NEW HIRE
Guide to:
INSURANCE ENROLLMENT

2012 Plan Year

Granite
SCHOOL DISTRICT
From here, anything's possible

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Welcome to Granite!

This is the 2012 New Hire's Guide to Insurance - created to inform you, a newly hired employee, of the insurance choices you have available to you as a contract employee of the Granite School District. The several plan choices offered by the District have been created to fulfill a wide range of needs for you and your family.

This booklet has been prepared to illustrate and help you understand those options available in addition to guiding you as you complete the enrollment process.

INTRODUCTION

The information contained in this booklet is provided to highlight District sponsored benefit plans and details the contribution and premium rates for the 2012 calendar/plan year. A section of this booklet is dedicated to each type of plan. **This booklet is not intended to contain all of the information an individual may need to understand the provisions of a plan.** Refer to the carrier's literature for specific details. In the event there is a discrepancy between the information contained in this booklet, the plan document(s) will apply. No rights shall accrue to you and/or your eligible dependents because of any statement, error or omission in this booklet. The District intends to continue these insurance plans but reserves the right to modify or terminate such plans at any time or without notice. Participation in these plans are provided to eligible contract employees of the District and does not constitute a guarantee of employment. Participation also requires continued employment and eligibility and is subject to the terms and conditions of the plan documents.

ELECTIONS ARE BINDING

Enrollment in the plan(s) is binding for the 2012 calendar/plan year. **Mid-year cancellation is not permitted** unless a qualified life status change occurs. The only exceptions allowed are if you are decreasing/cancelling voluntary life insurance coverage.

LIFE STATUS CHANGES

Employees are eligible to make modifications to the level of coverage (not the type of coverage) if, during the plan year, a qualified life or employment status change occurs. Recognized life status changes are: marriage, divorce or legal separation, birth, adoption, a dependent ceasing to satisfy dependent eligibility requirements, death, or an employment status change. Employees have 30 calendar days from the date the qualified life status change occurs to complete the applicable change form(s) in the District HR Benefits Office.

PREMIUM CONTRIBUTIONS

All employee premium deductions are assessed on a monthly basis over a 12 month period.

WHEN COVERAGE BEGINS

Coverage under most elected insurance plan(s) will commence after 90 calendar days calculated from your contract hire date.

Contents

SelectHealth	www.selecthealth.org 801-442-5038 or 1-800-538-5038
Regence BlueCross BlueShield of Utah	www.ut.regence.com 1-866-240-9580
Dental Select	www.dentalselect.com 801- 495-3000 or 1-800-999-9789
National Benefit Services	www.nbsbenefits.com 801-532-4000 or 1-800-274-0503
Opticare of Utah	www.opticareofutah.com 1-800-363-0950
CIGNA (LTD)	www.cigna.com 1-800-362-4462
Regence Life and Health Insurance	1-800-286-1129 (claims only)
Utah Retirement Systems	www.urs.org 801-366-7720 or 1-800-688-4015
The Principal/Educators Mutual	www.principal.com 801-262-7476 or 1-800-662-5850

Contact Information

Granite School District	www.graniteschools.org
Granite Benefits Office	385-646-4528 or 385-646-4179
Granite Payroll Office	385-646-4311 or 385-646-4313
Granite Human Resources Office	385-646-4511

CHANGES

PHARMACY BENEFIT CHANGE FOR 2012

The pharmacy co-payments for each of the five medical plans are changing according to the table below:

Prescription Drugs	30-Day Supply	90-Day Supply
Generic/Tier 1	$20 per prescription	$40 per prescription
Preferred/Tier 2	$40 per prescription	$80 per prescription
Non-Preferred/Tier 3	$70 per prescription	$140 per prescription

CO-PAYMENT CHANGE FOR 2012

Plan	General Office Visit	Specialty Office Visit
Select Med	$25	$35
Select Med Plus	$30	$40
Value Care	$25	$35
Value Care Plus	$30	$40

EMPLOYEE (EE) & SPOUSE (SP) PREMIUM CONTRIBUTION CHANGE FOR 2012

Overall, Granite School District will continue to pay the majority of the medical insurance premium. Effective January 1, 2012, the District will pay **93%** of the medical insurance premium contribution for full-time contract employees and their non-spouse dependents, while full-time contract employees contribute **7%** of the costs. The District will contribute up to **78%** of the medical insurance premium contribution for employees electing coverage for their legal spouse.

It is worthy to note that medical insurance premium contributions are assessed pre-tax (prior to taxes being withheld). This lowers the amount of income on which an employee must pay taxes.

The monthly employee premium contribution structure for coverage under a medical insurance plan is detailed under the medical insurance section of this Guide.

NEW Life and LTD Carriers!

LONG-TERM DISABILITY CARRIER (CIGNA) FOR 2012

For the 2012 open enrollment period only, CIGNA will offer all teachers a one time opportunity to enroll in the voluntary LTD plan without having go through medical underwriting (***even if you have been denied LTD coverage before***).

LIFE INSURANCE CARRIER (REGENCE LIFE) FOR 2012

For the 2012 open enrollment period only, Regence Life and Health will offer all employees the opportunity to elect up to $400,000 optional life insurance and spouses up to $50,000 optional life insurance without having to go through medical underwriting (***even if you have been denied coverage before***)

MEDICAL

At SelectHealth, we know you have many options when choosing a health plan. Here are just some of the reasons why we may be an exceptional choice for you.

- **EXCEPTIONAL SERVICE**

Health insurance doesn't have to be complicated. We can help you with everything from finding the right doctor to understanding your benefits. We want our members to live well so we provide a number of wellness resources to supplement our health plan benefits.

- **MEMBER SERVICES**

Life doesn't stop at 5 p.m. SelectHealth Member Services offers extended hours to answer your questions and help to resolve your concerns. Member Services is available weekdays from 7:00 a.m. to 8:00 p.m. and Saturdays from 9:00 a.m. to 2:00 p.m. by calling 801-442-5038.

- **MEMBER ADVOCATES**

Member Advocates help you find the right doctor for your needs - even on short notice! Member Advocates can assist in appointment scheduling, finding the closest doctor or facility with the nearest available appointment.

- **MY HEALTH ONLINE TOOLS**

Log on! You have 24-hour access to view your claims, review explanation of benefits, view amounts paid year-to-date, utilize decision support tools and personalized health and wellness information on our secure member website. Get connected at www.selecthealth.org/myhealth.

- **PHARMACY BENEFITS MADE SIMPLE**

Managing your prescriptions is made simple. While you can't control the cost of prescription medication, using generic drugs can lower your out-of-pocket expenses. Through the "Generic Sample" program, SelectHealth offers members their first 30-day fill of select generic prescriptions free! Additionally, at a participating "Retail-90" pharmacy, members are able to receive up to a three-month supply of medication at a more affordable copayment.

- **DISCOUNTS, DISCOUNTS AND MORE DISCOUNTS**

Members are more likely to embrace a healthy lifestyle when it costs less. Member discounts and wellness resources add more value to your health plan. SelectHealth gives you many discounts simply by presenting your SelectHealth ID card. Discount/wellness resources include health club and fitness center memberships, spas, LASIK eye surgery, nutritional supplements, eyewear, hearing aids, alternative medicine, and drug education. For more information about these discounts, visit www.selecthealth.org/discounts.

- **HEALTHY BEGINNINGS**

Pregnancy is a special time and 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 case management when needed, for employees and their spouses.

- **CARE/DISEASE MANAGEMENT**

SelectHealth encourages healthy lifestyles. Helping our members to achieve and maintain healthy lives is a top priority. Trained registered nurse care managers are available to assist our members with various health concerns and can help coordinate services between providers and patients. Our disease management program provides members with educational materials, newsletters, follow-up phone calls and additional support for conditions such as allergies and rhinitis, asthma, cholesterol, congestive heart failure, depression, diabetes, high-risk pregnancy, hypertension, migraines and oncology.

- **NATIONAL ACCREDITATION**

SelectHealth was the first National Committee for Quality Assurance (NCQA) accredited commercial health plan in Utah and has held that accreditation since 1993. In rating a health plan, NCQA examines how well a plan helps its members stay healthy, get better, manage chronic illness, access qualified providers and receive care when services are needed. Our excellent accreditation status illustrates our commitment to helping members stay healthy and to provide the highest quality of care when they are sick.

