SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

2018-2019 CLASSIFIED PLAN SUMMARY

Lucia Mar Unified School District

	Plan 1 100-G $20	Plan 2 80-G $30	Plan 3 80-L $30	Plan 4 80-M $40	*HSA ELIGIBLE* Plan 5 MINIMUM VALUE	*HSA ELIGIBLE* 2-Tier ANCHOR BRONZE
MEDICAL - CALENDAR YEAR Deductibles & Maximums	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Individual/Family Deductibles	$500/$1,000	$500/$1,000	$2,000/ $4,000	$3,000/ $6,000	$5,000/ $10,000*	$5,000/ $10,000*
Individual/Family Out-of-Pocket (OOP) Max (includes medical deductibles, co-insurance and co-pays)	$1,000/ $3,000	$2,000/ $4,000	$4,000/ $8,000	$4,000/ $8,000	$6,350/ $12,700* *Includes Rx	$6,350/ $12,700* *Includes Rx
PROFESSIONAL SERVICES						
Office Visit (OV) co-pay	$20	$30	$30	$40	30% after Deductible	30% after Deductible
Urgent Care co-pay	$20	$30	$30	$40	30% after Deductible	30% after Deductible
Specialists/Consultants co-pay	$20	$30	$30	$40	30% after Deductible	30% after Deductible
Prenatal, postnatal office visit co-pay	$20	$30	$30	$40	30% after Deductible	30% after Deductible
Scans: CT, CAT, MRI, PET etc.	0%	20%	20%	20%	30%	30%
Diagnostic X-ray & Laboratory Procedures	0%	20%	20%	20%	30%	30%
Infertility (diagnosis/treatment of causes of infertility)	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Preventive Care (includes physical exams & screenings)	0%, Deductible Waived	0%, Deductible Waived	0%, Deductible Waived	0%, Deductible Waived	0%, Deductible Waived	0%, Deductible Waived
HOSPITAL & SKILLED NURSING FACILITY SERVICES						
Emergency Room visit (waived if admitted)	0% $100 co-pay	20% $100 co-pay	20% $100 co-pay	20% $100 co-pay	30% $100 co-pay	30% $100 co-pay
Inpatient Hospital (preauthorization required)	0%	20%	20%	20%	30%	30%
Outpatient Hospital	0%	20%	20%	20%	30%	30%
Surgery, Outpatient (performed in Surgery Center)	0%	20%	20%	20%	30%	30%
Surgery, Outpatient (performed in a Hospital)	0%	20%	20%	20%	30%	30%
MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT						
INPATIENT: Facility Based Care (preauth required)	0%	20%	20%	20%	30%	30%
OUTPATIENT: Facility Based Care (preauth required)	0%	20%	20%	20%	30%	30%
OTHER SERVICES						
Acupuncture - Limits apply	0%	20%	20%	20%	30%	30%
Ambulance (Ground or Air)	0% $100 co-pay	20% $100 co-pay	20% $100 co-pay	20% $100 co-pay	30% $100 co-pay	30% $100 co-pay
Chiropractic - Limits apply	0%	20%	20%	20%	30%	30%
Durable Medical Equipment (DME)	0%	20%	20%	20%	30%	30%
Physical and Occupational Therapy - Limits apply	0%	20%	20%	20%	30%	30%
PHARMACY BENEFITS						
Plan	**200/10-35**	**200/10-35**	**200/10-35**	**200/10-35**	**Minimum Value Rx - Subject to Medical Ded.**	**Anchor Bronze Rx - Subject to Medical Ded.**
Individual/Family Brand & Specialty Rx Deductibles	$200/$500	$200/$500	$200/$500	$200/$500	Included with Medical deductible	Included with Medical deductible
Individual/Family Rx Out-of-Pocket (OOP) Max (includes Rx deductibles and co-pays)	$2,500/ $3,500	$2,500/ $3,500	$2,500/ $3,500	$2,500/ $3,500	Included with Medical OOP Max	Included with Medical OOP Max
Generic co-pay/30 days supply	$0 at Costco $10 at Other Network	$0 at Costco $10 at Other Network	$0 at Costco $10 at Other Network	$0 at Costco $10 at Other Network	$9	$9
Brand co-pay/30 days supply	$35	$35	$35	$35	$35	$35
Specialty co-pay/up to 30 days supply	Must Use Navitus Mail $35	Must Use Navitus Mail $35	Must Use Navitus Mail $35	Must Use Navitus Mail $35	Mail $35	Mail $35
Mail Order (Generic-Brand co-pay/90 days supply)	$0-$90	$0-$90	$0-$90	$0-$90	$18-$90	$18-$90

