Benefits at Salt Lake County

2024 Contacts

Medical

SelectHealth
(801) 442-5038
www.selecthealth.org

PEHP
(801) 366-7555
www.pehp.org

Health Savings Account

Fidelity
(800) 544-3716
www.netbenefits.com

Dental

Cigna
(800) 244-6224
www.cigna.com

Vision

VSP
(800) 877-7195
www.vsp.com

Flexible Spending Accounts

ASI Flex
(800) 659-3035
www.asiflex.com

Life and AD&D, Disability

The Standard
(800) 628-8600
www.standard.com

Employee Assistance Program

VEST (previously Blunovus)
(385) 205-6789
www.blunovus.com

Legal

ARAG Legal Services
(800) 247-4184
www.araglegal.com

Voluntary Benefits

Review summaries and enroll for the following at slcounty.corestream.com. Call 888-935-9595 or contact customerservice@corestream.com with questions

Accident, Critical Illness, Hospital Indemnity

MetLife
(800) 438-6388
www.mybenefits.metlife.com

Auto & Home

Farmers Insurance
(800) 438-6381, Code A20
www.myautohome.farmers.com

Identity Theft Protection

Norton LifeLock
(800) 607-9174
www.my.Norton.com

Pet Insurance

Nationwide My Pet Protection
(877) 738-7874

Tuition Repayment Support

GradFin
(844) 472-3346

Benefits at Salt Lake County

2024 Contacts

Pension, Hybrid & 401(k)

URS
(801) 366-7700
www.urs.org

Onsite Clinic

HealthyMe Clinic
Government Center South Building 2-500
(385) 468-0555

Wellness Program

Healthy Lifestyles
(385) 468-4061
myhealthylifestyles@slco.org

Fitness Center

Government Center Fitness Center
(385) 468-1798

Benefits Team

(385) 468-0580
benefits@slco.org

Additional Open Enrollment & Claims Support

Allison Miner, GBS Account Manager
(801) 819-7793
allison.miner@gbsbenefits.com

Raquel Goodbeau, GBS Acct Support
(801) 819-7789
Raquel.Goodbeau@gbsbenefits.com

Mayors Finance – Payroll

Payroll Department
(385) 468-7070
MF-Payroll@slco.

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.

This guide is designed to highlight your benefit options so that you can make the best possible decisions for you and your family. Use this guide as a resource when enrolling for benefits during this Open Enrollment period. The choices you make will remain in effect during the plan year, unless you have a qualifying major life event.

This guide is intended as a help, but does not replace individual plan documents. Please refer to these and other carrier-provided materials for more information.

Table of Contents

Benefits Overview

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

- **Take advantage of the tools available to you.** That includes this guide, as well as your 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 because the wrong decision could be costly.
- **Don't miss the deadline and keep record of your enrollment!** Pay attention to the enrollment deadline and be sure to enter your benefit elections in PeopleSoft in a timely manner. It is important to review your paycheck to ensure the accuracy of payroll deductions. Notify Benefits immediately if there are any discrepancies.

Who Is Eligible?

Elected, Appointed, Time-Limited and Merit employees are eligible for benefits. If you are hired to regularly work 20 or more hours per week, coverage will begin on the first day you begin working at Salt Lake County. You may also enroll your eligible dependents in the same plans you choose for yourself.

Eligible dependents include your legal spouse, your adult designee and your natural, adopted or step-child(ren). The dependent age limit for children on your medical plan is age 26, but may vary for other benefits offered. Disabled children over age 26 may be eligible for continued health coverage upon approval by the carrier.

How do I Designate an Adult Designee?

Salt Lake County offers coverage to a non-spouse or adult designee. An adult designee can be your significant other to whom you are not married or a family member with whom you share a relationship. To qualify, both parties must:

- Be unmarried and over age 18 (a child must be over the age of 26 and not disabled)
- Share a permanent residence for at least 12-months
- Provide IRS acceptance of the relationship status or proof of common financial obligations

If you meet the criteria, you must complete an adult designee affidavit and supply the required financial documentation within 31 days. Contact Benefits for more information.

The IRS taxes an "imputed income" for this benefit, which will increase your taxable income for the year. The cost of including your adult designee will be added to your gross earnings and be subject to income tax.

Benefits Overview

When Do I Enroll?

You can enroll for coverage within 31 days of your date of hire, or during the annual open enrollment period. Outside of your open enrollment period, if you experience a life event such as marriage, birth, death or divorce you can change your coverage within the 30 days following that qualifying event.

Making Changes During The Year

The IRS provides strict regulations about the changes to pre-tax elections during the plan year. Once you enroll in benefits, you will not be able to make any changes to your elections until the 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
- Change in number of dependents
- A dependent no longer meets the eligibility requirements
- You and/or your dependent becomes eligible or loses eligibility for Medicare, Medicaid or the Children's Health Insurance Program (CHIP)
- Employee or dependents change in employment status resulting in loss or gain of eligibility for employer sponsored benefits
- A court or administrative order

It is your responsibility to notify the Benefits Department within 30 days after a qualified life event. Any benefit changes must be directly related to the qualified life event.

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 with Salt Lake County ends

Your dependent(s) coverage ends:

- When your coverage ends, or
- The last day of the month in which the dependent is no longer eligible

Health Care Reform and You

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

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 and Uniform Glossary annually during open enrollment. Please contact Benefits should you need an additional copy.

Open Enrollment Overview

Open Enrollment provides an annual opportunity to make changes or additions to your benefits package for the upcoming year. Following are important change occurring for 2024 and tasks you will need to complete.

When Is Open Enrollment?

Open Enrollment will begin on October 30 and run through midnight on November 17, 2023. All changes made during this time will take effect on January 1, 2024.

What's Changed for 2024?

Life & Disability Insurance
Salt Lake County is happy to announce changes to the life and disability plans. Starting January 1, these enhanced benefits will be administered by The Standard.

New Life Insurance Limits
Under the Standard, Guarantee Issue limits for voluntary life insurance have increased. Employees may now elect up to $300,000 in coverage without a health questionnaire. Because the Standard is offering a true Open Enrollment, you can enroll or add coverage for 2024 as if you were a new employee. New requests above $300,000 or spouse requests above $50,000 will require a health questionnaire which can be completed online.

Grandfathered Coverage
The Standard will grandfather coverage amounts in place as of December 31, 2023. If you have coverage above the guaranteed amount, you will not need to be approved again. New or increased coverage will be subject to underwriting.

Update Your Beneficiary
Unlike previous years, life insurance elections will be made in PeopleSoft. It is very important that you log in to enter your beneficiary information.

Enhanced Disability
Short- and Long-Term Disability insurances will both see enhancements as well. Short-Term Disability benefits will now pay out up to $3,000 weekly and participants may use sick and vacation time to supplement the plans income replacement of 66.67%.

Similarly, Long-Term Disability will now replace 60% of pre-disability income up to $15,000 monthly.

Increased HSA Contribution Limits
The HSA contribution for self-only High Deductible health coverage has risen to $4,150. If you are enrolled in HDHP family coverage, you will be able to add $8,300 to your HSA in 2024. If you are age 55 or older, the option to add an additional $1000 "catch-up" contribution remains unchanged.

Medical Premiums
The medical plan has incurred a funding increase for 2024 which has impacted the monthly premium rates for all plans and tiers.

Open Enrollment Overview

If you are a full-time employee (30+ hours) on the HDHP plan, the County will continue to pay your premiums in full. HDHP premiums for part-time employees (20-29 hours) and PPO plan premiums for all employees have been adjusted to reflect the increase, however the County will continue to subsidize the total costs at the same percentage paid on your behalf in 2023.

What Do I Need to Do?

- Review the 2024 Open Enrollment materials and attend a Benefits Fair. This is a great opportunity to ask questions and 'shop' for coverage.
- Review your elections in PeopleSoft. Many of your elections will carry over from 2023. Take a moment to make sure you are in the plans that best align with your needs for 2024.
- Enroll in the Health or Dependent Care FSA. Your elections in these plans will not roll over and no changes can be made after January 1, without you first experiencing a life event.
- Validate your HSA election and take advantage of increased limits. To ensure you receive the County contribution from January 1, make sure you have an election of $0 or more. Waived coverage will not receive the County's full contribution of $600 or $1200.
- Update your dependent data. Required 1095-C filings require your dependent's name and SSN. Use this time to make sure PeopleSoft matches the name and number on your dependent's cards.
- Attach beneficiaries to your life insurance elections. Anyone can be named a beneficiary so long as their personal information is saved in PeopleSoft. Naming a beneficiary ensures that your benefits go to the person of your choosing.
- Make and save all changes before midnight on November 17, 2023. Access to the Open Enrollment window will be removed after this time.

Medical

PEHP and SelectHealth

Salt Lake County offers two medical plan administrators, SelectHealth, which provides access to the IHC network, and PEHP, which predominately uses the University of Utah, Steward Health and Mountain Star networks. Each carrier offers two types of plans, a Traditional PPO or High Deductible qualified to use with a Health Savings Account (HSA). Coverage is mirrored between the PPO and HDHP plans.

How Do I Choose A Plan?

Most members will first select between the PPO and HDHP options, then look to see which carrier offers the greater access to the hospitals and physicians they prefer to see. Members may pay additional out of pocket costs when seeking care outside their chosen network.

A PPO will have a lower deductible, but charge a higher premium.

A HDHP will have a lower monthly premium, but a higher deductible. If you are enrolled in the HDHP you can contribute to a HSA to cover these extra costs. HSA contributions reduce your taxable income, saving you money, and County participants receive an annual employer contribution of $600/Single or $1200/Family as well.

Who May I Cover?

You may cover yourself, your spouse or AD, and dependent children to age 26. Disabled, dependent children may be covered after age 26 with approval from the carrier. Contact Benefits for details.

What Will I Pay?

The county pays the entire premium if you enroll in the HDHP plan and a significant portion of the Traditional plan's premium.

Benefit-eligible employees scheduled 20-29 hours will pay as shown below.

Biweekly Employees 30+ Hours

Coverage	PPO Plan	HDHP Plan
Employee Only	$67.21	$0
Employee + One	$147.63	$0
Employee + Family	$198.89	$0

Biweekly Employees 20-29+ Hours

Coverage	PPO Plan	HDHP Plan
Employee Only	$134.31	$85.85
Employee + One	$295.38	$246.92
Employee + Family	$397.85	$246.92

Health Savings Account

Fidelity

A Health Savings Account (HSA) paired with our qualified high deductible health plan helps you and your family plan, save and pay for qualified health care expenses. An HSA empowers you to build savings for health care expenses in a tax advantaged account.

Advantages of Health Savings Accounts

A Health Savings Account (HSA) is a tax advantaged savings account that you own and control. Here are some of the benefits:

- Funds roll over from year-to-year and never expire
- Portable when you move jobs or retire
- Triple tax advantage: you won't pay taxes on contributions, distributions, or earnings
- Able to invest your funds to grow your money tax-free
- Contribution elections can be changed mid-year without a life

Who Is Eligible?

You must be enrolled in our qualified high deductible health plan 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 an HSA?

Each year the IRS establishes the maximum contribution limit. The chart below represents the limits for 2024. 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

2024 Health Savings Account Limits

Coverage	2023 Limit	2024 Limit
Single	$3,850	$4,150
Family	$7,750	$8,300
Catch Up (Age 55+)	$1,000	$1,000

What Is A Qualified Expense?

You can use money in your HSA to pay for any qualified health care expenses for you, your spouse and your tax dependents, even if they are not covered on your plan.

Health Savings Account

Fidelity

Examples of qualified health care expenses include: your insurance plan deductibles, copayments, and coinsurance; doctor's office visits; prescriptions; dental treatments and x-rays; and eyeglasses and vision exams 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.

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.

NEW

Canadian Prescription Savings Program

GBS Rx Advantage

What is Volunteer Prescription Savings Program?

The Volunteer Savings Program allows the employer and members to save between 30% to 50% off brand-name medications through mail-order shipping from Canadian pharmacy partners through GBS Rx Advantage. While this program is not mandatory, every effort is being made to help reduce prescription costs.

Is there a copay for prescriptions filled through your company?

There are no copays charged to participants. The high program savings allows the employer to offer the program at no charge to members.

How do I enroll in the Volunteer Prescription Savings Program?

You will receive an email from Benefits introducing the program which will include information from GBS Rx Advantage. You may also receive an email from GBS Rx Advantage with an intake form to be completed.

What medications are included in the program?

Brand-name oral medications as well as a few select brand-injectables, brand-antidiabetic meds and brand-inhalers. Controlled substances are not eligible for this program. If you are on one of the High Deductible Health Plans (HDHP), restrictions may apply.

Common Medications

This is not an all-inclusive list. Please inquire about other brand-name medications with GBS Rx Advantage by calling 801-819-7853 or emailing holly.green@gbsbenefits.com.

- Anoro Ellipta
- Biktarvy
- Bydureon
- Eliquis
- Entresto
- Incruse Ellipta
- Januvia
- Jardiance 10mg
- Latuda
- Lialda
- Serevent Diskus
- Spiriva
- Tradjenta
- Trintellix
- Triumeq
- Trulicity
- Victoza
- Xarelto
- Xigduo
- Xiidras

GBS Rx Advantage

Prescription Savings

Strategies to Save

The average American spends about $1,200 each year on prescription drugs. And with drug prices on the rise, 1 in 4 Americans are paying more today than they were a year ago. Consider the following ways to help lower your bills for pills:

- Go generic or ask your doctor or pharmacist if there's a similar drug with a generic version.
- Compare prices by using an app, like GoodRx, to find the least expensive option. Call pharmacies as well.
- Order a 90-day supply and look into a mail-order program.
- Sign up for a drugstore or chain store reward program to receive coupons and accumulate points.
- Use a preferred pharmacy in your network.

If you have prescription drug questions, talk to your pharmacist for additional cost-cutting tips and guidance.

GoodRx

Stop paying too much for your prescriptions! With the GoodRx 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, 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.

1. On the web:
   https://www.goodrx.com/
   Instantly look up current drug prices at CVS, Walgreens, Walmart, Costco, and other local pharmacies.
2. On your phone: Available in the App Store or Google Play. Or, simply visit m.goodrx.com from your phone.

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.

Dental

Cigna

Cigna Dental PPO offers a national network and competitive discounts. Your DPPO allows you to see any licensed dentist, but using an in-network provider will ensure you minimize your out-of-pocket expenses.

How Does the Plan Work?

Your reimbursement levels and annual maximum benefit will be determined by whether your dentist participates with Cigna, and in which network. Eligible services will be covered no matter where you go, but you will receive the greatest annual benefit and pay the lowest out-of-pocket costs by using a Cigna PPO Advantage provider.

Log in to my.cigna.com to search out participating providers, view claims, access your digital ID card and more.

Who May I Cover?