Select:Med

- $25.00 office visit copayment (PRIMARY CARE)
- $35.00 Specialty copayment (SECONDARY CARE)
- In-network coverage only
- $750.00 per person annual deductible (up to 3 person annual deductible maximum)
- 80% covered for eligible major medical expenses after deductible
- Eligible dependents covered up to age 26

Select:Med+

- $30.00 office visit copayment (PRIMARY CARE)
- $40.00 Specialty copayment (SECONDARY CARE)
- In *and* out-of-network coverage available
- $750.00 per person *in-network* annual deductible (up to 3 person annual deductible maximum)
- 80% covered for *in-network* eligible major medical expenses after deductible
- Eligible dependents covered up to age 26

As a SelectHealth member you will have access to Intermountain Healthcare's nationally recognized facilities as well as contracted hospitals and clinics that meet SelectHealth's high quality standards. So you can rest assured that you will receive the best healthcare available. The following hospitals and clinics are closest to you:

HOSPITALS

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

INTERMOUNTAIN INSTACARE & KIDSCARE CLINICS

Taylorsville InstaCare & KidsCare
West Jordan InstaCare & KidsCare
Sandy InstaCare
Sandy Kidscare
Saratoga Springs InstaCare
Riverton InstaCare & KidsCare
Murray KidsCare
Bountiful Kidscare & InstaCare
Layton InstaCare
North and South Ogden InstaCare
North Orem InstaCare
Holiday InstaCare
Ogden KidsCare
Sugar House InstaCare & KidsCare
Syracuse InstaCare
Highland InstaCare

For a complete list of SelectHealth facilities and participating physicians, visit www.selecthealth.org.

NOTE: Primary Care providers are family medicine, geriatrics, internal medicine, pediatrics,

SelectHealth. Simply there.™

selecthealth℠

MEDICAL

We are 3 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 Rx**

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.

ValueCare

- $25.00 office visit copayment (PRIMARY CARE)
- $35.00 Specialty copayment (SECONDARY CARE)
- In network coverage only
- $750.00 per person *in-network* annual deductible (up to 3 person annual deductible maximum)
- 80% covered for eligible major medical expenses after deductible
- Eligible dependents covered up to age 26

ValueCare Plus

- $30.00 office visit copayment (PRIMARY CARE)
- $40.00 Specialty copayment (SECONDARY CARE)
- In *and* out-of-network coverage available
- $750.00 per person *in-network* annual deductible (up to 3 person annual deductible maximum)
- Eligible major medical expenses after deductible:
  CATEGORY 1 = 80%
  CATEGORY 2 = 70%
  CATEGORY 3 = 60%
- Eligible dependents covered up to age 26

The following Regence BlueCross BlueShield facilities are closest to you:

HOSPITALS

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

URGENT CARE CLINICS

After Hours Medical
First Med Urgent Care
IHC Insta/Kids Care
Ogden Clinic
Wee Care Pediatrics

For a complete list of Regence facilities and participating physicians, visit www.ut.regence.com.

NOTE: Primary Care providers are family medicine, internal medicine, pediatrics, obstetrics & gynecology.

REGENCE BCBS

A health plan is a promise: To be here for each other.

Regence

2012 MEDICAL PLAN 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**	**Category 1**	**Category 2**	**Category 3**
Dependent Age Maximum	26	26		26	26		
New Hire Waiting Period	90 Days From Contract Hire Date	90 Days From Contract Hire Date		90 Days From Contract Hire Date	90 Days From Contract Hire Date		
Pre-Existing Conditions*	12 months	12 Months		12 Months	12 Months		
Annual Deductible	$750 per person	$750 per person	$1300 per person	$750 per person	$750 per person	$750 per person	$750 per person
	3 Deductible Max ($2250)	3 Deductible Max. ($2250)	3 Deductible Max. ($3900)	3 Deductible Max. ($2250)	3 Deductible Max. ($2250)	6 Deductible Max. ($4500)	6 Deductible Max. ($4500)
Deductible Toward	DOES	DOES	DOES	DOES NOT	DOES NOT	DOES NOT	DOES NOT
Out-of-Pocket Maximum	count toward	count toward	count toward	count toward	count toward	count toward	count toward
	OOP Maximum	OOP Maximum	OOP Maximum	OOP Maximum	OOP Maximum	OOP Maximum	OOP Maximum
Out-of-Pocket Maximum	Employee $1500	Employee $1500	Employee $2000	Employee $1500	Employee $1500	Employee $1500	Employee $1500
	Employee & 1 $2500	Employee & 1 $2500	Employee & 1 $4000	Employee & 1 $2500	Employee & 1 $2500	Employee & 1 $2500	Employee & 1 $2500
	Employee & 2+ $3500	Employee & 2+ $3500	Employee & 2+ $4500	Employee & 2+ $3500	Employee & 2+ $3500	Employee & 2+ $3500	Employee & 2+ $3500
Office Visits							
Office Visit (General) **	$25 copay per visit	$30 copay per visit	60% after deductible	$25 copay per visit	$30 copay per visit	70% after deductible	60% after deductible
Office Visit (Specialty)	$35 copay per visit	$40 copay per visit	60% after deductible	$35 copay per visit	$40 copay per visit	70% after deductible	60% after deductible
X-Ray/Lab Tests - Minor	Included in copay	Included in copay	60% after deductible	Included in copay	Included in copay	70% after deductible	60% after deductible
X-Rab/Lab Test - Major	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	70% after deductible	60% after deductible
Preventative Services							
Routine Physical (1 per yr)	100%	100%	Not Covered	100%	100%	100%	Not Covered
Pap Office Visit	100%	100%	Not Covered	100%	100%	100%	Not Covered
Mammogram/Lab Tests	100%	100%	Not Covered	100%	100%	100%	Not Covered
Well Child Care	100%	100%	Not Covered	100%	100%	100%	Not Covered
Immunizations	100%	100%	Not Covered	100%	100%	100%	Not Covered
Eye Exam	100%	100%	Not Covered	100%	100%	100%	Not Covered
Eyewear	Discount Program	Discount Program	Discount Program	Discount Program	Discount Program	Discount Program	Discount Program
Maternity Care							
Initial Prenatal Office Visit	$25 copay (1st visit only)	$30 copay (1st office visit)	60% after deductible	$25 copay (1st visit only)	$30 copay (1st visit only)	70% after deductible	60% after deductible
Care/Delivery/Profess. Fees ③	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	70% after deductible	60% after deductible
Newborn Adoption Benefit ④	Subject to maternity care	Subject to maternity care	Subject to maternity care	Subject to maternity care	Subject to maternity care	Subject to maternity care	Subject to maternity care
	benefit; not to exceed $4,000	benefit; not to exceed $4,000	benefit; not to exceed $4,000	benefit; not to exceed $4000	benefit; not to exceed $4,000	benefit; not to exceed $4,000	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	70% after deductible	60% after deductible
Skilled Nursing Facility ⑤	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	70% after deductible	60% after deductible
Rehabilitation Services ⑤	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	70% after deductible	60% after deductible
Professional Fees	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	70% after deductible	60% after deductible
Outpatient Services							
Facility Charges	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	70% after deductible	60% after deductible
Surgical Fees	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	70% after deductible	60% after deductible
Rehabilitation Services ⑤	$35 copay after deductible	$40 copay after deductible	60% after deductible	$35 copay after deductible	$40 copay after deductible	70% after deductible	60% after deductible
Home Health / Hospice	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	70% after deductible	60% after deductible
Chemo/Radiation/Dialysis	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	70% after deductible	60% after deductible
Emergency Services							
Emergency Room	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	70% after deductible	60% after deductible
Ground Ambulance	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	70% after deductible	60% after deductible
Air Ambulance	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	70% after deductible	60% after deductible

* Pre-existing condition applies to members who are 19 years or older in certain circumstances; refer to Granite School District Summary Plan Description for details

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

2012 MEDICAL PLAN 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**	**Category 1**	**Category 2**	**Category 3**
Durable Medical Equipment ③							
Inpatient or Outpatient	80% after deductible	80% after deductible	60% after deductible	80% after deductible	80% after deductible	70% after deductible	60% after deductible
Chiropractic Care ⑤							
Office Visit	Not Covered	Not Covered	60% after deductible	Not Covered	$35 copay per visit	70% after deductible	60% after deductible
Mental Health ③⑤⑥							
Inpatient Visit ⑤⑥	80%	80%	50% after deductible	80%	70%	50% after deductible	50% after deductible
Outpatient Visit ⑤⑥	$35 copay then 100%	$40 copay then 100%	50% after deductible	$35 copay then 100%	50%	50% after deductible	50% after deductible
Prescription Drugs ③⑤⑥							
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	$20.00 per prescription	$20.00 per prescription		$20.00 per prescription	$20.00 per prescription		
Preferred/Tier 2 ⑧	$40.00 per perscription	$40.00 per prescription		$40.00 per perscription	$40.00 per prescription		
Non-Preferred/Tier 3	$70.00 per perscription	$70.00 per prescription		$70.00 per perscription	$70.00 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	$40.00 per prescription	$40.00 per prescription		$40.00 per prescription	$40.00 per prescription		
Preferred/Tier 2 ⑧	$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	80% after deductible	80% after deductible	60% after deductible	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	70% 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 It is the responsibility of the enrollee seeking credit for Creditable Coverage to obtain and provide the Plan with applicable certification(s) of coverage from prior Creditable plans within a timely manner.

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 Not applied toward annual out-of-pocket maximum.

⑦ 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.

⑧ There are differences in the prescription preferred drug formularies between SelectHealth and Regence. You are encouraged to study the formularies when selecting participation in a medical plan.