LUCIA MAR UNIFIED SCHOOL DISTRICT

2018-2019

2 TIER ANCHOR BRONZE PLAN BENEFIT SUMMARY

In accordance with requirements of the Affordable Care Act.

Attention Lucia Mar Employees:

All employment groups, Certificated, **Classified** & Management are eligible to sign up for the 2 Tier Anchor Bronze Plan. Please review the benefit summary below for more details.

Features of the plan include:

- This plan is HSA compliant. Members are allowed to make pre-tax deferrals into a Health Savings Account (HSA) at a financial institution of your choice with an unlimited year to year carryover.
- Medical and Prescription only with a $5,000 deductible. Plan coverage, once the deductible is met is 70% (you pay 30%). The Maximum Out-Of-Pocket (OOP) is $6,350 which may be comprised of a combination of the deductible and co-insurance payments. There is no option for dental, vision or life coverage through SISC if this plan is selected.
- Prescriptions are subject to the deductible, $5,000 before the designated prescription co-pays apply.
- This plan covers a single employee OR the employee + child(ren) ONLY - Spouses are NOT eligible on this plan.
- Premiums are on a two-tier structure of "single" (employee) or employee + child(ren).
- The plan year runs October 1 - September 30, but deductibles and OOP maximums reset on a *calendar-year* basis.
- Office visit co-pays are subject to the deductible of $5,000. After the deductible is met, the plan pays 30%. Once the Maximum OOP of $6,350 is met, the plan will pay at 100% for the remainder of the calendar year.
- Costco provides a $0 generic co-pay at their walk-in pharmacy (membership not required). The deductible must be met before the $0 co-pay will be applied.

DID YOU KNOW??

Insurance industry standards (not the District, SISC, nor Anthem independently) require that:

* When one holds their own insurance plan as well as coverage under a spouse, the plan issued directly to them is **ALWAYS** that person's primary coverage; the spouse's coverage must be used as the secondary coverage. Use of a spouse's plan in lieu of your own to obtain a better, or more convenient, benefit is considered fraudulent and could be subject to audit by Anthem and/or the other provider resulting in back-charges due by you for any services incorrectly paid by the plan.
* When children are covered by both parents, the parent with the first birthday of the calendar year (not by age) is the primary coverage provider for the children; the other is the secondary coverage - you may not choose which order to apply the plans. Keep this in mind when selecting your plan to assure your children are covered most efficiently between the two plans. If the parent with the later birthday can provide better coverage for the children and you wish to make that their primary coverage, the first birthday parent must not cover them.

QUESTIONS OR CONCERNS? PLEASE CONTACT
ANASTACIA MALM
805-474-3000 x1192 or anastacia.malm@lmusd.org

Lucia Mar Unified School District Classified Delta Dental PPO Premier Incentive Plan (#7074-7016)

Plan Benefit Highlights for:	**PPO Incentive ($1,700/$1,500) no Orthodontic**
Group No:	**Active, Retirees, and Cobra**
Network:	**PPO/Premier** ***The plan provides an additional $200 toward the calendar year maximum when you visit a PPO dentist. Look for this information for the dentist of your choice on the Delta find a provider website to take advantage of this additional amount: (Other network affiliations:** Delta Dental PPO)

In this incentive plan, Delta Dental pays 70% of the contract allowance for covered basic services and major services during the first year of eligibility. The coinsurance percentage will increase by 10% each year (to a maximum of 100%) for each enrollee if that person visits the dentist at least once during the year. If an enrollee does not use the plan during the calendar year, the percentage remains at the level attained the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.

