Corona-Norco Unified School District

2018-19 Employee Benefits

Management & Confidential RETIREES

Please read all information carefully!

IMPORTANT!

Medical, Dental and Vision plans will automatically rollover to the new year

CORONA-NORCO UNIFIED SCHOOL DISTRICT

OPEN ENROLLMENT—Learning Center South

August 28-29, 2018
11:00-4:30 pm

Retirees making changes or payments are welcome to visit the Benefits Department during the week of **August 20-24, 2018** from **9:00am-12pm**

Kaiser Hearing Aid Benefits

Effective October 1, 2018, SISC will be adding a hearing aid benefit to all Kaiser, DHMO and Senior Advantage plans.

- $500 allowance per device
- 1 device per ear
- 2 devices per 36 months

If you plan to make changes to:

Medical Plan

□ Complete a paper SISC medical enrollment form and plan election form. Make sure to sign and date all forms. Forms can be found on the District's website under the Benefit Department page at: www.cnusd.k12.ca.us

Dental and Vision Plans

□ Dental and Vision plan changes are completed online through Benefit Bridge at: benefitbridge.com/coronanorco. For technical support please call (800)814-1862. Benefit Bridge online open enrollment is open online **July 6 —August 28, 2018.**

- If you are not making changes, you are not required to come in.
- The datasheet is for informational purposes only. We no longer require a signature or a returned copy .
- Your current plan(s) will continue into the new plan year.
- New payment amounts are effective October 1, 2018 through September 30, 2019. (July and August are skip months)
- Life Insurance invoice and payments are due to the District by **November 1, 2018.**

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SISC Anthem Medical Plans

Plan Features	ANTHEM PREMIER HMO CNMA	ANTHEM CLASSIC HMO CNMA	ANTHEM CLASSIC PPO CNMA		ANTHEM HSA	
			PPO Provider	Non-PPO Provider	PPO Provider	Non-PPO Provider
Calendar Year Deductible						
Individual	None	None	$300		$1,500	
Family			$600		$3,000	
Calendar Year Co-Pay Max (excluding Prescription Drug)						
Individual	$1,000	$2,000	$1,000		$3,000	
Family	$2,000	$4,000	$3,000		$6,000	
Hospital						
Inpatient Copay (per admission)	No charge	$250 copay	20%	0% (up to $600/day)	10%	0% (up to $600/day)
Outpatient Facility / Surgery Services	No charge	$125 copay	20%	50%	10%	0%
Emergency Services						
Emergency Room	$100 copay	$100 copay	$100 copay + 20%		$100 copay Plus 10%	0%
Ambulance	$100 per trip	$100 per trip	20%		10%	
Physician Services (Includes Mental Health and Substance Abuse)						
Office Visits - Primary	$10 copay	$20 copay	$20 copay	0%	10%	0%
Office Visits - Specialist	$10 copay	$40 copay	$20 copay	0%	10%	0%
Urgent Care Visits (Out of service area)	$10 copay	$20 copay	$20 copay	0%	10%	0%
Diagnostic X-Ray/Lab						
Lab and X-Ray	No charge	No charge	20%	0%	10%	0%
Advanced Imaging (CT, MRI, PET)	$100 copay	$100 copay	20%	0%	10%	0%
Prescription Drugs Retail Pharmacy						
Generic (up to 30-day supply)	$7 copay	$7 copay	$7 copay		$9 copay after deductible	
Brand - Formulary (up to 30-day supply)	$25 copay	$25 copay	$25 copay		$35 copay after deductible	
Mail Order Pharmacy						
Generic (up to 90-day supply)	$0 copay	$0 copay	$0 copay		$18 copay after deductible	
Brand - Formulary (up to 90-day supply)	$60 copay	$60 copay	$60 copay		$90 copay after deductible	
Durable Medical Equipment						
DME	20%	20%	20%	0%	10%	0%
Infertility Testing/Treatment						
Infertility Services	50%	50%	Not covered		Not covered	
Chiropractic						
Office Visit	$10 copay	$10 copay	20%	0%	10%	0
# of visits per year (max)	30 per year	30 per year	If medically necessary		If medically necessary	
Tenthly rates: Deductions (Oct. 2018–Sept. 2019)						
Single:	**$808.80**	**$765.60**	**$832.80**		**$646.80**	
Employee + One (Spouse or child)	**$1,572.00**	**$1,485.60**	**$1,620.00**		**$1,294.80**	
Family	**$2,199.60**	**$2,074.80**	**$2,266.80**		**$1,844.40**	

