



OPEN ENROLLMENT INFORMATION FOR 2009/2010

To: **Certificated, Classified, Confidential and Management Employees**

From: Melissa Kennedy, Personnel Analyst

Date: August 15, 2009

Effective July 1, 2007, the District moved to California's Value Trust (CVT) for medical, dental and vision benefits. CVT requires 100% participation of all full-time employees; benefits are available to part-time employees at employee discretion. (Classified employees must work a minimum of 4.0 hours per day to be eligible for coverage.)

**The benefits you select at this time will be in force
10/01/2009 through 9/30/2010.**

Important CVT Enrollment Information

- 100% participation of full-time employees in medical, dental and vision plans. (Full-time is defined as 1.0 FTE for Certificated and 8.0 hours per day for Classified)
- Medical Plan choices include four PPO plans utilizing the Anthem Blue Cross network, www.anthem.com/ca and two Kaiser HMO options (plan descriptions attached).
- Dental and vision coverage are provided by Delta Dental and VSP - administered by CVT (plan descriptions attached).
- Make sure that your enrollment form is legible and is completed with birth dates and social security numbers for dependents before submitting to H/R.

**Open enrollment for the 2009/2010 school year will be conducted from
August 18, 2009 to September 18, 2009.**

Medical Insurance

Listed below are the medical plans and monthly cost, depending on *single, double, or family* coverage. All full-time employees pay 10% of the cost for the major medical plan they select from the list in the following charts. (If you work less than full-time, your premiums would be pro-rated for medical, dental and vision to your percentage of employment. Contact Human Resources at 837-7703 for the exact cost for pro-rated coverage.)

There are 6 medical plans from which to choose. A complete description of coverage is attached:

Kaiser Plan 3

	Total Cost	Full Time Employee Contribution	District Contribution
Employee Only	560.00	56.00	504.00
Employee plus one	963.00	96.30	866.70
Employee plus two or more	1215.00	121.50	1093.50

Kaiser Plan 7

	Total Cost	Employee Contribution	District Contribution
Employee Only	517.0	51.70	465.30
Employee plus one	888.00	88.80	799.20
Employee plus two or more	1121.00	112.10	1008.90

Anthem Blue Cross PPO 2B

	Total Cost	Full Time Employee Contribution	District Contribution
Employee Only	632.0	63.20	568.80
Employee plus one	1083.00	108.30	974.70
Employee plus two or more	1371.00	137.10	1233.90

Anthem Blue Cross PPO 4A

	Total Cost	Full Time Employee Contribution	District Contribution
Employee Only	599.00	59.90	539.10
Employee plus one	1028.0	102.80	925.20
Employee plus two or more	1300.00	130.00	1170.00

Anthem Blue Cross PPO 7C

	Total Cost	Full Time Employee Contribution	District Contribution
Employee Only	537.00	53.70	483.30
Employee plus one	921.00	92.10	828.90
Employee plus two or more	1164.00	116.40	1047.60

Anthem Blue Cross PPO 10D

	Total Cost	Full Time Employee Contribution	District Contribution
Employee Only	371.00	37.10	333.90
Employee plus one	636.00	63.60	572.40
Employee plus two or more	800.00	80.00	720.00

FLEX PLAN

American Fidelity manages our Section 125 Flexible Spending Accounts for Unreimbursed Medical Expenses, Dependent Day Care and your contribution towards your medical insurance. You must meet with an American Fidelity representative to enroll in this money savings plan. We will have representatives in the District during open enrollment. *The schedule is will be sent to your site under separate cover. You are responsible for calling American Fidelity at 1-800-365-8306, ext. 0, to schedule your appointment.*

If you meet with an American Fidelity representative, you can elect to set aside pre-tax dollars for your out-of-pocket medical, dental and vision expenses not otherwise reimbursed by insurance and for day-care costs. You can save significant taxes as these amounts are deducted from your salary before taxes are withheld.

DEPENDENTS and QUALIFYING EVENTS

Except during open enrollment, dependents may only be added/dropped within 31 days of a qualifying event. Below are a few examples that are considered qualifying events:

- Birth of a child
- Marriage
- Divorce
- Increase/decrease in hours
- Change in student status
- Gain or loss of insurance coverage

Please contact the Human Resources Department if you have additional questions regarding qualifying events.

