Employee Benefits

Everything you need to know about your benefits at Granite School District from January 1, 2024 to December 31, 2024

Benefits at Granite School District

2024 Contacts

Medical
Select Health
(801) 442-5038
www.selecthealth.org

Regence BCBS
(888) 367-2112
www.regence.com

Pharmacy - RX
Express Scripts
(800) 282-2881
www.express-scripts.com

Specialty Pharmacy - RX
Accredo
(800) 803-2523
www.accredo.com

Dental
Ameritas
(800) 999-9789
www.dentalnetwork.ameritas.com/dentalselect

Vision
MetLife
(800) 363-0950
https://idoc.metlife.com/members/MetLife/FindAProvider/Index

Flexible Spending Account
National Benefit Services
(801) 532-4000
www.nbsbenefits.com

Voluntary Benefits

Accident, Critical Illness & Hospital
MetLife
(800) 438-6388
https://www.metlife.com/GSD/

Voluntary ID Theft
MetLife Powered by Aura
(844) 931-2872
https://my.aura.com/start

Voluntary Pet Insurance
MetLife
(800) 438-6388
www.metlife.com/getpetquote

For escalated claims & product questions:
GBS Voluntary Support
(801) 819-7744
vbcustomerservice@gbsbenefits.com

Life and AD&D
Lincoln Financial Group
(877) 275-5462
www.lfg.com

Long Term Disability
LifeMap
(801) 286-1129
www.lifemapco.com

Retirement
Utah Retirement Systems
(801) 366-7770
www.urs.org

Human Resources
(800) 286-1129
www.graniteschools.org/hr

Benefits Office
(385) 646-4528
benefits@graniteschools.org
www.graniteschools.org/hr/benefits

The benefits in this guide are effective January 1, 2024 - December 31, 2024. This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

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

We are committed to providing our employees with quality benefits programs that are comprehensive, flexible and affordable. Giving our employees the best in benefit plans is one way we can show you that as an employee, YOU are our most important asset.

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Benefits Overview

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

1. **Take advantage of the tools available to you.** That includes this guide, access to plan information, provider directories, and enrollment materials.
2. **Be a smart shopper.** If you were buying a car or purchasing a home, you would do a lot of research beforehand. You should do the same for benefits because the wrong decision could be costly.
3. **Don't miss the deadline and keep record of your enrollment!** Pay attention to the enrollment deadline and be sure to provide Human Resources with your benefit elections in a timely manner. It is important to review your paycheck to ensure the accuracy of payroll deductions. Notify HR immediately if there are any discrepancies.

Who Is Eligible?

If you are hired as a contract coverage will begin on the first day of the month following your date of hire. You may also enroll your eligible dependents in the same plans you choose for yourself.

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

When Do I Enroll?

You can enroll for coverage within 30 days of your date of hire, or during the annual open enrollment period. Outside of your open enrollment period, the only time you can change your coverage is within 30 days after you experience a qualifying event.

Benefits Overview

Making Changes During The Year

The IRS provides strict regulations about the changes to pre-tax elections during the plan year. Once you enroll in benefits, you will not be able to make any changes to your elections until the next annual open enrollment period, unless you experience a qualified life event.

Qualified life events include, but are not limited to:

- Change in your legal marital status
- Birth of a child
- A dependent no longer meets the eligibility requirements
- You and/or your dependent becomes eligible or loses eligibility for Medicare, Medicaid or the Children's Health Insurance Program (CHIP)
- Employee or dependents change in employment status resulting in loss or gain of eligibility for employer sponsored benefits
- A court or administrative order

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

When Coverage Ends

For most benefits, coverage will end on the last day of employment.

- 9/10 month contracts will end August 31, if contract is completed.
- Your employment with Granite School District ends

Your dependent(s) coverage ends:

- When your coverage ends, or
- Day of 26th birthday in which the dependent is no longer eligible

Health Care Reform and You

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

In addition to the plan information in this Benefits Guide, you can also review a Summary of Benefits and Coverage for each medical plan. This requirement of the ACA standardizes health plan information so that you can better understand and compare plan features. The SBC document can be found on the benefits webpage: https://www.graniteschools.org/hr/benefits/benefit-options/

Insurance Premium & Wellness Incentive

2024 Wellness Incentive

To avoid the $10 monthly Granite Well-Being insurance premium increase for the 2025 plan year, employees will be asked to complete one of the two options below between January 1, 2024, and December 15, 2024. Failure to complete one of the options by the given deadline will result in an additional $10 monthly medical premium for the 2025 plan year.

Complete a biometric screening through the Wellness Center

Complete a "biometric screening" through the Wellness Center. Please keep in mind you do not need to schedule a physical to earn the incentive, only a biometric screening, a physical is highly recommended.

Or

Complete a biometric screening through your personal physician

Complete a biometric screening through your physician and return the completed physician form to the Benefits Department. The physician form can be found online at:
http://www.graniteschools.org/hr/benefits/granite-well-being/

If you fail to complete one of the two options by December 15, 2024, the insurance premium increase will begin on January 1, 2025.

Granite Well-Being is committed to helping you become aware of your own personal health. Participation in the Granite Well-Being program is available to all contract employees. If you need assistance or have questions, please contact the Benefits Department at 382-646-4528 or benefits@graniteschools.org

Biometric Screening & Wellness Premium Surcharge FAQ

For employees with medical coverage through Granite School District

How do I avoid the $10/month medical premium surcharge for the 2024 plan year?

Complete a biometric screening any time between January 1, 2024 - December 15, 2024.

Do I have to complete a biometric screening even though I did it last year?

Yes. Employees will be asked to complete the biometric screening once per plan year to avoid a premium surcharge the following plan year.

Do I have to wait an entire year to get my biometric screening done again?

If you choose to have your biometric screening done through Granite Wellness Center, you can go at any time, regardless of when your last visit was with your doctor. If you choose to go through your physician, you will have to wait a year from your last visit.

What is a biometric screening and why is it important?

