Utah County
HEART of UTAH

2019 **Benefit Summary**

Table of Contents

Benefits Overview

Utah County is proud to offer a comprehensive benefits package to eligible, career-service employees who work 20 or more hours per week. The complete benefits package is briefly summarized in this booklet. You may request plan booklets, which give you more detailed information about each of these programs.

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

Benefit Plans Offered

- Medical
- Health Savings Account (HSA)
- Flexible Spending Account (FSA)
- Dental
- Vision
- Life and Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Life and AD&D
- Voluntary Short-Term Disability
- Long-Term Disability
- Health Savings Account (HSA)
- Voluntary Hospital Indemnity
- Voluntary Critical Illness
- Voluntary Accident

Eligibility

You and your dependents are eligible for Utah County benefits on the first of the month following 30 days of employment.

Eligible dependents are your spouse, children under age 26, disabled dependents of any age, or Utah County eligible dependents. Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 30 days.

Open Enrollment

The medical and dental plan year is from January 1, 2019 through December 31, 2019. The next open enrollment period will be held in October.

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 Events

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:

- Loss of Dependent Coverage (including spousal coverage through employer)
- Marriage
- Divorce
- Legal Separation
- Birth of a Child
- Adoption or Change in Custody
- Death

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 programs 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 health plan (CHIP) under Title XXI of the Social Security Act (see enclosed disclosure).

Share Network

Utah County accesses the SelectHealth Share Network to offer health care at a contracted, negotiated price as part of their network. Before seeing a provider or seeking treatment, you should always make sure that provider participates in the SelectHealth Share network. Using the Share Network of providers and facilities is part of the overall Share Program in which Utah County participates.

The Share Program offers enhanced care for our employees and their families through a narrower network of providers that have proven to offer high quality, low cost care with a priority in treating an overall patient, not just specific symptoms. There are a few items all members need to complete within the Share Program to ensure they are receiving the best care possible. Please see below for those items.

SelectHealth Share®

SelectHealth Share aims to improve your health through commitments called engagements.

We've created the checklist on the next page to help you complete your engagements and live the healthiest life possible.

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

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

NEED HELP?

Need help finding a doctor or making an appointment?

PHONE **800-515-2220**

PRIMARY CARE PROVIDERS

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

INTERMOUNTAIN CONNECT CARE®

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

INTERMOUNTAIN INSTACARE®

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

HOSPITALS

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

SPECIALISTS

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

LOCAL CLINICS

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

EMERGENCY CARE

If you have an emergency, call 911 or go to the nearest hospital—we've got you covered anywhere you are.

INTERMOUNTAIN HEALTH ANSWERS®

Our free nurse line is available 24/7 to ease your mind. Call **844-501-6600** about any condition.

selecthealth.

continued on next page

SelectHealth Share Checklist

YOUR FIRST 90 DAYS* (ALL EMPLOYEES)

Create an online *My Health* account. This is key to accessing your Healthy Living tools and tracking your engagements. It's your health hub.

Pick your Primary Care Provider (PCP). Once you choose your doc, make sure to tell us via *My Health* or by calling Member Services at **800-538-5038**. Establishing a PCP is critical. From getting care quickly when you need it to referrals, your PCP is your #1.

Attend a work-site health screening event or obtain the screening from a physician. This is how we establish your health baseline and figure out the best plan for you.

Complete the annual online health assessment on the Healthy Living website (via your *My Health* account). Your assessment can identify health risks so you can address them sooner rather than later.

Establish and contribute to a Health Savings Account (HSA). This is for those of you who have a high-deductible health plan and contribute at least 25% of your annual deductible. Consider this your health bucks account—a real lifesaver when you need it.

YOUR FIRST NINE MONTHS* (ALL EMPLOYEES)

Complete at least one online digital health coaching program. Receive tips and resources on improving any health issues—and hey, we all have at least one. Log in to *My Health*, and find "Digital Coaching" in the Healthy Living section of your dashboard.

At least one 30-day check-in. So, remember that digital coaching and health assessment you completed? You need to check in so we know how you're doing. You'll receive an email, and all you need to do is click the email link to get started.

Get moving with Virgin Pulse. This is a two-part engagement. First, create a Virgin Pulse account. This is where we track your activity. Then, complete at least two of the wellness/activity campaigns. Keep in mind, company team challenges, 7,000 steps in 20 days, or Healthy Habits Challenges all count as activity campaigns.

*of the plan year

A FEW EXTRAS

For employees who have a condition, or are of a specific age and/or gender, there are a few special engagements that will help you feel your best. And because we care, these are also required.

Complete age- and gender-based screenings

- Women age 42-69: One mammogram every two years
- Women age 24-64: One Pap test every three years.
- Men and women age 51-80: One colonoscopy every 10 years, or other colorectal cancer screening once every 1-5 years

Complete prediabetes education. If your health screening/assessment indicates you have prediabetes, you will need to complete prediabetes education. Plus, we'll reward you for improving your health with a Healthy Rewards Visa cash card.

Take advantage of these educational opportunities:

- Meet with your PCP and discuss options to avoid prediabetes.
- Attend Intermountain Healthcare's Prediabetes 101 class.
- Complete three Medical Nutrition Therapy visits.
- Complete the Weigh to Health Program.
- Meet twice with a SelectHealth® Wellness Coach (visits must be at least 30 days apart).

Participate in disease management. If you have asthma, diabetes, Chronic Obstructive Pulmonary Disease (COPD), or heart failure, you may need to work with a SelectHealth care manager. Plus, we'll reward you for improving your health with Healthy Rewards Visa® cash cards.

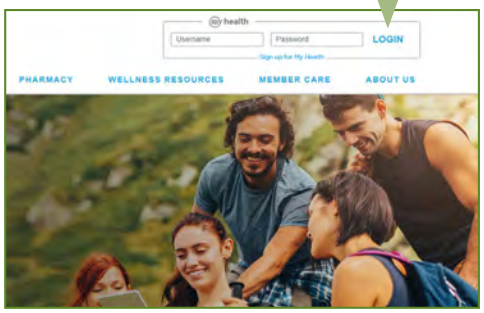
selecthealth.

How to Participate in Healthy Living℠

FOR SELECTHEALTH SHARE®

1. **Attend Your Workplace Health Education and Screening Event.** Get personalized health coaching and a biometric screening at our Health & Wellness display at your worksite—or, if you prefer, see your primary care doctor prior to the event.

