ADAMS 14
Inspire. Educate. Empower.

Benefits Enrollment & Change Form

BENEFITS SUMMARY

A Rate Sheet has been included showing the cost for benefit plans for employee and/or family members.

MEDICAL INSURANCE – The district offers medical insurance through Kaiser Permanente.

DHMO PLAN – This plan has a $300 Individual/$600 Family deductible. Out of pocket limit is $3000 Individual/$6000 Family. You must pay all the costs up to the deductible amount before this plan begins to pay for covered services. The deductible does not apply to preventive care services, services with copays and prescription drugs.

HMO PLAN – Traditional Plan – There is no deductible. Out of pocket limit is $2000 Individual/$4,500 Family

Comparison summaries for both plans can be found on the district website @ www.adams14.org and more information regarding Kaiser can be found on http://my.kp.org/acsd14/.

Questions to consider in choosing your plan:

- **Are you expecting a health event in 2016/17**
  Having a baby, colonoscopy, or surgery
- **How much will the plan cost you?**
  Monthly premiums, copayments, deductibles and co-insurance
- **How will you use the plan?**
  Cost predictability with copayments
  Utilization simply for annual preventive services

DELTA DENTAL OF COLORADO – Dental coverage – Available at no charge for the employee.

VISION SERVICE PLAN (VSP) – Vision coverage – Available at no charge for the employee.

◊ Additional benefits such as Tax Sheltered Annuities, Flexible Spending/Dependent Daycare Accounts, AFLAC and others are available. Please contact one of the Human Resources Specialists for further information.

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Benefits Enrollment & Change Form

- ☐ **New Enrollment**
- ☐ **Open Enrollment**
- ☐ **Family Status Change**
  - ☐ Add Dependent(s)
  - ☐ Remove Dependents(s)
- ☐ **Work Status Change**
  - ☐ Increase/Decrease in Hours
  - ☐ Return From Leave
- ☐ **Cancel Coverage**
- ☐ **Name/Address Change**

****Reason for Change:**

- ☐ **Birth/Adoption/Legal Guardianship**
- ☐ **Marriage**
- ☐ **Divorce/Legal Separation**
- ☐ **Death**
- ☐ **Over-age Limit**
- ☐ **Loss of Coverage**
- ☐ **Other Coverage**
- ☐ **No Change**

Date of Event

___/___/___
___/___/___
___/___/___
___/___/___
___/___/___
___/___/___
___/___/___

EMPLOYEE INFORMATION

FIRST NAME	LAST NAME	MI	EFFECTIVE DATE

SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER M / F	DATE OF HIRE	WORK PHONE

HOME ADDRESS	CITY	STATE	ZIP CODE	STATUS: FULL TIME / PART TIME

HOME PHONE	SCHOOL DIST. RESIDENCY	WORK LOCATION	☐ CLASSIFIED ☐ CERTIFIED ☐ ADMINISTRATIVE ☐ SUPPORT / TECH

SELECT MEDICAL PLAN:	SELECT DENTAL PLAN:	SECLECT VISION PLAN:
☐ **Kaiser Permanente** / DHMO	☐ **Delta Dental** / DPO Plan	☐ **VSP** / Vision Service Plan
☐ **Kaiser Permanente** / HMO	☐ I ELECT TO WAIVE THIS COVERAGE	☐ I ELECT TO WAIVE THIS COVERAGE
☐ I ELECT TO WAIVE THIS COVERAGE		

SELECT MEDICAL COVERAGE:	SELECT DENTAL COVERAGE:	SELECT VISION COVERAGE:
☐ Employee Only	☐ Employee Only	☐ Employee Only
☐ Employee and Spouse	☐ Employee and Spouse	☐ Employee Plus One
☐ Employee and Child(ren)	☐ Employee and Child(ren)	☐ Employee Plus Two or More
☐ Employee, Spouse and Child(ren)	☐ Employee, Spouse and Child(ren)	

PLEASE LIST ALL TO BE COVERED OR CHANGED

ADD	DROP	LAST NAME	FIRST NAME	MI	SSN REQUIRED	RELATION CODE **	BIRTH DATE (REQUIRED)	FORM	MEDICAL	DENTAL	VISION
		Employee				SELF					

** Relationship Codes: SP = Spouse DE = Dependent DD = Disabled Dependent

Signature: _____ **Date:** _____

H.R. Representative Signature: _____ **Date:** _____

Adams 14, in partnership with the community, will ***inspire, educate*** *and* ***empower*** *every student to succeed in the 21st Century.*

Group Health Plan Waiver Form

Print Name: _____ S.S.N.: _____

Date of Hire: _____

You now have the opportunity to enroll for group health plan coverage with Adams County School District 14 health plans. If you do not enroll yourself and any eligible dependents now, you will not have another opportunity to enroll yourself or your dependents (unless you qualify for a special enrollment which is explained below). Your next opportunity to enroll will be during "Open Enrollment".

