# Corona-Norco Unified School District

# 2019 Employee Benefits

# Certificated Early RETIREES (non-management)

**IMPORTANT!**

**If you are not making changes to your medical, dental, and/or vision plans, your current plans will automatically rollover to the new year.**

CnTa

Corona-Norco Teachers Association

# CORONA-NORCO UNIFIED SCHOOL DISTRICT

***OPEN ENROLLMENT—Learning Center South***

**October 9, 2018**

**12:30 p.m. - 4:30 p.m.**

***Retirees are welcome to come into the Benefits Office from October 15—19, 2018 from 9:00 am—11:00 am***

*All Medical, Dental, and Vision changes are completed online at:*
**https://www.myaresonline.com/account/Login**
**Online Enrollment will be open from October 9 — November 2, 2018**

- All changes are completed online. 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 January 1, 2019 through December 31, 2019. (July and August are skip months)
- Life Insurance invoice and payments (by check only) are due to the District by November 1, 2018.

***Online Enrollment Changes are from October 9— November 2, 2018***

***Medical, Dental, and Vision Plans***

**https://www.myaresonline.com/account/Login**

If you need assistance logging in, please contact VEBA support at (888) 276-0250.

When making changes to include new dependents, you must include eligibility documents (i.e. birth certificates, 1st page of current federal tax return). **You can upload your documents online.** Documents are due by **November 2, 2018**.

# VEBA UNITED HEALTH CARE PLANS

| Plan Features | VEBA PHMO Network 1 | VEBA PHMO Network 2 | VEBA PHMO Network 3 | VEBA UHC HMO SVA (SignatureValue Advantage) | VEBA UHC PPO Select Plus (In Network) | VEBA UHC PPO Select Plus (Out of Network) |
|---|---|---|---|---|---|---|
| Calendar Year Deductible | | | | | | |
| Individual | None | None | None | $500 | $500 | |
| Family | | | | $1,500 | $1,000 | |
| Calendar Year Co-Pay Max (excluding Prescription Drug) | | | | | | |
| Individual | $3,000 | $3,000 | $3,000 | $3,000 | $2,000 | $4,000 |
| Family | $6,000 | $6,000 | $6,000 | $6,000 | $4,000 | $8,000 |
| Hospital | | | | | | |
| Inpatient Copay (per admission) | No charge | No charge | $250 copay | $500 copay | 20% after deductible | 50% after deductible |
| Outpatient Facility / Surgery Services | No charge | No charge | No charge | $100 copay | 20% after deductible | 50% after deductible |
| Emergency Services | | | | | | |
| Emergency Room | $100 copay | $100 copay | $200 copay | $100 copay | $100 copay | |
| Ambulance | No charge | No charge | No charge | No charge | 20% after deductible | |
| Physician Services (Includes Mental Health and Substance Abuse) | | | | | | |
| Office Visits - Primary | $10 copay | $20 copay | $35 copay | $20 copay | $20 copay | 50% after deductible |
| Office Visits - Specialist | $10 copay | $20 copay | $35 copay | $30 copay | $20 copay | 50% after deductible |
| Urgent Care Visits (Part of Medical Group) | $10 copay | $20 copay | $35 copay | $20 copay | $50 copay | 50% after deductible |
| Urgent Care Visits (Out of service area) | $50 copay | $50 copay | $50 copay | $50 copay | N/A | |
| Diagnostic X-Ray/Lab | | | | | | |
| Lab and X-Ray | No charge | No charge | No charge | No charge | No charge | 50% after deductible |
| Advanced Imaging (CT, MRI, PET) | No charge | No charge | No charge | $200 copay | 20% after deductible | 50% after deductible |
| **Prescription Drugs** ***Retail Pharmacy ($5 extra pharmacy co-pay when filled at a non Express Advantage Network Pharmacy)** | | | | | | |
| Generic | $15 copay* | $15 copay* | $15 copay* | $20 copay* | $15 copay | |
| Brand - Formulary | $30 copay* | $30 copay* | $30 copay* | $35 copay* | $30 copay | |
| Non-Formulary | 50% | 50% | 50% | 50% | 50% * no out of network Rx | |
| Mail Order Pharmacy (90 day supply) | | | | | | |
| Generic | $30 copay | $30 copay | $30 copay | $40 copay | $30 copay | |
| Brand - Formulary | $60 copay | $60 copay | $60 copay | $70 copay | $60 copay | |
| Non-Formulary | 50% | 50% | 50% | 50% | 50% copay | |
| Durable Medical Equipment | | | | | | |
| DME | No charge | No charge | No charge | No charge | 20% after deductible | 50% after deductible |
| Infertility Testing/Treatment | | | | | | |
| Infertility Services | Not covered | Not covered | Not covered | Not covered | Not covered | |
| Chiropractic *No Acupuncture on HMO Plans* | | | | | $20 copay per visit (24 visits per year) | 50% coinsurance after deductible is met |
| Office Visit | $10 copay | $20 copay | $30 copay | $30 copay | | |
| # of visits per year (max) | Unlimited | Unlimited | Unlimited | Unlimited | | |
| **Tenthly rates: Deductions : Jan.—Dec 2019** | | | | | | |
| **Single:** | **$738.00** | **$812.00** | **$848.00** | **$618.00** | **$1,106.00** | |
| **Employee + Spouse** | **$1,487.00** | **$1,639.00** | **$1,713.00** | **$1,242.00** | **$2,231.00** | |
| **Employee + Child(ren)** | **$1,405.00** | **$1,548.00** | **$1,618.00** | **$1,174.00** | **$2,063.00** | |
| **Family** | **$2,127.00** | **$2,345.00** | **$2,451.00** | **$1,775.00** | **$3,195.00** | |