A biometric screening is a clinical assessment that can help identify your risk for certain diseases and medical conditions. By identifying your risk, you can discuss a plan of action with your doctor or the Care Management RN at Granite Wellness Center and make healthy lifestyle changes to support a positive wellbeing.

How is the biometric screening conducted and what information is being collected?

A small blood sample will be taken to measure different health indicators. These measurements can include a lipid panel and A1c, along with height, weight, and vital signs.

Where can I complete the biometric screening?

You can schedule an appointment at Granite Wellness Center or see your primary care physician. To schedule an appointment through Granite Wellness Center, please call 801-964-9355 or go to www.mypremisehealth.com.

Are there any forms I need to submit for proof of screening?

If you receive your screening through Granite Wellness Center, you will not need to complete a form. You will be asked to complete a consent form at the time of appointment.

If you receive your screening through your primary care physician, you will need to complete the Physician Form and submit it to the benefits department by December 15th. Here is the link to the form: https://www.graniteschools.org/hr/benefits/granite-well-being/

Does my spouse need to complete the requirements?

No, spouses are not required.

I am a new employee. Do I need to complete the biometric screening?

If you were hired after July 1, 2023, you do not need to complete the screening for the 2024 plan year only.

Granite Wellness Center

Granite School District provides an onsite Wellness Center for its contract employees and dependents who are on one of the District's medical insurance plans. Granite is concerned about the upward trend of rising healthcare costs, the health of its employees, attracting and retaining good quality employees. The District views the Wellness Center as a long term solution to help address those concerns. Granite takes great pride in leading the charge for a better healthcare experience.

Services Include:

- Primary Care
- Mental Health
- Physical Therapy
- Biometric Screening
- Wellness Coaching
- Rx Dispensing
- Lab Services
- Specialist Referrals
- Acute Care
- Preventive Exams/Physicals
- Condition Management
- Behavioral Health Counseling
- Vaccinations\Immunizations
- Care Coordination

Enhanced Technology:

- Manage appointments on web or phone
- Receive prompts and reminder on phone
- eVisits
- Quality care anytime anywhere
- After hours telephonic care
- Wellness vitals, remote monitoring through mobile apps

Address:

4163 South 3200 West

West Valley City, UT 84119

801-964-WELL (9355)

Hours of Operation:

Monday - Friday 7:00am- 7:00pm

Saturday 8:00am - 1:00pm

Download the Flyer

Visit Premise Health

Wellness Center Frequently Asked Questions

Who can use the Wellness Center?

The Wellness Center is open to all contract employees, retirees (Pre-Medicare), and dependents age 2 or older who are enrolled in one of the District's medical plans.

Is there a cost to utilize the Wellness Center?

All services provided are free of charge (e.g., office visits, procedures, labs, medication dispensing, counseling services). If you need additional services provided at other healthcare facilities, standard charges will apply based on the structure of your medical benefit.

What services are offered?

Services at the Wellness Center include comprehensive primary care, preventive exams and physicals, acute care, wellness coaching, biometric screenings, behavioral health counseling, lab services, condition management, vaccinations and immunizations, specialist referrals and care coordination, mental health, physical therapy and medication dispensing.

How do I make an appointment?

Schedule directly at www.mypremisehealth.com or call the center at 801-964-WELL (9355).

Is there an online portal or mobile app?

Yes, you can schedule appointments, view your health records and much more on the My Premise Health portal. If you are a contract employee, you can register for a My Premise Health portal account at www.mypremisehealth.com or you can download the My Premise Health mobile app (Apple or Android). If you are a dependent or retiree, you can register for the member portal at your appointment, or by calling the Wellness Center to request an activation link, or by emailing support at MyPHSupport@PremiseHealth.com.

Are appointments required or can I walk in?

It is highly recommended that you schedule an appointment in advance. Please note that same day and walk-in appointments are not guaranteed and will have limited availability.

What medication dispensing services are offered at the Wellness Center?

The Wellness Center is licensed to provide limited medication dispensing services based on a partial formulary of common medications utilized by members. If a Wellness Center provider prescribes a medication for you that is available to be dispensed, you can pick up your pre-packaged medication at the Wellness Center. If the medication is not available, you can pick up your prescription at a local pharmacy.

What is the cost for medications dispensed at the Wellness Center?

All medications dispensed at the Wellness Center are free of charge. If a prescription is picked up at a local pharmacy, standard charges will apply based on the structure of your prescription drug benefits.

continued on next page...

Wellness Center Frequently Asked Questions

Can I bring in a prescription from an outside provider and have it filled at the Center?

No, the Wellness Center is not able to fill a prescription from an outside provider.

Can I use the Wellness Center for lab orders from an outside or community provider?

Yes, the Wellness Center can perform blood draws ordered by a community provider, simply schedule a lab appointment. On the day of appointment, please present your lab order to the Wellness Center. Lab results will be sent by the lab to the outside provider.

Do I need to bring an insurance card or ID to my appointment?

Yes, please be prepared to show your insurance card and valid form of personal ID (such as a driver's license) for identity verification.

If I get hurt on the job, can/should I go to the Wellness Center?

No, the Wellness Center is currently not an approved provider for workers' compensation claims.

Is my personal health information secure? Will Granite School District have access?

Your personal health information is confidential, and your data is kept secure. The Wellness Center operates in accordance with HIPAA and works diligently to protect all health records. Premise Health can't share any personal health information without your permission. Rest assured; your personal health information is not shared with Granite School District. Additionally, Premise Health operates through a private network utilizing Epic and other software systems that is not accessible by Granite School District. A notice of privacy practices is available for review within the Wellness Center.

Check out the Wellness Center

Online Benefits Enrollment

Employee Navigator

Please follow the steps below to elect or waive coverage for the current plan year.