You may cover yourself, your spouse or AD, and dependent children to age 26. Disabled, dependent children may be covered after age 26 with approval from the carrier. Contact Benefits for details.

What Will I Pay?

The county pays the entire premium if you enroll in the HDHP plan and a significant portion of the Traditional plan's premium.

Benefit-eligible employees scheduled 20-29 hours will pay as shown below.

Biweekly Employees 30+ Hours

Coverage	Biweekly Rate
Employee Only	$5.27
Employee + One	$6.74
Employee + Family	$10.15

Biweekly Employees 20-29+ Hours

Coverage	Biweekly Rate
Employee Only	$10.53
Employee + One	$13.48
Employee + Family	$20.31

Vision

VSP Vision Care

Vision insurance provides coverage for eye exams and eyewear costs not included in your medical benefits. This voluntary coverage provides access to thousands of private practice doctors and retail locations nationwide. Your VSP benefits include eye exams and annual spending allowances for eyewear.

What Services are Covered?

You'll get great care from a VSP network doctor, including a comprehensive eye exam. This exam not only helps you see well but helps a doctor detect signs of eye conditions and health conditions like diabetes or high blood pressure.

Members also receive an annual allowance to apply toward the purchase of prescription glasses or contacts. The plan also provides extra savings for the purchase of additional glasses or sunglasses, or services such as laser vision correction.

Using Your Benefit is Easy

Create an account on vsp.com to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. No member card is needed; at your appointment just tell them you have VSP.

Biweekly Rates Advantage Plan - Enhanced	
Employee Only	$3.58
Employee + One	$7.43
Employee + Two or more	$11.51

Flexible Spending Account

ASI Flex

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

How It Works

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

Things to Consider

- Be conservative when estimating your annual election amount. The IRS has a strict use it or lose it" rule. You will forfeit any funds left in your account after the end of the plan year.
- Your 2024 contributions must be used for expenses you incur January 1, 2024-December 31, 2024.
- The health care and dependent care FSAs are two separate accounts and funds cannot be transferred between accounts.
- You cannot stop or change your FSA contribution amount during the year unless you have a qualified change in family status.
- Expenses reimbursed through an FSA cannot be used as a deduction or credit on your federal income taxes.

FSA Reimbursement Options

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

Maximum Plan Year Contribution	**Medical Care** Up to $3,200	**Limited Purpose** Up to $3,200	**Dependent Care** Up to $5,000 ($2,500 if married filing separately)
Eligible Uses	Deductibles and copays for Medical, Dental, Vision or Rx	Dental and Vision Expenses Only	Cost of childcare for dependents under 13 so you and your spouse can work

Basic Life and AD&D

The Standard

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

Basic Life Insurance and Accidental Death and Dismemberment (AD&D)

Salt Lake County provides all eligible employees with a basic group life insurance and accidental death and dismemberment coverage at no cost to you. Public safety officers who die or are dismembered in an accident while acting in the line of duty may receive an additional benefit. You may continue the basic life or AD&D benefits if you leave the County by exercising the plan's portability or conversion options.

Plan Features:

Life Benefit Amount: $50,000
AD&D Benefit Amount: $50,000
Line of Duty: $50,000

Age Reductions:
Reduces to $25,000 at age 71; $12,550 at age 76

Additional Plan Services

You also receive the following benefits at no additional cost:

Life Services Toolkit
The Life Services Toolkit helps you or your beneficiaries cope with grief and loss, get answers to legal questions, plan a memorial or a funeral, and address financial concerns. It also gives you access to online will preparation and other estate planning documents.

AD&D Occupational Assistance
The AD&D Occupational Assistance service provides access to a Workplace Possibilities (SM) Consultant who helps you return to productive work and life following a specified accidental dismemberment.

Travel Assistance
Travel Assistance provides you with assistance for pre-trip planning, medical assistance services, emergency transportation services, travel and technical assistance services and legal referral.

Voluntary Life and AD&D

The Standard

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

Coverage	Election Increments	Maximum Benefit	Guaranteed Issue
Employee Benefit	$25,000	$500,000	$300,000
Spouse Benefit	$25,000	$500,000	$50,000
Child Benefit	$5,000	$15,000	$15,000

Coverage	Election Increments	Minimum Benefit	Maximum Benefit
Employee AD&D	$25,000	$25,000	$250,000
Family AD&D	$25,000	$25,000	$250,000

Employee & Spouse Age	Rate per $1,000
<25	$0.050
25-29	$0.060
30-34	$0.080
35-39	$0.090
40-44	$0.100
45-49	$0.150
50-54	$0.230
55-59	$0.430
60-64	$0.660
65-69	$1.270
70+	$2.060

Child Rate per $5,000

$0.48

Note: The premium is based on the cost for one child regardless of how many children covered.

Employee AD&D Rate per $1,000 of Coverage

$0.02

Employee and Family AD&E Rate per $1,000 of Coverage

$0.03

Short Term Disability

The Standard

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

Short-term Disability

Short-term disability provides a source of income should your qualified disability keep you from working for more than a week.

Definition of Disability

The definition of disability is used to determine an employee's eligibility for benefits. An individual's physical or mental inability to perform the major duties of his/her occupation because of illness or injury

Plan Features	Short Term Disability
Benefit Amount	**66.67% of weekly salary**
Maximum Benefit	**$3,000 weekly**
Benefit Waiting Period	**14 Days**
Maximum Benefit Duration	**11 weeks**

Use of Accrued Sick and Vacation

You may use your accrued sick or vacation time to compensate your benefit waiting period. Once benefits begin, you may use accrued hours to make up the difference between your disability payment and the pay you would receive for working your regular shift. This County pay will also be used to collect premiums for your other benefits (medical, etc.).

Scheduled Hours	Accrued hours you may claim
40	13
30	10
25	8
20	7

Short Term Disability

The Standard

Premium Rates

Employee Age	Monthly Rate
<35	$0.0192
35 - 49	$0.0203
50 - 59	$0.0326
60+	$0.0484

How To Calculate Premium

1. Divide you annual earnings by 52 = weekly earnings
2. Multiply your weekly earnings by .6667 = weekly benefit
3. Multiply your weekly benefit by your age-banded monthly rate = monthly premium
4. Multiply your monthly premium by 12 then divide by 26 = biweekly payroll deduction

Premium Worksheet

A. Annual Salary	B. Weekly Salary (Box A / 52)	C. Weekly Benefit (Box B x .6667	D. Monthly Rate (Box C x Rate)	E. Biweekly Deduction (Box D x 12 / 26)

Long Term Disability

The Standard

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

Employer Paid Long-term Disability

Long-term disability provides an ongoing source of income if your disability is prolonged.

Definition of Disability

The definition of disability is used to determine an employee's eligibility for benefits. An individual's physical or mental inability to perform the major duties of his/her occupation because of illness or injury

Plan Features	Short Term Disability
Benefit Amount	**60% of monthly salary**
Maximum Benefit	**$15,000 monthly**
Benefit Waiting Period	**90 days**
Maximum Benefit Duration	**2 years own occupation or Social Security Normal Retirement Age**

Employee Assistance Program

VEST (formerly Blunovus)

VEST's services are designed to care for the mental health and wellbeing of you and your family. VEST provides service in two ways -- through in-the-moment support and traditional counseling.

In-the-Moment Situation Support

VEST provides a 24/7/365 support through their Care Center. The CARE Center is an anonymous and unlimited resource to provide in-the-moment support with whatever is happening in your life. Whether you need referrals for services or just someone to talk to, a Care Connector will be there offering a listening ear and tools to help you cope.

EAP Support

The second service provided by VEST is EAP support. Whether you need short-term counseling or a financial or legal consultation, the EAP will connect you with a local provider – using your responses about preferences or needs to find the best possible fit. As with the CARE Center conversations, all EAP services are confidential and free.

Additional Services

In addition to coaching and counseling, VEST provides access to a wide variety of expert courses on demand through their website, monthly webinars and other activities. Members can also sign up to receive weekly tips and wellness tips sent out by Hope, while Norm shares weekly helps for supervisors and managers.

Get Connected!

Get started by downloading the free VEST app from the Apple or Android store or by using the QR code below.

- Use the code "SL County" to register,
- Select "Text" or "Talk" to reach a Care Connector.

You can also reach VEST by calling: 385-205-6789

Legal

ARAG Legal Insurance

Life is full of events that have a legal element. For many, legal insurance provides peace of mind knowing an attorney's help is within easy reach. With ARAG legal insurance your attorney fees are 100% paid for a variety of covered legal matters.

What Services are Covered?

ARAG covers a broad range of coverage and services such as:

- Wills and estate planning
- Real estate and home ownership
- Traffic tickets and license suspension
- Landlord disputes
- Family law matters
- Small claims court
- Consumer fraud
- Personal property disputes
- Divorce
- Bankruptcy
- And more...

For a full list of services visit ARAGlegal.com/myinfo and enter access code 18702slc

How Does Legal Insurance Work?

Members pay a biweekly premium for access to ARAG's national network of 14,000+ attorneys who average 20 years of experience. Your attorney fees are paid in full for most covered legal matters when you work with a network attorney. For non-covered services not excluded by the plan, you may receive at least 25% off the network attorney's normal rate.

Identity Theft Protection

Additionally, members who enroll in the Ultimate Advisor Plus program receive protection to guard against identity theft - including tracking changes to your credit file, and providing full-service restoration service if your ID is stolen.

Biweekly Rates	
Ultimate Advisor	$8.42
Ultimate Advisor Plus	$10.15

Voluntary Benefits

Powered by Corestream

Your unique insurance needs may extend beyond your core benefits. Through our voluntary benefits offerings you can meet the need for Auto to Accident insurance while enjoying discounts and the convenience of payroll deduction.

How Do I Enroll?

Enrollments for the voluntary services listed below are made through the Corestream system. This system will be available to you through the Open Enrollment period.

Where Can I Learn More?

For a full list of services visit slcountyvoluntarybenefits.com or use the QR code below:

A variety of options to meet your unique needs.

Accident Insurance	There are things that may lead to an accident and out-of-pocket expenses. Get protected.
Auto & Home Insurance	Cover your car, boat, motorcycle, home & more.
Critical Illness Insurance	Gain the power to make treatment decisions when you experience a heart attack, cancer or stroke.
Discount Shopping	Shop the brands you love with exclusive discounts you can't get anywhere else.
Hospital Indemnity Insurance	Achieve peace of mind with coverage to help ease your financial responsibility while you recover.
Identity Theft Protection	Protect your financial and social wellness from identity thieves.
Pet Health Insurance	Give more to your furbabies. Save on vet expenses for accidents, illnesses and more, nationwide.
Purchase Financing	Buy a variety of products such as computers, cameras, and furniture via payroll deduction.
Student Loan Refinancing	Find the perfect plan whether you need a new loan, refinance or loan forgiveness.

Healthy Lifestyles

Employee Wellness Program

Purpose

As part of SLCo Health Department, Healthy Lifestyles Employee Wellness Program rewards you for investing in your health. Our mission is to create a culture of holistic wellness for employees and their spouses/adult designees to achieve their personal health goals. We use evidence-based practices to educate and encourage participants to engage in sustainable healthy lifestyle behaviors to enhance their well-being. To register for Healthy Lifestyles, email **myhealthylifestyles@slco.org** and start earning points towards incentives for engaging in Healthy Lifestyles wellness activities and programs.

Incentives

IAll SLCo employees and their spouse/adult designee can participate in the Healthy Lifestyles program and earn prizes. SLCo employees and their spouse/adult designee who are eligible for benefits are qualified to earn up to a $250 Healthy Lifestyles cash rebate AND $275 HSA incentive by participating in a variety of wellness activities throughout the year.

Earning Points

Participants begin earning points January 1st and conclude point earnings on October 31st of each year. Incentive amounts are determined by the number of points participants earn during this period. Cash rebates will be distributed in December and HSA incentives will be issued in January of each year.

IMPORTANT: Participants must submit proof of an annual physical examination conducted by a medical practitioner to qualify for incentives.

Points	Cash Reward	HSA Reward
1-449	$50	$50
450-699	$175	$175
700-899	$200	$200
900+	$250	$275

PEHP Health & Benefits

Traditional

Summit

MEDICAL BENEFITS GRID: WHAT YOU PAY

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions.

Percentages indicate your share of PEHP's In-Network Rate.

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $500 Double/family plans: $500 per person, $1,000 per family *One person cannot meet more than $500*	Single plans: $1,000 Double/family plans: $1,000 per person, $2,000 per family *One person cannot meet more than $1,000*
Plan year Out-of-Pocket Maximum *Please refer to the Master Policy for exceptions to the Out-of-Pocket Maximum*	Single plans: $3,500 Double/family plans: $3,500 per person, $7,000 per family *One person cannot meet more than $3,500*	Single plans: $5,000 Double/family plans: $5,000 per person, $10,000 per family *One person cannot meet more than $5,000*
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge	Not covered
PEHP VALUE PROVIDERS		
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	Starting at $10 co-pay per visit	Not applicable
PROFESSIONAL SERVICES		
Salt Lake County HealthyMe Medical Clinic	$10 co-pay per visit	Not applicable
Primary Care Visits | *Includes office surgeries and inpatient visits*	$25 co-pay per visit after deductible	30% after deductible
Specialist Visits | *Includes office surgeries and inpatient visits*	$35 co-pay per visit after deductible	30% after deductible
Surgery and Anesthesia	20% after deductible	30% after deductible
Emergency Room Specialist Visits	$35 co-pay per visit after deductible	$35 co-pay per visit after deductible
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less*	No charge after deductible	30% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350*	20% after deductible	30% after deductible
Mental Health and Substance Abuse *No preauthorization required for outpatient service.* *Inpatient services require preauthorization*	**Outpatient:** $35 co-pay after deductible per visit. **Inpatient:** 20% after deductible	30% after deductible
PRESCRIPTION DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	**Tier 1:** $10 co-pay **Tier 2:** 25% of discounted cost, $25 minimum / $75 maximum **Tier 3:** 50% of discounted cost, $50 minimum / $100 maximum	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. You pay any balance
90-day Pharmacy *Maintenance only*	**Tier 1:** $20 co-pay **Tier 2:** 25% of discounted cost, $50 minimum / $150 maximum **Tier 3:** 50% of discounted cost, $100 minimum / $200 maximum	Not covered

In- and Out-of-Network deductibles and Out-of-Pocket Maximums accrue separately.

*Out-of-Network Providers may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or out-of-pocket maximum. You pay 20% of the In-Network Rate after Out-of-Pocket Maximum is met for Out-of-Network Providers.

