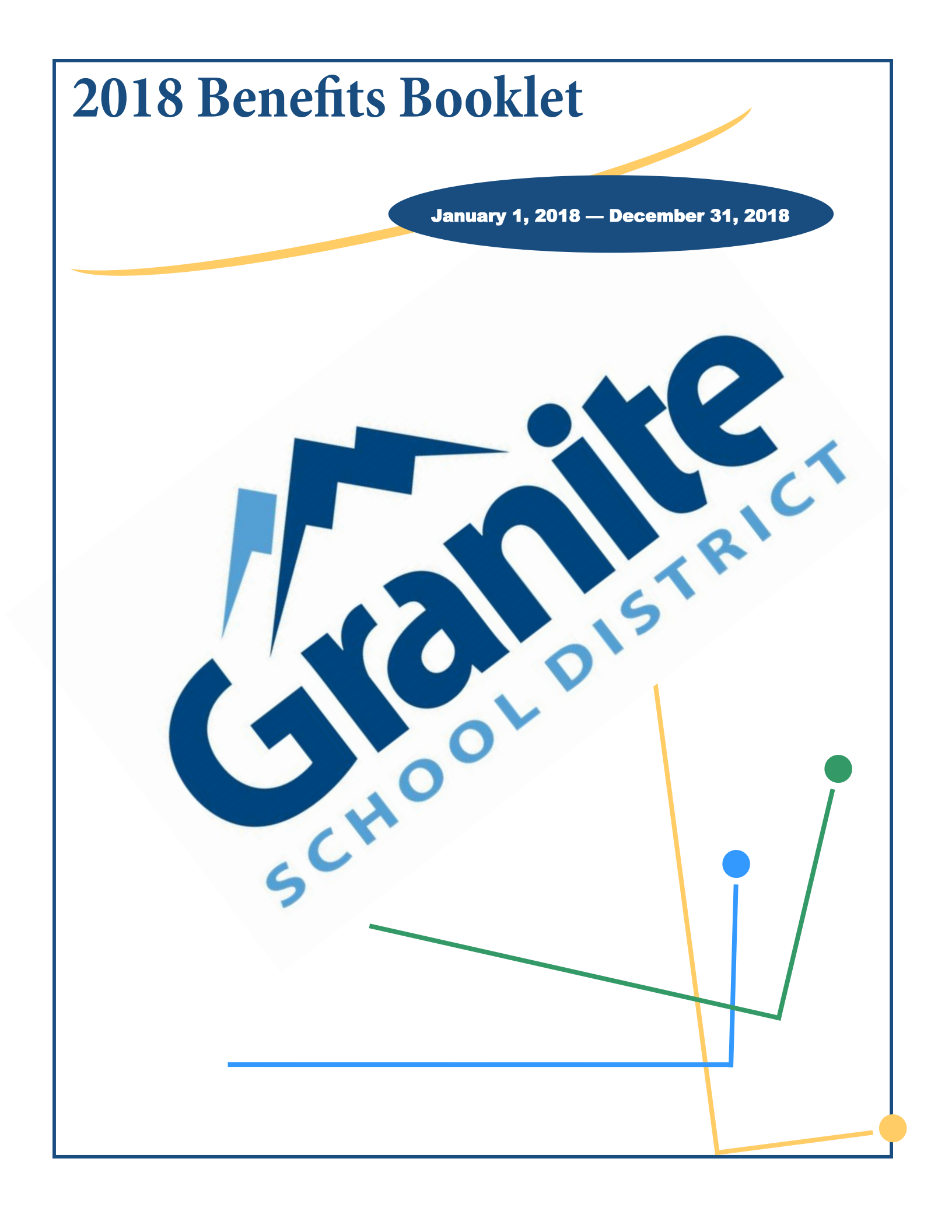
2018 Benefits Booklet

January 1, 2018 — December 31, 2018



Insurance Premium & Wellness Incentive

To avoid the $10 monthly Granite Well-Being insurance premium increase for plan year 2018. You will need to complete steps listed below between January 1, 2017 and December 31, 2017. The Well-Being monthly premium will be an additional $10 per month for the entire plan year of 2018.

Your doctor visit must be after January 1, 2017 and before December 31, 2017

Step 1 Login to H2U and create your own personal account.

- Login: http://www.h2u.com/mountainstar
- First time login users will select "No" when asked if they have participated in the wellness program before. Access Code Required **# MSGSD114**

Step 2 Complete the Health Risk Assessment (HRA) online at H2U.

Step 3 Complete Biometric Screening at one of our Benefit Fairs held in October.

- **You are DONE!** - No Additional Reporting is required.

OR

Complete Biometric Screening by seeing your own personal physician.

- **Complete the physician form and return to Benefit Department**
  -Physician Form found online at :
  http://www.graniteschools.org/hr/benefits/granite-well-being/
- **You are DONE!** - No Additional Reporting is required.

The insurance premium increase will begin on your January 1, 2018 paycheck.

Granite Well-Being is committed to helping you become aware of your own personal health. Participation in the Granite Well-Being program is available to all contract employees. If you need assistance, have questions, or unable to complete the three steps. Please contact the Benefits Department at 385-646-4528 or benefits@graniteschools.org we will be happy to help.

2018 Benefit Changes

- No plan design changes for 2018

Avoiding the $10 Monthly Premium Increase

1. What must I do to avoid the $10 increase added to regular monthly medical premiums for 2017? Login to H2U and create an account, complete the two required activities Biometric Screening & Personal Health Assessment (PHA). First time login users will select "No" when asked if they have participated in the wellness program before. Access Code Required # **MSGSD114** *http://www.h2u.com/mountainstar*

2. What is a biometric screening and why is it important? A biometric health screening is a short health examination that indicates your risk for certain diseases and medical conditions. It helps you understand where you should take action to improve your health.

3. How is the biometric screening conducted and what information is being collected?
The screening uses certain body measurements and a small blood sample. Data collected:
• Height and weight, which is used to calculate body mass index (BMI)
• Systolic and diastolic blood pressure
• Total cholesterol
• HDL cholesterol
• Glucose

4. Where can I complete the biometric screening? One of the Benefit Fairs held in October or your personal doctor.

5. What evaluation must my doctor do and is there a cost? A routine physical is all that is needed. Annual physicals are Free ($0 copay) if done in network.

6. How will I report seeing my doctor and is there a special form that must be completed? Yes, there is a special form that will need to be completed and returned to the benefit department by 12/31/17. The form can be found online at the following website: *http://www.graniteschools.org/hr/benefits/granite-well-being/*

7. What is the Personal Health Assessment (PHA)? The PHA is a health survey that you will complete online at the H2U website.

8. When must the two required activities be completed? Must be completed between 1/1/17- 12/31/17

9. How do I report completion of the required activities? Completing the PHA online will automatically be reported, bioscreenings done at Benefit Fairs will automatically be reported. Bioscreening done by personal physician, Physician Form will need to be turned into Benefit Department.

10. Does my spouse need to complete the two requirements? No

11. I am retired do I need to complete the activities? No, retirees will not be required to complete the activities.

12. *I don't have medical insurance with the district do I need to complete the activities?* No, only contract employees who have insurance with Granite School District.

13. I am a new employee, do I need to complete the activities? No, new employees hired between 7/1/17 & 12/31/17 will not be required to complete the activities for 2018 plan year.

NO PERSONAL MEDICAL INFORMATION IS EVER SHARED WITH GRANITE SCHOOL DISTRICT

Carrier Contact Information

Select Health	Medical	www.selecthealth.org	801-442-5038
Regence BC/BS	Medical	www.ut.regence.com	866-240-9580
Dental Select	Dental	www.dentalselect.com	801-495-3000
National Benefit Services	FSA	www.nbsbenefits.com	801-532-4000
Opticare of Utah	Vision	www.opticareofutah.com	800-363-0950
Aetna	LTD	www.aetna.com	866-326-1380
LifeMap	Life Insurance	www.lifemapco.com	800-286-1129
Utah Retirement Systems	Retirement	www.urs.org	801-366-7770
Allstate	Accident/critical Illness	www.allstateatwork.com	800-521-3535

Granite School District Contact Information

Granite School District	www.graniteschools.org	385-646-5000
Benefits Office	www.graniteschools.org/hr/benefits	385-646-4528
Email	benefits@graniteschools.org	
Fax		385-646-4319
Payroll Office	www.graniteschools.org/payroll	385-646-4311
Human Resources Office	www.graniteschools.org/hr	385-646-4511

Important Information

$50 Late Fee will be charged to employees who fail to waive or complete their elections during Open Enrollment

Benefit Information

Medical—Hospitals/Kidscare/Instacare Clinics—Select Health

HOSPITALS

Alta View Hospital
Davis Hospital Center
Heber Valley Medical Center
Intermountain Medical Center
LDS Hospital
McKay Dee Hospital Center
Mountain West Medical Center
Park City Medical Center
Primary Children's Hospital
Riverton Hospital
TOSH (Orthopedic Specialty Hospital)

INSTACARE/KIDSCARE CLINICS

Bountiful Kidscare/Instacare
Highland Instacare
Holiday Instacare
Layton Instacare
Murray Kidscare
North/South Ogden Instacare
North Orem Instacare
Ogden Kidscare
Riverton Kidscare/Instacare
Sandy Kidscare/Instacare
Saratoga Springs Instacare
Sugar House Kidscare/Instacare
Syracuse Instacare
Taylorsville Kidscare/Instacare
West Jordan Kidscare/Instacare

Medical—Hospitals/Kidscare/Urgent Care—Regence BC/BS

HOSPITALS

Center Jordan Valley Hospital
Center Pioneer Valley Hospital
Lone Peak Hospital
Ogden Regional Medical Center
Primary Children's Hospital
St Marks Hospital
University of Utah Medical

KIDSCARE/URGENT CARE

After Hours Medical
First Med Urgent Care
IHC Kidscare/Instacare
Ogden Clinic
Wee Care Pediatrics

Medical—Select Health

Health insurance doesn't have to be complicated. We'll help you with everything from finding the right doctor to understanding your benefits. Our resources will help you live the healthiest life possible.

CONNECT CARE – A skilled clinician is just a swipe or click away with Intermountain Connect Care. Use your computer, tablet, or phone to video connect with a doctor or nurse practitioner anytime (24/7 access). Visit intermountainconnectcare.org or download the app for Android or iOS.

MEDICAL COST ESTIMATOR - We can give you an estimate of how much you'll need to budget using your benefits, where you live, and your plan's provider network. For example, we can estimate the cost of cataract removal, including charges for the facility, provider, and anesthesiologist. Bundling these numbers together, we'll estimate your costs, including how much your plan will cover and what you will pay.

MEMBER SERVICES – Life doesn't stop at 5 p.m. SelectHealth Member Services (800-538-5038) offers extended hours to answer your questions and help resolve your concerns. We're available weekdays from 7:00 a.m. to 8:00 p.m. and Saturdays from 9:00 a.m. to 2:00 p.m.

MEMBER ADVOCATES – If you need help finding the right doctor—even on short notice—Member Advocates can assist in appointment scheduling and finding the closest available doctor, specialist, or facility. Call them at 800-515-2220.

INTERMOUNTAIN HEALTH ANSWERS – Talk to a registered nurse about your health concerns. It is free and you get access to the knowledge of an expert 24/7. Dial 844-501-6600 to connect.

MY HEALTH ONLINE TOOLS – Our secure member portal lets you view your claims, review explanations of benefits, see amounts paid year-to-date, and get personalized health and wellness information.

SELECTHEALTH MOBILE APP – If you've got your phone, we've got you covered. With the SelectHealth® mobile app, you have access to your health plan whenever—and wherever—you need it.