Special Enrollments:

If you are declining enrollment of yourself or your dependents (including your spouse) because of other health insurance coverage, you will qualify for future enrollment if you lose health insurance coverage. A request must be made within 30 days of your loss of coverage's end date. In addition to loss of coverage, you will qualify for enrollment if you have a life status change such as a new dependent as a result of marriage, birth, adoption, or placement for adoption. A request must be made within 30 days of your new dependent status.

Please check the box if you are covered by other health insurance. ☐

I understand that by not enrolling in plan coverage now, the opportunity to enroll later is limited as explained above.

Signature: _____ Date: _____

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Monthly Medical, Dental and Vision Rates
Effective August 1, 2016 – July 31, 2017

Plan Coverage Level	Total Premium	District Paid	Employee Deduction
Kaiser Health Plan (DHMO)			
Employee Only	$474.90	$451.83	$23.07
Employee + One Dependent	$949.79	$465.38	$484.41
Employee + Family	$1,519.66	$481.65	$1,038.01
Kaiser Health Plan (HMO)			
Employee Only	$518.21	$451.31	$66.90
Employee + One Dependent	$1036.43	$464.36	$572.07
Employee + Family	$1,658.29	$480.03	$1,178.26
Delta Dental of Colorado			
Employee Only	$27.55	$27.55	$0.00
Employee + One Dependent	$63.21	$27.55	$35.66
Employee + Family	$115.18	$27.55	$87.63
VSP- Vision Service Plan			
Employee Only	$6.57	$6.57	$0.00
Employee + One Dependent	$16.57	$7.40	$9.17
Employee + Family	$26.43	$8.21	$18.22
VOYA – Life Insurance			
Employee Only			$0.00
Dependent(s) $1,000/spouse/$1,000 dep. Children			$.45

Insurance coverage begins the first of the month following the first day worked in a Benefitted job position.

Monthly premiums are due at the end of the month prior to the month of coverage.

With the Delta Dental PPO plus Premier plan, you and your family members may visit any licensed dentist, but you will receive the greatest out-of-pocket savings if you see a Delta Dental PPO provider. Participating providers file claims directly with Delta Dental and accept Delta Dental's reimbursement in full. You are responsible only for your deductible and coinsurance (as determined by your plan), as well as any charges for non-covered services up to Delta Dental's approved amount. If you choose to see an out-of-network provider, you will incur additional out-of-pocket expenses, and you will be billed the total amount the provider charges (called balance-billing). When you see a Delta Dental PPO or Premier® provider, you are protected from balance-billing.

Advantages of the Delta Dental PPO plus Premier plan:

▶ **SAVINGS:** Delta Dental PPO providers offer subscribers the greatest savings. And, in some areas, you will still save money if you need a service that is not covered. Non-covered services will be billed at a discounted rate if you go to a PPO provider.

▶ **CHOICE:** If you choose to visit a Premier provider, you will still save money because Premier providers also accept discounted fees (however, discounts are not as great as if you see a PPO provider).

▶ **NETWORK:** Delta Dental's dual network has nearly 103,000 PPO providers and 155,000 Premier providers nationwide.

To find a participating provider or to see if your current provider is in the PPO network, visit our website at **deltadentalco.com** and click on the **Find a Dentist** search tool. Or use our free mobile app for iPhone and Android.

Looking for a dentist? Concerned about costs? PPO providers offer you the greatest savings.

Service: Porcelain Crown (*Benefit illustration only.* Example assumes deductible has been met.)

	Greatest Savings ◄		► Least Savings
	Protected from balance-billing		Not protected from balance-billing
Network	Delta Dental PPO Provider	Delta Dental Premier Provider	Out-of-Network Provider
Procedure Cost	$1,000	$1,000	$1,000
Maximum Provider Can Charge Patient	$710	$950	Unlimited
Maximum Provider Can Charge Insurance (MPA)*	$710	$950	$660
Benefit Percentage	50%	50%	50%
Delta Dental Pays	$355	$475	$330
You Pay	$355	$475	$670

You can also contact our customer relations department, Monday–Friday 8 a.m. to 6 p.m. Mountain Time, at 1-800-610-0201 (toll-free) or customer_service@ddpco.com.

