

Employee
Benefits Guide

October 1, 2020 - September 30, 2021

WEBER SCHOOL DISTRICT

2020-2021 Employee Benefits Guide

If you have questions regarding...	Contact	Call	Click
Medical	University Of Utah Health Plans	(888) 271-5870	www.uhealthplan.utah.edu
Medical	SelectHealth	(800) 538-5038	www.selecthealth.org
Health Savings Account	HealthEquity	(866) 346-5800	www.healthequity.com
Dental	Dental Select	(800) 999-9789	www.dentalselect.com
Voluntary Vision	Opticare	(800) 363-0950	www.opticareofutah.com
Voluntary Vision	Dental Select	(800) 999-9789	www.dentalselect.com
Flexible Spending Account	National Benefit Services	(800) 274-0503	www.nbsbenefits.com
Basic Life and AD&D **Voluntary Life**	LifeMap	(800) 794-5390	www.lifemapco.com
Travel Assistance	LifeMap	(800) 230-5170	www.lifemapco.com
Voluntary Long-Term Disability	Lincoln Financial Group	(800) 423-2765	www.lfg.com
Employee Assistance Program	Blomquist Hale	(800) 926-9619	www.blomquisthale.com
Insurance Advisor	Denise House *GBS Benefits, Inc.*	(801) 842-0130	denise.house@gbsbenefits.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.

Important Information

Weber School District

Weber School District's Benefits and You

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

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

- **Take Advantage Of The Tools Available**
  That includes this guide, access to plan information, provider directories, and enrollment materials.

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

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

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

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

Enrollment & Eligibility

Who is Eligible?

Teachers are eligible to enroll for medical benefits if they are working any number of hours, and are eligible for flexible spending, dental and vision benefits at 20 hours per week. Classified employees hired before 7/1/2013 are eligible to enroll for medical benefits if they are working at least 30 hours per week, and flexible spending, dental and vision at 20 hours per week. Classified employees hired on or after 7/1/2013 are eligible to enroll for medical, dental, vision and flexible spending benefits if they are working at least 30 hours per week; no benefits are available for those working under 30 hours per week. New employees may be subject to a 60 day wait to begin medical benefits; otherwise medical benefits begin on the first day of eligible employment. Flexible spending, dental, vision will begin on the first day of the month following the date of eligible employment. Your married or unmarried dependents are eligible through the month when they turn 26 years old.

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

Open Enrollment is August 1st - August 31st for an effective date of October 1st, 2020. 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

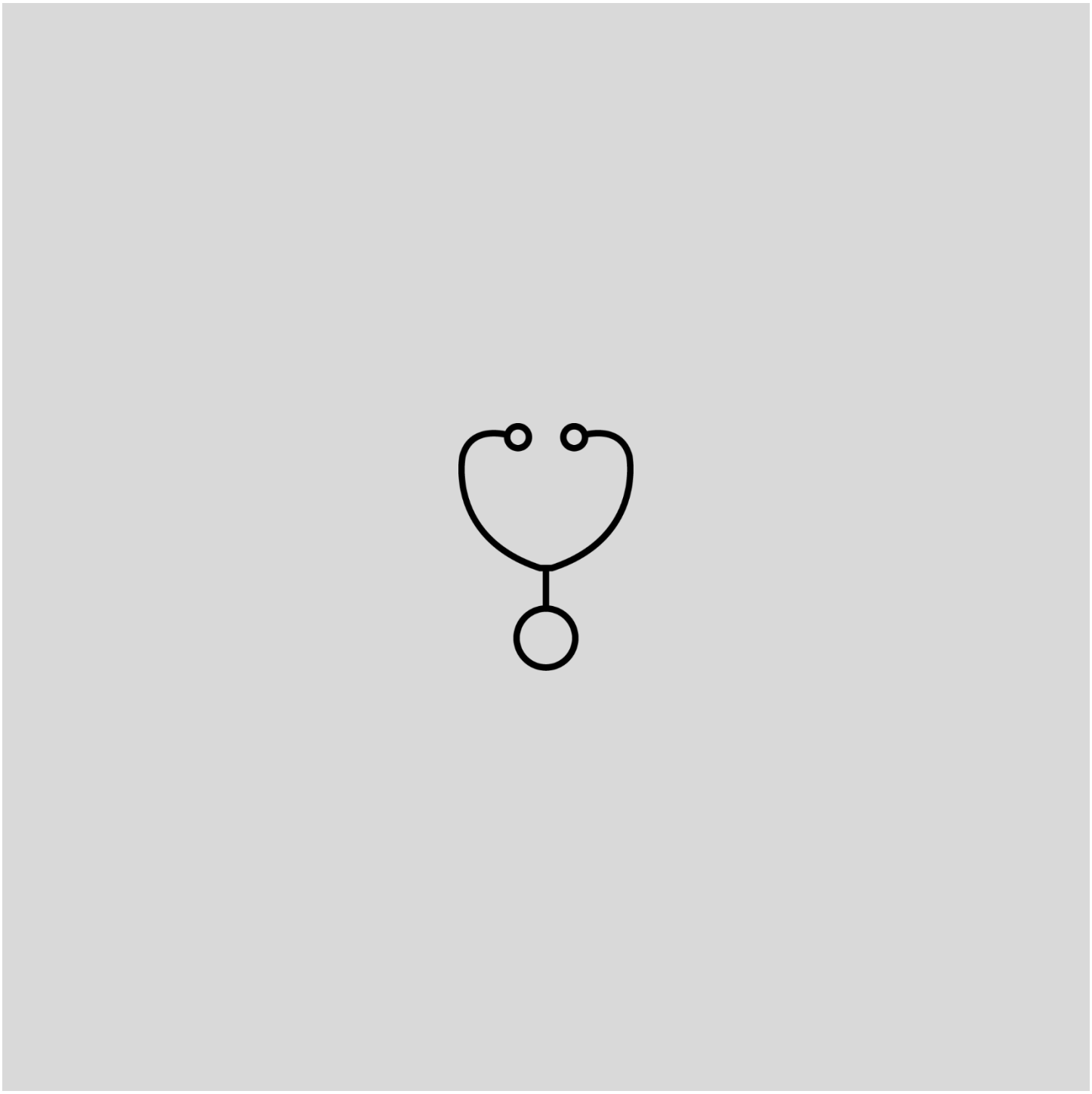
Once you enroll in or decline benefits, you will not be able to make any changes to your elections until our next annual open enrollment period, unless you experience a qualified life event. Qualified life events include, but are not limited to:

- 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

University of Utah Health Plans

Medical - University Of Utah Health Plans

	Healthy Preferred EPO Copay	Healthy Premier PPO QHDHP-Embedded*			
	Participating Only	Participating		Non-Participating	
		Individual	Family	Individual	Family
Deductible - Plan Year	$2,000 Individual / $4,000 Family	$2,800	$5,600	$5,200	$10,400
Out Of Pocket Maximum	$4,500 Individual / $9,000 Family	$3,000	$6,000	$6,000	$12,000
Office Visits					
Preventative	Covered 100%	Covered 100%		Not Covered	
Virtual Visit	Covered 100%	0% AD		Not Covered	
Primary Care	$30 Copay	20% AD		50% AD	
Specialist	$40 Copay	20% AD		50% AD	
Urgent Care	$40 Copay	20% AD		50% AD	
Hospital Visits					
Outpatient	20% AD	20% AD		50% AD	
Inpatient	20% AD	20% AD		50% AD	
Emergency Room	$250 Copay AD	20% AD		See Participating	
Mental Health					
Office Visit	$30 Copay	20% AD		50% AD	
Inpatient	20% AD	20% AD		50% AD	
Prescription					
Deductible	$100 Per Individual	Medical Deductible Applies			
Tier 0 *Preventive*	Covered 100%	Covered 100%		Not Covered	
Tier 1 *Preferred Generic*	$10 Copay Retail AD $25 Mail Order AD	20% AD Retail 20% AD Mail Order			
Tier 2 *Preferred Brand & Non-Preferred Generic*	$45 Copay Retail AD $100 Mail Order AD	20% AD Retail 20% AD Mail Order			
Tier 3 *Non-Preferred Brand*	$70 Copay Retail AD $175 Mail Order AD	20% AD Retail 20% AD Mail Order			
Tier 4 *Preferred Specialty Drugs*	20% AD Retail Not Available for Mail Order	20% AD Retail Not Available for Mail Order			
Maintenance Medication *Some Maintenance Medication is not subject to deductible, please see website for medication formulary*	NA	Medical Deductible Waived Tier 1M: $10 Copay Tier 2M: $25 Copay			

***Yearly Deductible - Embedded:** All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.
***Out-of-Pocket Maximum - Embedded:** All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount. Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum.

WEBER SCHOOL DISTRICT - 10/01/2020	OUTLINE OF COVERAGE	
HEALTHY PREFERRED EPO $2000-$4500-20%	IN-NETWORK	OUT-OF-NETWORK
HEALTH PLANS UNIVERSITY OF UTAH	You are responsible to pay the amounts shown below	
DEDUCTIBLE, OUT OF POCKET MAXIMUM, CONDITIONS		
Benefit Accrual Period	Plan Year	Not Covered
Self Only Coverage Deductible	$2,000	Not Covered
Self Only Coverage Out of Pocket Maximum	$4,500	Not Covered
Family Coverage Deductible - per Person/Family	$2,000/$4,000	Not Covered
Family Coverage Out of Pocket Maximum - per Person/Family	$4,500/$9,000	Not Covered
Pre-Existing Conditions	None	None
Lifetime Maximum Plan Payment	None	None
PREVENTIVE SERVICES		
Primary Care Provider (PCP)	Covered 100%	Not Covered
Specialist	Covered 100%	Not Covered
Eye Exam – Limit 1 per person per year	Covered 100%	Not Covered
Adult and Pediatric Immunizations	Covered 100%	Not Covered
Elective Immunizations (herpes zoster (shingles), rotavirus)	Covered 100%	Not Covered
Minor Diagnostic Services	Covered 100%	Not Covered
Other Preventive Services	Covered 100%	Not Covered
OUTPATIENT SERVICES		
Telehealth Services - Medical	Covered 100%	Not Covered
Telehealth Services - Mental Health	$30 Copay	Not Covered
Primary Care Provider Office Visits	$30 Copay	Not Covered
Mental Health or Substance Abuse Office Visits	$30 Copay	Not Covered
Specialist Office Visits	$40 Copay	Not Covered
Chiropractic Services – Up to 12 visits per year	$60 Copay	Not Covered
After Hours or Urgent Care Clinic	$40 Copay	Not Covered
Emergency Room – Waived if admitted to the hospital	$250 Copay AD	$250 Copay AD
Ambulance (Air or Ground) – Emergencies Only	20% AD	20% AD
Minor Diagnostic Services	Covered 100%	Not Covered
Major Diagnostic Services	20% AD	Not Covered
Rehabilitation or Habilitation Services - 40 days combined/yr	20% AD	Not Covered
Allergy Treatment and Serum	20% AD	Not Covered
Outpatient Surgical Services	20% AD	Not Covered
Other Medical Services Performed at an Outpatient Facility	20% AD	Not Covered
INPATIENT SERVICES *		
Inpatient Hospital, Surgical or Medical	20% AD	Not Covered
Maternity Physician Services	20% AD	Not Covered
Skilled Nursing Facility/Rehab Facility – 60 days combined/yr	20% AD	Not Covered
Hospice Facility	20% AD	Not Covered
Mental Health or Substance Abuse Facility	20% AD	Not Covered
OTHER BENEFITS *		
Injectable Drugs and Specialty Medications	20% AD	Not Covered
Hospice Care Provided at Home	20% AD	Not Covered
Home Health Care – Up to 60 visits per year	20% AD	Not Covered
Durable Medical Equipment (DME)	20% AD	Not Covered
Medical Supplies	20% AD	Not Covered
Adoption – Must take place within 90 days of birth	Up to $4,000 reimbursement AD ~	

WEBER SCHOOL DISTRICT - 10/01/2020	OUTLINE OF COVERAGE	
HEALTHY PREFERRED EPO $2000-$4500-20%	IN-NETWORK	OUT-OF-NETWORK
HEALTH PLANS UNIVERSITY OF UTAH	You are responsible to pay the amounts shown below	
PRESCRIPTION BENEFITS * ^		
Pharmacy Deductible - Per Person/Family (Per Year)	$100	Not Covered
Retail Pharmacy (Up to 30 Day Supply)		
Tier 0 (Preventive Drugs)	Covered 100%	Not Covered
Tier 1 (Preferred Generic Drugs)	$10 Copay APD	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic Drugs)	$45 Copay APD	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	$70 Copay APD	Not Covered
Tier 4 (Preferred Specialty Drugs) ±	20% APD	Not Covered
Mail Order Pharmacy ±± (up to 90 Day Supply – Selected Drugs)		
Tier 0 (Preventive Drugs)	Covered 100%	Not Covered
Tier 1 (Preferred Generic Drugs)	$25 Copay APD	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic Drugs)	$100 Copay APD	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	$175 Copay APD	Not Covered
Tier 4 (Preferred Specialty Drugs)	Not Available	Not Covered

* Preauthorization may be required.
~ Up to $4,000 reimbursement for covered adoption expenses after deductible has been met.
^ Generic medications required or member responsible for copay/coinsurance plus cost difference between brand name and generic medication.
± 90 day supply can be obtained through designated Mail Order Pharmacy and select network pharmacies, including any University of Utah Health Pharmacy, for Tier 0, 1, 2, and 3 drugs
±± Specialty Drugs require Prior Authorization and must be filled through a designated Specialty Pharmacy

All deductible, copay and coinsurance amounts are based on the allowed amounts and not on the provider's billed charges. You are responsible to pay for excess charges on covered services obtained from Out-of-Network providers and facilities. Excess charges are not applied to the Medical Out-of-Pocket Maximums.

To remain compliant with state and federal regulations, including the Affordable Care Act (ACA), these benefits are subject to change (1) Primary Care Physicians are those with a primary specialty of General Medicine, Family Medicine, Internal Medicine, Pediatrics, and OB/Gyn. (2) Frequency and/or quantity limitations apply to some preventive care and medical supplies. (3) University of Utah Health Plans provides a $4000 adoption indemnity as outlined by the state of Utah. Medical deductible, copay, or coinsurance listed under the benefit applies. (4) All covered services obtained outside the United States, except for urgent or emergency conditions, will be paid at the Out-of-Network benefit. (5) Certain Exclusions or preauthorization may apply for services and prescription drugs. Please refer to your policy for more information.

For more information, please call Customer Service at (833) 981-0213 from 8:00 am to 6:00 pm, Monday – Friday. In-Network benefits will be applied to all Utah providers within the Healthy PREFERRED Network. All Healthy PREFERRED benefits are administered by University of Utah Health Plans.