Eligibility	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to age **26**	
Deductibles Deductibles waived for D & P?	N/A N/A	
Maximums	The maximum benefit paid per calendar year is **$1,700*** per person in-network (this amount includes the additional $200 for using a PPO dentist. See note above under Network) The maximum benefit paid per calendar year is **$1,500** per person out-of-network	
Waiting Period(s)	Basic Benefits None	Major Benefits None

Benefits and Covered Services*	**In-PPO Premier Network****	**Non-Delta Providers****
Diagnostic & Preventive Services (D & P) Exams, 2 cleanings per cal year, x-rays	70-100 %	70-100% UCR
Basic Services Fillings, simple tooth extractions, sealants	70-100 %	70-100% UCR
Endodontics (root canals) Covered Under Basic Services	70-100 %	70-100% UCR
Periodontics (gum treatment) Covered Under Basic Services	70-100 %	70-100% UCR
Oral Surgery Covered Under Basic Services	70-100 %	70-100% UCR
Major Services Crowns, inlays, onlays, and cast restorations	70-100 %	70-100% UCR
Prosthodontics Bridges, dentures, implants	50 %	50% UCR
Dental Accident Benefits	100% (separate $1,000 maximum per person per calendar year)	

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for out-of-network dentists.

Delta Dental of California 100 First St. San Francisco, CA 94105	**Customer Service** **866-499-3001**	**Claims Address** P.O. Box 997330 Sacramento, CA 95899-7330

deltadentalins.com

Lucia Mar Unified School District Classified Delta Dental PPO Plan (#7074-7216)

Plan Benefit Highlights for:	**PPO $1,500 without Orthodontic**
Group No:	**Active, Retiree, and Cobra**

Eligibility	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to age **26**		
Deductibles Deductibles waived for D & P?	In-Network: **N/A** Out-of-Network: **$25** per person, **$75** per family, per plan year		
	In-Network: **N/A** Out-of-Network: **No**		
Maximums	The maximum benefit paid per calendar year is **$1,500** per person in-network The maximum benefit paid per calendar year is **$1,000** per person out-of-network		
Waiting Period(s)	Basic Benefits None	Major Benefits None	Orthodontics None

Benefits and Covered Services*	**In-PPO Network****	**Out-of-PPO Network****
Diagnostic & Preventive Services (D & P) Exams, 2 cleanings, x-rays	100 %	50 %
Basic Services Fillings, simple tooth extractions, sealants	100 %	50 %
Endodontics (root canals) Covered Under Basic Services	100 %	50 %
Periodontics (gum treatment) Covered Under Basic Services	100 %	50 %
Oral Surgery Covered Under Basic Services	100 %	50 %
Major Services Crowns, inlays, onlays and cast restorations	100 %	50 %
Prosthodontics Bridges, dentures, implants	50 %	50 %
Dental Accident Benefits	100% (separate $1,000 maximum per person per calendar year)	50%

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of California 100 First St. San Francisco, CA 94105	**Customer Service** 866-499-3001	**Claims Address** P.O. Box 997330 Sacramento, CA 95899-7330

deltadentalins.com

Your VSP Vision Benefits

Welcome to VSP® Vision Care. We'll help keep you and your eyes healthy through personalized care from a doctor you can trust.

Your eyes say a lot about you and can even tell your VSP doctor about you. During your WellVision Exam®, your VSP doctor will look for vision problems and signs of health conditions too.

Getting started is a breeze.

- **Find the right VSP doctor for you.** You'll find plenty to choose from at **vsp.com** or by calling **800.877.7195**.
- **Already have a VSP doctor?** At your appointment, tell them you're a VSP member.
- **Check out your coverage and savings.** Visit **vsp.com** to see your benefits anytime and check out how much you saved with VSP after your appointment.