- With our secure app, you can:
- View, email, and fax images of your ID Card
- Search for doctors and hospitals
- See Intermountain InstaCare® wait times and locations, even reserve your place in line
- View your benefits and claims, including year-to-date totals
- Look up pharmacies and medications

PHARMACY BENEFITS MADE SIMPLE – It's easy to view your family's prescriptions or find out how much a drug will cost. Log in to My Health and view the drugs your plan covers, examine your claims, compare drug prices, see prescription prices and lower-cost alternatives, find a pharmacy, and check for drug interactions.

DISCOUNTS AND MORE DISCOUNTS – We know that embracing a healthy lifestyle is easier when it costs less. As a SelectHealth member, you have discounts on everyday products and services, including:

- Acupuncture
- Health clubs
- Hearing aids
- LASIK vision surgery
- Massage therapy

The process is simple—no enrollment forms, fees, or payroll deductions—just great savings when you mention that you are a SelectHealth member and show your ID Card. To learn more, visit www.selecthealth.org/discounts.

HEALTHY BEGINNINGS – Pregnancy is a special time so our free prenatal program provides support and resources for expectant mothers. In addition to pregnancy education materials, the program includes a risk assessment screening and provides high-risk care management when needed.

CARE MANAGEMENT – Registered nurses can help with health concerns and coordinate services between providers and patients. Our care managers provide educational materials, newsletters, follow-up phone calls and additional support for conditions such as asthma, heart failure, depression, diabetes, and cancer.

NATIONAL ACCREDITATION – Remember, SelectHealth is Utah's top-ranked health plan, according to NCQA's Health Insurance Plan Rankings 2014–2015. Our ranking is based on how well we help our members stay healthy, get better, manage chronic illness, access qualified providers, and receive care when services are needed.

Medical—Regence BC/BS

We are three million members strong, being here for our families, coworkers and neighbors, helping each other be and stay healthy and provide support in time of need. And Regence BlueCross BlueShield has been here for members for more than 90 years.

WE ARE PROUD TO BE BLUE

The strength of the BlueCross and BlueShield brand is unsurpassed, and our reach is global. Our members can access healthcare across the country and around the world. Our vision of a new kind of healthcare system doesn't stop with our own members. We want to transform the system for everyone, because together we can do better.

TOGETHER, WE CAN DO BETTER

Regence defines success by how well we advocate for - and make a difference in - the health of our members. You have invested trust and resources in Regence , and we repay you by investing in products and services that deliver value every day, especially when you need care.

AN ONLINE SUPERTOOL - myREGENCE.com

Making healthy choices can be a difficult task in our complex world. Regence members value a trusted advisor to help you navigate the healthcare system and help you live a healthier life. MyRegence.com is a member-only website designed to advise Regence members on healthcare and lifestyle options, navigate through the health care system and reward healthy choices. Using myRegence.com you are able to view your claims and personal account information, compare hospitals, find information regarding a procedure's cost and quality based on your personal needs, use the interactive health and medical encyclopedia and even engage in conversations through open forums that allow members to interact with healthcare experts and with each other.

REGENCE OmedaRX

For more than 20 years, Regence Rx has successfully managed pharmacy benefits for more than 2.2 million members of The Regence Group. Regence Rx offers a pharmacy network of more than 50,000 pharmacies nationwide including two mail-order options, education tools and information, preferred medication/formulary support, call center support and prescription claims processing - online, electronic and real-time.

REGENCE ADVANTAGES

Regence offers value-added programs (not insurance benefits) that offer great savings to members from leading health-related companies and are offered by Regence in addition to your medical plan. Regence Advantages include weight management discount programs (Jenny Craig), fitness center memberships, LASIK/PRK eye surgery, cosmetic dermatology, cosmetic dentistry, acupuncture, child safety and health products, eyewear, hearing aids, and bicycle and skating helmets.

THE BLUECARD PROGRAM

Across the country and around the world… we've got you covered. When you are a BlueCross BlueShield plan member with a suitcase logo on your member ID card (applicable for the ValueCare and ValueCare Plus plans), the BlueCard program gives you access to doctors and hospitals almost everywhere, giving you the peace of mind that you'll be able to find the healthcare provider you need.

2018 MEDICAL COMPARISON CHART

Insurance Company	SelectHealth			Regence BlueCross BlueShield of Utah		
Plan Name	Select: Med	Select: Med Plus		ValueCare	ValueCare Plus	
	In-Network	In-Network	Out-of-Network	In-Network	In-Network	Out-Network
Dependent Age Maximum	26	26		26	26	
Benefit Start Date	1st of Month Following Hire Date	1st of Month Following Hire Date		1st of Month Following Hire Date	1st of Month Following Hire Date	
Annual Deductible	$1000 per person	$1000 per person	$1500 per person	$1000 per person	$1000 per person	$1500 per person
Deductible Toward Out-of-Pocket Maximum	3 Deductible Max ($3000) DOES count toward OOP Maximum	3 Deductible Max. ($3000) DOES count toward OOP Maximum	3 Deductible Max. ($4500) DOES count toward OOP Maximum	3 Deductible Max. ($3000) DOES count toward OOP Maximum	3 Deductible Max. ($3000) DOES count toward OOP Maximum	6 Deductible Max. ($4500) DOES count toward OOP Maximum
Out-of-Pocket Maximum	Employee $2000 Employee & 1 $3000 Employee & 2+ $4000	Employee $2000 Employee & 1 $3000 Employee & 2+ $4000	Employee $2500 Employee & 1 $4500 Employee & 2+ $5000	Employee $2000 Employee & 1 $3000 Employee & 2+ $4000	Employee $2000 Employee & 1 $3000 Employee & 2+ $4000	Employee $2500 Employee & 1 $4500 Employee & 2+ $5000
Office Visits *						
Office Visit (General) **	$40 copay per visit	$40 copay per visit	60% after deductible	$40 copay per visit	$40 copay per visit	60% after deductible
Office Visit (Specialty)	$50 copay per visit	$50 copay per visit	60% after deductible	$50 copay per visit	$50 copay per visit	60% after deductible
X-Ray/Lab Tests - Minor	Included in copay	Included in copay	60% after deductible	Included in copay	Included in copay	60% after deductible
X-Rab/Lab Test - Major	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	60% after deductible
Preventative Services						
Routine Physical (1 per yr)	100%	100%	Not Covered	100%	100%	Not Covered
Pap Office Visit	100%	100%	Not Covered	100%	100%	Not Covered
Mammogram/Lab Tests	100%	100%	Not Covered	100%	100%	Not Covered
Well Child Care	100%	100%	Not Covered	100%	100%	Not Covered
Immunizations	100%	100%	Not Covered	100%	100%	Not Covered
Eye Exam	100%	100%	Not Covered	100%	100%	Not Covered
Eyewear	Discount Program	Discount Program	Discount Program	Discount Program	Discount Program	Discount Program
Maternity Care ①						
Initial Prenatal Office Visit	$40 copay (1st visit only)	$40 copay (1st office visit)	60% after deductible	$40 copay (1st visit only)	$40 copay (1st visit only)	60% after deductible
Care/Delivery/Profess. Fees ③	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	60% after deductible
Newborn Adoption Benefit ④	Subject to maternity care benefit; not to exceed $4,000	Subject to maternity care benefit; not to exceed $4,000	Subject to maternity care benefit; not to exceed $4,000	Subject to maternity care benefit; not to exceed $4000	Subject to maternity care benefit; not to exceed $4,000	Subject to maternity care benefit; not to exceed $4,000
Inpatient Services ③						
Medical-Surgical Admission	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	60% after deductible
Skilled Nursing Facility ⑤	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	60% after deductible
Rehabilitation Services ⑤	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	60% after deductible
Professional Fees	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	60% after deductible
Outpatient Services						
Facility Charges	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	60% after deductible
Surgical Fees	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	60% after deductible
Rehabilitation Services ⑤	$40 copay after deductible	$40 copay after deductible	60% after deductible	$40 copay after deductible	$40 copay after deductible	60% after deductible
Home Health / Hospice ③	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	60% after deductible
Chemo/Radiation/Dialysis	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	60% after deductible
Emergency Services						
Urgent Care	$35 copay per visit	$40 copay per visit	60% after deductible	$35 copay per visit	$40 copay per visit	60% after deductible
Emergency Room	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	60% after deductible
Ground Ambulance	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	60% after deductible
Air Ambulance	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	60% after deductible

*All copays now apply to out of pocket maximum

** General Office Visit Includes: Family Medicine, Pediatrics, Internal Medicine, OBGYN (Geriatrics SelectHealth only)

2018 MEDICAL COMPARISON CHART

Insurance Company	SelectHealth			Regence BlueCross BlueShield of Utah		
Plan Name	Select: Med	Select: Med Plus		ValueCare	ValueCare Plus	
	In-Network	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network
Durable Medical Equipment ③						
Inpatient or Outpatient	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	60% after deductible
Chiropractic Care ⑤						
Office Visit	Not Covered	Not Covered	60% after deductible	Not Covered	$40 copay per visit	60% after deductible
Mental Health ③⑤						
Inpatient Visit ⑤	80%	80%	50% after deductible	80%	70%	50% after deductible
Outpatient Visit ⑤	$40 copay then 100%	$40 copay then 100%	50% after deductible	$40 copay then 100%	$40 copay then 100%	50% after deductible
Autism ③⑤						
Inpatient Visit ⑤	80%	80%	50% after deductible	80%	70%	50% after deductible
Outpatient Visit ⑤	$40 copay then 100%	$40 copay then 100%	50% after deductible	$40 copay then 100%	$40 copay then 100%	50% after deductible
Prescription Drugs ③						
Retail	**Up to a 30-Day Supply**	**Up to a 30-Day Supply**		**Up to a 30-Day Supply**	**Up to a 30-Day Supply**	
Generic/Tier 1	$10.00 per prescription	$10.00 per prescription		$10.00 per prescription	$10.00 per prescription	
Preferred/Tier 2 ⑦	$50.00 per perscription	$50.00 per prescription		$50.00 per perscription	$50.00 per prescription	
Non-Preferred/Tier 3	$80.00 per perscription	$80.00 per prescription		$80.00 per perscription	$80.00 per prescription	
Mail Order	**Up to a 90-Day Supply**	**Up to a 90-Day Supply**		**Up to a 90-Day Supply**	**Up to a 90-Day Supply**	
Generic/Tier 1	$20.00 per prescription	$20.00 per prescription		$20.00 per prescription	$20.00 per prescription	
Preferred/Tier 2 ⑦	$80.00 per prescription	$80.00 per prescription		$80.00 per prescription	$80.00 per prescription	
Non-Preferred/Tier 3	$140.00 per prescription	$140.00 per prescription		$140.00 per prescription	$140.00 per prescription	
Injectable Drugs ③						
Received at Pharmacy	Subject to pharmacy tiers	Subject to pharmacy tiers		Subject to pharmacy tiers	Subject to pharmacy tiers	
Received via Home Health	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	60% after deductible
Formulary Drug List						
	www.selecthealth.org/pharmacy/plans			www.regencerx.com		

HOW TO FIND A PARTICIPATING PHYSICIAN OR FACILITY

Insurance Company	SelectHealth		Regence BlueCross BlueShield of Utah	
Plan Name	Select: Med	Select: Med Plus	ValueCare	ValueCare Plus
Member Services	801-442-5038	801-442-5038	1-866-240-9580	1-866-240-9580
Web Site Address	www.selecthealth.org	www.selecthealth.org	www.ut.regence.com	www.ut.regence.com
Provider Network Lookup	Select Med	Select Med Plus	ValueCare	ValueCare Plus

① No benefit for dependent children

② Specificed immunizations only. Refer to the Summary Plan Desription(s).

③ Preauthorization is required on the following: inpatient services; maternity stays longer than two days for a normal delivery or longer than four days for a cesarean; DME items: insulin pumps and continuous glucose monitors, negative pressure wound therapy, electrical pump, prosthetics, motorized/customed wheelchairs, DME over $5,000: home health nursing services; certain injectable and prescription drugs; and pain management/pain clinic services. If you fail to precertify, benefits are reduced to 50 percent and will not be applied to your out of pocket max.

