OREM

2021

BENEFITS ENROLLMENT GUIDE

Effective | January 1, 2021

BENEFIT PROGRAM INFORMATION

For information about…	Go to…
Your Benefits	Amy Peterson HR Generalist 801.229.7196 ampeterson@orem.org
Customer Service Support	NFP Client Services 800.553.3903 NFPUTClientServices@nfp.com
Medical Plan	PEHP 800.765.7347 www.pehp.org
Health Savings Account	HealthEquity 866.346.5800 www.healthequity.com
Dental Plan	Dental Select 800.999.9789 www.dentalselect.com
Vision Plan	EyeMed 866.939.3633 www.eyemedvisioncare.com
Supplemental Health Benefits (Accident, Hospital, Critical Illness)	Eli Swenson Supplemental Health Benefits Specialist 385.352.9379 eli.swenson@nfp.com
Flexible Spending Accounts	HealthEquity 866.346.5800 www.healthequity.com
Life & Disability	The Standard 800.547.9515 www.standard.com
Voluntary Life	The Standard 800.547.9515 www.standard.com
Employee Assistance Program	Blomquist Hale 800.926.9619 www.blomquisthale.com
Wellness Program	Scott Swift Wellness Committee Chair 801.229.7186
Life Services Toolkit &Travel Assistance Program	The Standard 888.937.4783 www.standard.com

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

BENEFIT PROGRAM INFORMATION

BENEFITS OVERVIEW

Orem City offers a comprehensive benefits package to promote health and wellness along with financial security for both you and your family. The complete benefit package is briefly summarized in this enrollment guide. Please be sure to review it carefully so that you are able to elect the coverage that is most appropriate for your personal situation. If there is any discrepancy between the insurance carrier's certificate of coverage and this guide, the insurance carrier's certificate of coverage is the prevailing document.

ELIGIBILITY

Coverage begins for enrolled employees on their first day of employment.

To obtain benefits you must satisfy the following:

- You must be a full-time employee working 30 hours or more per week
- If eligible, you may enroll your spouse and dependent children on the offered benefit plans
- Dependent children are eligible if less than 26 years of age

ELIGIBLE DEPENDENTS

- Legally married spouse
- Your natural, adopted or stepchildren to age 26 for medical plans, and up to age 26 for unmarried dependents for the dental, vision, dependent life, and voluntary life plans.

OPEN ENROLLMENT

The medical, dental, vision and flexible spending account plan year is from Jan. 1, 2021, through Dec. 31, 2021. The next open enrollment period will be held in November.

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

QUALIFYING CHANGES

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

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

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

- You, your spouse or child loses coverage under either a Medicaid plan under Title XIX or under a state child health plan (CHIP) under Title XXI of the Social Security Act due to a loss of eligibility for that program's coverage

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

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MEDICAL

PEHP—STAR HSA Option 2 Qualified High Deductible Health Plan		
	In-Network	Out-of-Network*
Preventive Care Services Primary Care Provider Specialist Physician Diagnostic Tests (Lab, X-Ray)	Covered 100%	50% AD
Deductible	You Pay	You Pay
(Individual/Family)	$3,000/6,000 (Embedded)	$3,250/$6,500
Out of Pocket Maximum (Individual/Family) Includes Copays, Coinsurance & Deductibles	$4,000/$8,000 (Embedded)	$5,500/$11,000
Office Visits	You Pay	You Pay
Primary Care Provider	20% AD	50% AD
Specialist Physician	20% AD	50% AD
Urgent Care	20% AD	50% AD
Prescriptions	Tier 1 / Tier 2 / Tier 3	
30 Day Supply	$15 AD / $30 AD / $65 AD	
Mail Order- 90 Day Supply	$30 AD / $60 AD / $130 AD	
Diagnostic Lab/X-Ray Services	You Pay	You Pay
Minor	20% AD	50% AD
Major	20% AD	50% AD
Hospital Services**	You Pay	You Pay
Outpatient	20% AD	50% AD
Inpatient	20% AD	50% AD
Maternity	20% AD	50% AD
Durable Medical Equipment**	20% AD	50% AD
Emergency Room	20% AD	
Mental Health Services**	You Pay	You Pay
Office Visits	20% AD	50% AD
Inpatient / Outpatient	20% AD	50% AD
Chiropractic (20 Visits Per Year)	20% AD	Not Covered

AD: After Deductible; HDHP: High Deductible Health Plan

Embedded: If one person in a family hits the individual deductible and out-of-pocket limits in a calendar year, benefits will be paid at 100% for the remainder of the year.

*Member pays balance of billed charges above In-Network Rate.

**Preauthorization may be required

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 beginning of this guide.

FULL-TIME EMPLOYEE COST

PEHP STAR HSA Option 2 Medical Plan	Employee Cost Per Pay Period (24)
Employee Only	$20.00
Family	$40.00

PART-TIME EMPLOYEE COST

PEHP STAR HSA Option 2 Medical Plan	Employee Cost Per Pay Period (24)
Employee Only	$54.50
Family	$320.47

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HEALTH SAVINGS ACCOUNT

What is a Health Savings Account (HSA)?

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

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

You and/or your employer may contribute to your HSA, up to the legal maximum. **In 2021, the maximum annual contribution for single enrollee set by the IRS is $3,600, and the maximum family contribution is $7,200.** A catch-up contribution, up to an additional $1,000, is allowed for individuals who are 55 years or older. Please see the contribution chart below to determine the amount contributed to your HSA by your employer.

What you can do with your HSA

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

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

HSA/HDHP Annual Limits		
	Individual Coverage	**Family Coverage**
2021 Maximum Contribution to HSA	$3,600	$7,200
Catch-up Contribution (age 55 & older)	$1,000	$1,000

Coverage	Total Annual Employer Contribution	Optional HSA Match
Employee Only	$1,800	$200
Family	$3,600	$400

Employer HSA is paid quarterly in January, April, July, and October. The funds are contributed with the first paycheck of each quarter.

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MEDICAL

PEHP—Traditional Plan Option 4		
	In-Network	Out-of-Network*
Preventive Care Services Primary Care Provider Specialist Physician Diagnostic Tests (Lab, X-Ray)	Covered 100%	40% AD
Office Visits	You Pay	You Pay
Primary Care Provider	$30	40% AD
Specialist Physician	$40	40% AD
Urgent Care	$50	40% AD
Prescriptions*	Tier 1 / Tier 2 / Tier 3	
30 Day Supply	$15 / $30 / $65	
Mail Order- 90 Day Supply	$30 / $60 / $130	
Deductible	You Pay	You Pay
(Individual/Family)	$1,500/$3,000	$2,250/$4,500
Out of Pocket Maximum (Individual/Family) Includes Copays, Coinsurance & Deductibles	$3,000/$6,000	$4,500/$9,000
Diagnostic Lab/X-Ray Service	You Pay	You Pay
Minor	Covered 100%	40% AD
Major	20% AD	40% AD
Hospital Services**	You Pay	You Pay
Outpatient	20% AD	40% AD
Inpatient	20% AD	40% AD
Maternity	20% AD	40% AD
Durable Medical Equipment**	20% AD	40% AD
Emergency Room	$200 AD	
Mental Health Services**	You Pay	You Pay
Office Visits	20% AD	Not Covered
Inpatient / Outpatient	20% AD	Not Covered
Chiropractic (20 Visits Per Year)	Applicable office copay per visit	Not Covered

AD: After Deductible

*Member pays balance of billed charges above In-Network Rate.

