

6500 Arapahoe, PO Box 9011
Boulder, Colorado 80301
303-447-5031
www.bvsd.org

Boulder Valley School District Benefits

*Employees (except PERA retirees) working in a regular position assigned .5 FTE or 20 hours per week or greater are eligible for benefits, including **Health, Dental, and Life Insurance, Long Term Disability Insurance, and Medical and Dependent Care Flexible Spending Accounts.** Temporary positions lasting less than 90 days are not eligible for benefits. Substitutes, community school building monitors, summer grounds workers, student workers, interns, extra-duty contracts, as-needed positions, and PERA retirees are not eligible.*

Benefits include:

- *Medical Insurance - Choice of two Great-West Healthcare Plans or Kaiser*
- *Delta Dental Insurance*
- *Flexible Spending Plans (Health, Child Care, Transportation)*
- *Long Term Disability Insurance*
- *\$20,000 Term Life Insurance*
- *Employee Assistance Program*

- *All BVSD employees are covered by Colorado Public Employees' Retirement Association (PERA); PERA also offers BVSD employees a supplemental life insurance policy. Visit www.copera.org or call 303-832-9550*
- *BVSD offers voluntary 401k (through PERA), 457, and 403b tax deferred savings plans. Visit <http://bvsd.org/benefits/Pages/default.aspx>*

Benefit enrollment packets are available for you to pick up in Human Resources or on the BVSD website at <http://bvsd.org/benefits/Pages/default.aspx>.

Office hours are 7:30 am to 5:00 pm, Monday – Friday (Monday-Thursday during June and July).

Enrollment forms for Medical and/or Dental Insurance and Flexible Spending Plans must be submitted to Human Resources within 30 days of starting work or becoming eligible. The District will not automatically enroll you in medical or dental insurance. If you waive coverage now, you may enroll at the next open enrollment period. The District has one medical and dental open enrollment period per year, during the month of May, with changes becoming effective July 1. Your enrollment in the Long Term Disability and the Life Insurance is automatic.

Employees who enroll in medical and/or dental insurance and have contribution deducted (dependent coverage or premium plan) will automatically be enrolled in the **Section 125 Pre-Tax Premium Deduction Plan**. This benefit increases your take home salary, but also reduces PERA includable salary. If you ***do not*** want this benefit, you must complete the opt-out form. **If you are nearing retirement, take time to evaluate whether or not you should participate in the Section 125 Plan.**

Please contact Susana Aguirre at 303-447-5022 with any questions.

Complete Benefits information is available online on the district website:
<http://bvsd.org/benefits/Pages/default.aspx>

**2009-2010 Health and Dental Premiums
In effect 7/1/09 - 6/30/10**

Monthly Employee Contribution

(Monthly premiums are deducted Pre-Tax
unless employee opts-out)

GREAT WEST - PPO STANDARD

Employee only	\$0
Employee + 1 dependent *	\$516
Employee + children	\$658
Employee + family	\$1,131

GREAT WEST - PPO BASIC

Employee only	\$0
Employee + 1 dependent *	\$192
Employee + children	\$285
Employee + family	\$596

KAISER PERMANENTE PLAN 220

Employee only	\$0
Employee + 1 dependent *	\$274
Employee + children	\$378
Employee + family	\$728

DELTA DENTAL

Employee only	\$0
Employee + 1 dependent *	\$28
Employee + children	\$33
Employee + family	\$60

*For Employee + 1 dependent, dependent can be spouse, domestic partner, or unmarried dependent child (up to age 25).

The District will contribute \$430 per employee per month to the health fund for all plans and \$36 per employee per month for dental.

Boulder Valley School District
P. O. Box 9011
Boulder, CO 80303
(720)561-5022

GREAT-WEST

Group #359644

1-800-663-8081

Website: www.mygreatwest.com

KAISER

Group #11000

303-338-3800

Website: www.kaiserpermanente.org

DELTA DENTAL

Group #1996

303-741-9305

Website: www.deltadentalco.com

PLANNED BENEFITS/COBRA

(303) 221-2783

www.cci-pbs.com

Boulder Valley School District

Employee Benefits

720-561-5022

Website: <http://www.bvsd.org/benefits/Pages/default.aspx>



Boulder Valley
Public Schools

6500 Arapahoe, PO Box 9011
Boulder, Colorado 80301
303-447-5022

<http://bvsd.org>

Division of Human Resources

LIFE INSURANCE BENEFICIARY DESIGNATION

I understand I have a \$20,000 life insurance policy (depending on my position with the district). This coverage is through CIGNA.