Information Needed When Adding Dependents

- Name
- Social Security Number(s)
- Dates of Birth
- Home Address (if separate from yours)

Step 1: Getting Started

- Click the link below or in your web browser type www.employeenavigator.com
- **Username** - If you have misplaced your credentials, reach out to Human Resources.
- **Reset Password** - Employees can reset passwords on login screen.
- Click "New User Registration" (first time user)
- Create Your Account:
    - First Name
    - Last Name
    - Company Identifier **GRANITESD**
    - Last 4 Digits of SSN
    - Birth Date
- On the home screen (once logged in) look for "**Start Enrollment**".

Step 2: Verify Your Personal and Dependent Information

- Personal Information - Validate all information is accurate.
- Dependent Information:
    - To update information, click "**Edit**", upon completion click "**Save**".
    - Select "**Add Dependent**" if you currently do not see them listed.
- Once all your dependents have been added/updated, click "**Save & Continue**".
- **Please note:** If your company offers supplemental life insurance you need to add your spouse and children as dependents in this screen.

Step 3: Making Your Open Enrollment Elections

- Complete all benefits through each step of the enrollment process (enroll or waive).
- Click "**Save & Continue**" at the end of each benefit screen.

Step 4: Confirm Your Elections

- Upon completion, please verify everything in the "**Enrollment Summary Screen**".
- Click "**Click To Sign**" to complete your open enrollment elections.

Important Information

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

Click Here to learn about the new benefits offered by Granite School District!

Medical

Three-Tier Network

Your insurance plan is changing to a three tier plan, which is designed to save you money on healthcare expenses while providing you the greatest access.

Here's How it Works

You now have three benefit "tiers" of coverage combined into one plan. Each tier is tied to a different provider network. Select Health has combined: Select Value+SelectMed=SelectMed Plus. Regence has combined Focal/Point+Valuecare+Valuecare Plus.

TIER 1

Select Value/Focal Point
Tier 1 gives you the richest benefits and the best bang for your buck

- **Lower member cost sharing:** Depending on your plan, you may pay less for care through coinsurance and deductibles.
- **Lower overall costs:** Doctors and Facilities will charge you less for many services and procedures
- **Combined deductible/out of pocket:** Expenses you pay in Tier 1 or 2 will count towards both the Tier 1 and Tier 2 deductible and out of pocket maximum.
- **Prescriptions count:** Any money you spend out of pocket to pay for covered prescriptions will count towards your deductible and out of pocket maximum.

TIER 2

Select Med/Value Care
Tier 2 gives you greater access

- **Slightly higher overall costs:** Doctors and facilities may charge you slightly more for some services.
- **Greater access:** There are more in network provider and more in network facilities when compared to Tier 1.
- **Combined deductible/out of pocket**: Expenses you pay in Tier 1 or 2 will count towards both the Tier 1 and Tier 2 deductible and out of pocket maximum.
- **Prescriptions count**: Any money you spend out of pocket to pay for covered prescriptions will count towards your deductible and out of pocket maximum.

TIER 3

Select Med Plus/Value Care Plus
Tier 3 gives you unlimited access (out of network benefits) at higher costs

- **Total Freedom:** See any provider or go to any facility you want for covered services.
- **Higher costs:** Your coinsurance and overall costs for care will be higher when compared to Tiers 1 and 2 and providers and facilities may ask you to pay the difference between what they charge and the allowed amount.
- **Separate deductible/out of pocket:** None of the out-of-pocket expenses you incur on Tier 1, Tier 2, or on prescription drugs will count toward your Tier 3 deductible or out of pocket maximum.
- **Certain Services:** Some services (such as preventive care) are not covered when done by an out of network provider. We recommend calling Member Services to confirm your coverage and benefits before using out of network providers.

Click Here to Learn More

Medical

Select Health

Connect Care

For urgent care needs, a skilled clinician is just a swipe or click away. Use your computer, tablet, or phone to video connect with a doctor or nurse practitioner anytime (24/7 access). To access Connect Care for urgent care click the mini app within the Select Health app, or in the MyHealth+ app, or visit www.intermountainconnectcare.org.

Psychiatric Care is now available through Connect Care from anywhere in Utah or Idaho (only). Receive the same quality care for mild to moderate conditions i.e. anxiety, depression and more. Appointments are available from 7am to 7pm daily including same day appointments. To access Connect Care for Psychiatric Care go to the MyHealth+ app and choose Connect Care Behavioral Health, or call 833-442-2670, or visit www.intermountainhealthcare.org/accessing-care/telehealth/connect-care/behavioral-health.

Medical Cost Estimator

We can give you an estimate of how much you'll need to budget using your benefits, where you live, and your plan's provider network. We'll estimate your costs, including how much your plan will cover and what you will pay. To access the cost estimator logon to your Select Health account at www.selecthealth.org or use the Select Health app.

Member Services

Life doesn't stop at 5:00pm. Select Health Member Services 800-538-5038 offers extended hours to answer your questions and help resolve your concerns. We're available weekdays from 7:00am to 8:00pm and Saturdays from 9:00am to 2:00pm.

Member Advocates

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

Intermountain Health Answers

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

Coverage Outside of the Country

If you are traveling outside of the country and need urgent or emergent care, visit the nearest doctor or hospital. You may need to pay for the treatment at the time of service. If you do, keep your receipt and submit it along with a Claim Reimbursement Form. Click here to download the form.

Healthy Beginnings

Pregnancy is a special time, so our free prenatal program provides support and resources for expectant mothers. In addition to pregnancy education materials, the program includes a risk assessment screening and provides high-risk care management when needed. Visit www.selecthealth.org for more information or call 866-442-5052.

Continued on next page…

Medical

Select Health

Select Health Mobile App

With the Select Health® mobile app, you have access to your health plan whenever and wherever you need it.

With our secure app, you can:

- View, email, and fax images of your ID Card
- Search for doctors and hospitals
- View your benefits and claims, including year-to-date totals

Intermountain Healthcare MyHealth+ App

This personalized mobile app brings powerful tools from across your health experience into one place.

With this secure app, you have access to:

- Symptom Checker
- Access medical records and visit summaries
- Manage prescriptions
- Access telehealth services (i.e. Connect Care)

Discounts And More Discounts

As a Select Health member, you have discounts on everyday products and services, including:

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

The process is simple just mention that you are a Select Health member and show your ID Card. To learn more, visit www.selecthealth.org/discounts.