Visit **selecthealth.org**.

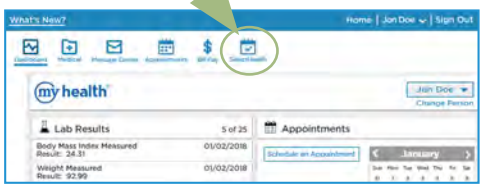


2. **Create a *My Health* Account.** Log in to ***My Health*** to learn more about your benefits, view claims, check lab results, compare prescription drug prices, and participate in Healthy Living.

   Problems logging in? Call Online Services at **800-442-5502** weekdays, from 7:00 a.m. to 8:00 p.m., and Saturdays, from 7:00 a.m. to 3:00 p.m.

Register or log in to your ***My Health*** account.

Click the **SelectHealth** button at the top of the page.



3. **Select Your Primary Care Provider.** Log in to your ***My Health*** account. Choose "**Select Primary Provider**" from your Member Checklist. Then scroll down and click on "**Select New Primary Care Provider**" on the lower-left-hand corner of the page. Using the "**Find a Doctor**" tool, select "**+Add as Primary Care Provider (PCP)**" below the provider of your choice.

Select **Primary Provider** to choose your physician.

Choose **Health Assessment** from the **Member Checklist**.

4. **The Health Assessment.** Our health assessment helps you discover connections between everyday lifestyle choices and your long-term health. Because there are many aspects to health, this assessment includes four categories: Biometrics, Body, Mind, and Lifestyle.

Take your **Health Assessment**.

continued on next page

selecthealth.

Medical Benefits

Administered by SelectHealth

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with an excellent medical plan through SelectHealth.

SelectHealth Share—HSA Qualified High Deductible Health Plan	
	In-Network
Annual Deductible (individual/family)	$2,000/$4,000
Annual Out-of-Pocket Maximum (individual/family)	$3,000/$6,000
Coinsurance	20%
DOCTOR'S OFFICE	
Office Visits (PCP/SCP)	$15 AD/$25 AD
Preventative Care	Covered 100%
Connect Care -Telehealth	$49
PRESCRIPTION DRUGS	
Retail – 30-day supply	
Generic	$7 AD
Brand Name Preferred	$21 AD
Brand Name Non-Preferred	$42 AD
Specialty	$100 AD
Mail Order – 90-day supply	
Generic	$7 AD
Brand Name Preferred	$42 AD
Brand Name Non-Preferred	$126 AD
HOSPITAL SERVICES	
Emergency Room	$75 AD
Urgent Care	$35 AD
Inpatient	20% AD
MENTAL HEALTH SERVICES	
Inpatient Services	20% AD
Outpatient Services	20% AD
OTHER SERVICES	
Maternity Services	20% AD

AD: After Deductible

SelectHealth Share-HSA QHDHP Employee Cost Per Pay Period (24)			
	Full-Time	¾ Time	½ Time
Employee Only	$0.00	$0.00	$138.55
Employee + One	$0.00	$0.00	$280.60
Family	$0.00	$0.00	$375.95

Career Service Employee* Status Definition	
Full-Time	Regularly scheduled 40 hours per week
¾ Time	Regularly scheduled 30–39.5 hours per week
½ Time	Regularly scheduled 20–25 hours per week

*The waiver incentive is available if you waive medical insurance offered by Utah County.

2019 Benefit Summary

SelectHealth Share—Signature Traditional Plan	
	In-Network
Annual Deductible (individual/family)	$1,000/$2,000
Annual Out-of-Pocket Maximum (individual/family)	$3,000/$6,000
Coinsurance	20%
DOCTOR'S OFFICE	
Office Visits (PCP/SCP)	$25/$40
Preventative Care	Covered 100%
Connect Care	$10
PRESCRIPTION DRUGS	
Retail – 30-day supply	
Deductible	$100 Per Person
Generic	$15
Brand Name Preferred	$30 APD
Brand Name Non-Preferred	$50 APD
Specialty	$100 APD
Mail Order – 90-day supply	
Generic	$15
Brand Name Preferred	$60 APD
Brand Name Non-Preferred	$150 APD
HOSPITAL SERVICES	
Emergency Room	$250 AD
Urgent Care	$40
Inpatient	20% AD
MENTAL HEALTH SERVICES	
Inpatient Services	20% AD
Outpatient Services	20%
OTHER SERVICES	
Maternity Services	20% AD
Chiropractic	$20

AD: After Deductible

SelectHealth Share Signature Plan Employee Cost Per Pay Period (24)			
	Full-Time	¾ Time	½ Time
Employee Only	$44.75	$44.75	$183.30
Employee + Spouse	$90.60	$90.60	$371.20
Family	$121.35	$121.35	$497.30

Career Service Employee* Status Definition	
Full-Time	Regularly scheduled 40 hours per week
3¾ Time	Regularly scheduled 30–39.5 hours per week
½ Time	Regularly scheduled 20–25 hours per week

The waiver incentive is available if you waive medical insurance offered by Utah County.

Utah County provides a waiver incentive for those of you that have selected other medical plans outside of what Utah County offers. You will see from the graph below, depending on your employment the allotted amount you are offered per pay-period.

Waiver Incentive Utah County Contributions to Employee's Paycheck Per Pay Period			
	Full-Time	¾ Time	½ Time
Employee Only	$40.00	$30.00	$20.00
Employee + Spouse	$80.00	$60.00	$40.00
Family	$80.00	$60.00	$40.00

The waiver incentive is available if you waive medical insurance offered by Utah County.

Preventive Care

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

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

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

NEED MORE INFORMATION?

