correction	15% off Retail Price or 5% Off Promotional Pricing	N/A

Be sure to choose a provider from the Access Network.

This plan may offer in-network and out-of-network-benefits. However, to receive the maximum benefits from the plan you should always use participating providers. To find a provider, use the respective contact information shown on the first page in this guide.

EyeMed Vision High Plan	Employee Cost Per Pay Period (24) (Full Time, 3/4 Time, 1/2 Time)
Employee Only	$2.90
Two-Party	$5.46
Family	$8.00

CAFETERIA PLAN

You have the option to participate in an employee benefit that may increase your spendable income and lower your taxes. A Cafeteria Plan allows you to pay for your portion of the group benefit premium, un-reimbursed health care expenses, and dependent or child care services with **pre-tax dollars**. With a Cafeteria Plan, contributions are deducted from your paycheck before state and federal taxes. By making these contributions with pre-tax dollars, you will reduce your taxable income **and take home a larger portion of your paycheck.**

Three Components of the Cafeteria Plan:

1. **Group Benefit Premiums:** A Cafeteria Plan allows your portion of group medical, dental, vision, and most supplemental plan premiums to be deducted from your paycheck on a pre-tax basis.

2. **Flexible Spending Account (FSA)-Health Care Reimbursement (Including Dental and Vision):** Each year, you may set aside up to $2,600 pre-tax dollars to pay for qualifying out-of-pocket medical, dental, vision, and some over the counter expenses. **A Limited Purpose Flexible Spending plan, associated with HSA participation can only be used for dental and vision expenses.**

3. **Flexible Spending Account (FSA)-Dependent Care Reimbursement**: Each year, you may set aside up to $5,000 pre-tax dollars (or $2,500 if you are married and filing individually) to pay for eligible dependent care expenses. This may include child care, elder care, or other eligible dependent care. Funds are available for reimbursement only as they are deducted from your paycheck.

There are two types of Cafeteria Plan Flexible Spending Accounts Available:

Flexible Spending Account–To be used without HSA Account Participation

Limited Purpose Flexible Spending Account–To be used with HSA Account Participation

Facts You Should Know:

- Participation is voluntary
- Participation in the plan simply allows you to pay for qualified expenses with pre-tax dollars
- Flexible Spending Accounts are subject to the “use it or lose it” rule,. Participants may forfeit any balance in the account(s) at the end of the plan year
- Over-the-counter medications and other items will not be eligible without a prescription. See IRS list for eligible expenses

Example of Savings Using a Flexible Spending Account		
	Without Flexible Spending	With Flexible Spending
Gross Income	$40,000	$40,000
Pre-Tax Expenses for Health/Dependent Care	$0	$2,500
Taxable Income	$40,000	$37,500
Less Taxes	$10,279	$9,563
After-Tax Expenses for Health	$2,500	$0
Spendable Income	$27,221	$27,938
Your Savings With Flexible Spending		**$716**

LIFE & DISABILITY

CIGNA- Basic Life, AD&D, Dependent Life	
Employee Life Benefit	$40,000
Employee AD&D	Matches Basic Life Benefit
Spouse Life Benefit	$10,000
Child(ren) Life Benefit	$10,000

AD&D: Accidental Death & Dismemberment

CIGNA - Long-Term Disability	
Elimination Period	120 days
Benefit Percentage	60%
Maximum Monthly Benefit	$5,000
Benefit Duration	Social Security Normal Retirement Age
Definition of Disability	2 years-own occupation
Mental Illness/Substance Abuse	24 months
Pre-Existing Condition Limitations*	3/3/12

* This limitation applies to conditions for which an employee receives medical services within three months of the effective date of coverage. No benefits are payable for a disability resulting from such condition until the employee has been covered for three consecutive months with no medical care for the condition, or until the employee has been covered for 12 consecutive months.

Utah County - Survivor Income	
This benefit is paid to the surviving spouse and/or children of an employee who dies while covered by the life insurance. The benefit is based on the monthly Utah County salary at the time of the employee's death.	
Benefits Paid to:	
Spouse	To age 65 or remarriage, whichever comes first
Child(ren)	Benefits are paid to eligible unmarried child(ren) under age 21 if there is no surviving spouse. If more than one eligible child survives, a 20% benefit shall be divided equally among the children.
Benefit Amount:	
Spouse only	30% of the employee's monthly pay
Child(ren) only	20% of the employee's monthly pay
Spouse and child(ren)	40% of the employee's monthly pay

Your employer pays the full cost for basic life, accidental death and dismemberment (AD&D) and long-term disability (LTD) benefits for all benefit eligible employees.