Employee Name: _____

Social Security: _____

Signature: _____ Date: _____

I designate the following as my beneficiary:

Primary Beneficiary: If you list more than one beneficiary, payment will be divided equally among them.

Contingent Beneficiary: (person to receive payment if your primary beneficiary(ies) is deceased). If you list more than one beneficiary, payment will be divided equally among them.



Boulder Valley
Public Schools

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<http://bvsd.org>

Division of Human Resources

**BOULDER VALLEY SCHOOL DISTRICT
WAIVER OF MEDICAL/DENTAL COVERAGE
CERTIFICATION FORM**

I have elected to waive medical/dental (circle one of both) coverage. This waiver will continue until further notice. If I choose to return to the medical/dental plan, I must re-enroll during the next benefit enrollment period. Unless a qualifying even has occurred, I understand that I may not enroll my family until the open enrollment period.

This is to certify that I have medical coverage through:

(Name of insurance carrier)

I understand that I will have no medical coverage through any other Boulder Valley School District RE-2 plan

Effective: _____

Employee Signature: _____

Date: _____

Printed Name: _____

Social Security Number: _____



INSURANCE BENEFITS ENROLLMENT/CHANGE FORM

Read all Plan Summaries before completing this form. This form is for BVSD benefit eligible employees enrolling in **medical and / or dental** coverage OR making changes to their existing coverage. Please use a pen to complete each section, **sign the form**, and return it to Human Resources.

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 Boulder, Colorado 80301
 720-561-5022
<http://www.bvsd.org>

Section 1: Action

<input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> CHANGE <input type="checkbox"/> NEW ENROLLMENT <input type="checkbox"/> REINSTATE <input type="checkbox"/> CANCEL ALL COVERAGE				EFFECTIVE DATE (MM/DD/CCYY) _____/_____/_____																															
ENROLLMENT FOR: <input type="checkbox"/> Myself <input type="checkbox"/> Myself & my spouse <u>OR</u> child <input type="checkbox"/> Myself & my children <input type="checkbox"/> Myself & my family		PLAN SELECTION: <table style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Medical</td> <td style="text-align: center;">Ee+</td> <td style="text-align: center;">Ee+</td> <td style="text-align: center;">Ee+</td> </tr> <tr> <td style="text-align: center;">Great West STANDARD PPO</td> <td style="text-align: center;">Ee</td> <td style="text-align: center;">1 Dep</td> <td style="text-align: center;">Children</td> </tr> <tr> <td style="text-align: center;">Great West BASIC PPO</td> <td style="text-align: center;">Fam</td> <td></td> <td></td> </tr> <tr> <td style="text-align: center;">KAISER Plan 220</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		Medical	Ee+	Ee+	Ee+	Great West STANDARD PPO	Ee	1 Dep	Children	Great West BASIC PPO	Fam			KAISER Plan 220	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental <table style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Delta Dental - PPO</td> <td style="text-align: center;">Ee+</td> <td style="text-align: center;">Ee+</td> <td style="text-align: center;">Ee+</td> </tr> <tr> <td></td> <td style="text-align: center;">Ee</td> <td style="text-align: center;">1 Dep</td> <td style="text-align: center;">Children</td> </tr> <tr> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		Delta Dental - PPO	Ee+	Ee+	Ee+		Ee	1 Dep	Children		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CHANGING INFORMATION: <input type="checkbox"/> Updating general information <input type="checkbox"/> Transferring to a different plan <input type="checkbox"/> Adding a dependent <input type="checkbox"/> Deleting a dependent Reason for change: _____	
Medical	Ee+	Ee+	Ee+																																
Great West STANDARD PPO	Ee	1 Dep	Children																																
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	Ee	1 Dep	Children																																
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																

Section 2: About You

Employee Name (Last / First / MI)		Sex	Social Security No.	Position / School or Department	
Employee Date of Birth (MM/DD/CCYY)	Home Phone	Work Phone		Date of Hire	
Home Address (Street)			City	State	Zip Code