④ Allowable adoption amount as outlined by the state of Utah. Medical deductible and copay/coinsurance applies.

⑤ Limited number of visits per calendar year. Refer to the Summary Plan Decription(s).

⑥ Mandatory generic substitution enforced when a generic drug is available or you must pay the the preferred or nonpreferred copay plus the difference in cost between name brand and generic drug.

⑦ There are differences in the prescription preferred drug formularies between SelectHealth and Regence.

Pharmacy

- Your selection of a medical insurance carrier determines your prescription drug carrier. There are differences in the preferred drug formularies between SelectHealth and Regence BlueCross BlueShield of Utah. It is strongly recommended that in making your medical insurance plan selection, you also review and compare the differing prescription drug formularies and the injectable benefit carefully.

- The prescription drug benefit covers most commonly prescribed medications approved by the FDA. As with other health plan benefits, the coverage provided by the prescription drug benefit has limitations and exclusions. For certain drugs, the plan normally provides coverage up to specific dispensing limits. To determine if a specific drug or quantity is covered and/or if a particular drug requires prior authorization or step therapy, contact the medical insurance carrier directly.

- To get the maximum value from the prescription drug benefit program, **YOU ARE REQUIRED TO USE GENERIC DRUGS** when available. If no generic drug is available, ask your physician to prescribe a drug from the preferred drug listing. If you insist on a brand name drug when a generic is available, you will be assessed the applicable brand name copayment *plus* the difference in the cost between the brand name drug and the generic drug.

Pharmacy—Select Health

- Preferred drug formulary: www.selecthealth.org
- The preferred drug formulary is subject to change on a monthly basis
- By using the Retail 90 program or the Intermountain Home Delivery Pharmacy, you can obtain a three-month supply of prescription medication for a 60-day copayment
- Most injectable medications require prior authorization and may be covered at 80% after the deductible

Pharmacy—Regence BC/BS

- Preferred drug formulary: www.omedarx.com
- The preferred drug formulary is subject to change on a quarterly basis
- Generic Incentive program eliminates your copayment for the first 30-day fill of select generic prescriptions at a retail pharmacy
- By using the Mail Order pharmacy benefit, you can obtain a three-month supply of prescription medication for a 60 day copayment
- Most injectable medications require prior authorization and may be covered through the pharmacy benefit

Generic Prescriptions

By now, we've all heard of the national generic prescription drug programs that are being offered by national "big box" retailers like Wal-Mart Walgreens, and Target and even some regional/local retailers like Smith's grocery store.

BIG BOX RETAILER

SO WHAT IS IN IT FOR YOU (and the District as a whole) if each of us, instead of running our generic prescriptions through the District's insurance program, choose to fill our generic prescriptions through one of the national "big box" retailer's generic prescription drug programs? You guessed it…

BIG MONEY, BIG SAVINGS

Did You Know?

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

Tips

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

How Do I Use "Big Box" Generic Prescription Drug Program?

- Discuss the prescription being issued with your doctor. Ask if a generic medication is available to treat you. If a generic is available, the prescription must be written for the generic drug.
- Take your prescription (or have your physician call it in) to one of the "big box" retailers offering a generic pharmacy benefit program.
- Tell the pharmacist that you would like to fill the generic prescription through their generic prescription drug program. (In doing so, you will not need to show your Granite medical ID card).
- Receive a 30-day supply of generic medication for $4.00 (versus the $20.00 copayment you would have had to pay if you used the District's medical insurance) or receive a 90-day supply of generic medication at $10.00 (versus the $40.00 copayment you would have had to pay if you used the District's medical insurance). See… big savings!

"Big Box" Store Prescription Drug Web Page.

Target—www.target.com

Wal-Mart & Sam's Club—www.walmart.com

Walgreens—www.walgreens.com

Smiths Pharmacy—www.smiths.com

DENTALSELECT

Web Portal Access

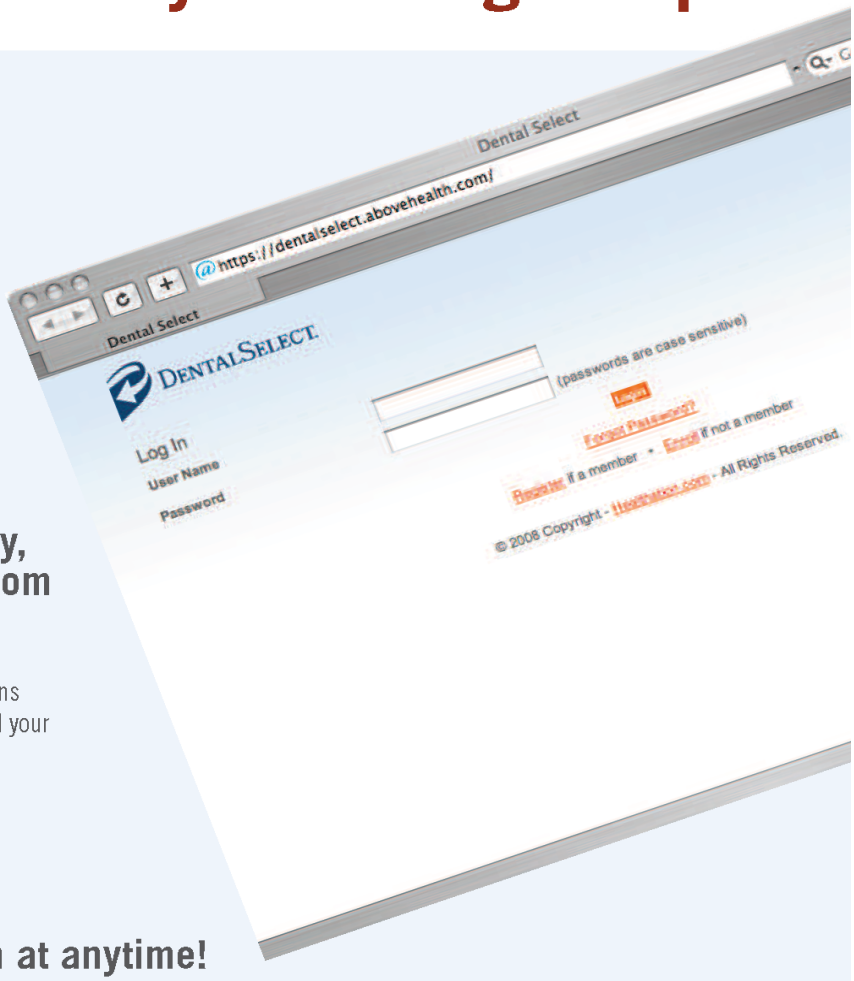
Toll Free Phone: 800-999-9789 Toll Free Fax: 888-673-5328 DentalSelect.com

Web Account Access
Right at your fingertips!

Connect.

As a member you can:

- View your Claim Status
- Order ID cards
- View your Explanation of Benefits
- View your Yearly Maximum Balance
- Update your Personal Information



Right.

Portal Registration is easy, go to www.dentalselect.com

1. Select member login from the homepage
2. Click on "Register"
3. Read and accept the terms and conditions
4. Enter Date of Birth, Member Number and your Social Security Number
5. Submit Registration

Now!

You are now able to login at anytime!

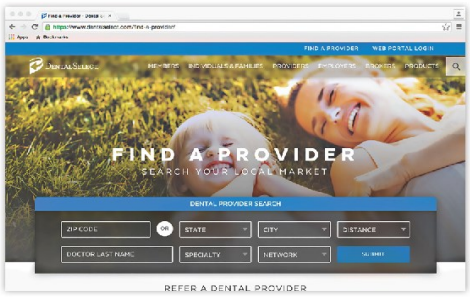
For assistance, call a Customer Service Representative at:

1-800-999-9789

Dental—Dental Select

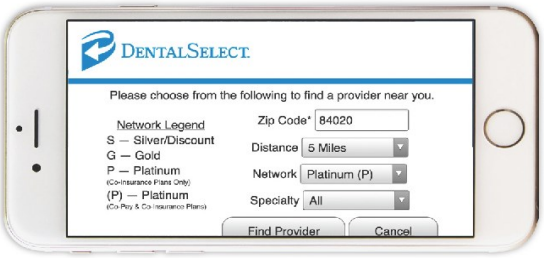
TWO SIMPLE WAYS TO FIND A DENTIST

① VISIT OUR WEBSITE



CLICK "FIND A PROVIDER" ON ANY PAGE

② DOWNLOAD OUR MOBILE APP



Download on the App Store

ANDROID APP ON Google play

REFER A DENTIST

Know a dentist you'd like to have join Dental Select's network? Simply visit our website and click on the Find a Provider link at the top of the page. From there, navigate to the "Refer a Dental Provider" section to provide the dentist's name and contact information. Our team will reach out and invite them to join our network.

DENTALSELECT

VISIT US AT
WWW.DENTALSELECT.COM

UT2016 PRO.01.9000310 02/16

Dental—Dental Select

Summary of Benefits For:
Granite School District

Silver Discount Plan	
Silver Network- 1389 Providers	
PREVENTIVE	
Routine exams, cleanings (2 per year), topical fluoride, x-rays	Up to **90%** Fee Reduction
BASIC	
Fillings, extractions, oral surgery	Up to **60%** Fee Reduction
MAJOR	
Crowns, bridges, dentures, endodontics, and periodontics	Up to **50%** Fee Reduction
ORTHODONTICS	
Children & Adults	**20% Discount**
Lifetime Maximum	**No Maximum**
MAXIMUM BENEFIT	
Per Year Preventive, Basic and Major services per person, per year	**No Maximum**
DEDUCTIBLE	
Per Person	**$0**
Family Max	**$0**
SPECIALISTS	
Endodontists, Oral Surgeons, Pediatric, Periodontists, Prosthodontists	**20% Discount**

09/28/2017 12:12PM

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

Dental—Dental Select

DENTALSELECT.

Dental Summary

Toll Free Phone: 800-999-9789 Toll Free Fax: 888-998-8703 DentalSelect.com

Summary of Benefits For:
Granite School District

	Co-Pay Medium Plan	
	Gold Network- 1812 Providers	
	Contracted Dentist	Non-Contracted Dentist
PREVENTIVE *Routine exams, cleanings (2 per year), topical fluoride, x-rays*	100%	See Out of Network Payment
BASIC *Fillings, extractions, oral surgery*	Fixed Co-Pays, Refer to Co-Pay Schedule	See Out of Network Payment
MAJOR *Crowns, bridges, dentures, endodontics, periodontics*	0% Contracted Fees Apply	No Benefit
ORTHODONTICS *Children and Adults* *Waiting Period* *Lifetime Maximum* *All Members*	50% No Waiting Period $1000.00 20% Discount	50%
MAXIMUM BENEFIT *Applies to Preventive, Basic and Major Services* *Per Year:*	No Maximum	
DEDUCTIBLE *Applies to Basic and Major Services* *Per Calendar Year*	No Deductible	
SPECIALISTS *Endodontists, Oral Surgeons, Pediatric, Periodontists, Prosthodontists. For pediatric specialists see schedule of co-payments.*	20% Discount	No Discount

09/28/2017 12:02PM

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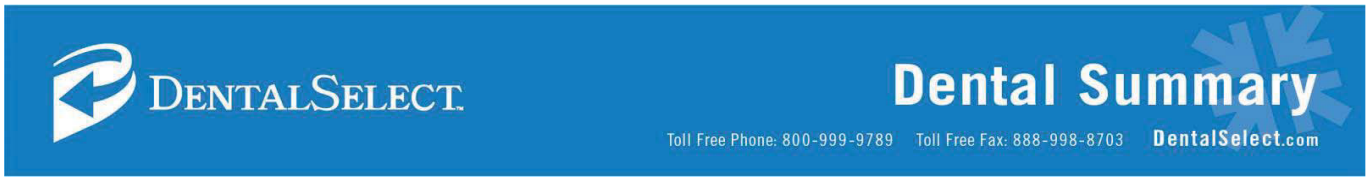
Dental—Dental Select



Summary of Benefits For:
Granite School District

	Co-Pay High Plan	
	Gold Network- 1812 Providers	
	Contracted Dentist	Non-Contracted Dentist
PREVENTIVE *Routine exams, cleanings (2 per year), topical fluoride, x-rays*	100%	See Out of Network Payment
BASIC *Fillings, extractions, oral surgery*	Fixed Co-Pays, Refer to Co-Pay Schedule	See Out of Network Payment
MAJOR *Crowns, bridges, dentures, endodontics, periodontics*	Fixed Co-Pays, Refer to Co-Pay Schedule	See Out of Network Payment
ORTHODONTICS *Children and Adults* *Waiting Period* *Lifetime Maximum* *All Members*	50% No Waiting Period $1000.00 20% Discount	50%
MAXIMUM BENEFIT *Applies to Preventive, Basic and Major Services* *Per Year:*	No Maximum	
DEDUCTIBLE *Applies to Basic and Major Services* *Per Calendar Year*	No Deductible	
SPECIALISTS *Endodontists, Oral Surgeons, Pediatric, Periodontists, Prosthodontists. For pediatric specialists see schedule of co-payments.*	20% Discount	No Discount

09/28/2017 12:02PM

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

Dental—Dental Select

DENTALSELECT.