THE BENEFITS LISTED ARE IN SUMMARY FORM ONLY

They are for illustrative purposes only and should not be construed to be complete in and of themselves. In case of conflict, the respective legal plan documents will apply. All deductible/copay/coinsurance amounts and plan payments are based on eligible charges only and not the provider's billed or other charges. You are responsible to pay for extra charges in excess of eligible charges for covered services obtained from non-participating providers and facilities. Such excess charges are not applied to the medical out-of-pocket maximum. Payment percentages listed will be paid according to the respective carrier's fee schedule.

2012

MEDICAL INSURANCE CONTRIBUTION RATES

Insurance Company Name	SelectHealth		Regence BlueCross BlueShield of Utah	
Plan Name	Select Med	Select Med Plus	Value Care	Value Care Plus
Full-Time (1.0 FTE)				
Employee	$31.91	$32.56	$31.91	$32.56
Employee & Child	$62.23	$63.49	$62.23	$63.49
Employee & Children	$90.95	$92.79	$90.95	$92.79
Employee & Spouse	$146.26	$149.21	$146.26	$149.21
Employee & Spouse & Child(ren)	$205.30	$209.45	$205.30	$209.45
Part-Time (.8750 FTE)				
Employee	$56.99	$58.14	$56.99	$58.14
Employee & Child	$111.13	$116.37	$111.13	$116.37
Employee & Children	$162.42	$165.70	$162.42	$165.70
Employee & Spouse	$156.06	$159.21	$156.06	$159.21
Employee & Spouse & Child(ren)	$220.46	$224.92	$220.46	$224.92
Part-Time (.83 FTE)				
Employee	$77.50	$79.07	$77.50	$79.07
Employee & Child	$151.14	$154.19	$151.14	$154.19
Employee & Children	$220.89	$225.35	$220.89	$225.35
Employee & Spouse	$165.86	$169.21	$165.86	$169.21
Employee & Spouse & Child(ren)	$235.62	$240.38	$235.62	$240.38
Part-Time (.80 FTE)				
Employee	$91.18	$93.02	$91.18	$93.02
Employee & Child	$177.81	$181.40	$177.81	$181.40
Employee & Children	$259.87	$265.12	$259.87	$265.12
Employee & Spouse	$195.13	$199.07	$195.13	$199.07
Employee & Spouse & Child(ren)	$277.20	$282.80	$277.20	$282.80
Part-Time (.75 FTE)				
Employee	$113.98	$116.28	$113.98	$116.28
Employee & Child	$222.26	$226.75	$222.26	$226.75
Employee & Children	$324.84	$331.40	$324.84	$331.40
Employee & Spouse	$243.92	$248.84	$243.92	$248.84
Employee & Spouse & Child(ren)	$346.50	$353.50	$346.50	$353.50

All rates listed are *MONTHLY c* ontribution rates for coverage.

2012

MEDICAL INSURANCE CONTRIBUTION RATES

Insurance Company Name	SelectHealth		Regence BlueCross BlueShield of Utah	
Plan Name	Select Med	Select Med Plus	Value Care	Value Care Plus
Part-Time (.69 FTE)				
Employee	$141.33	$144.19	$141.33	$144.19
Employee & Child	$275.60	$281.17	$275.60	$281.17
Employee & Children	$402.80	$410.94	$402.80	$410.94
Employee & Spouse	$302.45	$308.56	$302.45	$308.56
Employee & Spouse & Child(ren)	$429.65	$438.33	$429.65	$438.33
Part-Time (.67 FTE)				
Employee	$150.45	$153.49	$150.45	$153.49
Employee & Child	$293.38	$299.31	$293.38	$299.31
Employee & Children	$428.79	$437.45	$428.79	$437.45
Employee & Spouse	$321.97	$328.47	$321.97	$328.47
Employee & Spouse & Child(ren)	$457.37	$466.61	$457.37	$466.61
Part-Time (.6250 FTE)				
Employee	$170.97	$174.42	$170.97	$174.42
Employee & Child	$333.39	$340.12	$333.39	$340.12
Employee & Children	$487.26	$497.10	$487.26	$497.10
Employee & Spouse	$365.87	$373.26	$365.87	$373.26
Employee & Spouse & Child(ren)	$519.74	$530.24	$519.74	$530.24
Part-Time (.5625 FTE)				
Employee	$199.46	$203.49	$199.46	$203.49
Employee & Child	$388.95	$396.81	$388.95	$396.81
Employee & Children	$568.47	$579.95	$568.47	$579.95
Employee & Spouse	$426.85	$435.47	$426.85	$435.47
Employee & Spouse & Child(ren)	$606.37	$618.62	$606.37	$618.62
Part-Time (.50 FTE)				
Employee	$227.96	$232.56	$227.96	$232.56
Employee & Child	$444.52	$453.50	$444.52	$453.50
Employee & Children	$649.68	$662.80	$649.68	$662.80
Employee & Spouse	$487.83	$497.68	$487.83	$497.68
Employee & Spouse & Child(ren)	$692.99	$706.99	$692.99	$706.99

All rates listed are *monthly* contribution rates for coverage.

PART-TIME CONTRACT EMPLOYEES:
As per the Professional and Negotiated Agreement, you must contribute a proportional (HIGHER) share of premiums for coverage in the District's self-funded medical insurance program.

Granite SCHOOL DISTRICT
From here, anything's possible

Pharmacy Benefit

- 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.

selecthealth℠

- Preferred drug formulary: www.selecthealth.org/pharmacy/plans
- The preferred drug formulary is subject to change on a monthly basis
- Generic Sample program eliminates your copayment for the first 30-day fill of select generic prescriptions at a retail pharmacy
- By using the Retail 90 program or the Medco By Mail 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 at 80% after the deductible

Regence

- Preferred drug formulary: www.regencerx.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 sixty-day copayment
- Most injectable medications require prior authorization and may be covered through the pharmacy benefit

INSTANTLY SAVE YOURSELF 3 or 4 BUCKS!

Instead of running your generic prescriptions through your District medical insurance plan, instantly save yourself $3.00 or $4.00 by getting your generic prescriptions filled through one of the "big box" retailer's generic drug programs. Not only are you saving yourself $3.00 or $4.00 per generic prescription but also taking a pro-active step to reduce "District-dollars" spent on prescription drugs!

	Up to a **30-DAY RETAIL** Supply	Up to a **30-DAY RETAIL** Supply	Up to a **90-DAY RETAIL** Supply	Up to a **90-DAY MAIL** Supply
	Wal-Mart & Target National Program	**Granite Insurance**	Wal-Mart & Target National Program	**Granite Insurance**
GENERIC DRUGS	**$4.00***	$20.00	**$10.00***	$40.00
PREFERRED BRAND-NAME DRUGS		$40.00		$80.00
NON-PREFERRED BRAND-NAME DRUGS		$70.00		$140.00

* Up to 350 select generic medications available at Wal-Mart . (Wal-Mart Store Inc. Press Release - May 5, 2008.)
Up to 300 select generic medications available at Target. (Target Web Site - May 2008.)

All programs dispense 30-day and 90-day supply of drugs at commonly prescribed dosages.

Ouch !

TALK ABOUT A PILL THAT IS DIFFICULT TO SWALLOW…

Did you know that for the 2011 year, the second largest piece of the "insurance-dollar pie" for Granite School District was spent on prescription drug coverage? Because Granite's medical and prescription drug benefit is entirely self-funded, that means that nearly ten million (yep, million!) "District-dollars" were spent solely on prescription drug coverage!

One of the major health care challenges we face both as individuals and as a District is the mounting cost of prescription drug coverage. Let's spend a bit reviewing some national and local cost-saving prescription drug programs that are available to keep more money in your wallet, free up "District dollars" and also talk a bit about why choosing generic medication can save oodles for all!

Read on...

BIG BOX RETAILER

GENERIC PRESCRIPTION DRUG PROGRAMS

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 and Target and even some regional/local retailers like Smith's grocery store.

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.

Target
http://sites.target.com/site/en/health/page.jsp?contentId=WCMP04-040590

Wal-Mart & Sam's Club
http://i.walmartimages.com/i/if/hmp/fusion/customer_list.pdf

Walgreens
https://webapp.walgreens.com/MYWCARDWeb/pdf/Value-PricedGenericsList.pdf

Smiths Pharmacy
http://www.smithsfoodanddrug.com/generic/Pages/alpha_listing.aspx

HOW DO I USE A "BIG BOX" RETAILER'S 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!

Go Generic!

WHAT EXACTLY IS A GENERIC DRUG?

A generic drug is the same as a brand name drug in dosage, safety, strength, quality, the way it works, the way it is taken and the way it should be used. It has gone through the same rigorous FDA testing that brand-name drugs go through before coming to market.

IF BRAND-NAME DRUGS AND GENERIC DRUGS HAVE THE SAME ACTIVE INGREDIENTS, WHY DO THEY LOOK DIFFERENT?