Care Management

Registered nurses can help with health concerns and coordinate services between providers and patients. Our care managers provide educational materials, newsletters, follow-up phone calls and additional support for conditions such as asthma, heart failure, depression, diabetes, and cancer. Visit www.selecthealth.org/wellness/care-management or call 800-442-5305.

National Accreditation

Select Health is Utah's top-ranked health plan, according to NCQA's Health Insurance Plan Rankings 2017-2018. Our ranking is based on how well we help our members stay healthy, get better, manage chronic illness, access qualified providers, and receive care when services are needed.

Pharmacy Benefit Manager
Express Scripts

For detailed pharmacy information, visit www.express-scripts.com

Specialty Pharmacy
Accredo

For specialty medication, contact Accredo, Specialty Pharmacy.

Medical

Select Health

	Tier 1 Value Network You Pay	Tier 2 Med Network You Pay	Out-of-Network You Pay
Deductible	$1,000/person $3,000/family max		$1,500/single $5,000/family max
Out-of-Pocket Maximum	$2,000/person $4,000/family max		$2,500/single $5,000/family max
Preventive Care	Covered in Full	Covered in Full	40% AD
Office Visits			
Primary Care	$30	$40	40% AD
Specialist	$40	$50	40% AD
Urgent Care	$50	$50	40% AD
Hospital Services			
Inpatient	20% AD	20% AD	40% AD
Outpatient	20% AD	20% AD	40% AD
Mental Health Services			
Office Visit	$30	$40	40% AD
Inpatient	20% AD	20% AD	40% AD
Outpatient	20%	20%	40% AD
Emergency Room	20% AD		

Pharmacy *Express Scripts*	**Standard Drugs**	**Maintenance Drugs**
Tier 1	$10	$20
Tier 2	$50	$100
Tier 3	$80	$160
Specialty	$80 for pharmacy, 20% for medical	$80 for pharmacy, 20% for medical

AD = After Deductible

Download the Full Plan Summary

Select Health Provider Search

Medical

Regence BlueCross BlueShield

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 - Regence.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. Regence.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 www.regence.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 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, eye-wear, hearing aids, and bicycle and skating helmets.

Coverage Outside of the Country

As a Blue Cross and Blue Shield member, you take your healthcare benefits with you when you are abroad. Through the Blue Cross Blue Shield Global Core program, you have access to doctors and hospitals around the world. Click here to learn more.

Pharmacy Benefit Manager

Express Scripts

For detailed pharmacy information, visit www.express-scripts.com

Specialty Pharmacy

Accredo

For specialty medication, contact Accredo, Specialty Pharmacy.

Medical

Regence BlueCross BlueShield

	Tier 1 Focal Point Network You Pay	Tier 2 Value Care Network You Pay	Out-of-Network You Pay
Deductible	$1,000/person $3,000/family max		$1,500/single $5,000/family max
Out-of-Pocket Maximum	$2,000/person $4,000/family max		$2,500/single $5,000/family max
Preventive Care	Covered in Full	Covered in Full	40% AD
Office Visits			
Primary Care	$30	$40	40% AD
Specialist	$40	$50	40% AD
Urgent Care	$50	$50	40% AD
Hospital Services			
Inpatient	20% AD	20% AD	40% AD
Outpatient	20% AD	20% AD	40% AD
Mental Health Services			
Office Visit	$30	$40	40% AD
Inpatient	20% AD	20% AD	40% AD
Outpatient	20%	20%	40% AD
Emergency Room	20% AD		
Vision Services *Administered by VSP*			
Exam	Covered in Full		Up to $45 reimbursed
Glasses	20% discount off retail pricing		No Benefit
Contacts	15% discount off retail pricing		No Benefit

Pharmacy *Express Scripts*	**Standard Drugs**	**Maintenance Drugs**
Tier 1	$10	$20
Tier 2	$50	$100
Tier 3	$80	$160
Specialty	$80 for pharmacy, 20% for medical	$80 for pharmacy, 20% for medical

AD = After Deductible

Download the Full Plan Summary

Regence BCBS Provider Search

Flexible Spending Account

National Benefit Services

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

How It Works

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

Things To Consider

- Be conservative when estimating your annual election amount. The IRS has a strict "**use it or lose it**" rule. You will forfeit any funds left in your account after the end of the plan year.
- Your 2024 contributions must be used for expenses you incur January 1, 2024-March 15, 2025.
- The health care and dependent care FSAs are two separate accounts and funds cannot be transferred between accounts.
- You cannot stop or change your FSA contribution amount during the year unless you have a qualified change in family status.
- Expenses reimbursed through an FSA cannot be used as a deduction or credit on your federal income taxes.

FSA Reimbursement Options

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

	Health Care FSA	Dependent Care FSA
Maximum Plan Year Contribution Amount	Up to $3,200	Up to $5,000 ($2,500 if married and filing separate income tax returns)
Examples of Eligible Expenses	Medical, Rx, Dental, & Vision Deductible, Coinsurance, and Copays	Cost of childcare for children under age 13 so you and your spouse can go to work or look for work

Prescription Savings

Strategies to Save

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

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

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

GoodRx

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

Isn't health insurance all I need?

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

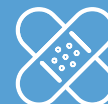
How can I find these savings?

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

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

Please Note:

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



Accident Insurance

MetLife

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

With MetLife Group Accident Insurance, you can have peace of mind knowing:

- Coverage is guaranteed issue - no evidence of insurability required.
- Benefits are paid directly to you.
- Benefits are paid in addition to any other coverage.
- Coverage is portable and may be continued if the employee leaves the group.
- Employee or Family coverage available.