Dental Summary

Toll Free Phone: 800-999-9789 Toll Free Fax: 888-998-8703 DentalSelect.com

Summary of Benefits For:

Granite School District

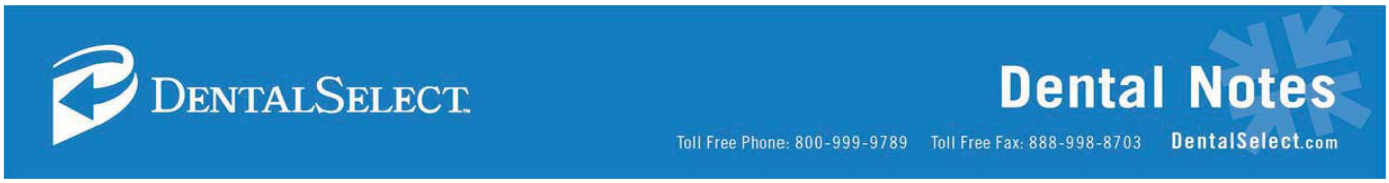
80th R&C

	Indemnity Classic Plan	
	Platinum Network- 2373 Providers	
	Contracted Dentist	Non-Contracted Dentist
PREVENTIVE *Routine exams, cleanings (2 per year), topical fluoride, x-rays*	80%	80% of R&C
BASIC *Composite fillings, extractions, oral surgery, sealants, space maintainers*	70% No Waiting Period	60% of R&C
MAJOR *Crowns, bridges, dentures, endodontics, periodontics*	40% No Waiting Period	40% of R&C
ORTHODONTICS *Children and Adults* *Waiting Period* *Lifetime Maximum* *All Members*	40% No Waiting Period $1000.00 20% Discount	40%
MAXIMUM BENEFIT *Applies to Preventive, Basic and Major Services* *Benefit Period is:* *Per Calendar Year*	$1000.00	
DEDUCTIBLE *Applies to Basic and Major Services* *Per Benefit Period* *Per Person:* *Family Maximum:*	$50.00 $150.00	$50.00 $150.00
SPECIALISTS *Endodontists, Oral Surgeons, Pediatric, Periodontists, Prosthodontists*	**Contracted Specialist payment:** 1) You receive a 20% discount off the Specialist fee 2) Plan pays according to the General Dentists Schedule of Fees 3) Member pays the difference between plan payment and discounted Specialist fee **Non-contracted Specialist payment:** Paid the same as non-contracted dentists	

09/28/2017 12:02PM

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

Dental—Dental Select



Dental Notes For:

Granite School District

Network Access

General Dentists

Dental Select participating general dentists accept the Platinum or Gold fee schedule as payment in full.

Specialists (Include Pediatric, Endodontist, Prosthodontist, Oral Surgeon, Periodontist, Orthodontist*)

Coinsurance Plans

*Contracted Orthodontist: The member may receive a discount of up to 20% off of the contracted Orthodontist's fee.

Contracted Specialists - Utah
Dental Select Signature or Platinum Networks: Services rendered by a Dental Select Participating Specialist will be reimbursed as follows.

1)You receive a 20% discount off the Specialist's fee.
2)Plan pays according to the General Dentists Schedule of Fees.
3)Member is responsible for the difference between the Plan's payment & the discounted Specialist's fee.

Non-Contracted Specialists:

UCR- No discount - including Orthodontists. The plan will pay based on Reasonable & Customary fees. The Member is responsible for the difference between the plan's payment and the Specialist's fee.

Co-Pay Plans - See Schedule of co-payments for member responsibility

Minnesota

Dental Select participating general dentists utilize the Premier network. Services rendered will be reimbursed according to the Premier network fee schedule as payment in full.

Plan Notes

Silver

Discount only; no benefit will be paid.

Co-Pay Plans

COVERAGE: CO-PAYS: The member's co-payments in the Schedule of Covered Services are subject to change on January 1, of each year. Specialist Discount: Discount only; no benefit will be paid. IN NETWORK: General Dentists: Accept a combination of fixed co-pay and plan payment as payment in full. OUT OF NETWORK: The member will be responsible for paying the difference between what the dentist charges and the plan payment.

UCR

CONTRACTED: General Dentists: All payments made by the plan are based on the Platinum contracted fee schedule. NON-CONTRACTED: Dental Select will allow up to the reasonable and customary charge for the dental procedures and services after the required deductible amount, as shown. Charges above the plan payment are the member's responsibility. DISCOUNT: Discount only; no benefit will be paid.

This summary of benefits is current as of 09/11/2017. To verify up to date benefits, please contact Dental Select Member Services (1-800-999-9789) or refer to your current Certificate of Insurance.

09/28/2017 12:02PM

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

Vision—Opticare of Utah

Opticare of Utah and Standard Optical are happy to announce $1,000 off LASIK surgery ($500 per eye) good at Standard Optical only. With Opticare of Utah you have the choice to use your benefits anywhere you want! It's important to remember vision insurance is a retail product, so it is very different from your dental and medical insurance. This means that it is important to shop around for the best price and the best eyewear suitable for your needs.

We give you options to shop anywhere you would like, so choose any of the three networks below to purchase your eyewear.

Select Network

Any ***Standard Optical*** location. Pay nothing out-of-pocket for standard plastic lenses, scratch resistant coating & ultra violet protection. Pick a frame under $70.00 and you now just received a pair of glasses and paid nothing out-of-pocket. Instead of glasses you prefer to wear contacts you pay nothing for anything under $70.00. If you wear both glasses and contacts, it's best to use your contact lens benefit first and then receive up to 50% off unlimited backup pairs of eye glasses throughout the year (Standard Optical locations only). These benefits are every 12 months. LASIK discounts of $500 off per eye (Standard Optical only).

Broad Network

Any Shopko, Eye Masters, America's Best and over 45 Independent shops statewide. Standard plastic lenses have just a $10 co-pay, and scratch resistant coating and ultra violet protection for just another $20 co-pay. Pick a frame under $60 and pay nothing out-of-pocket for that frame. You now just received a pair of glasses for $30 in the Broad Network. Instead of glasses you prefer to wear contacts there is no cost for anything under $60.00. If you wear both glasses and contacts, it's best to use your contact lens benefit first and then receive up to 25% off unlimited backup pairs of eye glasses throughout the year (Broad Network only). These benefits are every 12 months.

Out of Network

Any provider not listed on the provider list is considered Out-of-Network (i.e. Wal-Mart, Costco, Sam's Club, etc.). So if you would like to purchase your eyewear somewhere not found on our provider list, that's fine. We will reimburse you directly. You can be reimbursed up to $70 for any lens options, $50 on frames or instead of glasses you prefer to wear contacts you will be reimbursed $50 on contact lenses. Reimbursement form is found online at www.opticareofutah.com.

Remember for unlimited backup pairs of eyeglasses you can get up to 50% off within the Select (*Standard Optical locations only)* and up to 25% off within the Broad Network.

Please see Summary of Benefits for more details on how the plan works. Feel free to go online for updated provider listings at www.opticareofutah.com.

Important NOTE: Eye exams are **NOT** covered under this voluntary vision insurance program. Rather an eye exam is covered under each of the District's medical insurance plans.

Eye care is a critical part of overall health care. An eye exam is more than just a means to prescription eyewear; regular comprehensive eye exams can give early detection to many eye and systemic diseases, lowering overall healthcare costs. Approximately 50% of the U.S. population requires corrective vision as well as 80% over the age of 45. Vision insurance is a vehicle to help fund the cost of these expenses.

Vision—Coverage

	Select Network	Broad Network	Out-of-Network
Eye Exams			
No Eye Examination Benefit			
Standard Plastic lenses			
Single Vision	100% Covered	$20 Co-pay	$70 Alowance for lenses, options, and coatings
Bifocal (FT 28)	100% Covered	$20 Co-pay	
Trifocal (FT 7x28)	100% Covered	$20 Co-pay	
Lens Options			
*Progressive (Standard plastic no-line)	$50 Co-pay	$75 Co-pay	
*Premium Progressive Options	20% Discount	No Discount	
*Glass lenses	15% Discount	15% Discount	
Polycarbonate	$40 Co-pay	25% Discount	
High Index	$80 Co-pay	25% Discount	
Coatings			
Scratch Resistant Coating	100% Covered	$10 Co-pay	
Ultra Violet protection	100% Covered	$10 Co-pay	
Other Options	Up to 25%	Up to 25%	
A/R, edge polish, tints, mirrors, etc.			
Frames			
Allowance based on retail pricing	$70 Allowance	$60 Allowance	$50 Allowance
Additional Eyewear			
**Additional pairs of glasses throughout the year	Up to 50% off retail	Up to 25% off retail	
Contacts			
Contact benefits is I lieu of lens and frame benefit.			
Additional contact purchases			
Conventional	Up to 20% off	Retail	
Disposables	Up to 10% off	Retail	
Frequency			
Exams, Lenses, Frames, Contacts	Every 12 months	Every 12 months	Every 12 months
Refractive Surgery			
Lasik	$500 off per eye	Not Covered	Not Covered

*Co-pays for progressive lenses may vary. This is a summary of plan benefits. The actual policy will detail all plan limitations and exclusions.

Discounts
Any item listed as a discount in the benefit outline above is a merchandise discount only and not an insured benefit. Providers may offer additional discounts.

** 50% discount at Standard Optical locations only. All other Network discounts vary from 20% - 35%.
***Must purchase full year supply to receive discounts on select brands. See provider for details.
****LASIK(Refractive surgery) Standard Optical Locations ONLY. LASIK services are not an insured benefit – this is a discount only.
All pre & post operative care is provided by Standard Optical only and is based on Standard Optical retail fees.

Out of Network—Allowances are reimbursed at 78% when discounts are applied to merchandise. Promotional items or online purchases not covered. For more information please visit www.opticareofutah.com or call 800-363-0950.

Visit Our Providers

In Network Providers

Opticare of Utah has over 150 providers located in the State of Utah and over 20,000 nationwide.
To locate a provider in your area view our website:

www.opticareofutah.com

From the home page, click FIND an Opticare Provider and search by network

In Network will allow you to locate providers in your area by zip code in the state of Utah.

Out of State will allow you to search our Nationwide Network to find a provider Out side of the state of Utah by zip code.

Out of Network Options

You may view instructions and download forms for Out of Network Claims using the Locate a Provider/Out-of-Network drop-down tab.