**Preauthorization may be required
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 beginning of this guide.

FULL-TIME EMPLOYEE COST

PEHP Traditional Option 4 Medical Plan	Employee Cost Per Pay Period (24)
Employee Only	$50.65
Family	$151.95

PART-TIME EMPLOYEE COST

PEHP Traditional Option 4 Medical Plan	Employee Cost Per Pay Period (24)
Employee Only	$126.63
Family	$379.88

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DENTAL

Dental Select –Indemnity Classic Platinum Network Plan		
	In-Network	Out-of-Network*
Deductible (Individual/Family)	$50/$150	
	Plan Pays	
Preventive Services Routine Exams, Cleanings (2 per year), Topical Fluoride, X-rays	Covered 100%	100% of R&C**
Basic Services Composite Fillings, Extractions, Endodontics, Periodontics, Oral Surgery, Space Maintainers, Sealants	80%	80% of R&C**
Major Services Crowns, Bridges, Dentures, Full Implants	50%	50% of R&C**
Calendar Year Maximum	$2,000	
Orthodontia- Children (Under 19)	50%	50%
Orthodontia-All Members	20% Discount	No Benefit
Orthodontia Lifetime Maximum	$1,500	

*You pay the difference between billed and allowed charges, if any. The non-network percentage of benefits is based on the allowable amount applicable for the same service that would have been rendered by a network provider.

**R&C—Reasonable and Customary

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 beginning of this guide.

Discount Only - No benefit will be paid.

FULL-TIME EMPLOYEE COST

Dental Select Indemnity Classic Dental Plan	Employee Cost Per Pay Period (24)
Employee Only	$0.00
Family	$0.00

PART-TIME EMPLOYEE COST

Dental Select Indemnity Classic Dental Plan	Employee Cost Per Pay Period (24)
Employee Only	$7.70
Family	$25.84

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VISION

EyeMed– Vision Care Plan		
	In-Network	**Out-of-Network Reimbursement***
Examinations	Once Every 12 Months	
Lenses or Contact Lenses	Once Every 12 Months	
Frames	Once Every 12 Months	
Exam w/Dilation as Necessary	$10 Copay	Up to $40
Frames -Allows ANY Frame at Provider Location to be Chosen	$0 Copay; 20% Off Balance Over $130 Allowance	Up to $91
Standard Plastic Lenses		
Single Vision	$10 Copay	Up to $30
Bifocal	$10 Copay	Up to $50
Trifocal	$10 Copay	Up to $70
Lenticular Lenses	$10 Copay	Up to $70
Standard Progressive	$75 Copay	Up to $50
Premium Progressive (Tier 1-3)	$95-$120 Copay	Up to $50
Premium Progressive (Tier 4)	$75 Copay; 20% Off Retail Price less $120 Allowance	Up to $50
Lens Options		
Standard Anti-Reflective	$45	
Premium Anti-Reflective (Tier 1-2)	$57-68	
Premium Anti-Reflective (Tier 3)	20% Off Retail Price	Not Covered
Photochromic—Non-Glass	$75	
Standard Polycarbonate	$40	
Standard Scratch Resistance	$0 Copay	
Tint (Solid & Gradient)	$0 Copay	Up to $12
UV Coating	$0 Copay	
All Other Lens Options	20% Off Retail Price	Not Covered
Contact Lens Exam Options		
Standard Contact Lens Fit & Follow Up	Up to $40	Not Covered
Premium Contact Lens Fit & Follow Up	10% Off Retail Price	Not Covered
Contact Lens - Materials		
Conventional Contacts (in Lieu of Lenses)	$0 Copay, $130 Retail Allowance, 15% Discount off Balance Over $130	Up to $130
Disposable Contacts (in Lieu of Lenses)	$0 Copay, $130 Retail Allowance	Up to $130
Medically Necessary Contacts	$0 Copay, Paid in Full	Up to $210
Additional Eyewear Purchases	40% off Additional Pairs of Glasses Purchased Within the Same Plan Year, Once the Benefit Above has Been Utilized	Not Covered
Lasik and PRK Vision Correction	15% off Retail Price or 5% Off Promotional Pricing	Not Covered

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 beginning of this guide.

EMPLOYEE COST

EyeMed Vision Plan	Employee Cost Per Pay Period (24)
Employee Only	$3.69
Employee + Spouse	$7.00
Employee + Child(ren)	$7.37
Family	$10.84

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SUPPLEMENTAL HEALTH BENEFITS

ACCIDENT (OFF JOB) PLAN BENEFITS

	Silver Plan	Platinum Plan
Accident Coverage	Off Job	Off Job
Accidental Death and Dismemberment	Employee: $10,000 Spouse: $5,000 Child: $5,000	Employee: $50,000 Spouse: $25,000 Child: $5,000
Accidental Death: Seatbelts and Airbags Benefit	Seatbelts: $10,000 Seatbelt and Airbag: $15,000	Seatbelts: $10,000 Seatbelt and Airbag: $15,000
Wellness Benefit	**Provides a $100 per year benefit for completing certain routine wellness screenings or procedures (refer to plan for example procedures)**	**Provides a $150 per year benefit for completing certain routine wellness screenings or procedures (refer to plan for example procedures)**
Child Organized Sports	**25% increase to Child Benefits**	**25% increase to Child Benefits**
Catastrophic Loss	Quadriplegia: 100% AD&D Loss of speech and hearing (both ears): 100% of AD&D Loss of cognitive function: 100% of AD&D Hemiplegia: 50% of AD&D Paraplegia: 50% of AD&D	Quadriplegia: 100% AD&D Loss of speech and hearing (both ears): 100% of AD&D Loss of cognitive function: 100% of AD&D Hemiplegia: 50% of AD&D Paraplegia: 50% of AD&D
Accident Emergency Room Treatment	$150	$250
Accident Follow-Up Visit—Doctor	$25 up to 6 treatments	$75 up to 6 treatments
Air Ambulance	$750	$1,500
Ambulance	$150	$300
Burns (2nd Degree/3rd Degree)	9 sq inches to 18 sq inches: $0/$2,000 18 sq inches to 35 sq inches: $1,000/$4,000 Over 35 sq inches: $3,000/Up to $12,000	9 sq inches to 18 sq inches: $0/$2,000 18 sq inches to 35 sq inches: $1,000/$4,000 Over 35 sq inches: $3,000/Up to $12,000
Coma	$7,500	$12,500
Concussions	$100	$300
Dislocations	Schedule up to $3,000	Schedule up to $7,000
Emergency Dental Work	$200/Crown $50/Extraction	$400/Crown $100/Extraction
Epidural Pain Management	$100, 2 times per accident	$100, 2 times per accident
Eye Injury	$200	$300
Fracture	Schedule up to $4,000	Schedule up to $8,000
Hospital Admission	$750	$1,500
Hospital Confinement	$150/day, up to 1 year	$300/day, up to 1 year
Hospital ICU Admission	$1,500	$3,000
Hospital ICU Confinement	$300/day — up to 15 days	$600/day — up to 15 days
Initial Physician's office/Urgent Care Facility Treatment	$75	$125
Knee Cartilage	$250	$750
Joint Replacement (hip/knee/shoulder)	$1,500/$750/$750	$3,500/$1,750/$1,750
Laceration	Schedule up to $300	Schedule up to $500
Ruptured Disc with Surgical Repair	$250	$750
Surgery (Cranial, Open Abdominal, Thoracic)	$1,000 Hernia: $200	$1,500 Hernia: $300
Tendon/Ligament/Rotator Cuff	1: $250 2 or more: $500	1: $750 2 or more: $1,500
X-Ray	$30	$50

RATES PER PAY PERIOD (24)

	Silver Plan	Platinum Plan
Employee	$5.83	$10.39
Employee & Spouse	$10.08	$17.67
Employee & Child(ren)	$10.93	$18.51
Employee & Family	$15.17	$25.79

Minimum of 5 employees must enroll for policy to be issued.

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SUPPLEMENTAL HEALTH BENEFITS

HOSPITAL PLAN BENEFITS		
	Plan 1	Plan 2
Daily Hospital Confinement	$100	$100
Daily ICU Confinement	$100	$200
Hospital Admission Benefit (Inpatient) One Benefit per Covered Person Per Plan Year	$1,000	$1,500
Qualified Wellness Visit Reimbursement One Benefit per Covered Person Per Plan Year	**$100**	**$150**

Hospital Admission benefit is payable once per year, per person.

Daily Hospital & Daily ICU Confinement benefits are payable up to 30 combined days per year, per person.

Hospital admission & confinement benefits are not payable for a newborn unless the child is admitted to the Neonatal ICU.

