

Conejo Valley
Unified School District
Benefits Administration
School Sites
EMPLOYEE BENEFITS 2021-2022

Poms & Associates Insurance Brokers | CA License #0814733



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CONTACTS

District Office

750 Mitchell Road
Newbury Park, CA 91320

Name/Title	Phone Number	Fax Number
Liz Grigsby– Benefits Specialist e-mail: egrigsby@conejousd.org	(805) 498-4557 x7411	N/A

District Benefits Website: www.conejousd.org

Click on Departments > Human Resources > Employee Benefits

Anthem Blue Cross - HMO

801 South Figueroa Street, 5th Floor
Los Angeles, CA 90017
Group Number/Purchaser ID: 275928
www.anthem.com

Name/Title	Phone Number	Fax Number
Customer Service Call Center	(800) 759-3030	N/A
IngenioRx Pharmacy/Pre-Authorizations	(833) 296-5039	N/A
IngenioRx – Mail Order Service	(833) 296-5039	N/A

Anthem Blue Cross - PPO

801 South Figueroa Street, 5th Floor

Los Angeles, CA 90017

Group Number/Purchaser ID: 275928

www.anthem.com

Name/Title	Phone Number	Fax Number
Customer Service Call Center	(800) 759-3030	N/A
IngenioRx Pharmacy/Pre-Authorizations	(833) 296-5039	N/A
IngenioRx – Mail Order Service	(833) 296-5039	N/A

Kaiser Permanente

3100 Thornton Ave., 4th Floor

Burbank, CA 91504

Group Number/Purchaser ID: 101877

www.kaiserpermanente.org

Name/Title	Phone Number	Fax Number
Administrative support for Members Hours: 7am – 7pm, seven days a week	(800) 464-4000	N/A

Delta Dental

12898 Towne Center Drive

Cerritos, CA 90703

Group Number/Purchaser ID: 1349

www.deltadentalca.org

Name/Title	Phone Number	Fax Number
Customer Service	(800) 765-6003	N/A

VSP

111 West Ocean Blvd., Suite 1625
Long Beach, CA 90802
Group Number/Purchaser ID: 12146862
www.vsp.com

Name/Title	Phone Number	Fax Number
Customer Service		
Questions regarding plan coverage & eligibility	(800) VSP-7195	N/A

Standard Life Insurance Company

P.O. Box 4744
Portland, OR 96208
Group Number/Purchaser ID: 503030-3000
www.standard.com

Name/Title	Phone Number	Fax Number
Life Benefits	800-628-8600	N/A
Customer Service	888-937-4783	N/A

MEDICAL INSURANCE

Anthem Blue Cross HMO

Plan:	HMO
Carrier:	Anthem Blue Cross
Policy Number:	275928
Plan Renewal Date:	7/1/2022
Dependent Age Limit:	Until age 26

Deductible

Individual	N/A
Family	N/A
Hospital Admission	N/A

Annual Copay Maximum

Individual	\$1,000
Family	\$2,000

Hospital Services

Room & Board	No Charge
Surgery	No Charge
Emergency	\$100 (waived if admitted)

Physician Services

Office Visit	\$30
Hospital Visit	No Charge
Diagnostic X-Ray & Lab	No Charge

Extended Care

Home Health (up to 100 visits/yr)	No Charge
Out-patient Physical Therapy	\$30 per visit
Hospice	No Charge

Prescription Drugs

Retail (30-day supply)

Generic	\$15
Brand	\$30
Brand- Non Formulary	\$50

Mail Order (90-day supply)

Generic	\$30
Brand	\$60
Brand – Non Formulary	\$100

Mental Health

Inpatient	No Charge
Outpatient	\$30 copay

Alcohol & Substance Abuse

Inpatient	No Charge
Outpatient	\$30 copay
Detox	No Charge

Wellness

Periodic Health Evaluations	No Charge
Routine Immunizations	No Charge
Hearing Screening	No Charge

Vision

Exams	No Charge
Frames	Not covered
Lenses	Not covered

Other Services

Skilled Nursing Facility	No Charge
Durable Medical Equipment	20% of allowed charges, max \$5,000/calendar yr
Ambulance	No Charge
Chiropractic	\$30 per visit, 20 visit calendar yr. max

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It is not intended to be all inclusive. For complete details on exclusions and limitations, refer to the plan booklets.

Anthem Blue Cross PPO

Plan:	PPO
Carrier:	Anthem Blue Cross
Policy Number:	275928
Plan Renewal Date:	7/01/2022
Dependent Age Limit:	Until age 26

	PPO	Non-PPO
Lifetime Maximum		Unlimited
Deductible		
Individual	\$500	\$1,000
Family	\$1,250	\$3,000
Annual Out of Pocket Maximum		
Individual	\$2,000	\$8,000
Family	\$4,000	\$16,000
Physician Services		Member pays: 60%
Office Visit	80%	+ \$25 copay
Hospital Services		
Room & Board	80%	40%
Surgery	80%	40%
Emergency	80%, deduct. waived if admitted	80%, deduct. waived if admitted
Prescription Drugs		
Deductible		\$100/member
<u>Retail</u>		
Generic	\$15 up to 30-day supply	
Brand	\$30 up to 30-day supply	
<u>Mail Order</u>		
Generic	\$30 up to 90-day supply	
Brand	\$60 up to 90-day supply	
Mental Health		
Inpatient	80%	40%
Outpatient	80%	40%

Alcohol & Substance**Abuse**

Inpatient	80%	40%
Outpatient	80%	40%

Wellness

Routine Physical Exams	No Charge	Member pays: 60% + \$25 copay
Well Child	No Charge	Member pays: 60% + \$25 copay