WEBER SCHOOL DISTRICT - 10/01/2020	OUTLINE OF COVERAGE	
HEALTHY PREMIER PPO $2800-$3000-20% HDHP	IN-NETWORK	OUT-OF-NETWORK
HEALTH PLANS UNIVERSITY OF UTAH	You are responsible to pay the amounts shown below	
DEDUCTIBLE, OUT OF POCKET MAXIMUM, CONDITIONS		
Benefit Accrual Period	Plan Year	Plan Year
Self Only Coverage Deductible	$2,800	$5,200
Self Only Coverage Out of Pocket Maximum	$3,000	$6,000
Family Coverage Deductible - per Person/Family	$2,800/$5,600	$5,200/$10,400
Family Coverage Out of Pocket Maximum - per Person/Family	$3,000/$6,000	$6,000/$12,000
Pre-Existing Conditions	None	None
Lifetime Maximum Plan Payment	None	None
PREVENTIVE SERVICES		
Primary Care Provider (PCP)	Covered 100%	Not Covered
Specialist	Covered 100%	Not Covered
Eye Exam – Limit 1 per person per year	Covered 100%	Not Covered
Adult and Pediatric Immunizations	Covered 100%	Not Covered
Elective Immunizations (herpes zoster (shingles), rotavirus)	Covered 100%	Not Covered
Minor Diagnostic Services	Covered 100%	Not Covered
Other Preventive Services	Covered 100%	Not Covered
OUTPATIENT SERVICES		
Telehealth Services - Medical	0% AD	Not Covered
Telehealth Services - Mental Health	20% AD	Not Covered
Primary Care Provider Office Visits	20% AD	50% AD
Mental Health or Substance Abuse Office Visits	20% AD	50% AD
Specialist Office Visits	20% AD	50% AD
Chiropractic Services – Up to 12 visits per year	20% AD	50% AD
After Hours or Urgent Care Clinic	20% AD	50% AD
Emergency Room – Waived if admitted to the hospital	20% AD	20% AD
Ambulance (Air or Ground) – Emergencies Only	20% AD	20% AD
Minor Diagnostic Services	20% AD	50% AD
Major Diagnostic Services	20% AD	50% AD
Rehabilitation or Habilitation Services - 40 days combined/yr	20% AD	50% AD
Allergy Treatment and Serum	20% AD	50% AD
Outpatient Surgical Services	20% AD	50% AD
Other Medical Services Performed at an Outpatient Facility	20% AD	50% AD
INPATIENT SERVICES *		
Inpatient Hospital, Surgical or Medical	20% AD	50% AD
Maternity Physician Services	20% AD	50% AD
Skilled Nursing Facility/Rehab Facility – 60 days combined/yr	20% AD	50% AD
Hospice Facility	20% AD	50% AD
Mental Health or Substance Abuse Facility	20% AD	50% AD
OTHER BENEFITS *		
Injectable Drugs and Specialty Medications	20% AD	50% AD
Hospice Care Provided at Home	20% AD	50% AD
Home Health Care – Up to 60 visits per year	20% AD	50% AD
Durable Medical Equipment (DME)	20% AD	50% AD
Medical Supplies	20% AD	50% AD
Adoption – Must take place within 90 days of birth	Up to $4,000 reimbursement AD ~	

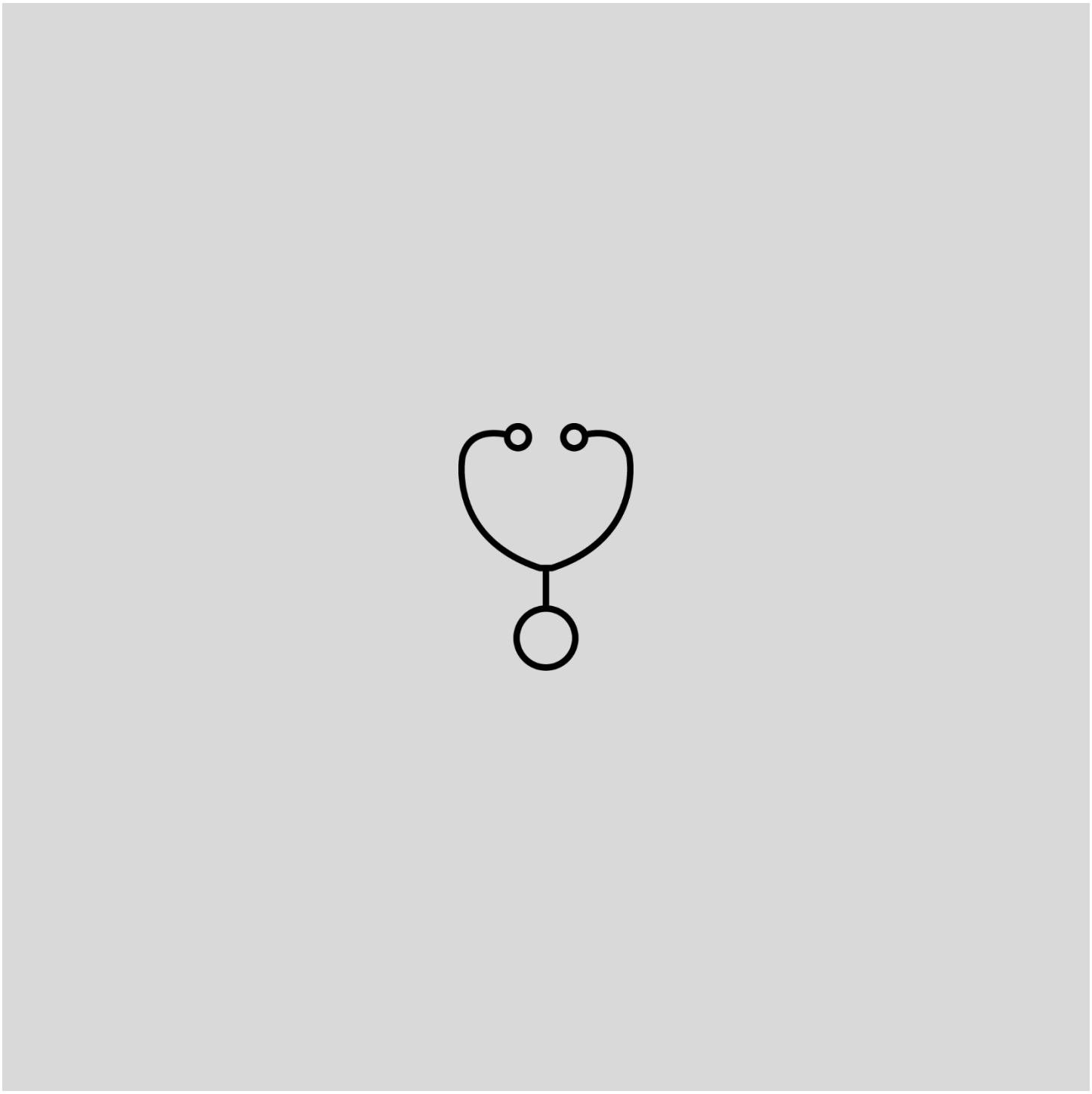
WEBER SCHOOL DISTRICT - 10/01/2020	OUTLINE OF COVERAGE	
HEALTHY PREMIER PPO $2800-$3000-20% HDHP	IN-NETWORK	OUT-NETWORK
HEALTH PLANS UNIVERSITY OF UTAH	You are responsible to pay the amounts shown below	
PRESCRIPTION BENEFITS * ^		
Pharmacy Deductible - Per Person/Family (Per Year)	Included in Medical	Not Covered
Retail Pharmacy (Up to 30 Day Supply)		
Tier 0 (Preventive Drugs)	Covered 100%	Not Covered
Tier 1 (Preferred Generic Drugs)	20% AD	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic Drugs)	20% AD	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	20% AD	Not Covered
Tier 4 (Preferred Specialty Drugs) ±	20% AD	Not Covered
Mail Order Pharmacy ±± (up to 90 Day Supply – Selected Drugs)		
Tier 0 (Preventive Drugs)	Covered 100%	Not Covered
Tier 1 (Preferred Generic Drugs)	20% AD	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic Drugs)	20% AD	Not Covered
Tier 3 (Non-Preferred Brand Drugs)	20% AD	Not Covered
Tier 4 (Preferred Specialty Drugs)	Not Available	Not Covered
Preventive Maintenance Drugs (Limited Drug Categories)		
Tier 1 (Preferred Generic Drugs)	$10 Copay, Ded Waived	Not Covered
Tier 2 (Preferred Brand and Non-Preferred Generic Drugs)	$25 Copay, Ded Waived	Not Covered

* Preauthorization may be required.
~ Up to $4,000 reimbursement for covered adoption expenses after deductible has been met.
^ Generic medications required or member responsible for copay/coinsurance plus cost difference between brand name and generic medication.
± 90 day supply can be obtained through designated Mail Order Pharmacy and select network pharmacies, including any University of Utah Health Pharmacy, for Tier 0, 1, 2, and 3 drugs
±± Specialty Drugs require Prior Authorization and must be filled through a designated Specialty Pharmacy

All deductible, copay and coinsurance amounts are based on the allowed amounts and not on the provider's billed charges. You are responsible to pay for excess charges on covered services obtained from Out-of-Network providers and facilities. Excess charges are not applied to the Medical Out-of-Pocket Maximums.

To remain compliant with state and federal regulations, including the Affordable Care Act (ACA), these benefits are subject to change (1) Primary Care Physicians are those with a primary specialty of General Medicine, Family Medicine, Internal Medicine, Pediatrics, and OB/Gyn. (2) Frequency and/or quantity limitations apply to some preventive care and medical supplies. (3) University of Utah Health Plans provides a $4000 adoption indemnity as outlined by the state of Utah. Medical deductible, copay, or coinsurance listed under the benefit applies. (4) All covered services obtained outside the United States, except for urgent or emergency conditions, will be paid at the Out-of-Network benefit. (5) Certain Exclusions or preauthorization may apply for services and prescription drugs. Please refer to your policy for more information.

For more information, please call Customer Service at (833) 981-0213 from 8:00 am to 6:00 pm, Monday – Friday. In-Network benefits will be applied to all Utah providers within the Healthy PREMIER Network and all out of state providers in the FirstHealth Network. All Healthy PREMIER benefits are administered by University of Utah Health Plans.



Medical

Selecthealth

Medical - SelectHealth

	Select:Value	Select:Med+ HealthSave-Embedded*			
	Participating Only	Participating		Non-Participating	
		Individual	Family	Individual	Family
Deductible - Plan Year	$2,000 Individual / $4,000 Family	$2,800	$5,600	$3,000	$6,000
Out Of Pocket Maximum	$4,500 Individual / $9,000 Family	$3,000	$6,000	$4,500	$9,000
Office Visits					
Preventative	Covered 100%	Covered 100%		Not Covered	
Primary Care	$30 Copay	$15 Copay AD		40% AD	
Specialist	$60 Copay	$25 Copay AD		40% AD	
Urgent Care	$60 Copay	$35 Copay AD		40% AD	
Hospital Visits					
Outpatient	20% AD	20% AD		40% AD	
Inpatient	20% AD	20% AD		40% AD	
Emergency Room	$250 Copay AD	$75 Copay AD		See Participating	
Mental Health					
Office Visit	$30 Copay	$15 Copay AD		40% AD	
Outpatient	20% AD	20% AD		40% AD	
Inpatient	20% AD	20% AD		40% AD	
Prescription					
Deductible	$100 Per Individual	Medical Deductible Applies			
Tier 1	$10 Copay Retail AD $10 Mail Order AD	$7 Copay Retail AMD $7 Mail Order AMD			
Tier 2	$35 Copay Retail AD $70 Mail Order AD	$21 Copay Retail AMD / $42 Mail Order AMD			
Tier 3	$60 Copay Retail AD $180 Mail Order AD	$42 Copay Retail AMD $126 Mail Order AMD			
Tier 4	$100 Copay Retail AD	$100 Copay Retail AMD			
Maintenance Medications	NA	Some Maintenance Medications are not subject to deductible, visit selecthealth.org for a list of qualified medications.			

***Yearly Deductible - Embedded:** All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.
***Out-of-Pocket Maximum - Embedded:** All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount. Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum.

selecthealth

VALUE NETWORK

MEMBER PAYMENT SUMMARY	
	IN-NETWORK When using in-network providers, you are responsible to pay the amounts in this column. Services from out-of-network providers are not covered (except emergencies).
CONDITIONS AND LIMITATIONS	
Lifetime Maximum Plan Payment - *Per Person*	None
Pre-Existing Conditions (PEC)	None
Benefit Accumulator Period	plan year
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5]	**IN-NETWORK**
Self Only Coverage, 1 person enrolled - per plan year	
Deductible	$2,000
Out-of-Pocket Maximum	$4,500
Family Coverage, 2 or more enrolled - per plan year	
Deductible - per person/family	$2000/$4000
Out-of-Pocket Maximum - per person/family	$4500/$9000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)	
INPATIENT SERVICES	**IN-NETWORK**
Medical, Surgical and Hospice[4]	20% after deductible
Skilled Nursing Facility4 - Up to 60 days per plan year	20% after deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4]	20% after deductible
Up to 40 days per plan year for all therapy types combined	
PROFESSIONAL SERVICES	**IN-NETWORK**
Office Visits & Minor Office Surgeries	
Primary Care Provider (PCP)[1]	$30
Secondary Care Provider (SCP)[1]	$60
Allergy Tests	See Office Visits Above
Allergy Treatment and Serum	20%
Major Surgery	20%
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	**IN-NETWORK**
Primary Care Provider (PCP)[1]	Covered 100%
Secondary Care Provider (SCP)[1]	Covered 100%
Adult and Pediatric Immunizations	Covered 100%
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%
Diagnostic Tests: Minor	Covered 100%
Other Preventive Services	Covered 100%
VISION SERVICES	**IN-NETWORK**
Preventive Eye Exams	Covered 100%
All Other Eye Exams	$60
OUTPATIENT SERVICES[4]	**IN-NETWORK**
Outpatient Facility and Ambulatory Surgical	20% after deductible
Ambulance (Air or Ground) - *Emergencies Only*	20% after deductible
Emergency Room - *(In-Network facility)*	$250 after deductible
Emergency Room - *(Out-of-Network facility)*	$250 after deductible
Intermountain InstaCare® Facilities, Urgent Care Facilities	$60
Intermountain KidsCare® Facilities	$30
Intermountain Connect Care®	Covered 100%
Chemotherapy, Radiation and Dialysis	20% after deductible
Diagnostic Tests: Minor[2]	Covered 100%
Diagnostic Tests: Major[2]	20% after deductible
Home Health, Hospice, Outpatient Private Nurse	20% after deductible
Outpatient Cardiac Rehab	Covered 100%
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	$60 after deductible

MPS-HMO 01/01/20

See other side for additional benefits

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VALUE NETWORK

MEMBER PAYMENT SUMMARY

IN-NETWORK

MISCELLANEOUS SERVICES	IN-NETWORK
Durable Medical Equipment (DME)[4]	20% after deductible
Miscellaneous Medical Supplies (MMS)[3]	20% after deductible
Autism Spectrum Disorder	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services
Maternity and Adoption[4,6]	See Professional, Inpatient or Outpatient
Cochlear Implants[4]	See Professional, Inpatient or Outpatient
Infertility - *Select Services* *(Max Plan Payment $1,500/ plan year; $5,000 lifetime)*	*50% after deductible
Donor Fees for Covered Organ Transplants[4]	20% after deductible
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	See Professional, Inpatient or Outpatient
OPTIONAL BENEFITS	**IN-NETWORK**
Mental Health and Chemical Dependency[4]	
Office Visits	$30
Inpatient	20% after deductible
Outpatient	20%
Residential Treatment[2]	20% after deductible
Chiropractic - American Specialty Health (ASH) - 800-678-9133	$20 (up to 20 visits per plan year)
Injectable Drugs and Specialty Medications[4]	20% after deductible
Bariatric Surgery *(Up to one surgery/lifetime)* [4]	See Professional, Inpatient or Outpatient
PRESCRIPTION DRUGS	
Pharmacy Deductible - Per Person per plan year	$100
Prescription Drug List (formulary)	RxSelect®
Prescription Drugs - *Up to 30 Day Supply of Covered Medications* [4]	
Tier 1	$10
Tier 2	$35 after pharmacy deductible
Tier 3	$60 after pharmacy deductible
Tier 4	$100 after pharmacy deductible
Maintenance Drugs - *90 Day Supply (Mail-Order, Retail90 ®)-selected drugs* [4]	
Tier 1	$10
Tier 2	$70 after pharmacy deductible
Tier 3	$180 after pharmacy deductible
Generic Substitution Required	Generic required or must pay copay plus cost difference between name brand and generic

1 Refer to **selecthealth.org/findadoctor** to identify whether a provider is a primary or secondary care provider.

2 Refer to your Certificate of Coverage for more information.

3 Frequency and/or quantity limitations apply to some preventive care and MMS services.

4 Preauthorization is required for certain services. Benefits may be reduced or denied if you do not preauthorize certain services with out-of-network providers. Please refer to Section 11--" Healthcare Management", in your Certificate of Coverage, for details.

5 All deductible/copay/coinsurance amounts are based on the allowed amounts and not on the providers billed charges. Out-of-Network Providers or Facilities have not agreed to accept the Allowed Amount for Covered Services. When this occurs, you are responsible to pay for any charges that exceed the amount that SelectHealth pays for Covered Services. These fees are called Excess Charges, and they do not apply to your Out-of-Pocket Maximum.

6 SelectHealth provides a $4000 adoption indemnity as outlined by the state of Utah. Medical deductible, copay, or coinsurance listed under the benefit applies and may exhaust the benefits prior to any plan payments.