In the United States, trademark laws do not allow generic drugs to look exactly like the brand-name drug. However, the generic drug must have the same active ingredients. Colors, flavors, and certain other parts may be different, but these things don't effect the way the drug works and how they are looked at by the FDA.

WHY DO GENERICS COST SO MUCH LESS THAN BRAND-NAME DRUGS?

Creating a drug costs a lot of money. When new drugs are first made, the pharmaceutical company patents them. Most drug patents are protected for 17 years and they protect the company that made the drug first by not allowing anyone else to make or sell the drug during the period of time the patent is in force. When the patent expires, other drug companies can start selling the generic version of the drug after testing the generic and receiving FDA approval. Since generic drug makers do not develop a drug from scratch, the costs to bring the drug to the market are less. Ironically, it is possible that your generic is made by the same company that makes the brand-name drug. Brand-name firms are responsible for manufacturing approximately 50 percent of generic drugs.

DO GENERIC DRUGS TAKE LONGER TO WORK IN THE BODY?

Nope! All generic drugs must show the FDA that it performs in the same way as the brand-name drug - including working in the same way (strong, pure, stable) and in the same amount of time as brand-name drugs.

WHAT IS THE BEST SOURCE OF INFORMATION ABOUT GENERIC DRUGS?

Contact your doctor, pharmacist or other healthcare worker for information on your generic drugs. You can also visit the FDA website at: www.fda.gov/cder and click on "consumer education."

DENTAL

DENTALSELECT™

Silver

- 1050+ participating dental providers
- This is not a dental insurance product but rather, a fee-for-service product. In-network benefits only
- No annual deductible
- No annual maximum benefit
- Benefits largely based on a copayment structure
- Includes a 20% discount on orthodontia (children and adults) with no waiting period and no lifetime maximum benefit
- Discounts on cosmetic procedures offered
- Eligible dependents covered up to age 26

Gold Medium

- 1420+ participating dental providers
- Copayment plan. In and out-of-network benefits
- No annual deductible
- No annual maximum benefit
- Fixed low copayment structure
- 100% in-network coverage for most preventive care dental services
- 50% orthodontics benefit (child and adult) with no waiting period / $1000 lifetime benefit
- Discount on cosmetic procedures offered
- Eligible dependents covered up to age 26

Gold High

- 1420+ participating dental providers
- Copayment plan. In and out-of-network benefits
- No annual maximum or deductible.
- Fixed low copayment structure
- 100% *in-network* coverage for most preventive care dental services
- Includes paid benefit for many major services
- 50% *in-network* orthodontics benefit (child and adult) with no waiting period / $1000 lifetime benefit
- Discounts on cosmetic procedures offered
- Eligible dependents covered up to age

Platinum

- 2030+ participating dental providers
- Coinsurance plan. Includes both an in and out-of-network benefit
- $50/$150 annual deductible
- $1,000 per member, per year maximum benefit
- 80% *in and out-of-network* coverage for preventive dental services
- 70% *in-network* coverage for basic care dental services
- 40% *in and out-of-network* orthodontia benefits (child and adult) with no waiting period / $1000 lifetime benefit
- Discounts on cosmetic procedures offered
- Eligible dependents covered up to age 26

	SILVER	GOLD "MEDIUM"	GOLD "HIGH"	PLATINUM
Single Coverage	$2.80	$17.00	$22.00	$38.00
Two-Party Coverage	$5.10	$31.00	$40.00	$69.00
Family Coverage	$8.00	$48.00	$63.00	$121.00

2012 DENTAL PLAN COMPARISON CHART

DentalSelect

Granite School District

	SILVER	GOLD "MEDIUM"		GOLD "HIGH"		PLATINUM	
	The Silver plan is a fee-for-service DISCOUNT plan that requires you to receive services from a participating (in-network) Silver provider. The Silver plan is not an insurance product. In-network specialists offer a 20% discount on covered services. No benefit will be paid	The Gold "Medium" plan is a COPAY plan that offers you the flexiblity to receive services from a Gold participating (in-network) provider. The "Medium" plan also provides a *limited* out-of-network benefit whereby you can go to any dentist of your choosing. The amount listed in the out-of-network column represents the flat amount Dental Select will pay toward services received using an out-of-network provider. In-network specialists offer a 20% discount on covered services. No benefit will be paid. However, a paid benefit is available for limited services from Pediatric Specialists. See complete co-pay schedule for specifics.		The Gold "High" plan is a COPAY plan that offers you the flexiblity to receive services from a Gold participating (in-network) provider. The "High" plan also provides a *limited* out-of-network benefit whereby you can go to any dentist of your choosing. The amount listed in the out-of-network column represents the flat amount Dental Select will pay toward services received using an out-of-network provider. In-network specialists offer a 20% discount on covered services. No benefit will be paid. However, a paid benefit is available for limited services from Pediatric Specialists. See complete co-pay schedule for specifics.		The Platinum plan is a COINSURANCE plan that offers you total freedom and flexiblity to receive services from a provider that is in or out of the Platinum network. The percentatges listed reflect the amount that is covered under the Platinum plan. See Plan Notes for Specialist payment information.	
	In-Network / General Dentist **Member Payment**	In-Network General Dentist **Member Copayment**	Out-of-Network **Maximum Payment by Dental Select**	In-Network General Dentist **Member Copayment**	Out-of-Network **Maximum Payment by Dental Select**	In-Network **Payment by Dental Select**	Out-of-Network **Payment by Dental Select**
Annual Deductible	$0.00	$0.00	$0.00	$0.00	$0.00	$50.00 Individ. / $150.00 Family	$50.00 Individ. / $150.00 Family
Annual Coverage Maximum	No Maximum	No Maximum	No Maximum	No Maximum	No Maximum	$1,000.00	$1,000.00
Specialists	20% Discount	20% Discount	No Benefit	20% Discount	No Benefit	See Plan Notes	See Plan Notes
Code Procedure Description							
PREVENTIVE							
D0120 Periodic oral exam	$17.00	$0.00	$17.00	$0.00	$17.00	80% of Fee Schedule	80% of R&C
D0150 Comprehensive exam	$15.00	$0.00	$19.00	$0.00	$19.00	80% of Fee Schedule	80% of R&C
D0170 Re-evaluation	$11.00	$0.00	$16.00	$0.00	$16.00	80% of Fee Schedule	80% of R&C
D0210 Intraoral Compl. ser. including bitewings	$35.00	$0.00	$37.00	$0.00	$37.00	80% of Fee Schedule	80% of R&C
D0220 Intraoral - periapical - first film	$8.00	$0.00	$8.00	$0.00	$8.00	80% of Fee Schedule	80% of R&C
D0230 Intraoral - periapical - each add film	$6.00	$0.00	$6.00	$0.00	$6.00	80% of Fee Schedule	80% of R&C
D0240 Intraoral - occlusal film	$5.00	$0.00	$6.00	$0.00	$6.00	80% of Fee Schedule	80% of R&C
D0250 Extraoral - first film	$4.00	$0.00	$4.00	$0.00	$4.00	80% of Fee Schedule	80% of R&C
D0260 Extraoral - each additional	$4.00	$0.00	$4.00	$0.00	$4.00	80% of Fee Schedule	80% of R&C
D0272 Bitewings - two films	$12.00	$0.00	$14.00	$0.00	$14.00	80% of Fee Schedule	80% of R&C
D0330 Panoramic film	$37.00	$0.00	$37.00	$0.00	$37.00	80% of Fee Schedule	80% of R&C
D1110 Prophylaxis - adults	$37.00	$0.00	$37.00	$0.00	$37.00	80% of Fee Schedule	80% of R&C
D1120 Prophylaxis - child	$25.00	$0.00	$25.00	$0.00	$25.00	80% of Fee Schedule	80% of R&C
BASIC							
D0140 Limited oral examination	$10.00	$0.00	$12.00	$0.00	$12.00	70% of Fee Schedule	60% of R&C
D1351 Sealant - per tooth (14 & under)	$19.00	$12.00	$8.00	$12.00	$8.00	70% of Fee Schedule	60% of R&C
AMALGAM (Silver) FILLINGS							
D2140 Amalgam - 1 surf. primary or permanent	$41.00	$11.00	$32.00	$11.00	$32.00	70% of Fee Schedule	60% of R&C
D2150 Amalgam - 2 surf. primary or permanent	$51.00	$19.00	$34.00	$19.00	$34.00	70% of Fee Schedule	60% of R&C
D2160 Amalgam - 3 surf. primary or permanent	$62.00	$26.00	$38.00	$26.00	$38.00	70% of Fee Schedule	60% of R&C
D2161 Amalgam - 4 surf. primary or permanent	$71.00	$34.00	$39.00	$34.00	$39.00	70% of Fee Schedule	60% of R&C
ANTERIOR COMPOSITE (White) FILLINGS							
D2330 Resin - 1 surf. anterior	$63.00	$33.00	$32.00	$33.00	$32.00	70% of Fee Schedule	60% of R&C
D2331 Resin - 2 surf. anterior	$74.00	$36.00	$40.00	$36.00	$40.00	70% of Fee Schedule	60% of R&C
D2332 Resin - 3 surf. anterior	$84.00	$42.00	$44.00	$42.00	$44.00	70% of Fee Schedule	60% of R&C
D2335 Resin - 4 surf. or involving incis. Angle	$99.00	$50.00	$51.00	$50.00	$51.00	70% of Fee Schedule	60% of R&C
POSTERIOR COMPOSITE (White) FILLINGS							
D2391 Resin - 1 surf. posterior prim. or perm.	$63.00	$32.00	$32.00	$32.00	$32.00	70% of Fee Schedule	60% of R&C
D2392 Resin - 2 surf. posterior prim. or perm.	$84.00	$48.00	$39.00	$48.00	$39.00	70% of Fee Schedule	60% of R&C
D2393 Resin - 3 surf. posterior prim. or perm.	$102.00	$60.00	$45.00	$60.00	$45.00	70% of Fee Schedule	60% of R&C
D2394 Resin - 4+ surf. post. prim. or post.	$108.00	$66.00	$48.00	$66.00	$48.00	70% of Fee Schedule	60% of R&C
INLAYS / ONLAYS							
D2642 Onlay - porc./ceram. - 2 surfaces	$326.00	$328.00	$0.00	$200.00	$128.00	40% of Fee Schedule	40% of R&C
D2643 Onlay - porc./ceram. - 3 surfaces	$367.00	$371.00	$0.00	$230.00	$141.00	40% of Fee Schedule	40% of R&C
D2644 Onlay - porc./ceram. - 4 surfaces	$412.00	$418.00	$0.00	$265.00	$153.00	40% of Fee Schedule	40% of R&C
CROWNS							
D2740 Crown - porc./ceram. substrate	$416.00	$431.00	$0.00	$271.00	$160.00	40% of Fee Schedule	40% of R&C
D2750 Crown - porc. fused to high noble metal	$460.00	$472.00	$0.00	$287.00	$185.00	40% of Fee Schedule	40% of R&C
D2751 Crown - porc. fused to predom base metal	$437.00	$441.00	$0.00	$290.00	$151.00	40% of Fee Schedule	40% of R&C
D2752 Crown - porc. fused to noble metal	$442.00	$446.00	$0.00	$293.00	$153.00	40% of Fee Schedule	40% of R&C
D2790 Crown - full cast high noble metal	$415.00	$417.00	$0.00	$260.00	$157.00	40% of Fee Schedule	40% of R&C
D2791 Crown - full cast predom. base metal	$349.00	$355.00	$0.00	$210.00	$145.00	40% of Fee Schedule	40% of R&C
D2792 Crown - full cast noble metal	$353.00	$360.00	$0.00	$210.00	$150.00	40% of Fee Schedule	40% of R&C
D2930 Prefab stainl. stl. crown - primary tooth	$64.00	$65.00	$0.00	$65.00	$0.00	40% of Fee Schedule	40% of R&C
D2931 Prefab stainl. stl. crown - perm tooth	$66.00	$67.00	$0.00	$37.00	$0.00	40% of Fee Schedule	40% of R&C

