Corona-Norco Unified School District
2019-2020 Employee Benefits

Classified & Supervisory RETIREES

IMPORTANT!

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

Any changes made during open enrollment for medical, dental, and vision will be effective October 1, 2019

Please read all information carefully!

CORONA-NORCO UNIFIED SCHOOL DISTRICT

OPEN ENROLLMENT—Learning Center South

August 20 - 21, 2019

12:00 - 4:30 pm

Retirees making changes or payments are welcome to visit the Benefits Department during the week of **August 12 -16, 2019** from **9:00am -12:00pm**

2019-2020 Changes

Effective October 1, 2019 Delta Dental PPO Plan will include a $500 Lifetime Mouth Guard Benefit.

Medical Eye Services (MES) benefit will be enhanced to: $0 Co-pay, Exam every 12 months, Lenses every 12 months, Frames every 24 months, Contact Lenses every 12 months with an increased allowance up to $150.00

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 Benefits 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 **July 29, 2019 - August 23, 2019**.

- Your current plan(s) will continue into the new plan year.
- New payment amounts are effective October 1, 2019 through September 30, 2020. (July and August are skip months)
- Life Insurance invoice and payments are due to the District by November 1, 2019.

SISC Anthem Medical Plans

PLAN FEATURES	ANTHEM PREMIER HMO CSEA	ANTHEM CLASSIC HMO CSEA	ANTHEM CLASSIC PPO 20 CSEA		ANTHEM CLASSIC PPO 40 CSEA	
			PPO Provider	Non-PPO Provider	PPO Provider	Non-PPO Provider
Calendar Year Deductible						
Individual	None	None	$300		$3,000	
Family			$600		$6,000	
Calendar Year Co-Pay Max (excluding Prescription Drug)						
Individual	$1,000	$2,000	$1,000		$4,000	
Family	$2,000	$4,000	$3,000		$8,000	
Hospital						
Inpatient Copay (per admission)	No charge	$250 copay	20%	0% (up to $600/day)	20%	0% (up to $600/day)
Outpatient Facility / Surgery Services	No charge	$125 copay	20%	50%	20%	50%
Emergency Services						
Emergency Room	$100 copay	$100 copay	$100 visit/+20%		$100 copay + 20%	
Ambulance	$100 per trip	$100 per trip	20%		20%	
Physician Services (Includes Mental Health and Substance Abuse)						
Office Visits - Primary	$10 copay	$20 copay	$20 copay	0%	$40 copay	0%
Office Visits - Specialist	$10 copay	$40 copay	$20 copay	0%	$40 copay	0%
Urgent Care Visits (Out of service area)	$10 copay	$20 copay	$20		$40	
Diagnostic X-Ray/Lab						
Lab and X-Ray	No charge	No charge	20%	0%	20%	0%
Advanced Imaging (CT, MRI, PET)	$100 copay	$100 copay	20%	0%	20%	0%
Prescription Drugs						
Retail Pharmacy						
Generic (up to 30-day supply)	$7 copay	$10 copay	$7 copay		$10 copay	
Brand - Formulary (up to 30-day supply)	$25 copay	$35 copay Rx Deductible: **$200 Single $500 Family**	$25 copay		$35 copay Rx Deductible: **$200 single $500 family**	
Mail Order Pharmacy						
Generic (up to 90-day supply)	$0 copay	$0 copay	$0 copay		$0 copay	
Brand - Formulary (up to 90-day supply)	$60 copay	$90 copay	$60 copay		$90 copay Rx Deductible: **$200 single/$500 family**	
Durable Medical Equipment						
DME	20%	20%	20%	0%	20%	0%
Infertility Testing/Treatment						
Infertility Services	Not Covered	Not Covered	Not covered		Not covered	
Chiropractic/Acupuncture						
Office Visit	$10 copay	$10 copay	20%	0%	20%	0%
# of combined visits per year (max)	30 per year	30 per year	12 visits a Calendar Year		12 visits a Calendar Year	
Tenthly Deductions (October 2019—Sept. 2020)						
Single	**$834.00**	**$746.40**	**$859.20**		**$604.80**	
Employee + One	**$1,621.20**	**$1,458.00**	**$1,670.40**		**$1,174.80**	
Family	**$2,266.80**	**$2,044.80**	**$2,337.60**		**$1,642.80**	

THIS MATERIAL DOES NOT CREATE NOR CONFER ANY RIGHTS; IT IS ONLY A BRIEF OUTLINE OF THE PLANS AND IS NOT TO BE ACCEPTED OR CONSIDERED AS A SUBSTITUTE FOR THE PROVISIONS OF THE MASTER POLICIES.

***Employee + Child(ren) tier is only available to employees enrolled in the tier as of June 30, 2013.**

SISC Kaiser Medical Plans

Plan Features	KAISER HIGH PLAN	KAISER DHMO
Calendar Year Deductible		
Individual	None	$1,000
Family		$2,000
Calendar Year Co-Pay Max (excluding Prescription Drug)		
Individual	$1,500	$3,000
Family	$3,000	$6,000
Hospital		
Inpatient Copay (per admission)	No charge	20% after deductible
Outpatient Facility / Surgery Services	$20 copay	20% after deductible
Emergency Services		
Emergency Room	$100 copay	20% after deductible
Ambulance	$50 per trip	$150 per trip
Physician Services (Includes Mental Health and Substance Abuse)		
Office Visits - Primary & Specialist	$20 copay	$20 copay
Urgent Care	$20 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	No charge ($150 eyewear allowance every 24 mos)	No charge
Diagnostic X-Ray/Lab		
Lab and X-Ray	No charge	$10 copay $50 (MRI, CT, PET)
Prescription Drugs **Retail Pharmacy**		
Generic	$10 copay up to 100 day	$10-30 day $20-60 day $30-100 day
Brand - Formulary	$20 copay up to 100 day	$30-30 day $60-60 day $90-100 day
Mail Order Pharmacy		
Generic	$10 up to 100 day	$10-30 day $20-100 day
Brand - Formulary	$20 up to 100 day	$30-30 day $60-100 day
Durable Medical Equipment		
DME	20% Coinsurance	20% (deductible doesn't apply)
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% (deductible doesn't apply)
Chiropractic/Acupuncture		
Office Visit	$10 copay	$10 copay
# of combined visits per year (max)	30 visits per year	30 visits per year
Deductions (October 2019 — Sept. 2020)		
Single:	**$709.20**	**$627.60**
Employee + One (Spouse or Child)	**$1,393.20**	**$1,232.40**
Family	**$1,950.00**	**$1,725.60**

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) New Devices	Plan pays 90% of PPO approved fee $500 lifetime Mouth Guard Benefit	Plan pays 80% of Delta approved fee 80% lifetime Mouth Guard Benefit	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. 2019 –Sept. 2020) **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 12 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 $150	Up to $150
Medically Necessary	Paid in full	Up to $250
Tenthly Rates: Deductions (Oct. 2019 - Sept. 2020)		
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. 2019 - Sept. 2020)	
Single	$9.88
Employee + One (Spouse or Child)	$20.64
Employee + Family	$29.65

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.