For any questions or concern please contact us at:
(801) 869-2020 or (800) 363-0950

service@opticareofutah.com

Select In Network

Standard Optical

Broad In Network

Visionworks

SHOPKO eyecare center

AMERICA'S BEST CONTACTS & EYEGLASSES

INDEPENDENT OPTOMETRY NETWORK

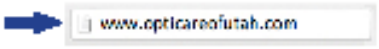
FirstLook Vision Network

Register and Print Member ID Cards Online

Printing member ID cards is simple! This guide will walk you through each step of the process.

1 Access the member portal

1a Go to www.opticareofutah.com



1b Click the "MEMBERS" link in the left navigation

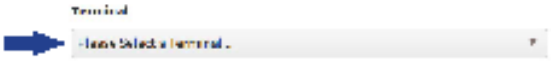
1c Click the "MANAGE YOUR ACCOUNT" banner

2 Register as a new user

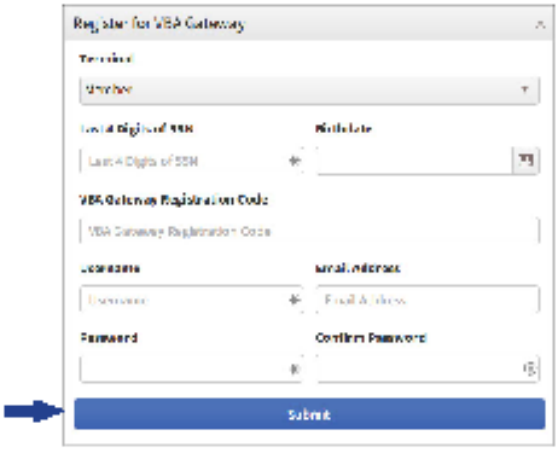
- If you have already registered, skip to step 3.
- Have your gateway registration code ready. *(This is your full Member ID - Please contact us if you need this for your initial registration - 1-800-363-0950)*

2a Click on "Click here to register"

2b Click the drop down menu, select "Member"

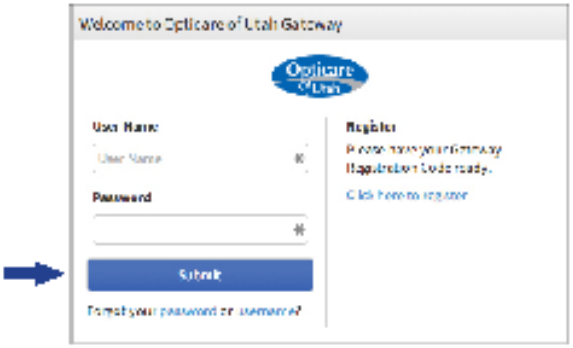


2c Fill out the form with the necessary details, then click the "Submit" button



3 Obtain ID Cards

3a Log into your account



3b Hover over the menu icon, select "Print Temp. ID Card"

3c Print Temporary ID Card. Scoll down and click "Print"

FLEX SPENDING-FSA

Remember it is

USE IT or *LOSE IT*

What Is A Flexible Spending Account?

Sometimes referred to as a Cafeteria Plan, Flex Plan or a Section 125 Plan, a Flexible Spending Account (FSA) lets you set aside a certain amount of your paycheck into a health care reimbursement account or a dependent day care reimbursement account - before paying federal, state, or Social Security taxes. This can save you 20-30% on out-of-pocket costs, depending on your personal tax rate.

How Do Flexible Spending Accounts Work?

During open enrollment, you decide how much of your pay you want to deposit into your reimbursement account(s). When you have determined how much expense you will have for the upcoming plan year (January 1– December 31, 2017), that amount is divided evenly over 12 pay periods and is automatically deducted from your paycheck before taxes are assessed. Once eligible expenses are incurred, you simply file a request to receive reimbursement from your account.

How Do I Use My Flexible Spending Money?

For a health care reimbursement account, you have two ways of paying for eligible expenses with money you contributed to your flex account. You can elect to have a NBS Flex Card and the service provider is paid directly from your flex funds at the point of service OR you can pay for the expense out of your own pocket and then submit a claim seeking reimbursement by providing the receipt(s) to NBS. NBS processes claims daily so you will receive your reimbursement funds quickly. At your request, NBS can also set you up on a continual reimbursement program so that predictable expenses, such as day care, can be reimbursed automatically on a monthly basis.

Can I Make Changes During The Plan Year?

Contributions cannot be changed or stopped during the plan year unless a qualified life status change occurs. These are outlined in the FAQs section of this booklet. Please note that if employment with the District is discontinued, you will not be able to receive reimbursement for expenses incurred after you have discontinued employment.

What If I Don't Use All My FSA Money This Plan Year?

Careful planning is important! At the end of the plan year (December 31, 2017), if you have money "left over" in your health care reimbursement account, you can continue to incur claims and use your debit card (if applicable) or submit claims for those qualified health care expenses until March 15 following the plan year. The Internal Revenue Code does not allow the plan to return your unused contributions to you after March 15 following the plan year. Any contributions remaining after March 15 will be forfeited by the participant.

USE IT OR LOSE IT!!!

FSA Health Care Account

A health care reimbursement account can be used to reimburse you or your family for out-of-pocket medical and dental expenses that are not typically paid by the District's medical and dental insurance programs.

The maximum annual contribution to a health care expense account is $212.50 per month = $2,550 per year

For a listing of eligible health care reimbursements go to: www.nbsbenefits.com

FSA Dependent Day Care Account

The dependent day care reimbursement account reimburses you for qualified day care expenses in order for you and your spouse (if married) to work and/or go to school.

To Qualify for dependent day care, your dependent(s) must be:

- A Child under the age of 13
- A child, spouse or other dependent that is physically or mentally incapable of self-care and spends at least 8 hours a day in your household

The maximum annual contribution to a dependent day care expense account is $416.66 per month = $5,000 per year

FSA Debit Card

Monthly fee to have the convenience of a FSA Debit Card = $3.55
Monthly fee to have a FSA account without a Debit Card = $2.05
Cards do not work for Dependent Daycare

Talk About Convenience!

The NBS Flex Card is a Master Card that is credited with the annual amount you elect to contribute toward a health care reimbursement account only (dependent day care reimbursement accounts are not eligible for the NBS Flex Card program). When you incur an eligible health care expense, you simply present your NBS Flex Card to the merchant and have them run the NBS Flex Card as a Master Credit Card. As you use the NBS Flex Card, your annual election balance will be reduced by the amount of your qualified purchases.

Basic Life Insurance

Contact Employees

- **Full-time** contract employees of the District, the cost of coverage for Basic Life is **PAID BY THE DISTRICT.**
- **Part-time** contract employees who elect to participate in basic term life insurance coverage will be assessed a proportional share of the cost of coverage based on their FTE status.

Granite School District basic life insurance policy is equal to an employee's base contract salary, rounded to the next higher number with maximum benefit of $100,000.

Travel Assistance — You and dependents, when 100 or more miles away from home, or outside of your home country, can obtain emergency medical, travel, and personal security assistance 24 hours a day, anywhere in the world. You can find out more about this benefit by visiting the LifeMap website at LifeMapCo.com, click on Employers and Employees, then click on Our Plans at the far top left and click on Travel Assistance or by contacting United Healthcare Global Assistance Services directly at 1 -800-537-2029, your Global Assistance ID Number is 333191.

This product is not insured by LifeMap Assurance Company. It is a service provided and administered through UHC Global Assistance Services, a leading provider of international travel assistance services.

Voluntary Life Insurance

Employee Policy

Policies issued in increments of:	$10,000
Minimum policy amount:	$10,000
Guarantee issue amount new hires	**$400,000**
Maximum policy amount:	$500,000
Age limitation:	None

Statement of health required for any increase (new and existing) beyond the $400,000 guarantee issue.

Rate based on employee's age and the policy amount desired.

Spouse Policy

Policies issued in increments of:	$5,000
Minimum policy amount:	$5,000
Guarantee issue amount new hires	**$50,000**
Maximum policy amount:	$100,000
Age limitation:	None

Maximum policy amount can't exceed the elected amount by the employee.

Statement of health required for any increase (new and existing) beyond the $50,000 guarantee issue.

Rate based on employee's age and not the spouse's age and the policy amount desired.

Unmarried Child Policy

Policies issued in increments of:	$1,000
Minimum policy amount:	$1,000
Maximum policy amount:	$10,000
Age limitation:	Age 26

Statement of health not required for child policy.

Rate based on policy desired amount.

Voluntary Life Insurance Rates

EMPLOYEE POLICY	
Changes in age band rates take place on the next payroll following the age change. Rates per $10,000	
< 25	$0.41
25-29	$0.44
30-34	$0.61
35-39	$0.80
40-44	$1.00
45-49	$1.46
50-54	$2.24
55-59	$3.71
60-64	$6.42
65-69	$11.63
70-74	$18.83
75-79	$30.50
80-84	$30.50
85 >	$30.50

SPOUSE POLICY	
Changes in age band rates take place on the next payroll following the age change. Rates per $5,000	
< 25	$0.22
25-29	$0.33
30-34	$0.39
35-39	$0.44
40-44	$0.50
45-49	$0.77
50-54	$1.38
55-59	$2.26
60-64	$4.13
65-69	$7.08
70 >	$11.55

CHILD POLICY	
Not based on age but rather policy amount elected. Rates per $1,000	
$1,000	$0.19
$2,000	$0.38
$3,000	$0.57
$4,000	$0.75
$5,000	$0.94
$6,000	$1.13
$7,000	$1.31
$8,000	$1.50
$9,000	$1.69
$10,000	$1.87

LifeMap™

Only when an employee purchases a voluntary life insurance policy on themselves can they purchase additional life insurance for their spouse and dependent children.

Where both spouses work for the District, each employee and dependent(s) may not be covered more than once.

To Determine The Monthly Premium

	EMPLOYEE POLICY	SPOUSE POLICY
1. Find the employees age bracket in the respective table below. *Remember! An employee's age is used for calculating rates for both an employee policy and a spouse policy.* Write the rate shown in the age bracket here ……..……...……...>	_____	_____
2. Determine the policy amount you would like. Write the policy amount you would like here ……..…..>	_____	_____
3. Divide the policy amount you would like by the respective policy increment in which a policy is issued (*employee policies issued in increments of $10,000; spouse policies issued in increments of $5,000).* State the policy amount in increments ..……..…>	_____	_____
4. Multiply the age bracket rate (1) by the policy increment (3). This is the monthly premium for optional term life policy coverage……...…>	_____	_____

Voluntary AD&D Insurance

An accidental death and dismemberment policy (also known as AD&D) is a form of insurance covering very specific types of injuries or death as a result of an accident. In the event of accidental death, an AD&D policy will pay benefits *in addition* to any life insurance held. There are some exclusions to an AD&D policy such as death by illness, natural causes or suicide.

EMPLOYEE ONLY POLICY

- Policies issued in increments of: $10,000
- Rate per ten thousand: $0.17
- Minimum policy amount: $20,000
- Maximum policy amount: $500,000
- *Policy only covers the employee only*

FAMILY PROTECTION POLICY

- Policies issued in increments of: $10,000
- Rate per ten thousand: $0.25
- Minimum policy amount: $20,000
- Maximum policy amount: $500,000
- *Policy that lists employee, spouse and children:*
  Spouse eligible for 40% of the policy amount; children eligible for 10% of the policy amount
- *Policy that lists the employee and their spouse:*
  Spouse eligible for 50% of the policy amount
- *Policy that lists children only:*
  Children eligible for 15% of the policy amount

ACCIDENTAL LOSS OF	BENEFIT
Life	100%
A hand	50%
A foot	50%
Sight in one eye	50%
Any combination of the above	100%
Thumb and index finger on same hand	25%
Speech and hearing in both ears	100%
Speech	50%
Hearing in both ears	50%
Paralysis of one arm and one leg/same side	50%
Paralysis of both legs	50%
Paralysis of both arms and both legs	100%

To determine the monthly premium of a Employee Only policy:

1. Determine the policy amount you desire …>
2. Divide the policy amount by $10,000 increments……>
3. Rate per $10,000……...>
4. Multiply the increments (2) by the rate (3) This is the monthly premium for coverage…>

EMPLOYEE POLICY	FAMILY POLICY
_____	_____
_____	_____
$0.17	$0.25
_____	_____

Disability Insurance

Accidents and illnesses tend to be unpredictable events. If you become disabled, your ability to make a living could be restricted. What would happen if you were unable to work for weeks, months or even years? Disability coverage replaces a percentage of your income on a monthly basis in the event you are unable to work due to an accident or illness.