Employee Cost
$0.00

VOLUNTARY LIFE

In addition to the basic life insurance provided by your employer, you have the option to buy supplemental life insurance. To purchase any of these plans talk to your HR director.

CIGNA- Voluntary Life	
Employees:	
Benefit Amount	$10,000 increments
Minimum Benefit	$10,000
Maximum Benefit	$300,000*
Guarantee Issue Amount	The lesser of 3 times annual compensation to a maximum of $300,000 at hire (with evidence of insurability for late entrants).
Portability Option	Included
Spouse:	
Benefit Amount	$5,000 increments
Minimum Benefit	$5,000
Maximum Benefit	$200,000 (not to exceed 100% of employee voluntary life)*
Guarantee Issue Amount	$20,000 at hire (with evidence of insurability for late entrants).
Portability Option	Included
Child(ren):	Birth to 26 years
Option 1-Benefit Amount	$5,000
Option 2-Benefit Amount	$10,000
Portability Option	Included

*Basic life benefits illustrated on previous page ($40,000 for employee/$10,000 for spouse) do not count toward the maximum benefit amounts for voluntary life.

Voluntary Life Rates		
Monthly Rates for Every $1,000 of Coverage		
Age Band	Rate per $1,000 Smoker	Rate per $1,000 Non-Smoker
< 25	$0.117	$0.065
25-29	$0.117	$0.065
30-34	$0.143	$0.065
35-39	$0.195	$0.078
40-44	$0.312	$0.130
45-49	$0.494	$0.221
50-54	$0.741	$0.338
55-59	$1.001	$0.481
60-64	$1.586	$0.819
65-69	$2.912	$1.638
70-74	$5.200	$3.432
75+	$8.801	$6.279

Child(ren) Voluntary Life Rates	
$5,000 Benefit	$0.78
$10,000 Benefit	$1.56

OTHER VOLUNTARY

You have the option to pay for supplemental voluntary insurance. To purchase any of these plans talk to your HR department.

Insurer	Insurance	Description
Colonial	Short-Term Disability	Replaces a portion of your income to help make ends meet if you become disabled from a covered accident or covered sickness.
Colonial	Accident	Helps offset the unexpected medical expenses, such as emergency room fees, deductibles and copayments, that can result from a fracture, dislocation or other covered accidental injury.
Colonial	Cancer	Helps offset the out-of-pocket medical and indirect, non-medical expenses related to cancer that most medical plans don't cover. This coverage also provides a benefit for specified cancer-screening tests.
Colonial	Critical Illness	Complements your major medical coverage by providing a lump-sum benefit that you can use to pay the direct and indirect cost related to a covered critical illness, which can often be expensive and lengthy.
Colonial	Hospital Confinement	Provides a lump-sum benefit for a covered hospital confinement and a covered out-patient surgery to help offset the gaps caused by copayments and deductibles that are not covered by most major medical plans.
Colonial	Life	Enables you to tailor coverage for your individual needs and helps provide financial security for your family members.

- Coverage is available for your spouse and children with most products.
- Benefits are paid directly to you, unless you specify otherwise.
- With most plans, you can continue coverage when you retire or change jobs, with no increase in premiums.
- With most plans you receive benefits regardless of any other insurance you may have.

Employee Cost
Contact Colonial for enrollment forms and cost.

EMPLOYEE ASSISTANCE PROGRAM

Intermountain EAP	
Eligibility	Services are offered to employees and spouses /dependent children.
Service Fees	The entire cost of EAP services is covered in a monthly fee paid by your employer. Services provided by Intermountain Healthcare are free, with no copayment or deductible required.
Services	**Individual counseling—**brief, solution-focused therapy model **Marital and relationship counseling—**relationship seminars and marital counseling **Family counseling—**supports parents' attempts to assist their children **Group counseling—**therapy and educational groups available **Financial counseling and referrals—**training in cash flow management skills. Referral to community resources, if necessary. **Elder Care support and referrals—**offers support in finding Elder Care for your parents and aging loved ones. Provides support in assessing your elder's overall situation, determining next steps to take, and identifying appropriate local services and resources. Offers support with the relationship issues that accompany this process. **Crisis intervention services—**assistance available 24 hours a day, seven days a week. **Educational seminars—**generally presented at worksite and designed to offer specific, helpful suggestions on a variety of topics, ranging from wellness to work-life issues.
Locations	Intermountain Healthcare has full-time offices in Bear River, Bountiful, Brigham City, Logan, Ogden, Salt Lake City, Murray, Sandy, West Valley, Provo, Richfield, Delta, Mt. Pleasant, Cedar City, Panguitch, and St. George.
EAP Referrals	Some types of problems will not respond to the short-term therapy offered by the EAP and are referred to community providers. The cost of referred services are not covered by the EAP.
Confidentiality	The EAP is a confidential service and no one will know that you used it. In addition to secure filing systems, disclosure of any information to third parties is performed only with your written consent in compliance with professional, federal and state confidentiality guidelines.