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
SPECIALTY DRUGS | ***For Drug Tier info, see the Covered Drug List at www.pehp.org***		
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay after deductible **Tier B:** 20%. $150 maximum co-pay after deductible	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20% after deductible. No maximum co-pay **Tier B:** 20% after deductible. No maximum co-pay	**Tier A:** 40% after deductible. No maximum co-pay **Tier B:** 40% after deductible. No maximum co-pay
Specialty Medications, through Home Health or Accredo *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay after deductible **Tier B:** 20%. $150 maximum co-pay after deductible **Tier C1:** 10%. No maximum co-pay after deductible **Tier C2:** 20%. No maximum co-pay after deductible **Tier C3:** 30%. No maximum co-pay after deductible	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	20% after deductible	30% after deductible
Urgent Care Facility	$45 co-pay per visit after deductible	30% after deductible
Emergency Room *Medical emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	$150 co-pay after deductible per visit	$150 co-pay after deductible per visit
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	20% after deductible	
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less, when the only services performed are diagnostic testing*	No charge after deductible	30% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350, when the only services performed are diagnostic testing*	20% after deductible	30% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	20% after deductible	30% after deductible
Physical and Occupational Therapy *Outpatient – up to 20 visits per plan year for each therapy type*	$35 co-pay after deductible per visit	30% after deductible
Mental Health & Substance Abuse	20% after deductible	30% after deductible
INPATIENT FACILITY SERVICES		
Medical & Surgical *All out-of-network facilities and some in-network facilities require preathorization.* *See Master Policy for details*	20% after deductible	30% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	20% after deductible	30% after deductible
Hospice	No charge after deductible	30% after deductible
Rehabilitation *Up to 60 days per plan year. Requires preauthorization*	20% after deductible	30% after deductible
Mental Health & Substance Abuse *Requires Preauthorization*	20% after deductible	30% after deductible

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption | *See Master Policy for benefit limits*	No charge, plan pays up to $4,000 per adoption	
Allergy Serum	20% after deductible	30% after deductible
Autism Spectrum Disorder	$25 co-pay after deductible	30% after deductible
Bariatric Surgery *Requires Preauthorization. Up to one surgery per lifetime.*	20% after deductible	Not covered
Chiropractic care | *Up to 10 visits per plan year*	$35 co-pay after deductible per visit	$35 co-pay after deductible per visit
Durable Medical Equipment *Some DME requires preauthorization. Visit www.pehp.org for complete list.*	20% after deductible Summit Network: Alpine Home Medical	30% after deductible
Medical Supplies *See Master Policy for benefit limits*	20% after deductible	30% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	No charge after deductible	30% after deductible
Injections *Includes allergy injections. See above for allergy serum*	**Under $50:** No charge after deductible **Over $50:** 20% after deductible	30% after deductible
Infertility Services | *Select services only. See Master Policy for details.*	50% after deductible	50% after deductible
Temporomandibular Joint Dysfunction** *Non-surgical. Up to $1,000 lifetime maximum*	50% after deductible	50% after deductible

**Does not apply to the out-of-pocket maximum.

PEHP Health & Benefits

HDHP

Summit

MEDICAL BENEFITS GRID: WHAT YOU PAY

Refer to the Master Policy for specific criteria for the benefits listed below, as well as information on limitations and exclusions.

Percentages indicate your share of PEHP's In-Network Rate.

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
DEDUCTIBLES, PLAN MAXIMUMS, AND LIMITS		
Plan year Deductible *Applies to Out-of-Pocket Maximum*	Single plans: $2,000 Double/family plans: $4,000 *One person or a combination can meet the $4,000 double/family deductible*	Single plans: $2,000 Double/family plans: $4,000 *One person or a combination can meet the $4,000 double/family deductible*
Plan year Out-of-Pocket Maximum	Single plans: $3,500 Double/family plans: $7,000 *One person or a combination can meet the $7,000 double/family maximum*	Single plans: $8,000 Double/family plans: $16,000 *One person or a combination can meet the $16,000 double/family maximum*
ANNUAL PREVENTIVE CARE		
Preventive services allowed by Affordable Care Act *Annual physical exam, immunizations.* *See full list at www.pehp.org/preventiveservices*	No charge	Not covered
PEHP VALUE PROVIDERS		
PEHP Value Providers *Cash Back opportunities available. Visit www.pehp.org/valueproviders*	20% after deductible	Not applicable
PROFESSIONAL SERVICES		
Salt Lake County HealthyMe Medical Clinic	$10 co-pay after deductible per visit	Not applicable
Primary Care Visits | *Includes office surgeries and inpatient visits*	$25 co-pay after deductible	30% after deductible
Specialist Visits | *Includes office surgeries and inpatient visits*	$35 co-pay after deductible	30% after deductible
Surgery and Anesthesia	10% after deductible	30% after deductible
Emergency Room Specialist Visits	$35 co-pay after deductible	$35 co-pay after deductible
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less*	No charge after deductible	30% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350*	20% after deductible	30% after deductible
Mental Health and Substance Abuse *No preauthorization required for outpatient service.* *Inpatient services require preauthorization*	**Outpatient:** $35 co-pay after deductible per visit. **Inpatient:** 10% after deductible	30% after deductible
PRESCRIPTION DRUGS | ***All pharmacy benefits for The HDHP Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at www.pehp.org***		
30-day Pharmacy *Retail only*	**Tier 1:** $10 co-pay **Tier 2:** 25% of discounted cost, $25 minimum / $75 maximum **Tier 3:** 50% of discounted cost, $50 minimum / $100 maximum	Plan pays up to the discounted cost, minus the preferred co-pay, if applicable. You pay any balance
90-day Pharmacy *Maintenance only*	**Tier 1:** $20 co-pay **Tier 2:** 25% of discounted cost, $50 minimum / $150 maximum **Tier 3:** 50% of discounted cost, $100 minimum / $200 maximum	Not covered

In- and Out-of-Network deductibles and Out-of-Pocket Maximums accrue separately.

*Out-of-Network Providers may charge more than the In-Network Rate unless they have an agreement with you not to. Any amount above the In-Network Rate may be billed to you and will not count toward your deductible or out-of-pocket maximum. You pay 20% of the In-Network Rate after Out-of-Pocket Maximum is met for Out-of-Network Providers.

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
PRESCRIPTION DRUGS | ***All pharmacy benefits for The HDHP Plan are subject to the deductible. For Drug Tier info, see the Covered Drug List at www.pehp.org***		
Specialty Medications, retail pharmacy *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 20%. $150 maximum co-pay	Plan pays up to discounted cost, minus the applicable co-pay. You pay any balance
Specialty Medications, office/outpatient *Up to 30-day supply*	**Tier A:** 20%. No maximum co-pay **Tier B:** 20%. No maximum co-pay	**Tier A:** 40%. No maximum co-pay **Tier B:** 40%. No maximum co-pay
Specialty Medications, through Home Health or Accredo *Up to 30-day supply*	**Tier A:** 20%. $150 maximum co-pay **Tier B:** 20%. $150 maximum co-pay **Tier C1:** 10%. No maximum co-pay **Tier C2:** 20%. No maximum co-pay **Tier C3:** 30%. No maximum co-pay	Not covered
OUTPATIENT FACILITY SERVICES		
Outpatient Facility and Ambulatory Surgical Center	10% after deductible	30% after deductible
Urgent Care Facility	$45 co-pay after deductible	30% after deductible
Emergency Room *Medical emergencies only, as determined by PEHP.* *If admitted, inpatient facility benefit will be applied*	$150 co-pay after deductible	$150 co-pay after deductible
Ambulance (ground or air) *Medical emergencies only, as determined by PEHP*	10% after deductible	
Diagnostic Tests, Labs, X-rays – Minor *For each test allowing $350 or less*	No charge after deductible	30% after deductible
Diagnostic Tests, Labs, X-rays – Major *For each test allowing more than $350*	20% after deductible	30% after deductible
Chemotherapy, Radiation, and Dialysis *Dialysis from out-of-network provider requires Preauthorization*	10% after deductible	30% after deductible
Physical and Occupational Therapy *Outpatient – up to 20 visits per plan year for each therapy type*	$35 co-pay after deductible per visit	30% after deductible
Mental Health & Substance Abuse	20% after deductible	30% after deductible
INPATIENT FACILITY SERVICES		
Medical & Surgical *All out-of-network facilities and some in-network facilities require preathorization.* *See Master Policy for details*	10% after deductible	30% after deductible
Skilled Nursing Facility and Residential Treatment *Non-custodial. Up to 60 days per plan year. Requires preauthorization*	10% after deductible	30% after deductible
Hospice	No charge after deductible	30% after deductible
Rehabilitation *Up to 45 days per plan year. Requires preauthorization*	10% after deductible	30% after deductible
Mental Health & Substance Abuse *Requires Preauthorization*	10% after deductible	30% after deductible

	In-Network Provider	Out-of-Network Provider* *Balance billing may apply*
MISCELLANEOUS SERVICES		
Adoption | *See Master Policy for benefit limits*	No charge after deductible, plan pays up to $4,000 per adoption	
Allergy Serum	10% after deductible	30% after deductible
Autism Spectrum Disorder	$25 co-pay after deductible	30% after deductible
Bariatric Surgery *Requires Preauthorization. Up to one surgery per lifetime.*	10% after deductible	Not covered
Chiropractic care | *Up to 10 visits per plan year*	$35 co-pay after deductible per visit	$35 co-pay after deductible per visit
Durable Medical Equipment *Some DME requires preauthorization. Visit www.pehp.org for complete list.* *See Master Policy for benefit limits*	20% after deductible Summit Network: Alpine Home Medical	30% after deductible
Medical Supplies *See Master Policy for benefit limits*	10% after deductible	30% after deductible
Home Health/Skilled Nursing *Up to 60 visits per plan year. Requires Preauthorization*	No charge after deductible	30% after deductible
Injections *Includes allergy injections. See above for allergy serum*	10% after deductible	30% after deductible
Infertility Services | *Select services only. See Master Policy for details.*	50% after deductible	50% after deductible
Temporomandibular Joint Dysfunction *Non-surgical. Up to $1,000 lifetime maximum*	50% after deductible	50% after deductible

SALT LAKE COUNTY OPTION 2 01/01/2024

selecthealth

VALUE AND MED NETWORKS

Administered by SelectHealth

	SCHEDULE OF BENEFITS		
	TIER 1 VALUE When using In-Network Providers, you are responsible to pay the amounts in this column. These providers might not be available in all areas.	**TIER 2 MED** 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.
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5,6]	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Self Only Coverage, 1 person enrolled - per calendar Year			
Deductible	$500		$1,000
Out-of-Pocket Maximum	$3,500		$5,000
Family Coverage, 2 or more enrolled - per calendar Year			
Deductible - per person/family	$500/$1000		$1000/$2000
Out-of-Pocket Maximum - per person/family	$3500/$7000		$5000/$10000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)			
INPATIENT SERVICES	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Medical, Surgical and Hospice[4]	20% after Deductible	20% after Deductible	30% after Deductible
Hospital Level Care at Home[4]	20% after Deductible	20% after Deductible	Not Covered
Skilled Nursing Facility[4] - Up to 60 days per calendar Year	20% after Deductible	20% after Deductible	30% after Deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4] Up to 40 days per calendar Year for all therapy types combined	20% after Deductible	20% after Deductible	30% after Deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after Deductible	20% after Deductible	30% after Deductible
PROFESSIONAL SERVICES	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits & Minor Office Surgeries			
Primary Care Provider (PCP)[1]	$25 after Deductible	$25 after Deductible	30% after Deductible
Primary Care Provider (PCP) Virtual Visits[1]	Covered 100%	Covered 100%	Not Covered
Specialist/Secondary Care Provider (SCP)[1]	$35 after Deductible	$35 after Deductible	30% after Deductible
Salt Lake County HealthyMe Medical Clinic	$10	$10	Not Covered
Allergy Tests	See Office Visits Above	See Office Visits Above	30% after Deductible
Allergy Treatment and Serum	20% after Deductible	20% after Deductible	30% after Deductible
Major Surgery	20% after Deductible	20% after Deductible	30% after Deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	20% after Deductible	20% after Deductible	30% after Deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Provider (PCP)[1]	Covered 100%	Covered 100%	Not Covered
Specialist/Secondary Care Provider (SCP)[1]	Covered 100%	Covered 100%	Not Covered
Salt Lake County HealthyMe Medical Clinic	Covered 100%	Covered 100%	Not Covered
Adult and Pediatric Immunizations	Covered 100%	Covered 100%	Not Covered
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%	Covered 100%	Not Covered
Diagnostic Tests: Minor	Covered 100%	Covered 100%	Not Covered
Other Preventive Services	Covered 100%	Covered 100%	Not Covered
VISION SERVICES	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Preventive Eye Exams	Covered 100%	Covered 100%	Not Covered
All Other Eye Exams	$35 after Deductible	$35 after Deductible	30% after Deductible
OUTPATIENT SERVICES[4]	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Facility	20% after Deductible	20% after Deductible	30% after Deductible
Ambulatory Surgical Center	20% after Deductible	20% after Deductible	30% after Deductible
Imaging Center	20% after Deductible	20% after Deductible	30% after Deductible
Ambulance (Air or Ground) - *Emergencies Only*	20% after Deductible	20% after Deductible	See In-Network Benefit
Emergency Room	$150 after Deductible	$150 after Deductible	See In-Network Benefit
Intermountain InstaCare® Facilities, Urgent Care Facilities	$45 after Deductible	$45 after Deductible	30% after Deductible
Intermountain KidsCare® Facilities	$25 after Deductible	$25 after Deductible	Not Available
Intermountain Connect Care®	$25 after Deductible	$25 after Deductible	Not Available
Radiation	20% after Deductible	20% after Deductible	30% after Deductible
Dialysis	20% after Deductible	20% after Deductible	30% after Deductible
Diagnostic Tests: Minor[2]	Covered 100% after Deductible	Covered 100% after Deductible	30% after Deductible
Diagnostic Tests: Major[2]	20% after Deductible	20% after Deductible	30% after Deductible
Home Health, Hospice, Outpatient Private Nurse *Up to 60 visits per calendar Year*	Covered 100% after Deductible	Covered 100% after Deductible	30% after Deductible
Outpatient Cardiac Rehab	Covered 100%	Covered 100%	30% after Deductible
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	$35 after Deductible	$35 after Deductible	30% after Deductible

See other side for additional benefits

selecthealth

VALUE AND MED NETWORKS

Administered by SelectHealth

	SCHEDULE OF BENEFITS		
	TIER 1 VALUE	**TIER 2 MED**	**OUT-OF-NETWORK**
MISCELLANEOUS SERVICES	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Durable Medical Equipment (DME)[4]	20% after Deductible	20% after Deductible	30% after Deductible
Miscellaneous Medical Supplies (MMS)[3]	20% after Deductible	20% after Deductible	30% after Deductible
Autism Spectrum Disorder	20% after Deductible	20% after Deductible	Not Covered
Maternity[4]	See Professional, Inpatient or Outpatient	See Professional, Inpatient or Outpatient	30% after Deductible
Cochlear Implants[4]	See Professional, Inpatient or Outpatient	See Professional, Inpatient or Outpatient	Not Covered
Infertility - *Select Services*	50% after Deductible	50% after Deductible	50% after Deductible
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	50% after Deductible	50% after Deductible	50% after Deductible
Chiropractic	$35 after In-Network Deductible		
OTHER BENEFITS	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Mental Health and Chemical Dependency[4]			
Office Visits	$35 after Deductible	$35 after Deductible	30% after Deductible
Virtual Visits	Covered 100%	Covered 100%	30% after Deductible
Inpatient	20% after Deductible	20% after Deductible	30% after Deductible
Outpatient	20% after Deductible	20% after Deductible	30% after Deductible
Residential Treatment[2]	20% after Deductible	20% after Deductible	30% after Deductible
Gender Dysphoria	See Professional, Inpatient or Outpatient and Mental Health Services	See Professional, Inpatient or Outpatient and Mental Health Services	30% after Deductible
Adoption[4,7]	Covered 100% for 1st $4000		
Injectable Drugs, Chemotherapy, and Specialty Medications[4]	20% after Deductible	20% after Deductible	30% after Deductible
Bariatric Surgery *(Up to one surgery/lifetime)*[4]	See Professional, Inpatient or Outpatient	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	$10		
Tier 2	25% with a minimum of $25 and maximum of $75 after In-Network Deductible		
Tier 3	50% with a minimum of $50 and maximum of $100 after In-Network Deductible		
Tier 4 (*Must be filled at Intermountain Specialty Pharmacy*)	20% with a maxium of $150 after In-Network Deductible		
Maintenance Drugs - *90 Day Supply (Mail-Order, Retail90®)-selected drugs*[4]			
Tier 1	$20		
Tier 2	25% with a minimum of $50 and maximum of $150 after In-Network Deductible		
Tier 3	50% with a minimum of $100 and maximum of $200 after In-Network 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 Summary Plan Description 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 Summary Plan Description, for details.