RATES PER PAY PERIOD (24)		
	Plan 1	Plan 2
Employee Only	$11.40	$15.39
Employee Plus Spouse	$24.03	$32.47
Employee Plus Children	$17.14	$23.08
Employee Plus Family	$29.72	$40.16
Rate Guarantee	Rates are guaranteed for two years	
Minimum of 5 employees must enroll for policy to be issued.		

PLAN HIGHLIGHTS

- **Guaranteed issue; no medical questions**
- **No pre-existing conditions exclusions**
- No deductibles
- Portable
- Coverage offered on a voluntary basis

Note: The state of California requires its residents to be enrolled in an overlying medical plan in order to enroll for Voluntary Hospital Indemnity.

SUPPLEMENTAL HEALTH BENEFITS

CRITICAL ILLNESS PLAN BENEFITS		
Covered Condition (Lump Sum Payments)	First Occurrence	Second Occurrence
Heart Attack, Invasive Cancer, Stroke, Kidney (Renal) Failure, Heart Failure, Organ Failure	100%	50%
Carcinoma in situ and Arteriosclerosis	30%	0%
Benign Brain Tumor	75%	0%
Enhanced Covered Conditions	First Occurrence of these additional illnesses: Addison's Disease 30%, ALS (Lou Gehrig's Disease) 100%, Alzheimer's Disease 50%, Coma 100%, Huntington's Disease 30%, Multiple Sclerosis 30%, Loss of Speech, Sight or Hearing 100%, Parkinson's Disease 100%, Permanent Paralysis 50% for 1 limb, 100% for 2 limbs, Severe Burns 100%	
Childhood Covered Conditions	100 % of Child Benefit for the First Occurrence of Cerebral Palsy, Cleft lip/palate, Club Foot, Cystic Fibrosis, Down's Syndrome, Muscular Dystrophy, Spina Bifida, Type 1 Diabetes	
Cancer Vaccine	$50 per lifetime for receiving a Cancer Vaccine	
Dependent Age Limits	Childbirth to 26 years	
Wellness (Health Screening) Benefit	**$150**	

RATES PER PAY PERIOD (24)		
Critical Illness Insurance Cost		
Rate per Employee or Spouse if applicable		
Employee/Spouse Premium Cost		
(Spouse rate is based on Employee's Age)		
Guarantee Issue	**$5,000**	**$20,000**
Age	Premium Rate	Premium Rate
<30	$1.03	$4.10
30-39	$2.23	$8.90
40-49	$4.18	$16.70
50-59	$8.40	$33.60
60-69	$14.85	$59.40
70+	$21.78	$87.10
***Minimum of 5 employees must enroll for policy to be issued.**		

All child(ren) under the age of 26 will automatically be covered for 25% of the employee's elected amount at no additional cost.

Age-banded premium rates are based on the age at last birthday. They will change on the policy anniversary date coinciding with or next following the Insured's age.

Note: Premium/Benefit is payable in US currency.

Age Reduction: For Insureds age 70 and over, the Amount of Insurance is subject to automatic reduction. Upon the Insured's attainment of the specified age below, the Amount of Insurance will be reduced to the applicable percentage. This reduction also applies to Insureds who are age 70 or over on their Individual Effective Date. Age: 70, Percentage of available or in force amount at age 69: 50%. The Dependent spouse Amount of Insurance will reduce in the same manner as the Insured's Amount of Insurance upon the Dependent spouse's attainment of the reducing age. The Child Amount of Insurance will continue at the percentage (reflected on the Plan Description) of the Insured's Amount of Insurance prior to any reductions due to age.

Rate Guarantee: We guarantee the final premium rates for 24 months from the Policy effective date.

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SUPPLEMENTAL HEALTH BENEFITS

APPROVED ACCIDENT WELLNESS VISITS

- Bone Marrow testing
- Breast Ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CAE (blood test for colon cancer)
- Chest X-ray
- Colonoscopy/Virtual Colonoscopy
- Flexible Sigmoidoscopy
- Hemoccult Stool Analysis
- Mammography
- Pap smear/Thin Prep Pap Test
- PSA (blood test for prostate cancer)
- Thermography
- Blood test for Triglycerides
- Completion of a Smoking Cessation or Weight Reduction program
- Fasting Blood Glucose Test
- Serum Cholesterol Test (to determine level of HDL and LDL)
- Serum Protein Electrophoresis (blood test for myleloma)
- Stress Test (on a bicycle or treadmill)
- Double Contrast Barium Enema
- EKG
- Immunizations
- Routine/Annual Physicals
- Skin Cancer Biopsy

APPROVED HOSPITAL PLAN HEALTH SCREENINGS

- Bone Marrow testing
- Breast Ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CAE (blood test for colon cancer)
- Chest X-ray
- Colonoscopy/Virtual Colonoscopy
- Flexible Sigmoidoscopy
- Hemoccult Stool Analysis
- Mammography
- Pap smear/Thin Prep Pap Test
- PSA (blood test for prostate cancer)
- Thermography
- Blood test for Triglycerides
- Completion of a Smoking Cessation or Weight Reduction program
- Fasting Blood Glucose Test
- Serum Cholesterol Test (to determine level of HDL and LDL)
- Serum Protein Electrophoresis (blood test for myleloma)
- Stress Test (on a bicycle or treadmill)
- Cancer Genetic Mutation Test
- Lymphocyte Genome Sensitivity Test (LGS)

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SUPPLEMENTAL HEALTH BENEFITS

APPROVED CRITICAL ILLNESS HEALTH SCREENINGS

- Bone Marrow testing
- Breast Ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CAE (blood test for colon cancer)
- Chest X-ray
- Colonoscopy/Virtual Colonoscopy
- Flexible Sigmoidoscopy
- Hemoccult Stool Analysis
- Mammography
- PSA (blood test for prostate cancer)
- Thermography
- Blood test for Triglycerides
- Completion of a Smoking Cessation or Weight Reduction program
- Fasting Blood Glucose Test
- Serum Cholesterol Test (to determine level of HDL and LDL)
- Serum Protein Electrophoresis (blood test for myleloma)
- Stress Test (on a bicycle or treadmill)
- Cancer Genetic Mutation Test

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Did you incur a claim eligible for Supplemental Health Benefits?

DO YOU NEED HELP SUBMITTING A CLAIM FOR YOUR ACCIDENT, HOSPITAL AND CRITICAL ILLNESS PLANS OR HAVE QUESTIONS REGARDING THOSE PLANS?

CONTACT US

Claim forms vary based on the plan(s) you have elected and the type of claim you are submitting. To submit a claim, contact our NFP Supplemental Health Benefits Specialist for the appropriate form(s):

Eli Swenson
Direct: 385-352-9379
Cell: 801-592-0771
eli.swenson@nfp.com

WHAT TO EXPECT	
Wellness Claims	To file a wellness claim, you will need to complete a claim form and include a copy of the itemized bill or Explanation of Benefits as documentation of the wellness visit.
Accident, Hospital, & Critical Illness Claims	To file a claim for an accident, hospital confinement, or diagnosis of a critical illness, you will need to complete a claim form and include copies of any itemized and any other documentation related to your treatment.

FLEXIBLE SPENDING ACCOUNT

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

Three Components of the Flexible Spending Account:

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

2. **Flexible Spending Account (FSA)-Health Care Reimbursement (Including Dental and Vision):** Each year, you may set aside up to $2,750 pre-tax dollars to pay for qualifying out-of-pocket medical, dental, vision, and some over the counter expenses. **A Limited Purpose Flexible Spending plan, associated with HSA participation can only be used for dental and vision expenses.**

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

There are two types of Flexible Spending Accounts Available:

Flexible Spending Account–To be used without HSA Account Participation

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

Facts You Should Know:

- Participation is voluntary
- Participation in the plan simply allows you to pay for qualified expenses with pre-tax dollars
- Flexible Spending Accounts are subject to the “use it or lose it” rule. Participants may forfeit any balance in the account(s) at the end of the plan year.
- Over-the-counter medications and other items are eligible without a prescription.

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

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BASIC LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

Life Insurance and Accidental Death & Dismemberment (AD&D) benefits provide you and your loved ones financial protection in the event of an illness, accident, or death.