Vision

Exams	
Frames	Not covered
Lenses	

Other Services

Skilled Nursing Facility	80%	80%
Durable Med.	80%	40%
Equipment		

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and limitations, refer to the plan booklets.*

Kaiser

Plan:	HMO
Carrier:	Kaiser Permanente
Policy Number:	101877
Plan Renewal Date:	7/1/2022
Dependent Age Limit:	Until age 26

Deductible

Individual	N/A
Family	N/A
Hospital Admission	N/A

Annual Copay Maximum

Individual	\$1,500
Family	\$3,000

Hospital Services

Room & Board	No Charge
Outpatient Surgery	No Charge
Emergency	\$100 per visit (does not apply if admitted)

Physician Services

Office Visit	\$30 per visit
Hospital Visit	No Charge
Diagnostic X-Ray & Lab	No Charge

Extended Care

Home Health	No Charge (up to 100 visits per calendar year)
Out-patient	\$30 per visit
Physical-Therapy	
Hospice	No Charge

Alcohol & Substance Abuse

Inpatient (Detox Only)	No Charge
Outpatient	
Individual session	\$30 per visit
Group session	\$5 per visit

Wellness

Routine Physical Exam	No Charge
Routine Immunizations	No Charge

Hearing Screening	No Charge
Prescription Drugs	
<i>Retail- 30 day supply</i>	
Generic	\$15
Brand	\$30
<i>Mail Order- 90 day supply</i>	
Generic	\$30
Brand	\$60
Vision	
Exam	No Charge
Frames	Not covered
Lenses	Not covered
Mental Health	
Inpatient	No Charge (up to 45 days per calendar year)
Outpatient	
Individual session	\$30 per visit
Group session	\$15 per visit
Other Services	
Skilled Nursing Facility	No Charge (up to 100 days per calendar year)
Durable Medical Equipment	20%
Ambulance	\$50 per trip
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Kaiser Bronze Plan

Plan:	Bronze HMO
Carrier:	Kaiser Permanente
Policy Number:	101877
Plan Renewal Date:	7/1/2022
Dependent Age Limit:	Until age 26

Deductible

Individual	\$4,500
Family	\$9,000

Annual Copay Maximum

Individual	\$6,000
Family	\$12,000

Hospital Services

Room & Board	40%
Outpatient Surgery	40%
Emergency	\$250 per visit (does not apply if admitted)

Physician Services

Office Visit	\$50 per visit
Hospital Visit	40%
Diagnostic X-Ray & Lab	40%

Extended Care

Home Health	No Charge (up to 100 visits per calendar year)
Out-patient Physical-Therapy	\$50 per visit
Hospice	No Charge

Alcohol & Substance Abuse

Inpatient (Detox Only)	40%
Outpatient	
Individual session	\$50 per visit
Group session	\$5 per visit

Wellness

Routine Physical Exam	No Charge
Routine Immunizations	No Charge
Hearing Screening	No Charge

Prescription Drugs*Retail- 30 day supply*

Generic	\$15
Brand	\$35

Mail Order- 90 day supply

Generic	\$30
Brand	\$70

Vision

Exam	No Charge
Frames	Not covered
Lenses	Not covered

Mental Health

Inpatient	No Charge (up to 45 days per calendar year)
Outpatient	
Individual session	\$50 per visit
Group session	\$5 per visit

Other Services

Skilled Nursing Facility	40% (up to 100 days per calendar year)
Durable Medical Equipment	40%
Ambulance	40%

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and limitations, refer to the plan booklets.*

DENTAL INSURANCE

Delta Dental

Carrier:	Delta Dental
Policy Number:	1349
Plan Renewal Date:	7/1/2022
Dependent Age Limit:	Until age 19 or 26, if full-time student

Annual Maximum	\$1,700 In network/ \$1,500 Out of Network
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Calendar Year Deductible

Individual	N/A
Family	N/A

Preventive & Diagnostic:

Office Exams	70% - 100%
Cleanings	70% - 100%
X-Rays	70% - 100%

Basic Services

Basic Restorative	70% - 100%
Endodontics	70% - 100%

Major Restoration

Prosthodontics	50%
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Implants	50%
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Orthodontia (Child only)

Maximum	50% to \$1,000 lifetime max. per person
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VISION INSURANCE

VSP

Carrier:	VSP
Policy Number:	12146862
Plan Renewal Date:	7/1/2022
Dependent Age Limit:	Until age 19 or 26, if full-time student

	Provider	Non- Provider
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Vision Care Services:	Every 12 months	
Vision Examination	Covered in full	\$45 Reimbursement

Vision Care Materials:	Every 24 months	
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Lenses:		
Single Vision	Covered in full	\$45 Reimbursement
Bifocal	Covered in full	\$65 Reimbursement

Frames:	\$150 Allowance	\$45 Reimbursement
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Contact Lenses:	Every 24 months	
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Visually Necessary		
Professional Fees & Materials	Covered in full	\$210 Reimbursement

Elective		
Professional Fees & Materials	\$100 Allowance	\$105 Allowance

Covered Contact Lenses		
Professional Fees & Materials	Covered in full	\$210 Reimbursement

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LIFE INSURANCE

Standard Insurance Company

Carrier: Standard Insurance Company

Policy Numbers: 503030-3000

Plan Renewal Date: 7/1/2022

Term Life

Schedule of Life Insurance

Basic Life & AD&D	\$50,000
Basic Dep. Life & AD&D	\$1,500
Buy-up option	\$5,000
Supplemental Life & AD&D	\$50,000
Supplemental Plus Life & AD&D	\$50,000

Dependent Life Benefit:

\$1,500

NOTES:

