Q. What are the changes in benefits for next year?

A. APS employees will experience changes in both the health and dental plans effective July 1, 2011. APS' health plans, Kaiser Permanente and UnitedHealthcare will now include a deductible ($500 for individual coverage and $1000 for family coverage) and 10% co-insurance for hospitalization, surgical, emergency services and some in-office procedures. In addition, the copayments for office visits, not including preventative care will increase to $25.00 for primary care physician visits and $50.00 for specialist office visits.

Dental benefits under the district's Delta Dental plan will now include full coverage allowance for composite fillings on rear teeth and will also pay for implants, subject to the annual plan maximum of $1250.

Q. Why is APS making these plan design changes?

A. Under the current health plan designs, APS would have experienced a 14.7% rate increase for Kaiser Permanente and 14.1% rate increase for UnitedHealthcare. These rate increases represent $2.7 million. The plan design changes result in a slightly decreased premium rate for employees and for APS.

Health insurance now represents approximately 9% of the district's general fund budget at $25.8 million. The plan design changes will assist in addressing the $25 million short fall and is expected to stabilize the annual increases in health insurance costs.

Q. Who actually made this decision?

A. The District's Insurance Committee, an advisory group comprised of representatives from the Classified Employees' Council (CEC), the Aurora Education Association (AEA), and the School Executives of Aurora (SEA), recommended the changes to Superintendent Barry and the District Leadership team.

Superintendent Barry and the District Leadership team accepted the recommendation, which was also supported by the APS Board of Education.

Q. Who gave the Insurance Committee feedback on this option?

A. Members of the District Insurance Committee were expected to take the information to and obtain feedback from the constituents they represent.

Q. Will my premiums in my payroll deductions increase?

A. No, monthly premiums will decrease slightly during the 2011-12 fiscal year.

Q. How will the plan design change affect me?

A. The affect of the plan design change will vary based upon an individual's medical needs and conditions. Those with chronic or significant health conditions should contact their health insurance company to discuss the plan and impact of the change.

Q. How can I get more information?

A. Representatives from both Kaiser Permanente and UnitedHealthcare will be in attendance at each of the Open Enrollment meetings to provide information and answer questions. In addition, there are webinars on the APS Benefits website for both Kaiser Permanente and UnitedHealthcare. UnitedHealthcare has established an information line for APS members at 1-866-873-3903.

Q. Do I need to complete a new enrollment form?

A. You will need to complete an enrollment form if you are changing medical plans, or adding or deleting dependents.

Q. What other options did the committee consider?

A. Both the committee and the District Leadership Team researched and considered other options, such as Kaiser Permanente as the sole healthcare provider and different levels of deductible/co-insurance. It was determined the $500/1000 deductible level and 10% co-insurance option would be the most cost effective for our organization.

Q. Is there a way offset healthcare costs?

A. As an employee of APS, a portion of your salary before taxes may be withheld to reimburse medical expenses incurred during the year. A medical Flexible Spending Account (FSA) may be advantageous, as income taxes are not paid on the portion of your salary credited to the account. However, each individual should make the decision regarding this option based upon his/her own financial circumstances.

Q. How does the deductible and co-insurance plan work?

A. Routine office visits are covered with a set copay, which is not subject to your deductible limit. More extensive services, including hospitalization and outpatient surgery, are subject to the deductible and coinsurance. This means you'll pay for them out-of-pocket until you've reached the plan year deductible limit - $500 for individual coverage and $1000 for family coverage. After that, you share the cost of medical services with the insurance provider by paying 10 percent of the costs until you reach your out-of-pocket maximum for the year - $2500 for individual coverage $5000 for family coverage.

Once you reach your out-of-pocket maximum, the medical/insurance provider will pay 100 percent of most covered services, beyond copayments for the remainder of the plan year.