Section 3: List Dependents

Last Name	First Name	M.I.	Sex	Date of Birth	Social Security No.	Coverage Selection	Check one
Spouse						<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Add <input type="checkbox"/> Delete
Child						<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Add <input type="checkbox"/> Delete
Child						<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Add <input type="checkbox"/> Delete
Child						<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Add <input type="checkbox"/> Delete
Child						<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Add <input type="checkbox"/> Delete
Child						<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Add <input type="checkbox"/> Delete

Section 4: Conditions for Enrollment

The information provided above is true and correct to the best of my knowledge. I authorize any health care provider, insurance company, or other organization, institution, or person that has any information regarding my benefit eligibility or claims to release such information to the claims administrator. A copy of this authorization shall be considered as effective and valid as the original. I understand that any misrepresentation on this document may be cause for dismissal and may result in my coverage being void as of its effective date with no benefits payable. I understand that if I later apply for coverage I am currently waiving, pre-existing conditions exclusions and other limitations may apply. If I have declined any of the above-listed coverages, I understand that I will not be covered for these group plan benefits for which I am eligible. I understand that I may have to submit evidence of insurability if I want these coverages at a later day. I authorize Boulder Valley School District to reduce my pre-tax pay to pay for the medical coverage benefits I have elected. I understand I am required to fill out a district "opt-out" form to have these deductions taken after-taxes and submit it along with this enrollment form.

I further authorize Boulder Valley School District to continue these pre-tax or after-tax payroll deductions until such time as I elect to change or stop such elections.

Employee Signature	Date	Employer Signature	Date
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DISCLOSURE INFORMATION

I hereby apply for all non-contributory coverages under my employer's plan and any contributory coverages that I have elected on the front of this application.

Health coverage

I understand that I must submit a Certificate or evidence of prior creditable coverage to receive credit towards the satisfaction of any pre-existing condition limitation specified in my employer's plan; and to be eligible for credit, the gap between the two coverages must be 63 days or less.

I and/or my eligible dependent(s) will be considered a "Special Applicant" if:

- I did not previously elect to cover myself and/or my eligible dependent(s) under my employer's policy/plan because of other health coverage and I later apply because the other coverage terminated involuntarily; or
- I did not previously elect to cover myself and/or my eligible dependent(s) and I later apply for coverage because of a change in my family status resulting from marriage, birth or adoption of a child. I understand that to qualify as a "Special Applicant" I must apply for health coverage for myself and/or my eligible dependent(s) within 31 days after:
- Coverage under the prior health plan ends; or I marry; or I acquire a new child through birth, adoption or placement of a child for adoption.

I will be considered a late applicant if:

- I fail to qualify as a "Special Applicant" because I did not apply within the 31 days as specified above; or
- I did not previously elect to cover myself and/or my eligible dependents and I later apply.

As a late applicant applying for health coverage, I realize that I may only be allowed entrance to the plan during the open enrollment period. As a late applicant, I realize that my entry to the plan may be subject to special enrollment requirements and that I must contact my Plan Administrator for details.

For all coverages

I hereby authorize any insurance company, health care provider, or other entity or person having knowledge of anyone listed on this application to give this new carrier or their designated agent(s) any and all records pertaining to such person's medical history for purposes of review, investigation or evaluation. For application purposes, this authorization is valid for 30 months from the date I sign it. For purposes of claims, reimbursement and receipt of services rendered, this authorization is valid during the term of such person's coverage for evaluation of the nature and medical necessity of the services received. I am, or my authorized representative is, entitled to a copy of this signed authorization. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for such violation.

This Disclosure Information forms a part of the Application for Membership as fully as if it were contained over the applicant's signature.



Coordination of Benefits

I hereby authorize Kaiser Permanente to bill my spouse's or any other dependent's primary group insurance carrier for all services provided or arranged by Participating Physicians and to coordinate benefits and/or reimbursements with other health or insurance companies. I request that payment be made to Kaiser Permanente on any bills for services furnished for myself or any dependents on my plan. I also authorize Kaiser Permanente to release any information regarding the medical treatment needed for this claim. I further authorize this copy to be used in place of the original.

Advance Directives

Federal law requires Kaiser Permanente to tell you about your right to make healthcare decisions.

Colorado law recognizes the right of an adult to accept or reject medical treatment, artificial nourishment and hydration, and cardiopulmonary resuscitation.