# VEBA KAISER PERMANENTE PLANS

| Plan Features | VEBA Kaiser Standard $20 | VEBA Kaiser Standard $30 |
|---|---|---|
| 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 | $20 copay | $30 copay |
| Emergency Services | | |
| Emergency Room | $50 copay | $100 copay |
| Ambulance | No charge | $150 copay |
| Physician Services (Includes Mental Health and Substance Abuse) | | |
| Office Visits - Primary & Specialist | $20 copay | $30 copay |
| Urgent Care | $20 copay | $30 copay |
| Diagnostic X-Ray/Lab | | |
| Lab and X-Ray | No charge | No charge |
| **Prescription Drugs** Retail Pharmacy | | |
| Generic | $15-30 day<br>$30-60 day<br>$45-100 day | $15-30 day<br>$30-60 day<br>$45-100 day |
| Brand - Formulary | $30-30 day<br>$60-60day<br>$90-100 day | $30-30 day<br>$60-60 day<br>$90-100 day |
| Mail Order Pharmacy | | |
| Generic | $15-30 day<br>$30-100 day | $15-30 day<br>$30-100 day |
| Brand - Formulary | $30-30 day<br>$60-100 day | $30-30 day<br>$60-100 day |
| Durable Medical Equipment | | |
| DME | No charge | 20% |
| Infertility Testing/Treatment | | |
| Infertility Services | $20 copay | 50% |
| Chiropractic *No Acupuncture* | | |
| Office Visit | $20 copay | $30 copay |
| # of visits per year (max) | Unlimited | Unlimited |
| **Tenthly rates: Deductions Jan – Dec 2019** | | |
| **Single:** | **$733.20** | **$714.00** |
| **Employee + Spouse** | **$1,546.80** | **$1,509.60** |
| **Employee + Child(ren)** | **$1,412.40** | **$1,387.20** |
| **Family** | **$1,984.80** | **$1,936.80** |



*** Detailed information regarding explanation of all VEBA plans and Enrollment Instructions are posted on the District's Website.**

# DELTA DENTAL

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 | $50 per person<br>$150 per family<br>(per calendar year) | $50 per person<br>$150 per family<br>(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 70% of PPO approved fee | Plan pays 50% of Delta approved fee | Member pays applicable co-payments |
| Prosthodontic Care (bridges, dentures) **Implants** | 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. |
| **Tenthly Rates:**<br>**Deductions Jan - Dec 2019**<br>**Single**<br>**Employee + Spouse**<br>**Employee + Child(ren)**<br>**Family** | <br><br>**$61.25**<br>**$114.25**<br>**$113.54**<br>**$169.66** | | <br><br>$27.80<br>$51.54<br>$51.90<br>$74.78 |

# MES VISION PLAN

| Medical Eye Services Vision Plan Highlights | | |
|---|---|---|
| **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 $125* 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 Jan - Dec 2019**<br>**Single**<br>**Employee + One (Spouse or Child)**<br>**Employee + Family** | <br>**$6.87**<br>**$13.79**<br>**$17.74** | |