Granite's disability insurance program is a **"bundled"** program. If you participate in disability insurance coverage, you will be enrolled in both short and long-term disability coverage.

Long Term Disability

- For permanent and continuous disability (greater than 120 calendar days in duration calculated from last day worked)
- Claim considered once the "LTD Elimination Period" has been reached - an absence greater than 120 calendar days calculated from last day worked
- Subject to submitting a comprehensive application and medical history documenting the incapacitation and permanence of the disability
- Paid benefits subject to medical health underwriting and approval from the carrier
- Paid benefit subject to ongoing medical re-certification as established by the carrier
- Benefit rate: 66 2/3% of base contract salary for teachers, classified and secretarial employees; 60% of base contract salary for middle managers and administrators. Max benefit normal retirement age.
- If claim is awarded, employee loses employment status with GSD as of the date of the award
- Medical insurance and basic term life insurance coverage, for the former employee only (not spouse/children), continues for 24 months (only) from date of award at no cost to former employee
- For duration of award status, former employee continues to accrue years of service credit toward a future full retirement with Utah Retirement Systems
- **NOTE: The long-term disability plan does not cover pre-existing conditions that existed 3 months prior to the start of your coverage unless the disability began after being covered for twelve consecutive months under the disability program.**

Short Term Disability

- For temporary disability (defined as 120 calendar days or less in duration calculated from first contract day missed)
- Provisional contract employees are not eligible to participate in STD coverage
- Intended to serve as an "income bridge" for employees with little or no accrued leave balances. "Bridges" the period of time between a temporary disability and a return to work OR toward fulfilling the "LTD Elimination Period" in order to submit a claim for long-term disability benefits
- Subject to submitting an initial application and medical statement documenting the temporary disability and a short waiting period without pay
- Paid benefit subject to medical re-certification on a monthly basis
- Benefit rate: 80% of daily rate
- Employee remains deemed an active employee
- Insurance coverage elections continue while receiving short-term disability benefits
- Sick leave, personal/vacation leave and years of service do not accrue while receiving short-term disability benefits
- **NOTE: The short-term disability plan does not provide coverage for any short-term disability resulting from or related to a condition which existed prior to the effective date of coverage**

Disability Insurance

Why Have Disability Insurance

Accidents and illnesses tend to be unpredictable events. If you become disabled, your ability to make a living could be restricted. What would happen if you were unable to work for weeks, months or even years? Disability coverage replaces a percentage of your income on a monthly basis in the event you are unable to work due to an accident or illness.

Granite's disability insurance program is a "bundled" program. If you participate in disability insurance coverage, you will be enrolled in both short and long-term disability coverage.

Teachers:

- Participation in the disability insurance program is voluntary and you must elect to have and pay for disability coverage.
- The benefit maximum is to normal social security retirement age
- The cost of disability insurance coverage is listed below.

	Semi-Monthly	Monthly
<$34,999	$9.00	$18.00
$35,000—$49,999	$9.25	$18.50
$50,000—$64,999	$9.50	$19.00
>$65,000	$10.00	$20.00

Is The Disability Benefit Taxable

Short-term disability benefit payments are taxable for all classes of employees. Long-term disability benefit payments are taxable for all classes of employees except for teachers.

Accident\Critical Illness Insurance

Accident insurance can help provide you with a cushion to help cover expenses and living costs when you get hurt unexpectedly. While you can count on health insurance to cover medical expenses, it doesn't usually cover indirect costs that can arise with a serious or even not-so-serious injury. You may end up paying out of your own pocket for things like transportation, over-the-counter medicine, day care or sitters and extra help around the house. With accident insurance, the benefits you receive can help take care of these extra expenses and anything else that comes up.

Critical Illness insurance provides a lump sum benefit to help you cover the out-of-pocket expenses associated with a critical illness diagnosis.

Accident\Critical Illness Insurance You Can Have Peace Of Mind

- Coverage is guaranteed issue – no evidence of insurability required at initial enrollment.
- Benefits are paid directly to you unless assigned to someone else.
- Benefits are paid in addition to any other coverage.
- Coverage that supplements your exiting medical benefits
- Coverage is portable and may be continued if the employee leaves the group.
- Employee or Family coverage available.

Accident Plan Highlights Include

- Accidental Death & Dismemberment coverage up to $40,000
- Dislocation & Fracture benefits up to $4,000/$6,000
- Initial Hospital Confinement of $1,500/$2,000, Daily Hospital Confinement of $200/$300 a day
- Physical Therapy of $30/day for up to 6 treatments per accident
- Outpatient Physician's Treatment Benefit of $50/$100 available for visiting a doctor on an outpatient basis for any reason (can be claimed up to twice per calendar year, per person or four times with dependent coverage)

Critical Illness Plan Highlights Include

- Coverage for diagnosis of Heart Attack, Stroke, Coronary Artery By-Pass Surgery, Major Organ Transplant, End Stage Renal Failure, Invasive Cancer, Carcinoma In Situ.
- Wellness Benefit pays $50 per covered person, per year, for completing a covered wellness exam.
- Waiver of Premium included.

For a complete description of benefits, please refer to brochure of plan design or certificate of coverage. Allstate Benefits is the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), a wholly-owned subsidiary of The Allstate Corporation.

Accident\Critical Illness Insurance

	Low Plan	High Plan
Accidental Death & Dismemberment Coverage (Benefit amount payable is multiplied by 5 when accidental death is the result of a Common Carrier)	Up to $40,000 Employee; $20,000 Spouse; $10,000 Children	Up to $60,000 Employee; $30,000 Spouse; $15,000 Children
Dislocations & Fractures	Up to $4,000	Up to $6,000
Ambulance	$200 Regular/$600 Air	$300 Regular/$900 Air
Accident Physician's Treatment	$100	$150
X-Rays	$200	$300
Emergency Room Services	$200	$300
Hospital Confinement	$1,000 ($200/day)	$1,500 ($300/day)
Outpatient Physician's Treatment Benefit	$50	$50

Monthly Premiums

	EE	EE+SP	EE+CH	F
Low Plan	$7.60	$17.36	$26.94	$36.82
High Plan	$10.2	$23.82	$35.97	$47.49

Accident\Critical Illness Insurance

Critical Illness insurance provides a lump sum benefit to help you cover the out-of-pocket expenses associated with a critical illness diagnosis.

With Allstate Benefits Group Critical Illness Insurance you can have peace of mind knowing -

Coverage is **GUARANTEE ISSUE** – Allstate extended the guarantee issue offer – no health questions asked even if you've declined this plan in past years

Benefits are paid directly to you unless assigned.

Coverage that supplements your existing medical benefits.

Coverage is portable and may be continued if Employee leaves the group.

Covered dependents receive 50% of the basic-benefit amount shown in your employer-selected plan, and 100% of the Wellness Benefit.

Plan Highlights include* -

Coverage for diagnosis of Heart Attack, Stroke, Coronary Artery By-Pass Surgery, Major Organ Transplant, End Stage Renal Failure, Invasive Cancer, Carcinoma In Situ.

Wellness Benefit pays $50 per covered person, per year, for completing a covered wellness exam.

LOW PLAN - $10,000 BASIC BENEFIT AMOUNT

non-tobacco

Ages	EE	EE+SP	EE+CH	F
18-35	$7.95	$12.05	$7.95	$12.05
36-50	$18.15	$27.35	$18.15	$27.35
51-60	$37.85	$56.90	$37.85	$56.90
61-63	$59.05	$88.70	$59.05	$88.70
64+	$87.65	$131.60	$87.65	$131.60

LOW PLAN - $10,000 BASIC BENEFIT AMOUNT

tobacco

Ages	EE	EE+SP	EE+CH	F
18-35	$12.55	$18.95	$12.55	$18.95
36-50	$30.85	$46.40	$30.85	$46.40
51-60	$64.55	$96.95	$64.55	$96.95
61-63	$93.15	$139.85	$93.15	$139.85
64+	$138.95	$208.55	$138.95	$208.55

HIGH PLAN - $20,000 BASIC BENEFIT AMOUNT

non-tobacco

Ages	EE	EE+SP	EE+CH	F
18-35	$13.66	$20.61	$13.66	$20.61
36-50	$34.06	$51.21	$34.06	$51.21
51-60	$73.46	$110.31	$73.46	$110.31
61-63	$115.85	$173.90	$115.85	$173.90
64+	$173.05	$259.70	$173.05	$259.70

HIGH PLAN - $20,000 BASIC BENEFIT AMOUNT

tobacco

Ages	EE	EE+SP	EE+CH	F
18-35	$22.84	$34.39	$22.84	$34.39
36-50	$59.45	$89.30	$59.45	$89.30
51-60	$126.85	$190.40	$126.85	$190.40
61-63	$184.07	$276.22	$184.07	$276.22
64+	$275.66	$413.61	$275.66	$413.61

Allstate Policyholder Contact Information

Allstate Benefits Customer Care Center at: **800-521-3535**

Allstate Benefits Policyholder and Claims Website: https://www.allstatebenefits.com/mybenefits

****For a complete description of benefits, please refer to brochure of plan design or certificate of coverage. Allstate Benefits I s the marketing name used by American Heritage Life Insurance Company (Home Office, Jacksonville, FL), a wholly-owned subsidiary of The Allstate Corporation***

Welfare Association

Is a way for employees to help take care of employees. When a Welfare Association member passes away, all other current participating association members make a one-time $5.00 contribution via payroll deduction to the designated beneficiary of the deceased member. Membership in the Welfare Association is voluntary, benefit payments may vary depending on the number of members

Being A Member

- Welfare Association membership is applicable only to an employee - spouses and dependent children are not covered.
- Membership in the Welfare Association is completely voluntary and can be cancelled during.
- There is no cost for participation in the Welfare Association unless a current participating Association member passes away.
- No Welfare Association benefit will be payable during the first twelve (12) months of membership unless the death is deemed accidental as per a Certified Death Certificate.
- Participation and benefits in the Association end when you terminate employment and/or retire employment from the District. No continuation privileges are available when employment ends.