Your employer offers an Employee Assistance Program (EAP) through Intermountain Healthcare. This resource can be used to resolve distressing work or life related issues. To schedule your appointment call 800-832-7733 or visit intermountainhealthcare.org/eap

Advantage Choice

The Benefits You Can Depend On.

Advantage Choice benefit plans provide access to packages that helps you save money by providing discounts on out-of-pocket medical costs and uncovered services. All benefits are available for your immediate family upon receipt of the membership kit.

Please select one of the following

Advocacy Package ☐	Advocacy Plus Package ☐	Advocacy Complete Package ☐	Fun Lifestyle Package ☐
• Teladoc • Medical Health Advisor • Medical Bill Saver TM • NurselineTM • Doctors Online • Health Wealth Connection	• Teladoc • Medical Health Advisor • Medical Bill Saver TM • Nurseline TM • Doctors Online • Health Wealth Connection • Vision • Dental • Pharmacy • Pet Care • Lab Testing • MRI & CT Scans • Hearing Aids • Diabetic Management	• Teladoc • Medical Health Advisor • Medical Bill Saver TM • NurselineTM • Doctors Online • Health Wealth Connection • Vision • Dental • Pharmacy • Pet Care • Lab Testing • MRI & CT Scans • Hearing Aids • Diabetic Management • Legal Care Direct • Safe Identity (Family) • Roadside Assistance	• Recreation Savings • Golf & Ski Savings • Dining Savings • My Deals Mobile App
Advocacy Package	Advocacy Plus Package	Advocacy Complete Package	Fun Lifestyle Package
$8.00/mo.	$12.00/mo.	$15.00/mo.	$7.00/mo.

Defined Benefit Plan

Participation in a Utah Retirement System (URS) pension plan is mandatory for most Career Service* employees. Plans vary based upon employee's hire date. The County pays all or a portion depending on which URS plan the employee is eligible to participate in.
This valuable benefit provides retirement income based upon salary, length of service, and /or contributions. Visit the URS website for more information (www.urs.org).

Defined Contribution Plans**

401(k) Retirement Plan

All Career Service* employees hired after January 2012 will automatically be enrolled after 60 days, and deductions of 6.2% will be taken from the employee's gross salary unless the employee makes a different payroll election. The employee has the option to make pre-tax or post-tax (ROTH 401k) contributions through payroll deductions. Upon completion of probation Utah County will make a dollar-for-dollar matching contribution up to 6.2%.
At retirement, termination of employment, or age 59 1/2, employees may elect partial withdrawals, structured payments, lump sum amounts, or may choose to defer distribution until a later date. Early-withdrawal tax penalties may apply.

457(b) Deferred Compensation Plan

The 457(b) Deferred Compensation Plan is voluntary for Career Service* employees.
Payroll deductions are withheld before income taxes are calculated and are not taxable until withdrawn.
At retirement or termination of employment, employees may elect partial withdrawals, structured payments, lump sum amounts, or may choose to defer distribution until a later date.
The entire balance (less tax withholdings) of the account may be distributed to the employee at retirement or termination. There is NO early withdrawal penalty assessed on a 457(b) account.

*Eligible employees include appointed, elected, and retained by election.