* Not applied to Medical out-of-pocket maximum.

To contact Member Services, call 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m., Saturdays, from 9:00 a.m. to 2:00 p.m. TTY users should call 711.

Benefits are administered and underwritten by SelectHealth, Inc. [SM] ***(domiciled in Utah).***

selecthealth

MED NETWORK / HEALTHSAVE PRODUCT

	MEMBER PAYMENT SUMMARY	
	IN-NETWORK When using in-network providers, you are responsible to pay the amounts in this column.	**OUT-OF-NETWORK** When using out-of-network providers, you are responsible to pay the amounts in this column.
CONDITIONS AND LIMITATIONS		
Lifetime Maximum Plan Payment - *Per Person*	None	
Pre-Existing Conditions (PEC)	None	
Benefit Accumulator Period	plan year	
Maximum Annual Out-of-Network Payment - (per plan year)	None	None
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5]	**IN-NETWORK**	**OUT-OF-NETWORK**
Self Only Coverage, 1 person enrolled - per plan year		
Deductible	$2,800	$3,100
Out-of-Pocket Maximum	$3,000	$4,500
Family Coverage, 2 or more enrolled - per plan year		
Deductible - per person/family	$2800/$5600	$3100/$6200
Out-of-Pocket Maximum - per person/family	$3000/$6000	$4500/$9000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)		
INPATIENT SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Medical, Surgical and Hospice[4]	20% after deductible	40% after deductible
Skilled Nursing Facility4 - Up to 60 days per plan year	20% after deductible	40% after deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4]	20% after deductible	40% after deductible
Up to 40 days per plan year for all therapy types combined		
PROFESSIONAL SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits & Minor Office Surgeries		
Primary Care Provider (PCP)[1]	$15 after deductible	40% after deductible
Secondary Care Provider (SCP)[1]	$25 after deductible	40% after deductible
Allergy Tests	See Office Visits Above	Not Covered
Allergy Treatment and Serum	20% after deductible	Not Covered
Major Surgery	20% after deductible	40% after deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after deductible	40% after deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	**IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Provider (PCP)[1]	Covered 100%	Not Covered
Secondary Care Provider (SCP)[1]	Covered 100%	Not Covered
Adult and Pediatric Immunizations	Covered 100%	Not Covered
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%	Not Covered
Diagnostic Tests: Minor	Covered 100%	Not Covered
Other Preventive Services	Covered 100%	Not Covered
VISION SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Preventive Eye Exams	Covered 100%	Not Covered
All Other Eye Exams	$25 after deductible	40% after deductible
OUTPATIENT SERVICES[4]	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Facility and Ambulatory Surgical	20% after deductible	40% after deductible
Ambulance (Air or Ground) - *Emergencies Only*	20% after deductible	See In-Network Benefit
Emergency Room - *(In-Network facility)*	$75 after deductible	See In-Network Benefit
Emergency Room - *(Out-of-Network facility)*	$75 after deductible	See In-Network Benefit
Intermountain InstaCare® Facilities, Urgent Care Facilities	$35 after deductible	40% after deductible
Intermountain KidsCare® Facilities	$15 after deductible	Not Available
Intermountain Connect Care®	Covered 100% after deductible	Not Available
Chemotherapy, Radiation and Dialysis	20% after deductible	40% after deductible
Diagnostic Tests: Minor[2]	Covered 100% after deductible	40% after deductible
Diagnostic Tests: Major[2]	20% after deductible	40% after deductible
Home Health, Hospice, Outpatient Private Nurse	20% after deductible	40% after deductible
Outpatient Cardiac Rehab	Covered 100% after deductible	40% after deductible
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	$25 after deductible	40% after deductible

See other side for additional benefits

selecthealth

MED NETWORK / HEALTHSAVE PRODUCT

	MEMBER PAYMENT SUMMARY	
	IN-NETWORK	**OUT-OF-NETWORK**
MISCELLANEOUS SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Durable Medical Equipment (DME)[4]	20% after deductible	40% after deductible
Miscellaneous Medical Supplies (MMS)[3]	20% after deductible	40% after deductible
Autism Spectrum Disorder	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services	See Professional, Inpatient, Outpatient, or Mental Health and Chemical Dependency Services
Maternity and Adoption[4,6]	See Professional, Inpatient or Outpatient	40% after deductible
Cochlear Implants[4]	See Professional, Inpatient or Outpatient	Not Covered
Infertility - *Select Services (Max Plan Payment $1,500/ plan year; $5,000 lifetime)*	50% after deductible	Not Covered
Donor Fees for Covered Organ Transplants[4]	20% after deductible	Not Covered
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	See Professional, Inpatient or Outpatient	Not Covered
OPTIONAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Mental Health and Chemical Dependency[4]		
Office Visits	$15 after deductible	40% after deductible
Inpatient	20% after deductible	40% after deductible
Outpatient	20% after deductible	40% after deductible
Residential Treatment[2]	20% after deductible	40% after deductible
Injectable Drugs and Specialty Medications[4]	20% after deductible	40% after deductible
Bariatric Surgery *(Up to one surgery/lifetime)*[4]	See Professional, Inpatient or Outpatient	Not Covered
PRESCRIPTION DRUGS		
Prescription Drug List (formulary)	RxSelect®	
Prescription Drugs-*Up to 30 Day Supply of Covered Medications*[4]		
Tier 1	$7 after in-network deductible	
Tier 2	$21 after in-network deductible	
Tier 3	$42 after in-network deductible	
Tier 4	$100 after in-network deductible	
Maintenance Drugs-*90 Day Supply (Mail-Order,Retail90®)-selected drugs*[4]		
Tier 1	$7 after in-network deductible	
Tier 2	$42 after in-network deductible	
Tier 3	$126 after in-network deductible	
Preventive Prescription Drugs[3]-*Up to 30 Day Supply of Covered Medications*[4]		
Tier 1	$7	
Tier 2	$21	
Tier 3	$42	
Tier 4	$100	
Preventive Maintenance Drugs[3]-*90 Day Supply (Mail-Order,Retail90®)-selected drugs*[4]		
Tier 1	$7	
Tier 2	$42	
Tier 3	$126	
Generic Substitution Required	Generic required or must pay copay plus cost difference between name brand and generic	

1 Refer to **selecthealth.org/findadoctor** to identify whether a provider is a primary or secondary care provider.

2 Refer to your Certificate of Coverage for more information.

3 Frequency and/or quantity limitations apply to some preventive care and MMS services.

4 Preauthorization is required for certain services. Benefits may be reduced or denied if you do not preauthorize certain services with out-of-network providers. Please refer to Section 11--" Healthcare Management", in your Certificate of Coverage, for details.

5 All deductible/copay/coinsurance amounts are based on the allowed amounts and not on the providers billed charges. Out-of-network Providers or Facilities have not agreed to accept the Allowed Amount for Covered Services. When this occurs, you are responsible to pay for any charges that exceed the amount that SelectHealth pays for Covered Services. These fees are called Excess Charges, and they do not apply to your Out-of-Pocket Maximum.

6 SelectHealth provides a $4000 adoption indemnity as outlined by the state of Utah. Medical deductible, copay, or coinsurance listed under the benefit applies and may exhaust the benefits prior to any plan payments.

All covered services obtained outside the United States, except for routine, urgent, or emergency conditions require preauthorization.

To contact Member Services, call 800-538-5038 weekdays, from 7:00 a.m. to 8:00 p.m., Saturdays, from 9:00 a.m. to 2:00 p.m. TTY users should call 711.

Benefits are administered and underwritten by SelectHealth, Inc.℠ (domiciled in Utah).

Stretching Your Rx Dollar

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

› **On the Web:** https://www.goodrx.com/
Instantly look up current drug prices at CVS, Walgreens, Walmart, Costco, and other local pharmacies.
Please Note:
- Prescription drug pricing displayed on the GoodRx Comparison Tool may be more or less than your insurance drug card.
- Please be sure to compare all discount pricing options before you purchase.
- Check your insurance carrier's pharmacy benefit before purchasing a 90 day supply.

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

Generic Prescriptions

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

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

Did You Know?

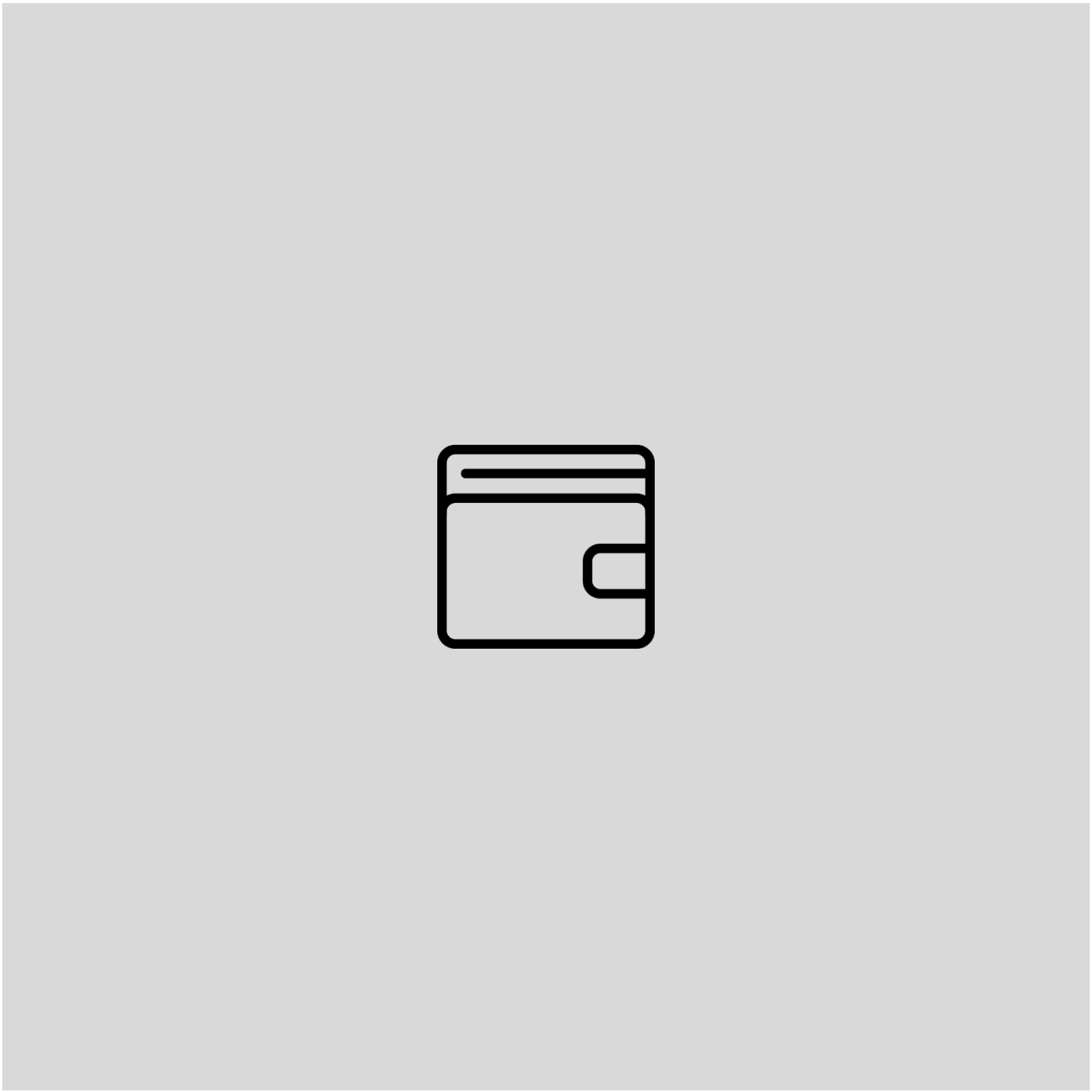
Even if the generic substitute for one of your prescription drugs is not on one of the $4 lists, generic drugs are often 80% less expensive than brand name drugs, so switching to a generic will have a large impact on your pocketbook whether you switch pharmacies or not. To see if you would benefit from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

Tips

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

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

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



Flexible Spending Account

National Benefit Services

FLEXIBLE BENEFITS PLAN

Weber School District

Employer ID NBS759236

PLAN HIGHLIGHTS

Login at: my.nbsbenefits.com

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

DETERMINING CONTRIBUTIONS

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

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

GENERAL PLAN INFORMATION

Plan Year End:……..…September 30th
Run-out Period:……..……...…90 Days

Maximum Medical Limit……..…...…Current IRS limit $2,750
…See Code Section 125(i)(2) or current enrollment information

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

Health FSA Grace Period……...……75 days
Dependent Care Grace Period:……..……...…...75 days

WHEN AM I ELIGIBLE TO PARTICIPATE

You will be eligible to join the Plan as of your date employment. Teachers will be eligible to participate if they work 20 hours or more per week. Classified Employee hired before July 1, 2013 will be eligible to participate if they work at least 20 hours per week. Classified Employees hired on or after July 1, 2013 are eligible to participate if they work at least 30 hours per week.

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

WHAT TYPE OF BENEFITS ARE AVAILABLE

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

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

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

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

NBS Welfare Benefit Service Center
8523 S. Redwood Road
West Jordan, UT 84088
801-532-4000 or 1-800- 274-0503
Fax: 1-800-478-1528

nbs national benefit services

Weber School District Cafeteria Plan
Weber School District

Plan Contact Person:
Robert D. Petersen
5320 South Adams Ave. Parkway
Ogden, Utah 84405
(801) 476-7800

Flexible Benefits Plan
Highlights Continued

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

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

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

HOW DO I RECEIVE REIMBURSEMENTS

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

Claim forms must be submitted no later than 90 days after the end of the Plan Year for the Health Flexible Spending Account and the Dependent Care Flexible Spending Account. However, if you have unused contributions in your Flexible Spending Accounts from the immediately preceding plan year, and you incur qualified medical care and/or dependent care expenses during the grace period; you may be reimbursed for those expenses as if the expenses had been incurred in the prior plan year. Any monies left from the previous plan year will be forfeited following the grace and run-out period.

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

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

WHO ARE HIGHLY COMPENSATED & KEY EMPLOYEES

Under the Internal Revenue Code, "highly compensated employees" and "key employees" generally are Participants who are officers, shareholders or highly paid.

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

Updated: 1/16/2020

NBS Welfare Benefit Service Center
8523 S. Redwood Road
West Jordan, UT 84088
801-532-4000 or 1-800- 274-0503
Fax: 1-800-478-1528

Weber School District Cafeteria Plan
Weber School District

Plan Contact Person:
Robert D. Petersen
5320 South Adams Ave. Parkway
Ogden, Utah 84405
(801) 476-7800

Health Savings Account

Health Equity

Health Savings Account

About Health Savings Accounts

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

The HSA Advantage

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

Who is eligible?

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

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

How much can I contribute to my HSA?

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

	2020
Self-Only	$3,550
Family	$7,100

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

Determining Your Annual Contribution

Your allowed annual contribution is calculated based on the number of months covered by a qualified HDHP plan and your coverage type (self-only or family). For example, if you have self-only coverage 8 months of the year, your maximum contribution limit is $2,333. Formula: $2,333 = 8 x ($3,500 / 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.)