Plan Features	Benefit Amounts
Accident Physician Treatment	$150 doctor / $250 urgent care
X-ray	$200
Ambulance	$400 ground / $1,250 air
ER Service	$300
Dislocation/Fracture Benefit	Up to $10,000
Hospital Confinement/Daily Benefit	$1,500 admission / $300 daily
Accident Follow-Up Visits	$100
Lacerations	Up to $800
Burns	Up to $20,000
Wellness Benefit	$75/per covered person per year

Accident Plan Semi Monthly Premiums	
Employee Only	$4.97
Employee & Spouse	$9.61
Employee & Child(ren)	$11.33
Family	$13.45

Download the Full Plan Summary

Critical Illness

MetLife

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

Plan Highlights include

- **100 % Coverage for diagnosis of**: Benign Brain Tumor, Invasive Cancer, Coma, Loss of Sight, hearing or speech, Paralysis, Heart Attack, Sudden Cardiac Arrest, Kidney Failure, Major Organ Transplant, ALS, Alzheimer's, MS, Muscular Dystrophy, Parkinson's Disease, Systemic Lupus, Sever Burns, Stroke and 8 Childhood Conditions.
- **50% coverage for:** Coronary Artery Bypass Graft.
- **25% Coverage for:** Non-Invasive Cancer, 11 Infectious Diseases (must be in hospital for 5 consecutive days)
- **5% coverage for:** Skin Cancer

Plan Features	Employee	Spouse	Dependent
Coverage	$15,000 or $30,000	50% of employees initial benefit	50% of the employee's initial benefit
Guarantee Issue	Up to $30,000	Up to $15,000	Up to $15,000
Pre-Existing	None	None	None
Wellness Benefit *Must complete a health screening*	$50	$50	None

	$15,000		$30,000	
Age	**Employee**	**Employee + Spouse**	**Employee**	**Employee + Spouse**
<30	$3.62	$5.57	$5.85	$9.08
30-39	$5.34	$8.15	$8.40	$12.98
40-49	$8.78	$13.58	$15.15	$23.03
50-59	$15.60	$24.38	$28.80	$44.70
60 +	$27.45	$43.28	$52.50	$82.50
Dependent Coverage	Included in EE cost at 50%, no additional premium			

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Hospital Indemnity

MetLife

An overnight stay in the hospital in expensive, and there may be additional costs unrelated to your stay such as having a baby or missing work. Hospital Confinement coverage pays a cash benefit when you are admitted for an overnight stay. You can use the monies to pay for medical bills not covered by insurance, or in any way you see fit.

With MetLife Group Critical Illness Insurance, you can have peace of mind knowing:

- Benefits from a Hospital Indemnity plan can be used to assist you in paying deductibles, coinsurance, out of network costs, daily living expenses, etc.
- Benefits are paid regardless of other coverage and this plan is compatible with Health Savings Accounts.

Benefits Include

Guarantee Issue	Yes
Pre-Existing	None
Maternity Waiting Period	None
First Day Hospital Confinement	$1,000/4 time per calendar year
Daily Hospital Benefit *Up to 31 Days*	$200 per day
Intensive Care *Up to 15 days*	$200 per day
Rehabilitation Unit *Up to 15 days*	$200 per day
Newborn Confinement Benefit	$50 for 2 days

Hospital Indemnity Plan Semi-Monthly Premiums	
Employee Only	$8.56
Employee & Spouse	$16.09
Employee & Child(ren)	$12.82
Family	$20.35

Download the Full Plan Summary

Dental

Ameritas - Gold Network - Low Co-Pay Plan

Co-Pay Plan Plan Features	In-Network You Pay	Out-of-Network You Pay
Deductible *Waived for Preventive Services and Orthodontics*	No Deductible	
Annual Maximum	No Maximum	
Preventive Care X-rays, cleanings, exams	Covered in Full	See Out-of-Network Payment
Basic Care *Fillings, extractions, root canals*	Fixed Co-Pays Refer to Co-Pay Schedule	See Out-of-Network Payment
Major Care *Dentures, crowns, bridges*	No Coverage	No Coverage
Orthodontic Care *For children and adults*	50%	50%
Orthodontic Lifetime Maximum	$1,000 per person	

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Ameritas Provider Search

Dental

Ameritas - Gold Network - High Co-Pay Plan

Co-Pay Plan Plan Features	In-Network You Pay	Out-of-Network You Pay
Deductible *Waived for Preventive Services and Orthodontics*	No Deductible	
Annual Maximum	No Maximum	
Preventive Care *X-rays, cleanings, exams*	Covered in Full	See Out-of-Network Payment
Basic Care *Fillings, extractions, root canals*	Fixed Co-Pays Refer to Co-Pay Schedule	See Out-of-Network Payment
Major Care *Dentures, crowns, bridges*	Fixed Co-Pays Refer to Co-Pay Schedule	See Out-of-Network Payment
Orthodontic Care *For children and adults*	50%	50%
Orthodontic Lifetime Maximum	$1,000 per person	

Download the Full Plan Summary

Ameritas Provider Search

Dental

Ameritas - Platinum Network - Low Plan

PPO R&C Classic Plan Features	**In-Network** You Pay	**Out-of-Network** You Pay
Deductible *Waived for Preventive Services and Orthodontics*	$50/person $150/family	
Annual Maximum	$1,000 per person	
Preventive Care X-rays, cleanings, exams	20%	20% of R&C
Basic Care *Fillings, extractions, root canals*	30%	30% of R&C
Major Care *Dentures, crowns, bridges*	60%	60% of R&C
Orthodontic Care *For children and adults*	50%	50%
Orthodontic Lifetime Maximum	$1,000 per person	

AD = After Deductible
R&C = Reasonable & Customary

Download the Full Plan Summary

Ameritas Provider Search

Dental

Ameritas - Platinum Network - High Plan

PPO R&C Classic Plan Features	**In-Network** You Pay	**Out-of-Network** You Pay
Deductible *Waived for Preventive Services and Orthodontics*	$50/person $150/family	
Annual Maximum	$1,500 per person	
Preventive Care X-rays, cleanings, exams	Covered in Full	Covered in Full of R&C
Basic Care *Fillings, extractions, root canals*	20%	20% of R&C
Major Care *Dentures, crowns, bridges*	50%	50% of R&C
Orthodontic Care *For children and adults*	50%	50%
Orthodontic Lifetime Maximum	$1,000 per person	

AD = After Deductible
R&C = Reasonable & Customary

Download the Full Plan Summary

Ameritas Provider Search

Vision

MetLife

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

Granite School District's vision insurance entitles you to specific eye care benefits as outlined below.