5 All Deductible/Copay/Coinsurance amounts are based on the Allowed Amount and not on billed charges. Out-of-Network Providers or Facilities may not accept the Allowed Amount for Covered Services. When this occurs, you may be responsible for Excess Charges.

6 Certain Services as noted on this document and in your Summary Plan Description are not subject to the Deductible.

7 The plan 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.

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.

SALT LAKE COUNTY OPTION 2 01/01/2024

selecthealth

VALUE AND MED NETWORKS / HSA QUALIFIED

Administered by SelectHealth

SCHEDULE OF BENEFITS	TIER 1 VALUE When using In-Network Providers, you are responsible to pay the amounts in this column. These providers might not be available in all areas.	TIER 2 MED 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.
MEDICAL DEDUCTIBLE AND MEDICAL OUT-OF-POCKET[5,6]	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Self Only Coverage, 1 person enrolled - per calendar Year			
Deductible	$2,000		$2,000
Out-of-Pocket Maximum	$3,500		$8,000
Family Coverage, 2 or more enrolled - per calendar Year			
Deductible	$4,000		$4,000
Out-of-Pocket Maximum	$7,000		$16,000
(Medical and Pharmacy Included in the Out-of-Pocket Maximum)			
INPATIENT SERVICES	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Medical, Surgical and Hospice[4]	10% after Deductible	10% after Deductible	30% after Deductible
Hospital Level Care at Home[4]	10% after Deductible	10% after Deductible	Not Covered
Skilled Nursing Facility[4] - Up to 60 days per calendar Year	10% after Deductible	10% after Deductible	30% after Deductible
Inpatient Rehab Therapy: Physical, Speech, Occupational[4]	10% after Deductible	10% after Deductible	30% after Deductible
Up to 40 days per calendar Year for all therapy types combined			
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	10% after Deductible	10% after Deductible	30% after Deductible
PROFESSIONAL SERVICES	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits & Minor Office Surgeries			
Primary Care Provider (PCP)[1]	$25 after Deductible	$25 after Deductible	30% after Deductible
Primary Care Provider (PCP) Virtual Visits[1]	Covered 100% after Deductible	Covered 100% after Deductible	Not Covered
Specialist/Secondary Care Provider (SCP)[1]	$35 after Deductible	$35 after Deductible	30% after Deductible
Salt Lake County HealthyMe Medical Clinic	$30 each visit, then $10 after Deductible		Not Covered
Allergy Tests	See Office Visits Above	See Office Visits Above	30% after Deductible
Allergy Treatment and Serum	10% after Deductible	10% after Deductible	30% after Deductible
Major Surgery	10% after Deductible	10% after Deductible	30% after Deductible
Physician's Fees - *(Medical, Surgical, Maternity, Anesthesia)*	10% after Deductible	10% after Deductible	30% after Deductible
PREVENTIVE SERVICES AS OUTLINED BY THE ACA[2,3]	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Primary Care Provider (PCP)[1]	Covered 100%	Covered 100%	Not Covered
Specialist/Secondary Care Provider (SCP)[1]	Covered 100%	Covered 100%	Not Covered
Salt Lake County HealthyMe Medical Clinic	Covered 100%	Covered 100%	Not Covered
Adult and Pediatric Immunizations	Covered 100%	Covered 100%	Not Covered
Elective Immunizations - herpes zoster (shingles), rotavirus	Covered 100%	Covered 100%	Not Covered
Diagnostic Tests: Minor	Covered 100%	Covered 100%	Not Covered
Other Preventive Services	Covered 100%	Covered 100%	Not Covered
VISION SERVICES	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Preventive Eye Exams	Covered 100%	Covered 100%	Not Covered
All Other Eye Exams	$35 after Deductible	$35 after Deductible	30% after Deductible
OUTPATIENT SERVICES[4]	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Facility	10% after Deductible	10% after Deductible	30% after Deductible
Ambulatory Surgical Center	10% after Deductible	10% after Deductible	30% after Deductible
Imaging Center	10% after Deductible	10% after Deductible	30% after Deductible
Ambulance (Air or Ground) - *Emergencies Only*	20% after Deductible	20% after Deductible	See In-Network Benefit
Emergency Room	$150 after Deductible	$150 after Deductible	See In-Network Benefit
Intermountain InstaCare® Facilities, Urgent Care Facilities	$45 after Deductible	$45 after Deductible	30% after Deductible
Intermountain KidsCare® Facilities	$25 after Deductible	$25 after Deductible	Not Available
Intermountain Connect Care®	Covered 100% after Deductible	Covered 100% after Deductible	Not Available
Radiation	10% after Deductible	10% after Deductible	30% after Deductible
Dialysis	10% after Deductible	10% after Deductible	30% after Deductible
Diagnostic Tests: Minor[2]	Covered 100% after Deductible	Covered 100% after Deductible	30% after Deductible
Diagnostic Tests: Major[2]	10% after Deductible	10% after Deductible	30% after Deductible
Home Health, Hospice, Outpatient Private Nurse	Covered 100% after Deductible	Covered 100% after Deductible	30% after Deductible
Up to 60 visits per calendar Year			
Outpatient Cardiac Rehab	Covered 100% after Deductible	Covered 100% after Deductible	30% after Deductible
Outpatient Rehab/Habilitative Therapy: Physical, Speech, Occupational	$35 after Deductible	$35 after Deductible	30% after Deductible

See other side for additional benefits

selecthealth

VALUE AND MED NETWORKS / HSA QUALIFIED

Administered by SelectHealth

	SCHEDULE OF BENEFITS		
	TIER 1 VALUE	**TIER 2 MED**	**OUT-OF-NETWORK**
MISCELLANEOUS SERVICES	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Durable Medical Equipment (DME)[4]	10% after Deductible	10% after Deductible	30% after Deductible
Miscellaneous Medical Supplies (MMS)[3]	10% after Deductible	10% after Deductible	30% after Deductible
Autism Spectrum Disorder	10% after Deductible	10% after Deductible	Not Covered
Maternity[4]	See Professional, Inpatient or Outpatient	See Professional, Inpatient or Outpatient	30% after Deductible
Cochlear Implants[4]	See Professional, Inpatient or Outpatient	See Professional, Inpatient or Outpatient	Not Covered
Infertility - *Select Services*	50% after Deductible	50% after Deductible	50% after Deductible
TMJ (Temporomandibular Joint) Services - *Up to $2,000 lifetime*	50% after Deductible	50% after Deductible	50% after Deductible
Chiropractic	$35 after In-Network Deductible		
OTHER BENEFITS	**IN-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Mental Health and Chemical Dependency[4]			
Office Visits	$35 after Deductible	$35 after Deductible	30% after Deductible
Virtual Visits	Covered 100% after Deductible	Covered 100% after Deductible	30% after Deductible
Inpatient	10% after Deductible	10% after Deductible	30% after Deductible
Outpatient	10% after Deductible	10% after Deductible	30% after Deductible
Residential Treatment[2]	10% after Deductible	10% after Deductible	30% after Deductible
Gender Dysphoria	See Professional, Inpatient or Outpatient and Mental Health Services	See Professional, Inpatient or Outpatient and Mental Health Services	30% after Deductible
Adoption[4,7]	Covered 100% for 1st $4000		
Injectable Drugs, Chemotherapy, and Specialty Medications[4]	20% after Deductible	20% after Deductible	30% after Deductible
Bariatric Surgery *(Up to one surgery/lifetime)*[4]	See Professional, Inpatient or Outpatient	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	$10 after In-Network Deductible		
Tier 2	25% with a minimum of $25 and maximum of $75 after In-Network Deductible		
Tier 3	50% with a minimum of $50 and maximum of $100 after In-Network Deductible		
Tier 4	20% with a maximum of $150 after In-Network Deductible		
Maintenance Drugs-*90 Day Supply (Mail-Order,Retail90®)-selected drugs*[4]			
Tier 1	$20 after In-Network Deductible		
Tier 2	25% with a minimum of $50 and maximum of $150 after In-Network Deductible		
Tier 3	50% with a minimum of $100 and maximum of $200 after In-Network Deductible		
Deductible Waiver	Certain prescription drugs are not subject to the 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 Summary Plan Description 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 Summary Plan Description, for details.

5 All Deductible/Copay/Coinsurance amounts are based on the Allowed Amount and not on billed charges. Out-of-Network Providers or Facilities may not accept the Allowed Amount for Covered Services. When this occurs, you may be responsible for Excess Charges.

6 Certain Services as noted on this document and in your Summary Plan Description are not subject to the Deductible.

7 The plan 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.

Cigna Dental Benefit Summary
Salt Lake County
Plan Renewal Date: 01/01/2024

Administered by: Cigna Health and Life Insurance Company

This material is for informational purposes only and is designed to highlight some of the benefits available under this plan. Consult the plan documents to determine specific terms of coverage relating to your plan. Terms include covered procedures, applicable waiting periods, exclusions and limitations. **Your DPPO plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket expenses.**

Benefit Plan Features	***Total Cigna DPPO Network***		***Non-Network***
Network Options	Cigna DPPO Advantage	Cigna DPPO	See Non-Network Reimbursement
Reimbursement Levels	Fee Schedule	Discount on Fees	Maximum Reimbursable Charge
Calendar Year Benefits Maximum Applies to: Class I, II, III & IX expenses	$2,000	$1,200	$1,200
Calendar Year Deductible Individual Family	 $0 $0	 $50 $150	 $50 $150
Benefit Highlights	***Plan Pays***	***Plan Pays***	***Plan Pays***
Class I: Diagnostic & Preventive Oral Evaluations Prophylaxis: routine cleanings X-rays: routine X-rays: non-routine Fluoride Application Sealants: per tooth Space Maintainers: non-orthodontic Emergency Care to Relieve Pain (Note: This service is administrated at the in network coinsurance level.)	100% No Deductible	80% No Deductible	80% No Deductible
Class II: Basic Restorative Restorative: fillings (Includes composite (white/tooth-colored) fillings on molars.) Endodontics: minor and major Periodontics: minor and major Oral Surgery: minor and major Anesthesia: general and IV sedation	90% No Deductible	60% After Deductible	60% After Deductible
Class III: Major Restorative Inlays and Onlays Prosthesis Over Implant Crowns: prefabricated stainless steel / resin Crowns: permanent cast and porcelain (Includes porcelain on all teeth or white/tooth-colored crowns on all teeth) Bridges and Dentures Denture Relines, Rebases and Adjustments Repairs: bridges, crowns and inlays Repairs: dentures	50% No Deductible	40% After Deductible	40% After Deductible
Class IV: Orthodontia Coverage for Employee and All Dependents Lifetime Benefits Maximum: $1,750	50% No Deductible	40% No Deductible	40% No Deductible
Class IX: Implants	50% No Deductible	40% After Deductible	40% After Deductible
Benefit Plan Provisions:			
In-Network Reimbursement	For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Fee Schedule or Discount Schedule.		
Non-Network Reimbursement	For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 80th percentile of all provider submitted amounts in the geographic area. The dentist may balance bill up to their usual fees.		

Cross Accumulation	All deductibles, plan maximums, and service specific maximums cross accumulate between in and out of network. Benefit frequency limitations are based on the date of service and cross accumulate between in and out of network.
Calendar Year Benefits Maximum	The plan will only pay for covered charges up to the yearly Benefits Maximum, when applicable. Benefit-specific Maximums may also apply.
Calendar Year Deductible	This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply.
Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of $200 is proposed.
Oral Health Integration Program®	The Cigna Dental Oral Health Integration Program offers enhanced dental coverage for customers with certain medical conditions. There is no additional charge to participate in the program. Those who qualify can receive reimbursement of their coinsurance for eligible dental services. Eligible customers can also receive guidance on behavioral issues related to oral health. Reimbursements under this program are not subject to the annual deductible, but will be applied to the plan annual maximum. For more information on how to enroll in this program and a complete list of terms and eligible conditions, go to www.mycigna.com or call customer service 24/7 at 1-800-Cigna24.
Timely Filing	Out of network claims submitted to Cigna after 365 days from date of service will be denied.
Benefit Limitations:	
Missing Tooth Limitation	For teeth missing prior to coverage with Cigna, the amount payable is 50% of the amount otherwise payable until covered for 12 months; thereafter, considered a Class III expense.
Oral Evaluations/Exams	2 per calendar year.
X-rays (routine)	Bitewings: 4 per calendar year.
X-rays (non-routine)	Complete series of radiographic images and panoramic radiographic images: Limited to a combined total of 1 per 36 months.
Diagnostic Casts	Payable only in conjunction with orthodontic workup.
Cleanings	2 per calendar year, including periodontal maintenance procedures following active therapy.
Fluoride Application	1 per calendar year for children under age 26.
Sealants (per tooth)	Limited to posterior tooth. 1 treatment per tooth every 36 months for children under age 17.
Space Maintainers	Limited to non-orthodontic treatment for children under age 19.
Crowns, Bridges, Dentures and Partials	Replacement every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Denture and Bridge Repairs	Reviewed if more than once.
Denture Relines, Rebases and Adjustments	Covered if more than 6 months after installation.
Prosthesis Over Implant	1 every 60 months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.