WEB
selecthealth.org/wellness-resources

PHONE
800-538-5038

selecthealth

Preventive Care Services

Adult Preventive Services (ages 18 and older)

Laboratory Tests

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

Procedures

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

Examinations/Counseling

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

Immunizations

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

Contraception

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

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

Pediatric Preventive Services (younger than age 18)

Procedures/Counseling

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

Laboratory Tests

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

Immunizations

(As recommended by the CDC/ACIP)

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

Obstetrical Preventive Services

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

Laboratory Tests

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

Breast-feeding Supplies and Support

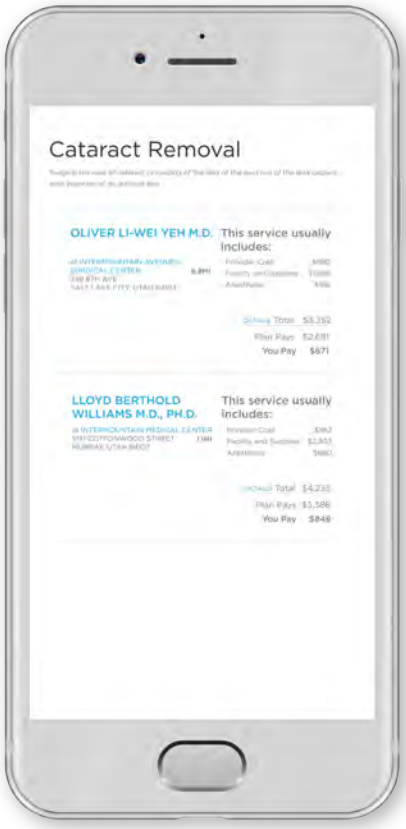
- Breast Pump, Electronic AC or DC (one per birth)
- Lactation Class (one per birth at a SelectHealth-approved facility)

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

selecthealth

Online Tools

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



MEDICAL COST ESTIMATOR

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

ID CARDS

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

REQUEST A CALL

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

CHAT WITH US

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

HEALTHCARE INFORMATION

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

selecthealth.

We Can Help

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

selecthealth.

Health Savings Account (HSA)

Administered by HealthEquity

What is a Health Savings Account (HSA)?

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

Who is eligible for a Health Savings Account?

Anyone who satisfies all of the following:

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

When do I use my HSA?

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

- Use your HSA debit card to pay for any out-of-pocket expenses.
- You may choose to pay with another form of payment, receiving reimbursement at a later date.
- You can choose to save your HSA dollars for future medical expenses.

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

Benefits of an HSA

- Pay for qualified medical, dental and vision expenses with tax-free dollars.
- Lower health insurance premiums with an HSA qualified health plan.
- Keep your contributions year after year and watch your balance grow. There is no "use it or lose it" rule. It's yours.
- Invest your balance over the threshold amount to grow your HSA further.
- If you participate in the High Deductible Health Plan (HDHP), and contribute to your HSA, you are eligible for a company match.

How much can be contributed to an HSA?

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

Type of Coverage	2019 Maximum Annual Contribution
Individual	$3,500*
Family	$7,000*
***A $1,000 additional catch up contribution is allowed for account holders age 55+**	

These limits include contributions from all sources, including those from Utah County.

Employer Contribution

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 chart on medical page.

By participating in the Share Program, you may receive additional Utah County contributions to your HSA when you complete the activities below, beyond the dollar for dollar match.

Wellness incentive available for Share Engagement	
Up to Single: $600	Receive: • $100 for completing the online Health Assessment • $100 for attendance at the Health Education Screening Event(s) (if you cannot make an event, you can go to your healthcare provider for your annual screenings) • $200 for completing two Wellness/Activity Campaigns • $200 for completing at least one online Digital Health Coaching
Up to 2-Party/Family: $1,200	Receive: • $200 for completing the online Health Assessment • $200 for attendance at the Health Education Screening Event(s) (if you cannot make an event, you can go to your healthcare provider for your annual screenings) • $400 for completing two Wellness/Activity Campaigns • $400 for completing at least one online Digital Health Coaching

HealthEquity®

HOW IT WORKS

At the doctor's office...

1 Receive services

With an HSA-qualified plan, copays are not typically required at the time of service. Be sure to present your insurance ID card. If your healthcare provider requires a deposit, it will be applied to your invoice.

2 Provider bills health plan

Provider submits a claim to your health plan for services provided.

3 Health plan sends EOB

An explanation of benefits (EOB) is sent to you outlining the negotiated or allowed charges and summarizes your year-to-date deductible and co-insurance totals. In some cases, your health plan may send a copy of your claim to HealthEquity, which will appear in the member portal.

4 Provider sends invoice

The provider sends you an invoice, or statement, reflecting the allowed charges. Make sure the amount matches the EOB sent by your health plan. If not, contact your health plan.

5 Pay invoice with HSA

You can pay for qualified medical expenses with your HSA debit card or create an online payment that is sent directly to the provider or as a reimbursement to you.

HealthEquity®

At the pharmacy...

1 Obtain prescription

Obtain a legal prescription from your doctor for required medication and present it, along with your insurance ID card, at the pharmacy.

2 Pharmacy verifies insurance coverage

The pharmacy checks with your insurance on-the-spot to determine the amount you owe for the prescription.

3 Pay for your prescription

The pharmacy fills your prescription and you pay the determined amount owed. The expense is automatically applied to your deductible or coinsurance. Your HSA debit card is a convenient method of payment.

Over-the-counter medication

The IRS does not allow HSA funds to be used for over-the-counter (OTC) medicines without a prescription. You can ask your doctor to write a prescription for OTC medicines or supplies that you frequently use so that you can use your HSA to pay for these items.

HealthEquity®

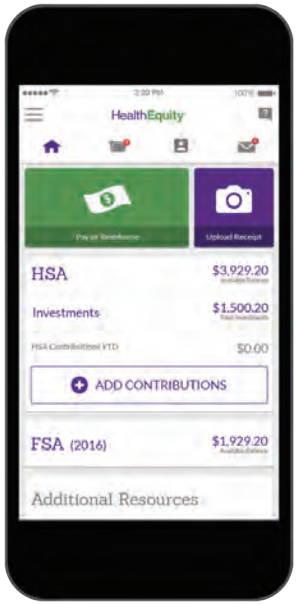
ONLINE MEMBER PORTAL

Introduction

The online member portal is a powerful tool that gives you access to all account management features. To access your account, visit www.MyHealthEquity.com.

sample screenshot

HealthEquity®



sample

Now available on-the-go

The HealthEquity mobile app[1] provides easy, on-the-go access to all of your health accounts. The free app provides comprehensive tools to help you manage transactions and maximize your health savings.

CONVENIENT, POWERFUL TOOLS:

On-the-go access

You can access all account types wherever you go.

Photo documentation

Simply take a photo with your device to initiate claims and payments.

Send payments and reimbursements

You can send payments to providers or reimburse yourself for out-of-pocket expenses.

Manage debit card transactions

Link your debit card transactions to claims and documentation.

View claims status

View the status of claims as well as link payments and documentation to claims.

Make claims

Create new reimbursement claims for FSA and HRA transactions.

For help with the mobile app, contact us at:

866.346.5800

available every hour of every day

[1] Accounts must be activated via the HealthEquity website in order to use the mobile app.