BENEFICIARY DESIGNATION

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

The Standard- Basic Life, AD&D, Dependent Life	
Employee Life Benefit	Class 1 (Employees) - 1 times annual salary to a maximum of $250,000 with a minimum coverage amount of $50,000 Class 2 (City Council Employees and Mayor) -$50,000 Class 3 (Retired Employees) - $5,000
Employee AD&D	Class 1 & 2—Equal to your Basic Life Amount Class 3—Not Applicable
Benefit Age Reduction	Reduces to 50% at Age 70

AD&D: Accidental Death & Dismemberment

Orem City pays the full cost for basic life, accidental death and dismemberment (AD&D) benefits for all employees.

EMPLOYEE COST

$0.00

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

SHORT-TERM DISABILITY

Disability insurance benefits replace a portion of your income if you are unable to work for a period of time due to a qualified off-the-job injury or illness.

EMPLOYEE PAID SHORT-TERM DISABILITY

This coverage replaces a portion of your income when you can't work because of a qualifying disability. Even if you're healthy now, it's important to protect yourself and the people who count on your income. This insurance can help you pay the bills when you're unable to work.

The Standard– Voluntary Short-Term Disability	
Benefit Percentage	60% of Weekly Earnings ($15 minimum per week)
Maximum Weekly Benefit	$2,000
Benefit Commencement Period	14 Days Accident / 14 Days Sickness
Extended Benefit Waiting Period	60 Days for any qualifying disability caused by physical disease, pregnancy or mental disorder occurring during the first 12 months of coverage
Maximum Benefit	120 Days

Voluntary Short-Term Disability Rates	
Rate Per $10 of Weekly Benefit	
Age Band	Rate per $10
< 30	$0.35
30-34	$0.383
35-39	$0.299
40-44	$0.279
45-49	$0.339
50-54	$0.398
55-59	$0.552
60+	$0.673

Use this Formula to Calculate Your Premium Payment

Weekly Earnings	Rate		Monthly Cost
	X	/10	=$

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

SHORT-TERM DISABILITY FAQ

FILING A SHORT-TERM DISABILITY CLAIM

Report a claim as soon as you believe you will be absent from work beyond 14 calendar days (60 calendar days if you are subject to the extended benefit waiting period). If you are uncertain about how long you will be absent or whether you should file a claim or not, we suggest that you proceed with filing a claim right away. This offers you some peace of mind and allows for The Standard to begin its review and issue a timely payment if appropriate. You may report a claim up to four weeks in advance of a planned disability absence, such as childbirth or scheduled surgery.

HOW DO I FILE A CLAIM?

To file a paper claim, contact your benefits administrator or go to www.standard.com to download,
complete and print a claim packet. A typical application for disability benefits contains the following documents:

- Employee's Statement
- Employer's Statement
- Attending Physician's Statement (APS)
- Authorization to Obtain and Release Information

WHEN I REPORT MY CLAIM, WHAT INFORMATION WILL I NEED TO PROVIDE?

You will be asked to provide the following information – in addition to other questions about your absence:

- Employer name: City of Orem
- Group Policy Number: 751866
- Name and Social Security Number
- Last day you were at work
- Nature of claim/medical information
- Physician's contact information (name, address, phone and fax number)

WHERE DO I SEND THE COMPLETED FORMS?

You can fax completed forms to The Standard at 800-378-6053. Completed forms can also be mailed to: Standard Insurance Company
PO Box 2800
Portland, OR 97208

HOW LONG DOES IT NORMALLY TAKE TO MAKE A CLAIM DECISION?

Once The Standard receives the required paperwork, which includes the Employee's Statement, Employer's Statement, Attending Physician's Statement and Authorization to Obtain and Release Information, it will take approximately one week to make a claim decision. If The Standard has not made a decision within one week, you will be notified with additional details.

IF MY CLAIM FOR BENEFITS IS APPROVED, HOW LONG WILL IT TAKE TO RECEIVE MY FIRST CHECK?

Once The Standard receives the required paperwork, which includes the Employee's Statement, Employer's Statement, Attending Physician's Statement and Authorization to Obtain and Release Information, it will take approximately one week to make a claim decision. If The Standard has not made a decision within one week, you will be notified with additional details.

WHO SHOULD I CALL WITH QUESTIONS ABOUT MY CLAIM?

If you have already filed a claim, please call The Standard's Disability Benefits toll-free number, 800-368-1135. If you are looking for general information, please contact your benefits administrator.

WHO IS RESPONSIBLE FOR NOTIFYING CITY OF OREM IN MY ABSENCE?

It is your responsibility to follow the normal City of Orem absence reporting procedures by notifying your supervisor, and Human Resources / Benefit team of your absence.

WHEN SHOULD I FILE A SHORT-TERM DISABILITY (STD) CLAIM AS A RESULT OF PREGNANCY OR CHILDBIRTH?

Please file your claim for STD benefits as soon as you cease working due to your pregnancy or childbirth. You may also report a claim up to four

SHORT-TERM DISABILITY FAQ

HOW LONG AM I CONSIDERED DISABLED FOLLOWING CHILDBIRTH?

For all occupations you are considered disabled for six weeks after a vaginal delivery or eight weeks after a caesarian section delivery. The disability periods noted are assuming there were no complications following childbirth. The disability period may be extended if complications arise.

WHAT HAPPENS IF MY DELIVERY OCCURS WITHIN THE BENEFIT WAITING PERIOD? DO I STILL RECEIVE SIX WEEKS OF BENEFITS?

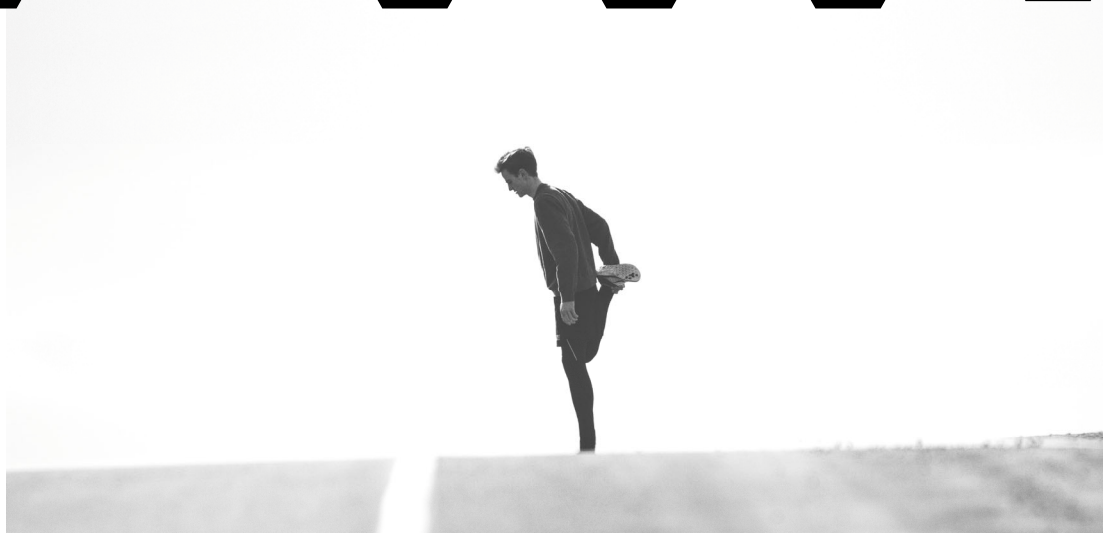
STD benefits are only paid for the period of disability following the benefit waiting period.
Following an uncomplicated vaginal delivery, you are considered disabled for six weeks. This means in some instances when childbirth occurs during the benefit waiting period, benefits will be paid for less than six weeks.

WHAT SHOULD I DO IF I HAVE COMPLICATIONS FOLLOWING MY CHILDBIRTH?

If complications arise following childbirth that will prevent you from recovering during the normal recovery period, your doctor will need to provide The Standard with written documentation of your specific limitations and restrictions. This documentation may include the completion of an attending physician's statement or pregnancy questionnaire, and/or copies of your medical records. Once this information has been received, your claim will be reviewed for an extension of STD benefits.