Changes to dependent coverage are required within 31 days of a qualifying event. Employees are responsible for submitting appropriate paperwork with the Human Resources Department within 31 days of experiencing a qualifying event.

Dependent children are covered until their 25th birthday if they are either a full-time student or an IRS dependent. If your child is over age 25 and disabled, they may be eligible to continue on your insurance coverage pending physician documentation.

DOMESTIC PARTNER COVERAGE

All district employees are able to enroll their domestic partner on their insurance coverage. If you wish to provide coverage for your domestic partner, please contact the Human Resources Department for the required CVT forms. Under federal tax law, coverage for domestic partners must be reported as additional earnings.

FORMS

We have attached the following forms for your use:

- CVT Medical Plan Coverage Matrix
- Delta Dental and VSP coverage summary

**If you desire to make a change in medical plans during this open enrollment period
please pick up your enrollment forms at the District Office.**

**FOR MORE INFORMATION, CONTACT MELISSA KENNEDY IN HUMAN
RESOURCES @ 837-7703 or mkennedy@wusd.org**

CVT PLANS FOR WINDSOR UNIFIED SCHOOL DISTRICT 2009/2010

BENEFIT	PPO PLAN 2 B	PPO PLAN 4 A	PPO PLAN 7 C	PPO PLAN 10 D	KAISER 3	KAISER 7
MAJOR MEDICAL*	Deductible: 0 Coinsurance: 100%	Deductible: \$100 Ind / \$300 family Coinsurance: 90/10 Out-of-Pocket Max: \$300 per person + deductible	Deductible: \$250 Ind / \$750 family Coinsurance: 80/20 Out-of-Pocket Max: \$1,000 per person + deductible	Deductible: \$2,000 Ind / \$6,000 family Coinsurance: 80/20 Out-of-Pocket Max: \$4,000 per person + deductible	No Deductible	No Deductible
LIFETIME MAX PER PERSON	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	No Lifetime maximum	No Lifetime Maximum
DOCTOR VISITS	\$10 co-pay	\$10 co-pay (co-pay not applied to deductible or out-of-pocket max)	\$20 co-pay (co-pay not applied to deductible or out-of-pocket max)	Major Medical*	Covered, \$10 Copay	Covered, \$25 Copay
ANNUAL PHYSICAL	Up to \$200/year for employee and spouse; balance to Major Med*	Up to \$200/year for employee and spouse; balance to Major Medical*	Up to \$200/year for employee and spouse; balance to Major Med*	Up to \$200/ year for employee & spouse	Covered, \$10 Copay	Covered, \$25 Copay
IMMUNIZATIONS	Employee & spouse covered under annual physical allowance. Paid at 100% Par Rate to Preferred Providers for covered dependent children.	Major Medical* Employee & spouse covered under annual physical allowance.	Major Medical* Employee & spouse covered under annual physical allowance.	Major Medical* Employee & spouse covered under annual physical allowance.	Covered, No Charge	Covered, No Charge