*The maximum a provider can charge your insurance company is called the Maximum Plan Allowance (MPA). The MPA for an out-of-network provider is always lower than in-network MPA. Delta Dental pays a portion of the MPA only, which exposes you to balance-billing from an out-of-network provider.

deltadentalco.com

DELTA DENTAL

Delta Dental PPO PLAN

Adams County School District 14 – Group #1065

MAXIMUM BENEFIT Calendar Year Orthodontic Lifetime	$1,500 per person $1,500 per person
CALENDAR YEAR DEDUCTIBLE Applies to Basic and Major Services, except for fillings	Per Person Deductible - $25.00 for PPO dentist Per Person Deductible - $50.00 for Premier and non-participating dentist
WHO CAN BE COVERED	Employee, Spouse and Dependent Children to age 26. Orthodontics for employees, spouses & dependent children.

NETWORK		COVERED SERVICES	BENEFIT INFORMATION (subject to Delta Dental guidelines)
PPO Dentist	PREMIER Or Non-Par		
PREVENTIVE AND DIAGNOSTIC SERVICES			
100%	100%	Oral Evaluation	Limited to 2 evaluations in a 12 month period
		Bitewing X-rays	Limited to 2 sets in a 12 month period
		Full Mouth X-rays	Limited to 1 in a 36 month period
		Routine Cleaning	Limited to 2 cleanings in a 12 month period – (if patient history shows prior periodontal treatment, 2 additional cleanings may be allowed)
		Fluoride Treatments	Limited to 2 treatments 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%	70%	Amalgam Fillings	Benefits on the same surface limited to 1 in 12 months
		Resin, Composite Fillings	Benefits limited to anterior teeth only
80%	40%	General Anesthesia	Benefit with covered Oral Surgery only
		Surgical Periodontal (gums)	Benefit once every 36 months
		Root Canal Therapy	
MAJOR SERVICES (Crowns, Bridges, Partials, Dentures)			
50%	40%	Crowns	Benefit 1 in 60 months on same tooth- not a benefit under age 12
		Dentures, Partials, Bridges	Benefit 1 in 60 months- not a benefit under age 16
ORTHODONTICS (Braces)			
50%	50%	Complete Orthodontic Evaluation. Active Orthodontic Treatment. For employees, spouses & dependents.	

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 # is 800 610-0201
Group has Annual Open Enrollment

***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.*

Your Vision Benefits Summary

VSP. Vision care for life

Get the best in eyecare and eyewear with ADAMS COUNTY SCHOOL DISTRICT #14 and VSP® Vision Care.

Using your VSP benefit is easy.

- **Register at vsp.com.** Once your plan is effective, review your benefit information.
- **Find an eyecare provider who's right for you.** The decision is yours to make—choose a VSP doctor, a participating retail chain, or any out-of-network provider. To find a VSP provider, visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Best EyeCare

You'll get the highest level of care, including a WellVision Exam®– the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP provider, you'll get the most out of your benefit, have lower out-of-pocket costs, and your satisfaction is guaranteed.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like Anne Klein, bebe®, Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more[1]. Visit **vsp.com** to find a VSP provider who carries these brands.

Plan Information

VSP Coverage Effective Date: 09/01/2015
VSP Provider Network: VSP Signature

Benefit	Description	Copay
	Your Coverage with a VSP Provider	
WellVision Exam	• Focuses on your eyes and overall wellness • Every plan year*	$5
Prescription Glasses		
Frame	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • $80 allowance at Costco • 20% savings on the amount over your allowance • Every other plan year	$0
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every plan year	$0
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancements • Every plan year	$50 $80 - $90 $120 - $160
Contacts (instead of glasses)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every plan year	Up to $60
Additional Coverage	• Diabetic Eyecare Plus Program	
Extra Savings	**Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor	

Your Coverage with Out-of-Network Providers

Visit **vsp.com** for details, if you plan to see a provider other than a VSP network provider

Exam	up to $50
Frame	up to $70
Single Vision Lenses	up to $50
Lined Bifocal Lenses	up to $75
Lined Trifocal Lenses	up to $100
Progressive Lenses	up to $75
Contacts	up to $105

[redacted]

Visit **vsp.com** or call **800.877.7195** for more details on your vision coverage and exclusive savings and promotions for VSP members.

[1]Brands/Promotion subject to change