ARE BENEFITS PAID FOR PERIODS OF CHILD-PARENT BONDING, BREAST FEEDING OR CHILD ILLNESS?

Disability benefits are paid only while you are unable to work at your own occupation. The actual amount and length benefits are paid is based upon your Group Policy. No benefits are paid for periods of child-parent bonding, breast feeding, or child illness.



LONG-TERM DISABILITY

The Standard - Long-Term Disability	
Elimination Period	120 days
Benefit Percentage	66 2/3%
Line of Duty Benefit	100% of Monthly Income (Police & Firefighters)
Maximum Monthly Benefit	$10,000
Benefit Duration	Social Security Normal Retirement Age
Definition of Disability	2 years-own occupation
Mental Illness/Substance Abuse	36 months

Your employer pays the full cost for long-term disability (LTD) benefits for all employees.

EMPLOYEE COST

$0.00

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

VOLUNTARY LIFE

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

The Standard- Voluntary Life	
Employees:	
Benefit Amount	$10,000 increments
Minimum Benefit	$10,000
Maximum Benefit	$600,000
Guarantee Issue Amount	$300,000
Benefit Age Reduction	Reduces to 50% at Age 70
Late Entrants (other than at hire)	Subject to evidence of insurability
Spouse:	
Benefit Amount	$5,000 increments
Minimum Benefit	$5,000
Maximum Benefit	$400,000 (not to exceed 100% of employee voluntary life)*
Guarantee Issue Amount	$50,000
Benefit Age Reduction	Reduces to 50% at Age 70
Late Entrants (other than at hire)	Subject to evidence of insurability
Child(ren):	
Option 1-Benefit Amount	$5,000
Option 2-Benefit Amount	$10,000

*Basic life benefits illustrated on previous page do not count toward the maximum benefit amounts for voluntary life.

Employee Voluntary Life Rates		
Monthly Rates for Every $10,000 of Coverage		
Age Band	Non-Smoker	Smoker
< 30	$0.53	$0.92
30-34	$0.53	$1.12
35-39	$0.63	$1.60
40-44	$1.02	$2.43
45-49	$1.75	$3.88
50-54	$2.67	$5.82
55-59	$3.78	$7.86
60-64	$6.40	$12.42
65-69	$12.85	$22.80
70+	$13.44	$20.37

Spouse Voluntary Life Rates		
Monthly Rates for Every $5,000 of Coverage		
Age Band	Non-Smoker	Smoker
< 30	$0.27	$0.46
30-34	$0.27	$0.56
35-39	$0.32	$0.80
40-44	$0.51	$1.22
45-49	$0.88	$1.94
50-54	$1.34	$2.91
55-59	$1.89	$3.93
60-64	$3.20	$6.21
65-69	$6.43	$11.40
70+	$6.72	$10.19

Child(ren) Voluntary Life Rates	
Monthly Rates for Every $5,000 of Coverage	
$5,000	$0.60
$10,000	$1.20

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

Blomquist Hale
SOLUTIONS

WHEN LIFE GETS CHALLENGING
WE CAN HELP

The Blomquist Hale Solutions Program provides direct, **face-to-face** guidance to address virtually any stressful life situation or problem. Not to mention there is absolutely **no cost** to you. Meeting with our team is simple. Call to schedule an appointment today. **(800) 926-9619**

Count On:

- ☑ 24/7 Crisis Service
- ☑ 100% Confidential
- ☑ Professional, Friendly Team
- ☑ Convenient Locations
- ☑ Extended Hours
- ☑ No Co-pay Required

WE CAN HELP WITH

- Marital & Family Counseling 
- Stress, Anxiety or Depression 
- Personal & Emotional Challenges 
- Grief or Loss 
- Financial or Legal Problems 
- Substance Abuse or Addictions 
- Senior Care Planning 

To access our no cost online webinars, please go to:
https://blomquisthale.com/Work-Shops.html

WELLNESS

OREM FAMILY FITNESS CENTER

- Free family pass to the Fitness Center
- Includes access to the indoor pools, fitness classes and weight and cardio equipment for you and your immediate family members living in the same household

Benefit eligible employees receive a free family pass to the Orem Fitness Center. Services include full access to the fitness center, including pools, weight room and cardio areas and aerobics classes (Yoga, Pilates, Spinning, etc.)

UTA PASS

- Free Eco-Pass for all employees
- Use on buses, Trax, Frontrunner (not valid on Ski, Paratransit, Park City Connect, or Special services).

LIBRARY CARD BENEFIT

- For all benefit eligible employees, regardless if an Orem Resident

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

LIFE SERVICES TOOLKIT

Group Life Insurance through your employer gives you assurance that your family will receive some financial assistance in the event of a death. But coverage under a group Life policy from Standard Insurance Company (The Standard) does more than help protect your family from financial hardship after a loss. We have partnered with Morneau Shepell to offer a lineup of additional services that can make a difference now and in the future.

Online tools and services can help you create a will, make advanced funeral plans and put your finances in order. After a loss, beneficiaries can consult experts by phone or in person, and obtain other helpful information online.

The Life Services Toolkit is automatically available to those insured under a group Life insurance policy from The Standard. Recipients of an Accelerated Benefit can access services for 12 months after the date of payment.

SERVICES TO HELP YOU NOW

Visit the Life Services Toolkit website at www.standard.com/mytoolkit (enter username "assurance") for information and tools to help you make important life decisions.

- **Estate Planning Assistance:** Online tools walk you through the steps to prepare a will and create other documents, such as living wills, powers of attorney and health care agent forms.
- **Financial Planning:** Consult online services to help you manage debt, calculate mortgage and loan payments, and take care of other financial matters with confidence.
- **Health and Wellness:** Timely articles about nutrition, stress management and wellness help employees and their families lead healthy lives.
- **Identity Theft Protection:** Check the website for ways to thwart identity thieves and resolve issues if identity theft occurs.
- **Funeral Arrangements:** Use the website to calculate funeral costs, find funeral-related services and make decisions about funeral arrangements in advance.

SERVICES FOR YOUR BENEFICIARY

Life insurance beneficiaries can access services for 12 months after the date of death. Recipients of an Accelerated Benefit can access services for 12 months after the date of payment.

These supportive services can help your beneficiary cope after a loss:

- **Grief Support:** Clinicians with master's degrees are on call to provide confidential grief sessions by phone or in person. Beneficiaries are eligible for up to six face-to-face sessions and unlimited phone contact.
- **Legal Services:** Beneficiaries can obtain legal assistance from experienced attorneys. They can:
  - Schedule an initial 30-minute office and a telephone consultation with a network attorney. Beneficiaries who wish to retain a participating attorney after the initial consultation receive a 25% rate reduction from the attorney's normal hourly or fixed fee rates.
  - Obtain an estate-planning package that consists of a simple will, a living will, a health care agent form and a durable power of attorney.
- **Financial Assistance:** Beneficiaries have unlimited phone access to financial counselors who can help with issues such as budgeting strategies, and credit and debt management, including hour-long sessions on topics requiring more in-depth discussion.
- **Support Services:** During an emotional time, beneficiaries can receive help planning a funeral or memorial service. Work-life advisors can guide them to resources to help manage household repairs and chores; find child care and elder care providers; or organize a move or relocation.
- **Online Resources:** Beneficiaries can easily access additional services and features on the Life Services Toolkit website for beneficiaries, including online resources to calculate funeral costs, find funeral-related services and make decisions about funeral arrangements.

HOW TO ACCESS SERVICES

Visit www.standard.com/mytoolkit (user name + support), or call the phone assistance line at 800-378-5742

TRAVEL ASSISTANCE

EXPLORE THE WORLD WITH CONFIDENCE

Things can happen on the road. Passports get stolen or lost. Unforeseen events or circumstances derail travel plans. Medical problems surface at the most inconvenient times. Travel Assistance can help you navigate these issues and more at any time of the day or night.

You and your spouse are covered with Travel Assistance – and so are kids through age 25 – with your group insurance from Standard Insurance Company (The Standard).

SECURITY THAT TRAVELS WITH YOU

Travel Assistance is available when you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure. It offers aid before and during your trip, including:

- Passport, visa, weather and currency exchange information, health hazards advice and inoculation requirements
- Emergency ticket, credit card and passport replacement, funds transfer and missing baggage
- 24/7/365 phone access to registered nurses for health and medication information, symptom decision support, and help understanding treatment options
- Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employees' home, including repatriation of remains
- Connection to medical care providers, interpreter services, a local attorney, consular office or bail bond services
- Return travel companion if travel is disrupted due to emergency transportation services or return dependent children if left unattended due to prolonged hospitalization
- Logistical arrangements for ground transportation, housing and/or evacuation in the event of political unrest and social instability; for more complex situations, assists with making arrangements with providers of specialized security services

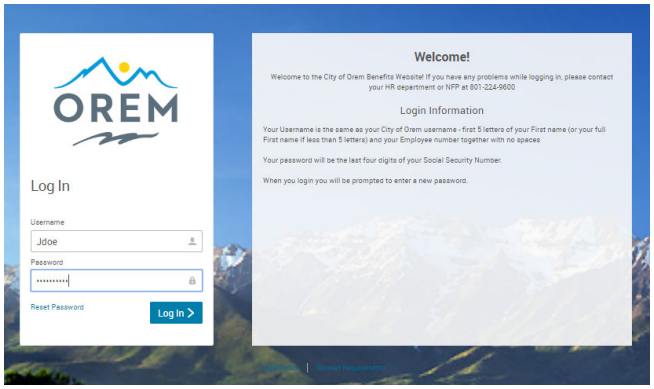
CONTACT TRAVEL ASSISTANCE

United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda- 800-527-0218
Everywhere else- 1-410-453-6330
Assistance@uhcglobal.com
www.standard.com/travel

BSWIFT

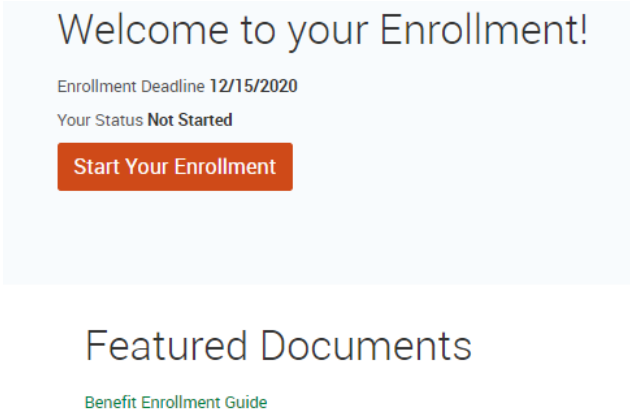
LOG IN

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



GET STARTED

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

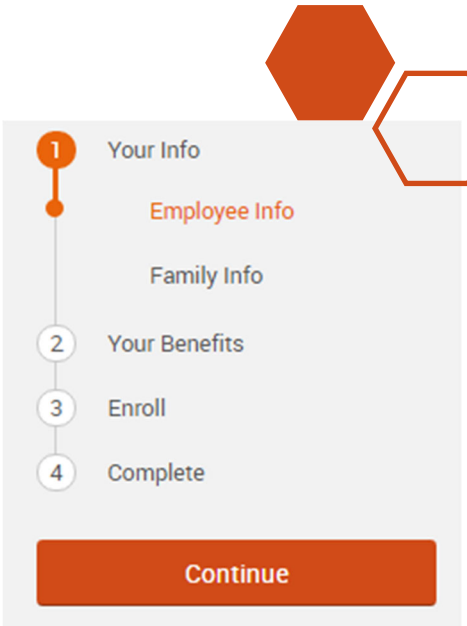


ENROLLMENT 4 STEPS

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

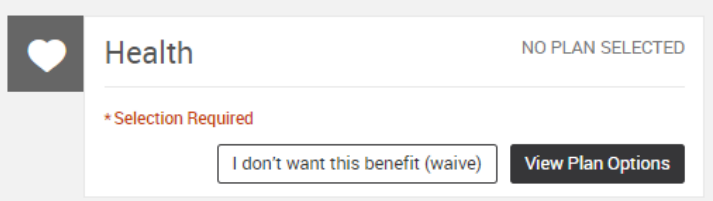
STEP 1: VERIFY PERSONAL & FAMILY INFORMATION

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



STEP 2: SELECT YOUR BENEFITS

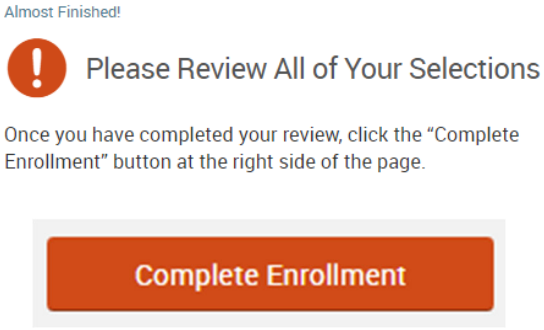
You will see a page listing all the plan types. Select your benefit by type by clicking on the View Plan Options button in each plan type box. Make sure to click on the family members at the top that you would like to be covered for each plan.



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

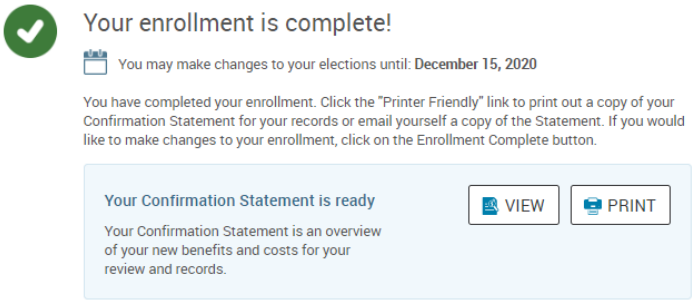
STEP 3: CONFIRM AND SAVE YOUR ELECTIONS!

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



STEP 4 : COMPLETE YOUR ENROLLMENT

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



Additional Information

YOU'RE COVERED

PEHP Pays for **Preventive Benefits** at 100%*

Don't put off that test or immunization. Preventive benefits are covered at no cost to you when you see a contracted provider — even before you meet your deductible.

Covered Preventive Services for Adults

(Ages 18 and older)

» Preventive physical exam visits for adults, one time per plan year including:
  › Blood pressure screening
  › Basic/comprehensive metabolic panel
  › Complete blood count
  › Urinalysis
» Abdominal aortic aneurysm one-time screening for men aged 65-75 who have ever smoked.
» Alcohol misuse screening and counseling.
» Aspirin use for men ages 45-79 and women ages 55-79, covered under the pharmacy benefit when prescribed by a physician.
» Cholesterol screening for adults of certain ages or at higher risk.
» Colorectal cancer screening for adults ages 50 to 75 using fecal occult blood testing, sigmoidoscopy, or colonoscopy.
PEHP covers Conscious Moderate Sedation for Colonoscopy's. If you don't have an ASA score of P3 or higher, or a Mallampati score of III or higher, General Anesthesia or Monitored Anesthesia Care is not covered for those providers that bill separately for it. Check with your doctor to find out if you meet these requirements.
» Depression screening for adults.
» Type 2 diabetes screening for adults with high blood pressure.
» Diet counseling for adults at higher risk for chronic disease including hyperlipidemia, obesity, diabetes, and cardiovascular disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists including registered dietitians.
» HIV screening for all adults at higher risk.
» Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
  › Hepatitis A
  › Hepatitis B
  › Herpes zoster (shingles age 60 and above)
  › Human papillomavirus (HPV)
    » males age 9-21 Gardasil
    » females age 9-26 Gardasil or Cervarix
  › Influenza (flu shot)
  › Measles, mumps, rubella
  › Meningococcal (meningitis)
  › Pneumococcal (pneumonia)
  › Tetanus, diphtheria, pertussis (Td or Tdap)
  › Varicella (chickenpox)

Learn more about immunizations and see the latest vaccine schedules at www.cdc.gov/vaccines/.

» Obesity screening and counseling for all adults by primary care clinicians to promote sustained weight loss for obese adults.
» Sexually transmitted infection (STI) prevention counseling for adults at higher risk.
» Tobacco use screening for all adults and cessation interventions for tobacco users.
» Syphilis screening for all adults at higher risk.

Covered Preventive Services Specifically for Women, Including Pregnant Women

» Preventive gynecological exam, two per plan year.
» Anemia screening on a routine basis for pregnant women.
» Bacteriuria urinary tract or other infection screening for pregnant women.
» BRCA counseling about genetic testing for women at higher risk.
» BRCA testing for women at higher risk, requires preauthorization from PEHP.
» Breast cancer mammography screenings one time per plan year for women over 40.
» Breast cancer chemoprevention counseling for women at higher risk.
» Breast cancer medications for women at higher risk. Tamoxifen or Raloxifene.
» Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women.
Coverage allows for either a manual or electric breast pump within 12 months after delivery. Hospital grade breast pumps when medically necessary and preauthorized by PEHP are also included.
» Cervical cancer screening (pap smear) for women ages 21-65.

Continued on next page

Continued from previous page

» Chlamydia infection screening for younger women and other women at higher risk.
» Contraception: Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs.
  › Covered services/devices include: One IUD every two years (including removal), generic oral contraceptives, NuvaRing, Ortho Evra, diaphragms, cervical caps, emergency contraceptives (Ella, and generics only), injections, hormonal implants (including removal), Essure, and tubal ligation.
» Domestic and interpersonal violence screening and counseling for all women.
» Folic acid supplements for women who may become pregnant, covered under the pharmacy benefit when prescribed by a physician.
» Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
» Gonorrhea screening for all women at higher risk.
» Hepatitis B screening for pregnant women at their first prenatal visit.
» Human immunodeficiency virus (HIV) screening and counseling for sexually active women.
» Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older in conjunction with cervical cancer screening (pap smear).
» Osteoporosis screening for women over age 60 depending on risk factors.
» Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
» Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users.
» Sexually transmitted infections (STI) counseling for sexually active women.
» Syphilis screening for all pregnant women or other women at increased risk.

Covered Preventive Services Specifically for Children

(Younger than age 18)

» Preventive physical exam visits throughout childhood as recommended by the American Academy of Pediatrics including:
  › Behavioral assessments for children of all ages;
  › Blood pressure screening for children;
  › Developmental screening for children under age 3 and surveillance throughout childhood;
  › Oral health risk assessment for young children;
» Alcohol and drug use assessments for adolescents.
» Autism screening for children at 18 and 24 months.
» Cervical dysplasia (pap smear) screening for sexually active females.
» Congenital hypothyroidism screening for newborns.
» Depression screening for adolescents.
» Dyslipidemia screening for children at higher risk of lipid disorders.
» Fluoride chemoprevention supplements for children without fluoride in their water source.
» Gonorrhea preventive medication for the eyes of all newborns.
» Hearing screening for all newborns, birth to 90 days old.
» Height, weight, and body mass index measurements for children.
» Hematocrit or hemoglobin screening for children.
» Hemoglobinopathies or sickle cell screening for newborns.
» HIV screening for adolescents at higher risk.
» Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
  › Diphtheria, tetanus, pertussis (Dtap);
  › Haemophilus influenzae type b (Hib);
  › Hepatitis A;
  › Hepatitis B;
  › Human papillomavirus (HPV);
    » Males age 9-21 Gardasil;
    » Females age 9-26 Gardasil or Cervarix;
  › Inactivated poliovirus;
  › Influenza (Flu Shot);
  › Measles, mumps, rubella;
  › Meningococcal (meningitis);
  › Pneumococcal (pneumonia);
  › Rotavirus;
  › Varicella (chickenpox).
  Learn more about immunizations and see the latest vaccine schedules at www.cdc.gov/vaccines/.
» Iron supplements for children ages 6 to 12 months at risk for anemia.
» Obesity screening and counseling.
» Phenylketonuria (PKU) screening for this genetic disorder in newborns.
» Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk.
» Tuberculin testing for children at higher risk of tuberculosis.
» Vision screening for all children one time between ages 3 and 5.

Coverage for Specific Drugs

Payable through the Pharmacy Plan when received at a participating pharmacy with a prescription from your doctor. Over-the-counter purchases are not covered. See applicable Benefits Summary for coverage information.
» Aspirin use for men age 45-79 and women age 55-79.
» Breast cancer medications for women at higher risk. Tamoxifen or Raloxifene.
» Folic acid supplements for women who may become pregnant.
» Fluoride chemoprevention supplements for children without fluoride in their water source.
» Iron supplements for children ages 6 to 12 months at risk for anemia.
» Tobacco use cessation interventions, up to the maximum approved dose and duration per plan year.

Additional Preventive Services When Enrolled in The STAR Plan

(doesn't apply to Jordan School District)
(doesn't apply to Utah Basic Plus)

Adults
» Eye exam, routine. One per plan year.
» Glaucoma screening.
» Glucose test.
» Hearing exam.
» Hypothyroidism screening.
» Phenylketones test.
» Prostate cancer screening.
» PSA (prostate specific antigen) screening.
» Refraction exams.
» Blood typing for pregnant women.
» Rubella screening for all women of child bearing age at their first clinical encounter.

Children
» Eye exam, routine. One per plan year.
» Glaucoma screening.
» Hearing exam.
» Hypothyroidism screening.
» Refraction exams.

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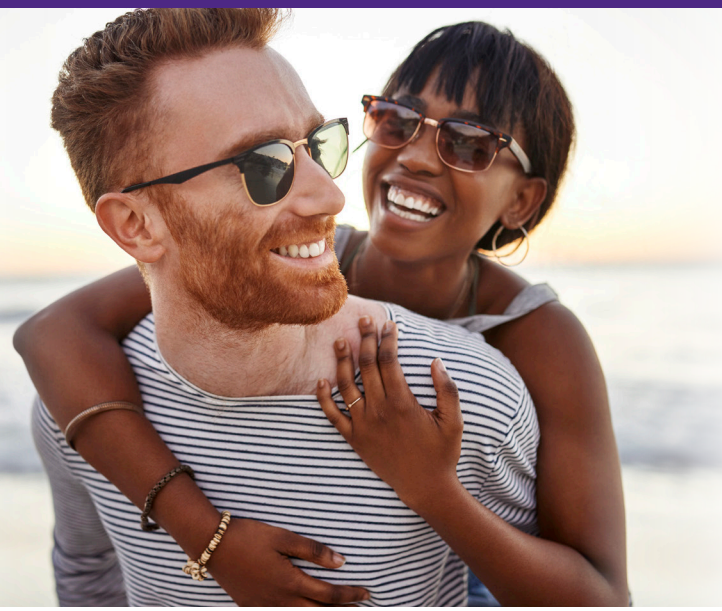
* PEHP processes claims based on your provider's clinical assessment of the office visit. If a preventive item or service is billed separately, cost sharing may apply to the office visit. If the primary reason for your visit is seeking treatment for an illness or condition, cost sharing may apply. Certain screening services, such as a colonoscopy or mammogram, may identify health conditions that require further testing or treatment. If a condition is identified through a preventive screening, any subsequent testing, diagnosis, analysis, or treatment are not considered preventive services and are subject to the appropriate cost sharing.

ACCELERATE YOUR HEALTH SAVINGS

Combining a HealthEquity HSA with an HSA-qualified health plan delivers incredible benefits



BUILD HEALTH SAVINGS

Choose a low premium health plan.

HSA-qualified health plans offer the lowest premiums, enabling you to unlock immediate savings. Just put the money you would have paid toward traditional premiums into your HSA. Voila! Long-term health savings.

MAXIMIZE TAX SAVINGS

Pre-tax contributions help reduce your annual taxable income.

Your HSA earns tax-free interest and you never pay taxes or penalties when you withdraw HSA dollars for qualified expenses. See a full list of qualified medical expenses at **Learn.HealthEquity.com/QME**

KEEP YOUR MONEY—FOREVER

Spend it. Save it. Invest it.[2] It's yours.

Unlike flexible spending accounts (FSA), money in your HSA rolls over year after year—even if you change employers or health plans.

HSA triple-tax advantage[1]

- Make pre-tax contributions
- Grow tax-free interest earnings
- Enjoy tax-free distributions for qualified medical expenses

SAVE FOR RETIREMENT

Your HealthEquity HSA works like a second 401(k).

Invest your HSA dollars into low-cost mutual funds, then watch your earnings grow tax-free. When you're 65, you can withdraw HSA dollars for any expense—you'll just need to pay regular income taxes. Of course, if you use that money for qualified medical expenses, you never pay taxes at all.[3]

[1]HSAs are never taxed at a federal income tax level when used appropriately for qualified medical expenses. Also, most states recognize HSA funds as tax deductible with very few exceptions. Please consult a tax advisor regarding your state's specific rules.

[2]Investments are subject to risk, including the possible loss of the principal invested, and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. Investing through the HealthEquity investment platform is subject to the terms and conditions of the Health Savings Account Custodial Agreement and any applicable investment supplement. Investing may not be suitable for everyone and before making any investments, review the fund's prospectus.

[3]After age 65, if you withdraw funds for any purpose other than qualified medical expenses, you will be subject to income taxes. Funds withdrawn for qualified medical expenses will remain tax-free.

HealthEquity®

MAYBE YOU'VE HAD AN HSA BEFORE, BUT YOU'VE NEVER HAD AN HSA LIKE THIS

Get support 24/7

Call us day or night. Our US-based service team measures success by problems solved. We'll do whatever it takes.

Say goodbye to hassle

Log in and manage everything via our simple mobile app.[4] Want to submit a claim? Easy. Just snap a photo and you're on your way.

Stay informed

Check out our vast library of webinars, tutorials, videos, calculators, and more. You'll find tips and tricks to make the most of your HSA.

JOIN FIVE MILLION+ HEALTH SAVERS

For more than two decades we've empowered some of the biggest companies in the world—and the smartest savers on the block.

Enroll today. Talk to your benefits team.

866.735.8195 | HealthEquity.com/Learn

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

HealthEquity does not provide legal, tax or financial advice. Always consult a professional when making life changing decisions.

HIPAA

Your information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Get an electronic or paper copy of your medical record

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

Ask us to correct health and claims records

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

For certain health information, you can tell us your choices about what we share.

- If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

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

Treat you

- We can use your health information and share it with other professionals who are treating you.
- *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- *Example: We use health information about you to manage your treatment and services.*

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.
- *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

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

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

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

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

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

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.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

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

To request special enrollment or obtain more information, use the contact information in the front of this guide.

Women's Health and Cancer Rights Act Enrollment Notice

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

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

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

If you would like more information on WHCRA benefits, call your Plan Administrator.

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

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

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

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

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

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 January 31, 2020. Contact your State for more information on eligibility –

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

Employee Rights Under the Family and Medical Leave Act

Leave Entitlement

A covered employer must grant an eligible employee up to a total of 12 workweeks of unpaid, job-protected leave in a 12 month period for one or more of the following reasons :

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered service member's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the service member with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

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

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

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

Eligibility Requirements

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

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

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

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

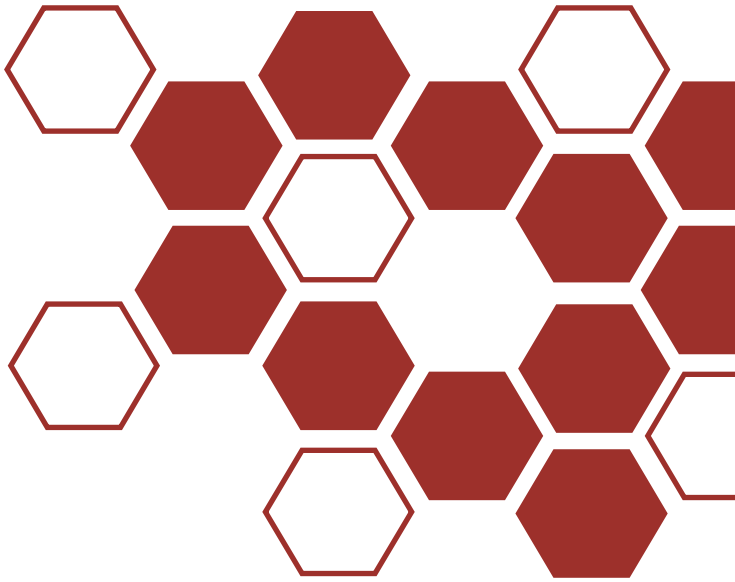
Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

Employer Responsibilities

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint: 1-866-4-USWAGE or www.dol.gov/whd



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

State	Website	Phone
Alabama	http://myalhipp.com/	1-855-692-5447
Alaska	http://myakhipp.com/	1-866-251-4861
Arkansas	http://myarhipp.com/	1-855-692-7447
California	https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx	1-800-541-5555
Colorado	http://www.healthfirstcolorado.com	1-800-221-3943
Florida	http://flmedicaidtplrecovery.com/hipp/	1-877-357-3268
Georgia	https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp	1-678-564-1162 Ext. 2131
Indiana	http://www.in.gov/fssa/hip/	1-877-438-4479
Iowa	https://dhs.iowa.gov/ime/members	1-800-338-8366
Kansas	http://www.kdheks.gov/hcf/default.htm	1-800-792-4884
Kentucky	https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx	1-855-459-6328
Louisiana	www.medicaid.la.gov	1-888-342-6207
Maine	http://www.maine.gov/dhhs/ofi/public-assistance/index.html	1-800-442-6003
Massachusetts	http://www.mass.gov/eohhs/gov/departments/masshealth	1-800-862-4840
Minnesota	https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp	1-800-657-3739
Missouri	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	1-573-751-2005
Montana	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	1-800-694-3084
Nebraska	http://www.ACCESSNebraska.ne.gov	1-855-632-7633
Nevada	http://dhcfp.nv.gov/	1-800-992-0900
New Hampshire	https://www.dhhs.nh.gov/oii/hipp.htm	1-603-271-5218
New Jersey	http://www.state.nj.us/humanservices/dmahs/clients/medicaid/	1-609-631-2392
New York	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina	https://medicaid.ncdhhs.gov/	1-919-855-4100
North Dakota	http://www.nd.gov/dhs/services/medicalserv/medicaid/	1-844-854-4825
Oklahoma	http://www.insureoklahoma.org	1-888-365-3742
Oregon	http://www.oregonhealthcare.gov/index-es.html	1-800-699-9075
Pennsylvania	https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx	1-800-692-7462
Rhode Island	http://www.eohhs.ri.gov/	1-855-697-4347
South Carolina	http://www.scdhhs.gov	1-888-549-0820
South Dakota	http://dss.sd.gov	1-888-828-0059
Texas	http://gethipptexas.com/	1-800-440-0493
Utah	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip	1-877-543-7669
Vermont	http://www.greenmountaincare.org/	1-800-250-8427
Virginia	https://www.coverva.org/hipp/	1-800-432-5924
Washington	https://www.hca.wa.gov/	1-800-562-3022
West Virginia	http://mywvhipp.com	1-855-699-8447
Wisconsin	https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf	1-800-362-3002
Wyoming	https://wyequalitycare.acs-inc.com/	1-307-777-7531

NOTES

About NFP

NFP is a leading insurance broker and consultant that provides employee benefits, property and casualty, retirement and individual private client solutions through our licensed subsidiaries and affiliates. Our expertise is matched by our commitment to each client's goals and is enhanced by our investments in innovative technologies in the insurance brokerage and consulting space.

NFP has more than 5,600 employees and global capabilities. Our expansive reach gives us access to highly rated insurers, vendors and financial institutions in the industry, while our locally based employees tailor each solution to meet our clients' needs. We've become one of the largest insurance brokerage, consulting and wealth management firms by building enduring relationships with our clients and helping them realize their goals.

For more information, visit www.nfp.com.