PREVENTIVE CARE FOR CHILDREN	Paid at 100% Par Rate to Preferred Providers. Covered, as long as eligible	Major Medical* Covered, as long as eligible	Major Medical* Covered, as long as eligible	Major Medical* Covered, as long as eligible	Covered, No Charge Up to Age 2 After Age 2 - \$10 Copay	Covered, \$15 Copay Up to Age 2 After Age 2 - \$25 Copay
WELL WOMAN: PAP SMEAR/ MAMMOGRAM	Paid at 100% Par Rate to Preferred Providers.	Major Medical*	Major Medical*	Major Medical*	Pap Smear-Covered, \$10 Copay Mammogram-Covered, No Charge	Pap Smear-Covered, \$25 Copay Mammogram-Covered, No Charge
OUTPATIENT X-RAY & LAB	Paid at 100% Par Rate to Preferred Providers	Major Medical*	Major Medical*	Major Medical*	Covered, No Charge	Covered, No Charge
PHYSICAL THERAPY	Paid at 100% Par Rate to Preferred Providers. (Co-pay, if app) Non-Par Providers limited to 13 visits per year, max \$25 per visit.	Major Medical* (Copay, if applicable) Non-Par Providers limited to 13 visits per year, max \$25 per visit.	Major Medical* (Copay, if applicable) Non-Par Providers limited to 13 visits per year, max \$25 per visit.	Major Medical* (Copay, if applicable) Non-Par Providers limited to 13 visits per year, max \$25 per visit.	Covered, \$10 Copay	Covered, \$25 Copay
CHIROPRACTIC	Paid at 100% Par Rate to Preferred Providers. (Co-pay, if applicable.) Non-Par Providers limited to a combined maximum of 13 visits per year, max \$25 per visit.	Major Medical* (Co-pay, if applicable) Non-Par Providers limited to 13 visits per year, max \$25 per visit.	Major Medical* (Co-pay, if applicable.) Non-Par Providers limited to 13 visits per year, max \$25 per visit.	Major Medical* (Co-pay, if applicable.) Non-Par Providers limited to 13 visits per year, max \$25 per visit.	Not Covered	Not Covered
ACUPUNCTURE	Paid at 100% Par Rate to Preferred Providers (Co-pay, if applicable) Max of 12 visits per calendar year	Major Medical* (Co-pay, if applicable) Max of 12 visits per calendar year	Major Medical* (Co-pay, if applicable) Maximum of 12 visits per calendar year	Major Medical* Maximum of 12 visits per calendar year	Covered, \$10 Copay Referral by Plan Physician	Covered, \$25 Copay Referral by Plan Physician
HOSPITAL INPATIENT	Paid at 100% Par Rate to Preferred Providers. Unlimited days. Semi private room	Major Medical* Unlimited days, semi-private room	Major Medical* Unlimited days, semi-private room	Major Medical* Unlimited days, semi-private room	Covered, No Charge	Covered, \$250 Copay

