Gulfport School District

CADENCE Insurance
A Gallagher Company

Coverage & Costs

Medical Insurance - *Base Plan*

Carrier: BCBS of MS

Your Monthly Contribution: (Hired before 1/1/2006)-Legacy	
Employee	$0.00
Employee + Spouse	$527.00
Employee +Spouse + Child(ren)	$802.00
Employee + Child	$137.00
Employee + Children	$350.00

Your Monthly Contribution: (Hired on or after 1/1/2006)-Horizon	
Employee	$0.00
Employee + Spouse	$527.00
Employee +Spouse + Child(ren)	$802.00
Employee + Child	$137.00
Employee + Children	$350.00

2025 Plan Year Benefits

	In-Network	Out-of-Network
Deductible:	$1,800 Individual	$1,800 Individual
	$3,300 Family	$3,300 Family
Office Copay: Primary/Specialist	Ded. & Coins.	Ded. & Coins.
Coinsurance:	80%	60%
Out of Pocket Maximum:	$6,500 Individual	No Limit
	$13,000 Family	No Limit
Emergency Room:	1st Visit $50 copay	Ded. & Coins.
	2nd Visit $200 copay	
	Every visit after Ded. & Coins.	
Urgent Care:	Ded. & Coins.	Ded. & Coins.
Diagnostic Services:	Ded. & Coins.	Ded. & Coins.
Inpatient Hospital:	Ded. & Coins.	Ded. & Coins.
Outpatient Hospital:	Ded. & Coins.	Ded. & Coins.
Retail Pharmacy: *30 day supply*	$75 Preventive Medications Deductible	
	Generic: $12	Employee pays 100%, then request reimbursement of the in-network amount, less the applicable deductible or copay
	Preferred Brand: $45	
	Non-preferred Brand: $100	
	Non-preferred Brand: $100	
	Specialty: $100	Not Covered
Preventive Care	100%	Not Covered

Medical Insurance - *Select Plan*

Carrier: BCBS of MS

Your Monthly Contribution: (Hired before 1/1/2006)-Legacy	
Employee	$20.00
Employee + Spouse	$620.00
Employee +Spouse + Child(ren)	$896.00
Employee + Child	$231.00
Employee + Children	$442.00

Your Monthly Contribution: (Hired on or after 1/1/2006)-Horizon	
Employee	$50.00
Employee + Spouse	$650.00
Employee +Spouse + Child(ren)	$926.00
Employee + Child	$261.00
Employee + Children	$472.00

	In-Network	Out-of-Network
Deductible:	$1,800 Individual	$2,300 Individual
	$3,600 Family	$4,600 Family
Office Copay: Primary/Specialist	$25 / 20%	Ded. & Coins.
Coinsurance:	80%	60%
Out of Pocket Maximum:	$6,500 Individual	No Limit
	$13,000 Family	No Limit
Emergency Room:	1st Visit $50 copay	Ded. & Coins.
	2nd Visit $200 copay	
	Every visit after Ded. & Coins.	
Urgent Care:	Ded. & Coins.	Ded. & Coins.
Diagnostic Services:	Ded. & Coins.	Ded. & Coins.
Inpatient Hospital:	Ded. & Coins.	Ded. & Coins.
Outpatient Hospital:	Ded. & Coins.	Ded. & Coins.
Retail Pharmacy: *30 day supply*	$75 Preventive Medications Deductible	
	Generic: $12	Employee pays 100%, then request reimbursement of the in-network amount, less the applicable deductible or copay.
	Preferred Brand: $45	
	Non-preferred Brand: $100	
	Non-preferred Brand: $100	
	Specialty: $100	Not Covered
Preventive Care	100%	Not Covered

Coverage & Costs

Dental Insurance

Carrier: Guardian

Your Monthly Contribution:

Employee	**$20.15**
Employee + Spouse	**$39.56**
Employee + Child(ren)	**$54.17**
Family	**$80.23**

2025 Plan Year Benefits

	In-Network:	Out-of-Network:
Annual Individual Deductible: *(waived for preventive)*	**$50**	**$50**
Annual Family Deductible:	**$150**	**$150**
Per Person Benefit Maximum:	**$1,500**	**$1,500**
Lifetime Orthodontia Maximum:	**$1,000**	**$1,000**
Preventive: exams, cleaning, bitewing X-Rays, fluoride treatments (to age 16), sealants (to age 16), and space maintainers/harmful habit appliances.	**100%**	**100%**
Basic: X-Rays, fillings, simple extractions, single crowns, repair & Maintenance of crowns, bridges & dentures, inlays, onlays and veneers.	**90%**	**80%**
Major: Bridges & dentures, endodontics services, complex extractions, general anesthesia, combined cleanings/perio maintenance, periodontal services and periodontal surgery.	**60%**	**50%**
Orthodontic Services: Available to Dependent Children to age 26	**50%**	**50%**

Vision Insurance

Carrier: Unum

Your Monthly Contribution:

Employee	**$7.86**
Employee + Spouse	**$15.72**
Employee + Child(ren)	**$17.20**
Family	**$26.78**

Benefit Frequency:		
Exams	**Once every 12 Months**	
Lenses or Contacts	**Once every 12 Months**	
Frames	**Once every 12 Months**	
Copays / Allowance:	**In-Network:**	**Out-of-Network:**
Exams	**$10 Copay**	**Up to $35**
Single Vision Lenses	**Covered after $10 Copay**	**Up to $25**
Bifocal Lenses	**Covered after $10 Copay**	**Up to $40**
Trifocal Lenses	**Covered after $10 Copay**	**Up to $50**
Lenticular Lenses	**$80 Allowance**	**Up to $50**
Progressive Lenses	**$70 Allowance**	**Up to $40**
Lens Options:		
Scratch resistant coating	**Covered at Wal-Mart only**	**N/A**
Polycarbonate Lenses *(for children to age 19)*	**Covered**	**N/A**
Frames:	**Up to $130 Allowance**	**Up to $50 retail**
Contact Lens: (In lieu of frames and lenses)		
Medically Necessary	**Up to $210 Allowance**	**Up to $210**
Elective	**Up to $130 Allowance**	**Up to $100**

Important Contacts:

	Carrier/Contact:	Telephone:	Website or Email:
Medical Insurance	**Blue Cross Blue Shield**	**800-222-8046**	www.bcbsms.com
Dental Insurance	**Guardian**	**888-600-1600**	www.guardiananytime.com
Vision Insurance	**Unum**	**888-400-9304**	www.alwaysassist.com
Gulfport School District Contact	**Faynaisa Hawkins**	**228-865-4607**	faynaisa.hawkins@gulfportschools.org
Cadence Insurance Account Representative For Dental & Vision Insurance	**Pam Thomas**	**228-563-6112**	pam_thomas@ajg.com

The Summary Above Has Been Provided For Your Convenience. Please Refer To Carrier Summary of Benefits For A Complete Listing Of Benefits And Coverage Available Under Each Plan Option.