That's it! We'll handle the rest—no ID card necessary or claim forms to complete.

Visit the Eyecare Discovery Center® at **vsp.com** for eye health articles, videos, and interactive games.

Keep your eyes healthy and your vision clear with VSP.

Contact VSP | **vsp.com** **800.877.7195**

VSP® Vision care for life

JOB#1750CM 5/09

Lucia Mar Unified School District Classified Vision Plan

SISC and VSP provide you an affordable eyecare plan.

Signature Plan C – Dual Copay $15/$25

Your Coverage from a VSP Doctor

WellVision Exam® focuses on your eye health and overall wellness ..... ***every calendar year***

Prescription Glasses

Lenses ..... ***every calendar year***

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

Frame ..... ***every calendar year***

- *$150.00 allowance for frame of your choice*
- *$170.00 featured frame brands*
- *20% off the amount over your allowance*
- *$80 allowance at Costco*

~OR~

Contact Lens Allowance ..... ***every calendar year***

$105.00 allowance for contacts and the contact lens exam (fitting and evaluation).

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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*

Contacts

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

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*

Co-Payments

Exam Copay……$xx.xx
Materials Copay (Glasses)……$xx.xx

If you see a non-VSP provider, you'll receive a lesser benefit. Before seeing a non-VSP provider, call us at 800.877.7195 for more details.

Out-of-Network Reimbursement Amounts:

Exam ..... *Up to $35.00*
Single vision lenses ..... *Up to $25.00*
Lined bifocal lenses ..... *Up to $40.00*
Lined trifocal lenses ..... *Up to $50.00*
Frame ..... *Up to $30.00*
Contacts ..... *Up to $90.00*

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.

LUCIA MAR UNIFIED SCHOOL DISTRICT
2018/2019 CLASSIFIED INSURANCE RATES

YOUR ANNUAL DISTRICT PAID BENEFIT (FULL-TIME EMPLOYEES): $10,000.00

MEDICAL PLAN 1
(40316H)

New $20 Co-pay

Daily Hours	*District Pays*	w/ DELTA DENTAL PREMIER (7074-7016) You Pay (10thly)	OR	w/ DELTA DENTAL PPO (7074-7216) You Pay (10thly)
8 HOURS	*$1,000.00*	**$764.85**		**$756.45**
7 HOURS	*$875.00*	**$889.85**		**$881.45**
6 HOURS	*$750.00*	**$1,014.85**		**$1,006.45**
5 HOURS	*$625.00*	**$1,139.85**		**$1,131.45**
4 HOURS	*$500.00*	**$1,264.85**		**$1,256.45**

MEDICAL PLAN 2
(40308E)

Daily Hours	*District Pays*	w/ DELTA DENTAL PREMIER (7074-7016) You Pay (10thly)	OR	w/ DELTA DENTAL PPO (7074-7216) You Pay (10thly)
8 HOURS	*$1,000.00*	**$558.45**		**$550.05**
7 HOURS	*$875.00*	**$683.45**		**$675.05**
6 HOURS	*$750.00*	**$808.45**		**$800.05**
5 HOURS	*$625.00*	**$933.45**		**$925.05**
4 HOURS	*$500.00*	**$1,058.45**		**$1,050.05**

MEDICAL PLAN 3
(40316K)

Daily Hours	*District Pays*	w/ DELTA DENTAL PREMIER (7074-7016) You Pay (10thly)	OR	w/ DELTA DENTAL PPO (7074-7216) You Pay (10thly)
8 HOURS	*$1,000.00*	**$395.25**		**$386.85**
7 HOURS	*$875.00*	**$520.25**		**$511.85**
6 HOURS	*$750.00*	**$645.25**		**$636.85**
5 HOURS	*$625.00*	**$770.25**		**$761.85**
4 HOURS	*$500.00*	**$895.25**		**$886.85**

