DENTAL - *Provided by Guardian Life Ins. Co.*

BENEFIT	Preferred Plan	Select Plan	Custom With Ortho
CY Max	$1500 / $1500	$1000	$1500 / $1000
Deductible			
Individual	$50	$50	$50
Family	$150	$150	$150
Preventive	100% / 100%	100% / 80%	100% / 80%
Basic	90% / 80%	80% / 70%	90% / 80%
Major	60% / 50%	50% / 40%	60% / 50%
Orthodontia	Not Covered	Not Covered	Covered
Children Only			50%
Lifetime Max			$1000
Non-Network	UCR 90th %	UCR 90th %	UCR 90th %
Rollover Amt	$350	$250	$250
Monthly Rates:			
Employee	$41.00	$25.19	$42.00
EE & Spouse	$80.00	$48.75	$82.00
EE & Child(ren)	$100.00	$58.29	$84.00
Family	$142.00	$82.32	$127.00

VISION - *Provided by Vision Service Plan (VSP)*

BENEFIT	In-Network	Non-Network
Examination	$10 Copay, 1 exam every 12 months	
Material Copay	$10	
Lenses	Every 12 Months	
Contacts	In Lieu of Lenses	
Frames	Every 24 Months	
Frame Maximum	$120 plus 20% discount on amount above the allowance	$50
Laser Surgery	15% discount on PRK, LASIK and Custom LASIK	
Other Benefits	20% discount on non-covered services such as designer frames, tinted lenses, and progressive bifocals.	
Monthly Rates:		
Employee	$5.30	
Employee & Spouse	$10.60	
Employee & Child(ren)	$11.00	
Family	$18.10	

LIFE INSURANCE - *Provided by The Hartford*

BENEFIT	$25,000
Monthly Rate:	$5.00

EAP - *Provided by The Hartford*

Telephonic Counseling Sessions	**Unlimited**
Monthly Rate:	Included in the Life Insurance Rate

Contact Information

Health Plan Questions	Heffernan Insurance Brokers Kristen Beeman Employee Benefit Department 800 234-6787
Eligibility, Billing, & COBRA	United Administrative Services 408-288-4460
Guardian Dental	Member Services 1-800-541-7846
Vision Service Plan	Member Services 800-877-7195
Hartford Life Ins.	1-800-523-2233 gdbcustomerservice@hartfordlife.com
Hartford EAP	1-800-964-3577 www.guidanceresources.com

ABC Golden Gate Chapter Office

Jackie Martin - (800) 748-6742
jackie@abc-ggc.org

This document is intended to be a benefit summary only.
All Summary Plan Documents take precedence.

Prepared by Heffernan Insurance Brokers

HEFFERNAN INSURANCE BROKERS

A Member of the Heffernan Group
License #0564249

Golden Gate Chapter

SUMMARY OF EMPLOYEE BENEFIT PLANS

Member Firms

January 1 – December 31, 2010

MEDICAL BENEFITS OFFERED BY ABC-GGC…

As a Member of the ABC-GGC Benefit Trust Fund, you and your employees are eligible to participate in medical, dental, vision, life insurance and EAP Counseling services.

Choose from the following Medical Plans:

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PLAN HIGHLIGHTS	HMO OPTIONS			HSA PLAN	PPO PLAN	
	PacifiCare Preferred HMO	PacifiCare Select HMO	Kaiser HMO	Kaiser HSA High Deductible	UHC/PacifiCare PPO	
				Deductible applies to all services except as noted below	Network	Non-Network
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	$5,000,000	
Annual Deductible						
Individual	None	None	None	$1,500 (for self only enrollment)	$250	
Family	None	None	None	$3,000 (entire amount must be met if EE & 1 or more dependents are enrolled)	$500	
Out of Pocket Maximum						
Individual	$2,000	$2,000	$1,500	$1,500 (for self only enrollment)	$2,000	$6,000
Family	$5,000	$5,000	$3,000	$3,000 (entire amount must be met if EE & 1 or more dependents are enrolled)	$4,000	$12,000
Professional Services						
PCP	$15 Copay	$20 Copay	$20 Copay	100% after deductible	$20 Copay	60% after deductible
Specialist	$15 Copay	$20 Copay	$20 Copay	100% after deductible	$20 Copay	60% after deductible
Physical Therapy	$15 Copay	$20 Copay	$20 Copay	100% after deductible	80% after deductible	60% after deductible
Hospital Services						
Inpatient	$250 Copay	80% after $250 Copay	$250 Copay	100% after deductible	80% after deductible	60% after $500 deductible
Outpatient	$100 Copay	$50 Copay	$20 Copay	100% after deductible	80% after deductible	60% after $250 deductible
Emergency Room	$100 Copay	$50 Copay	$100 Copay	100% after deductible	$50 Copay	$50 Copay
Lab & X-Ray	No Charge	No Charge	No Charge	100% after deductible	$20 Copay	60% after deductible
Well Care						
Baby	No Charge	No Charge	$5 Copay	No Charge, Deductible Doesn't Apply	80% after deductible	60% after deductible
Adult	$15 Copay	$20 Copay	$5 Copay	No Charge, Deductible Doesn't Apply	$20 Copay	60% after deductible
Vision & Hearing	$15 Copay	$20 Copay	$20 Copay	100% after deductible	$20 Copay	60% after deductible
Mental Heath						
Inpatient	$250 Copay	80% after $250 Copay	$250 Copay	100% after deductible	80% after deductible	Not Covered
Outpatient	$15 Copay	$20 Copay	$20 Copay	100% after deductible	90% after deductible	70% after deductible
Chemical Dependency						
Inpatient	$250 Copay	80% after $250 Copay	$250 Copay	100% after deductible	90% after deductible	70% after deductible
Outpatient	$15 Copay	$20 Copay	$20 Copay	100% after deductible	80% after deductible	60% after deductible
Prescription Drug						
Retail (30 days)						
Generic	$20 Copay	$20 Copay	$10 Copay	100% after deductible	$20 Copay	
Brand	$30 Copay	$30 Copay	$30 Copay	100% after deductible	$30 Copay	
Mail Order						
Generic	$40 Copay	$40 Copay	$20 Copay	100% after deductible	$40 Copay	
Brand	$60 Copay	$60 Copay	$60 Copay	100% after deductible	$60 Copay	
Monthly Rate:						
Employee Only	$411.07	$375.62	$353.06	$306.74	$614.82	
EE & Spouse	$930.42	$850.13	$798.98	$694.16	$1,346.54	
EE & Child(ren)	$814.27	$743.12	$698.36	$712.73	$1,168.22	
EE & Family	$1,298.24	$1,185.25	$1,113.92	$967.76	$1,869.16	