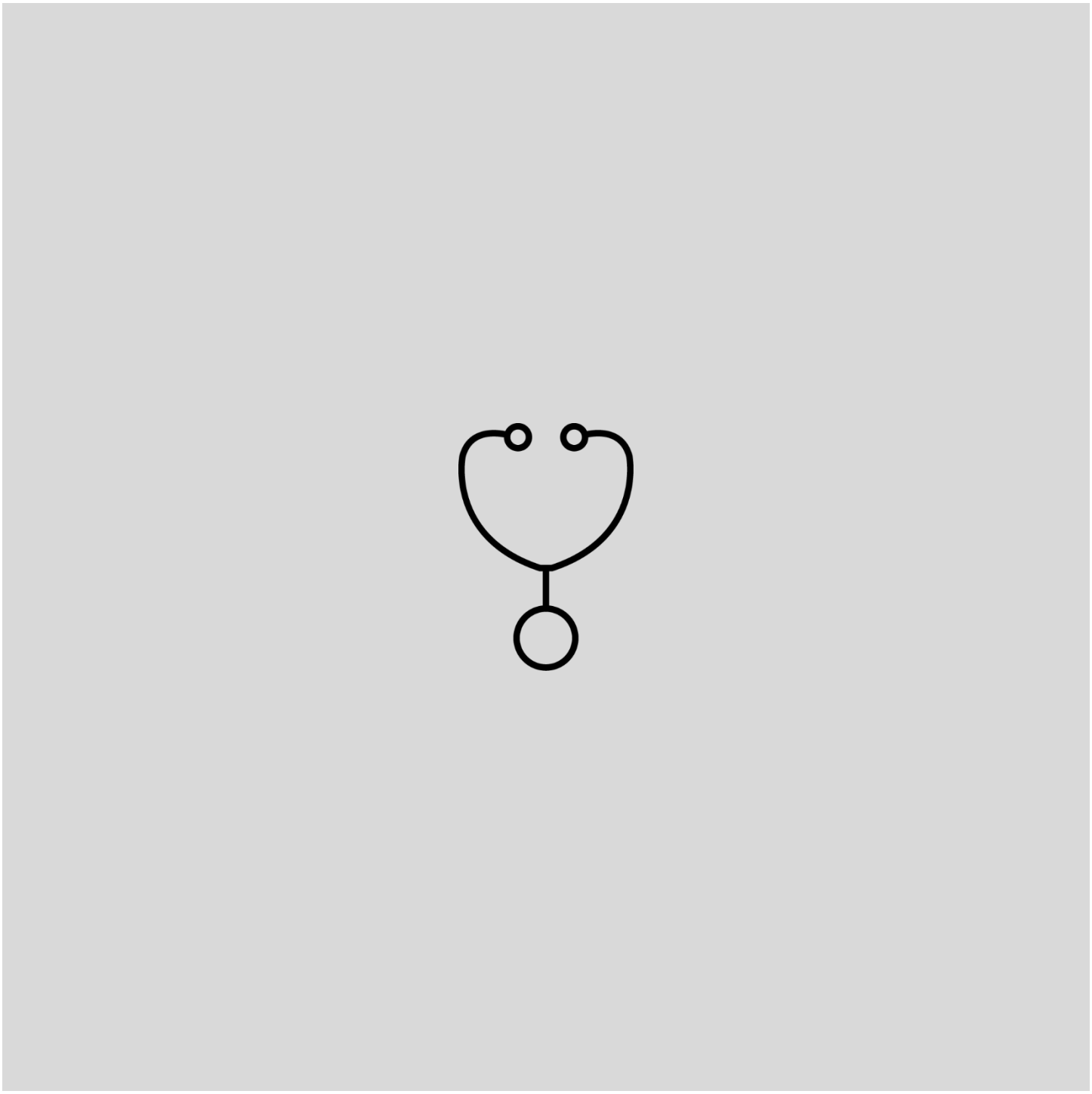
› **Important**
Any funds you withdraw for non-qualified expenses will be taxed at your income tax rate plus a 20% tax penalty if you're under age 65. After age 65, you pay taxes but no penalty.

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.



Kannact

WEBER SCHOOL DISTRICT

IF YOU COULD EFFECTIVELY MANAGE YOUR CHRONIC CONDITION FROM HOME, WOULD YOU?

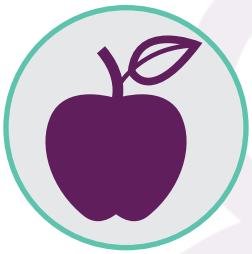
Kannact has a better way to manage your chronic condition. It's an optional, no-cost benefit for employees and dependents on the health plan.

Obesity
Type 1 Diabetes
Type 2 Diabetes

Arrhythmias
Hypertension
High Cholesterol

Peripheral Artery Disease
Coronary Artery Disease
Congestive Heart Failure

ENROLL TODAY & RECEIVE THE FOLLOWING FOR FREE



Custom meal plans, shopping lists, & meal delivery discounts

Unlimited testing supplies delivered to your door

Personal workout regimens for your lifestyle

Bluetooth app to track biometric trends

24/7 access to clinical coaching staff

If you are currently living with one or more of the listed conditions, have a family history of stroke or heart attack, or have a diagnosis related to Diabetes, Hypertension, or Cardiovascular Disease/Risk, contact Kannact today!

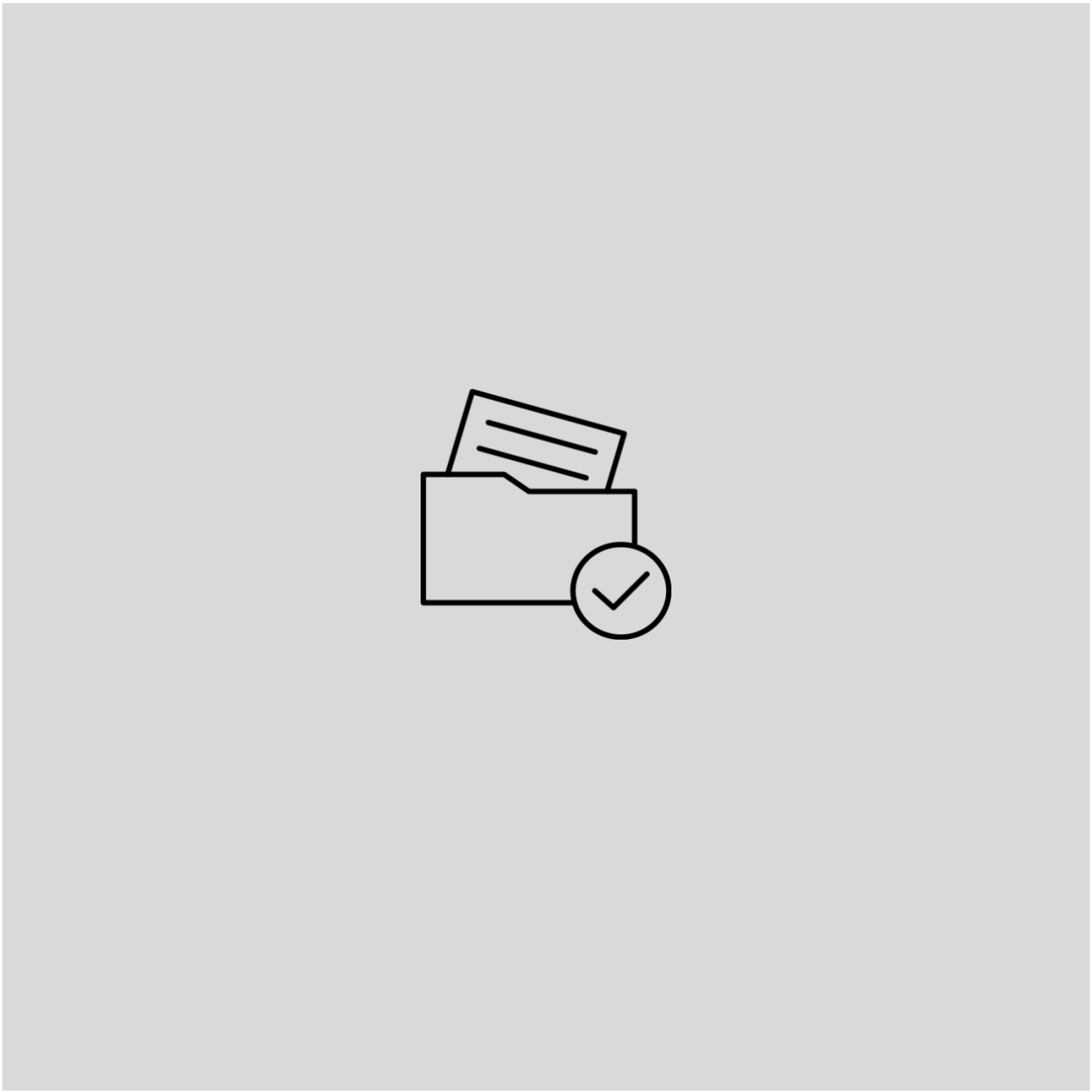
SIGN UP IN LESS THAN 3 MINUTES!

www.kannact.com/wsd

Kannact™

QUESTIONS?

(855) 722-5513
support@kannactnow.com



Employee Assistance Program

Blomquist Hale

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**

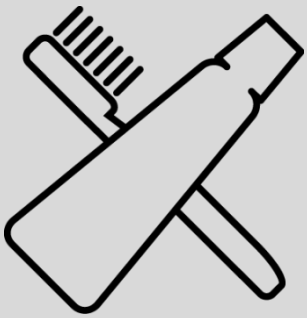
Count On:

- ☑ 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



Dental

Dental Select

Dental Summary

DentalSelect

Summary of Benefits for:

Weber School District

	Co-Pay Plan	
	Gold Network	
PREVENTIVE	**Contracted Dentist**	**Non-Contracted Dentist**
Routine exams, cleanings (2 per year), topical fluoride, x-rays	**100%**	**No Benefit**
BASIC		
Fillings, extractions, oral surgery	**Fixed Co-Pays, Refer to Co-Pay Schedule**	**No Benefit**
MAJOR		
Crowns, bridges, dentures, endodontics, periodontics	**Fixed Co-Pays, Refer to Co-Pay Schedule**	**No Benefit**
ORTHODONTICS		
All Members:	**20% Discount**	**No Benefit**
Lifetime Maximum:	**No Maximum**	
Waiting Period:	**No Waiting Period**	
MAXIMUM BENEFIT		
Applies to Preventive, Basic and Major Services — *Benefit Period is:* ***Per Contract Year***	**No Maximum**	
DEDUCTIBLE		
Applies to Basic and Major Services — *Per Year:*	**No Deductible**	

The benefits illustrated are in summary form only. They should not be construed as complete in and of themselves. They are only for comparison and in the case of a discrepancy, the plan documents apply. Please refer to the Group Certificate Booklet for a complete description of benefits, limitations and exclusions.

Gold Network

Schedule of Copay/Plan Payments for Participating General Dentists & Pediatric Specialists
Effective January 1, 2020

DentalSelect

ADA CODE	PROCEDURE DESCRIPTION	GENERAL DENTIST IN-NETWORK MEMBER CO-PAY	PEDIATRIC SPECIALIST IN-NETWORK MEMBER CO-PAY OR DISCOUNT
D0120	Periodic oral evaluation - established patient	$0	$0
D0140	Limited oral evaluation - problem focused	$0	20% Discount
D0150	Comprehensive oral evaluation - new or established patient	$0	$0
D0160	Detailed and extensive oral evaluation - problem focused, by report	$0	20% Discount
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0	20% Discount
D0180	Comprehensive periodontal evaluation - new or established patient	$0	20% Discount
D0210	Intraoral - complete series of radiographic images	$0	$0
D0220	Intraoral - periapical first radiographic image	$0	$0
D0230	Intraoral - periapical each additional radiographic image	$0	$0
D0240	Intraoral - occlusal radiographic image	$0	$0
D0250	Extra-oral – 2D projection radiographic image	$0	$0
D0251	Extra-oral posterior dental radiographic image	$0	$0
D0270	Bitewing - single radiographic image	$0	$0
D0272	Bitewings - two radiographic images	$0	$0
D0273	Bitewings - three radiographic images	$0	$0
D0274	Bitewings - four radiographic images	$0	$0
D0277	Vertical bitewings - 7 to 8 radiographic images	$0	$0
D0330	Panoramic radiographic image	$0	$0
D0340	2D Cephalometric radiographic image – acquisition, measurement and analysis	20% Discount	20% Discount
D0470	Diagnostic casts	20% Discount	20% Discount
D1110	Prophylaxis - adult	$0	$0
D1120	Prophylaxis - child	$0	$0
D1208	Topical application of fluoride – excluding varnish (age 14 & under)	$0	$0
D1351	Sealant - per tooth (age 14 & under)	$13	20% Discount
D1353	Sealant repair – per tooth (age 14 & under)	$16	20% Discount
D1510	Space maintainer - fixed - unilateral (age 14 & under)	$92	20% Discount
D1516	Space maintainer – fixed – bilateral, maxillary (age 14 & under)	$131	20% Discount
D1517	Space maintainer – fixed – bilateral, mandibular (age 14 & under)	$131	20% Discount
D1520	Space maintainer - removable - unilateral (age 14 & under)	$101	20% Discount
D1526	Space maintainer – removable – bilateral, maxillary (age 14 & under)	$156	20% Discount
D1527	Space maintainer – removable – bilateral, mandibular (age 14 & under)	$156	20% Discount
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$20	20% Discount
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	$20	20% Discount
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	$14	20% Discount
D2140	Amalgam - one surface, primary or permanent	$18	20% Discount
D2150	Amalgam - two surfaces, primary or permanent	$24	20% Discount
D2160	Amalgam - three surfaces, primary or permanent	$31	20% Discount
D2161	Amalgam - four or more surfaces, primary or permanent	$40	20% Discount
D2330	Resin-based composite - one surface, anterior	$37	20% Discount
D2331	Resin-based composite - two surfaces, anterior	$41	20% Discount
D2332	Resin-based composite - three surfaces, anterior	$48	20% Discount
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$53	20% Discount
D2390	Resin-based composite crown, anterior	$80	20% Discount
D2391	Resin-based composite - one surface, posterior	$36	20% Discount
D2392	Resin-based composite - two surfaces, posterior	$54	20% Discount
D2393	Resin-based composite - three surfaces, posterior	$66	20% Discount
D2394	Resin-based composite - four or more surfaces, posterior	$71	20% Discount
D2610	Inlay - porcelain/ceramic - one surface	$224	20% Discount
D2620	Inlay - porcelain/ceramic - two surfaces	$236	20% Discount
D2630	Inlay - porcelain/ceramic - three or more surfaces	$239	20% Discount
D2642	Onlay - porcelain/ceramic - two surfaces	$237	20% Discount
D2643	Onlay - porcelain/ceramic - three surfaces	$264	20% Discount
D2644	Onlay - porcelain/ceramic - four or more surfaces	$287	20% Discount
D2650	Inlay - resin-based composite - one surface	$162	20% Discount
D2651	Inlay - resin-based composite - two surfaces	$176	20% Discount
D2652	Inlay - resin-based composite - three or more surfaces	$193	20% Discount
D2662	Onlay - resin-based composite - two surfaces	$173	20% Discount
D2663	Onlay - resin-based composite - three surfaces	$202	20% Discount
D2664	Onlay - resin-based composite - four or more surfaces	$202	20% Discount
D2710	Crown - resin-based composite (indirect)	$128	20% Discount
D2712	Crown - ¾ resin-based composite (indirect)	$128	20% Discount
D2720	Crown - resin with high noble metal	$281	20% Discount
D2721	Crown - resin with predominantly base metal	$270	20% Discount
D2722	Crown - resin with noble metal	$272	20% Discount
D2740	Crown - porcelain/ceramic	$325	20% Discount
D2750	Crown - porcelain fused to high noble metal	$313	20% Discount
D2751	Crown - porcelain fused to predominantly base metal	$313	20% Discount
D2752	Crown - porcelain fused to noble metal	$313	20% Discount
D2753	Crown-porcelain fused to titanium and titanium alloys	$313	20% Discount
D2780	Crown - 3/4 cast high noble metal	$300	20% Discount
D2781	Crown - 3/4 cast predominantly base metal	$257	20% Discount
D2782	Crown - 3/4 cast noble metal	$266	20% Discount
D2783	Crown - 3/4 porcelain/ceramic	$285	20% Discount
D2790	Crown - full cast high noble metal	$277	20% Discount
D2791	Crown - full cast predominantly base metal	$262	20% Discount
D2792	Crown - full cast noble metal	$260	20% Discount
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$26	20% Discount
D2920	Re-cement or re-bond crown	$27	20% Discount
D2929	Prefabricated porcelain/ceramic crown – primary tooth	$107	20% Discount
D2930	Prefabricated stainless steel crown - primary tooth	$75	20% Discount
D2931	Prefabricated stainless steel crown - permanent tooth	$83	20% Discount
D2933	Refabricated stainless steel crown with resin window	$101	20% Discount
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$101	20% Discount
D2940	Protective restoration	$28	20% Discount