CONTINUED ON REVERSE SIDE ➔

		SILVER	GOLD "MEDIUM"		GOLD "HIGH"		PLATINUM	
ENDODONTICS (ROOT CANALS)								
D3110	Pulp cap - direct excl. final rest.	$19.00	$20.00	$0.00	$20.00	$0.00	40% of Fee Schedule	40% of R&C
D3120	Pulp cap - indirect excl. final rest.	$15.00	$15.00	$0.00	$15.00	$0.00	40% of Fee Schedule	40% of R&C
D3220	Therapeutic pulpotomy	$48.00	$49.00	$0.00	$49.00	$0.00	40% of Fee Schedule	40% of R&C
D3310	Root Canal therapy - anterior	$246.00	$247.00	$0.00	$165.00	$82.00	40% of Fee Schedule	40% of R&C
D3320	Root Canal therapy - bicuspid	$308.00	$310.00	$0.00	$220.00	$90.00	40% of Fee Schedule	40% of R&C
D3330	Root Canal therapy - molar	$395.00	$395.00	$0.00	$303.00	$92.00	40% of Fee Schedule	40% of R&C
D3346	Retreatment root canal - anterior	$217.00	$220.00	$0.00	$168.00	$52.00	40% of Fee Schedule	40% of R&C
D3347	Retreatment root canal - bicuspid	$268.00	$270.00	$0.00	$202.00	$68.00	40% of Fee Schedule	40% of R&C
D3348	Retreatment root canal - molar	$341.00	$342.00	$0.00	$257.00	$85.00	40% of Fee Schedule	40% of R&C
PERIODONTICS								
D4341	Perio - root planing - per quad	20% discount	$98.00	$0.00	$79.00	$19.00	40% of Fee Schedule	40% of R&C
D4355	Full mouth debridement	$62.00	$63.00	$0.00	$54.00	$9.00	40% of Fee Schedule	40% of R&C
D4910	Perio. Maint. proc. after active therapy	$71.00	$72.00	$0.00	$55.00	$17.00	40% of Fee Schedule	40% of R&C
PROSTHODONTICS (DENTURES)								
D5110	Complete denture - upper	$510.00	$512.00	$0.00	$401.00	$111.00	40% of Fee Schedule	40% of R&C
D5120	Complete denture - lower	$510.00	$512.00	$0.00	$401.00	$111.00	40% of Fee Schedule	40% of R&C
D5130	Immediate denture - upper	$530.00	$532.00	$0.00	$421.00	$111.00	40% of Fee Schedule	40% of R&C
D5140	Immediate denture - lower	$530.00	$532.00	$0.00	$421.00	$111.00	40% of Fee Schedule	40% of R&C
D5211	Maxil. part. denture - resin base	20% discount	$419.00	$0.00	$326.00	$93.00	40% of Fee Schedule	40% of R&C
D5212	Mand. part. denture - resin base	20% discount	$419.00	$0.00	$326.00	$93.00	40% of Fee Schedule	40% of R&C
ORAL SURGERY								
D7111	Extraction primary tooth	$37.00	$22.00	$17.00	$22.00	$17.00	70% of Fee Schedule	60% of R&C
D7140	Extraction erupted tooth	$46.00	$27.00	$20.00	$27.00	$20.00	70% of Fee Schedule	60% of R&C
D7210	Surgical removal of erupted tooth	$83.00	$59.00	$26.00	$59.00	$26.00	70% of Fee Schedule	60% of R&C
D7220	Removal impacted tooth - soft tissue	$102.00	$78.00	$28.00	$78.00	$28.00	70% of Fee Schedule	60% of R&C
D7230	Remov. Impacted tooth - partial bony	20% discount	$98.00	$34.00	$98.00	$34.00	70% of Fee Schedule	60% of R&C
D7240	Remov. Impacted tooth - complete bony	20% discount	$115.00	$34.00	$115.00	$34.00	70% of Fee Schedule	60% of R&C
D7510	Incision & drainage intraoral abcess	20% discount	$62.00	$0.00	$62.00	$0.00	70% of Fee Schedule	60% of R&C
ORTHODONTIA								
D8010	Children and Adults	20% discount	50%	50%	50%	50%	40% of Fee Schedule	40% of R&C
through	Additional In-Network Discount	n/a	20% discount	n/a	20% discount	n/a	20% discount	n/a
D8680	Lifetime Maximum	No Maximum	$1,000.00	$1,000.00	$1,000.00	$1,000.00	$1,000.00	$1,000.00
MISCELLANEOUS								
D0999	OSHA infection and sterilization	$10.00	$10.00	$0.00	$10.00	$0.00	n/a	n/a
D9110	Palliative Treatment	$29.00	$30.00	$0.00	$30.00	$0.00	70% of Fee Schedule	60% of R&C
D2940	Sedative Fillings	$30.00	$30.00	$0.00	$30.00	$0.00	70% of Fee Schedule	60% of R&C
D9430	Office visit - no other services	$25.00	$25.00	$0.00	$25.00	$0.00	70% of Fee Schedule	60% of R&C
D9440	Office visit - after hours	$36.00	$37.00	$0.00	$37.00	$0.00	70% of Fee Schedule	60% of R&C
D9972	External bleaching per arch	20% discount	$100.00	$0.00	$100.00	$0.00	20% discount	No Benefit

PLAN NOTES

R&C - Reasonable and Customary Fees for Utah

Platinum Plan Notes

In-Network Specialists - After 20% discount, all payments made by the plan are based on the Platinum Fee Schedule. Member is responsible for the difference between the plan payment and the discounted specialist's fee.

Out-of-Network General Dentists and Specialists - Payments are based on R&C. Member is responsible for the difference between the plan payment and the dentist's fee.

To find a participating provider, please visit Dental Select's online provider directory at www.DentalSelect.com, or call 800-999-9789 for assistance in locating a provider in your area.