Each adult has the right to establish, in advance of the need for medical treatment, any directives and instructions for the administration of medical treatment in the event the person lacks the decisional capacity to provide informed consent to or refusal of medical treatment. (Colorado Revised Statutes: CRS 15-14-504)

Kaiser Permanente will not discriminate against you whether or not you have an advance directive and will follow the requirements of Colorado law respecting advance directives. If you have an advance directive, please give a copy to the Kaiser Permanente medical records department or to your provider.

A healthcare provider or healthcare facility shall provide for the prompt transfer of the principal to another healthcare provider or healthcare facilities if such healthcare provider or healthcare facility wishes not to comply with an agent's medical treatment decision on the basis of policies based on moral convictions or religious beliefs. (CRS 15-14-507)

Two brochures are available: *Your Right to Make Health Care Decisions* and *Making Health Care Decisions*. For copies of these brochures or for more information, please call the Customer Service at 303-338-3800.

Terms and Conditions

I expressly authorize any doctor or hospital to furnish Kaiser Permanente any records concerning me or any other member of my family.

To the best of my knowledge, the information I have provided is complete and true and I understand that falsification by me will allow Kaiser Permanente to recover payments made, cancel my membership and/or refuse to pay claims.

I hereby apply for enrollment for myself and my eligible family dependents listed. I understand that if this application is accepted by Kaiser Permanente, the benefits for which we will be eligible will be in accordance with the master contract applicable to the type of plan for which we are enrolled.

I authorize payroll deduction for whatever amounts are necessary to pay my health plan coverage.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.



MEDICAL BENEFIT SUMMARY*

Effective July 1, 2009



GENERAL SERVICES	KAISER HMO – Plan 220	GREAT WEST BASIC PLAN OPEN ACCESS NETWORK	GREAT WEST STANDARD PLAN OPEN ACCESS NETWORK	NON-NETWORK FOR GREAT WEST BASIC AND STANDARD PLANS
Plan Year Deductible (excludes copays)	No Deductible	\$1,500 Individual \$3,000 Family	\$500 Individual \$1,000 Family	\$6,000 Individual \$12,000 Family
Coinsurance	N/A	20%	20%	50%
Out of Pocket Maximum (includes deductible)	\$2,000 Individual \$4,500 Family	\$4,500 Individual \$9,000 Family	\$2,750 Individual \$5,500 Family	\$13,500 Individual \$27,000 Family
Lifetime Maximum	No Lifetime Maximum	\$5,000,000 per member	\$5,000,000 per member	\$5,000,000 per member
Physician Visit	\$20 Copay	\$25 Copay	\$25 Copay	50% after deductible – up to Out of Pocket Maximum
Specialist Visit	\$40 Copay	20% after deductible Up to Out-of-Pocket Maximum	\$50 Copay	50% after deductible – up to Out of Pocket Maximum
Preventive Care • Immunizations • Routine physicals • X-Ray & Lab (excluding High Tech Radiology) • Basic Gynecological care • Routine Mammogram	\$20 Copay	\$25 Copay Physician	\$25 Copay Physician \$50 Copay Specialist	50% after deductible - up to Out of Pocket Maximum
Colonoscopy	\$70 Copay	\$70 Copay	\$70 Copay	50% after deductible – up to Out of Pocket Maximum
Performance Pharmacy Plan (includes contraceptives) Tier 1 = Generic Tier 2 = Preferred Tier 3 = Non-preferred	\$15 Generic Copay \$30 Brand Copay Per prescription up to a 60-day supply (certain drugs limited to a 30-day supply) Drugs may be ordered by mail	Retail Pharmacy ~ 30 day supply \$5 Generic Copay \$30 Tier 2 brand \$50 Tier 3 brand Retail Pharmacy ~ 90 day supply \$15 Generic Copay \$90 Tier 2 brand \$150 Tier 3 brand Mail Order ~ 90 day supply \$12.50 Generic Copay \$75 Tier 2 brand \$125 Tier 3 brand	Retail Pharmacy ~ 30 day supply \$5 Generic Copay \$30 Tier 2 brand \$50 Tier 3 brand Retail Pharmacy ~ 90 day supply \$15 Generic Copay \$90 Tier 2 brand \$150 Tier 3 brand Mail Order ~ 90 day supply \$12.50 Generic Copay \$75 Tier 2 brand \$125 Tier 3 brand	Appropriate copay level +50% of the full cost of the prescription



