GGUSD Insurance Options 01/01/2018 - 12/31/2018

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	In-Network Individual: $2,500 Family: $7,500 Non-Network Individual: $3,500 Family: $12,700 (member always responsible for amount exceeding allowable rates even after meeting OOP Max)	In-Network Individual: $2,500 Family: $7,500 Non-Network NO COVERAGE	In-Network Individual: $2,000 Family: $6,000 Non-Network 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)
Chiropractic / Acupuncture Office Visit	$25 copay + 20% coinsurance (30% coinsurance for Non-Network)	$25 copay (Limit 60 visits per Calendar year; combined with Physical Therapy, Chiropractic & Acupuncture)	Chiropractic: $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)	0% coinsurance	$100 copay / day ($300 max per admission)
Emergency Room (True emergency medical condition treated as In-Network until patient stabilized)	$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 (Non-Network covered as In-Network; contact PCP or medical group first)
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:** In-Network: 20% coinsurance Non-Network: 30% coinsurance plus amount exceeding allowable rates	- Usage: Calendar Year - **Provider Network:** CA ONLY: Blue Cross PPO Prudent Buyer Large Group - **Coinsurance:** In-Network ONLY: 0% coinsurance	- Usage: Calendar Year - **Provider Network:** CA ONLY: 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	Anthem Blue Cross: 800-888-8288

DENTAL OPTIONS		
Plan Features	**Self-Insured Dental PPO (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% of Negotiated Rates (NR) to 105% of Usual and Customary Rates (UCR). (4 times per year)	Plan pays 100% (2 times per year)
Major/Minor services	In-Network: plan pays 90% of NR Non-Network*: plan pays 105% of UCR *providers could balance bill you; best to stay In-Network	Plan pays 100% for most covered services. See Schedule of Benefits for details.
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: Dental Guard Preferred PPO	- Usage: Calendar Year - **Provider Network:** CA ONLY: DHMO Concordia Plus - Must elect Primary Dentist
Contact	Guardian: 800-541-7846	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 Signature
Contact	800-877-7195

LIFE
Regular: $50,000 Management: $70,000
Dependent coverage: - Spouse Regular: $1,000 -Spouse Management: $5,000 - Child under 6 months: $100 - Child 6 months up to age 26: $1,000
***Don't forget to keep Insurance Department updated on beneficiares
MetLife
800-438-6388

~Optional~ FSA (PayPro)	
Health Care limit	$2,600 **(up to $500 carryover of unused funds)**
Dependent Care limit	$5,000
Network/Info	Usage: Calendar Year To continue FSA plans, you must re-enroll each year.
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/insurance**

10/2/2017