MEDICAL PLAN 4
(40726D)

Daily Hours	*District Pays*	w/ DELTA DENTAL PREMIER (7074-7016) You Pay (10thly)	OR	w/ DELTA DENTAL PPO (7074-7216) You Pay (10thly)
8 HOURS	*$1,000.00*	**$266.85**		**$258.45**
7 HOURS	*$875.00*	**$391.85**		**$383.45**
6 HOURS	*$750.00*	**$516.85**		**$508.45**
5 HOURS	*$625.00*	**$641.85**		**$633.45**
4 HOURS	*$500.00*	**$766.85**		**$758.45**

MEDICAL PLAN 5
(40726A)

NEW! HSA ELIGIBLE

Daily Hours	*District Pays*	w/ DELTA DENTAL PREMIER (7074-7016) You Pay (10thly)	OR	w/ DELTA DENTAL PPO (7074-7216) You Pay (10thly)
8 HOURS	*$1,000.00*	**$184.05**		**$175.65**
7 HOURS	*$875.00*	**$309.05**		**$300.65**
6 HOURS	*$750.00*	**$434.05**		**$425.65**
5 HOURS	*$625.00*	**$559.05**		**$550.65**
4 HOURS	*$500.00*	**$684.05**		**$675.65**

All packages include $50,000 Life Ins, Vision, Behavioral Health & Supplemental Cancer coverage

The Deadline to turn in benefit forms for Open Enrollment:
June 8, 2018

2 TIER ANCHOR BRONZE PPO PLAN (70726B)

Offer for Classified Employees 4+ hours

With the assistance of Self-Insured Schools of California (SISC), LMUSD is offering a plan in accordance with the Affordable Care Act effective 10/01/14. You are receiving this notice because our records indicate you fall within eligibility parameters. Enrollment in the plan is not required; however, in order to meet strict compliance requirements, you must return this form acknowledging receipt of the information providing the *opportunity* to enroll. If you wish to enroll please obtain enrollment paperwork from Human Resources.

ELIGIBILITY - All permanent Classified employees holding one or more positions totaling four hours per day, five days per week are eligible to opt-in to this plan. Those opting in may elect a coverage level of employee or employee + child(ren); **spouses, domestic partners and retirees may not be added.**

ENROLLMENT - Participation in the Bronze plan is voluntary. The plan year runs October 1 - September 30. Current staff and active subs eligible for the plan will be provided with a designated open enrollment period each year in which they may opt-in or out of the Bronze plan for the following plan year. If enrollment is elected, the employee must complete an enrollment form, provide required documentation (birth certificate) if enrolling dependent children, sign a payment agreement and remit the first premium payment due by the 20th of the month prior to the first coverage month. Those that choose to opt-out will be required to wait until the following year's open enrollment for the next opportunity to enroll. Newly-hired staff/subs falling within eligibility parameters of the plan will be provided the opportunity to enroll in time to begin coverage October 1st or the first day of the month following the date of hire (DOH) if hired mid-plan year, depending on DOH.

2 Tier Anchor Bronze Plan
70726B

Daily Hours	*District Pays*	Employee You Pay (10thly)	OR	Employee + Child(ren) You Pay (10thly)
8 HOURS	*$1,000*	**$0.00**		**$14.00**
7 HOURS	*$875.00*	**$0.00**		**$139.00**
6 HOURS	*$750.00*	**$0.00**		**$264.00**
5 HOURS	*$625.00*	**$20.60**		**$389.00**
4 HOURS	*$500.00*	**$145.60**		**$514.00**

70% ANTHEM BLUE CROSS PPO PLAN (GROUP #70308B)	
Medical **& Prescription** Deductible	$5,000 indiv / $10,000 fam
Calendar Year Out Of Pocket Max	$6,350 indiv / $12,700 fam
Office visit co-pay	Subject to Deductible. The plan pays 30% AFTER deductible is met
Prescriptions (generic / brand name)	$9 / $35 AFTER deductible is met