Davis Vision Plan Features	In-Network You Pay	Out-of-Network You Pay
Frames *Once every 12 months*	$70 Allowance +20% off remaining balance	$50 Allowance
Lenses		
Single Bifocal Trifocal	100% covered	$70 Allowance for lenses, options and coatings
Contact Lenses *In Lieu of Eyeglasses* *Once every 12 months*		
Conventional/Disposable	$70 Allowance	$50 Allowance

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MetLife Provider Search

Basic Life and AD&D

Lincoln Financial Group

Who is Eligible?

All contract employees are eligible, please see the plan documents for complete details.

Granite School District provides all eligible employees with Basic Group Life and Accidental Death and Dismemberment (AD&D) coverage at **no cost to you!**

Basic Term Life and AD&D

Life insurance will pay your beneficiary a lump-sum payment should you pass away while covered under the terms of this policy. The money can help your family pay for basic living expenses, final arrangements, tuition, and more.

AD&D insurance is also available, it can pay an additional amount if you die from a covered accident or survive an accident but have certain serious injuries.

Beneficiary Designation

We recommend that you designate a beneficiary for your life insurance policy(ies). A beneficiary is the person (or people, estate, trust, etc.) to whom benefits will be paid in the event of your death. You may change your beneficiary at any time during the plan year.

Age Reduction

Coverage amounts begin to reduce at age 65.

Conversion

You can convert your group term life coverage to an individual life insurance policy without providing evidence of insurability if you lose coverage due to leaving your job or for another reason outlined in the plan contract. AD&D benefits cannot be converted.

Continuation of Coverage

You may be able to continue your coverage if you leave your job for any reason other than sickness, injury, or retirement.

Additional Services

- Accident Plus - If you suffer an AD&D loss in an accident, you may also receive benefits for the following on top of your core AD&D benefits: coma, plegia, education, child-care, spouse training, and more.
- LifeKeys services provide access to counseling, financial, and legal support.
- TravelConnect services give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home.

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Plan Features	Basic Life	AD&D
Employee Benefit Amount	1x Base Salary up to $100,000	1x Base Salary up to $100,000

Supplemental Life and AD&D

Lincoln Financial Group

Optional Life Insurance and AD&D

You also have the option to purchase additional life insurance coverage for yourself, your spouse, and your dependent children to age 26. However, you may only elect coverage for your dependents if you elect additional coverage for yourself. You pay for the cost of additional coverage through payroll deductions on a post-tax basis. Rates are based on your age and the amount you elect. Please see Employee Navigator for your calculated rate.

Employee Plan Features:

- Life Benefit Amount: *Up to $500,000 in $10,000 Increments*
- AD&D Benefit Amount: *Up to $500,000 in $10,000 Increments*
- Maximum Benefit: *$500,000*
- Guaranteed Issue: *Up to $500,000*
- Age Reductions: *Reduces to 65% at age 65; 45% at age 70; 30% at age 75; 20% at age 80; 15% at age 85; 10% at age 90.*

Spouse Plan Features:

- Life Benefit Amount: *Up to $100,000 in $5,000 Increments*
- AD&D Benefit Amount: *Up to $100,000 in $5,000 Increments*
- Maximum Benefit: *$100,000*
- Guaranteed Issue: *Up to $50,000*

Dependent Plan Features:

- Life Benefit Amount: *Up to $10,000 in $1,000 Increments*
- AD&D Benefit Amount: *Up to $10,000 in $1,000 Increments*

Term Life Coverage Rates

Rates shown are based on a monthly deduction

Age Band	Employee Per $1,000	Spouse Per $1,000	Child Per $1,000
< 25	$0.041	$0.041	$0.187
25-29	$0.044	$0.044	*Note: The premium paid for child coverage is based on the cost of coverage for one child, regardless of how many children you have.*
30 - 34	$0.061	$0.061	
35 - 39	$0.079	$0.079	
40 - 44	$0.088	$0.088	
45 - 49	$0.132	$0.132	
50 - 54	$0.202	$0.202	
55 - 59	$0.378	$0.378	
60 - 64	$0.581	$0.581	
65 - 69	$1.118	$1.118	
70 - 74	$1.813	$1.813	
75+	$1.813	$1.813	

AD&D Coverage Rates

Employee Rate	Family Rate
$0.017 / per $1,000 of benefit	$0.025 / per $1,000 of benefit

Download the Full Plan Summary

Disability

LifeMap

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.

Teachers

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

Annual Salary	Monthly Cost
<$34,999	$21.00
$35,000-$49,999	$21.50
$50,000-$64,999	$22.00
>$65,000	$23.00

Disability

LifeMap

Long-Term Disability

- Paid benefits subject to medical health underwriting and approval from the carrier
- Benefit rate: 66 2/3% of base contract salary for teachers, classified and secretarial employees; 60% of base contract salary for middle managers and administrators. Max benefit normal retirement age.
- For duration of award status, former employee continues to accrue years of service credit toward a future full retirement with Utah Retirement Systems.
- **NOTE: The long-term disability plan does not cover pre-existing conditions that existed 3 months prior to the start of your coverage unless the disability began after being covered for twelve consecutive months under the disability program.**

Short-Term Disability

- For temporary disability (defined as 120 calendar days or less in duration calculated from first con- tract 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**

ID Theft Protection

MetLife ID Theft powered by Aura

Protect your privacy, identity, and finances.