ADA CODE	PROCEDURE DESCRIPTION	GENERAL DENTIST IN-NETWORK MEMBER CO-PAY	PEDIATRIC SPECIALIST IN-NETWORK MEMBER CO-PAY OR DISCOUNT
D2950	Core buildup, including any pins when required	$68	20% Discount
D2951	Pin retention - per tooth, in addition to restoration	$16	20% Discount
D2952	Post and core in addition to crown, indirectly fabricated	$110	20% Discount
D2953	Each additional indirectly fabricated post - same tooth	$56	20% Discount
D2954	Prefabricated post and core in addition to crown	$89	20% Discount
D2957	Each additional prefabricated post - same tooth	$44	20% Discount
D2960	Labial veneer (resin laminate) - chairside	$210	20% Discount
D2961	Labial veneer (resin laminate) - laboratory	20% Discount	20% Discount
D2962	Labial veneer (porcelain laminate) - laboratory	20% Discount	20% Discount
D3110	Pulp cap - direct (excluding final restoration)	$22	20% Discount
D3220	Therapeutic pulpotomy (excluding final restoration)	$46	20% Discount
D3221	Pulpal debridement, primary and permanent teeth	$51	20% Discount
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$49	20% Discount
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$60	20% Discount
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$188	20% Discount
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$241	20% Discount
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$332	20% Discount
D3346	Retreatment of previous root canal therapy - anterior	$256	20% Discount
D3347	Retreatment of previous root canal therapy - premolar	$296	20% Discount
D3348	Retreatment of previous root canal therapy - molar	$365	20% Discount
D3351	Apexification/recalcification – initial visit	$105	20% Discount
D3352	Apexification/recalcification – interim medication replacement	$48	20% Discount
D3353	Apexification/recalcification - final visit	$146	20% Discount
D3410	Apicoectomy - anterior	20% Discount	20% Discount
D3421	Apicoectomy - premolar (first root)	20% Discount	20% Discount
D3425	Apicoectomy - molar (first root)	20% Discount	20% Discount
D3426	Apicoectomy (each additional root)	20% Discount	20% Discount
D3430	Retrograde filling - per root	20% Discount	20% Discount
D3450	Root amputation - per root	$136	20% Discount
D3920	Hemisection (including any root removal), not including root canal therapy	$103	20% Discount
D4210	Gingivectomy/gingivoplasty - 4+ contiguous teeth/tooth bounded spaces per quadrant	20% Discount	20% Discount
D4211	Gingivectomy/gingivoplasty - 1-3 contiguous teeth/tooth bounded spaces per quadrant	20% Discount	20% Discount
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	20% Discount	20% Discount
D4240	Gingival flap proc. Incl. root planing - 4+ contiguous teeth/tooth bounded spaces per quadrant	20% Discount	20% Discount
D4241	Gingival flap proc. Incl. root planing - 1-3 contiguous teeth/tooth bounded spaces per quadrant	20% Discount	20% Discount
D4249	Clinical crown lengthening – hard tissue	20% Discount	20% Discount
D4260	Osseous surgery – 4+ contiguous teeth/tooth bounded spaces per quadrant	20% Discount	20% Discount
D4261	Osseous surgery – 1-3 contiguous teeth/tooth bounded spaces per quadrant	20% Discount	20% Discount
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	20% Discount	20% Discount
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	20% Discount	20% Discount
D4266	Guided tissue regeneration - resorbable barrier, per site	20% Discount	20% Discount
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	20% Discount	20% Discount
D4270	Pedicle soft tissue graft procedure	20% Discount	20% Discount
D4273	Autogenous connective tissue graft procedure, first tooth	20% Discount	20% Discount
D4275	Non-autogenous connective tissue graft, first tooth	20% Discount	20% Discount
D4276	Combined connective tissue and double pedicle graft, per tooth	20% Discount	20% Discount
D4277	Free soft tissue graft procedure, first tooth	20% Discount	20% Discount
D4278	Free soft tissue graft procedure, each additional contiguous tooth	20% Discount	20% Discount
D4283	Autogenous connective tissue graft procedure – each additional contiguous tooth	20% Discount	20% Discount
D4285	Non-autogenous connective tissue graft procedure – each additional contiguous tooth	20% Discount	20% Discount
D4320	Provisional splinting - intracoronal	20% Discount	20% Discount
D4321	Provisional splinting - extracoronal	20% Discount	20% Discount
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$85	20% Discount
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$61	20% Discount
D4355	Full mouth debridement to enable a comp. oral evaluation and diagnosis on a subsequent visit	$70	20% Discount
D4381	Antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	20% Discount	20% Discount
D4910	Periodontal maintenance	$59	20% Discount
D5110	Complete denture - maxillary	$404	20% Discount
D5120	Complete denture - mandibular	$404	20% Discount
D5130	Immediate denture - maxillary	$439	20% Discount
D5140	Immediate denture - mandibular	$439	20% Discount
D5211	Maxillary partial denture – resin base	$392	20% Discount
D5212	Mandibular partial denture – resin base	$392	20% Discount
D5213	Maxillary partial denture - cast metal framework with resin denture bases	$445	20% Discount
D5214	Mandibular partial denture - cast metal framework with resin denture bases	$445	20% Discount
D5282	Removable unilateral partial denture – one piece cast metal, maxillary	20% Discount	20% Discount
D5283	Removable unilateral partial denture – one piece cast metal, mandibular	20% Discount	20% Discount
D5410	Adjust complete denture - maxillary	$22	20% Discount
D5411	Adjust complete denture - mandibular	$22	20% Discount
D5421	Adjust partial denture - maxillary	$22	20% Discount
D5422	Adjust partial denture - mandibular	$22	20% Discount
D5511	Repair broken complete denture base, mandibular	$44	20% Discount
D5512	Repair broken complete denture base, maxillary	$44	20% Discount
D5520	Replace missing or broken teeth - complete denture (each tooth)	$37	20% Discount
D5611	Repair resin partial denture base, mandibular	$48	20% Discount
D5612	Repair resin partial denture base, maxillary	$48	20% Discount
D5621	Repair cast partial framework, mandibular	$52	20% Discount
D5622	Repair cast partial framework, maxillary	$52	20% Discount
D5630	Repair or replace broken retentive clasping materials – per tooth	$62	20% Discount
D5640	Replace broken teeth - per tooth	$41	20% Discount
D5650	Add tooth to existing partial denture	$56	20% Discount
D5660	Add clasp to existing partial denture - per tooth	20% Discount	20% Discount
D5710	Rebase complete maxillary denture	20% Discount	20% Discount
D5711	Rebase complete mandibular denture	20% Discount	20% Discount
D5720	Rebase maxillary partial denture	20% Discount	20% Discount
D5721	Rebase mandibular partial denture	20% Discount	20% Discount
D5730	Reline complete maxillary denture (chairside)	$89	20% Discount
D5731	Reline complete mandibular denture (chairside)	$89	20% Discount
D5740	Reline maxillary partial denture (chairside)	$83	20% Discount
D5741	Reline mandibular partial denture (chairside)	$83	20% Discount
D5750	Reline complete maxillary denture (laboratory)	$118	20% Discount
D5751	Reline complete mandibular denture (laboratory)	$118	20% Discount
D5760	Reline maxillary partial denture (laboratory)	$116	20% Discount
D5761	Reline mandibular partial denture (laboratory)	$116	20% Discount
D5810	Interim complete denture (maxillary)	20% Discount	20% Discount
D5811	Interim complete denture (mandibular)	20% Discount	20% Discount
D5820	Interim partial denture (maxillary)	20% Discount	20% Discount
D5821	Interim partial denture (mandibular)	20% Discount	20% Discount
D5850	Tissue conditioning, maxillary	$38	20% Discount

ADA CODE	PROCEDURE DESCRIPTION	GENERAL DENTIST IN-NETWORK MEMBER CO-PAY	PEDIATRIC SPECIALIST IN-NETWORK MEMBER CO-PAY OR DISCOUNT
D5851	Tissue conditioning, mandibular	$38	20% Discount
D6010	Surgical placement of implant body: endosteal implant	20% Discount	20% Discount
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	20% Discount	20% Discount
D6040	Surgical placement: eposteal implant	20% Discount	20% Discount
D6050	Surgical placement: transosteal implant	20% Discount	20% Discount
D6055	Connecting bar – implant supported or abutment supported	20% Discount	20% Discount
D6056	Prefabricated abutment – includes modification and placement	20% Discount	20% Discount
D6057	Custom fabricated abutment – includes placement	20% Discount	20% Discount
D6058	Abutment supported porcelain/ceramic crown	20% Discount	20% Discount
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	20% Discount	20% Discount
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	20% Discount	20% Discount
D6061	Abutment supported porcelain fused to metal crown (noble metal)	20% Discount	20% Discount
D6062	Abutment supported cast metal crown (high noble metal)	20% Discount	20% Discount
D6063	Abutment supported cast metal crown (predominantly base metal)	20% Discount	20% Discount
D6064	Abutment supported cast metal crown (noble metal)	20% Discount	20% Discount
D6065	Implant supported porcelain/ceramic crown	20% Discount	20% Discount
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	20% Discount	20% Discount
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	20% Discount	20% Discount
D6068	Abutment supported retainer for porcelain/ceramic FPD	20% Discount	20% Discount
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	20% Discount	20% Discount
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	20% Discount	20% Discount
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	20% Discount	20% Discount
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	20% Discount	20% Discount
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	20% Discount	20% Discount
D6074	Abutment supported retainer for cast metal FPD (noble metal)	20% Discount	20% Discount
D6075	Implant supported retainer for ceramic FPD	20% Discount	20% Discount
D6076	Implant sup. retainer for porc. fused to metal FPD (titanium, titanium alloy, or high noble metal)	20% Discount	20% Discount
D6077	Implant sup. retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	20% Discount	20% Discount
D6080	Implant maintenance procedures when prostheses are removed and reinserted	20% Discount	20% Discount
D6082	Implant supported crown- porcelain fused to predominantly base alloys	20% Discount	20% Discount
D6083	Implant supported crown- porcelain fused to noble alloys	20% Discount	20% Discount
D6084	Implant supported crown- porcelain fused to titanium and titanium alloys	20% Discount	20% Discount
D6086	Implant supported crown- predominantly base alloys	20% Discount	20% Discount
D6087	Implant supported crown- noble alloys	20% Discount	20% Discount
D6088	Implant supported crown- titanium and titanium alloys	20% Discount	20% Discount
D6091	Repl. of semi-precision/precision attach. of implant/abutment sup. prosthesis, per attach.	20% Discount	20% Discount
D6092	Re-cement or re-bond implant/abutment supported crown	20% Discount	20% Discount
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	20% Discount	20% Discount
D6094	Abutment supported crown - (titanium)	20% Discount	20% Discount
D6097	Abutment supported crown- porcelain fused to titanium and titanium alloys	20% Discount	20% Discount
D6098	Implant supported retainer- porcelain fused to predominantly base alloys	20% Discount	20% Discount
D6099	Implant supported retainer for FPD- porcelain fused to noble alloys	20% Discount	20% Discount
D6100	Implant removal, by report	20% Discount	20% Discount
D6110	Implant /abutment supported removable denture for edentulous arch – maxillary	20% Discount	20% Discount
D6111	Implant /abutment supported removable denture for edentulous arch – mandibular	20% Discount	20% Discount
D6114	Implant /abutment supported fixed denture for edentulous arch – maxillary	20% Discount	20% Discount
D6115	Implant /abutment supported fixed denture for edentulous arch – mandibular	20% Discount	20% Discount
D6120	Implant supported retainer- porcelain fused to titanium and titanium alloys	20% Discount	20% Discount
D6121	Implant supported retainer for metal FPD- predominantly base alloys	20% Discount	20% Discount
D6122	Implant supported retainer for metal FPD- noble alloys	20% Discount	20% Discount
D6123	Implant supported retainer for metal FPD- titanium and titanium alloys	20% Discount	20% Discount
D6194	Abutment supported retainer crown for FPD (titanium)	20% Discount	20% Discount
D6195	Abutment supported retainer- porcelain fused to titanium and titanium alloys	20% Discount	20% Discount
D6205	Pontic - indirect resin based composite	$140	20% Discount
D6210	Pontic - cast high noble metal	$271	20% Discount
D6211	Pontic - cast predominantly base metal	$253	20% Discount
D6212	Pontic - cast noble metal	$264	20% Discount
D6240	Pontic - porcelain fused to high noble metal	$271	20% Discount
D6241	Pontic - porcelain fused to predominantly base metal	$257	20% Discount
D6242	Pontic - porcelain fused to noble metal	$275	20% Discount
D6243	Pontic- porcelain fused to titanium and titanium alloys	$275	20% Discount
D6245	Pontic - porcelain/ceramic	$290	20% Discount
D6250	Pontic - resin with high noble metal	$272	20% Discount
D6251	Pontic - resin with predominantly base metal	$246	20% Discount
D6252	Pontic - resin with noble metal	$255	20% Discount
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$224	20% Discount
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$222	20% Discount
D6610	Retainer onlay - cast high noble metal, two surfaces	$209	20% Discount
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$239	20% Discount
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$215	20% Discount
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$224	20% Discount
D6614	Retainer onlay - cast noble metal, two surfaces	$214	20% Discount
D6615	Retainer onlay - cast noble metal, three or more surfaces	$222	20% Discount
D6720	Retainer crown - resin with high noble metal	$284	20% Discount
D6721	Retainer crown - resin with predominantly base metal	$269	20% Discount
D6722	Retainer crown - resin with noble metal	$270	20% Discount
D6740	Retainer crown - porcelain/ceramic	$306	20% Discount
D6750	Retainer crown - porcelain fused to high noble metal	$297	20% Discount
D6751	Retainer crown - porcelain fused to predominantly base metal	$285	20% Discount
D6752	Retainer crown - porcelain fused to noble metal	$293	20% Discount
D6753	Retainer crown- porcelain fused to titanium and titanium alloys	$293	20% Discount
D6780	Retainer crown - 3/4 cast high noble metal	$269	20% Discount
D6781	Retainer crown - 3/4 cast predominantly base metal	$269	20% Discount
D6782	Retainer crown - 3/4 cast noble metal	$246	20% Discount
D6783	Retainer crown - 3/4 porcelain/ceramic	$277	20% Discount
D6784	Retainer crown ¾- titanium and titanium alloys	$269	20% Discount
D6790	Retainer crown - full cast high noble metal	$284	20% Discount
D6791	Retainer crown - full cast predominantly base metal	$273	20% Discount
D6792	Retainer crown - full cast noble metal	$275	20% Discount
D6930	Re-cement or re-bond fixed partial denture	$38	20% Discount
D7111	Extraction, coronal remnants – primary tooth	$25	20% Discount
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$35	20% Discount
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	$65	20% Discount
D7220	Removal of impacted tooth - soft tissue	$86	20% Discount
D7230	Removal of impacted tooth - partially bony	$115	20% Discount
D7240	Removal of impacted tooth - completely bony	$142	20% Discount
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$176	20% Discount
D7250	Removal of residual tooth roots (cutting procedure)	$74	20% Discount
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$130	20% Discount

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D7280	Exposure of an unerupted tooth	20% Discount	20% Discount
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	20% Discount	20% Discount
D7286	Incisional biopsy of oral tissue-soft	20% Discount	20% Discount
D7287	Exfoliative cytological sample collection	20% Discount	20% Discount
D7288	Brush biopsy - transepithelial sample collection	20% Discount	20% Discount
D7290	Surgical repositioning of teeth	20% Discount	20% Discount
D7310	Alveoloplasty in conjunction with extractions - 4+ teeth or tooth spaces, per quadrant	20% Discount	20% Discount
D7311	Alveoloplasty in conjunction with extractions - 1-3 teeth or tooth spaces, per quadrant	20% Discount	20% Discount
D7320	Alveoloplasty not in conjunction with extractions - 4+ teeth or tooth spaces, per quadrant	20% Discount	20% Discount
D7321	Alveoloplasty not in conjunction with extractions - 1-3 teeth or tooth spaces, per quadrant	20% Discount	20% Discount
D7471	Removal of lateral exostosis (maxilla or mandible)	$262	20% Discount
D7510	I & D of abscess - intraoral soft tissue	$79	20% Discount
D7511	I & D of abscess - intraoral soft tissue - complicated (incl. drainage of multiple fascial spaces)	$119	20% Discount
D7810-7899	TMJ Treatment	20% Discount	20% Discount
D7953	Bone replacement graft for ridge preservation - per site	$110	20% Discount
D7960	Frenulectomy - separate procedure not incidental to another procedure	$102	20% Discount
D7971	Excision of pericoronal gingiva	20% Discount	20% Discount
D8010-8680	Orthodontics	20% Discount	20% Discount
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$29	20% Discount
D9222	Deep sedation/general anesthesia – first 15 minutes	N/C	N/C
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	N/C	N/C
D9239	Intravenous moderate (conscious) sedation/analgesia- first 15 minutes	N/C	N/C
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	N/C	N/C
D9248	Non-intravenous conscious sedation	N/C	N/C
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$19	20% Discount
D9440	Office visit - after regularly scheduled hours	$37	20% Discount
D9944	Occlusal guard – hard appliance, full arch	$125	20% Discount
D9945	Occlusal guard – soft appliance, full arch	$122	20% Discount
D9946	Occlusal guard – hard appliance, partial arch	$92	20% Discount
D9951	Occlusal adjustment - limited	$32	20% Discount
D9972	External bleaching - per arch - performed in office	20% Discount	20% Discount
D9973	External bleaching - per tooth	20% Discount	20% Discount
D9995	Teledentistry – synchronous; real-time encounter	$0	$0

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NOTE 1: Any procedure not listed is available on a fee-for service basis. Also, the appropriate fee schedule and maximum allowable applies regardless of the plan type as well as whether a waiting period or annual maximum has been met.