Flexible Spending Accounts (FSAs)

Administered by American Benefits Group

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

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

How it Works

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

Things to Consider

- Be conservative when estimating your annual election amount. The IRS has a strict "use it or lose it" rule. If there is a balance in your account after the the end of the plan year, you have a grace period of 2.5 months to use funds from the prior plan year.
- Your 2019 contributions must be used for expenses you incur January 1, 2019 to December 31, 2019.
- There is a 30 day run out period after the plan year ends on December 31, 2019 in which you may request reimbursement from your 2019 elected FSA amount for claims incurred in 2019.
- The health care and dependent care FSA's are two separate accounts and funds cannot be transferred between accounts.
- The Dependent Care FSA cannot be used for a dependent's medical expenses.
- You cannot stop or change your FSA contribution amount during the year unless you have a qualified change in family status.
- Expenses reimbursed through an FSA cannot be used as a deduction or credit on your federal income taxes.
- You cannot be enrolled in an HSA and a Healthcare FSA during the same tax year, this includes a spouse's FSA and/or HSA. You are allowed to be enrolled in an HSA with a limited purpose FSA and/or Dependent Care FSA.

FSA Reimbursement Options

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

Dependent Care Flexible Spending Account

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

Limited Purpose FSA

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

Flexible Spending Account Options			
	Healthcare FSA	Dependent Care FSA	Limited Purpose FSA
Maximum Plan Year Contribution Amount	Up to $2,650	Up to $5,000 ($2,500 if married and filing separate income tax returns)	Up to $2,650
Examples of Eligible Expenses	Medical, RX, and dental expenses, hearing care and prescription eye care	Cost of child care for children under age 13	Dental and vision expenses. Can only be used for medical expense after you have met the deductible on the High Deductible Health Plan (HDHP)
Eligibility	Traditional (Medical Plan only)	Either Medical Plan	High Deductible Health Plan Only

Submit claims for reimbursement online at www.amben.com

Dental Benefits

Administered by Dental Select

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

Dental Select—Gold Plan	In-Network Benefits Only
Annual Deductible	No Deductible
Annual Benefit Maximum	No Maximum
Preventive Dental Services (cleanings, exams, x-rays)	100% Covered
Basic Dental Services (fillings, root canal therapy, oral surgery)	Up to 70% Coverage*
Major Dental Services (extractions, crowns, inlays, onlays,bridges, dentures, repairs)	Up to 50% Coverage*
Orthodontia Services	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

Dental Select—Platinum Plan	In-Network	Out-of-Network
Annual Deductible	$50/$150	
Annual Benefit Maximum	$1,500 per person per year	
Preventive Dental Services (cleanings, exams, x-rays)	100% Covered	80% of UCR
Basic Dental Services (fillings, root canal therapy, oral surgery)	80%	60% UCR
Major Dental Services (extractions, crowns, inlays, onlays,bridges, dentures, repairs)	50%	40% UCR
Orthodontia Services - Children under age 19	50%	
Orthodontia Lifetime Maximum	$1,500	
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 Specialists fee.*

2) After discount, plan pays according to the General Dentists Schedule of Fees

Dental Select Gold Plan	Employee Cost Per Pay Period (24) (Full Time, ¾ Time, ½ Time)	Dental Select Platinum Plan	Employee Cost Per Pay Period (24) (Full Time, ¾ Time, ½ Time)
Employee Only	$0.00	**Employee Only**	$5.06
Two-Party	$5.03	**Two-Party**	$18.79
Family	$12.86	**Family**	$35.91

Vision Benefits

Administered by EyeMed

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

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 in the back of this guide.

EyeMed Vision Base Plan	In-Network (Member Pays)	Out-of-Network (Reimbursement)
Eye Exam	$20 Copay	Up to $35 Allowance
FRAMES		
Any available frame at provider location.	$0 Copay, $100 Allowance; 20% off balance over $100	Up to $50 Allowance
LENSES		
Single Vision Lenses	$20 Copay	Up to $25 Allowance
Bifocal Lenses	$20 Copay	Up to $40 Allowance
Trifocal Lenses	$20 Copay	Up to $55 Allowance
Lense Options		
UV Coating	$15 Contracted Fee	Non-Contracted (Provider Discretion)
Tint (Solid and Gradient)	$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)	20% Off Retail Price	
Other Add-Ons and Services	20% Off Retail Price	
Contacts		
Conventional	$0 Copay, $115 Allowance; 15% off balance over $115	Up to $92 Allowance
Disposable	$0 Copay, $115 Allowance; 15% off balance over $115	Up to $92 Allowance
Medically Necessary	$0 Copay, Paid-In-Full	Up to $200 Allowance
Additional Eyewear Purchases	40% off additional pairs of glasses and 15% off conventional contact lenses purchased within the same plan year, once the beneit above has been utilized	N/A
Lasik and PRK Vision Correction	15% off retail price or 5% off promotional pricing	N/A
Frequency		
Examination	Once every 12 months	
Frames	Once every 24 months	
Lenses or Contact Lenses	Once every 12 months	

EyeMed Vision Base Plan	Employee Cost Per Pay Period (24) (Full Time, ¾ Time, ½ Time)
Employee Only	$2.90
Two-Party	$5.46
Family	$8.00

EyeMed Vision Buy Up Plan	In-Network (Member Pays)	Out-of-Network (Reimbursement)
Eye Exam	$20 Copay	Up to $35 Allowance
FRAMES		
Any available frame at provider location.	$0 Copay, $150 Allowance; 20% off balance over $150	Up to $75 Allowance
LENSES		
Single Vision Lenses	$20 Copay	Up to $25 Allowance
Bifocal Lenses	$20 Copay	Up to $40 Allowance
Trifocal Lenses	$20 Copay	Up to $55 Allowance
Lense Options		
UV Coating	$15 Contracted Fee	Non-Contracted (Provider Discretion)
Tint (Solid and Gradient)	$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)	20% Off Retail Price	
Other Add-Ons and Services	20% Off Retail Price	
Contacts		
Conventional	$0 Copay, $165 Allowance; 15% off balance over $165	Up to $132 Allowance
Disposable	$0 Copay, $165 Allowance; plus balance over $165	Up to $132 Allowance
Medically Necessary	$0 Copay, Paid-In-Full	Up to $200 Allowance
Additional Eyewear Purchases	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Lasik and PRK Vision Correction	15% off retail price or 5% off promotional pricing	N/A
Frequency		
Examination	Once every 12 months	
Frames	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	

EyeMed Vision Buy Up Plan	Employee Cost Per Pay Period (24) (Full Time, ¾ Time, ½ Time)
Employee Only	$4.03
Two-Party	$7.59
Family	$11.12

Life and Accidental Death & Dismemberment Insurance

Insured by Mutual of Omaha

Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump-sum payment if you pass away while employed by Utah County. The company provides basic life insurance of $40,000 at no cost to you. Your spouse is eligible for a $10,000 basic life benefit, and your child(ren) are eligible for $10,000.

Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or pass away in an accident. Utah County provides AD&D coverage of $40,000 at no cost to you. This coverage is in addition to your Utah County-paid life insurance described above.

Long-Term Disability Insurance

Insured by Mutual of Omaha

Meeting your basic living expenses can be a real challenge if you become disabled. Your options may be limited to personal savings, spousal income and possibly Social Security. Disability insurance provides protection for your most valuable asset—your ability to earn an income. Utah County provides Long-Term Disability insurance (LTD) coverage for you at no cost.

LTD coverage provides income when you have been disabled for 120 days or more. Your benefit is 60% of your monthly earnings, up to $5,000 per month. This amount may be reduced by other deductible sources of income or disability earnings. Benefit payments can continue to age 65 if you are under age 60 at the time of disability.

Voluntary Life and AD&D Insurance

Insured by Mutual of Omaha

You may purchase life and AD&D insurance in addition to the Utah County-provided coverage. You may also purchase life and AD&D insurance for your dependents if you purchase additional coverage for yourself. You are guaranteed coverage (the lesser of 5 times annual compensation to a maximum of $300,000, and 100% of the employee's benefit, up to $20,000, for your spouse) without answering medical questions if you enroll when you are first eligible.

Employee — Maximum of up to $500,000 in increments of $10,000

Spouse — Maximum of up to $200,000 in increments of $5,000, not to exceed 100% of employee voluntary life

Children (Birth to 26 years) — Minimum benefit $5,000; $10,000 maximum amount

Mutual of Omaha – Voluntary Life and AD&D Rates				
Age Band	Employee Rates (Per $1,000, Smoker)	Employee Rates (Per $1,000, Non-Smoker)	Spouse Rate (Per $1,000)	All Children Rate (Per $1,000)
< 25	$0.117	$0.065	$0.065	$0.156
25–29	$0.117	$0.065	$0.065	
30–34	$0.143	$0.065	$0.065	
35–39	$0.195	$0.078	$0.078	
40–44	$0.312	$0.130	$0.130	
45–49	$0.494	$0.221	$0.221	
50–54	$0.741	$0.338	$0.338	
55–59	$1.001	$0.481	$0.481	
60–64	$1.587	$0.819	$0.819	
65–69	$2.911	$1.638	$1.638	
70–74	$5.202	$3.431		
75+	$8.802	$6.278		

Voluntary Accident

Administered by Voya

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

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

Accident Hospital Care	
Surgery (open abdominal, thoracic)	$1,200
Surgery (exploratory or without repair)	$175
Blood, Plasma, Platelets	$600
Hospital Admission	$1,250
Hospital Confinement (per day to 365 days)	$375
Critical Care Unit Confinement (per day up to 15 days)	$600
Rehabilitation Facility Confinement (per day up to 90 days)	$200
Coma (duration of 14 or more days)	$17,000
Transportation (per trip up to 3 per accident)	$750
Lodging (per day up to 30 days)	$180
Family care (per child per day up to 45 days)	$25
Accident Care	
Initial Doctor Visit	$90
Urgent Care Facility Treatment	$225
Emergency Room Treatment	$225
Ground Ambulance	$360
Air Ambulance	$1,500
Follow-Up Doctor Treatment	$90
Chiropractic Treatment (up to 6 per accident)	$45
Medical Equipment	$120
Physical or Occupational Therapy (up to 6 per accident)	$45
Prosthetic Device (one)	$750
Prosthetic Device (two or more)	$1,200
Major Diagnostic Exams	$240
Outpatient Surgery (once per accident)	$225
X-ray	$45
Common Injuries	
Burns (2nd degree, at least 36% of body)	$1,250
Burns (3rd degree, at least 9 but less than 35 sq in of body)	$7,500
Burns (3rd degree, 35 or more sq in of body)	$15,000
Skin grafts	25% of burn benefit
Emergency Dental Work (Crown)	$350
Emergency Dental Work (Exctraction)	$90
Eye Injury (removal of foreign object)	$100
Eye Injury (surgery)	$350
Torn Knee Cartilage (surgery with no repair or if cartilage is shaved)	$225
Torn Knee Cartilage (surgical repair)	$800
Laceration* (treated - no sutures)	$30
Laceration* (sutures up to 2")	$60

Laceration* (sutures 2" to 6")	$240
Laceration* (sutures over 6")	$480
Ruptured Disk (surgical repair)	$800
Tendon, Ligament, Rotator Cuff (exploratory arthoscopic surgery with no repair)	$425
Tendon, Ligament, Rotator Cuff (1, surgical repair)	$825
Tendon, Ligament, Rotator Cuff (2 oe more, surgical repair)	$1,225
Concussion	$225
Paralysis (paraplegia)	$16,000
Paralysis (quadriplegia)	$24,000
Common Injuries - DISLOCATIONS Closed / Open Reduction	
Hip Joint	$3,850 / $7,700
Knee	$2,400 / $4,800
Ankle or foot bone(s) other than toes	$1,500 / $3,000
Shoulder	$1,600 / $3,200
Elbow	$1,100 / $2,200
Wrist	$1,100 / $2,200
Finger/Toe	$275 / $550
Hand bone(s) other than fingers	$1,100 / $2,200
Lower jaw	$1,100 / $2,200
Collarbone	$1,100 / $2,200
Partial dislocations	25% of the closed reduction amount
Common Injuries - FRACTURES Closed / Open Reduction	
Hip	$3,000 / $6,000
Leg	$2,500 / $5,000
Ankle	$1,800 / $3,600
Kneecap	$1,800 / $3,600
Foot (excluding toes, heel)	$1,800 / $3,600
Upper arm	$2,100 / $4,200
Forearm, hand, wrist (except fingers)	$1,800 / $3,600
Finger, Toe	$240 / $480
Vertebral body	$3,360 / $6,720
Vertebral processes	$1,440 / $2,880
Pelvis (except coccyx)	$3,200 / $6,400
Coccyx	$400 / $800
Bones of the face (except nose)	$1,200 / $2,400
Nose	$600 / $1,200
Common Injuries - FRACTURES Closed / Open Reduction	
Upper jaw	$1,500 / $3,000
Lower jaw	$1,440 / $2,880
Collarbone	$1,440 / $2,880
Ribs or rib	$400 / $800
Skull - Simple (except bones of the face)	$1,400 / $2,800
Skull - Depressed (except bones of the face)	$3,000 / $6,000
Sternum	$360 / $720
Shoulder blade	$1,800 / $3,600
Chip fractures	25% of the closed reduction amount