Aura Protection Includes

- **Identity Theft Protection:** Stay a step ahead of threats with credit monitoring & alerts, optional credit lock, and financial account monitoring to help keep your assets safe.
- **Customer Service:** Get $5 million identity theft insurance1 per adult member and 24/7 customer support to answer account, technical, or billing questions. Plus, resolution specialists provide white glove case management services to victims of fraud.
- **Financial Fraud Protection:** Get alerted to new inquiries to your credit, suspicious transactions on your bank accounts, and changes to your home or car title.
- **Privacy & Device Protection:** Shop, bank, and work online more safely and privately with safety tools including VPN/Wi-Fi security, antivirus, and password manager. Aura also requests removal of your personal info from data broker lists to help reduce spam like robocalls, robotexts, and more

Plan Features	Protection
Financial Fraud Protection	✓
Identity Theft Protection	✓
Privacy & Device Protection	✓
Family Safety	✓
Service and Support	✓

ID Theft Protection Semi-Monthly Premiums	
Employee Only	$4.00
Family	$6.63

Download the Full Plan Summary

Pet Insurance

MetLife Pet Insurance

More than ever, pets play such a huge role in our lives. We want to do everything to keep them safe and healthy. Help make sure your furry family members are protected against unplanned vet expenses for covered accidents or illnesses with MetLife Pet Insurance. **Premiums for this plan are not payroll-deducted**; you will be required to provide a payment method upon enrollment.

Why MetLife Pet Insurance?

- Flexible coverage with up to 90% reimbursement1 and freedom to visit any U.S. licensed vet
- Only provider to offer family plans, covering multiple cats and dogs on one policy
- 24/7 access to Telehealth Concierge Services–because accidents and illnesses don't always wait for your vet to be open
- Discounts up to 30% and additional offers on pet care, where available
- Optional Preventive Care coverage
- Coverage of previously covered pre-existing conditions when switching providers
- MetLife Pet mobile app to submit and track claims, manage your pet's health and wellness and find nearby pet services

How does MetLife Pet Insurance work?

Select and enroll in the coverage that's best for you and your pet

Download the mobile app

Take your pet to the vet

Pay the bill within 90 days and sent it with your claim documents to us via the mobile app, online portal, email, fax or mail

Receive reimbursement by check or direct deposit of the claim expense is covered under the policy

Get a Quote and Enroll Today

Visit: http://www.metlife.com/getpetquote
Call: 1.800.GETMET8

Be sure to let the representative know you are an employee of Granite School District.

Scan to sign up today!

Download the Full Plan Summary

Welfare Association

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

Being A Member

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

Frequently Asked Questions

Are there plans that require me to re-enroll from year-to-year?

YES!!! Flexible spending reimbursement account elections never "automatically" continue from year-to-year. If you participate in a flexible spending reimbursement account, you must re-enroll for the 2024 plan/calendar year.

When is the last day I can enroll?

The open enrollment period ends on October 18, 2024 at 7:00 p.m. No exceptions will be made to the deadline regardless of the circumstance provided for missing or being late after the deadline.

How much does Granite contribute toward medical insurance?

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

How can I get a list of participating doctors and dentists?

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

How old is too old for my dependent child(ren) to be covered?

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

What happens if I fail to remove an ineligible dependent?

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

Frequently Asked Questions

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 2024 open enrollment, coverage for teachers may be declined based upon medical health underwriting by the insurance carrier. Coverage that is subject to medical health underwriting is not effective until approval is received from the insurance company. The District will not begin to assess premium contributions until approval is received from the insurance carrier. The plan does not cover pre-existing conditions that existed 3 months prior to the start of your coverage unless the disability began after being covered under the long-term disability plan for 12 consecutive months.

Frequently Asked Questions

Will I receive new ID cards for 2024?

It depends. You will receive new ID cards for medical, but you will only receive new ID cards for dental, vision, or flex spending if you changed plans from 2023 to 2024 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 2024. Contact the Benefit Office for more details.

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.

Please Note: in order to make a change to a beneficiary, a valid ID must be presented in order for the change to be processed.

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 Payor Mandatory Reporting requirements effective January 1, 2024, for all subscribers and existing dependents are required by CMS (Center for Medicare and Medicaid).

Definitions

Deductible

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

Coinsurance

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

Copayment

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

Formulary

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

Generic Requirement

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

Health Maintenance Organization (HMO) Health Plan

A health care system in which participants obtain comprehensive health care services from a specified list of "in-network" providers/facilities who receive a fixed prepayment from the insurer.

Indemnity Plan

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

In-Network/Preferred Provider

A medical provider (doctor, hospital, pharmacy) who is a member of a health plan's network.

Out-of-pocket (OOP) Annual Maximum

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

Preferred Provider Organization (PPO) Health Plan

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

Initial Notice of COBRA Continuation of Coverage

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

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

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

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

Plan Information

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

Your Reporting Responsibilities:

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

COBRA Qualifying 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 peri- od, 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 book- let for specific information.

Initial Notice of COBRA Continuation of Coverage

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 peri- od 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.

Cost of Coverage

January 1, 2024 - December 31, 2024

Employees whose rates don't meet 9.12% affordability will automatically be adjusted

Medical Select Health/Regence 3 Tier Plan (Full Time 1.0 FTE)				
Status	Employee Per Pay Period	Employee Monthly	GSD Monthly	Employee Monthly - No Wellness
Employee Only	$22.76	$45.52	$650.28	$55.52
Employee & Child	$44.39	$88.77	$1,268.13	$98.77
Employee & Children	$64.87	$129.73	$1,853.37	$139.73
Employee & Spouse	$104.31	$208.62	$1,280.48	$218.62
Family	$146.42	$292.83	$1,822.47	$302.83

Medical Select Health/Regence 3 Tier Plan (Part Time .875 FTE)				
Status	Employee Per Pay Period	Employee Monthly	GSD Monthly	Employee Monthly - No Wellness
Employee Only	$40.64	$81.29	$614.51	$91.29
Employee & Child	$79.26	$158.51	$1,198.39	$168.51
Employee & Children	$115.83	$231.67	$1,751.43	$241.67
Employee & Spouse	$111.30	$222.60	$1,266.50	$232.60
Family	$157.23	$314.45	$1,800.85	$324.45