NOTE 2: Maximum coverage is $150 per calendar year for anesthesia service. (Anesthesia benefits for co-insurance plans only).

SELF-FUNDED GROUPS - Groups that are self-funded govern their own unique fee schedules and benefits, which may vary from Dental Select's standard plan designs and can include fees not listed. Please contact Customer Care for any questions regarding self-funded groups or their fee schedules.

FREQUENCY & PLAN LIMITATIONS MAY APPLY. A member's ID card is not a guarantee of benefits; plans and eligibility are subject to change. We recommend contacting Customer Care at 800-999-9789 for eligibility and benefit details for all patients.

N/C = Not Covered

INVISALIGN - Discount does not apply to Invisalign.

DentalSelect

Claims Submission:
PO Box 851917 Richardson, TX 75085
Benefit & Claims Questions:
Phone 800-999-9789 Fax 888-673-5328
www.dentalselect.com

• Proprietary Information •

Dental Summary

DentalSelect

Summary of Benefits for:

Weber School District

	EPO Classic	
	Platinum Network	
PREVENTIVE	**Contracted Dentist**	**Non-Contracted Dentist**
Routine exams, cleanings (2 per year), topical fluoride, x-rays	**100%**	**No Benefit**
BASIC		
Composite fillings, extractions, oral surgery, space maintainers, sealants	**60%**	**No Benefit**
	No Waiting Period	
MAJOR		
Crowns, bridges, dentures, endodontics, periodontics	**40%**	**No Benefit**
	12 Month Waiting Period	
ORTHODONTICS		
All Members:	**20% Discount**	**No Benefit**
MAXIMUM BENEFIT		
Applies to Preventive, Basic and Major Services — *Benefit Period is:* Per Contract Year	**$1,000.00**	
DEDUCTIBLE		
Applies to Basic and Major Services — *Per Benefit Period*		
Per Person:	**$50.00**	**No Benefit**
Family Maximum:	**$150.00**	

The benefits illustrated are in summary form only. They should not be construed as complete in and of themselves. They are only for comparison and in the case of a discrepancy, the plan documents apply. Please refer to the Group Certificate Booklet for a complete description of benefits, limitations and exclusions.

Dental Summary

DentalSelect

Summary of Benefits for:

Weber School District

	PPO Classic Platinum Network	
PREVENTIVE *Routine exams, cleanings (2 per year), topical fluoride, x-rays*	**Contracted Dentist** **100%**	**Non-Contracted Dentist** **60% of Fee Schedule**
BASIC *Composite fillings, extractions, endodontics, periodontics, oral surgery, space maintainers, sealants*	**80%** **No Waiting Period**	**60% of Fee Schedule**
MAJOR *Crowns, bridges, dentures*	**50%** **12 Month Waiting Period**	**30% of Fee Schedule**
ORTHODONTICS *Children under 19* *Waiting Periods* *Lifetime Maximum* *All Members:*	**50%** **12 Month Waiting Period** **$1,000.00** **20% Discount**	**30%** **No Benefit**
MAXIMUM BENEFIT *Applies to Preventive, Basic and Major Services* *Benefit Period is:* *Per Contract Year*	**$1,500.00**	
DEDUCTIBLE *Applies to Basic and Major Services* *Per Benefit Period* *Per Person:* *Family Maximum:*	 **$0.00** **$0.00**	 **$0.00** **$0.00**

The benefits illustrated are in summary form only. They should not be construed as complete in and of themselves. They are only for comparison and in the case of a discrepancy, the plan documents apply. Please refer to the Group Certificate Booklet for a complete description of benefits, limitations and exclusions.

Voluntary Vision

Dental Select

Vision Summary

DentalSelect

Summary of Benefits For:
Weber School District

	Choice Vision 13	
	EyeMed Insight Network	
	In-Network (Member Cost)	Out-of-Network (Reimbursement)
Exam with Dilation as Necessary	Not Covered	Not Covered
Frames (Any available frame at provider location)	$0 Co-Pay; $70 Allowance; 20% off balance over $70	Up to $50
Standard Plastic Lenses:		
Single Vision	$20	Up to $25
Bifocal	$20	Up to $40
Trifocal	$20	Up to $55
Standard Progressive Lenses	$85	Up to $40
Premium Progressive Lens	Tier 1: $105 Tier 2: $115 Tier 3: $130 Tier 4: $85 Co-Pay, 80% of charge less $120 allowance	Up to $40
Lens Options:		
UV Coating	$10	$5
Tint (Solid and Gradient)	$15	N/A
Standard Scratch-Resistance	$10	$5
Standard Polycarbonate	$40	N/A
Standard Anti-Reflective	$45	N/A
Premium Anti-Reflective	Tier 1: $57 Tier 2: $68 Tier 3: 80% of charge	N/A
Polarized	20% off Retail Price	N/A
Photochromatic/Transitions Plastic	$75	N/A
Other Add-ons and Services	20% off Retail Price	N/A
Contact Lenses	Declining Balance Allowance	
Conventional	$0 Co-Pay; $70 allowance; 15% off balance over $70	Up to $50
Disposables	$0 Co-Pay; $70 allowance; member responsible for balance over $70	Up to $50
Medically Necessary	$0 Co-Pay; Paid in Full	Up to $200
Laser Correction (US Laser Network) ***Lasik or PRK***	15% off retail price -or- 5% off promotional price	Not Covered
Additional Pairs Benefit	Members also receive a 40% discount off complete pair of prescription eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency		
Frame	Once every 12 months	Once every 12 months
Lenses or Contact Lenses	Once every 12 months	Once every 12 months
Lasik or PRK fromUS Laser Network	Once per Lifetime	Once per Lifetime

The benefits illustrated are in summary form only. They should not be construed as complete in and of themselves. They are only for comparison and in the case of a discrepancy, the plan documents apply. Please refer to the Group Certificate Booklet for a complete description of benefits, limitations and exclusions.

Vision Summary

DentalSelect

Summary of Benefits For:
Weber School District

	Choice Vision 14	
	EyeMed Insight Network	
	In-Network (Member Cost)	Out-of-Network (Reimbursement)
Exam with Dilation as Necessary	Not Covered	Not Covered
Frames	$0 Co-Pay; $120 Allowance; 20% off balance over $120	Up to $80
(Any available frame at provider location)		
Standard Plastic Lenses:		
Single Vision	$10	Up to $25
Bifocal	$10	Up to $40
Trifocal	$10	Up to $55
Standard Progressive Lenses	$75	Up to $40
Premium Progressive Lens	Tier 1: $95 Tier 2: $105 Tier 3: $120 Tier 4: $75 Co-Pay, 80% of charge less $120 allowance	Up to $40
Lens Options:		
UV Coating	$10	$5
Tint (Solid and Gradient)	$15	N/A
Standard Scratch-Resistance	$10	$5
Standard Polycarbonate	$40	N/A
Standard Anti-Reflective	$45	N/A
Premium Anti-Reflective	Tier 1: $57 Tier 2: $68 Tier 3: 80% of charge	N/A
Polarized	20% off Retail Price	N/A
Photochromatic/Transitions (Adults)	$75	N/A
Other Add-ons and Services	20% off Retail Price	N/A
Contact Lenses	Declining Balance Allowance	
Conventional	$0 Co-Pay; $120 allowance; 15% off balance over $120	Up to $80
Disposables	$0 Co-Pay; $120 allowance; member responsible for balance over $120	Up to $80
Medically Necessary	$0 Co-Pay; Paid in Full	Up to $200
Laser Correction (US Laser Network)	15% off retail price -or- 5% off promotional price	Not Covered
Lasik or PRK		
Additional Pairs Benefit	Members also receive a 40% discount off complete pair of prescription eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency		
Frame	Once every 12 months	Once every 12 months
Lenses or Contact Lenses	Once every 12 months	Once every 12 months
Lasik or PRK fromUS Laser Network	Once per Lifetime	Once per Lifetime

The benefits illustrated are in summary form only. They should not be construed as complete in and of themselves. They are only for comparison and in the case of a discrepancy, the plan documents apply. Please refer to the Group Certificate Booklet for a complete description of benefits, limitations and exclusions.

Voluntary Vision

Opticare of Utah

Opticare Plan: 70B

Weber School District	In Network	Out-of-network
Eye Exam		
No Eye Examination Benefit		
Standard Plastic Lenses		
Single Vision	$20 Co-pay	♦$70 Allowance for lenses, options, and coatings
Bifocal (FT 28)	$20 Co-pay	
Trifocal (FT 7x28)	$20 Co-pay	
Lens Options		
Progressive *(Standard plastic no-line)*	$75 Co-pay	
Premium Progressive Options	$125 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 *A/R, edge polish, tints, mirrors, etc.*	Up to 25% Discount	
Frames		
*Allowance Based on Retail Pricing	$70 Allowance	♦$50 Allowance
Additional Eyewear		
****Additional Pairs of Glasses Throughout the Year**	Up to 50% Off Retail	
Contacts		
Contact benefits is in lieu Of lens and frame benefit.	$70 Allowance	♦$50 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

Opticare Plan: 120B

Weber School District	In Network	Out-of-network
Eye Exam		
No Eye Examination Benefit		
Standard Plastic Lenses		
Single Vision	$10 Co-pay	♦$85 Allowance for lenses, options, and coatings
Bifocal (FT 28)	$10 Co-pay	
Trifocal (FT 7x28)	$10 Co-pay	
Lens Options		
Progressive *(Standard plastic no-line)*	$50 Co-pay	
Premium Progressive Options	$100 Co-pay	
Ultra Premium Progressive Options	Up to 20% Discount	
Polycarbonate	25% Discount	
High Index	25% Discount	
Coatings		
Scratch Resistant Coating	$10 Co-pay	
Ultra Violet protection	$10 Co-pay	
Other Options *A/R, edge polish, tints, mirrors, etc.*	Up to 25% Discount	
Frames		
Allowance Based on Retail Pricing	*$120 Allowance	♦$80 Allowance
Additional Eyewear		
****Additional Pairs of Glasses Throughout the Year**	Up to 50% Off Retail	
Contacts		
Contact benefits is in lieu Of lens and frame benefit.	$120 Allowance	♦$80 Allowance
Additional contact purchases:	Retail	
***Conventional	Retail	
***Disposables		
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.*

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◆***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

Opticare of Utah

Why Opticare of Utah?

Eyes are the window to the entire body.

Americans typically visit the doctor only when they have a problem. But if you visit the doctor only when symptoms start showing, it may be too late. In fact, the five leading causes of death, as reported by the CDC, are nearly irreversible and incurable when diagnosed late:

- Heart Disease
- Cancer
- Cerebrovascular Diseases (Stroke)
- Diabetes
- Nephritis / Kidney Diseases including Lupus

Routine exams are relatively inexpensive and often covered by insurance, and an OD can catch diabetes, hypertension, high blood pressure, cerebrovascular disease, cancer, auto-immune diseases, and each one of these leading causes of death.

Why you should have vision insurance:

Visual disorders are the second most prevalent health problem in the country, affecting over 130M people.

- 2/3 of all adults have a vision disorder that can be treated simply by glasses.
- Age Related Macular Degeneration (AMD) and Glaucoma are sight threatening diseases that cause 2M people to go blind annually.
- 90% of computer users have a vision related disorder; treated or untreated, and computer vision syndrome can cause migraines, contrast sensitivity and dry eye syndrome.

Financial implications:

Patients without vision insurance pay substantially more per year than those that have a plan; or make due with incorrect or outdated prescriptions.

Other benefits:

- Most importantly we are LOCAL and here to support you whenever needed.
- Nationwide Network opticareofutah.com
- Discounts for additional glasses throughout the year once initial benefits have been used.
- Competitive prices—two year guarantee with new groups.
- Plan designs for Group & Individual
- Onsite Opticare representative to help with open enrollments, monthly Q & A's & Health Fairs.
- RICH LASIK discount at Standard Optical

For a provider near you visit **opticareofutah.com**

Standard Optical Where Good Vision is Always in Fashion. | America's Best Contacts & Eyeglasses | FirstLook Vision Network | Independent Optometry Network | Visionworks

Basic Life and AD&D/ Voluntary Life

LifeMap

LifeMap
Insurance for every step of life.

This summary is provided for your convenience only and is not intended to be inclusive of all policy provisions. Please see your certificate for complete details. If there is any discrepancy between this document and the master policy, master policy provisions will prevail.

Weber School District
Active Certified and Classified Employees Eligible for the Medical Plan

Life and Accidental Death & Dismemberment (AD&D) Employer Paid	
Basic Life Insurance	$30,000
Basic AD&D Insurance	$30,000
Age Reduction	If you are still working the required number of hours to be eligible for this insurance at age 65, your benefits will reduce according to the following scale. Benefits reduce to: — At age: 65% — 65 50% — 70
AD&D Schedule	If due to an accident you die, lose a limb, sight of an eye or become paralyzed, the following benefits are available. 100% of the Basic AD&D: Life; Both hands; Both feet; Sight of both eyes; One hand and one foot; One hand and sight of one eye; One foot and sight of one eye; Quadriplegia 75% of the Basic AD&D: Paraplegia; Triplegia 25% of the Basic AD&D: Thumb and Index finger; Uniplegia 50% of the Basic AD&D: One hand; One foot; Sight of one eye; Speech; Hemiplegia; Hearing
Seat Belt Benefit	If you die in an automobile accident and were wearing your seat belt, your beneficiary (ies) will collect an amount equal to the AD&D benefit to a maximum of $ 10,000 in addition to the Basic Life and Basic AD&D benefits described above.
Accelerated Benefit	You may collect part of your Basic Life insurance prior to death if you are diagnosed as terminally ill and have a life expectancy of less than 12 months. You may apply for up to 80% of the Basic Life insurance in force, to a $24,000 maximum. The remaining benefit you do not elect is payable to your beneficiary upon your death.
Total Disability	If you become totally disabled (as defined by the policy) prior to age 60 and are disabled for at least 6 consecutive months, your Basic Life insurance may be continued until you reach age 65 without further premium payment by either your employer or you. At age 65 coverage terminates, however you may continue coverage by applying for a conversion policy at that time.
Additional Benefits Included	Adaptive Home/Vehicle, AirBag, Child Education, Coma, Day Care, Exposure and Disappearance, Felonious Assault, Rehabilitation, Repatriation, Spouse Education.
Basic Life Insurance Exclusions	None
AD&D Insurance Exclusions	Benefits are not payable for losses due to suicide or attempted suicide, riot, war or act of war, military service, felony, voluntary use of a controlled substance.
Conversion	You may convert your Basic Life insurance to an individual policy if your coverage is terminated due to termination of employment or other loss of eligibility. You have 31 days from the earliest of, the date your employment terminates or other loss of eligibility to apply for the Conversion policy.