Benefit Exclusions:
Covered Expenses will not include, and no payment will be made for the following:

- Procedures and services not included in the list of covered dental expenses;
- Diagnostic: cone beam imaging;
- Preventive Services: instruction for plaque control, oral hygiene and diet;
- Restorative: veneers of porcelain, ceramic, resin, or acrylic materials on crowns or pontics on or replacing the upper and or lower first, second and/or third molars;
- Periodontics: bite registrations; splinting;
- Prosthodontic: precision or semi-precision attachments;
- Procedures, appliances or restorations, except full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of dysfunction of the temporomandibular joint (TMJ), stabilize periodontally involved teeth or restore occlusion;
- Athletic mouth guards;
- Services performed primarily for cosmetic reasons;
- Personalization or decoration of any dental device or dental work;
- Replacement of an appliance per benefit guidelines;
- Services that are deemed to be medical in nature;
- Services and supplies received from a hospital;
- Drugs: prescription drugs;

- Charges in excess of the Maximum Reimbursable Charge.

This document provides a summary only. It is not a contract. If there are any differences between this summary and the official plan documents, the terms of the official plan documents will prevail.

Product availability may vary by location and plan type and is subject to change. All group dental insurance policies and dental benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna representative.

A copy of the NH Dental Outline of Coverage is available and can be downloaded at Health Insurance & Medical Forms for Customers | Cigna under Dental Forms.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company, and Cigna Dental Health, Inc.

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Click or tap "ID Cards"

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Unlock the full value of your dental plan with myCigna.

From programs that help improve your health to tools that help you manage your health spending, there's so much you can do on **myCigna.com** and the **myCigna App**.[3]

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- Compare dentists using Brighter Score™. Each score is based on affordability, patient experience and professional history.[4]
- Review coverage details and track claims.
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Cigna®

1. The transition to digital ID cards does not apply to the following: all insured medical clients sitused in Texas, New York, Florida and Colorado (ASO will be included); all medical clients sitused in Minnesota regardless of funding type; all D-HMO plans sitused in Texas; all D-HMO and D-PPO plans sitused in Georgia and Minnesota; all vision plans sitused in Georgia, Minnesota, and Texas. Clients with situs in Texas, North Carolina, New York, Tennessee, Colorado, Georgia and Florida will transition beginning with 7/1/2023 new and renewal effective dates unless prohibited by a state mandate.
2. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
3. Actual myCigna features may vary depending on your plan and customer profile.
4. Actual features may vary by dentist. These and other dentist directory features are for educational purposes only and should not be the sole basis for decision making. They are not a guarantee of the quality of care that will be provided to individual patients and you should consider all relevant factors when selecting a dentist.

A LOOK AT YOUR VSP VISION COVERAGE

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Enroll in VSP® Vision Care to get personalized care from a VSP network doctor at low out-of-pocket costs.

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Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

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Employee + One	$7.43
Employee + Two or more	$11.51

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Advantage Plan-Enhanced

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SAVINGS ON LENS ENHANCEMENTS

Accident Insurance

Benefits that may help cover costs such as those not covered by your medical plan.

Salt Lake County

Accident Insurance Benefits

With MetLife, you'll have a choice of two plans (called the "Low Plan" and the "High Plan") that provide payments in addition to any other insurance payments you may receive[1]. Here are just some of the covered events/services[2].

Accidental Injury Benefits	Low Plan Benefits	High Plan Benefits
Fracture Benefit*	$75 – $6,000 depending on the fracture and type of repair	$100 – $8,000 depending on the fracture and type of repair
Dislocation Benefit*	$75 – $6,000 depending on the dislocation and type of repair	$100 – $8,000 depending on the dislocation and type of repair
Second or Third Degree Burn Benefit	$75 – $7,500 depending on the degree of the burn and the percentage of burnt skin	$100 – $10,000 depending on the degree of the burn and the percentage of burnt skin
Concussion Benefit	$250	$400
Coma Benefit	$7,500	$10,000
Laceration Benefit	$35 – $300 depending on the length of the cut and type of repair	$50 – $400 depending on the length of the cut and type of repair
Broken Tooth Benefit	Crown $150 Filling $25 Extraction $75	Crown $200 Filling $50 Extraction $100
Eye Injury Benefit	$250	$300
Accident - Medical Services & Treatment Benefits	**Low Plan Benefits**	**High Plan Benefits**
Ambulance Benefit	Ground: $300 Air: $1,000	Ground: $300 Air: $1,000
Emergency Care Benefit	$50 – $100 depending on location of care	$75 – $150 depending on location of care
Physician Follow-Up Visit Benefit	$50	$75
Therapy Services Benefit (including physical therapy)	$25	$35
Medical Testing Benefit	$125	$200
Medical Appliance Benefit	$50 – $500 depending on the appliance	$100 – $1,000 depending on the appliance
Transportation Benefit	$300	$400
Pain Management Benefit (for epidural anesthesia)	$50	$100
Prosthetic Device Benefit	One device: $500 More than one device: $1,000	One device: $750 More than one device: $1,500

MetLife

Accident Insurance

Modification Benefit	$750	$1,000
Blood/Plasma/Platelets Benefit	$350	$400
Surgical Repair Benefit	$125-$1,250 depending on the type of surgery	$200-$2,000 depending on the type of surgery
Exploratory Surgery Benefit	$125	$200
Other Outpatient Surgery Benefit	$250	$300
Hospital Benefits	**Low Plan Benefits**	**High Plan Benefits**
Admission Benefit	$750 for the day of admission	$1,000 for the day of admission
ICU Supplemental Admission Benefit	$750 for the day of admission	$1,000 for the day of admission
Confinement Benefit (paid for up to 31 days per accident)	$150 per day	$200 per day
ICU Supplemental Confinement Benefit (paid for up to 31 days per accident)	$150 per day	$200 per day
Inpatient Rehabilitation Benefit (paid for up to 15 days per accident)	$100 per day	$200 per day
Accidental Death Benefit	**Low Plan Benefits**	**High Plan Benefits**
Accidental Death Benefit*	$25,000 $75,000 for accidental death on common carrier	$25,000 $75,000 for accidental death on common carrier
Accidental Dismemberment, Functional Loss &Paralysis Benefits	**Low Plan Benefits**	**High Plan Benefits**
Dismemberment/Functional Loss	$500 – $15,000 depending on the injury	$750 – $50000 depending on the injury
Paralysis	$7,500 - $15,000 depending on the number of limbs	$25000 - $50,000 depending on the number of limbs
Other Benefits	**Low Plan Benefits**	**High Plan Benefits**
Lodging Benefit* - for a companion of a covered person who is hospitalized	$100 per day	$200 per day

* Notes Regarding Certain Benefits

- Fracture and Dislocation benefits - Chip fractures are paid at 25% of the applicable fracture benefit and partial dislocations are paid at 25% of the applicable dislocation benefit.
- Accidental Death Benefit – The benefit amount will be reduced by the amount of any accidental dismemberment/functional loss/paralysis benefits and modification benefit paid for injuries sustained by the covered person in the same accident for which the accidental death benefit is being paid.
- Accidental Death Benefit – Common carrier refers to airplanes, trains, buses, trolleys, subways and boats.
- Lodging Benefit - The lodging must be at least 50 miles from the insured's primary residence.

Organized Sports Activity Injury Benefit Rider

This coverage includes an Organized Sports Activity Benefit Rider. The rider increases the amount payable under the Certificate for certain benefits by 25% for injuries resulting from an accident that occurred while participating as a player in an organized sports activity. The rider sets forth terms, conditions and limitations, including the covered persons to whom the rider applies.

Accident Insurance

Benefit Payment Example

Kathy's daughter, Molly, was riding her bike to school. On her way there she fell to the ground, was knocked unconscious, and was taken to the local emergency room (ER) by ambulance for treatment. The ER doctor diagnosed a concussion and a broken tooth. He ordered a CT scan to check for facial fractures too, since Molly's face was very swollen. Molly was released to her primary care physician for follow-up treatment, and her dentist repaired her broken tooth with a crown. Depending on her health insurance, Kathy's out-of-pocket costs could run into hundreds of dollars to cover expenses like insurance co-payments and deductibles. MetLife Group Accident Insurance payments can be used to help cover these unexpected costs.

Covered Event[3]	Benefit Amount
Ambulance (ground)	**$300**
Emergency Care	**$150**
Physician Follow-Up ($75 x 2)	**$150**
Medical Testing	**$200**
Concussion	**$400**
Broken Tooth (repaired by crown)	**$200**
Benefits paid by MetLife Group Accident Insurance	**$1,400**

Benefit amount is based on a sample MetLife plan design. Actual plan design and benefits may vary.

Questions & Answers

Q. Who is eligible to enroll for this accident coverage?

A. You are eligible to enroll yourself and your eligible family members![4] You need to enroll during your Enrollment Period and to be actively at work for your coverage to be effective.

Q. How do I pay for my accident coverage?

A. Premiums will be paid through payroll deduction, so you don't have to worry about writing a check or missing a payment.

Q. What happens if my employment status changes? Can I take my coverage with me?

A. Yes, you can take your coverage with you.[5] You will need to continue to pay your premiums to keep your coverage in force. Your coverage will only end if you stop paying your premium or if your employer offers you similar coverage with a different insurance carrier.

Q. Who do I call for assistance?

A. Contact a MetLife Customer Service Representative at 1 800- GET-MET8 (1-800-438-6388), Monday through Friday from 8:00 a.m. to 8:00 p.m., EST. Or visit our website: mybenefits.metlife.com.

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[1] Covered services/treatments must be the result of a covered accident or sickness as defined in the group policy/certificate. See your Disclosure Statement or Outline of Coverage/Disclosure Document for full details.
[2] Availability of benefits varies by state. See your Disclosure Statement or Outline of Coverage/Disclosure Document for state variations.
[3] Benefits and amounts are based on sample MetLife plan design. Plan design and plan benefits may vary.
[4] Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents to be covered are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Children may be covered to age 26. There are benefit reductions that may begin at age 65.
[5] Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.]

METLIFE'S ACCIDENT INSURANCE IS A LIMITED BENEFIT GROUP INSURANCE POLICY. The policy is not intended to be a substitute for medical coverage and certain states may require the insured to have medical coverage to enroll for the coverage. The policy or its provisions may vary or be unavailable in some states. There are benefit reductions that begin at age 65, if applicable. Like most group accident and health insurance policies, policies offered by MetLife may include waiting periods and contain certain exclusions, limitations and terms for keeping them in force. For complete details of coverage and availability, please refer to the group policy form GPNP12-AX or contact MetLife.

Benefits are underwritten by Metropolitan Life Insurance Company, New York, NY. Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See MetLife's Disclosure Statement or Outline of Coverage/Disclosure Document for full details.

Accident Insurance

Coverage that helps pay for expenses that may not be covered under your medical plan.

What is accident insurance?

Accident insurance works to supplement your medical coverage — and pays in addition to what your medical plan may or may not cover. It's coverage that helps provide a financial cushion for life's unexpected events by providing you with a lump-sum payment when your family needs it most. The payment you receive is yours to spend however you like. It pays for the expenses of medical tests, services, treatments or care for one of more than 150 covered events, as defined in your group certificate. This includes hospitalization resulting from an accident, and accidental death or dismemberment.[1]

Q. How does the payment work?

A. We make payments directly to you. The amount you receive will be in addition to any other insurance you might have, and you can spend it however you like. You might use it to help pay for medical plan deductibles and co-pays, out-of-network care, or even for your family's everyday living expenses. Whatever you need while recovering from an accident or injury, accident insurance is there to make life a little easier.

Q. Am I eligible to enroll for this coverage?

A. Yes, you can enroll both yourself and eligible family members. All you need to do is enroll during your enrollment period and be actively at work.

Q. I have a medical plan at work, so why do I need accident insurance?

A. Accidents can happen anytime, anywhere and always when you least expect them. What's more they can be costly.

Even the best medical plans can leave you with extra expenses to pay for services that just aren't covered. Things like plan deductibles, co-pays, extra costs for out-of-network care, or extra costs non-covered services. Many people aren't prepared to handle these extra costs, so having this extra financial support when the time comes may mean less worry for you and your family.

Accident insurance is a way for you to supplement your health care plan.

MetLife

ADF# AI1815.17

Accident Insurance

Q. Can I enroll for this insurance without having a medical exam?

A. Yes. Your accident coverage is guaranteed,[2] regardless of your health. You just need to be actively at work to be covered. There are no medical exams to take and no health questions to answer, so the whole process might be easier than you first thought.

Q. How much will it cost?

A. Accident insurance may cost less than you think. It's designed to be an economical way to supplement your health care plan. Exact rates can be found in the enrollment materials provided by your employer.

Q. How do I pay for my coverage?

A. You pay premiums through payroll deductions, so you don't have to worry about writing any checks or missing payments.

Q. When does my coverage begin?

A. Right away — your coverage starts on the effective date of your coverage. There are no waiting periods for it to begin.

Q. Are benefits paid directly to me or my health care provider?

A. Payments will be paid directly to you, not to the doctors, to the hospitals or to any other health care providers; the check is made payable to you. There's no need to coordinate this coverage with any other insurance you may have. Benefits are paid no matter what your other insurance plans may cover.

Q. If my employment status changes, can I take my coverage with me?

A. Yes. This coverage is portable, meaning you can take it wherever you go. Your coverage will only end if you stop paying your premium or if your employer offers you similar coverage with a different insurance carrier.[3]

Q. Can I use the benefit payment on anything I need?

A. Yes, you can use your payment as you see fit. Use it to help cover your medical insurance deductibles, co-pays, or household bills.

Q. Is the claims process simple?

A. Yes. Once we receive all the information, claims are generally processed within 10 business days. You only need one claim form per accident, and every claim is reviewed by a claims professional.

Have other questions?

Please call MetLife directly at
1 800 GET-MET8
1 800 438-6388
and talk with a benefits consultant.

1. Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See MetLife's Disclosure Statement or Outline of Coverage/Disclosure Document for full details.
2. Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents to be covered are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions apply to dependents serving in the armed forces or living overseas.
3. Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.

METLIFE'S ACCIDENT INSURANCE IS A LIMITED BENEFIT GROUP INSURANCE POLICY. The policy is not intended to be a substitute for medical coverage and certain states may require the insured to have medical coverage to enroll for the coverage. The policy or its provisions may vary or be unavailable in some states. There is a preexisting condition limitation for hospital sickness benefits, if applicable. MetLife's Accident Insurance may be subject to benefit reductions that begin at age 65. And, like most group accident and health insurance policies, policies offered by MetLife may contain certain exclusions, limitations and terms for keeping them in force. For complete details of coverage and availability, please refer to the group policy form GPNP12-AX or contact MetLife.