MEDICAL BENEFIT SUMMARY*

Effective July 1, 2009



GENERAL SERVICES	KAISER HMO – Plan 220	GREAT WEST BASIC PLAN OPEN ACCESS NETWORK	GREAT WEST STANDARD PLAN OPEN ACCESS NETWORK	NON-NETWORK FOR GREAT WEST BASIC AND STANDARD PLANS	
Durable Medical Equipment	20% Coinsurance / up to \$2,000 benefit paid by Health Plan per plan year	20% after network deductible Maximum of \$3,500 per plan year	100% covered - no deductible Maximum of \$3,500 per plan year	20% after network deductible Maximum of \$3,500 per plan year	
Oxygen	20% Coinsurance	20% after deductible Up to Out-of-Pocket Maximum	100% covered - no deductible	50% after deductible Up to Out of Pocket Maximum	
Lab & X-ray Services – outpatient, independent lab or related to an office visit	<u>Diagnostic Lab and X-ray</u> 100% Therapeutic X-ray \$40 copay each visit	20% after deductible Up to Out-of-Pocket Maximum (except for preventive care – covered at 100%)	20% after deductible – Up to Out-of-Pocket Maximum (except for preventive care – covered at 100%)	50% after deductible Up to Out of Pocket Maximum	
High Tech Radiology (MRI, Pet, CAT scans)	\$150 Copay Per procedure	20% after deductible Up to Out-of-Pocket Maximum	20% after deductible – Up to Out-of-Pocket Maximum	50% after deductible Up to Out of Pocket Maximum	
Spinal Adjustment Treatment	\$20 Copay 20 visits limit Per plan year	20% after deductible 60 visit maximum Per plan year	\$50 Copay 60 visit maximum Per plan year	50% after deductible 60 visit maximum Per plan year	
Emergency Room Care	\$150 Copay ¹	20% after network deductible Up to Out-of-Pocket Maximum	\$200 Copay (Lab & X-Ray Services subject to 20% coinsurance after deductible)	Basic Plan: Same as in-network	Standard Plan: Same as in-network
Urgent Care	After-hours care - \$75 Copay ¹	20% after deductible Up to Out-of-Pocket Maximum	\$100 Copay (Lab & X-Ray Services subject to 20% coinsurance after deductible)	50% after deductible Up to Out of Pocket Maximum	
Ambulance	20% Coinsurance up to a maximum of \$500 per trip	20% after network deductible Up to Out-of-Pocket Maximum	20% after network deductible Up to Out-of-Pocket Maximum	Same as in network	
Eye Exam	<u>1 every 12 months</u> – \$20 Copay	Not Covered	Not Covered	Not Covered	

¹ Kaiser - Special procedures (MRI/CT/PET) performed while receiving Emergency or Urgent Care Services will generate a separate copayment per procedure in addition to the emergency/urgent care copay.