Accident Bi-Weekly Rate	
Employee	$4.88
Employee + Spouse	$8.34
Employee + Children	$9.71
Family	$13.15

Employee*	Spouse*	Children	Home Modification Benefit	Vehicle Modification Benefit
$120,000	$60,000	$30,000	$5,000	$5,000

*Benefit reduces to 50% at age 65, and to 25% of the original benefit amount at age 70.

Employee	Spouse*	Children
$50	$50	$50

Wellness Benefit amount, to a maximum of $100 for all children

Voluntary Hospital Indemnity Insurance

Administered by Voya

When hospitalized, you may not realize that most primary health insurance plans do not cover all hospital costs. Hospital Indemnity Insurance can complement your medical coverage by helping to ease the financial impact of a hospitalization due to accident or illness. Coverage is available for employees, spouses, and families. Benefits are paid directly to employees unless otherwise specified and regardless of any other insurance. Eligible employees and dependents will be able to elect coverage during Open Enrollment regardless of prior health history. You must be insured under the policy for 30 days before benefits are payable. Voya pays predetermined cash directly to you for covered hospital, outpatient, nursing, transportation, or physician services.

Hospital Indemnity Bi-Weekly Rate	
Employee	$7.95
Employee + Spouse	$15.94
Employee + Children	$11.94
Family	$19.93

Hospital Indemnity Benefit	Employee	Spouse	Children
Hospital (1x Daily Benefit Amount)	$100	$100	$100
Critical Care Unit (2x Daily Benefit Amount)	$200	$200	$200
Rehabilitation Facility (.5x Daily Benefit Amount)	$50	$50	$50
Initial Hospital Confinement	$1,000	$1,000	$1,000

Voluntary Critical Illness

Administered by Voya

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

Base Module	
Heart attack (cardiac arrest is not a heart attack)	100%
Cancer	100%
Stroke	100%
Major organ transplant	100%
Coronary artery bypass	25%
Carcinoma in situ	25%
Major Organ Module	
Type 1 diabetes	100%
Severe burns	100%
Transient ischemic attacks (TIA)	10%
Ruptured or dissecting aneurysm	10%
Abdominal aortic aneurysm	10%
Thoracic aortic aneurysm	10%
Open heart surgery for valve replacement or repair	10%
Transcatheter heart valve replacement or repair	10%

Coronary angioplasty	10%
Implantable (or Internal) cardioverter defibrillator (ICD) placement	10%
Pacemaker placement	10%
Enhanced Cancer Module	
Benign brain tumor	100%
Skin cancer	10%
Bone marrow transplant	25%
Stem cell transplant	25%
Covered Benefit Amount	
Employee Benefit amount: Choice of $10,000, $20,000 or $30,000 Total maximum benefit: 2x the benefit amount	
Spouse Spouse coverage matches employee benefit schedule, additional benefits and riders. Benefit amount: Choice of $5,000, $10,000 or $15,000 Total maximum benefit: 2x the benefit amount	
Child Children's coverage matches employee benefit schedule, additional benefits and riders. Benefit amount: Choice of $5,000 or $10,000 Total maximum benefit: 2x the benefit amount	
Base Module	
Heart attack (cardiac arrest is not a heart attack)	100%
Cancer	100%
Stroke	100%
Major organ transplant*	100%
Coronary artery bypass	25%
Carcinoma in situ	25%
* Major organ transplant means the irreversible failure of your heart, lung, pancreas, entire kidney or liver, or any combination thereof, determined by a Physician specialized in care of the involved organ.	
Major Organ Module	
Type 1 diabetes	100%
Severe burns	100%
Transient ischemic attacks (TIA)	10%
Ruptured or dissecting aneurysm	10%
Abdominal aortic aneurysm	10%
Thoracic aortic aneurysm	10%
Open heart surgery for valve replacement or repair	10%
Transcatheter heart valve replacement or repair	10%
Coronary angioplasty	10%
Implantable (or Internal) cardioverter defibrillator (ICD) placement	10%
Pacemaker placement	10%
Enhanced Cancer Module	
Benign brain tumor	100%
Skin cancer	10%
Bone marrow transplant	25%
Stem cell transplant	25%

Riders	
Spouse Critical Illness Rider Children's Critical Illness Rider Wellness Benefit Rider	
Employee	$50
Spouse	$50
Child	50% of employee's Wellness Benefit amount, to a maximum of $100 for all children

Critical Illness Rates Employee		
	Non-Tobacco	**Tobacco**
Under 25	$0.195	$0.325
25-29	$0.205	$0.35
30-34	$0.23	$0.40
35-39	$0.285	$0.50
40-44	$0.385	$0.70
45-49	$0.56	$1.04
50-54	$0.81	$1.54
55-59	$1.145	$2.195
60-64	$1.55	$3.00
65-69	$1.985	$3.85
70+	$2.705	$5.275
Spouse		
	Non-Tobacco	**Tobacco**
Under 25	$0.20	$0.335
25-29	$0.215	$0.365
30-34	$0.225	$0.39
35-39	$0.275	$0.485
40-44	$0.375	$0.685
45-49	$0.545	$1.015
50-54	$0.825	$1.57
55-59	$1.225	$2.355
60-64	$1.58	$3.06
65-69	$2.01	$3.905
70+	$2.755	$5.375
Children		
$0.45 for $5,000 $0.90 for $10,000		

Voluntary Short-Term Disability

Administered by Voya

Voluntary Short-Term Disability (STD) insurance provides income if you become disabled due to an injury or illness. Benefits begin on the 8th day of any accident or sickness, and can continue for up to 13 weeks.