THE BENEFITS LISTED ARE IN SUMMARY FORM ONLY. The above should not be construed to be a complete list of procedures. Copayments and coinsurance percentages listed will be paid according to Dental Select's fee schedules outlined for the 2011 plan year. The summary of fees above are valid through December 31, 2012

VISION

Benefits Review for vision plan 70 C

Opticare of Utah and ***Standard Optical*** are happy to announce, ***NEW*** this year, **$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, Coscto, 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.

Opticare Plan: 70C

	Voluntary
Single	**$ 3.11**
Two Party	**$ 6.03**
Family	**$ 7.91**

Granite School District	Select Network	Broad Network	Out-of-network
Eye Exam			
No Eye Examination Benefit			
Standard Plastic Lenses			
Single Vision	100% Covered	$20 Co-pay	♦$70 Allowance 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 *A/R, edge polish, tints, mirrors, etc.*	Up to 25% Discount	Up to 25% Discount	
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 in lieu Of lens and frame benefit.	$70 Allowance	$60 Allowance	♦$50 Allowance
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 75% 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

Opticare of Utah

A Utah Top 100 Company

Select - In Network Providers

Standard Optical
Where Good Vision is Always in Fashion.

Sugarhouse	2190 Highland Dr	(801) 487-4138
Ogden	4305 South Harrison Blvd	(801) 479-5060
Provo	Provo Towne Center Mall	(801) 373-2254
Logan	1153 North Main	(435) 752-2092
Sandy	834 East 9400 South	(801) 572-9280
West Jordan	1658 West 9000 South	(801) 255-5454
Roy	5431 South 19th West	(801) 825-9703
Layton	Layton Hills Mall	(801) 546-0255
Lehi	1438 E Main St	(801) 753-7999
Bountiful	140 West 500 South	(801) 292-0479
Holladay	4878 S. Highland Dr., Creekside Plaza	(801) 272-8861
West Valley	1901 West Parkway Blvd	(801) 972-0203
Orem	1455 South State St	(801) 226-3044
St. George	250 Red Cliffs Dr	(435) 674-2020
Taylorsville	3754 West 5400 South	(801) 964-9911
Tooele	196 East 2000 North	(435) 882-4815
Murray	5289 South State St	(801) 506-1111

Broad - In Network Providers

EyeMasters®
Why pay more?
an Eye Care Centers of America company

Eye Masters	148 E. Winchester, Area C-D, Murray, UT 84107	(801) 269-8804
Eye Masters	635 E. 400 S. Salt Lake City, UT 84102	(801) 531-7513
Eye Masters	1134 E. 2100 S. Salt Lake City, UT 84106	(801) 463-2712
Eye Masters		(801) 572-4810

SHOPKO®
eyecare center

Shopko Optical	747 S. Main St. Brigham City, UT 84302	(435) 723-1800
Shopko Optical	1150 N. Main St. Layton, UT 84041	(801) 547-9100
Shopko Optical	1341 N. Main St. Logan, UT 84341	(435) 753-0700
Shopko Optical	5959 S. State St. Murray, UT 84107	(801) 261-1113
Shopko Optical	1018 Washington Blvd. Ogden, UT 84404	(801) 392-5100
Shopko Optical	125 S. State St. Orem, UT 84058	(801) 225-4700
Shopko Optical	2266 N. University Pkwy. Provo, UT 84604	(801) 373-1300
Shopko Optical	4060 Riverdale Rd. Riverdale, UT 84405	(801) 392-4300
Shopko Optical	2290 S. 1300 E. Salt Lake City, UT 84106	(801) 467-8989
Shopko Optical	5800 S. Redwood Rd. Salt Lake City, UT 84123	(801) 964-1300
Shopko Optical	2165 E. 9400 S. Sandy, UT 84093	(801) 942-7171
Shopko Optical	955 N. Main St. Spanish Fork, UT 84660	(801) 798-3557
Shopko Optical	190 S. 500 W. West Bountiful, UT 84010	(801) 295-9200
Shopko Optical	1553 W. 9000 S. West Jordan, UT 84088	(801) 561-7300
Shopko Optical	4850 W. 3500 S. West Valley City, UT 84120	(801) 967-6300

For additional information, please visit www.opticareofutah.com or call:

1-800-363-0950

Broad - In Network Providers

AMERICA'S BEST CONTACTS & EYEGLASSES

Newgate Mall	3735 Wall Avenue, Ogden, UT 84405	(801)627-4424
University Festival S.C.	1353 S State Street, Orem, UT 84097	(801)225-8500
America's Best	844 W Telegraph Street, Ste 3, Washington, UT 84780	(435)634-6737
Woods Cross Shops Ctr.	750 South 512 West, Woods Cross, UT 84087	(801)294-0230
America's Best	26 West 7200 South, Midvale, UT 84047	(801)561-1300

INDEPENDENT OPTOMETRY NETWORK

Dr. Ronald Kirk	46 N Main, Blanding, UT 84511	(435) 678-2324
Dr. David Albrecht	15 S 100 E, Beaver, UT 84713	(435) 438-2020
Alan Optical	990 South Medical Drive Brigham City, UT 84302	(435) 723-5868
Dr. Brian Whitney	66 West Harding Ave. STE B, Cedar City, UT 84720	(435) 586-9949
Dr. David Albrecht	70 East 200 North, Suite 2 Cedar City, UT 84720	(435) 586-0316
Dr. W. Scott Albrecht	1251 N. Northfield Rd., Ste. 215 Cedar City, UT 84720	(435) 865-9899
Dr. Russell Jackson	51 East 400 North, Suite 4A Cedar City, UT 84721	(435) 586-1500
Dr. Spencer Johnson	12357 S. 450 E. #2 Draper, UT 84020	(801) 572-9804
Dr. Chelle Nickle	57 N. Main Farmington, UT 84025	(801) 447-4393
Dr. David Burnett	57 N. Main Farmington, UT 84025	(801) 447-4393
Dr. Russell Jackson	210 South 100 West Fillmore, UT 84631	(435) 743-6572
Dr. Dustin Orgill	225 East Main Street, Suite F Grantsville, UT 84029	(435) 249-0530
Dr. David Graf	75 North 100 East, Gunnison, UT 84634	(435) 896-8142
Dr. R.L. Luekenga	75 North 100 East, Gunnison, UT 84634	(435) 896-8142
Dr. Michael Dorius	20 South 850 West #3, Hurricane, UT 84737	(435) 635-7766
Dr. Steven Sargent	568 S. Foothill Dr. #5, Kamas, UT 84036	(435) 783-4114
Dr. Robert Gray	785 E 200 S #9, Lehi, UT 84043	(801) 768-4100
Dr. Alan Rees	1097 North Main St.Logan, UT 84321	(435) 752-6110
Dr. Matthew Parry	1300 N. 500 E. ste: 350 Logan, UT 84341	(435) 752-7445
Dr. Shaun Larsen	3534 S 8301 W, Magna, UT 84044	(801) 250-5745
Dr. Roland Abundo	579 E. Fort Union Blvd., Midvale, UT 84047	(801) 255-8500
Dr. Marizel Derby(Exam Only)	7250 S Union Park Ave, Midvale, UT 84047	(801) 255-0704
Dr. Michael D Conklin	192 East 4500 South, Murray, UT 84107	(801) 261-2020
Dr. Walter Peterson	4877 South State St. Murray, UT 84107	(801) 288-0882
Dr. Todd Hackney	471 S Main, Moab, UT 84532	(435) 259-9441
Dr. Greg Pickett	1196 30th St., Ogden, UT 84403	(801) 399-9873
Dr. James Frost	1196 30th St., Ogden, UT 84403	(801) 399-9873
Dr. Douglas Satterfield	575 E. University Parkway ste: H155 Orem, UT 84097	(801) 225-3920
Dr. Barry Cook	92 N 400 E, Price, UT 84501	(435) 637-6290
Dr. Walter Peterson	177 North University Parkway Provo, UT 84604	(801) 373-1711
Dr. H. Brent Parker	120 E 200 N, Richfield, UT 84701	(435) 896-2020
Dr. David Graf	145 North 100 East, Richfield, UT 84701	(435) 896-8142
Dr. Mitchell Peterson	90 East Center, Richfield, UT 84701	(435) 896-5671
Dr. R.L. Luekenga	145 North 100 East, Richfield, UT 84701	(435) 896-8142
Dr. Jerald Jolley	2364 West 12600 South, Riverton, UT 84065	(801) 446-7600
Dr. Jodie Johnson	2360 West 12600 South, Riverton, UT 84065	(801) 446-7600
Dr. Jon Wilson	165 W 200 N, Roosevelt, UT 84066	(435) 722-2981
Dr. Scott Kowallis	165 W 200 N, Roosevelt, UT 84066	(435) 722-2981
Frameworks Eyewear	9720 S. 1300 E. ste: 200 Sandy, UT 84094	(801) 576-6433
Dr. David K. Morrill	2376 N 400 E Building A, Ste 101, Tooele, UT 84074	(435) 843-8333
Dr. Jed Winder	300 S. Main, Tooele, UT 84074	(435) 882-3233
Dr. Adam Hunt (Exam Only)	1851 W. Highway 40, Vernal, UT 84078	(435) 781-8601
Dr. Gordon Seitz	186 N Vernal Ave, Vernal, UT 84078	(435) 789-1552
Dr. Neldon Seitz	185 N Vernal Ave, Vernal, UT 84078	(435) 789-1552

For additional information, please visit www.opticareofutah.com or call:

1-800-363-0950

FLEX SPENDING

- **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 REIMBURSEMENT 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, 2012), 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 CHANGE OR CANCEL MY FLEX CONTRIBUTIONS 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.