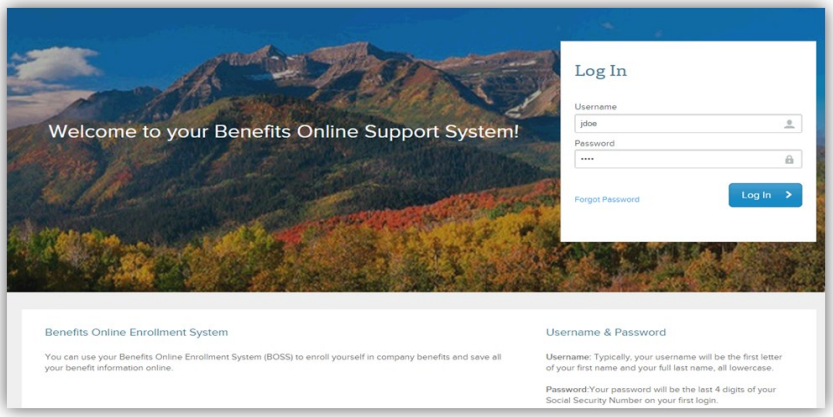
**FICA replacement

Retirement plan participants may want advice as they face complex decisions and choices that will define their retirement income potential in the future. Most feel unprepared to make these difficult decisions alone.

Our **RetireReady** program delivers participants the tools they need to get on track to retire successfully. NFP's retirement plan advisors are licensed and trained to deliver sound advice, rooted in research-proven retirement planning techniques and investment advisory services. To schedule your appointment with an NFP advisor, look for communication and instructions from your Human Resource department.

Log In

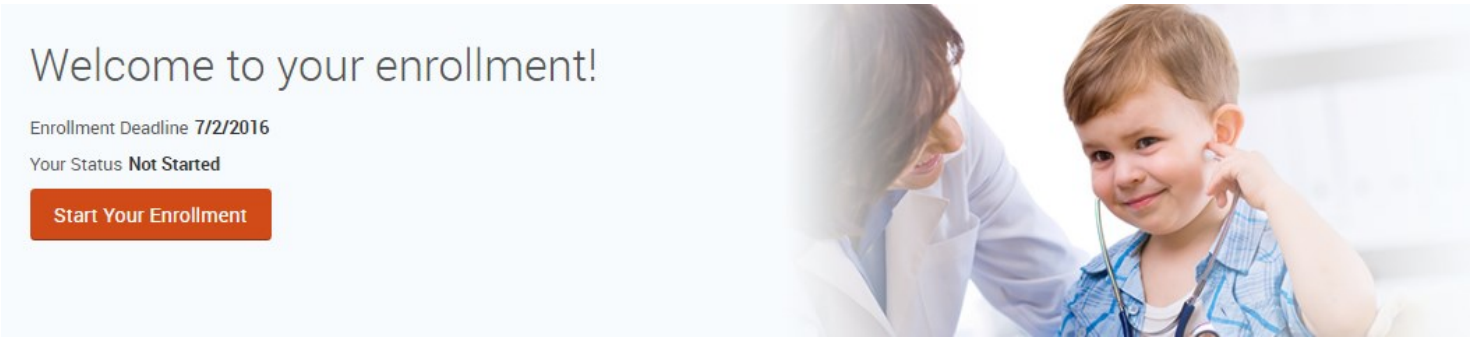
You can login directly to your online enrollment site by using the web address www.utahcounty.bswift.com. You will be directed to your company's login screen, similar to the picture below. **Instructions for your Username and Password will be in the bottom right hand corner of your login webpage.** Please contact your HR Department or NFP, at 1-801-224-9600 or 1-800-553-3903 if you have any problems logging in.



Get Started

Once you are logged in, you will be directed to your Home Page, similar to the picture below. Click the **Start Your Enrollment** button to begin your enrollment.

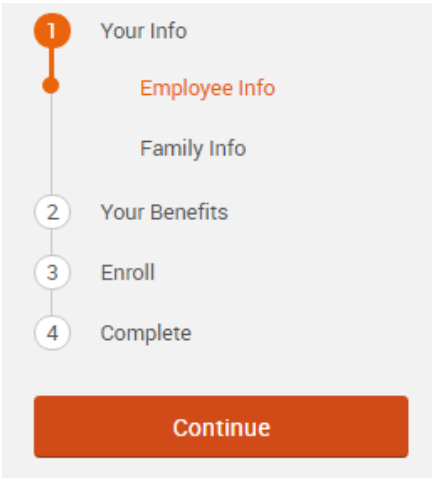
Enrollment: Four Steps



You must complete all four steps in order for your enrollment to be saved!