Per Pay Period	
Age	**$10 Weekly Benefit**
Under 40	$0.30
40-49	$0.28
50-59	$0.41
60+	$0.58

Intermountain Employee Assistance Program

Our Mission

- We provide counseling, support, information and education to employees, family members and managers.
- Our staff works together to provide high quality services in a timely, seamless manner.
- We care about our customers and are always looking for ways to improve our ability to serve them.
- Confidentiality is a cornerstone of our service.

EAP Counseling Services

We offer free, confidential counseling about many personal, family, and work-related problems. These include marital conflict, parenting, depression, substance abuse, and financial problems. You and your counselor will meet, assess the situation and develop a plan for improvement. If the assessment indicates EAP appropriateness, there are no session limits. If your problem requires a specialist or long-term care, you'll be referred to a provider through your medical insurance or community resources.

Help for Caregivers

While it can be rewarding to support your loved ones, care giving can be challenging and overwhelming. We provide information, resources, and coaching to employees and family members who are caregivers.

Examples of help include:

- Talking with a loved one about not driving
- Identifying safe housing arrangements
- Coping with emotional issues

Crisis Services

An EAP counselor is available by phone 24 hours a day, 7 days a week at 800.832. 7733. Crisis appointments are also available during weekdays.

Our Staff

A trademark of EAP is the highly trained and experienced staff. Members of our team are selected for their reputation of being the best in their field and for exemplifying the mission statement of the program. Continuing education supports the staff in maintaining their skills and keeping them on the cutting edge of mental health, substance abuse and EAP research and interventions.

Office Hours

Office hours are 7:30 a.m. to 5 p.m. (MST) Monday through Friday, with counselor appointments available during lunch hours and after 5 p.m. After 5 p.m. and on weekends, a crisis counselor is available by calling 800.832.7733. Counselors are also available by phone for consultations, referrals or crisis services.

Every effort is made to schedule clients in a timely and convenient manner. Our goal is to offer an appointment within 5 working days or at the client's earliest convenience. Clients with emergency situations receive same-day attention.

Website

Visit **intermountainhealthcare.org/eap** for valuable information. *Self-Care for Life's Challenges* provides quick information on common life problems, including a brief description of the topic, resources such as *Our Favorite Books,* and one-page *Quick Tips.*

Employee Assistance Programs – Covered 100% by Utah County

Employee Assistance Program Office Locations

Bear River

Bountiful

Brigham City

Logan

Ogden

Salt Lake City

Murray

Sandy

West Valley

Provo

Richfield

Delta

Mt. Pleasant

Cedar City

Panguitch

St. George

Burley, Idaho

Outside of Utah, we identify licensed, qualified professionals to provide EAP services.

Retirement

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 pretax 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 ½, employees may elect partial withdrawals, structured payments, lump sum amounts, or may choose to defer distribution until a later date. Earl-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

Contact Information

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

Benefit	Administrator	Phone	Website
Your Benefits – Benefits Administration Utah County HR	Joshua Hepworth	801.851.8167	joshuah@utahcounty.gov
	Brandon Chambers	801.851.8162	brandonbc@utahcounty.gov
Medical	SelectHealth	800.538.5038	www.selecthealth.org
Dental	Dental Select	800.999.9789	www.dentalselect.com
Vision	EyeMed Vision	866.939.3633	www.eyemedvisioncare.com
Life and Disability Insurance	Mutual of Omaha	800.377.9000	www.mutualofomaha.com
Health Savings Account	HealthEquity	866.346.5800	www.healthequity.com
Flexible Spending Account	American Benefits Group	800.499.3539	www.amben.com
Voluntary Benefits – Accident, Hospital Indemnity, Critical Illness, Voluntary Short-Term Disability	Voya	855.663.8692	www.voya.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

Per Pay Period Rates for Benefits

Benefit Plan	Full Time	¾ Time	½ Time
Medical—SelectHealth Share-HSA QHDHP			
Employee	$0.00	$0.00	$138.55
Employee + Spouse	$0.00	$0.00	$280.60
Family	$0.00	$0.00	$375.95
Medical—SelectHealth Share Signature Plan Traditional			
Employee	$44.75	$44.75	$183.30
Employee + Spouse	$90.60	$90.60	$371.20
Family	$121.35	$121.35	$497.30
Dental—Gold Plan			
Employee	$0.00	$0.00	$0.00
Two Party	$5.03	$5.03	$5.03
Family	$12.86	$12.86	$12.86
Dental—Platinum Plan			
Employee	$5.06	$5.06	$5.06
Two Party	$18.79	$18.79	$18.79
Family	$35.91	$35.91	$35.91
Vision—Base Plan			
Employee	$2.90	$2.90	$2.90
Two Party	$5.46	$5.46	$5.46
Family	$8.00	$8.00	$8.00
Vision—Buy Up Plan			
Employee	$4.03	$4.03	$4.03
Two Party	$7.59	$7.59	$7.59
Family	$11.12	$11.12	$11.12

Accident Monthly Rate	
Employee	$4.88
Employee + Spouse	$8.34
Employee + Children	$9.71
Family	$13.15

Hospital Indemnity Monthly Rate	
Employee	$7.95
Employee + Spouse	$15.94
Employee + Children	$11.94
Family	$19.93

*Please see pages 28-30 for Critical Illness and Voluntary Short-Term Disability.

Important Notices and Disclosures

Women's Health and Cancer Rights Act

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

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

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

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

Newborn's Act Disclosure

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

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

HIPAA Special Enrollment Rights

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

However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents.

However, you must request enrollment within 30 days or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

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

Qualified Medical Child Support Orders

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

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 **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 **866.444.EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)

COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) Colorado.gov/HCPF/Child-Health-Plan-Plus Customer Service: 800.359.1991 | State Relay 711
FLORIDA – Medicaid
http://flmedicaidtplrecovery.com/hipp 877.357.3268
GEORGIA – Medicaid
http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) 404.656.4507
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid http://www.indianamedicaid.com | 800.403.0864
IOWA – Medicaid
http://dhs.iowa.gov/hawk-i 800.257.8563
KANSAS – Medicaid
http://www.kdheks.gov/hcf 785.296.3512
KENTUCKY – Medicaid
http://chfs.ky.gov 800.635.2570
LOUISIANA – Medicaid
http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 888.695.2447
MAINE – Medicaid
http://www.maine.gov/dhhs/ofi/public-assistance/index.html 800.442.6003 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
http://www.mass.gov/eohhs/gov/departments/masshealth 800.862.4840
MINNESOTA – Medicaid
http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dwss.nv.gov 800.992.0900

NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603.271.5218 Hotline: NH Medicaid Service Center at 888.901.4999
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov 919.855.4100
NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html 800.699.9075
PENNSYLVANIA – Medicaid
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm 800.692.7462
RHODE ISLAND – Medicaid
http://www.eohhs.ri.gov 855.697.4347
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
http://www.greenmountaincare.org 800.250.8427
VIRGINIA – Medicaid and CHIP
Medicaid: http://www.coverva.org/programs_premium_assistance.cfm 800.432.5924 CHIP: http://www.coverva.org/programs_premium_assistance.cfm 855.242.8282

WASHINGTON – Medicaid
http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program 800.562.3022, ext. 15473
WEST VIRGINIA – Medicaid
http://mywvhipp.com/ 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf 800.362.3002
WYOMING – Medicaid
https://wyequalitycare.acs-inc.com 307.777.7531
VIRGINIA – Medicaid and CHIP
Medicaid: http://www.coverva.org/programs_premium_assistance.cfm 800.432.5924 CHIP: http://www.coverva.org/programs_premium_assistance.cfm 855.242.8282
WASHINGTON – Medicaid
http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program 800.562.3022, ext. 15473
WEST VIRGINIA – Medicaid
http://mywvhipp.com/ 855.MyWVHIPP 855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf 800.362.3002
WYOMING – Medicaid
https://wyequalitycare.acs-inc.com 307.777.7531

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 12/31/19)

HIPAA Privacy Notice

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

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

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

Our Commitment Regarding Health Information Privacy

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

Privacy Obligations of the Plans

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

How the Plans May Use and Disclose Health Information about You

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

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

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

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

To the Employer. The plans may disclose your PHI to designated Employer personnel so they can carry out their plan related administrative functions, including the uses and disclosures descried in this notice. Such disclosures will be made only to the Employer's Privacy Officer and personnel under the Privacy Officer's supervision. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: 1) may not be disclosed by the plans to any other employee and 2) will not be used by the Employer for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the Employer.

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

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

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

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

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

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

Special use and Disclosure Situations

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

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

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

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

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

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

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

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

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

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

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

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

Your Rights Regarding Health Information about you

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

Right to Inspect and Copy. You have the right to inspect and copy your PHI. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes. To inspect and copy health information maintained by the plans, submit your request in writing to the Privacy Officer. The plans may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the plans may deny your request to inspect and coy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

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

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

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

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

A Note About Personal Representatives

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

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

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

Change to this Notice

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

Notice of Breach of PHI

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

Complaints

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

Other Uses and Disclosures of Health Information

A plan must obtain your written authorization to use or disclose psychotherapy notes, to use PHI for marketing purposes, or to sell PHI. An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use and disclosure of psychotherapy notes. Plans (excluding long-term care plans) are prohibited from using or disclosing PHI that is genetic information for underwriting purposes.

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

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

Attention: Privacy Officer.

Updated and effective March 26, 2013

Prescription Drug Creditable Coverage Disclosure

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

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. Utah County has determined that the prescription drug coverage offered by the Utah County is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Utah County coverage will be affected. If you do decide to enroll in a Medicare prescription drug plan and drop your Utah County prescription drug coverage, be aware that you may not be able to get this coverage back.

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

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Utah County and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join. For more information about this notice or your current prescription drug coverage, please contact Human Resources.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & 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 inside back cover of your copy of the Medicare and You handbook for their telephone number) for personalized help.
- Call **800.MEDICARE** 800.633.4227). TTY users should call **877.486.2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at **800.772.1213**.

Remember to keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Mental Health Parity Notice

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

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

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

Family & Medical Leave Act (FMLA)

FMLA is designed to help employees balance their work and family responsibilities by allowing them to take reasonable unpaid leave for certain family and medical reasons. It also seeks to accommodate the legitimate interests of employers and promote equal employment opportunity for men and women. FMLA applies to all public agencies, all public and private elementary and secondary schools, and companies with 50 or more employees.

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

Circumstances Permitting Family and Medical Leave

- Birth of an employee's child (within 12 months after birth)
- Adoption of a child by an employee (within 12 months after placement)
- Placement of a child with the employee for foster care (within
- 12 months after placement)
- Care of a child, spouse or parent having a serious health condition
- Incapacity of the employee due to a serious health condition.
- Military Leave

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

Michelle's Law

"Michelle's Law" applies to Utah County as to certain dependents eligible for extended coverage while a student. Michelle's Law requires group health plans to provide continued coverage for certain dependents who are covered under Utah County group health plan as a student but lose their student status because they take a medically necessary leave of absence from school. This continuation of coverage is described below.

If your dependent is no longer a student, as defined in the plan, because he/she is on a medically necessary leave of absence, your dependent may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This continued coverage applies if, immediately before the first day of the leave of absence, your dependent was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

For purposes of this continued coverage, a "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any change in enrollment of the dependent at the institution, that:

3. begins while the dependent is suffering from a serious illness or injury,
4. is medically necessary, and
5. causes the dependent to lose student status for purposes of coverage under the plan.

The coverage provided to dependent during any period of continued coverage:

6. is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the plan would otherwise terminate, and
7. stays the same as if your dependent had continued to be a covered student and had not taken a medically necessary leave of absence.

If the coverage provided by the plan is changed under the plan during this one-year period, the plan must provide the changed coverage for the dependent for the remainder of the medically necessary leave of absence unless, as a result of the change, the plan no longer provides coverage for these dependents.

If you believe your dependent is eligible for this continued coverage, the dependent's treating physician must provide a written certification to the plan stating that your dependent is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

Coordination with COBRA Continuation Coverage

If your dependent is eligible for Michelle's Law's continued coverage and loses coverage under the plan at the end of the continued coverage period, continuation coverage under COBRA will be available at the end of Michelle's Law's coverage period and a COBRA notice will be provided at that time. If further federal guidance permits the plan to apply this continued coverage to the period of time COBRA coverage is available, the plan will reduce the COBRA period by any period of coverage under coverage extended under Michelle's Law.

Patient Protection Notice (PCP and OB/GYN Choice Notice)

Regence Blue Cross Blue Shield generally allows 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 medical provider at the number listed at the back of this book.

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

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, add:

You do not need prior authorization from [name of group health plan or issuer] 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 Regence Blue Cross Blue Shield at 888.231.8424.

Notes

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting