



EMPLOYEE BENEFITS GUIDE

JULY 1, 2018 – JUNE 30, 2019



If you have questions regarding...	Call	Click
General Benefits Information Greg Cox, <i>Human Resources</i>	(435) 716-9046	greg.cox@loganutah.org
Medical Cigna	(800) 244-6224	www.mycigna.com
Health Savings Account HealthEquity	(866) 346-5800	www.healthequity.com
Dental EMI Health	(800) 662-5851 (801) 262-7475	www.emihealth.com
Vision Opticare of Utah	(800) 363-0950 (801) 869-2020	www.opticareofutah.com
Life and AD&D The Hartford	(800) 303-9744	www.thehartford.com
Open Enrollment Questions, Escalated Claims Issues Lacey Hunter, <i>Account Manager</i>	(435) 554-7008	lacey.hunter@gsbenefits.com

This communication highlights some of your benefit plans. Your actual rights and benefits are governed by the official plan documents. If any discrepancy exists between this communication and the official plan documents, the plan documents will prevail. We reserve the right to change any benefit plan without notice. Benefits are not a guarantee of employment.

What's Inside

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

Enrollment & Eligibility
Medical
Health Savings Account
Dental
Vision
Life and AD&D
Wellness
Additional Benefits
Premiums

Enrollment & Eligibility



Logan City's Benefits and You

Welcome

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

Know Your Benefits

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

Take advantage of the tools available to you

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

Be a smart shopper

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

Don't miss the deadline and keep record of your enrollment!

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

The Affordable Care Act

The Individual Mandate

The Affordable Care Act (ACA) requires most individuals to obtain acceptable health insurance coverage for themselves and their family members or pay an annual tax penalty. In addition to the penalty, people without health insurance will still be responsible for 100 percent of the cost of their medical care. Please consult with a tax advisor with questions.

2018

\$695 per adult and \$347.50 for each child (up to \$2,085 for families), or 2.5% of your family income, whichever is greater.

Summary of Benefits and Coverage (SBC) and Uniform Glossary

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

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

Enrollment & Eligibility

Who is Eligible?

If you are hired as a full-time employee working 30 or more hours per week, coverage will begin on the first day of the month following the date of hire of qualified employment. You may also enroll your eligible dependents in the same plans you choose for yourself.

Eligible dependents include your legal spouse and your natural, adopted or step-child(ren). The dependent age limit for children on your medical plan is age 26, but may vary for other benefits offered.

How We Define Medical Benefits Eligibility

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

When to Enroll

You can enroll for coverage as a new hire, or during our annual open enrollment period. Outside of the annual open enrollment period, the only time you can change your coverage is if you experience a qualifying life event.

How to Make Changes

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

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

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

When Coverage Ends

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

Medical

Cigna



SUMMARY OF BENEFITS



Cigna Health and Life Insurance Co.
For - Logan City
Qualified HDHP Plan

Selection of a Primary Care Provider - your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

Direct Access to Obstetricians and Gynecologists - You do not need prior authorization from the plan 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, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

Plan Highlights

In-Network

Lifetime Maximum	Unlimited
Coinsurance	Your plan pays 80%
Maximum Reimbursable Charge	Not Applicable
Contract Year Deductible	Individual: \$2,000 Family: \$4,000

Out-of-Network

	Unlimited
	Your plan pays 60%
	80th Percentile
	Individual: \$4,000 Family: \$8,000

- Only the amount you pay for in-network covered expenses counts toward your in-network deductible. The amount you pay for out-of-network covered expenses counts toward both your in-network and out-of-network deductibles.
 - All eligible family members contribute towards the family plan deductible. Once the family deductible has been met, the plan will pay each eligible family member's covered expenses based on the coinsurance level specified by the plan.
 - This plan includes a combined Medical/Pharmacy plan deductible.
 - Prescription medications used to prevent any of the following medical conditions are not subject to the individual and/or family plan deductible: hypertension, high cholesterol, diabetes, asthma, osteoporosis, stroke, prenatal nutrient deficiency.
- Note:** Services where plan deductible applies are noted with a caret (^).

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Plan Highlights

In-Network

Individual: \$4,000
 Individual – In a Family: \$4,000
 Family: \$8,000

Out-of-Network

Individual: \$8,000
 Individual – In a Family: \$8,000
 Family: \$16,000

Contract Year Out-of-Pocket Maximum

- Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. The amount you pay for out-of-network covered expenses counts toward both your in-network and out-of-network out-of-pocket maximums.
- Plan deductible contributes towards your out-of-pocket maximum.
- All copays and benefit deductibles contribute towards your out-of-pocket maximum.
- Mental Health and Substance Use Disorder covered expenses contribute towards your out-of-pocket maximum.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.

Benefit

In-Network

Out-of-Network

Physician Services

Physician Office Visit – Primary Care Physician (PCP)/Specialist

- All services including Lab & X-ray

After the plan deductible is met, your plan pays 80%

After the plan deductible is met, your plan pays 60%

NOTE: Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist)

Surgery Performed in Physician's Office

After the plan deductible is met, your plan pays 80%

After the plan deductible is met, your plan pays 60%

Allergy Treatment/Injections Performed in Physician's Office

After the plan deductible is met, your plan pays 80%

After the plan deductible is met, your plan pays 60%

Allergy Serum

After the plan deductible is met, your plan pays 80%

After the plan deductible is met, your plan pays 60%

- Dispensed by the physician in the office

Cigna Telehealth Connection Services

After the plan deductible is met, your plan pays 80%

Not Covered

- Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, telephones and internet only when delivered by contracted medical telehealth providers (see details on myCigna.com)

Preventive Care

Preventive Care

Plan pays 100%

After the plan deductible is met, your plan pays 60%

- Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit.

Benefit	In-Network	Out-of-Network
Immunizations	Plan pays 100%	After the plan deductible is met, your plan pays 60%
Mammogram, PAP, and PSA Tests	Plan pays 100%	Plan pays based on place of service.
<ul style="list-style-type: none"> Coverage includes the associated Preventive Outpatient Professional Services. Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service. 		
Inpatient		
Inpatient Hospital Facility	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
Semi-Private Room: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate Private Room: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)): In-Network: Limited to the negotiated rate / Out-of-Network: Limited to ICU/CCU daily room rate		
Inpatient Hospital Physician's Visit/Consultation	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
Inpatient Professional Services <ul style="list-style-type: none"> For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists 	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
Outpatient		
Outpatient Facility Services	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
Outpatient Professional Services <ul style="list-style-type: none"> For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists 	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
Short-Term Rehabilitation - PCP	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
Short-Term Rehabilitation - Specialist Contract Year Maximums: <ul style="list-style-type: none"> Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy and Occupational Therapy – 20 days Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies. 	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.		

Benefit	In-Network	Out-of-Network
Chiropractic Care - PCP	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
Chiropractic Care - Specialist	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
<ul style="list-style-type: none"> Chiropractic Care - 12 days 		
Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.		
Cardiac Rehabilitation	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
<ul style="list-style-type: none"> Cardiac Rehabilitation – 36 days 		
Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.		
Other Health Care Facilities/Services		
Home Health Care	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
(includes outpatient private duty nursing subject to medical necessity)		
<ul style="list-style-type: none"> 30 days maximum per Contract Year (The limit is not applicable to mental health and substance use disorder conditions.) 16 hour maximum per day 		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
<ul style="list-style-type: none"> 30 days maximum per Contract Year 		
Durable Medical Equipment	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
<ul style="list-style-type: none"> Unlimited maximum per Contract Year 		
Breast Feeding Equipment and Supplies	Your plan pays 100%	After the plan deductible is met, your plan pays 60%
<ul style="list-style-type: none"> Limited to the rental of one breast pump per birth as ordered or prescribed by a physician Includes related supplies 		
External Prosthetic Appliances (EPA)	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
<ul style="list-style-type: none"> Unlimited maximum per Contract Year 		
Routine Foot Disorders	Not Covered	Not Covered

Benefit		In-Network	Out-of-Network
Medical Specialty Drugs			
Inpatient	<ul style="list-style-type: none"> This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges. 	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
Outpatient Facility Services	<ul style="list-style-type: none"> This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges. 	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
Physician's Office	<ul style="list-style-type: none"> This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's Office. This benefit does not cover the related Office Visit or Professional charges. 	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%
Home	<ul style="list-style-type: none"> This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges. 	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 60%

Place of Service - your plan pays based on where you receive services

Note: Services where plan deductible applies are noted with a caret (^).

Benefit	Physician's Office		Independent Lab		Emergency Room/ Urgent Care Facility		Outpatient Facility	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Laboratory	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 80% ^	Plan pays 60%	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Emergency Room/Urgent Care Services	Plan pays 80% ^	Plan pays 60%
Radiology	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Not Applicable	Not Applicable	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Emergency Room/Urgent Care Services	Plan pays 80% ^	Plan pays 60% ^

Place of Service - your plan pays based on where you receive services

Note: Services where plan deductible applies are noted with a caret (^).

Benefit	Physician's Office		Independent Lab		Emergency Room/ Urgent Care Facility		Outpatient Facility	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Advanced Radiology Imaging	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Not Applicable	Not Applicable	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Outpatient Facility Services	Covered same as plan's Outpatient Facility Services
Advanced Radiology Imaging (ARI) includes MRI, MRA, CAT Scan, PET Scan, etc. Note: All lab and x-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit								
Benefit	Emergency Room / Urgent Care Facility		Outpatient Professional Services		*Ambulance			
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Care	Plan pays 80% ^		Plan pays 80% ^		Plan pays 80% ^		Plan pays 80% ^	
Urgent Care	Plan pays 80% ^		Plan pays 80% ^		Not Applicable*			
*Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.								
Benefit	Inpatient Hospital and Other Health Care Facilities				Outpatient Services			
	In-Network		Out-of-Network		In-Network		Out-of-Network	
Hospice	Plan pays 80% ^		Plan pays 60% ^		Plan pays 80% ^		Plan pays 60% ^	
Bereavement Counseling	Plan pays 80% ^		Plan pays 60% ^		Plan pays 80% ^		Plan pays 60% ^	
Note: Services provided as part of Hospice Care Program								
Note: Services where plan deductible applies are noted with a caret (^).								
Benefit	Initial Visit to Confirm Pregnancy		Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges)		Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)		Delivery - Facility (Inpatient Hospital, Birthing Center)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Maternity	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 80% ^	Plan pays 60%	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit
Note: Services where plan deductible applies are noted with a caret (^).								

Benefit	Physician's Office		Inpatient Facility		Outpatient Facility		Inpatient Professional Services		Outpatient Professional Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Abortion (Non-elective procedures)	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^
Family Planning - Men's Services	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^
Includes surgical services, such as vasectomy (excludes reversals)										
Family Planning - Women's Services	Plan pays 100%	Covered same as plan's Physician's Office Services	Plan pays 100%	Plan pays 60% ^	Plan pays 100%	Plan pays 60% ^	Plan pays 100%	Plan pays 60% ^	Plan pays 100%	Plan pays 60% ^
Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician.										
Infertility	Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.									
Note: Services where plan deductible applies are noted with a caret (^).										
Benefit	Inpatient Hospital Facility				Inpatient Professional Services					
	Cigna LifeSOURCE Transplant Network ® Facility In-Network	Non-Lifesource Facility In-Network	Out-of-Network	Cigna LifeSOURCE Transplant Network ® Facility In-Network	Non-Lifesource Facility In-Network	Out-of-Network	Out-of-Network			
Organ Transplants	Plan pays 100% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 100% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 60% ^			
<ul style="list-style-type: none"> Travel Lifetime Maximum - Cigna LifeSOURCE Transplant Network® Facility: In-Network: \$10,000 maximum per Transplant per Lifetime 								Note: Services where plan deductible applies are noted with a caret (^).		
Benefit	Inpatient			Outpatient - Physician's Office			Outpatient - All Other Services			
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	Out-of-Network	
Mental Health	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 80% ^	Plan pays 60% ^	

7/1/2018

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Benefit	Inpatient		Outpatient - Physician's Office		Outpatient – All Other Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Substance Use Disorder	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^
<p>Note: Services where plan deductible applies are noted with a caret (^).</p> <p>Notes: Detox is covered under medical.</p> <ul style="list-style-type: none"> • Unlimited maximum per Contract Year • Services are paid at 100% after you reach your out-of-pocket maximum • Inpatient includes Residential Treatment • Outpatient includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy; also Partial Hospitalization 						
Mental Health and Substance Use Disorder Services						
Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs						
Cigna Total Behavioral Health - Inpatient and Outpatient Management						
<ul style="list-style-type: none"> • Inpatient utilization review and case management • Outpatient utilization review and case management • Partial Hospitalization • Intensive outpatient programs • Changing Lives by Integrating Mind and Body Program • Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management. • Narcotic Therapy Management • Complex Psychiatric Case Management 						
Pharmacy			In-Network		Out-of-Network	
Cost Share and Supply						
Cigna Pharmacy Plus Cost Share						
<ul style="list-style-type: none"> • Retail – up to 90-day supply (except Specialty up to 30-day supply) • Home Delivery – up to 90-day supply (except Specialty up to 30-day supply) 						
			<p>Retail (per 30-day supply): Generic: You pay 0% Preferred Brand: You pay 10% Non-Preferred Brand: You pay 20%</p> <p>Retail and Home Delivery (per 90-day supply): Generic: You pay 0% Preferred Brand: You pay 10% Non-Preferred Brand: You pay 20%</p>		<p>You pay 40% Your plan pays 60%</p>	

Pharmacy

In-Network

Out-of-Network

- Retail drugs may be obtained In-Network at a wide range of pharmacies across the nation.
- You can choose to fill your medications in a 30- or 90-day supply at any network pharmacy.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- When patient requests brand drug, patient pays the generic cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (unless the physician indicates "Dispense As Written" DAW).
- Your pharmacy benefits share an annual deductible and out-of-pocket maximum with the medical/behavioral benefits. The applicable cost share for covered drugs applies after the combined deductible has been met.
- Specialty Drugs provided at Home Delivery at the Retail (per 30-day supply) cost share.

Preventive Drugs:

In-Network Preventive drugs and products will not be subject to deductible. In addition, Federally required preventive drugs will not be subject to deductible and will be provided at no charge. This applies to drugs for:

- Hypertension, high cholesterol, diabetes, asthma, osteoporosis, stroke, prenatal nutrient deficiency

Additional Drugs Covered

Prescription Drug List:

Your Cigna Standard Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. To check which drugs are included in your plan, please log on to myCigna.com.

Some highlights:

- Coverage includes Self Administered injectables and optional injectable drugs – but excludes infertility drugs.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered.

Pharmacy Program Information

Pharmacy Clinical Management: Essential

Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for the medical condition, including:

- Prior authorization requirements.
- Step Therapy on select classes of medications and drugs new to the market
- Quantity limits, including maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Current users of Step Therapy medications will be allowed one 30-day fill during the first three months of coverage before Step Therapy program applies.
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- Your plan includes access to the TheraCare® program which works with customers to help them better understand their condition, medications and their side effects in addition to why it's important to take their medications exactly as prescribed by a physician.

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Pharmacy Program Information

Clinical Outcome Programs:

- Includes complex psychiatric case management
- Includes narcotic therapy management

Additional Information

Case Management

Coordinated by Cigna HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

Comprehensive Oncology Program

- Care Management outreach
- Case Management

Included

Healthy Pregnancies/Healthy Babies

- Care Management outreach
- Maternity Case Management
- Neo-natal Case Management

\$150 (1st trimester) / \$75 (2nd trimester)

Maximum Reimbursable Charge

Out-of-network services are subject to a Contract Year deductible and maximum reimbursable charge limitations. Payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. These charges are compiled in a database selected by Cigna. The health care professional may bill the customer the difference between the health care professional's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments and coinsurance.

Medicare Coordination

In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan to Medicare Part A and B as follows:

- a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
- an Employee, a former Employee, an Employee's Dependent, or former Employee's Dependent, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

When a person is eligible for Medicare A and B as described above, this plan will pay as the Secondary Plan to Medicare Part A and B **regardless if the person is actually enrolled in Medicare Part A and/or Part B and regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

One Guide

Available by phone or through myCigna mobile application. One Guide helps you navigate the health care system and make the most of your health benefits and programs.

7/1/2018

UT

Open Access Plus - Proclaim BE - QHDHP Plan - 7525757. Version# 11

Additional Information

Pre-Certification - Continued Stay Review - Preferred Care Management Inpatient - required for all inpatient admissions

In-Network: Coordinated by your physician

Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- 50% penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
- Benefits are denied for any admission reviewed by Cigna Healthcare and not certified.
- Benefits are denied for any additional days not certified by Cigna Healthcare.

Pre-Certification - Preferred Care Management Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing

In-Network: Coordinated by your physician

Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- 50% penalty applied to outpatient procedures/diagnostic testing charges for failure to contact Cigna Healthcare and to precertify admission.
- Benefits are denied for any outpatient procedures/diagnostic testing reviewed by Cigna Healthcare and not certified.

Pre-Existing Condition Limitation (PCL) does not apply.

Holistic health support for the following chronic health conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome/Weight Complications
- Osteoarthritis
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression

Your Health First - 200

Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

- Condition Management
- Medication adherence
- Risk factor management
- Lifestyle issues
- Health & Wellness issues
- Pre/post-admission
- Treatment decision support
- Gaps in care

7/1/2018

UT

Open Access Plus - Proclaim BE - QHDHP Plan - 7525757. Version# 11

Definitions

Coinsurance - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.

Copay - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.

Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.

Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.

Place of service - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.

Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.

Professional Services - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists

Transition of Care - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

Exclusions

What's Not Covered (not all-inclusive):

Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied at no cost to the insured by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider or pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amounts you are required to pay for a Covered Expense (as shown on The Schedule) then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payments prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an in-network benefit level or some other benefit level not otherwise applicable to the services received. Provided further, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a prescription medication or other product, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Coinsurance you are required to pay.
- Charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies,

7/1/2018

UT

Open Access Plus - Proclaim BE - QHDHP Plan - 7525757. Version# 11

Exclusions

- supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:
- o Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
 - o Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
 - o The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
 - o The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.
- In determining whether drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature.
 - Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
 - The following services are excluded from coverage regardless of clinical indications: abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupuncture; craniocervical/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
 - Surgical or non-surgical treatment of TMJ disorders and craniofacial muscle disorders.
 - Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to sound teeth are covered provided a continuous course of dental treatment is started within six months of an accident.
 - For medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
 - Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
 - Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
 - Infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of sperm, eggs or embryos are also excluded from coverage.
 - Reversal of male or female voluntary sterilization procedures.
 - Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasm, and premature ejaculation.
 - Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
 - Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs, and driver safety courses.
 - Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
 - Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.

7/1/2018

UT

Open Access Plus - Proclaim BE - QHDHP Plan - 7525757. Version# 11

Exclusions

- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Aids or devices that assist with non-verbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Corrective lenses and associated services (prescription exams and fittings), including eyeglass lenses and frames and contact lenses, except for the first pair of corrective lenses and associated services following treatment of keratoconus or cataract surgery.
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs, unless required by state or federal law.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a non-Participating Provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a non-Participating Provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit, with the exception that Utah law pertaining to coordination of benefits with a workers' compensation claim applies, if the employee or their health care provider on their behalf, has filed an application for hearing regarding a related workers' compensation claim with the Division of Adjudication; and Cigna has received a notice from the Labor Commission.
- Charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet unless provided as specifically described under Covered Expenses.
- Massage therapy.
- Abortion, unless otherwise specified in the covered services section of your document.
- Services or supplies for treatment of medical conditions related to, or occurring as a result of, an excluded service are also excluded, including follow-up care, unless such services or supplies are medically necessary and are otherwise covered under the terms of the plan.

7/1/2018

UT

Open Access Plus - Proclaim BE - QHDHP Plan - 7525757. Version# 11

These are only the highlights

This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence. This summary provides additional information not provided in the Summary of Benefits and Coverage document required by the Federal Government.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Tel-Drug, Inc., Tel-Drug of Pennsylvania, L.L.C. and HMO or service company subsidiaries of Cigna Health Corporation. "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

EHB State: UT

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file

a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>.



All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, Inc. ATTENTION: If you speak languages other than English, language assistance services, free of charge are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711). ATENCIÓN: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Danh cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

24 **Korean** – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자들과께서는 ID 카드 뒷면에 있는 전화번호로 연락해주시시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주시시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki deyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711)まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنایان: شماره 711 را شماره‌گیری کنید).

Spouse Eligibility

Effective July 1, 2017 Logan City has adopted a policy concerning medical benefits for a spouse of a Logan City employee who is offered medical insurance by their employer (i.e., covered spouse). If the employer of a covered spouse creates a policy to exclude primary coverage from a benefited Logan City Employee, then Logan City enacts the same policy for that covered spouse. The covered spouse will only be able to elect the City's medical plan as secondary coverage.

Health Savings Account

HealthEquity



Health Savings Account

About Health Savings Accounts

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

The HSA Advantage

A Health Savings Account offers you many advantages:

It's a Tax Saver:

- Contributions are excluded from federal income tax
- Your money grows tax-free
- Withdrawals used to pay for qualified health care expenses are also tax-free

Ownership: The money in your HSA is always yours. Unspent balances simply roll over from year to year until spent.

Flexibility: You decide when and how much to contribute to your account.

Portable: Your money stays put even if you change health plans or employers, or if you retire.

Who is eligible?

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

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

How much can I contribute to my HSA?

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

2018
Self Only: \$3,450
Family: \$6,850

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

Determining Your Annual Contribution

Your allowed annual contribution is calculated based on the number of months covered by a qualified HDHP plan and your coverage type (self-only or family). For example, if you have self-only coverage 8 months of the year 2018, your maximum contribution limit is \$2,300. Formula: $\$2,300 = 8 \times (\$3,450 / 12)$.

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

Our Banking Partner

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

Health Savings Account

Qualified Health Care Expenses

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

Qualified expenses include, but are not limited to:

- Acupuncture
- Alcoholism (rehab)
- Ambulance
- Amounts not covered under another health plan
- Annual physical examination
- Artificial limbs
- Birth control pills/prescription contraceptives
- Body scans
- Post-mastectomy breast reconstruction surgery
- Chiropractor
- Contact lenses
- Crutches
- Dental treatments
- Eyeglasses/eye surgery
- Hearing aids
- Long-term care expenses
- Medicines (prescribed)
- Nursing home medical care
- Nursing services
- Optometrist
- Lasik surgery
- Orthodontia
- Oxygen
- Stop-smoking programs
- Surgery, other than unnecessary cosmetic surgery
- Telephone equipment for the hearing-impaired
- Therapy
- Transplants
- Weight-loss program (prescribed)
- Wheelchairs
- Wigs (prescribed)

Non-qualified expenses include any expenses incurred before you establish your HSA. Other non-qualified expenses include, but are not limited to:

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

The following insurance premiums may be reimbursed from your HSA:

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

Important!

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

Documentation is Key

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

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

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

Dental

EMI Health





Costs Per Pay Period:

Employee Only:	\$2.50
Employee + 1:	\$7.00
Family:	\$11.00

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

DENTAL COVERAGE

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

OUTLINE OF COVERAGE

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

Group:	Logan City (Plan #2310)
Plan:	Advantage Co-Pay
Effective Date:	7/1/2018
Benefit Year:	Calendar
Plan Type:	Contributory / Self Funded

	In-Network	Out-of-Network
Type 1 - Preventive Oral Exams, Cleanings, X-rays, Fluoride	100%	See Claim Payment Schedule
Type 2 - Basic Fillings, Oral Surgery	See Co-Pay Schedule	See Claim Payment Schedule
Type 3 - Major Crowns, Bridges, Prosthodontics	See Co-Pay Schedule	See Claim Payment Schedule
Type 4 - Orthodontics Dependent children up to age (19)	Discount Only (Up to 25%)	No Coverage
Adults	Discount Only (Up to 25%)	No Coverage
Endodontics	Type 3 - See Co-Pay Schedule	Type 3 - See Claim Payment Schedule
Periodontics	Type 3 - See Co-Pay Schedule	Type 3 - See Claim Payment Schedule
Sealants	Type 2 - See Co-Pay Schedule	Type 2 - See Claim Payment Schedule
Space Maintainers	Type 2 - See Co-Pay Schedule	Type 2 - See Claim Payment Schedule
Specialists (** See note below)	20% Discount Only (Pediatric - See Co-Pay Schedule)	No Coverage

**All of the benefits outlined above are for services received from general and pediatric dentists. If participating specialists (including, but not limited to, oral surgeons, endodontists, periodontists, prosthodontists, and orthodontists) are used, insureds receive a discount only. There is no benefit for non-participating specialists.

Waiting periods	
Type 2 - Basic	None
Type 3 - Major	None
Type 4 - Orthodontics	N / A

Deductible	In and Out of Network Deductibles are Combined	
Per Person	\$0.00	\$0.00
Family Max	\$0.00	\$0.00
Deductible Applies To	N / A	N / A

Annual Maximum Per Person	None
Orthodontic Lifetime Maximum	N / A

Network / Reimbursement Schedule	Advantage	Advantage
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Provisions / Limitations / Exclusions	
Exams (including Periodontal), Cleanings and Fluoride	2 per year
Fluoride	Up to age 16
Sealants	Up to age 16
Space Maintainers	Up to age 16
Bitewing X-Rays	Up to 4, twice per year
Periapical X-Rays	6 per year
Panoramic X-Ray	1 every 3 years
Impacted Teeth	Covered in Type 2 - Basic
Anesthesia- (Age 8 and over for the extraction of impacted teeth only)	Covered in Type 3 - Major*
Anesthesia - (For children age 7 and under, once per year)	Covered in Type 3 - Major*
Implants / Implant Abutments	Covered in Type 3 - Major
Crowns, Pontics, Abutments, Onlays and Dentures	1 every 5 years per tooth
Fillings on the same surface	1 every 18 months

All Services are subject to EMI Health Table of Allowances. When using a Non-participating Provider, the insured is responsible for all fees in excess of the Table of Allowances.

* Anesthesia is not subject to waiting periods.

Co-Pays are subject to change January 1st of each year.



Costs Per Pay Period:

Employee Only:	\$5.00
Employee + 1:	\$22.00
Family:	\$42.00

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

DENTAL COVERAGE

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

OUTLINE OF COVERAGE

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

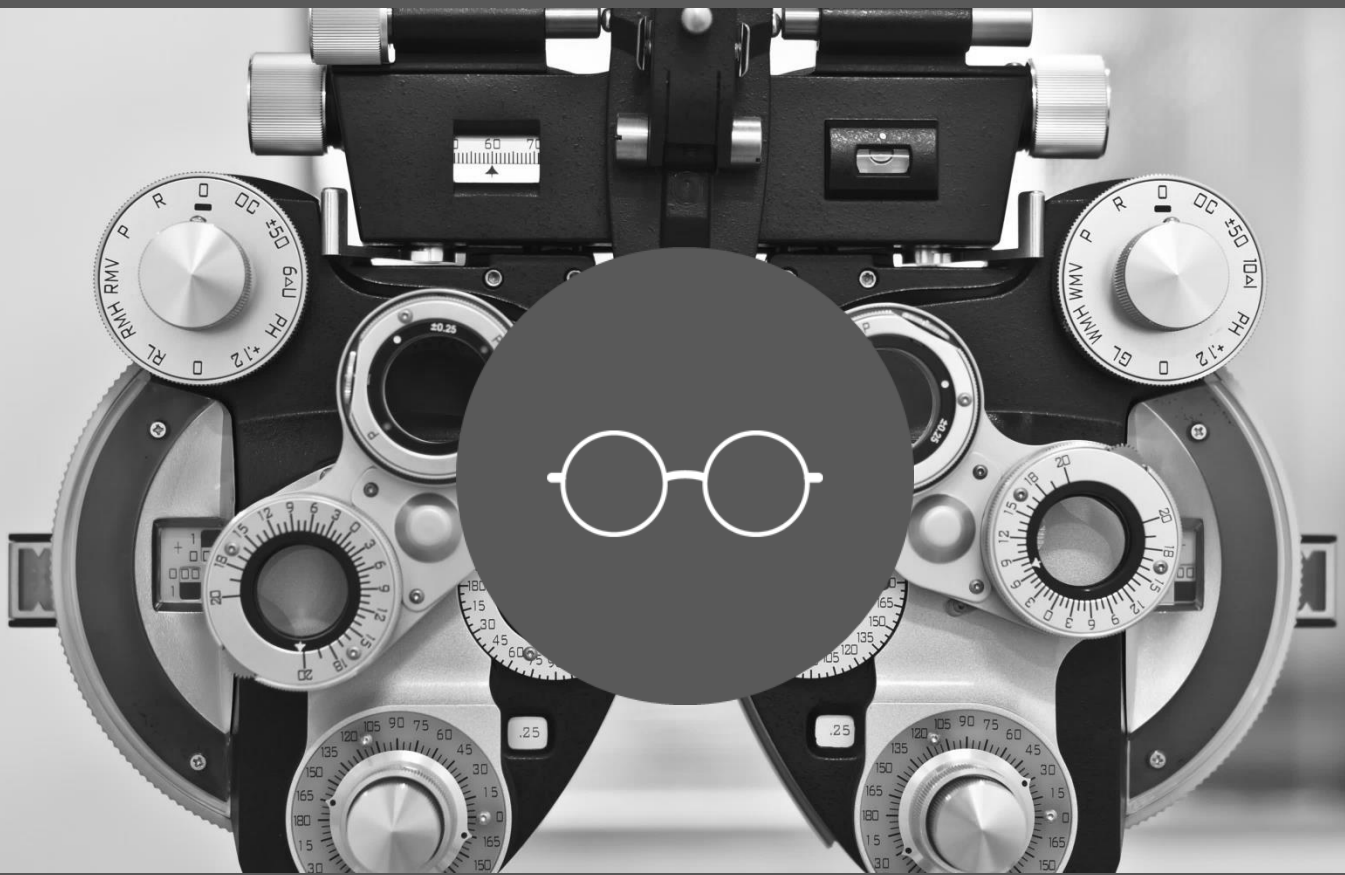
Group:	Logan City (Plan #2310)
Plan:	Premier Indemnity
Effective Date:	7/1/2018
Benefit Year:	Calendar
Plan Type:	Contributory / Self Funded

	In-Network	Out-of-Network
Type 1 - Preventive Oral Exams, Cleanings, X-rays, Fluoride	100%	100%
Type 2 - Basic Fillings, Oral Surgery	80%	80%
Type 3 - Major Crowns, Bridges, Prosthodontics	50%	50%
Type 4 - Orthodontics Dependent children up to age (19)	50%	50%
Adults	Discount Only (Up to 25%)	No Coverage
Endodontics	Type 3 - Major	Type 3 - Major
Periodontics	Type 3 - Major	Type 3 - Major
Sealants	Type 2 - Basic	Type 2 - Basic
Space Maintainers	Type 2 - Basic	Type 2 - Basic
Specialists	Member pays same as General Dentists	Member pays same as General Dentists
Waiting periods		
Type 2 - Basic	None	
Type 3 - Major	None	
Type 4 - Orthodontics	None	
Deductible	<i>In and Out of Network Deductibles are Combined</i>	
Per Person	\$100.00	\$100.00
Family Max	\$300.00	\$300.00
Deductible Applies To	Type 2 & Type 3	Type 2 & Type 3
Annual Maximum Per Person	\$1,000.00	
Orthodontic Lifetime Maximum	\$1,000.00	
Network / Reimbursement Schedule	Premier	R & C (80th)
Provisions / Limitations / Exclusions		
Exams (including Periodontal), Cleanings and Fluoride	2 per year	
Fluoride	Up to age 16	
Sealants	Up to age 16	
Space Maintainers	Up to age 16	
Bitewing X-Rays	Up to 4, twice per year	
Periapical X-Rays	6 per year	
Panoramic X-Ray	1 every 3 years	
Impacted Teeth	Covered in Type 2 - Basic	
Anesthesia- (Age 8 and over for the extraction of impacted teeth only)	Covered in Type 3 - Major*	
Anesthesia - (For children age 7 and under, once per year)	Covered in Type 3 - Major*	
Implants / Implant Abutments	Not Covered	
Crowns, Pontics, Abutments, Onlays and Dentures	1 every 5 years per tooth	
Fillings on the same surface	1 every 18 months	
All Services are subject to EMI Health Table of Allowances. When using a Non-participating Provider, the insured is responsible for all fees in excess of the Table of Allowances.		
* Anesthesia is not subject to waiting periods.		

Administered by Educators Health Plans Life, Accident & Health

Vision

Otpicare





Opticare Plan: 10-130B

Single	\$ 8.26
Two Party	\$13.48
Family	\$19.91

Logan City	In Network	Out-of-network
Eye Exam		
Eyeglass exam	\$10 Co-pay	◆\$40 Allowance
Contact exam	\$10 Co-pay	◆\$40 Allowance
Routine Dilation	100% Covered	Included above
Contact Fitting	Retail	Included above
Standard Plastic Lenses		
Single Vision	\$10 Co-pay	◆\$85 Allowance
Bifocal (FT 28)	\$10 Co-pay	for lenses,
Trifocal (FT 7x28)	\$10 Co-pay	options,
		and coatings
Lens Options		
Progressive (<i>Standard plastic no-line</i>)	\$50 Co-pay	
Premium Progressive Options	\$100 Co-pay	
Ultra Premium Progressive Options	Up to 20% Discount	
Polycarbonate	25% Discount	
High Index	25% Discount	
Coatings		
Scratch Resistant Coating	\$10 Co-pay	
Ultra Violet protection	\$10 Co-pay	
Other Options	Up to 25% Discount	
<i>A/R, edge polish, tints, mirrors, etc.</i>		
Frames		
*Allowance Based on Retail Pricing	\$130 Allowance	◆\$90 Allowance
Additional Eyewear		
**Additional Pairs of Glasses Throughout the Year	Up to 50% Off Retail	
Contacts		
Contact benefits is in lieu Of lens and frame benefit.	\$130 Allowance	◆\$90 Allowance
Additional contact purchases:		
***Conventional	Up to 20% Discount	
***Disposables	Up to 10% Discount	
Frequency		
Exams, Lenses, Frames, Contacts	Every 12 months	Every 12 months
Refractive Surgery		
****LASIK	\$250 Off Per Eye	Not Covered

Discounts

Any item listed as a discount is a merchandise discount only and not an insured benefit. Discounts vary by providers, see provider for details

*Up to 20% Discount off balance above Frame Allowance

** 50% discount varies by provider, ask provider for details.

*** Must purchase full year supply to receive discounts on select brands. See provider for details.

**** LASIK (Refractive surgery) Standard Optical Locations ONLY. LASIK services are not an insured benefit – this is a discount only.

All pre & post operative care is provided by Standard Optical only and is based on Standard Optical retail fees.

◆ **Out of Network** – Out of Network benefit may not be combined with promotional items. Online purchases at approved providers only.

For more Information please visit www.opticareofutah.com or call 800-363-0950



Area Provider Directory

Box Elder County

Dr. Alan Chapman	990 S Medical Dr G-2	Brigham City	UT (435) 723-5868
Box Elder Family Vision	34 S Main St	Brigham City	UT (435) 723-2485
Shopko Optical	747 S. Main St.	Brigham City	UT (435) 723-1800
Perry Eye Care	2480 S Highway 89 #B	Perry	UT (435) 239-8756
Smithfield Canyon Eye Care, LLC	1200 S Commerce Way	Perry	UT (435) 734-9843
Bear River Eye Center	495 W 600 N	Tremonton	UT (435) 257-7436
Lynn R Purcell OD	495 W 600 North	Tremonton	UT (435) 257-7436

Cache County

Baldwin Optical South Pointe	26 W Main St	Hyrum	UT (435) 245-7500
Baldwin Optical South Pointe	1451 North 200 East # 195	Logan	UT (435) 752-6110
Cache Valley Eye Associates	1300 North 500 East Suite 350	Logan	UT (435) 752-7445
Child & Family Eyecare Center	981 S Main #200	Logan	UT (435) 363-2980
Eye Care For You LLC	1300 N 200 East #195	Logan	UT (435) 752-6110
Eye Care For You LLC	1300 North 200 East, Suite 104	Logan	UT (435) 752-6453
Dr. Krystal Vision and Sunwear	550 East 1400 North, Suite P	Logan	UT (435) 787-2593
Logan Eye Institute	810 South 100 West Suite A	Logan	UT (435) 787-7200
Logan Optical	535 E. 1400 N. #130	Logan	UT (435) 753-5245
SEEHOLZER VISION	124 N Main	Logan	UT (435) 752-5334

Life and AD&D

The Hartford



Life and AD&D

Basic Life and AD&D

The Hartford

Each eligible employee has life insurance for themselves and their dependents. Logan City pays the full premium for this coverage.

Employee Life	\$75,000
Employee AD&D	\$75,000
Spouse Life	\$10,000
Children to age 20 (or 24 if full-time student)	\$5,000

Supplemental Life

Dependent Supplemental Life

The Hartford

	Employee	Spouse	Child(ren)
Minimum	\$10,000	\$10,000	\$10,000
Maximum	Lesser of 5x salary or \$400,000 in \$10,000 increments	Lesser of 100% of EE to \$200,000 in \$10,000 increments	Live birth through age 20 (or 24 if a full-time student) \$10,000
Guaranteed Issue	Lesser of 5x salary or \$400,000 rounded to nearest \$10,000	\$30,000	\$10,000

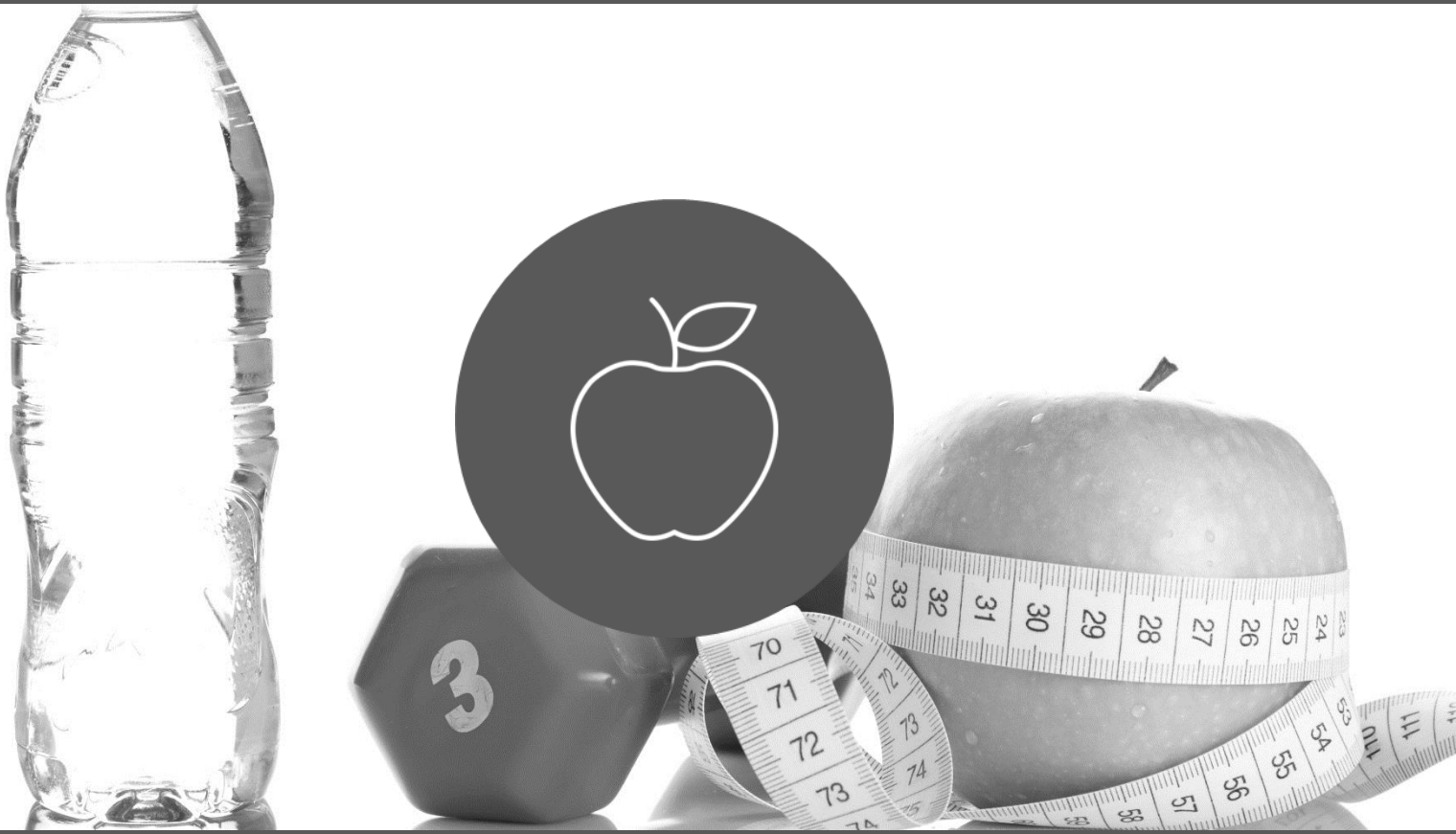
*The guarantee issue is the amount of coverage that NEW employees can apply for within 30 days of hire without providing evidence of insurability.

Employee/Spouse Monthly Rates Per \$1,000 of Coverage	
Ages	Rates
0-24	\$0.05
25-29	\$0.06
30-34	\$0.08
34-39	\$0.09
40-44	\$0.12
45-49	\$0.20
50-54	\$0.33
55-59	\$0.48
60-64	\$0.95
65-69	\$1.69
70-99	\$3.03

Dependent - \$1.00 Per month covers **ALL** eligible dependents with a benefit of \$10,000 for each dependent.

*Note: This publication is only a partial summary of benefits prepared by GBS Benefits, Inc. for your assistance and does not describe all elements of the summarized programs.

Wellness



Notice Regarding Wellness Program

The Health Management Program is a voluntary wellness program available to all employees and their spouses who are on the City's health insurance. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete an annual physical with your health care provider, which will include a blood test, and you must submit the signed Health Management Program Qualification Form to Human Resources.

However, employees and spouses who choose not to participate in the wellness program will pay \$60 each a month toward the cost of the health insurance. Although you are not required to complete an annual physical, only those who do so will receive the lower health insurance premium.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personal identifiable health information. The City of Logan will never disclose any of your personal information publicly, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you is provided in connection with the wellness program, will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed, except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who have access to your personal medical information is your health care provider.

In addition, all medical information will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach. In the event a data breach involving information you provide in connection with the wellness program occurs, we will notify you immediately.

You may not be discriminated against in employment because of the information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Greg Cox at 435-716-9046.

Additional Benefits



Stretching Your Rx Dollar

GBS Rx Comparison Tool

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

Isn't health insurance all I need?

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

How can I find these savings?

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

On the Web

Instantly look up current drug prices at CVS, Walgreens, Walmart, Costco, and other local pharmacies.

www.gbsbenefits.com/rxcomparisontool.html

Please Note:

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

On Your Phone

On the pricing tool main page (www.gbsbenefits.com/rxcomparisontool.html) you can select the mobile browser version from your phone. You will be prompted to install a GBS Rx bookmark (icon) on your phone's desktop. The next time you want to access the GBS Rx Pricing Tool, simply tap the icon on your phone's desktop and the mobile version of the tool will open in your phone's browser.

Generic Prescriptions

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

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

Did You Know?

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

Tips

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

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

Most of the generic programs offer approximately 150 to 300 generic drugs at a discounted price.

The generic drugs offered cover most diseases and most chronic conditions such as arthritis, heart disease, high blood pressure, depression and diabetes.

You may search for the generic medication on the pharmacy's website or contact the pharmacy to inquire if the generic medication the provider prescribed is on the pharmacy's \$4-Generic Drug List.

Premiums



Premiums

Medical

Cigna OAP - Health Management Participant			
Status	Total Premium Per Month	Employer Contribution Per Month	Employee Cost Per Month
Employee Only	\$418.69	\$418.69	\$0.00
Employee + 1	\$900.02	\$900.02	\$0.00
Family	\$1,234.88	\$1,234.88	\$0.00

Cigna OAP - Non - Health Management Participant				
Status	Total Premium Per Month	Employer Contribution Per Month	Employee Cost Per Month	Employee Cost Per Pay Period (24)
Employee Only	\$418.69	\$358.69	\$60.00	\$30.00
Employee + 1	\$900.02	\$840.02--\$780.02	\$60--\$120	\$30--\$60
Family	\$1,234.88	\$1174.08--\$1114.88	\$60--\$120	\$30--\$60

Dental

Advantage EPO				
Status	Total Premium Per Month	Employer Contribution Per Month	Employee Cost Per Month	Employee Cost Per Pay Period (24)
Employee Only	\$16.00	\$11.00	\$5.00	\$2.50
Employee + 1	\$31.00	\$17.00	\$14.00	\$7.00
Family	\$49.00	\$27.00	\$22.00	\$11.00

Premier Indemnity				
Status	Total Premium Per Month	Employer Contribution Per Month	Employee Cost Per Month	Employee Cost Per Pay Period (24)
Employee Only	\$36.00	\$26.00	\$10.00	\$5.00
Employee + 1	\$69.00	\$25.00	\$44.00	\$22.00
Family	\$116.00	\$32.00	\$84.00	\$42.00

Vision

Opticare of Utah				
Status	Total Premium Per Month	Employer Contribution Per Month	Employee Cost Per Month	Employee Cost Per Pay Period (24)
Employee Only	\$8.26	\$0.00	\$8.26	\$4.13
Employee + 1	\$13.48	\$0.00	\$13.48	\$6.74
Family	\$19.91	\$0.00	\$19.91	\$9.96





120 West Cache Valley BLVD, Suite 100
Logan, UT 84341
(435) 750-6232