MEDICAL BENEFIT SUMMARY*

Effective July 1, 2009



HOSPITAL SERVICES	KAISER HMO – Plan 220	GREAT WEST BASIC PLAN OPEN ACCESS NETWORK	GREAT WEST STANDARD PLAN OPEN ACCESS NETWORK	NON-NETWORK FOR GREAT WEST BASIC AND STANDARD PLANS
Inpatient Hospital Services <ul style="list-style-type: none"> Including anesthesia Requires pre-certification Lab & X-Ray based on Facility Network Status 	\$500 Copay per admission	20% after deductible Facility Charges only for services rendered at Boulder Community Hospital – 10% after the deductible	20% after deductible Facility Charges only for services rendered at Boulder Community Hospital – 10% after the deductible	50% after deductible Up to Out-of-Pocket Maximum
Outpatient Hospital Services <ul style="list-style-type: none"> Outpatient Surgery Including anesthesia Requires pre-certification Ambulatory Surgery Lab & X-Ray paid based on Facility Network Status 	\$200 Copay for each procedure in any setting other than inpatient	Up to Out-of-Pocket Maximum	Up to Out-of-Pocket Maximum	
Outpatient Surgery	\$200 Copay	20% after deductible Up to Out-of-Pocket Maximum	20% after deductible Up to Out-of-Pocket Maximum	50% after deductible Up to Out-of-Pocket Maximum
Hospice Care <ul style="list-style-type: none"> Inpatient Outpatient 	100% Covered (not covered outside the service area)	20% after deductible Up to Out-of-Pocket Maximum	20% after deductible - Up to Out-of-Pocket Maximum 100% covered - no deductible	50% after deductible Up to Out-of-Pocket Maximum
Skilled Nursing Facility Care	100% Covered 100 days per Plan Year at approved facilities. (not covered outside the service area)	20% after deductible 60 days per Plan Year Maximum Requires pre-certification	20% after deductible 60 days per Plan Year Maximum Requires pre-certification	50% after deductible 60 days per Plan Year Maximum Requires pre-certification
Home Health Care	100% Covered For medically necessary part-time home health care	20% after deductible Up to 1 visit per day/100 visits per Plan Year Maximum	100% covered - no deductible Up to 1 visit per day/100 visits per Plan Year Maximum	50% after deductible Up to 1 visit per day/100 visits per Plan Year Maximum
Transplants	See Inpatient and Outpatient Hospital Services	20% after deductible Up to Out-of-Pocket Maximum	20% after deductible Up to Out-of-Pocket Maximum	Not Covered



MEDICAL BENEFIT SUMMARY*

Effective July 1, 2009



MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES	KAISER HMO – Plan 220	GREAT WEST BASIC PLAN OPEN ACCESS NETWORK	GREAT WEST STANDARD PLAN OPEN ACCESS NETWORK	NON-NETWORK FOR GREAT WEST BASIC AND STANDARD PLANS
Mental Health Inpatient: Requires pre-certification	\$500 Copay per admission*	20% after deductible Up to Out-of-Pocket Maximum	20% after deductible Up to Out-of-Pocket Maximum	50% after deductible Up to Out-of-Pocket Maximum
Mental Health Outpatient:	\$20 Copay each visit*	20% after deductible Up to Out-of-Pocket Maximum	\$50 Copay per visit	50% after deductible Up to Out-of-Pocket Maximum
Chemical Dependency Inpatient: Requires pre-certification	\$500 Copay per admission	20% after deductible Up to Out-of-Pocket Maximum	20% after deductible Up to Out-of-Pocket Maximum	50% after deductible Up to Out-of-Pocket Maximum
Chemical Dependency Outpatient:	\$20 Copay each visit	20% after deductible Up to Out-of-Pocket Maximum	\$50 Copay per visit	50% after deductible Up to Out-of-Pocket Maximum
Outpatient Physical Therapy • 60 visit Maximum per Plan Year	\$20 Copay each visit (20 visits per year for each type of therapy i.e. physical, occupational, and speech therapy)	20% after deductible Up to Out-of-Pocket Maximum	\$50 Copay	50% after deductible Up to Out-of-Pocket Maximum
Outpatient Speech, Hearing and Occupational Therapy • 60 visit Maximum per Plan Year		20% after deductible Up to Out-of-Pocket Maximum	\$50 Copay	50% after deductible Up to Out-of-Pocket Maximum
	*Biologically based mental illness care – coverage is no less extensive than the coverage provided for any other physical illness.			

* This is a comparison tool for Great-West and Kaiser. For more specific, detailed information, see each individual Plan Benefit Summary.