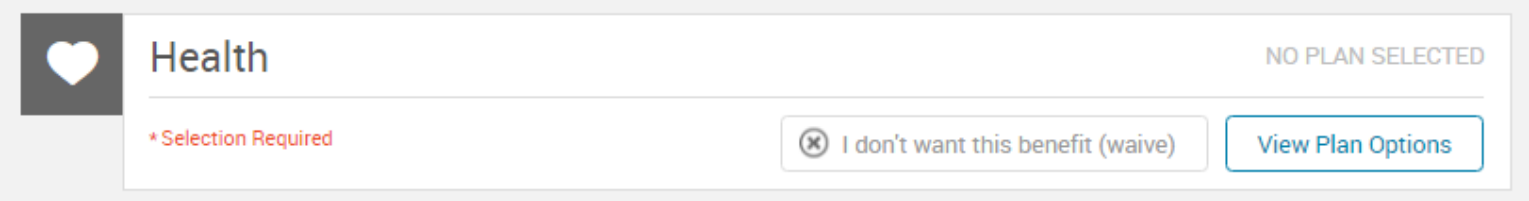
Step 1: Verify Personal and Family Information

You will be required to verify and update your personal and family information.



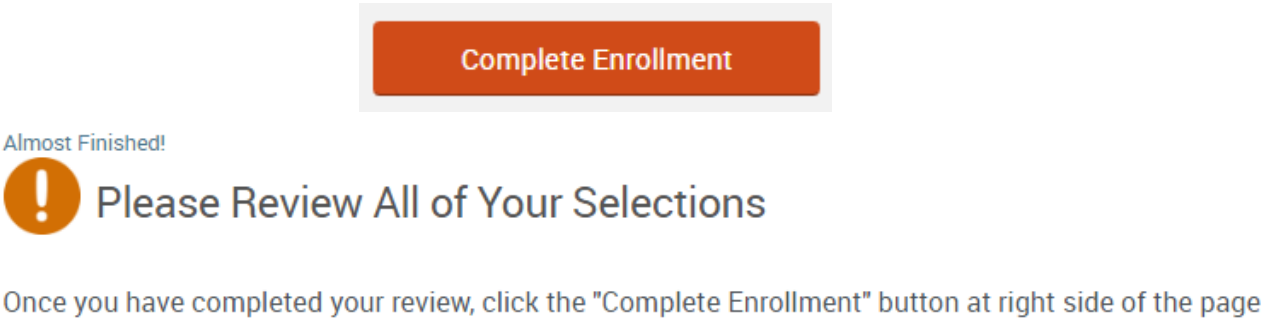
Step 2: Select Your Benefits

You will see a page listing all the plan types. Select your benefit by type by clicking on the View Plan Options button in each plan type box. Make sure to click on the family members at the top that you would like to be covered for each plan.



To make a selection, click the orange Select button next to the plan you want. Continue making selections for each plan type. If you wish, you may go back and edit a completed benefit by clicking View Plan Options again. When you are satisfied with your benefit elections, click Continue at the right of the page to be taken to the beneficiary designation page. In order for your elections to be saved, please be sure to complete the last step: Final Confirmation.

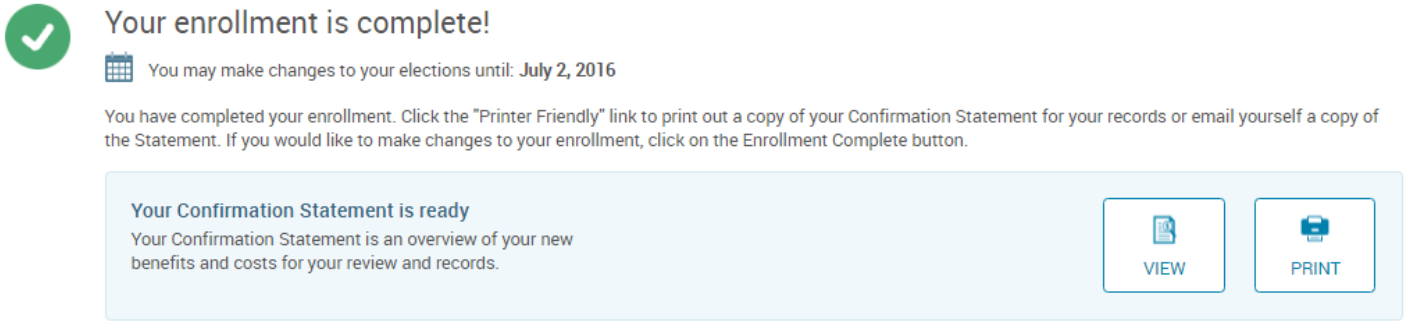
Step 3: Confirm and Save your Elections!



When you are finished reviewing your elections, read the agreement text for each benefit type, and then check the “I have finished my enrollment and agree to the statement(s) above” checkbox and click the **Complete Enrollment** button on the right.