- **DO I NEED TO SPEND ALL OF THE MONEY THIS PLAN YEAR?**

  Careful planning is important! At the end of the plan year (December 31, 2012), 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.

Health Care Reimbursement Account

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

The maximum annual contribution to a health care expense account is $600.00 per month = $7,200 per year

In 2013 Health Care Reform limits contribution to $2,500

Dependent Day Care Reimbursement 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.

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

Optional

NBS Debit Card

Monthly fee to have the convenience of a NBS Debit Card = $3.50

Monthly fee to have a flex account *without* a Debit Card = $2.00

Common expenses that qualify for reimbursement include:

- Annual deductibles
- Office visit copayments
- Coinsurance amounts
- Prescriptions and medical supplies
- Over-the-counter medications ***(Note: OTC medications will no longer be eligible without a doctor's prescription)***
- Eye surgery, glasses and contacts
- Mental health/psychiatric care
- Chiropractic services
- Orthodontics
- Rx weight loss programs
- Smoking cessation programs
- Physical and speech therapy

Go to www.nbsbenefits.com for a listing of eligible health care expenses.

To qualify, your dependent(s) must be:

- A child under the age of 13, or
- 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.

Dependent day care reimbursement is paid when you have received qualified dependent care with an accompanying paid receipt or invoice. A continual reimbursement option is available.

Note: If your family's annual income is over $20,000, this reimbursement option will most likely save you more money than the dependent care tax credit you take on your tax return. Contact your own personal financial planner for additional details.

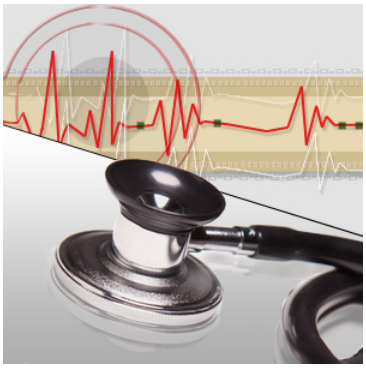
Talk about convenience!

The NBS Flex Card is a Visa 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 Visa credit card. As you use the NBS Flex Card, your annual election balance will be reduced by the amount of your qualified purchases.

NATIONAL BENEFIT SERVICES, LLC
Customer Care • Knowledge and Expertise • Organizational Excellence

Health Care Expense Account

Sample Expenses



Medical Expenses

Acupuncture
Addiction Programs and Products
Adoption (Medical expenses for baby birth)
Alternative Healer Fees
Ambulance
Arthritis Pain Relieving Creams
Artificial Limbs
Body Scans
Chiropractor
Contraceptives
Co-Payments
Crutches
Diabetes (i.e. Insulin, Glucose Monitor)
Eye Patches
Fertility Treatment
First Aid (i.e. Bandages, Gauze, Creams)
Hearing Aids & Batteries
Hypnosis (for treatment of illness)
Incontinence Products (i.e. Depends, Serene)
Joint Support Bandages and Hosiery
Lab Fees
Monitor Device (Blood Pressure, Cholesterol)
Physical Exams
Pregnancy tests
Prescription Drugs
Psychiatrist/Psychologist (for mental illness)
Physical Therapy
Smoking Cessation Relief (i.e. Patches, Gum)
Speech Therapy
Urinary Pain Relief
Vaccinations
Vaporizers or Humidifiers
Wart Removal Medication
Weight Loss Program Fees (with doctor's note)
Wheelchair

Dental Expenses

Artificial Teeth
Co-Payments
Deductibles
Dental Work
Dentures
Orthodontia Expenses
Preventative Care at Dentist Office
Bridges, Crowns, etc.

Vision Expenses

Braille - Books & Magazines
Contact Lenses
Contact Lens Solutions
Eye Exams
Eyeglasses
Laser Surgery
Office Fees
Guide Dog and its upkeep or other animal aid

Health care expenses that do not qualify as a federal income tax deduction under IRS code Section 213 do not qualify for payment through your spending account. The following list includes many of these common expenses that generally do not qualify for reimbursement.

Personal Hygiene (i.e. deodorant, soap, body powder, shaving cream, sanitary products, etc.)
Allergy Relief (oral medications, nasal spray)
Antacids and Heartburn Relief
Athlete's Foot Treatment
Breast Pump
Cold Medicines (i.e. makeup, lipstick, cotton swabs, cotton balls, baby oil)
Counseling (i.e. marriage and family counseling)
Dental Care - Routine (i.e. toothpaste, toothbrushes, dental floss, anti-bacterial mouthwashes, fluoride rinses, breath strips, teeth whitening/bleaching, etc.)
Exercise Equipment
Fever & Pain Reducers (i.e. Aspirin, Tylenol)
Hair Care (i.e. hair color, shampoo, conditioner, brushes, hair loss products)
Health Club or Fitness Program Fees
Homeopathic Supplements or herbs
Household or Domestic Help
Laser Hair Removal
Laxatives
Massage Therapy
Motion Sickness Medication
Nutritional and Dietary Supplements (i.e. bars, milkshakes, power drinks, Pedialyte)
Skin Care (i.e. sun block, moisturizing lotion, lip balm)
Sleep Aids (i.e. oral medications, snoring strips)
Stomach & Digestive Relief (i.e. Pepto-Bismol, Imodium, etc)
Tooth and Mouth Pain Relief (Orajel, Anbesol)
Vitamins
Weight Reduction Aids (i.e. Slimfast, appetite suppressants)

These expenses may be eligible if they are prescribed by a physician (If medically necessary for a specific condition)

NATIONAL BENEFIT SERVICES, LLC
Customer Care • Knowledge & Expertise • Organizational Excellence

8523 South Redwood Rd.
West Jordan, UT 84088
phone: 800.274.0503
fax: 866.909.6525

NEW— Life Carrier

Regence

Life and Health Insurance Company

New Hire Opportunity!

Do you need more life insurance? If it's been a while since you've assessed your life insurance needs, ***NOW'S THE TIME!*** With the change to Regence Life, we are offering a one time opportunity for new hires to enroll or increase your voluntary life insurance amount up to **$400,000** for yourself and up to **$50,000** for your spouse ***WITHOUT*** answering any medical questions.

Please take a moment to assess your current needs and

APPLY NOW!

Basic Life Insurance

COST OF GSD BASIC TERM LIFE INSURANCE

For full-time contract employees of the District, the cost of coverage under the plan is

PAID BY THE DISTRICT

GSD-SPONSORED BASIC TERM LIFE INSURANCE
for employees

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.

THE GSD BASIC TERM LIFE BENEFIT

The amount of a District-sponsored basic life insurance policy is equal to an employee's base contract salary, rounded to the next higher thousand to a maximum of $100,000.

INCLUDED IN THE POLICY

The District-sponsored basic term life policy contains a personal accidental death and dismemberment feature which may provide a benefit *in addition* to the amount of the basic term life policy amount. The personal accidental death and dismemberment provision may be available in accidental situations of:

Loss of life • Loss of sight • Loss of hearing
Loss of limb (hand, foot, arm, leg) • Paralysis
An airbag use benefit • A seat belt use benefit • A coma benefit

Regence
Life and Health Insurance Company

Travel Assistance — You and dependents traveling with you, 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 our website at www.regencelife.com and looking under the Products and Forms link or by contacting MEDEX directly at 1-800-537-2029, your MEDEX ID number is 333191.

This product is not insured by Regence Life and Health. It is a service provided through MEDEX, a leading provider of international travel assistance services.

Voluntary Life

VOLUNTARY TERM LIFE INSURANCE

for employees, your spouse and dependent children

EMPLOYEE POLICY

- Policies issued in increments of: $10,000
- Minimum policy amount: $10,000
- Guarantee issue amount **$400,000 -** *2012 only*
- 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
- Maximum policy amount: Cannot exceed the policy amount elected by the employee up to $100,000 whichever is less
- Guarantee issue amount: **$50,000 -** *2012 only*
- Age limitation None
- Rate based on: Employee's age (not the spouse's age) and the policy amount desired
- Statement of health: Required for any (new and existing) beyond the $50,000 guarantee issue.