Page 2	PPO PLAN 2 B	PPO PLAN 4 A	PPO PLAN 7 C	PLAN 10 D	KAISER 3	KAISER 7
HOSPITAL EMERGENCY ROOM	\$35 co-pay (co-pay waived if admitted as in-patient)	\$35 co-pay Major Medical* (co-pay not applied to deductible or out-of-pocket max and waived if admitted as in-patient)	\$35 co-pay Major Medical* (co-pay not applied to deductible or out-of-pocket max and waived if admitted as in-patient)	\$35 co-pay Major Medical* (co-pay not applied to deductible or out-of-pocket max and waived if admitted as in-patient)	Covered, \$35 Copay Waived if Admitted	Covered, \$100 Copay Waived if Admitted
RADIATION THERAPY, CHEMOTHERAPY & SURGERY	Paid at 100% Par Rate to Preferred Providers	Major Medical*	Major Medical*	Major Medical*	Covered, No Charge	Covered, No Charge
HOME HEALTH CARE	Paid at 100% Par Rate to Preferred Providers Limited to 100 visits per calendar year	Major Medical* Limited to 100 visits per calendar year	Major Medical* Limited to 100 visits per calendar year	Major Medical* Limited to 100 visits per calendar year	Covered, No Charge (Limits)	Covered, No Charge (Limits)
HOSPICE	100% of Covered Expense with a lifetime maximum of \$10,000	100% of Covered Expense with a lifetime maximum of \$10,000	100% of Covered Expense with a lifetime maximum of \$10,000	100% of Covered Expense with a lifetime maximum of \$10,000	Covered, No Charge	Covered, No Charge
DURABLE MEDICAL EQUIPMENT	Paid at 100% Par Rate to Preferred Providers	Major Medical*	Major Medical*	Major Medical*	Covered, No Charge In accord with DME Formulary	Covered, 20% coinsurance In accord with DME Formulary
AMBULANCE-GROUND/AIR	100% of covered charges	Major Medical*	Major Medical*	Major Medical*	Covered, No Charge If Medically Necessary	Covered, \$100 Per Trip
MENTAL HEALTH - INPATIENT	Facility charges paid at 80% to Preferred Providers up to a maximum of 30 days per calendar year.	After deductible met, facility charges paid at 80% to Preferred Providers up to a maximum of 30 days per calendar yr.	After deductible met, facility charges paid at 80% to Preferred Providers up to a maximum of 30 days per calendar year.	After deductible met, facility charges paid at 80% to Preferred Providers up to a maximum of 30 days per calendar year.	Covered, No Charge. 45 days per calendar year (Limits) No limits with AB88 Party	Covered, \$250 Per Admission 30 days per calendar year (limits) No limits with AB88 Party
MENTAL HEALTH & SUBSTANCE ABUSE PROFESSIONAL CHARGES (INPATIENT/OUTPATIENT)	50% up to a maximum of \$50 per visit to Preferred Providers & up to \$25 to Non-Par Providers. (Substance Abuse Limited to 50 Visits Per Year)	After deductible met, 50% up to a maximum of \$50 per visit to Preferred Providers & up to \$25 to Non-Par Providers. (Substance abuse limited to 50 visits per year)	After deductible met, 50% up to a maximum of \$50 per visit to Preferred Providers & up to \$25 to Non-Par Providers. (Substance Abuse Limited to 50 Visits Per Year)	After deductible met, 50% up to a maximum of \$50 per visit to Preferred Providers & up to \$25 to Non-Par Providers. (Substance abuse limited to 50 visits per year)	Mental Health: Covered, \$10 Copay, 20 visits per calendar year No limits with AB88 Party Sub. Abuse – Covered, \$10 Copay for individual visits; \$5 Copay for group visits (No limits)	Mental Health: Covered, \$25 Copay, 20 visits per calendar year No limits with AB88 Party Sub. Abuse – Covered, \$25 Copay for individual visits; \$5 Copay for group visits (No limits)
SUBSTANCE ABUSE INPATIENT	\$300 Copay – After copay met, MHN Provider 100%, Non-Par – 50%. Two Courses of Treatment during lifetime	\$300 Copay – After copay met, MHN Provider -- 100%, Non-MHN Provider – 50%. Two courses of treatment during lifetime.	\$300 Copay – After copay met, MHN Provider 100%, Non-Par – 50%. Two Courses of Treatment during lifetime	\$300 Copay – After copay met, MHN Provider -- 100%, Non-MHN Provider – 50%. Two courses of treatment during lifetime.	Detox – No Charge Transitional Residential Recovery Services - \$100 per admission (Limits) Residential Rehab (30 days cal Yr) – No Charge (Limits)	Detox – \$250 per admission Transitional Residential Recovery Services-\$100 per admission (limits)
PRESCRIPTION DRUGS (CO-PAYMENTS)	Retail \$7 Generic \$15 Brand \$30 Non Pref (30-day supply) Mail Order \$15 Generic \$35 Brand \$70 Non Pref (90-day supply)	Retail \$5 Generic \$22 Prefd (30-day supply) Mail Order \$10 Generic \$44 Prefd (90-day supply)	Retail \$7 Gen \$25 Prefd \$40 NonPref (30-day supply) Mail Order \$15 Gen \$60 Prefd \$90 NonPref (90-day supply)	Retail \$10 Generic 30% Preferred 50% Non-Pref (30-day supply) Mail Order \$25 Generic 30% Preferred 50% Non-Pref (90-day supply)	Retail \$10 Generic \$20 Brand (100 day supply) Mail Order \$10 Generic \$20 Brand (Refills Only)	Retail \$10 Generic \$30 Brand (Up to 30 day supply) Mail Order \$20 Generic \$60 Brand (Refills Only)