**Delta Dental PPO Plan - Customer Service Phone 303-741-9305
Boulder Valley School District Group #1996**

MAXIMUM BENEFIT			
Calendar Year		\$1500 per person	Combination of In and Out-of -Network
Orthodontic Lifetime - to age 19 only		\$1250 per person	Combination of In and Out-of-Network
TMJ Lifetime		\$1000 per person	Combination of In and Out-of-Network
DEDUCTIBLE		None In or Out-of-Network	
WHO CAN BE COVERED		Employee, Spouse and Dependent Children to 25. Orthodontic Benefits for dependent children to age 19.	
PPO*	NON-PPO **Premier & ***Non-Par	COVERED SERVICES	BENEFIT INFORMATION (subject to Delta Dental guidelines)
PREVENTIVE AND DIAGNOSTIC SERVICES			
100%	75%	Oral Evaluation	limited to 2 evaluations in a 12 month period
		Bitewing X-rays	limited to 1 sets in a 12 month period
		Full Mouth X-rays or Panoramic	limited to 1 in a 60 month period
		Routine Cleaning	limited to 2 cleanings in a 12 month period
		Fluoride Treatments	limited to 1 treatment in a 12 month period- to age 16
		Space Maintainers	for posterior primary teeth- to age 14
		Sealants	1 per tooth in 36 months- to age 15 on unrestored molars
BASIC SERVICES (Fillings, Endodontics (Root Canal), Periodontics (Gum Disease) and Oral Surgery (extractions))			
80%	75%	Amalgam Fillings	
		Resin, Composite	benefit for anterior teeth only-allowance for amalgam on posterior teeth
		Oral Surgery (Extractions)	
		General Anesthesia	benefit with covered Oral Surgery only
		Surgical Periodontal (gums)	
		Root Canal Therapy	
MAJOR SERVICES (Crowns, Bridges, Partials, Dentures)			
60%	50%	Crowns	
		Dentures, Partials, Bridges	benefit 1 in 60 months
ORTHODONTICS (Braces)			
60%	50%	Complete Orthodontic Evaluation	
		Active Orthodontic Treatment. Orthodontic benefits provided to dependent children to age 19.	
TMJ (Temporomandibular Joint (TMJ)/Myofacial Pain Dysfunction (MPD) Services)			
50%	50%	Provides intraoral services including diagnostic, preventive, interceptive services, and other related services for the treatment of pain or dysfunction.	

*The PPO percentage of benefits is based on the PPO Schedule of Allowance **The Premier percentage of benefits is limited to the Premier Maximum Plan Allowance.***The Non-Participating percentage of benefits is limited to the non-participating Maximum Plan Allowance. You will be responsible for the difference between the non-participating Maximum Plan Allowance and the full fee charged by the Dentist. To Find a Dentist- www.deltadentalco.com Customer Service Phone- (303) 741 9305 or (800) 610-0201. To file a claim, you can print a form from the BVSD web site and mail it to: Delta Dental CO, PO Box 173803, Denver, CO 80217. (Usually not necessary, most dentists will file with Delta for you) **LATE ENROLLMENT BENEFIT RESTRICTION:** There is no annual open enrollment period for dental. Those who do not enroll in the dental plan when initially eligible, or re-enroll, will be considered "Late Enrollees" and will be subject to a 12 month waiting period on Basic, Major, TMJ and Orthodontic Services. The "Late Enrollee" penalty does not apply to those covered by another group dental plan who enroll within 60 days of involuntary loss of the other dental coverage and to children who are enrolled on any anniversary prior to the 4th birthday.

Important Note: This form provides only a brief description of services covered under your contract and does not list those services which are limited or excluded from coverage. Your Employee Benefit Booklet provides a more complete explanation of your coverage, including limitations and exclusions. If differences exist between this Summary of Benefits and your Employee Benefit Booklet, the Benefit Booklet will govern.

BVSD Section 125 Plans for 2009

(¿Preguntas en Español? Llame a Susana Aguirre en Recursos Humanos al 303-447-5022.)

Pre-Tax Premium Deduction Plan and Pre-Tax Flexible Spending Plan

Open enrollment for participation in the **Section 125 Medical, Dependent Care and Transportation Spending Accounts** and **opting out of the Pre-Tax Premium Deduction Plan** is November 1 – 30. The plan year is January 1, 2010 - December 31, 2010.

Newly hired employees can enroll for the rest of the 2009 calendar year.

***Attention: Employees within four years of retirement, or employees thinking about individual or private insurance, please see note below!**

Flexible Spending Accounts

BVSD offers three plans to reduce taxable income: one based on eligible medical, dental, and vision expenses not covered by insurance; one based on dependent care expenses; and one based on mass transit expenses (i.e. bus).

- o The **Health Care Flexible Spending Account** allows you to defer a portion of your gross income (up to \$3,000) into a tax-free spending account which is used to pay for eligible medical, dental, and vision expenses for you and your eligible dependents. You will be able to use the debit card for some expenses (you still need to retain receipts).
- o The **Dependent Care Flexible Spending Account** allows you to defer a portion of your gross income (up to \$5,000) into an account which is used to reimburse eligible daycare expenses. The debit card is **not** available for Dependent Care.
- o The **Transportation Flexible Spending Account** allows you to pay for certain transportation expenses. Eligible expenses are any work-related Mass Transit expenses (i.e. Bus). The limit is \$115 per month.