CHILD POLICY

- Policies issued in increments of: $1,000
- Minimum policy amount: $1,000
- Maximum policy amount: $10,000
- Age limitation: Age 26
- Rate based on: Policy desired amount
- Statement of health: Not required for child policies

Regence Life and Health Insurance Company

VOLUNTARY TERM LIFE INSURANCE

for employees, your spouse and dependent children

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

TO DETERMINE THE MONTHLY PREMIUM FOR A VOLUNTARY TERM LIFE INSURANCE POLICY:

	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…...…>	_____	_____

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.

Regence

Life and Health Insurance Company

Voluntary AD&D

VOLUNTARY AD&D INSURANCE

WHAT IS 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.

Regence
Life and Health Insurance Company

VOLUNTARY AD&D PLAN PROVISIONS

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%

ADDITIONAL BENEFITS

Other features of the voluntary AD&D plan include a coma benefit, child care benefit, child education benefit, spouse education benefit, continuation of coverage benefit and beneficiary critical period benefit.

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

VOLUNTARY AD&D INSURANCE

for employees, your spouse and dependent children

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*

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……...> $0.17
4. Multiply the increments (2) by the rate (3) This is the monthly premium for coverage…> _____

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

To determine the monthly premium of a Family Protection Plus policy:

1. Determine the policy amount you desire …> _____
2. Divide the policy amount by $10,000 increments……> _____
3. Rate per $10,000……...> $0.25
4. Multiply the increments (2) by the rate (3) This is the monthly premium for coverage...> _____

Regence

Life and Health Insurance Company

New—Disability

Limited Time Long-Term Disability Offering for Teachers

Great News! **CIGNA is offering new teachers of Granite School District a limited time opportunity to apply for Long-term Disability benefits from CIGNA**. This coverage is affordable and often less expensive than if you buy it on your own. Plus, the premium is taken directly out of your paycheck so you don't have to write a check each month.

Disability Insurance can help you pay your bills and maintain your standard of living if you were to become disabled due to sickness or injury. **During this limited time, CIGNA is offering coverage without Medical Underwriting. Meaning all Granite School District contract teachers who enroll will be automatically approved without medical questions.**

Disability

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.

HOW MUCH DOES DISABILITY COVERAGE COST?

It depends on the type of employee you are.

TEACHERS:

Participation in the disability insurance program is voluntary and you must elect to have and pay for disability coverage. The cost of disability insurance coverage is

$20.07 per month.

*** CIGNA will offer teachers a one-time opportunity to enroll in LTD without having to go through medical underwriting***

CLASSIFIED/SECRETARIAL
MIDDLE MANAGER/ADMINISTRATOR:

Participation in the disability insurance program is provided by the District at no cost to you.

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.

DISABILITY INSURANCE
for employees

DISABILITY INSURANCE
for employees

SHORT-TERM DISABILITY BENEFITS
Administered by Granite School District

- 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**

LONG-TERM DISABILITY BENEFITS
Administered by CIGNA

- 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 or teachers, classified and secretarial employees; 60% of base contract salary for middle managers and administrators.
- 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 unless the disability began after being covered for twelve consecutive months under the disability program**

CIGNA®

WELFARE ASSOCIATION

HOW IT WORKS

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.

THE BENEFIT OF BEING A MEMBER

Because membership in the Welfare Association is voluntary, benefit payments vary depending on the number of members currently participating in the Association on a member's date of death.

ELIGIBLITY TO BE 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 at any time.

COST FOR MEMBERSHIP

There is no cost for participation in the Welfare Association unless a current participating Association member passes away.

LIMITATIONS OF MEMBERSHIP

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.

WHEN COVERAGE ENDS

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.

Granite
SCHOOL DISTRICT
From here, anything's possible

FAQs

- **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 2012 plan/calendar year.

- **WHEN IS THE LAST DAY I CAN ENROLL?**
  The open enrollment period ends on October 28, 2011 at 9:59 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?**

MEDICAL PLANS			**DENTAL PLANS**		
Select:Med	=	Age 26	Silver	=	Age 26
SelectMed Plus	=	Age 26	Gold Medium	=	Age 26
ValueCare	=	Age 26	Gold High	=	Age 26
ValueCare Plus	=	Age 26	Platinum	=	Age 26
OPTIONAL TERM LIFE	=	Age 26	**VOLUNTARY AD&D**	=	Age 26

- **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.

- **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 2012 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 unless the disability began after being covered under the long-term disability plan for 12 consecutive months.

- **WILL I RECEIVE NEW ID CARDS FOR 2012?**

It depends. You will receive new ID cards for Medical and dental. You will only receive new ID cards for vision, or flex spending if you changed plans from 2011 to 2012 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 2012. Both employees must select the same medical 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, 2010. SSNs for **all** subscribers and **existing** dependents are required by CMS (Center for Medicare & Medicaid) by 1/1/2011.

FAQs

GLOSSARY

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.

Granite School District
Notice of Privacy Policy & Practice

This Notice Describes How Medical Information About You May Be Used And Disclosed and How You Can Get Access To This Information. Please Review It Carefully.

WHO WILL FOLLOW THIS NOTICE

This notice describes the medical information practices of the Granite School District group health plan (the "Plan") in the administration of Plan claims.

OUR PLEDGE REGARDING MEDICAL INFORMATION

Granite School District, as a plan administrator, understands that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the health care claims reimbursed under the Plan for Plan administration purposes. This notice applies to all of the medical records we maintain on Granite School District employees. Your personal physician or health care provider may have different policies or notices regarding the physician's use and disclosure of your medical information created in the physician's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes our obligations and your rights regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment (as described by applicable regulations): We may use or disclose medical information about you to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including physicians, nurses, technicians, medical students or other hospital personnel who re involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions.

For Payment (as described in applicable regulations): We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment of services you receive from health care providers, to determine benefit responsibility under the Plan or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Plan will cover the treatment. We may also share medical information with a utilization review or precertification service provider. Likewise, we may share medical information with another entity to assist with the adjudication or subrogation or health claims or to another health plan to coordinate benefit payments.

For Health Care Operations (as described in applicable regulations): We may use and disclose medical information about you for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with any of the following: conducting quality assessment and improvement activities; underwriting, premium rating and other activities related to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

As Required By Law: We will disclose medical information about you when required to do so by federal, state or local law. For example, we may disclose medical information when required by a court order in a litigation proceeding such as malpractice action.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose medical information about you in a proceeding regarding the licensure of a physician.

SPECIAL SITUATIONS

Disclosure to Health Plan Sponsor (Granite School District). Information may be disclosed to another health plan maintained by Granite School District for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed for purposes of administering benefits under the Plan.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary, to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensations: We may release information about you for workers' compensation or similar programs. These programs provide benefits for work-relate injuries or illnesses.

Public Health Risks: We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and/or deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls or products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or conditions;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the hospital; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine a cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be

necessary (1) for the institution to provide you with healthcare; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we obtain about you:

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Official. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you make ask us to amend the information. You have the right to request an amendment for as long as the information s kept by or for the Plan.

To request an amendment, you request must be made in writing and submitted to the Privacy Official. In addition, you must provide the reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the medical information kept by or for the Plan;
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information which you would be permitted to inspect or copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment or health care operations.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Official. Your request must state a time period which may not be longer than six yeas and may not include dates before April 2003. Your request should indicate what for you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request.

To request restrictions, you must make your request in writing to the Privacy Official. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limitations to apply – for example, disclosures to your spouse.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at our web site, http://www.graniteschools.org/C6/Benefits/default.aspx
To obtain a paper copy of this notice, contact the Human Resources Privacy Official.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice on the Plan web site. This notice will contain on the first page, in the top right hand corner, the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the hospital or Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact Granite School District, ATTN: Privacy Official, 2500 S. State Street, Salt Lake City, Utah, 84115. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and we are required to retain our records of that care that we provided to you.

If you have any questions about this notice, please contact:

Granite School District
ATTN: Privacy Official
2500 S. State Street
Salt Lake City, Utah 84115

Granite School District
Initial Notice of COBRA Continuation Coverage Rights

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end.

TO: Each covered employee and their spouse and/or dependent children (if any)

FROM: Granite School District Human Resources – Benefits Office
2500 South State Street, Salt Lake City, UT 84115

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.

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.

Notice to Enrollees in a Self-Funded Nonfederal Government Group Health Plan

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. Granite School District has elected to exempt SelectMed (SelectHealth), SelectMedPlus (SelectHealth), ValueCare (Regence BlueCross BlueShield of Utah) and ValueCare Plus (Regence BlueCross BlueShield of Utah), from the following requirements:

1. Parity in the application of certain limits to mental health benefits. Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

The exemption from these Federal requirements will be in effect for the 2012 plan year beginning January 1, 2012 and ending December 31, 2012. The election may be renewed for subsequent plan years.

HIPAA also requires the Plan to provide covered employees and dependents with a "certificate of credible coverage" when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy.

Granite
SCHOOL DISTRICT

GRANITE SCHOOL DISTRICT

District Benefits Office

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Salt Lake City, UT 84115

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SCHOOL DISTRICT
From here, anything's possible