ALL PERCENTAGES ARE BASED ON PAYMENTS TO PLAN PROVIDERS, PHYSICIANS AND OTHER NETWORK PROVIDERS. Major Medical* - Deductible and coinsurance apply. Non-par (non-participating) providers receive payments based on the non-participating fee allowance and are subject to the deductibles and coinsurance of the plan. THIS SUMMARY IS FOR COMPARISON PURPOSES ONLY.

CALIFORNIA'S VALUED TRUST
DELTA DENTAL PLAN OF CALIFORNIA
INFORMATION SHEET

WINDSOR UNIFIED SCHOOL DISTRICT
PPO STANDARD SCHOOL INCENTIVE PLAN



Usual, Customary and Reasonable Fee Concept
Basic Services, Crowns and Cast Restorations:
CoPayment Schedule: 70/30 First Year
 80/20 Second Year
 90/10 Third Year
 100% Fourth Year

Prosthodontics CoPayment: 50/50

- \$1,500 MAXIMUM PER PATIENT PER CALENDAR YEAR
- 2 CLEANINGS PER PATIENT PER CALENDAR YEAR
- ORTHODONTICS PAID AT 50% UP TO \$750 FOR ADULTS AND CHILDREN

DELTA DENTAL PPO/PREMIER INCENTIVE PLAN

In Network-(using Delta PPO provider's) you will receive an additional \$200 annually toward your calendar year maximum over claims paid for providers in the Delta Premier Incentive Plan.

Out of Network- (using Delta Premier Providers) your claims are paid at incentive level without additional \$200 annual maximum.

100% payment for dental services rendered in case of an accident, subject to a SEPARATE \$1000 Annual Maximum

2009-2010 RATES

COMPOSITE \$117.19

Your vision. Our passion.



Where will your eyes take you today?

Whether it's a day in the life or a day to remember, you're covered. You're enrolled in VSP, and with us, you'll get the personalized eyecare you deserve. We'll help you see well, stay healthy and get the most out of life.

Valuable coverage.

If it takes you a minute to review your benefits coverage, or an hour, we know you'll:

- find a doctor in your neighborhood who's right for you
- enjoy a WellVision ExamSM focused on your health
- love your eyewear choices
- get great savings

Get started. It's a breeze.

Already have a VSP doctor?

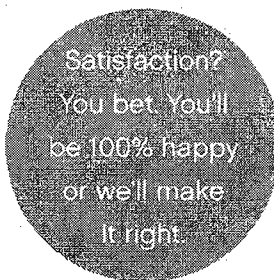
Make an appointment today.

New to VSP and need a doctor?

Go to vsp.com or call us at 800-877-7195.

Make an appointment and tell them you have VSP.

It's that easy.



Windsor Unified— Your eyecare benefit is brought to you by **California's Valued Trust and VSP.**

2009-2010 Composite Rate \$17.48

Your Coverage from a VSP Doctor

Exam covered in full..... every 12 months

Prescription Glasses

Lenses covered in full..... every 12 months

- Single vision, lined bifocal and lined trifocal lenses.
- Polycarbonate lenses for dependent children.

Frame..... every 24 months

- Frame of your choice covered up to \$130.00.
- Plus, 20% off any out-of-pocket costs.

~OR~

Contact Lens Care every 12 months

When you choose contacts instead of glasses, your \$120.00 allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts.

Current soft contact lens wearers may qualify for a special contact lens program that includes a contact lens evaluation and initial supply of replacement lenses. Learn more from your doctor or vsp.com.

Extra Discounts and Savings

Laser Vision Correction Discounts

Glasses and Sunglasses

- Average 30% savings on lens options such as scratch resistant and anti-reflective coatings and progressives
- 20% off additional prescription glasses and sunglasses, including lens options*

Contacts*

- 15% off cost of contact lens exam (fitting and evaluation)

* Available from any VSP doctor within 12 months of your last eye exam

Your Copays

Exam and Prescription Glasses \$15.00

Contacts No copay applies

Dollar for dollar you get the best value from your VSP benefit when you visit a VSP network doctor. If you decide not to see a VSP doctor, copays still apply. You'll also receive a lesser benefit and typically pay more out-of-pocket. You are required to pay the provider in full at the time of your appointment and submit a claim to VSP for partial reimbursement. If you decide to see a provider not in the VSP network, call us first at 800-877-7195.

Out-of-Network Reimbursement Amounts:

Exam Up to \$35.00

Lenses:

Single Vision Up to \$25.00

Lined Bifocal Up to \$40.00

Lined Trifocal Up to \$50.00

Frame Up to \$30.00

Contacts Up to \$105.00

VSP guarantees service from VSP network doctors only.

In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.