MetLife

Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166
1705 857011B L1219000268[exp0521][All States][DC,GU,MP,PR,VI]
AX12-AX16

Benefits are underwritten by Metropolitan Life Insurance Company, New York, New York. Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See MetLife's Disclosure Statement or Outline of Coverage/Disclosure Document for full details.

Critical Illness Insurance

Benefits you can use as you see fit, such as to help cover expenses that are not covered by your medical plan.

Salt Lake County

Critical Illness Insurance Benefits

Eligible Individual	Benefit Amount	Requirements
Coverage Options		
Employee	**$15,000 or $30,000**	Coverage is guaranteed provided you are actively at work. [1]
Spouse/Domestic Partner[2]	**100% of the Employee's Initial Benefit**	Coverage is guaranteed provided the employee is actively at work and the spouse/domestic partner is not subject to a medical restriction as set forth on the enrollment form and in the Certificate. [1]
Dependent Child(ren)[3]	**100% of the Employee's Initial Benefit**	Coverage is guaranteed provided the employee is actively at work and the dependent is not subject to a medical restriction as set forth on the enrollment form and in the Certificate. [1]

Benefit Payment

Your plan pays a lump-sum **Initial Benefit** upon the first verified diagnosis of a Covered Condition. Your plan also pays a lump-sum **Recurrence Benefit**[4] for a subsequent verified diagnosis of certain Covered Conditions as shown in the table below. A Recurrence Benefit is only available if an Initial Benefit has been paid for the same Covered Condition. There is a Benefit Suspension Period that applies to Recurrence Benefits. In addition, there is a Benefit Suspension Period that applies to Initial Benefits for different conditions.

The maximum amount that you can receive through your Critical Illness Insurance plan is called the **Total Benefit Amount** and is 3 times the amount of your Benefit Amount. This means that you can receive multiple benefit payments until you reach the maximum of $45,000 or $90,000.

Please refer to the table below for the percentage benefit payable for each Covered Condition.

Plan Design – Covered Conditions		
Initial Benefit means the benefit that is payable for a covered condition the first time that it occurs while coverage is in effect. The Initial Benefit amount is expressed as a percentage of the elected Benefit Amount.		
Recurrence Benefit means the benefit that is payable for another occurrence of the same covered condition for which MetLife has already paid a benefit. The Recurrence Benefit amount is expressed as a percentage of the Initial Benefit amount.		
Covered Conditions	***Initial Benefit***	***Recurrence Benefit***
Benign Tumor Category		
Benign Brain Tumor	100% of Benefit Amount	100% of Initial Benefit
Cancer Category		
Invasive Cancer	100% of Benefit Amount	100% of Initial Benefit
Non-Invasive Cancer	25% of Benefit Amount	100% of Initial Benefit
Skin Cancer	5% of Benefit Amount, but	NONE

MetLife

Critical Illness Insurance

	not less than $250	
Cardiovascular Disease Category		
Coronary Artery Bypass Graft (CABG) - *where surgery involving either a median sternotomy or minimally invasive procedure is performed*	100% of Benefit Amount	100% of Initial Benefit
Childhood Disease Category		
Cerebral Palsy	100% of Benefit Amount	NONE
Cleft Lip or Cleft Palate	100% of Benefit Amount	NONE
Cystic Fibrosis	100% of Benefit Amount	NONE
Diabetes (Type 1)	100% of Benefit Amount	NONE
Down Syndrome	100% of Benefit Amount	NONE
Sickle Cell Anemia	100% of Benefit Amount	NONE
Spina Bifida	100% of Benefit Amount	NONE
Functional Loss Category		
Coma	100% of Benefit Amount	100% of Initial Benefit
Loss of: Ability to Speak; Hearing; or Sight	100% of Benefit Amount	NONE
Paralysis of 2 or more limbs	100% of Benefit Amount	NONE
Heart Attack Category		
Heart Attack	100% of Benefit Amount	100% of Initial Benefit
Sudden Cardiac Arrest	100% of Benefit Amount	NONE
Infectious Disease Category		
Bacterial Cerebrospinal Meningitis	25% of Benefit Amount	NONE
Diphtheria	25% of Benefit Amount	NONE
Encephalitis	25% of Benefit Amount	NONE
Legionnaire's Disease	25% of Benefit Amount	NONE
Malaria	25% of Benefit Amount	NONE
Necrotizing Fasciitis	25% of Benefit Amount	NONE
Osteomyelitis	25% of Benefit Amount	NONE
Rabies	25% of Benefit Amount	NONE
Tetanus	25% of Benefit Amount	NONE
Tuberculosis	25% of Benefit Amount	NONE
Kidney Failure Category		
Kidney Failure	100% of Benefit Amount	NONE
Major Organ Transplant Category		
Major Organ Transplant *For bone marrow, heart, lung, pancreas, and liver*	100% of Benefit Amount	NONE
Progressive Disease Category		
Adrenal Hypofunction (Addison's Disease)	25% of Benefit Amount	NONE
ALS	100% of Benefit Amount	NONE
Alzheimer's Disease	100% of Benefit Amount	NONE

Critical Illness Insurance

Huntington's Disease	25% of Benefit Amount	NONE
Multiple Sclerosis	100% of Benefit Amount	NONE
Muscular Dystrophy	100% of Benefit Amount	NONE
Myasthenia Gravis	25% of Benefit Amount	NONE
Parkinson's Disease (Advanced)	100% of Benefit Amount	NONE
Poliomyelitis	25% of Benefit Amount	NONE
Systemic Lupus Erythematosus (SLE)	100% of Benefit Amount	NONE
Systemic Sclerosis (Scleroderma)	25% of Benefit Amount	NONE
Severe Burn Category		
Severe Burn	100% of Benefit Amount	100% of Initial Benefit
Stroke Category		
Stroke	100% of Benefit Amount	100% of Initial Benefit

* Notes Regarding Covered Conditions

MetLife will not pay a benefit for a Covered Condition that is diagnosed prior to the coverage effective date.

In most states there is a preexisting condition limitation. If advice, treatment or care was sought, recommended, prescribed or received during the three months prior to the effective date of coverage, we will not pay benefits if the covered condition occurs during the first six months of coverage. The preexisting condition limitation may not apply to all covered conditions and may vary by state. Refer to the Disclosure Document/Outline of Coverage for details.

- Alzheimer's Disease – Please review the Outline of Coverage/Disclosure Document for specific information about Alzheimer's disease.
- Cancer – Please review the certificate for specific information about cancer benefits. In most states, not all types of cancer are covered.
- Coronary Artery Bypass Graft – In certain states, the Covered Condition is Coronary Artery Disease.
- Heart Attack – The Heart Attack Covered Condition pays a benefit for the occurrence of a myocardial infarction, subject to the terms of the certificate. A myocardial infarction does not include sudden cardiac arrest.
- Major Organ Transplant – In most states, we will not pay a Major Organ Transplant benefit if a covered person is placed on the organ transplant list prior to coverage taking effect and subsequently undergoes a transplant procedure for the same organ while coverage is in effect. Covered organs may vary by state; refer to the Certificate for details. In some states, the condition is Major Organ Failure.
- Stroke – In certain states, the Covered Condition is Severe Stroke.
- The following benefits are not available in all states. Please review the Disclosure Statement or Outline of Coverage/Disclosure Document for details.
    - Coma
    - Loss of: Ability to Speak; Hearing; or Sight
    - Paralysis
    - Severe Burn

Health Screening Benefit MetLife will provide an annual benefit of $50/$100 based on benefit amount selected per calendar year for taking one of the eligible screening/prevention measures. The Health Screening Benefit is not available in certain states. Please review your Disclosure Statement or Outline of Coverage/Disclosure Document for specific state variations and exclusions around this benefit.

Example of How Benefits are Paid

The example below illustrates an employee who elected a Benefit Amount of $15,000.

Illness – Covered Condition	Payment
Heart Attack — first verified diagnosis	Initial Benefit payment of $15,000 or 100%
Kidney Failure – first verified diagnosis, two years later	Initial Benefit payment of $15,000 or 100%
Heart Attack — second verified diagnosis, four years later	Recurrence Benefit payment of $15,000 or 100%

Critical Illness Insurance

This example is for illustrative purposes only. The MetLife Group Policy and Certificate are the governing documents with respect to all matters of insurance, including coverage for specific illnesses. The specific facts of each claim must be evaluated in conjunction with the provisions of the applicable Policy and Certificate to determine coverage in each individual case.

Questions & Answers

Q. Who is eligible to enroll for this critical illness coverage?

A. You are eligible to enroll yourself and your eligible family members![5] You need to enroll during your Enrollment Period and to be actively at work for your coverage to be effective.

Q. How do I pay for my critical illness coverage?

A. Premiums will be paid through payroll deduction, so you don't have to worry about writing a check or missing a payment.

Q. What happens if my employment status changes? Can I take my coverage with me?

A. Yes, you can take your coverage with you.[6] You will need to continue to pay your premiums to keep your coverage in force. Your coverage will only end if you stop paying your premium or if your employer offers you similar coverage with a different insurance carrier.

Q. Who do I call for assistance?

A. Contact a MetLife Customer Service Representative at 1 800- GET-MET8 (1-800-438-6388), Monday through Friday from 8:00 a.m. to 8:00 p.m., EST. Or visit our website: *mybenefits.metlife.com*.

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[1] [Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents to be covered are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. MetLife will not pay a benefit for a Covered Condition that is diagnosed prior to the coverage effective date.]

[2] Coverage for Domestic Partners, civil union partners and reciprocal beneficiaries varies by state. Please contact MetLife for more information.

[3] Dependent Child coverage varies by state. Please contact MetLife for more information.

[4] Review the Disclosure Document or Outline of Coverage/Disclosure Document for information on which Covered Condition may be eligible for a Recurrence Benefit. There may be a Benefit Suspension Period between recurrences of the same Covered Condition, as well as occurrences of different Covered Conditions. There may be a limitation on the number of Recurrence Benefits payable per Covered Condition. We will not pay a benefit for a Covered Condition that is subject to a Benefit Suspension Period. If a Recurrence Benefit is payable for a Cancer Covered Condition, we will not pay such benefit unless the Covered Person has not had symptoms of or been treated for the same cancer for which we paid a benefit during the Treatment Free Period.

[5] Eligible Family Members means all persons eligible for coverage as defined in the Certificate.

[6] Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.

Critical Illness Insurance

Coverage that helps you and your family have the financial support to pay for some of the expenses of a serious illness that may not be covered by your medical plan.

What is critical illness insurance?

Critical illness insurance works to supplement your medical coverage — and pays in addition to what your medical plan may or may not cover. It's coverage that helps provide financial support when you or a loved one becomes seriously ill. Upon verified diagnosis, it provides you with a lump-sum payment of $15,000 or $30,000 in initial benefits. The payment you receive is yours to spend however you like.

Q. What's covered under this plan?

A. If you meet the group policy and certificate requirements, **critical illness insurance provides you with a lump-sum payment upon a verified diagnosis of these conditions:**

- Cancer[1]
- Heart Attack[2]
- Stroke[3]
- Coma[4]
- Severe Burn[4]
- Major Organ Transplant[5]
- Coronary Artery Bypass Graft[6]
- Kidney Failure
- Benign Brain Tumor
- Loss of: Ability to Speak; Hearing; or Sight[4]
- Paralysis[4]
- Sudden Cardiac Arrest
- 7 Childhood Diseases
- 10 Infectious Diseases
- 11 Progressive Diseases

Payments may be used to help pay for expenses generally not covered by medical and disability income coverage.

Q. What happens if I have a recurrence?

A. Your plan pays an additional benefit (Recurrence Benefit) if a medical condition reoccurs for: Benign Brain Tumor, Invasive Cancer, Non-Invasive Cancer, Heart Attack, a Stroke, a Coronary Artery Bypass Graft, Coma, and Severe Burn. A recurrence benefit is only available if the initial benefit has already been paid for the covered condition.[7] And there is a benefit suspension period (or waiting period) between recurrences.[7] Also, a 90-day treatment-free period applies to Invasive and Non-Invasive Cancer.

Q. Am I eligible to enroll for this coverage?

A. Yes, you can enroll both yourself and your eligible family members.[8] All you need to do is enroll during the enrollment period and be actively at work.

Q. I have a medical plan at work, so why do I need critical illness insurance?

A. One of the hardest parts of managing illnesses like Cancer, a Heart Attack, or a Stroke is providing the support and comfort your family needs beyond the cost of care.

Even the best medical and disability income plans can leave you with extra expenses like medical plan deductibles and co-pays or extra costs for out-of-network care. And if you're out of work because of a disability, it might be that only a portion of your pre-disability income is being paid to you. Many people aren't prepared to handle the extra costs that can come with a critical illness, so having this extra cash lump sum payment may mean less worry for you and your family.

ADF# CI543.14

MetLife

Critical Illness Insurance

Q. Can I enroll for this insurance without having a medical exam?

A. Yes. Your critical illness coverage is guaranteed,[9] regardless of your health. You need to be actively at work to be covered. There are no medical exams to take and no health questions to answer, so the whole process might be easier than you think.

Q. Are there any other benefits payable under this critical illness insurance plan?

A. Yes. Early detection of a serious illness is important to your recovery. We provide you with an extra $50 or $100 annual benefit per calendar year (based upon benefit elected) on top of your total benefit amount when you (or covered dependents) see your physician for eligible health screenings or prevention measures.[10]

Q. How do I pay for my coverage?

A. You pay premiums through payroll deductions, so you don't have to worry about writing any checks or missing payments.

Q. How much will it cost?

A. Critical illness insurance may cost less than you think. It's designed to be a way to supplement your health care and disability plans. Exact rates can be found in the enrollment materials provided by your employer.

Q. Are benefits paid directly to me or my health care provider?

A. Benefits will be paid directly to you, not to the doctors, to the hospitals or to any other health care providers. There's no need to coordinate with any other insurance you may have. Benefits are paid no matter what your other insurance plans may cover or pay.

Q. If my employment status changes, can I take my coverage with me?

A. Yes. This coverage is portable, meaning you can take it wherever you go. Your coverage will only end if you stop paying your premium or if your employer offers you similar coverage with a different insurance carrier.[11]

Have other questions?

Please call MetLife directly at
1 800 GET-MET8
1 800 438-6388
and talk with a benefits consultant.

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1. Please review the Disclosure Statement or Outline of Coverage/Disclosure Document for specific information about cancer benefits. Not all types of cancer are covered. Some cancers are covered at less than the Initial Benefit Amount. Skin Cancer is covered at 5%of the Initial Benefit Amount (but not less than $250).
2. The Heart Attack Covered Condition pays a benefit for the occurrence of a myocardial infarction, subject to the terms of the certificate. A myocardial infarction does not include sudden cardiac arrest.
3. In certain states, the Covered Condition is Severe Stroke.
4. Coma, Paralysis, Severe Burn, and Loss of: Ability to Speak; Hearing; Sight are not available in all states. Please review the Disclosure Statement or Outline of Coverage/Disclosure Document for details.
5. In most states, we will not pay a Major Organ Transplant benefit if a covered person is placed on the organ transplant list prior to coverage taking effect and subsequently undergoes a transplant procedure for the same organ while coverage is in effect. Refer to the Certificate for which organs are covered. In some states, the condition is Major Organ Failure.
6. In certain states, the Covered Condition is Coronary Artery Disease.
7. Please review the Disclosure Statement or Outline of Coverage/Disclosure Document for information on which Covered Conditions are eligible for a Recurrence Benefit. There may be a Benefit Suspension Period between recurrences of the same Covered Condition, as well as occurrences of different Covered Conditions. We will not pay a benefit for a Covered Condition that is subject to the Benefit Suspension Period. We will not pay a Recurrence Benefit for either Invasive Cancer or Non-Invasive Cancer unless the Covered Person has not had symptoms of or been treated for the Invasive Cancer or Non-Invasive Cancer for which we paid a benefit during the Treatment Free Period.
8. Eligible Family Members means all persons eligible for coverage as defined in the Certificate.
9. Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage.
10. The Health Screening Benefit is not available in certain states. Please review your Disclosure Statement or Outline of Coverage/Disclosure Document for specific state variations and exclusions around this benefit.
11. Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.

METLIFE CRITICAL ILLNESS INSURANCE (CII) IS A LIMITED BENEFIT GROUP INSURANCE POLICY. Like most group accident and health insurance policies, MetLife's CII policies contain certain exclusions, limitations and terms for keeping them in force. Product features and availability may vary by state. In most plans, there is a pre-existing condition exclusion. After a covered condition occurs, there is a benefit suspension period during which benefits will not be paid for a recurrence, except in the case of individuals covered under a New York certificate. Attained Age rates are based on 5-year age bands and will increase when a Covered Person reaches a new age band. A more detailed description of the benefits, limitations, and exclusions applicable can be found in the applicable Disclosure Statement or Outline of Coverage/Disclosure Document available at time of enrollment. For complete details of coverage and availability, please refer to the group policy form GPNP07-CI, GPNP09-CI or contact MetLife for more information. Benefits are underwritten by Metropolitan Life Insurance Company, New York, New York.

MetLife's Critical Illness Insurance is not intended to be a substitute for Medical Coverage providing benefits for medical treatment, including hospital, surgical and medical expenses. MetLife's Critical Illness Insurance does not provide reimbursement for such expenses.

Hospital Indemnity Insurance

Coverage to help with unexpected expenses, such as hospitalization expenses that may not be covered under your medical plan.

Salt Lake County

Hospital Indemnity Insurance Benefits

With MetLife, you'll have a choice of two comprehensive plans (called the "Low Plan" and the "High Plan") which provide lump sum cash payments for covered events regardless of any other payments you may receive from your medical plan. Here are just some of the covered benefits/services[B], when an accident or illness puts you in the hospital.[A]

Covered Benefits

Please contact MetLife for detailed definitions and state variations of covered benefits.

Hospital Benefits				
Subcategory	**Benefit Limits (Applies to Subcategory)**	**Benefit**	**Low Plan**	**High Plan**
Admission Benefit	4 time(s) per calendar year[1]	Admission[2]	$500	$1,000
		ICU Supplemental Admission (Benefit paid concurrently with the Admission benefit when a Covered Person is admitted to ICU)	$500	$1,000
Confinement Benefit	31 days per confinement[3] ICU Supplemental Confinement will pay an additional benefit for 15 of those days	Confinement[4]	$100	$200
		ICU Supplemental Confinement (Benefit paid concurrently with the Confinement benefit when a Covered Person is admitted to ICU)	$100	$200
Confinement Benefit for Newborn Nursery Care	2 day(s) per confinement	Confinement Benefit for Newborn Nursery Care[4]	$50	$50
Other Benefits				
Health Screening Benefit	1 time(s) per calendar year per covered person	Health Screening	$50	$100
Lodging*	15 days per calendar year	Lodging[6]	$100	$200

*Benefit(s) that requires prior Admission or Confinement

[1] If a covered person is readmitted within 90 days for the same or related sickness/injury for which we paid an Admission Benefit, an additional Admission Benefit is not payable.

[2] The admission Benefit for residents of ID will be increase to $575/$1,175 for plan design(s) Low/High because some benefits in this plan design are not available. See the Schedule of benefits in the ID certificate.

[3] If a covered person is confined again within 90 days for the same or related sickness/injury, we will treat the subsequent confinement as a continuation of the previous confinement.

[4] If the Admission Benefit is payable for a Confinement, the Confinement Benefit will begin to be payable the day after Admission.

[5] Payable for the period of newborn confinement for a newborn child who is not sick or injured.

MetLife

[7] The Lodging Benefit is for a companion accompanying a covered insured while hospitalized, provided that lodging is at least 50 miles from the insured's primary residence.

Benefit Payment Example for High Plan

Susan has chest pains at home, and after contacting her doctor, she is instructed to head to her local hospital. Upon arrival, the doctor examines Susan and advises that she requires immediate admission to the Intensive Care Unit for further evaluation and treatment. After two days in the Intensive Care Unit, Susan moves to a standard room and spends two additional days recovering in the hospital. Susan was released to her primary care physician for follow-up treatment and observation. Her primary doctor is now keeping a close watch over Susan's overall health. Depending on her health insurance, Susan's out-of-pocket costs could run into hundreds of dollars to cover expenses like insurance co-payments and deductibles. MetLife Group Hospital Indemnity Insurance payments can help cover these unexpected costs or in any other way Susan sees fit.

Covered Benefit	High Benefit Amount
Regular Hospital Admission (1x)	$1,000
ICU Supplemental Admission (1x)	$1,000
Regular Hospital Confinement (3 total days)	$600
ICU Supplemental Confinement (1 day)	$200
Benefits paid by MetLife Group Hospital Indemnity Insurance	$2,800

Benefit amount is based on a sample MetLife plan design. Plan design and plan benefits may vary.

Questions & Answers

Q. How do I enroll?

A. Enroll for coverage at Employer website.

Q. Who is eligible to enroll for this Hospital Indemnity coverage?

A. You are eligible to enroll yourself and your eligible family members. [C] You need to enroll during your Enrollment Period and be actively at work for your coverage to be effective. Dependents to be enrolled may not be subject to a medical restriction as set forth in the Certificate. Some states require the insured to have medical coverage.

Q. How do I pay for my Hospital Indemnity coverage?

A. Premiums will be paid through payroll deduction, so you don't have to worry about writing a check or missing a payment.

Q. What happens if my employment status changes? Can I take my coverage with me?

A. Yes, you can take your coverage with you. You will need to continue to pay your premiums to keep your coverage in force. Your coverage will only end if you stop paying your premium or if your employer cancels the group policy and offers you similar coverage with a different insurance carrier. [D]

Q. Who do I call for assistance?

A. Please call MetLife directly at 1-800-GET-MET8 (1-800-438-6388) and talk with a benefits consultant. Or visit our website: ***www.mybenefits.metlife.com***

[A] Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See your Disclosure Statement or Outline of Coverage/Disclosure Document for full details.

[B] Covered services/treatments must be the result of an accident or sickness as defined in the group policy/certificate. See your Disclosure Statement or Outline of Coverage/Disclosure Document for more details.

[C] Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents to be covered are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions may apply to dependents serving in the armed forces or living overseas."

[D] Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.

METLIFE'S HOSPITAL INDEMNITY INSURANCE IS A LIMITED BENEFIT GROUP INSURANCE POLICY. The policy is not intended to be a substitute for medical coverage and certain states may require the insured to have medical coverage to enroll for the coverage. The policy or its provisions may vary

or be unavailable in some states. Prior hospital confinement may be required to receive certain benefits. There may be a preexisting condition limitation for hospital sickness benefits. MetLife's Hospital Indemnity Insurance may be subject to benefit reductions that begin at age 65. Like most group accident and health insurance policies, policies offered by MetLife may contain certain exclusions, limitations and terms for keeping them in force. For complete details of coverage and availability, please refer to the group policy form GPNP12-AX, GPNP13-HI, GPNP16-HI or GPNP12-AX-PASG, or contact MetLife. Benefits are underwritten by Metropolitan Life Insurance Company, New York, New York. In certain states, availability of MetLife's Group Hospital Indemnity Insurance is pending regulatory approval.

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LifeLock Benefit Solutions

Opt-in to Cyber Safety

SALT LAKE COUNTY HUMAN RESOURCES Voluntary Benefits

www.slcountyvoluntarybenefits.com

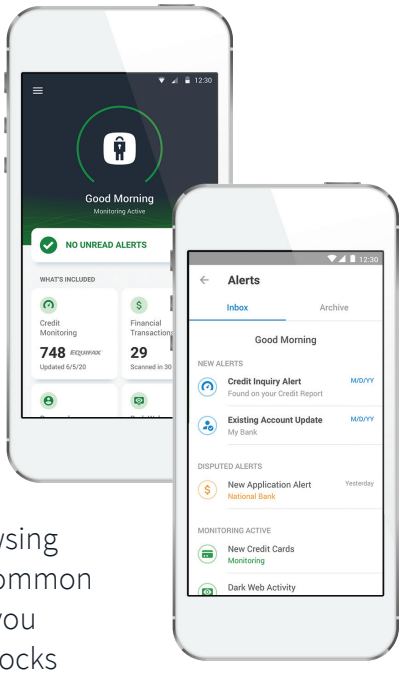
No one intends to be unsafe online. Help protect your identity and devices with Norton LifeLock Benefit Plans. Let us help you empower you and your family to live your digital lives safely.

Device Security

Anti-virus software and multi-layered, advanced security helps protect devices against existing and emerging threats, including malware and ransomware.

Online Privacy

Norton Secure VPN protects devices and helps keep online activity and browsing history private. Privacy Monitor scans common public people-search websites to help you opt-out. And SafeCam alerts you and blocks attempts to access your webcam.[1]



Screen modified for demonstration purposes.
Features may differ depending on plan.

Identity

We monitor for fraudulent use of personal information, and send alerts when a potential threat is detected.†

Home & Family

Take action to monitor your child's online activity with easy-to-use tools to set screen time limits, block unsuitable sites, and monitor search terms and activity history.

ENROLL TODAY

Take advantage of the special benefit plans and pricing by signing up through your benefit program and providing your **name, Social Security Number, date of birth, address, phone number and email address** for yourself and any dependents you wish to enroll.

HAVE AN EXISTING LIFELOCK MEMBERSHIP?

Don't forget to cancel your existing membership just prior to your benefit effective date by calling 800-607-9174.

No one can prevent all identity theft or cybercrime.
† We do not monitor all transactions at all businesses.
[1] Norton Cloud Backup, Norton SafeCam, Norton Family, and Norton Parental Control features are not supported on Mac, Windows 10 in S mode, and Windows running on ARM processor.

www.slcountyvoluntarybenefits.com

norton™ LifeLock Benefit Solutions

SALT LAKE COUNTY HUMAN RESOURCES Voluntary Benefits

PRICING: Bi-Weekly

	BENEFIT ESSENTIAL	BENEFIT PREMIER
Employee Only (18+ Years Old)	$3.23	$4.61
Employee + Family[Δ]	$5.99	$8.76

[Δ] The Norton Benefit Junior plan is for minors under the age of 18. LifeLock enrollment is limited to employees and their eligible dependents. Eligible dependents must live within the employee's household, or be financially dependent on employee. LifeLock services will only be provided after receipt and applicable verification of certain information about you and each family member. Please refer to employer group for the required information under your plan. In the event you do not complete the enrollment process for any family member, those individuals will not receive LifeLock services, but you will continue to be charged the full amount of the monthly membership selected until you cancel or modify your plan at your employer's next open enrollment period, which may be annually. Please note that we will NOT refund or credit you for any period of time during which we are unable to provide LifeLock services to any family member on your plan after your benefit effective date due to your failure to submit the information necessary to complete enrollment. If you do not complete the enrollment process for each family member, you may continue to pay more for LifeLock services than you otherwise would if you had selected a lower tier plan.

		BENEFIT ESSENTIAL	BENEFIT PREMIER
LIFELOCK IDENTITY THEFT PROTECTION	Identity Lock[1, 5]	●	●
	Home Title Monitoring[¶]		●
	Social Media Monitoring[*]	●	●
	Credit, Bank & Utility Account Freezes[**]	●	●
	LifeLock Identity Alert™ System[†]	●	●
	• Identity Verification Monitoring[†,**]	●	●
	• Telecom & Cable Applications for New Service	●	●
	• Payday - Online Lending Alerts[†]	●	●
	• Credit Alerts & Social Security Alerts[†]	●	●
	Mobile app (Android™ & iOS)[**] Downloading the app does not provide protection until enrollment has been completed.	●	●
	Dark Web Monitoring[**]	●	●
	• Dark Web Monitoring – Gamer Tags[**]	●	●
	• Dark Web Monitoring – Password Combo List	●	●
	Court Records Scanning		●
	USPS Address Change Verification	●	●
	Stolen Wallet Protection	●	●
	Reduced Pre-Approved Credit Card Offers	●	●
	Fictitious Identity Monitoring	●	●
	Phone Takeover Monitoring	●	●
	Data Breach Notifications	●	●
	Bank & Credit Card Activity Alerts[†,**]	●	●
	• Unusual Charge Alerts[†]	●	●
	• Recurring Charge Alert[†]	●	●
	Checking & Savings Account Application Alerts[†,**]		●
	Bank Account Takeover Alerts[†,**]		●
	401k & Investment Account Activity Alerts[†,**]	●	●
	File Sharing Network Searches	●	●
	Sex Offender Registry Reports	●	●
	Prior Identity Theft Remediation[9] This feature is separate from our Million Dollar Protection™ Package and does not provide coverage for lawyers and experts, reimbursement of stolen funds or compensation for personal expenses for events occurring during the 12 months prior to enrollment. See disclaimer for details.	●	●
	U.S.-based Identity Restoration Specialists	●	●
	24/7 Live Member Support	●	●
	Million Dollar Protection™ Package[†††] • Stolen Funds Reimbursement • Personal Expense Compensation • Coverage for Lawyers and Experts	*Up to $1 Million each*	*Up to $1 Million each*
	Credit Application Alerts[2,**]	*One-Bureau[1]*	*One-Bureau[1]*
	Credit Monitoring[1,**]	*One-Bureau[1]*	*Three-Bureau[1]*
	Credit Reports & Credit Scores[1,**] The credit scores provided are VantageScore 3.0 credit scores based on data from Equifax, Experian and TransUnion respectively. Third parties use many different types of credit scores and are likely to use a different type of credit score to assess your creditworthiness.	*One-Bureau[1] Monthly*	***On Demand –*** *One Bureau Daily/ Three-Bureau[1] Annual*
	Monthly Credit Score Tracking[1,**] The credit score provided is a VantageScore 3.0 credit score based on Equifax data. Third parties use many different types of credit scores and are likely to use a different type of credit score to assess your creditworthiness.		*One-Bureau[1]*
NORTON DEVICE SECURITY	Secures PCs, Mac & mobile devices[**]	*Up to 3 devices (Family gets 6 devices)*	*Up to 5 devices (Family gets 10 devices)*
	Online Threat Protection[**]	●	●
	Password Manager[**]	●	●
	Parental Control[4,**]	●	●
	Smart Firewall[**]	●	●
	Cloud Backup[3,**]	*10 GB*	*50 GB*
ONLINE PRIVACY	Secure VPN[**]	●	●
	Privacy Monitor	●	●
	SafeCam[3,**]	●	●

No one can prevent all identity theft or all cybercrime.

[1] If your plan includes credit reports, scores, and/or credit monitoring features ("Credit Features"), two requirements must be met to receive said features: (i) your identity must be successfully verified with Equifax; and (ii) Equifax must be able to locate your credit file and it must contain sufficient credit history information. IF EITHER OF THE FOREGOING REQUIREMENTS ARE NOT MET YOU WILL NOT RECEIVE CREDIT FEATURES FROM ANY BUREAU. If your plan also includes Credit Features from Experian and/or TransUnion, the above verification process must also be successfully completed with Experian and/or TransUnion, as applicable. If verification is successfully completed with Equifax, but not with Experian and/or TransUnion, as applicable, you will not receive Credit Features from such bureau(s) until the verification process is successfully completed and until then you will only receive Credit Features from Equifax. Any credit monitoring from Experian and TransUnion will take several days to begin after your successful plan enrollment. Please note that in order to enjoy all features in your chosen plan, such as bank account alerts, credit monitoring, and credit reports, it may require additional action from you and may not be available until completion.

[2] If your plan includes One Bureau Credit Application Alerts, two requirements must be met to receive said features: (i) your identity must be successfully verified with TransUnion; and (ii) TransUnion must be able to locate your credit file and it must contain sufficient credit history information. IF EITHER OF THE FOREGOING REQUIREMENTS ARE NOT MET YOU WILL NOT RECEIVE ONE BUREAU CREDIT APPLICATION ALERTS. One Bureau Credit Application Alerts will take several days to begin after your successful LifeLock plan enrollment.

[3] Norton Cloud Backup, Norton SafeCam, Norton Family, and Norton Parental Control features are not supported on Mac, Windows 10 in S mode, and Windows running on ARM processor).

[4] Norton Family and Norton Parental Control can only be installed and used on a child's Windows PC, iOS and Android devices but not all features are available on all platforms. Parents can monitor and manage their child's activities from any device – Windows PC, Mac, iOS and Android -- via our mobile apps, or by signing into their account at my.Norton.com and selecting Parental Control via any browser.

[5] Locking or unlocking your credit file does not affect your credit score and does not stop all companies and agencies from pulling your credit file. The credit lock on your Transunion Credit File will be unlocked if your subscription is downgraded or canceled.

[¶] Home Title Monitoring feature includes your home, second home, rental home, or other properties where you have an ownership interest.

[†] The LifeLock alert network includes a variety of product features and data sources. Although it is very extensive, our network does not cover all transactions at all businesses, so you might not receive a LifeLock alert in every single case.

[†††] Reimbursement and Expense Compensation, each with limits of up to $1 million for Norton LifeLock Benefit Essential, Norton LifeLock Benefit Premier, Benefit Elite, and Ultimate Plus, up to $100,000 for Advantage and Ultimate, and up to $25,000 for Standard, Command Center, Basic, and Benefit Junior and up to $1 million for coverage for lawyers and experts if needed, for all plans. Benefits under the Master Policy are issued and covered by United Specialty Insurance Company (State National Insurance Company, Inc. for NY State members). Policy terms, conditions and exclusions at: NortonLifeLock.com/legal.

[*] Does not include monitoring of chats or direct messages.

[**] These features are not enabled upon enrollment. Member must take action to activate this protection.

[9] Subject to eligibility requirements defined in Terms & Conditions. Norton reserves the right to change and/or cease services at any time.

Not all products, services and features are available on all devices or operating systems. System requirement information on Norton.com.

Norton™
LifeLock Benefit Plans

Congratulations on taking the first step toward a safer digital life.

To ensure that your identity, devices and privacy have the protection they need, please activate your membership.

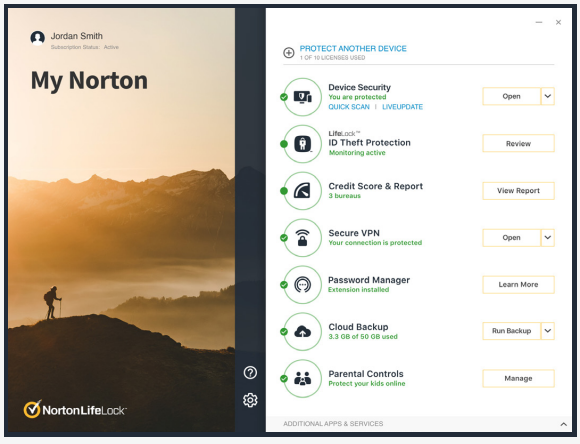
Activate your membership in 3 easy steps.

STEP 1
Verify your identity and create login credentials at norton.com/ebsetup.

STEP 2
Activate your plan features on your dashboard.

STEP 3
Download the Norton 360 and LifeLock Identity apps to receive alerts on-the-go.

Already a LifeLock member? After activation and logging in with your newly created credentials, your new plan will sync with your previous account.
Already a Norton member? Merge your accounts by clicking on "Sign in" rather than creating a new account.

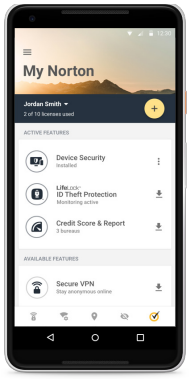


YOUR PERSONALIZED DASHBOARD

Your dashboard will walk you through activating the key features of your membership and gives you a quick snapshot of your account. You'll see important notifications that may need your attention at the top.

REVIEW AND MANAGE YOUR ALERTS ON-THE-GO

- Credit, Checking & Savings Account Activity Alerts†**
- 401k & Investment Account Activity Alerts†**
- Identity & Social Security Number Alerts††
- Bank & Credit Card Activity Alerts
- Unsafe website and compromised Wi-Fi network notifications



Screens are for demonstration purposes.

my.norton.com | 800-607-9174

WHAT IF I ALREADY HAVE IDENTITY PROTECTION?

What if I already have a Norton LifeLock account?

If you are an existing member, in most cases we will automatically transition your existing membership to the new Norton LifeLock Benefit Plan through your employer.

There are some circumstances that may require you to request termination of your current account before the new benefit membership can take effect, for example:

- Members enrolled in a Norton LifeLock retail plan with family members that they are not enrolling in the benefit offering. We do not auto-terminate members, leaving them without protection.
- Members enrolled through a third party partner and not billed directly by Norton LifeLock.
- Members enrolled through a different Norton LifeLock employee benefit plan, as the primary or dependent member.

In order for you to complete your transition, please call Norton LifeLock Member Services at 800-607-9174 close to your benefit effective date. Please mention to the representative that you would like to cancel your retail plan in order to enroll through your Employer's benefit program.

What if I already have identity protection through a different provider?

Not all identity theft protection plans are the same. Many provide basic credit monitoring and scores, but lack the ability to help with restoration. Years ago, that may have been enough but not with the sophisticated criminals we face today. If you are a victim of identity theft, having the ability to turn over the problems and have professionals work to fix on your behalf is truly important. In addition to full restoration services, Norton LifeLock adds extra layers of protection.

WE PROVIDE MUCH MORE.

PARENTAL CONTROL

IDENTITY THEFT PROTECTION

ONLINE PRIVACY

DEVICE SECURITY

Norton™ LifeLock Benefit Plans

HOW DOES NORTON LIFELOCK HELP PROTECT ME?

WE DETECT & ALERT†
We can detect a wide range of identity threats and will alert you if we find potentially suspicious activities.

WE DEFEND
We help block hackers from stealing personal information on your devices, and our personal virtual private network (VPN) helps keep your online activity private.

WE RESOLVE
If you become a victim of identity theft, one of our U.S.-based Identity Restoration Specialists will work to help restore it.

WE REIMBURSE†††
We provide coverage for lawyers and experts, if needed, plus reimbursement for personal expenses up to $1 million.†††

An essential part of your digital health and well-being,
Norton LifeLock empowers you to live your digital life more safely.

IDENTITY THEFT PROTECTION

Get alerts† for possible fraudulent use of your Social Security number, name, address and date of birth in applications for credit and services.

DEVICE SECURITY

Device protection against ransomware, viruses, spyware, malware, and other online threats. (PCs, Mac, smartphones, or tablets).

ONLINE PRIVACY**

Norton Secure VPN protects your devices on vulnerable connections and helps keep online activity and browsing history private. Privacy Monitor scans common public people-search websites to help you opt-out.

PARENTAL CONTROL**▽

Monitor your child's online activity, set screen time limits, block unsuitable sites, and monitor search terms and activity history.

24/7 LIVE MEMBER SUPPORT

For assistance including an identity-related question, call 800-607-9174. Agents specifically trained for Employee Benefit offerings are available Monday through Friday, from 9 a.m. to 7 p.m. EST.

FULL-SERVICE IDENTITY RESTORATION

Dedicated U.S.-based Identity Restoration Agents available to resolve your identity theft issues.

MILLION DOLLAR PROTECTION™ PACKAGE†††

Our Million Dollar Protection™ Package††† helps with compensation for qualified expenses up to $1 million to restore your identity.

† The LifeLock alert network includes a variety of product features and data sources. Although it is very extensive, our network does not cover all transactions at all businesses, so you might not receive a LifeLock alert in every single case.
** These features are not enabled upon enrollment. Member must take action to activate this protection.
††† Reimbursement and Expense Compensation, each with limits of up to $1 million for LifeLock with Norton Benefit Essential and LifeLock with Norton Benefit Premier. And up to $1 million for coverage for lawyers and experts if needed, for all plans. Benefits under the Master Policy are issued and covered by United Specialty Insurance Company (State National Insurance Company, Inc. for NY State members). Policy terms, conditions and exclusions at: NortonLifeLock. com/legal.

FREQUENTLY ASKED QUESTIONS

When can I expect my welcome email?
You should receive your Welcome email close to your effective date, from member.services@lifelock.com. The subject line is, “Activate Your NortonLifeLock Benefit Plan.”

Who is the welcome email sent to?
We will send the welcome email to the primary member, including your adult dependents' welcome emails. Please forward this along to any adult dependents so they can also set up their own online accounts. Minor dependents are simply reflected on the primary member's account.

What if I set up my account before my benefit effective date?
Upon logging into my.norton.com, you will be prompted to provide a product key or payment information because your benefit plan is not effective yet. If you created login credentials prior to receiving the welcome email or went directly at Norton.com to create an account, please go to norton.com/ebsetup to establish your account correctly. When asked to “Create Account” you should instead select “Sign In” and use the email address and password you initially used when trying to set up your account. This will merge the account you started to create with your benefit plan.

What happens if I don’t get my welcome email?
Check with your benefits team to make sure there isn't an error you need to address (your retail plan is still active, there's something preventing us from verifying your enrollment details, etc). Once you confirm you are successfully enrolled, follow the steps to set up your account at norton.com/ebsetup.

What if I do not set up my account?
Norton LifeLock will be monitoring your identity using the information from your enrollment (such as name, DOB, SSN) to notify you of accounts we detected being opened in your name or to let you know if we see your information on the dark web. However, to activate credit services, set up device security, add additional information for monitoring, or to update your contact preferences, you will need to set up the account.

If have a retail plan direct with LifeLock and I am moving to the new benefit plan, will I still get a welcome email?
Yes, you will still receive a welcome email and will need to follow the verification/activation steps.

If I had a retail plan prior to enrolling in the benefit, do I need to set everything up again in my new account?
Upon account activation, most of your information from your old account will transfer over. However, you will need to reactivate credit services, and if you used transaction monitoring previously, you will need to relink your financial accounts. You will see all your archived alerts in your new dashboard.

What should I do if I think I have been a victim of identity theft?
Please contact our member services team right away at 800-607-9174. Alternately, through the LifeLock Identity phone app, select ID Restoration and then ID Restoration Service to open a case.

Employee Benefits Member Support:

800-607-9174

Specialty Trained Agents

Dedicated agents available to answer questions
Monday through Friday, from 9am to 7pm EST

Nationwide® pet insurance FAQ

Do I need to re-enroll for this benefit every year?

No. Once enrolled, the policy will renew automatically each year at your renewal.

How can I make changes to my policy?

You can make changes to your policy during your policy renewal period. All changes are subject to underwriting approval.

When is the policy renewal period?

The renewal period starts 60 days before the policy's current 12-month term expires. The policy's effective date and expiration date can be found on the Declarations Page, which is included with the policy packet that is mailed to you at each new term.

What happens to my pet insurance policy if I am no longer with the company?

You will be notified and asked to update billing information in order to keep the policy active.

Will pre-existing conditions be covered?

Unfortunately, no. Like all pet insurers, we don't cover pre-existing conditions on any of our plans.

Can I still use my veterinarian?

Absolutely. You're free to visit any licensed veterinarian, anywhere in the world—even specialists and emergency providers.

If I have a pet other than a dog or cat, can I enroll?

Yes! If you want coverage for your bird, rabbit, reptile or other exotic pet, you'll find it with Nationwide®. To enroll in the Avian & Exotic Pet Plan, please call 877-738-7874.

What is vet*helpline*® and how does it work?

Veterinary experts are available 24/7 through **vet***helpline*®, a service provided exclusively for Nationwide® pet insurance members. You can get live help with any pet health concern, including identifying urgent care needs. Please note, a **vet***helpline* consultation is not a substitute for a visit to your primary veterinarian.

How do I file a claim?

It's easy. Simply pay your vet bill and then send us a claim for reimbursement via mail, email or online.

Mail: Nationwide Claims Dept., P. O. Box 2344, Brea, CA 92822-2344

Email: submitmyclaim@petinsurance.com

Online: Submit claims through your Nationwide Pet Account Access page at my.petinsurance.com. Please allow 48 hours from the time you submit your claim for it to appear online.

Get a quote at **PetsNationwide.com** • **877-738-7874**

Nationwide®