This summary is provided for your convenience only and is not intended to be inclusive of all policy provisions. Please see your certificate for complete details. If there is any discrepancy between this document and the master policy, master policy provisions will prevail.

*Must be under the age of 65 and retired under the employer's retirement plan.

Weber School District
*Retired Classified and Certified Employees

Life and Accidental Death & Dismemberment (AD&D) Employer Paid	
Basic Life Insurance	$30,000
Coverage Termination	Coverage terminates at age 65.
Basic Life Insurance Exclusions	None
Conversion	You may convert your Basic Life insurance to an individual policy if your coverage is terminated due to termination of employment or other loss of eligibility. You have 31 days from the earliest of, the date your employment terminates or other loss of eligibility to apply for the Conversion policy.

Dependent Life Employer Paid	
Dependent Life Benefits	$10,000 Spouse, $10,000 per Child
Eligible Dependents	Legal spouse and children to age 26. Please see certificate for definition of eligible dependent child.
Exclusions	None
Conversion	You may convert your Dependent Life insurance to an individual policy if your coverage is terminated due to termination of employment or other loss of eligibility. You have 31 days from the earliest of, the date your employment terminates or other loss of eligibility to apply for the Conversion policy.

This summary is provided for your convenience only and is not intended to be inclusive of all policy provisions. Please see your certificate for complete details. If there is any discrepancy between this document and the master policy, master policy provisions will prevail.

Weber School District

Voluntary Life Insurance (Payroll Deduction)

Eligibility	Active Employees and Board Members enrolled in the Basic Life plan, their spouses and eligible dependent children. Retirees are not eligible.
Amounts Available	• Employees may select from a minimum of $10,000 to $1,000,000 in $10,000 increments. • Spouses may select from a minimum of $5,000 to $250,000 in $5,000 increments. If both husband and wife work for Weber School District, the employee cannot enroll as a spouse. Spouses may enroll in the Voluntary Life plan even if the employee does not enroll. • Dependent Child(ren) coverage may be selected if the employee elects and is approved for coverage for him/herself. Coverage options are $5,000 or $10,000. Dependent children are eligible from birth to age 26.
Age Reduction	If you are still working the required number of hours to be eligible for this insurance at age 65, your benefits will reduce according to the following scale. Benefits reduce to: / At age: 65% / 65 50% / 70 35% / 75
Accelerated Benefit	You may collect part of your Voluntary Life insurance prior to death if you are diagnosed as terminally ill and have a life expectancy of less than 12 months. You may apply for up to 80% of the Voluntary Life insurance in force, to a $150,000 maximum. The remaining benefit you do not elect is payable to your beneficiary upon your death.
Underwriting and Effective Date	**Employee** - Employees may apply for up to $300,000 guarantee issue (no health statement "EOI" required) if applied for WITHIN 31 days of initial eligibility. Amounts of coverage over $300,000 applied for WITHIN 31 days of initial eligibility requires a health statement. **Spouse** – Spouses may apply for up to $50,000 guarantee issue (no health statement "EOI" required) if applied for WITHIN 31 days of initial eligibility. Amounts of coverage over $50,000 applied for WITHIN 31 days of initial eligibility requires a health statement. **Child(ren** – All amounts of coverage are guarantee issue (no health statement required) if coverage is applied for WITHIN 31 days of initial eligibility. All amounts of coverage applied for AFTER the initial 31 day eligibility period, including during annual enrollment periods, require a health statement to be submitted and approved by LifeMap Assurance Company. Any coverage requiring approval of a health statement is not effective until approved in writing by LifeMap Assurance Company. The effective date of approved coverage will be assigned by LifeMap Assurance Company. In some cases, we may request a Paramed Exam. If requested, the Paramed Exam will be at LifeMap Assurance Company's expense.
Total Disability	If you become totally disabled (as defined by the policy) prior to age 60 and are disabled for at least 6 consecutive months, your Voluntary Life insurance may be continued until you reach age 65 without further premium payment by either your employer or you.
Cost - Rates	**Employee and *Spouse Monthly Rate per $1,000 of Coverage** *Spouse's premium will be based on the employee's date of birth. **Age** / **Rate** / **Age** / **Rate** Under 34 / .06 / 55-59 / .37 35-39 / .08 / 60-64 / .44 40-44 / .10 / 65-69 / .72 45-49 / .16 / 70-74 / 1.35 50-54 / .22 / 75+ / 2.35 **Child(ren)** - $5,000 option - $ .78/family $10,000 option - $1.56/family
Exclusions	Benefits are not payable for losses due to suicide or attempted suicide during the first two years of coverage.
Conversion	You may convert your Voluntary Life insurance to an individual policy if your coverage is terminated due to termination of employment or other loss of eligibility. You have 31 days from the earliest of, the date your employment terminates or other loss of eligibility to apply for the Conversion policy.
Portability (Total Disability and Accelerated Benefits not available under the Portability provision)	Portability allows you and your covered dependents to continue your Voluntary Life insurance if your coverage ends, provided you are under age 65 and are not disabled. The rates charged will be the current Weber School District rates plus a billing fee. To elect coverage, please complete the Portability Application and return it with your premium check to LifeMap Assurance Company within 31 days from the date your group coverage ends. If elected, Portability coverage will end the earliest of when you reach age 65 or when this master policy terminates.

Weber School District

Voluntary Life Insurance

Monthly Payroll Deductions

Rates per $1000	$0.06	$0.08	$0.10	$0.16	$0.22	$0.37	$0.44	$0.72	$1.35	$2.35
Age	Under 35	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Benefit										
$ 5,000.00	$ 0.30	$ 0.40	$ 0.50	$ 0.80	$ 1.10	$ 1.85	$ 2.20	$ 3.60	$ 6.75	$ 11.75
$ 10,000.00	$ 0.60	$ 0.80	$ 1.00	$ 1.60	$ 2.20	$ 3.70	$ 4.40	$ 7.20	$ 13.50	$ 23.50
$ 15,000.00	$ 0.90	$ 1.20	$ 1.50	$ 2.40	$ 3.30	$ 5.55	$ 6.60	$ 10.80	$ 20.25	$ 35.25
$ 20,000.00	$ 1.20	$ 1.60	$ 2.00	$ 3.20	$ 4.40	$ 7.40	$ 8.80	$ 14.40	$ 27.00	$ 47.00
$ 25,000.00	$ 1.50	$ 2.00	$ 2.50	$ 4.00	$ 5.50	$ 9.25	$ 11.00	$ 18.00	$ 33.75	$ 58.75
$ 30,000.00	$ 1.80	$ 2.40	$ 3.00	$ 4.80	$ 6.60	$ 11.10	$ 13.20	$ 21.60	$ 40.50	$ 70.50
$ 35,000.00	$ 2.10	$ 2.80	$ 3.50	$ 5.60	$ 7.70	$ 12.95	$ 15.40	$ 25.20	$ 47.25	$ 82.25
$ 40,000.00	$ 2.40	$ 3.20	$ 4.00	$ 6.40	$ 8.80	$ 14.80	$ 17.60	$ 28.80	$ 54.00	$ 94.00
$ 45,000.00	$ 2.70	$ 3.60	$ 4.50	$ 7.20	$ 9.90	$ 16.65	$ 19.80	$ 32.40	$ 60.75	$ 105.75
$ 50,000.00	$ 3.00	$ 4.00	$ 5.00	$ 8.00	$ 11.00	$ 18.50	$ 22.00	$ 36.00	$ 67.50	$ 117.50
$ 55,000.00	$ 3.30	$ 4.40	$ 5.50	$ 8.80	$ 12.10	$ 20.35	$ 24.20	$ 39.60	$ 74.25	$ 129.25
$ 60,000.00	$ 3.60	$ 4.80	$ 6.00	$ 9.60	$ 13.20	$ 22.20	$ 26.40	$ 43.20	$ 81.00	$ 141.00
$ 65,000.00	$ 3.90	$ 5.20	$ 6.50	$ 10.40	$ 14.30	$ 24.05	$ 28.60	$ 46.80	$ 87.75	$ 152.75
$ 70,000.00	$ 4.20	$ 5.60	$ 7.00	$ 11.20	$ 15.40	$ 25.90	$ 30.80	$ 50.40	$ 94.50	$ 164.50
$ 75,000.00	$ 4.50	$ 6.00	$ 7.50	$ 12.00	$ 16.50	$ 27.75	$ 33.00	$ 54.00	$ 101.25	$ 176.25
$ 80,000.00	$ 4.80	$ 6.40	$ 8.00	$ 12.80	$ 17.60	$ 29.60	$ 35.20	$ 57.60	$ 108.00	$ 188.00
$ 85,000.00	$ 5.10	$ 6.80	$ 8.50	$ 13.60	$ 18.70	$ 31.45	$ 37.40	$ 61.20	$ 114.75	$ 199.75
$ 90,000.00	$ 5.40	$ 7.20	$ 9.00	$ 14.40	$ 19.80	$ 33.30	$ 39.60	$ 64.80	$ 121.50	$ 211.50
$ 95,000.00	$ 5.70	$ 7.60	$ 9.50	$ 15.20	$ 20.90	$ 35.15	$ 41.80	$ 68.40	$ 128.25	$ 223.25
$ 100,000.00	$ 6.00	$ 8.00	$ 10.00	$ 16.00	$ 22.00	$ 37.00	$ 44.00	$ 72.00	$ 135.00	$ 235.00
$ 105,000.00	$ 6.30	$ 8.40	$ 10.50	$ 16.80	$ 23.10	$ 38.85	$ 46.20	$ 75.60	$ 141.75	$ 246.75
$ 110,000.00	$ 6.60	$ 8.80	$ 11.00	$ 17.60	$ 24.20	$ 40.70	$ 48.40	$ 79.20	$ 148.50	$ 258.50
$ 115,000.00	$ 6.90	$ 9.20	$ 11.50	$ 18.40	$ 25.30	$ 42.55	$ 50.60	$ 82.80	$ 155.25	$ 270.25
$ 120,000.00	$ 7.20	$ 9.60	$ 12.00	$ 19.20	$ 26.40	$ 44.40	$ 52.80	$ 86.40	$ 162.00	$ 282.00
$ 125,000.00	$ 7.50	$ 10.00	$ 12.50	$ 20.00	$ 27.50	$ 46.25	$ 55.00	$ 90.00	$ 168.75	$ 293.75
$ 130,000.00	$ 7.80	$ 10.40	$ 13.00	$ 20.80	$ 28.60	$ 48.10	$ 57.20	$ 93.60	$ 175.50	$ 305.50
$ 135,000.00	$ 8.10	$ 10.80	$ 13.50	$ 21.60	$ 29.70	$ 49.95	$ 59.40	$ 97.20	$ 182.25	$ 317.25
$ 140,000.00	$ 8.40	$ 11.20	$ 14.00	$ 22.40	$ 30.80	$ 51.80	$ 61.60	$ 100.80	$ 189.00	$ 329.00
$ 145,000.00	$ 8.70	$ 11.60	$ 14.50	$ 23.20	$ 31.90	$ 53.65	$ 63.80	$ 104.40	$ 195.75	$ 340.75
$ 150,000.00	$ 9.00	$ 12.00	$ 15.00	$ 24.00	$ 33.00	$ 55.50	$ 66.00	$ 108.00	$ 202.50	$ 352.50
$ 155,000.00	$ 9.30	$ 12.40	$ 15.50	$ 24.80	$ 34.10	$ 57.35	$ 68.20	$ 111.60	$ 209.25	$ 364.25
$ 160,000.00	$ 9.60	$ 12.80	$ 16.00	$ 25.60	$ 35.20	$ 59.20	$ 70.40	$ 115.20	$ 216.00	$ 376.00
$ 165,000.00	$ 9.90	$ 13.20	$ 16.50	$ 26.40	$ 36.30	$ 61.05	$ 72.60	$ 118.80	$ 222.75	$ 387.75
$ 170,000.00	$ 10.20	$ 13.60	$ 17.00	$ 27.20	$ 37.40	$ 62.90	$ 74.80	$ 122.40	$ 229.50	$ 399.50
$ 175,000.00	$ 10.50	$ 14.00	$ 17.50	$ 28.00	$ 38.50	$ 64.75	$ 77.00	$ 126.00	$ 236.25	$ 411.25
$ 180,000.00	$ 10.80	$ 14.40	$ 18.00	$ 28.80	$ 39.60	$ 66.60	$ 79.20	$ 129.60	$ 243.00	$ 423.00
$ 185,000.00	$ 11.10	$ 14.80	$ 18.50	$ 29.60	$ 40.70	$ 68.45	$ 81.40	$ 133.20	$ 249.75	$ 434.75
$ 190,000.00	$ 11.40	$ 15.20	$ 19.00	$ 30.40	$ 41.80	$ 70.30	$ 83.60	$ 136.80	$ 256.50	$ 446.50
$ 195,000.00	$ 11.70	$ 15.60	$ 19.50	$ 31.20	$ 42.90	$ 72.15	$ 85.80	$ 140.40	$ 263.25	$ 458.25
$ 200,000.00	$ 12.00	$ 16.00	$ 20.00	$ 32.00	$ 44.00	$ 74.00	$ 88.00	$ 144.00	$ 270.00	$ 470.00
$ 205,000.00	$ 12.30	$ 16.40	$ 20.50	$ 32.80	$ 45.10	$ 75.85	$ 90.20	$ 147.60	$ 276.75	$ 481.75
$ 210,000.00	$ 12.60	$ 16.80	$ 21.00	$ 33.60	$ 46.20	$ 77.70	$ 92.40	$ 151.20	$ 283.50	$ 493.50
$ 215,000.00	$ 12.90	$ 17.20	$ 21.50	$ 34.40	$ 47.30	$ 79.55	$ 94.60	$ 154.80	$ 290.25	$ 505.25
$ 220,000.00	$ 13.20	$ 17.60	$ 22.00	$ 35.20	$ 48.40	$ 81.40	$ 96.80	$ 158.40	$ 297.00	$ 517.00
$ 225,000.00	$ 13.50	$ 18.00	$ 22.50	$ 36.00	$ 49.50	$ 83.25	$ 99.00	$ 162.00	$ 303.75	$ 528.75
$ 230,000.00	$ 13.80	$ 18.40	$ 23.00	$ 36.80	$ 50.60	$ 85.10	$ 101.20	$ 165.60	$ 310.50	$ 540.50
$ 235,000.00	$ 14.10	$ 18.80	$ 23.50	$ 37.60	$ 51.70	$ 86.95	$ 103.40	$ 169.20	$ 317.25	$ 552.25
$ 240,000.00	$ 14.40	$ 19.20	$ 24.00	$ 38.40	$ 52.80	$ 88.80	$ 105.60	$ 172.80	$ 324.00	$ 564.00
$ 245,000.00	$ 14.70	$ 19.60	$ 24.50	$ 39.20	$ 53.90	$ 90.65	$ 107.80	$ 176.40	$ 330.75	$ 575.75
$ 250,000.00	$ 15.00	$ 20.00	$ 25.00	$ 40.00	$ 55.00	$ 92.50	$ 110.00	$ 180.00	$ 337.50	$ 587.50
$ 260,000.00	$ 15.60	$ 20.80	$ 26.00	$ 41.60	$ 57.20	$ 96.20	$ 114.40	$ 187.20	$ 351.00	$ 611.00
$ 270,000.00	$ 16.20	$ 21.60	$ 27.00	$ 43.20	$ 59.40	$ 99.90	$ 118.80	$ 194.40	$ 364.50	$ 634.50
$ 280,000.00	$ 16.80	$ 22.40	$ 28.00	$ 44.80	$ 61.60	$ 103.60	$ 123.20	$ 201.60	$ 378.00	$ 658.00
$ 290,000.00	$ 17.40	$ 23.20	$ 29.00	$ 46.40	$ 63.80	$ 107.30	$ 127.60	$ 208.80	$ 391.50	$ 681.50

Dependent Child Rates: **$5,000 option - $.78 per month** **$10,000 option - $1.56 per month**

- Employees elect amounts between $10,000 and $1,000,000 in $10,000 increments.
- Spouses elect amounts between $5,000 and $250,000 in $5,000 increments.
- Spouse's premium will be based on the Employee's Date of Birth