Insurance Rates

Dental Select Rates

	Silver		Gold Medium		Gold High		Platinum	
Plans	**Semi-Monthly**	**Monthly**	**Semi-Monthly**	**Monthly**	**Semi-Monthly**	**Monthly**	**Semi-Monthly**	**Monthly**
Single	$1.00	$2.00	$7.00	$14.00	$10.00	$20.00	$16.00	$32.00
Two-Party	$2.00	$4.00	$13.00	$26.00	$17.00	$34.00	$30.00	$60.00
Family	$4.50	$9.00	$21.00	$42.00	$27.00	$54.00	$52.00	$104.00

Vision Rates

Plans	Semi-Monthly	Monthly
Single	$1.55	$3.11
Two-Party	$3.01	$6.03
Family	$3.95	$7.91

2018 EMPLOYEE MEDICAL CONTRIBUTION RATES

Employees whose rates don't meet 9.5% affordability will automatically be adjusted

Insurance Company	Select Health | Regence Blue Cross Blue Shield							
Plan Name	Select Med & Value Care				Select Med Plus & Value Care Plus			
Rates	Semi-Monthly	Monthly	GSD	Incentive Monthly	Semi-Monthly	Monthly	GSD	GWB Incentive Monthly
Full-Time (1.0 FTE)								
EE	$20.37	$40.74	$541.26	$50.74	$20.79	$41.58	$552.42	$51.58
EE & Child	$39.73	$79.45	$1,055.55	$89.45	$40.53	$81.06	$1,076.94	$91.06
EE & Children	$58.07	$116.13	$1,542.87	$126.13	$59.22	$118.44	$1,573.56	$128.44
EE & Spouse	$93.41	$186.82	$1,059.18	$196.82	$95.26	$190.52	$1,080.48	$200.52
EE & Sp & Child(ren)	$131.11	$262.21	$1,506.79	$272.21	$133.69	$267.38	$1,537.62	$277.38
Part-Time (.8750 FTE)								
EE	$36.38	$72.75	$509.25	$82.75	$37.13	$74.25	$519.75	$84.25
EE & Child	$70.94	$141.88	$993.13	$151.88	$72.38	$144.75	$1,013.25	$154.75
EE & Children	$103.69	$207.38	$1,451.63	$217.38	$105.75	$211.50	$1,480.50	$221.50
EE & Spouse	$100.76	$201.52	$1,090.25	$211.52	$103.82	$207.64	$1,112.13	$217.64
EE & Sp & Child(ren)	$142.57	$285.13	$1,547.88	$295.13	$146.91	$293.82	$1,579.38	$303.82
Part-Time (.83 FTE)								
EE	$49.47	$98.94	$483.06	$108.94	$50.49	$100.98	$493.02	$110.98
EE & Child	$96.48	$192.95	$942.05	$202.95	$98.43	$196.86	$961.14	$206.86
EE & Children	$141.02	$282.03	$1,376.97	$292.03	$143.82	$287.64	$1,404.36	$297.64
EE & Spouse	$105.91	$211.82	$1,034.18	$221.82	$108.04	$216.07	$1,054.93	$226.07
EE & Sp & Child(ren)	$150.37	$300.73	$1,468.27	$310.73	$153.43	$306.85	$1,498.15	$316.85
Part-Time (.80 FTE)								
EE	$58.20	$116.40	$465.60	$126.40	$59.40	$118.80	$475.20	$128.80
EE & Child	$113.50	$227.00	$908.00	$237.00	$115.80	$231.60	$926.40	$241.60
EE & Children	$165.90	$331.80	$1,327.20	$341.80	$169.20	$338.40	$1,353.60	$348.40
EE & Spouse	$124.60	$249.20	$996.80	$259.20	$127.10	$254.20	$1,016.80	$264.20
EE & Sp & Child(ren)	$176.90	$353.80	$1,415.20	$363.80	$180.50	$361.00	$1,444.00	$371.00
Part-Time (.75 FTE)								
EE	$72.75	$145.50	$436.50	$155.50	$74.25	$148.50	$445.50	$158.50
EE & Child	$141.88	$283.75	$851.25	$293.75	$144.75	$289.50	$868.50	$299.50
EE & Children	$207.38	$414.75	$1,244.25	$424.75	$211.50	$423.00	$1,269.00	$433.00
EE & Spouse	$155.75	$311.50	$934.50	$321.50	$158.88	$317.75	$953.25	$327.75
EE & Sp & Child(ren)	$221.13	$442.25	$1,326.75	$452.25	$225.63	$451.25	$1,353.75	$461.25

Contract Employees on Granite's medical insurance will need to complete their Biometric Screening and HRA during the 2017 plan year, 1/1/17-12/31/17.

Employees who do not complete the Biometric Screening & HRA will be charged an extra $10 per month for the 2018 Plan Year, 1/1/18-12/31/18.

2018 EMPLOYEE MEDICAL CONTRIBUTION RATES

Employees whose rates don't meet 9.5% affordability will automatically be adjusted

Insurance Company Name	Select Health | Regence Blue Cross Blue Shield							
Plan Name	Select Med & Value Care				Select Med Plus & Value Care Plus			
Rates	Semi-Monthly	Monthly	GSD	GWB Incentive Monthly	Semi-Monthly	Monthly	GSD	GWB Incentive Monthly
Part-Time (.69 FTE)								
EE	$90.21	$180.42	$401.58	$190.42	$92.07	$184.14	$409.86	$194.14
EE & Child	$175.93	$351.85	$783.15	$361.85	$179.49	$358.98	$799.02	$368.98
EE & Children	$257.15	$514.29	$1,144.71	$524.29	$262.26	$524.52	$1,167.48	$534.52
EE & Spouse	$193.13	$386.26	$859.74	$396.26	$197.01	$394.01	$876.99	$404.01
EE & Sp & Child(ren)	$274.20	$548.39	$1,220.61	$558.39	$279.78	$559.55	$1,245.45	$569.55
Part-Time (.67 FTE)								
EE	$96.03	$192.06	$389.94	$202.06	$98.01	$196.02	$397.98	$206.02
EE & Child	$187.28	$374.55	$760.45	$384.55	$191.07	$382.14	$775.86	$392.14
EE & Children	$273.74	$547.47	$1,111.53	$557.47	$279.18	$558.36	$1,133.64	$568.36
EE & Spouse	$205.59	$411.18	$834.82	$421.18	$209.72	$419.43	$851.57	$429.43
EE & Sp & Child(ren)	$291.89	$583.77	$1,185.23	$593.77	$297.83	$595.65	$1,209.35	$605.65
Part-Time (.6250 FTE)								
EE	$109.13	$218.25	$363.75	$228.25	$111.38	$222.75	$371.25	$232.75
EE & Child	$212.81	$425.63	$709.38	$435.63	$217.13	$434.25	$723.75	$444.25
EE & Children	$311.06	$622.13	$1,036.88	$632.13	$317.25	$634.50	$1,057.50	$644.50
EE & Spouse	$233.63	$467.25	$778.75	$477.25	$238.31	$476.63	$794.38	$486.63
EE & Sp & Child(ren)	$331.69	$663.38	$1,105.63	$673.38	$338.44	$676.88	$1,128.13	$686.88
Part-Time (.562 FTE)								
EE	$127.46	$254.92	$339.08	$264.92	$130.09	$260.17	$333.83	$270.17
EE & Child	$248.57	$497.13	$660.87	$507.13	$253.60	$507.20	$650.80	$517.20
EE & Children	$363.32	$726.64	$965.36	$736.64	$370.55	$741.10	$950.90	$751.10
EE & Spouse	$272.87	$545.75	$725.25	$555.75	$278.35	$556.70	$714.30	$566.70
EE & Sp & Child(ren)	$387.41	$774.82	$1,030.18	$784.82	$395.30	$790.59	$1,014.41	$800.59
Part-Time (.50 FTE)								
EE	$145.50	$291.00	$291.00	$301.00	$148.50	$297.00	$297.00	$307.00
EE & Child	$283.75	$567.50	$567.50	$577.50	$289.50	$579.00	$579.00	$589.00
EE & Children	$414.75	$829.50	$829.50	$839.50	$423.00	$846.00	$846.00	$856.00
EE & Spouse	$311.50	$623.00	$623.00	$633.00	$317.75	$635.50	$635.50	$645.50
EE & Sp & Child(ren)	$442.25	$884.50	$884.50	$894.50	$451.25	$902.50	$902.50	$912.50

Contract Employees on Granite's medical insurance will need to complete their Biometric Screening and HRA during the 2017 plan year, 1/1/17-12/31/17.

Employees who do not complete the Biometric Screening & HRA will be charged an extra $10 per month for the 2018 Plan Year, 1/1/18-12/31/18.

Frequently Asked Questions

- **ARE THERE PLANS THAT REQUIRE ME TO RE-ENROLL FROM YEAR-TO-YEAR?**

  YES!!! Flexible spending reimbursement account elections never "automatically" continue from year-to-year. If you participate in a flexible spending reimbursement account, you must re-enroll for the 2018 plan/calendar year.

- **WHEN IS THE LAST DAY I CAN ENROLL?**

  The open enrollment period ends on October 18, 2017 at 5:00 p.m. No exceptions will be made to the deadline regardless of the circumstance provided for missing or being late after the deadline.

- **HOW MUCH DOES GRANITE CONTRIBUTE TOWARD MEDICAL INSURANCE?**

  Overall, Granite contributes 93% of the medical insurance contribution for full-time employees and their non-spouse dependents. For full-time employees who elect to cover their spouse, the District contributes 78% of the medical insurance contribution.

- **HOW CAN I GET A LIST OF PARTICIPATING DOCTORS AND DENTISTS?**

  The most current list of participating providers (for medical and dental insurance plans) can be found on the respective company's web site. See the "Contact Information" page of this booklet for each insurance company's customer service telephone number and/or website address. The District Benefits Office does NOT have printed provider directories to give you.

- **HOW OLD IS TOO OLD FOR MY DEPENDENT CHILD(REN) TO BE COVERED?**

  Dependents can be covered up to age 26, insurance will end at midnight the day before their birthday.

- **WHAT HAPPENS IF I FAIL TO REMOVE AN INELIGIBLE DEPENDENT?**

  Failure to remove an ineligible dependent (ex-spouse or child) from the plan within 30 calendar days of their loss of eligibility is considered insurance fraud. Employees who fail to remove ineligible dependents in a timely manner: 1) will be responsible to pay the actual claims payments made by the plan for any care or services received by the ineligible dependent after the loss of eligibility, 2) waive the right to premium contribution adjustments that have been made by the employee through payroll deduction after the dependent was ineligible, 3) may waive the right to COBRA for the ineligible dependent and, 4) could subject the employee to District disciplinary action.

- **WHAT IS MEANT BY A "QUALIFIED LIFE STATUS CHANGE" AND HOW DOES IT EFFECT MY BENEFIT ELECTIONS?**

  Once you enroll, your elections are binding until the next annual open enrollment period in accordance with Section 125 of Internal Revenue Service (IRS) regulations. The only exception allowed is if you experience a "life status change" that qualifies you to make a change and the change is consistent with the event. Qualifying events include life-altering events such as marriage, divorce or legal separation, birth or adoption of a child, death of a spouse or dependent child, or gain or loss of employment and benefits for you, your spouse or your dependent child or if you are increasing/cancelling voluntary life insurance.

  Employees who experience a qualified life status change outlined above have 30 calendar days from the date the qualified event occurred to complete the applicable change form with the District Benefits Office in order to modify the level of coverage (not the type of coverage) they participate in.

Frequently Asked Questions… Cont.

- **WHAT PLANS HAVE LIMITATIONS, RESTRICTIONS, OR EXCLUSIONS?**

VOLUNTARY TERM LIFE INSURANCE

Coverage may be declined based upon medical health underwriting by the insurance carrier. Coverage that is subject to medical health underwriting is not effective until approval is received from the insurance company. The District will not begin to assess premium contributions until approval is received from the insurance carrier.

SHORT-TERM DISABILITY

Provisional employees of the District are not eligible for coverage under the short-term disability plan. Coverage for teachers may be declined based upon medical health underwriting by the insurance carrier. Coverage subject to medical health underwriting is not effective until approval is received from the insurance company. The District will not begin to assess premium contributions until approval is received from the insurance carrier. The plan does not provide coverage for any short-term disability resulting from or related to a condition which existed prior to the effective date of coverage.

LONG-TERM DISABILITY

After the 2018 open enrollment, coverage for teachers may be declined based upon medical health underwriting by the insurance carrier. Coverage that is subject to medical health underwriting is not effective until approval is received from the insurance company. The District will not begin to assess premium contributions until approval is received from the insurance carrier. The plan does not cover pre-existing conditions that existed 3 months prior to the start of your coverage unless the disability began after being covered under the long-term disability plan for 12 consecutive months.