SISC Kaiser Medical Plans

Plan Features	KAISER $10 PLAN CNMA	KAISER $20 PLAN CNMA
Calendar Year Deductible		
Individual	None	None
Family		
Calendar Year Co-Pay Max (excluding Prescription Drug)		
Individual	$1,500	$1,500
Family	$3,000	$3,000
Hospital		
Inpatient Copay (per admission)	No charge	No charge
Outpatient Facility / Surgery Services	$10 copay	$20 copay
Emergency Services		
Emergency Room	$100 copay	$100 copay
Ambulance	$50 per trip	$50 per trip
Physician Services (Includes Mental Health and Substance Abuse)		
Office Visits - Primary & Specialist	$10 copay	$20 copay
Urgent Care	$10 copay	$20 copay
Routine physical maintenance exams	No charge	No charge
Well-child preventive exams (to age 23 months)	No charge	No charge
Eye Exams ($150 eyewear allowance ever 24 months)	No charge ($150 eyewear allowance every 24 mos)	No charge ($150 eyewear allowance every 24 mos)
Diagnostic X-Ray/Lab		
Lab and X-Ray	No charge	No charge
Prescription Drugs Retail Pharmacy		
Generic	$10 copay up to 100 day supply	$10-30 day $20-60 day $30-100 day
Brand - Formulary	$10 copay up to 100 day supply	$30-30 day $60-60 day $90-100 day
Mail Order Pharmacy		
Generic	$10 copay up to 100 day supply	$10-30 day $20-100 day
Brand - Formulary	$10 copay up to 100 day supply	$30-30 day $60-100 day
Durable Medical Equipment		
DME	20% Coinsurance	20% Coinsurance
Hearing Aid	$500 allowance per device 1 device per ear 2 devices per 36 months	$500 allowance per device 1 device per ear 2 devices per 36 months
Infertility Testing/Treatment		
Infertility Services	50% Coinsurance	50% Coinsurance
Chiropractic & Acupuncture		
Office Visit	$10 copay	$10 copay
# of combined visits per year (max)	30 visits per year	30 visits per year
Tenthly rates: Deductions (October 2018-Sept. 2019)		
Single:	**$691.20**	**$676.80**
Employee + One (Spouse or child)	**$1,358.40**	**$1,329.60**
Family	**$1,902.00**	**$1,860.00**

DELTA DENTAL PLANS

More than 25,000 practicing dentists in California are Delta Dentists. Of these, 13,000 are PPO dentists. Although you are free to choose any dentist for treatment, you will save money by choosing a Delta PPO Dentist. This is because these dentists' fees are approved in advance by Delta. If you go to a non-PPO Dentist, Delta cannot assure you what percentage of the charged fee may be covered. Since the fees charged by non-PPO Dentists are typically higher, your share of the cost will be higher.

Dental Plan Highlights

	Delta Dental PPO Plan		DeltaCare USA Plan
	Delta PPO In-Network Dentist	**Non-PPO and Out-of-Network Dentist**	**HMO Dentist**
Maximum Annual Benefit	$1,500 per person	$1,500 per person	No annual maximum
Annual Deductible	$25 per person $75 per family (per calendar year)	$25 per person $75 per family (per calendar year)	Not Applicable
Diagnostic & Preventive Care (exams, x-rays, cleanings)	Plan pays 100% of PPO approved fee	Plan pays 80% of Delta approved fee	Member pays applicable co-payments
Basic Care (fillings, extractions)	Plan pays 90% of PPO approved fee	Plan pays 80% of Delta approved fee	Member pays applicable co-payments
Crowns, Jackets, Cast Restorations, Sealants and Endodontics	Plan pays 60% of PPO approved fee	Plan pays 50% of Delta approved fee	Member pays applicable co-payments
Prosthodontic Care (bridges, dentures) **Dental IMPLANT Coverage**	Plan pays 60% of PPO approved fee (up to a maximum allowance)	Plan pays 50% of Delta approved fee (up to a maximum allowance)	Member pays applicable co-payments
Orthodontia	Plan pays 50% of PPO approved fee (up to a $1,000 lifetime maximum per person)	Plan pays 50% of Delta approved fee (up to a $1,000 lifetime maximum per person)	Member pays from $1600-$1800 plus $350 start up fee. See Schedule of Benefits.
Deductions Oct. 2018-Sept. 2019 **Single** **Employee + Spouse** **Employee + Child(ren)** **Family**	 **$56.52** **$105.41** **$105.67** **$157.50**		 **$28.57** **$52.98** **$53.35** **$76.88**

VISION PLANS

MEDICAL EYE SERVICES (MES)

Benefits	Participating Provider	Non-Participating Provider
Examination Co-payment	$0	$0
Comprehensive Examination **Once in a 12 month period**	Paid in full	Up to $40
Lenses (per pair) - **Once in a 24 month period**	*Up to 61 mm eye size*	
Single Vision	Paid in full	Up to $30
Bifocal	Paid in full	Up to $50
Trifocal	Paid in full	Up to $65
Lenticular	Paid in full	Up to $125
Progressive Lenses	Up to $89.50	Up to $65
Frames - **Once in a 24 month period**	Up to $150* Retail	Up to $40
Contact Lenses (per pair)		
Cosmetic or Convenience	Up to $100	Up to $100
Medically Necessary	Paid in full	Up to $250
Tenthly Rates: Deductions (Oct. 2018—Sept. 2019)		
Single	**$7.11**	
Employee + One (Spouse or Child)	**$14.27**	
Employee + Family	**$18.36**	

VISION SERVICE PLAN (VSP)

Your Coverage from a VSP Doctor

WellVision Exam .....every 12 months

Prescription Glasses

Lenses.....every 12 months

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

Frame .....every 12 months

- *$120.00 allowance for a wide selection of frames*
- *20% off the amount over your allowance*

~OR~

Contact Lens Care

- **No copay every 12 months**

$120.00 allowance for contacts and the contact lens exam (fitting and evaluation).

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

Extra Discounts and Savings

Glasses and Sunglasses

- *Average 35 - 40% savings on all non-covered lens options*
- *30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last 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 Co-pays

Exam & Prescription Glasses	**$25.00**	**Contacts**	**No copay applies**

Your Coverage with Other Providers

Out of Network Coverage

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

Exam	*Up to $50*	Lined Bifocal Lenses	*Up to $75*
Contacts	*Up to $105*	Lined Trifocal Lenses	*Up to $100*
Frame	*Up to $70*	Progressive Lenses	*Up to $75*
Single Vision Lenses	*Up to $50*	Tints	*Up to $5*

Tenthly Rates: Deductions (Oct. 2018-Sept. 2019)	
Single	**$10.28**
Employee + One (Spouse or Child)	**$21.48**
Employee + Family	**$30.85**

VSP guarantees service from VSP 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.