Medical Select Health/Regence 3 Tier Plan (Part Time .83 FTE)				
Status	Employee Per Pay Period	Employee Monthly	GSD Monthly	Employee Monthly - No Wellness
Employee Only	$55.28	$110.55	$585.25	$120.55
Employee & Child	$107.79	$215.58	$1,141.32	$225.58
Employee & Children	$157.53	$315.07	$1,668.03	$325.07
Employee & Spouse	$118.29	$236.58	$1,252.52	$246.58
Family	$168.04	$336.07	$1,779.23	$346.07

Medical Select Health/Regence 3 Tier Plan (Part Time .80 FTE)				
Status	Employee Per Pay Period	Employee Monthly	GSD Monthly	Employee Monthly - No Wellness
Employee Only	$65.03	$130.06	$565.74	$140.06
Employee & Child	$126.81	$253.62	$1,103.28	$263.62
Employee & Children	$185.34	$370.67	$1,612.43	$380.67
Employee & Spouse	$139.17	$278.33	$1,210.77	$288.33
Family	$197.69	$395.38	$1,719.92	$405.38

Cost of Coverage

January 1, 2024 - December 31, 2024

Medical Select Health/Regence 3 Tier Plan (Part Time .75 FTE)				
Status	Employee Per Pay Period	Employee Monthly	GSD Monthly	Employee Monthly - No Wellness
Employee Only	$81.29	$162.58	$533.23	$172.58
Employee & Child	$158.51	$317.03	$1,039.88	$327.03
Employee & Children	$231.67	$463.34	$1,519.76	$473.34
Employee & Spouse	$173.96	$347.91	$1,141.19	$357.91
Family	$247.11	$494.23	$1,621.08	$504.23

Medical Select Health/Regence 3 Tier Plan (Part Time .69 FTE)				
Status	Employee Per Pay Period	Employee Monthly	GSD Monthly	Employee Monthly - No Wellness
Employee Only	$100.80	$201.59	$494.21	$211.59
Employee & Child	$196.56	$393.11	$963.79	$403.11
Employee & Children	$287.27	$574.54	$1,408.56	$584.54
Employee & Spouse	$215.71	$431.41	$1,057.69	$441.41
Family	$306.42	$612.84	$1,502.46	$622.84

Medical Select Health/Regence 3 Tier Plan (Part Time .67 FTE)				
Status	Employee Per Pay Period	Employee Monthly	GSD Monthly	Employee Monthly - No Wellness
Employee Only	$107.30	$214.60	$481.20	$224.60
Employee & Child	209.24	$418.47	$938.46	$428.47
Employee & Children	$305.80	$611.61	$1,371.49	$621.61
Employee & Spouse	$229.62	$459.24	$1,029.86	$469.24
Family	$326.19	$652.38	$1,462.92	$662.38

Medical Select Health/Regence 3 Tier Plan (Full Time .625 FTE)				
Status	Employee Per Pay Period	Employee Monthly	GSD Monthly	Employee Monthly - No Wellness
Employee Only	$121.93	$243.86	$451.94	$253.86
Employee & Child	$237.77	$475.54	$881.36	$485.54
Employee & Children	$347.50	$695.01	$1,288.09	$705.01
Employee & Spouse	$260.93	$521.87	$967.23	$531.87
Family	$370.67	$741.34	$1,373.96	$751.34

Cost of Coverage

January 1, 2024 - December 31, 2024

Medical Select Health/Regence 3 Tier Plan (Full Time .562 FTE)				
Status	Employee Per Pay Period	Employee Monthly	GSD Monthly	Employee Monthly - No Wellness
Employee Only	$142.42	$284.83	$410.97	$294.83
Employee & Child	$277.71	$555.43	$801.47	$565.43
Employee & Children	$405.88	$811.77	$1,171.33	$821.77
Employee & Spouse	$304.77	$609.54	$879.56	$619.54
Family	$432.94	$865.88	$1,249.42	$875.88

Medical Select Health/Regence 3 Tier Plan (Full Time .50 FTE)				
Status	Employee Per Pay Period	Employee Monthly	GSD Monthly	Employee Monthly - No Wellness
Employee Only	$162.58	$325.15	$370.65	$335.15
Employee & Child	$317.03	$634.05	$722.85	$644.05
Employee & Children	$463.34	$926.68	$1,056.43	$936.68
Employee & Spouse	$347.91	$695.83	$793.28	$705.83
Family	$494.23	$988.45	$1,126.85	$998.45

Cost of Coverage

January 1, 2024 - December 31, 2024

Dental Ameritas Low Co-Pay Plan			
Status	Employee Per Pay Period	Employee Monthly	GSD Monthly
Employee Only	$8.50	$17.00	$0.00
Two-Party	$15.50	$31.00	$0.00
Family	$25.00	$50.00	$0.00

Dental Ameritas High Co-Pay Plan			
Status	Employee Per Pay Period	Employee Monthly	GSD Monthly
Employee Only	$12.00	$24.00	$0.00
Two-Party	$20.50	$41.00	$0.00
Family	$32.50	$65.00	$0.00

Dental Ameritas Low PPO Plan			
Status	Employee Per Pay Period	Employee Monthly	GSD Monthly
Employee Only	$17.00	$34.00	$0.00
Two-Party	$31.50	$63.00	$0.00
Family	$54.50	$109.00	$0.00

Dental Ameritas High PPO Plan			
Status	Employee Per Pay Period	Employee Monthly	GSD Monthly
Employee Only	$19.50	$39.00	$0.00
Two-Party	$36.50	$73.00	$0.00
Family	$63.00	$126.00	$0.00

Vision MetLife Davis Vision Plan			
Status	Employee Per Pay Period	Employee Monthly	GSD Monthly
Employee Only	$1.76	$3.52	$0.00
Two-Party	$3.41	$6.82	$0.00
Family	$4.48	$8.95	$0.00

This Employee Benefits Guide was created for the employees of Granite School District by GBS Benefits.