Weber School District

Voluntary Life Insurance

Monthly Payroll Deductions Effective

Rates per $1000	$0.06	$0.08	$0.10	$0.16	$0.22	$0.37	$0.44	$0.72	$1.35	$2.35
Age	Under 35	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$ 300,000.00	$ 18.00	$ 24.00	$ 30.00	$ 48.00	$ 66.00	$ 111.00	$ 132.00	$ 216.00	$ 405.00	$ 705.00
$ 310,000.00	$ 18.60	$ 24.80	$ 31.00	$ 49.60	$ 68.20	$ 114.70	$ 136.40	$ 223.20	$ 418.50	$ 728.50
$ 320,000.00	$ 19.20	$ 25.60	$ 32.00	$ 51.20	$ 70.40	$ 118.40	$ 140.80	$ 230.40	$ 432.00	$ 752.00
$ 330,000.00	$ 19.80	$ 26.40	$ 33.00	$ 52.80	$ 72.60	$ 122.10	$ 145.20	$ 237.60	$ 445.50	$ 775.50
$ 340,000.00	$ 20.40	$ 27.20	$ 34.00	$ 54.40	$ 74.80	$ 125.80	$ 149.60	$ 244.80	$ 459.00	$ 799.00
$ 350,000.00	$ 21.00	$ 28.00	$ 35.00	$ 56.00	$ 77.00	$ 129.50	$ 154.00	$ 252.00	$ 472.50	$ 822.50
$ 360,000.00	$ 21.60	$ 28.80	$ 36.00	$ 57.60	$ 79.20	$ 133.20	$ 158.40	$ 259.20	$ 486.00	$ 846.00
$ 370,000.00	$ 22.20	$ 29.60	$ 37.00	$ 59.20	$ 81.40	$ 136.90	$ 162.80	$ 266.40	$ 499.50	$ 869.50
$ 380,000.00	$ 22.80	$ 30.40	$ 38.00	$ 60.80	$ 83.60	$ 140.60	$ 167.20	$ 273.60	$ 513.00	$ 893.00
$ 390,000.00	$ 23.40	$ 31.20	$ 39.00	$ 62.40	$ 85.80	$ 144.30	$ 171.60	$ 280.80	$ 526.50	$ 916.50
$ 400,000.00	$ 24.00	$ 32.00	$ 40.00	$ 64.00	$ 88.00	$ 148.00	$ 176.00	$ 288.00	$ 540.00	$ 940.00
$ 410,000.00	$ 24.60	$ 32.80	$ 41.00	$ 65.60	$ 90.20	$ 151.70	$ 180.40	$ 295.20	$ 553.50	$ 963.50
$ 420,000.00	$ 25.20	$ 33.60	$ 42.00	$ 67.20	$ 92.40	$ 155.40	$ 184.80	$ 302.40	$ 567.00	$ 987.00
$ 430,000.00	$ 25.80	$ 34.40	$ 43.00	$ 68.80	$ 94.60	$ 159.10	$ 189.20	$ 309.60	$ 580.50	$ 1,010.50
$ 440,000.00	$ 26.40	$ 35.20	$ 44.00	$ 70.40	$ 96.80	$ 162.80	$ 193.60	$ 316.80	$ 594.00	$ 1,034.00
$ 450,000.00	$ 27.00	$ 36.00	$ 45.00	$ 72.00	$ 99.00	$ 166.50	$ 198.00	$ 324.00	$ 607.50	$ 1,057.50
$ 460,000.00	$ 27.60	$ 36.80	$ 46.00	$ 73.60	$ 101.20	$ 170.20	$ 202.40	$ 331.20	$ 621.00	$ 1,081.00
$ 470,000.00	$ 28.20	$ 37.60	$ 47.00	$ 75.20	$ 103.40	$ 173.90	$ 206.80	$ 338.40	$ 634.50	$ 1,104.50
$ 480,000.00	$ 28.80	$ 38.40	$ 48.00	$ 76.80	$ 105.60	$ 177.60	$ 211.20	$ 345.60	$ 648.00	$ 1,128.00
$ 480,000.00	$ 28.80	$ 38.40	$ 48.00	$ 76.80	$ 105.60	$ 177.60	$ 211.20	$ 345.60	$ 648.00	$ 1,128.00
$ 490,000.00	$ 29.40	$ 39.20	$ 49.00	$ 78.40	$ 107.80	$ 181.30	$ 215.60	$ 352.80	$ 661.50	$ 1,151.50
$ 500,000.00	$ 30.00	$ 40.00	$ 50.00	$ 80.00	$ 110.00	$ 185.00	$ 220.00	$ 360.00	$ 675.00	$ 1,175.00
$ 510,000.00	$ 30.60	$ 40.80	$ 51.00	$ 81.60	$ 112.20	$ 188.70	$ 224.40	$ 367.20	$ 688.50	$ 1,198.50
$ 520,000.00	$ 31.20	$ 41.60	$ 52.00	$ 83.20	$ 114.40	$ 192.40	$ 228.80	$ 374.40	$ 702.00	$ 1,222.00
$ 530,000.00	$ 31.80	$ 42.40	$ 53.00	$ 84.80	$ 116.60	$ 196.10	$ 233.20	$ 381.60	$ 715.50	$ 1,245.50
$ 540,000.00	$ 32.40	$ 43.20	$ 54.00	$ 86.40	$ 118.80	$ 199.80	$ 237.60	$ 388.80	$ 729.00	$ 1,269.00
$ 550,000.00	$ 33.00	$ 44.00	$ 55.00	$ 88.00	$ 121.00	$ 203.50	$ 242.00	$ 396.00	$ 742.50	$ 1,292.50
$ 560,000.00	$ 33.60	$ 44.80	$ 56.00	$ 89.60	$ 123.20	$ 207.20	$ 246.40	$ 403.20	$ 756.00	$ 1,316.00
$ 570,000.00	$ 34.20	$ 45.60	$ 57.00	$ 91.20	$ 125.40	$ 210.90	$ 250.80	$ 410.40	$ 769.50	$ 1,339.50
$ 580,000.00	$ 34.80	$ 46.40	$ 58.00	$ 92.80	$ 127.60	$ 214.60	$ 255.20	$ 417.60	$ 783.00	$ 1,363.00
$ 590,000.00	$ 35.40	$ 47.20	$ 59.00	$ 94.40	$ 129.80	$ 218.30	$ 259.60	$ 424.80	$ 796.50	$ 1,386.50
$ 600,000.00	$ 36.00	$ 48.00	$ 60.00	$ 96.00	$ 132.00	$ 222.00	$ 264.00	$ 432.00	$ 810.00	$ 1,410.00
$ 650,000.00	$ 39.00	$ 52.00	$ 65.00	$ 104.00	$ 143.00	$ 240.50	$ 286.00	$ 468.00	$ 877.50	$ 1,527.50
$ 700,000.00	$ 42.00	$ 56.00	$ 70.00	$ 112.00	$ 154.00	$ 259.00	$ 308.00	$ 504.00	$ 945.00	$ 1,645.00
$ 750,000.00	$ 45.00	$ 60.00	$ 75.00	$ 120.00	$ 165.00	$ 277.50	$ 330.00	$ 540.00	$ 1,012.50	$ 1,762.50
$ 800,000.00	$ 48.00	$ 64.00	$ 80.00	$ 128.00	$ 176.00	$ 296.00	$ 352.00	$ 576.00	$ 1,080.00	$ 1,880.00
$ 850,000.00	$ 51.00	$ 68.00	$ 85.00	$ 136.00	$ 187.00	$ 314.50	$ 374.00	$ 612.00	$ 1,147.50	$ 1,997.50
$ 900,000.00	$ 54.00	$ 72.00	$ 90.00	$ 144.00	$ 198.00	$ 333.00	$ 396.00	$ 648.00	$ 1,215.00	$ 2,115.00
$ 950,000.00	$ 57.00	$ 76.00	$ 95.00	$ 152.00	$ 209.00	$ 351.50	$ 418.00	$ 684.00	$ 1,282.50	$ 2,232.50
$ 1,000,000.00	$ 60.00	$ 80.00	$ 100.00	$ 160.00	$ 220.00	$ 370.00	$ 440.00	$ 720.00	$ 1,350.00	$ 2,350.00

Dependent Child Rates: **$5,000 option - $.78 per month** **$10,000 option - $1.56 per month**

- Employees elect amounts between $10,000 and $1,000,000 in $10,000 increments.
- Spouses elect amounts between $5,000 and $250,000 in $5,000 increments.
- Spouse's premium will be based on the Employee's Date of Birth

Travel Assistance

LifeMap

TRAVEL ASSISTANCE PROGRAM

Gives you peace of mind, before, during and after travel.

So cruise the Caribbean with your family. Take that honeymoon in Italy. Or fly to Denmark for work. No matter your whereabouts, we're here to help.

LifeMap®
Insurance for every step of life.

AXA

Travel Assistance Program

Within the United States
1 (800) 230-5170
Outside the United States
+1 (630) 766-7772

TRAVEL ASSISTANCE PROGRAM

Travel is exciting, but there are so many details to consider when planning a trip. That's why your LifeMap Life Insurance includes the Travel Assistance program—so you'll have a team that can help keep you well and informed when traveling 100 or more miles away from home for up to 120 days. Think of it as your worldwide team of personal concierges.

HOW IT WORKS

LifeMap has partnered with AXA Assistance USA, Inc. to offer you and your loved ones the best in travel aid. Your no-cost Travel Assistance program includes help with travel and medical services.

1 Just pick up the phone

When traveling 100+ miles away from home—or outside the country—your AXA team is simply a call away.

2 Help 24/7

Whether traveling for business or pleasure, AXA has the professional staff and resources to provide you with around-the-clock support.

3 One for all (and all for one)

Immediate family members have access to the program when they travel, too. That means they can also receive emergency medical and travel assistance 24 hours a day—anywhere in the world.

WHAT TO EXPECT

As a worldwide leader in travel assistance, you'll get no less than the best from AXA—no matter what you need.

Pre-trip help

Be it help with an embassy, your passport, currency exchange or even the weather, you'll have someone to turn to 24/7.

Travel assistance

Need a translator or a legal referral while abroad? Whatever it is, your AXA team will get it done.

Medical Services

Call for doc referrals, replacement medications, medical record transfers or Critical Care Monitoring.

Repatriation

Should you need to come home for medical reasons, AXA will bring you back safely.

Travel assistance services are subject to specific terms, conditions and limitations. Please contact your employer for a full program description. For questions about the program, call 1 (800) 230-5170 or collect at +1 (630) 766-7772.

LifeMapCo.com

CALL AXA IF YOU REQUIRE:

- Medical and Dental Referrals
- Medical Evacuation or Repatriation
- Hospital Admission and Critical Care Monitoring
- Return of Mortal Remains
- Dispatch of Prescription Medication
- Lost Document and Luggage Assistance
- Emergency Cash and Bail Assistance
- General Travel Information

THIS IS NOT A MEDICAL INSURANCE CARD.
ALL SERVICES MUST BE AUTHORIZED AND PROVIDED BY AXA ASSISTANCE USA, INC. NO CLAIMS FOR REIMBURSEMENT WILL BE ACCEPTED

No claims for reimbursement for out-of-pocket expenses will be accepted. All additional costs are the responsibility of the member. Services must be authorized and arranged by AXA Assistance USA, Inc. designated personnel to be eligible for this program. Members subject to eligibility verification. Services will be provided as permitted under applicable law. Travel Assistance services are not insurance.

AXA Assistance USA, Inc. is an independent company and not a member of LifeMap Assurance Company®. Each organization is solely responsible for its own obligations.

LifeMap®
Insurance for every step of life.

Voluntary Long-Term Disability

Lincoln Financial Group

Lincoln Financial Group®
You're In Charge®

Group Long-Term Disability Insurance
Voluntary

SUMMARY OF BENEFITS

Sponsored by: **Weber School District**

All Full-Time Aides, Secretaries and Cooks
All Other Full-Time members working between 20-30 hours per week

Long-term disability is intended to protect your income for a long duration after you have depleted short-term disability or any sick leave your company may offer.

LTD Benefit				
	Monthly Benefit	**Maximum Benefit Duration**	**Own Occupation Period**	**Elimination Period**
Employee Paid Plan	66.67% of monthly salary up to $10,000 per month	Later of Age 65 or Social Security Normal Retirement Age	24 Months	120 Days
Pre-Existing Condition	You may not be eligible for benefits if you have received treatment for a condition within 3 months prior to your effective date under this policy until you have been covered under the policy for 12 months.			
Waiver of Premium	You will not be required to pay premium during any time of approved total or partial disability.			
Benefit Limitations	Mental Illness: 24 Months Substance Abuse: 24 Months Specified Illness: 24 Months			
Enrolling for Coverage				
Eligibility:	All employees in an eligible class. You are able to take advantage of this coverage now without a health examination. You may not be offered this opportunity again, or may be responsible for the cost of required examinations.			

Lincoln Financial Group®

Group Long-Term Disability Insurance

SUMMARY OF BENEFITS

Sponsored by: **Weber School District**

All Other Full-Time members working greater than 30 hours per week

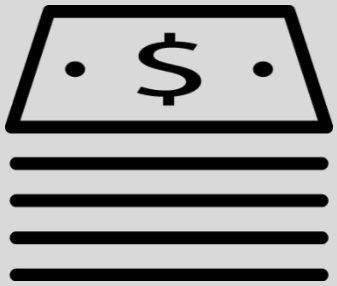
Long-term disability is intended to protect your income for a long duration after you have depleted short-term disability or any sick leave your company may offer.

LTD Benefit				
	Monthly Benefit	**Maximum Benefit Duration**	**Own Occupation Period**	**Elimination Period**
Employer Paid Plan	66.67% of monthly salary up to $10,000 per month	Later of Age 65 or Social Security Retirement Age	24 Months	120 Days
Pre-Existing Condition	You may not be eligible for benefits if you have received treatment for a condition within 3 months prior to your effective date under this policy until you have been covered under the policy for 12 months.			
Waiver of Premium	You will not be required to pay premium during any time of approved total or partial disability.			
Benefit Limitations	Mental Illness: 24 Months Substance Abuse: 24 Months Specified Illness: No Limit			

Enrolling for Coverage	
Eligibility:	All employees in an eligible class

Additional Benefits
Progressive Income Benefit, Family Care Expense Benefit, Survivor Income Benefit, EmployeeConnect - Employee Assistance Plan and Cost of Living Increase

See your Schedule of Benefits on your Certificate for more information



Premiums

Weber School District
2020 - 2021 Employee Premiums

MEDICAL

University of Utah WELLNESS Monthly Premiums		
Status	Healthy Preferred EPO Copay Plan (Traditional)	Healthy Premier PPO QHDHP
Single	$134.95	$98.01
Employee +1	$318.91	$235.42
Family	$483.39	$356.86

University of Utah NON - Wellness Monthly Premiums		
Status	Healthy Preferred EPO Copay Plan (Traditional)	Healthy Premier PPO QHDHP
Single	$151.61	$114.67
Employee +1	$335.58	$252.08
Family	$500.05	$373.53

SelectHealth WELLNESS Monthly Premiums		
Status	Select:Value	Select:Med+ *HealthSave*
Single	$134.95	$98.01
Employee +1	$318.91	$235.42
Family	$483.39	$356.86

SelectHealth NON - Wellness Monthly Premiums		
Status	Select:Value	Select:Med+ *HealthSave*
Single	$151.61	$114.67
Employee +1	$335.58	$252.08
Family	$500.05	$373.53

For more information regarding the wellness program, please contact Human Resources.

Weber School District - HSA Contributions		
Single : $743.00	Two-Party : $931.00	Family : $1,100.00

Lump sum will be provided mid October

DENTAL

Dental Select			
Status	Gold Co - Pay Plan	Platinum EPO Classic Plan	Platinum PPO Classic Plan
Single	$21.00	$25.00	$34.00
Employee +1	$42.00	$54.00	$64.00
Family	$65.00	$78.00	$119.00

VISION

Opticare Of Utah		
Status	70B	120B
Single	$2.71	$4.11
Employee +1	$5.31	$8.06
Family	$7.99	$12.12

EyeMed Network (Dental Select)	
Choice Vision 13	Choice Vision 14
$3.71	$6.48
$7.16	$12.55
$9.44	$16.46

Notes


GBS
A Leavitt Group Company