Step 4: Complete Your Enrollment

When you reach the **Confirmation Statement**, you have completed your enrollment and your elections will be saved. You may elect to **Print** or **Email** yourself a copy of this statement by utilizing the printer or email icons on the



Preventive Care

Many SelectHealth® plans cover preventive care at 100 percent*—that means no copay, coinsurance, or deductible.

For services to be covered as preventive, your doctor must bill claims with preventive codes. If a preventive service identifies a condition that needs further testing or treatment, your regular copays, coinsurance, or deductibles may apply. Unless otherwise indicated, these services are generally covered every 12 months. This information is subject to change at any time and additional limitations may apply. To verify if your service or supply is considered preventive, call Member Services at **800-538-5038**.

ADULT PREVENTIVE SERVICES

(Ages 18 and older)

LABORATORY TESTS

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

PROCEDURES

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

IMMUNIZATIONS

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

EXAMINATIONS/COUNSELING

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

CONTRACEPTION

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

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

selecthealth LIVe Well

PEDIATRIC PREVENTIVE SERVICES

(Younger than age 18)

EXAMINATIONS/COUNSELING

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

LABORATORY TESTS

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

IMMUNIZATIONS

(As recommended by the CDC/ACIP)

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

OBSTETRICAL PREVENTIVE SERVICES

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

LABORATORY TESTS

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

BREAST-FEEDING SUPPLIES AND SUPPORT

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

Questions? Call Member Services at 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 9:00 a.m. to 2:00 p.m.

**See your member materials for details about your preventive care benefits.*

HIPAA Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU CAN BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records
• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
• We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records
• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
• We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
• We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

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 per 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 [*choose one:* contacting your employer or contacting the Privacy Official listed the end of this notice].
• 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 Ave., 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:
• Share information with your family, close friends, or others involved in payment for your care
• Share information in a disaster relief situation

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:
• Marketing purposes
• Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization
• We can use and disclose your information to run our organization and contact you when necessary.
• We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
Example: We use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations, such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We 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.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you.

Model Notice of Special Enrollment Rights
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends.

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

Statement of HIPAA Portability Rights

IMPORTANT- KEEP THE CERTIFICATE OF GROUP HEALTH PLAN COVERAGE. This certificate is evidence of your coverage under the plan. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

Preexisting condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of our waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. **Most health coverage is creditable coverage including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide a certificate of group health plan coverage. If you do not receive a certificate for post coverage, talk to your new plan administrator.**

You can add up any creditable coverage you have, including the coverage shown on your certificate of group health plan coverage. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

- Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use the certificate of group health plan coverage as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption and placement for adoption.)

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against decimation based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by your certificate of group health plan coverage);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage if your have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

Special Information for people on FMLA leave. If you are taking leave under the Family and Medical Leave Act (FMLA) and you drop health coverage during your leave, any days without health coverage while on FMLA leave will not count toward a 63-day break in coverage. In addition, if you do not return from leave, the 30-day period to request special enrollment in another plan will not start before your FMLA leave ends.

- Therefore, when you apply for other health coverage, you should tell your plan administrator or health insurer about any prior FMLA leave.

State Flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA), toll free at 866-444-3272 for free (HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 800-633-4227 (ask for protecting your health insurance coverage). These publications and other useful information are also available online at www.dol.gov/ebsa, the DOL's interactive Web pages- Health Elaws, or www.cms.hhs.gov/healthinsreformforconsume/.

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**

You may be eligible for assistance paying your employer health plan premiums. Contact your state for more information on eligibility –

UTAH – Medicaid and CHIP

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

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

Phone: 1-866-435-7414

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

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Newborns' Act Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother of 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 of her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WHCRA Enrollment 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 states 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 for 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, call your plan administrator.

About NFP

At NFP, our solutions and expertise are matched only by our personal commitment to each client's goals. We're a leading insurance broker and consultant that provides employee benefits, property & casualty, retirement, and individual insurance and wealth management solutions through our licensed subsidiaries and affiliates. Our registered investment advisers and broker-dealers empower independent financial advisors with integrated technology, subject matter expertise and a suite of customized services.

NFP has more than 3,600 employees and global capabilities. Our expansive reach gives us access to highly rated insurers, vendors and financial institutions in the industry, while our locally based employees tailor each solution to meet our clients' needs. We've become one of the largest insurance brokerage, consulting and wealth management firms by building enduring relationships with our clients and helping them realize their goals.

For more information, visit www.nfp.com.