

GGUSD Insurance Options 10/01/16 - 12/31/2017

Insurance Department: 714-663-6523

| MEDICAL OPTIONS | | | |
|--|---|--|--|
| Plan Features | Self-Insured PPO (Nationwide) | Self-Insured EPO (CA Only) | HMO (CA Only) |
| Deductible | Individual: \$300 Family: \$900 | Individual: \$300 Family: \$900 | None |
| Out-Of-Pocket Max | <u>In-Network</u> Individual: \$2,500 Family: \$7,500 <u>Non-Network</u> Individual: \$3,500 Family: \$12,700 <small>(member always responsible for amount exceeding allowable rates even after meeting OOP Max)</small> | <u>In-Network</u> Individual: \$2,500 Family: \$7,500 <u>Non-Network</u> NO COVERAGE | <u>In-Network</u> Individual: \$2,000 Family: \$6,000 <u>Non-Network</u> NO COVERAGE |
| Primary / Specialist Office Visit | \$25 copay + 20% coinsurance (30% coinsurance for Non-Network) | \$25 copay | \$25 copay (Referral to Specialist needed from PCP) |
| Chiropractor / Acupuncture Office Visit | \$25 copay + 20% coinsurance (30% coinsurance for Non-Network) | \$25 copay (Limit 20 visits per Calendar year each) | **2017 change: Chiropractor: \$25 copay (Limit 60 visits per Calendar year; combined with Physical, Occupational & Speech Therapy) Acupuncture: No Coverage |
| Lab / Xray | 20% coinsurance (30% coinsurance for Non-Network) | 0% coinsurance | No Charge |
| Hospital Inpatient / Outpatient | 20% coinsurance (30% coinsurance for Non-Network) | **2016-2017 change: 0% coinsurance for In-Network (eliminated the tiered hospital system) | \$100 copay / day (\$300 max per admission) |
| Emergency Room <small>(True emergency medical condition treated as In-Network until patient stabilized)</small> | \$100 copay + 20% coinsurance (30% coinsurance for Non-Network) | \$100 copay | \$100 copay |
| Emergency Transportation | 20% coinsurance (30% coinsurance for Non-Network) | 0% coinsurance | No Charge |
| Urgent Care | \$25 copay + 20% coinsurance (30% coinsurance for Non-Network) | \$25 copay (Non-Network has no coverage) | \$25 copay **2017 change: (Non-Network covered as In-Network) |
| Prescription Drugs | \$5 - Most Generic \$10 - Brand Name & select Generic \$35 - Select (within each class) | \$5 - Most Generic \$10 - Brand Name & select Generic \$35 - Select (within each class) | \$5 - Most Generic \$15 - Brand Name & select Generic \$30 - Non-Formulary & Select |
| Network & Co-Insurance % | - Usage: Calendar Year - Provider Network: CA: Blue Cross PPO Prudent Buyer Large Group Outside of CA: National PPO (Blue Card PPO) - Coinsurance: <u>In-Network:</u> 20% coinsurance <u>Non-Network:</u> 30% coinsurance plus amount exceeding allowable rates | - Usage: Calendar Year - Provider Network: CA ONLY: Blue Cross PPO Prudent Buyer Large Group - Coinsurance: <u>In-Network ONLY:</u> 0% coinsurance | - Usage: Calendar Year - Provider Network: **2016-2017 change: CA ONLY: *10/1/16 - 12/31/16: United HealthCare SignatureValue (HMO) *1/1/17 - 12/31/17: Blue Cross HMO (CACARE) Large Group - Must elect Primary Care Physician (PCP) & stay within chosen Medical Group for services. - PCP & Medical Group can be changed by calling carrier. |
| Contact Info | EBA&M (Med): 855-322-7606 American Health Care (RX): 800-872-8276 | EBA&M (Med): 855-322-7606 American Health Care (RX): 800-872-8276 | <u>Anthem Blue Cross</u> 800-888-8288 |

| DENTAL OPTIONS | | |
|--------------------------------------|---|--|
| Plan Features | Self-Insured Dental (Nationwide) | Dental HMO (CA Only) |
| Deductible | Individual: \$25 Family: \$75 | None |
| Annual Limit | \$2,000 per member | None |
| Preventive (routine teeth cleanings) | Plan pays 90% (4 times per year) | Plan pays 100% (2 times per year) |
| Major/Minor services | <u>In-Network:</u> plan pays 90% <u>Non-Network:</u> plan pays 90% of allowable rates only **2016-2017 change: adding Implant coverage | Plan pays 100% for most covered services |
| Orthodontia | Plan pays 50% up to \$2,800 lifetime max | Member pays \$1,500 for patient under 19 & \$2,000 for patient 19 and older |
| Network/Info | - Usage: Calendar Year - Provider Network: CA & Outside of CA: First Dental Health "PPO/EPO" | - Usage: Calendar Year - Provider Network: CA ONLY: DHMO Concordia Plus - Must elect Primary Dentist |
| Contact | EBA&M: 855-322-7606 | United Concordia: 866-357-3304 |

| VISION | |
|---------------------|--|
| Eye Exam: | \$25 copay (1 per 12 mos) |
| Frames OR Contacts: | Standard Lenses \$0 copay (1 per 12 mos) \$120-140 frame allowance (1 per 24 mos) OR \$105 contacts allowance (1 per 12 mos) |
| 2nd Pair Benefit: | Standard Lenses \$0 copay (1 per 12 mos) OR \$200 contacts allowance (1 per 12 mos) |
| Network/Info | - Usage: Date of Service to Date of Service - Provider Network: VSP |
| Contact | 800-877-7195 |

| LIFE | |
|------|--|
| | Regular: \$50,000 Management: \$70,000 |
| | <u>Dependent coverage:</u> - Spouse Regular: \$1,000 - Spouse Management: \$5,000 - Child under 15 days: \$100 - Child 15 days through age 20: \$1,000 - Child through age 24 (if full-time student): \$1,000 |
| | ***Don't forget to keep Insurance Department updated on beneficiaries |
| | **2016-2017 change: MetLife (from Lincoln Financial Group) |
| | 800-438-6388 |

| ~Optional~ FSA (PayPro) | |
|-------------------------|---|
| Health Care limit | \$2600 (up to \$500 carryover of unused funds) |
| Dependent Care limit | \$5,000 |
| Network/Info | Usage: Plan Year 1/1/17 to 12/31/17 (unavailable 10/1/16 to 12/31/16) |
| Contact | 951-656-9273 |

Note: This chart is for your convenience and is not a complete benefit description; please refer to Summary Plan Descriptions (SPDs) available at www.ggusd.us (Departments/Insurance)