- **WILL I RECEIVE NEW ID CARDS FOR 2018?**

It depends. You will receive new ID cards for medical. You will only receive new ID cards for vision, or flex spending if you changed plans from 2017 to 2018 or enrolled in these plans for the first time. If you misplace your ID cards or desire an extra ID card, you can request them by contacting the insurance company directly. See the "Contact Information" pages of this booklet for each insurance company's customer service telephone number and/or web site address.

- **MY SPOUSE ALSO WORKS FOR GSD AS A CONTRACT EMPLOYEE. HOW DOES INTERNAL DUAL COVERAGE WORK?**

If an employee is eligible for coverage under the District's medical plan and is also eligible as the spouse of another covered employee, the two coverages will supplement one another so that the benefit payments for such individuals with internal dual coverage will be made up to 100% of the eligible medical expense.

Internal dual coverage status is not automatic. For internal dual coverage medical benefits to apply, each eligible employee seeking internal dual coverage status must re-enroll in the dual coverage during the mandatory on-line enrollment for 2017. Both employees must select the same medical tier and insurance company administering coverage (i.e., both employees must select coverage under a Regence BlueCross BlueShield plan or both must select coverage under a SelectHealth plan).

- **HOW CAN I CHANGE MY BENEFICIARY?**

Employees may change beneficiary designations for basic life insurance, voluntary life insurance, voluntary accidental death and dismemberment insurance, 401(k) participation and Utah State Retirement defined benefit plans at any time. Change forms are available from the District Benefits Office. You can also change this during the online enrollment

- **WILL I HAVE TO KNOW THE SOCIAL SECURITY NUMBERS (SSNs) FOR COVERED DEPENDENTS WHEN I RE-ENROLL?**

Yes, the District is required to comply with the Center for Medicare & Medicaid (CMS) Medicare Secondary Payer Mandatory Reporting requirements effective January 1, 2018 SSNs for **all** subscribers and **existing** dependents are required by CMS (Center for Medicare & Medicaid).

Definitions

DEDUCTIBLE—A deductible is a fixed dollar amount during the plan year (calendar year) that an insured person pays before the insurer starts to make payments for covered services.

COINSURANCE—A fixed percentage that a participant pays for medical expenses after the deductible amount is paid.

COPAYMENT—A fixed dollar amount that a participant pays when a specified medical service is received, regardless of the total charge for the service. The insurer (Granite School District) is responsible for the rest of the total charge.

FORMULARY—A formulary is a list of prescription drugs that are preferred by a health plan for use. A formulary may include generic and brand-name drugs and is subject to change as determined by the health plan.

GENERIC REQUIREMENT—Granite's policy requiring a participant to receive generic drugs when available.

HEALTH MAINTENANCE ORGANIZATION (HMO) HEALTH PLAN—A health care system in which participants obtain comprehensive health care services from a specified list of "in-network" providers/facilities who receive a fixed prepayment from the insurer.

INDEMNITY PLAN—A type of medical plan that allows the participant to choose any provider without effect on reimbursement. These plans reimburse the patient and/or providers as expenses are incurred.

IN-NETWORK/PREFERRED PROVIDER—A medical provider (doctor, hospital, pharmacy) who is a member of a health plan's network.

OUT-OF-POCKET (OOP) ANNUAL MAXIMUM—The maximum dollar amount per calendar year of eligible medical charges payable by a member directly to providers, such as deductibles, copayments and coinsurance. Except as otherwise noted in the plan, the plan will pay up to 100% of medical charges during the remainder of the plan year once the out-of-pocket annual maximum is satisfied.

PREFERRED PROVIDER ORGANIZATION (PPO) HEALTH PLAN—A plan where coverage is provided to participants through a network of selected health care providers (physicians, hospitals, pharmacies). The participant is allowed the flexibility to receive services "out-of-network" but will incur larger costs in the form of higher deductibles, higher coinsurance rates or non-discounted charges from the provider.

Initial Notice of COBRA Continuation Coverage

All family members must read this notice carefully. This notice applies to any employee, spouse and/or dependent covered by the employer's group health plan. If you have questions regarding any of the information contained in this notice, it is your responsibility to contact the employer or Plan administrator.

"You" in this notice refers to the employee, spouse or dependent child who is (or becomes) covered under the health plan.

This notice contains a summary of your health insurance continuation rights under federal COBRA law. **This notice DOES NOT change or alter your current status on the insurance plan(s) in any way.** If you are (or become) insured under the employer's group health plan as the employee, spouse or dependent child of the employee, you may be eligible for continuation coverage if you would lose coverage due to a qualifying event such as:

1. Employee's Voluntary Termination
2. Employee's Involuntary Termination
3. Employee's Reduction of Hours
4. Death of the Employee
5. Employee's Medicare Entitlement
6. Divorce or Legal Separation
7. A Dependent Child Ceasing to be a Dependent
8. The Bankruptcy of the Employer *Title XI,U.S. Code

PLAN INFORMATION: For detailed plan information, please refer to your insurance booklet. Your "insurance booklet" may be referred to as a Summary Plan Description (SPD), benefits booklet or Certificate of Coverage which may be available by contacting the employer or plan administrator listed above. The information contained in the insurance booklet may not be altered by any statements made by representatives of the employer. Some states also have health insurance continuation rules. Please check your insurance booklet for further information regarding specific state continuation laws that may apply to you.

YOUR REPORTING RESPONSIBILITIES: The employee, spouse and/or dependent child would have the responsibility to inform the employer or plan administrator of a divorce or legal separation or a dependent child ceasing to be a dependent child within 60 days. Plan terms regarding a dependent's eligibility status may be found in your insurance booklet. The 60-day period would run from the later of the event date of the date coverage is lost due to the event. If the employer or plan administrator does not become informed of one of these events by the end of the 60-day period, continuation coverage might not have to be offered. The employer has a form in his/her office that may be completed and submitted to the employer or plan administrator if you or a family member would experience one of these events.

COBRA QUALIFIYING EVENT NOTICE: If a loss of group health insurance coverage would occur due to a qualifying event, the employer or plan administrator would notify you of your right to elect continuation coverage (subject in certain instances to you informing the employer or plan administrator that an event occurred as outlined in the previous paragraph).

COBRA QUALIFIED BENEFICIARIES: Each employee, spouse and dependent child covered under the group health plan at the time of a qualifying event would be a qualified beneficiary and would have independent rights under COBRA. Additionally, a child born to or placed for adoption with the covered employee during the period of continuation coverage will be provided beneficiary status under COBRA if the covered employee elects to continue coverage and if the child is enrolled in the plan. Incapacitated qualified beneficiaries would have special rights. If a qualified beneficiary were incapacitated, other specific individuals could elect on his/her behalf by contacting the employer or plan administrator listed on page one. COBRA qualified beneficiaries may also be allowed all options that active employees have under the plan, under the same terms and condition as active employees.

COBRA ELECTIONS: You would be allowed 60 days to make an election of continuation coverage (60-days from the later of the date of the notice or the date your group health insurance coverage would end due to the qualifying event). In most instances, if continuation coverage were elected and paid for within the proper time frames, your coverage would continue without interruption. The employer or plan administrator does reserve the right to verify your eligibility if you did elect continuation coverage, and if you were not eligible, they reserve the right to terminate that coverage retroactively. Under certain circumstances, COBRA time frames could be extended beyond those outlined in this notice. If you sign a waiver regarding your continuation coverage, you may revoke the waiver during the election period. Any claims that occur within the waiver period might not be covered.

HMO INFORMATION: If you participated in an HMO or a walk-in clinic, and you used the provider's services during the election period, the employer's plan may allow the employer, at the employer's option, to treat such use as a constructive election of COBRA continuation coverage. You would be obligated to pay any applicable charge for the coverage within 45 days of the constructive election. Not all employers recognize constructive elections. HMOs may provide region specific coverage. For a COBRA qualified beneficiary moving outside the region, coverage may be reduced similarly to that of active employees outside of the region; however, if an existing plan would cover active employees in that region, qualified beneficiaries must be allowed the option of coverage on that plan. In certain circumstances, coverage may be eliminated or provided for emergency services only. Please refer to your insurance booklet for specific information.

Initial Notice of COBRA Continued

PREMIUM PAYMENTS: If you were to elect, you would be allowed 45 days from the date you elect COBRA continuation coverage to pay the premiums due from the loss of coverage date (retroactive premium). The 45-day period would begin on the date your election was sent to the employer or plan administrator. In order to maintain your eligibility for continuation coverage, the retroactive premium should be paid by the 45th day. Premium payments may be made in monthly increments. Under certain circumstances, COBRA premiums may be paid on a pre-tax basis under a Section 125 (cafeteria) plan established by the employer. The employer may charge up to 102% of the regular group health premium for continuation coverage. You would be allowed a 30-day grace period on each monthly premium (longer than 30 days if the employer or an active employee has a longer period). Failure to pay any premium (retroactive, monthly, etc.) could cause your continuation of coverage to be retroactively terminated.

DURATION OF COVERAGE: If you were to continue your group health insurance coverage under COBRA, you would be provided the same coverage as similarly situated employees. Under COBRA, health insurance coverage may be continued for 18 months if the qualifying event were termination or a reduction in hours. The other events (excluding bankruptcy) would allow 36 months of continuation coverage. Bankruptcy of the employer has special rules that would pertain to the company's retirees. The continuation coverage time periods will run from the date of the qualifying event.

COBRA EXTENSIONS: The 18-month period (following a termination or reduction in hours) could be extended if another qualifying event (death of the employee, divorce or legal separation, employee's Medicare entitlement or a dependent child ceasing to be a dependent) were to occur during that 18-month period. You would need to notify the employer or plan administrator if you were to experience a second qualifying event and would like to extend your coverage. If any qualified beneficiary were to be deemed disabled by the Social Security Administration before the end of the first 60 days of continuation coverage, all qualified beneficiaries may be eligible to extend their COBRA coverage up to 29 months from the date of the termination or reduction of hours. To receive this additional coverage, the employer or plan administrator must be notified of the disability determination before the expiration of the 18 months and within 60 days of the determination. The employer or plan administrator would also need to be notified that qualified beneficiaries were deemed no longer disabled within 30 days of that determination. If deemed no longer disabled, all qualified beneficiaries would no longer be eligible for the additional 11 months of continuation coverage. From the 19th month to the 29th month, up to 150% of the applicable group health premium for this extension of coverage could be charged if the disabled qualified beneficiary is part of the coverage extension.

REASONS CONTINUATION COVERAGE COULD TERMINATE EARLY *(Prior to the maximum coverage period):*

The employer no longer provides group health coverage;

The premium for your continuation coverage is not paid in a timely manner;

After the date you elect COBRA continuation coverage, you become covered under another group health plan:

- That does not contain any exclusions or limitation with respect to any pre-existing condition that applies to you,
- Where the pre-existing condition limitation does no apply to you,
- When you have satisfied any pre-existing condition clauses that did apply to you; or

After the date you elect COBRA continuation of coverage, you become entitled to Medicare.

Your COBRA continuation coverage may be retroactively terminated for cause (i.e., fraudulent activity) on the same basis that the plan terminates the coverage of a similarly situated active employee for cause. Additionally, Health FSA's (Section 125 or cafeteria plan) may have a separate, earlier expiration date.

ADDITIONAL INFORMATION: If you would experience a qualifying event, you would not have to show that you were insurable in order to continue your insurance coverage under COBRA. Coverage might also extend if you are covered under a retiree plan and would lose that coverage due to a COBRA qualifying event. The employer or plan administrator must allow you to enroll in a conversion plan, if such plan is available under the employer's group health insurance plan.

COBRA notifications will be sent to your last known address. This makes it imperative that you keep the employer informed of your current address and address changes. Please also notify the employer if you add a spouse of dependent to your group health insurance coverage.

"You" in this notice refers to the employee, spouse or dependent child who is (or becomes) covered under the health plan.