If you choose to enroll, be conservative when estimating your election so that you are sure to spend your entire election amount. Any unused funds at the end of the plan year are forfeited. You cannot change your election during the plan year **unless** you have a qualifying change in status (change in marital status, change in number of dependents, change in employment status of participant or spouse). The change you elect must be consistent with the status change.

***NOTE: employees within four years of retirement or employees thinking about individual or private insurance: This is also the Open Enrollment period to opt out of the Section 125 Pre-Tax Premium Deduction. If you are already opted out, you don't need to fill out the form again. You will remain in this status unless you opt in again.**

If you are thinking about retiring within four years:

All employees who contribute a portion of their monthly insurance premiums or have dependent coverage are automatically enrolled in the **Section 125 Pre-Tax Premium Deduction Plan**. This benefit increases your take home pay, but also reduces PERA-includable salary. Any money placed in a Section 125 Plan is not considered salary for PERA purposes. Subsequently, the amount of your PERA benefit will be lower. If you are thinking about retiring within the next four years, you may **not** want this benefit. You must **opt out** during open enrollment by completing the BVSD Section 125 – Opt Out Form.

If you are considering individual or private coverage for dependents:

You cannot drop health or dental coverage for your dependents mid-year if you are enrolled in the Section 125 Pre-Tax Premium Deduction Plan **unless** you have a qualifying change in status (change in marital status, change in number of dependents, change in employment status of participant or spouse). The change you elect must be consistent with the status change. If you are considering individual or private coverage for dependents, you must **opt out** during open enrollment by completing the BVSD Section 125 – Opt Out Form.

ENROLLMENT FORMS ARE AVAILABLE ON THE DISTRICT WEBSITE ON THE BENEFITS PAGE

<http://www.bvsd.org/C14/Benefits/default.aspx>

Please call Susana Aguirre in HRD at 303-447-5022 with questions.

Boulder Valley School District

2008 Flexible Benefits Plan Enrollment (Section 125 Plan)

(For calendar year January 1, 2008 – December 31, 2008)

_____ Name (please print)		_____ School/Worksite	
_____ Home Address		_____ City	_____ State
_____ Social Security Number		() _____ Day Time Phone Number	() _____ Evening Phone Number

Each year, to continue or begin participation in one or more reimbursement accounts, you must enroll by completing the following:

PLEASE FILL IN AMOUNTS AS APPLICABLE FOR THE FLEX PLAN(S) YOU WISH TO PARTICIPATE IN:

1. Health Care Reimbursement Account:

- a. Total **annual** (calendar year) deduction
- b. Number of monthly payroll deductions (10 - 12)
- c. **Monthly** payroll deduction (a divided by b)

Maximum \$3,000/calendar year

\$ _____

\$ _____

2. Dependent Care (e.g., daycare) Reimbursement Account:

- a. Total **annual** (calendar year) deduction
- b. Number of monthly payroll deductions (10 - 12)
- c. **Monthly** payroll deduction (a divided by b)

Maximum \$5,000/family/calendar year

\$ _____

\$ _____

3. Transportation (mass transit) Reimbursement Account:

- a. Total **annual** (calendar year) deduction
- b. Number of monthly payroll deductions (10 - 12)
- c. **Monthly** payroll deduction (a divided by b)

Maximum \$115 per month

\$ _____

\$ _____

I have read the information about the flexible benefits plan and wish to participate in at least one of the BVSD Flex Plan reimbursement accounts, as I have indicated above. I understand that election in one or more of these options is irrevocable during the plan year except in case of certain qualifying events (contact Human Resources for details). In addition to reducing my state and federal taxable gross salary and Medicare wages, BVSD Flex will reduce the amount on which eligible PERA benefits are calculated. If I have elected one or more of the reimbursement accounts, I understand that I will forfeit any amounts not claimed for reimbursement and must furnish complete information to the plan administrator. I understand reimbursement may be denied due to Internal Revenue Service restrictions (i.e., non-allowable expenses).

Signature

Date

Benefits Office use only:

Enrollment: New Change Effective Date: ____/____/____