Medical

Medical

At Delta Dental, we understand that employee health is a priority and that your overall well-being is important to you and to the success of the company. We offer comprehensive and competitive medical plans that provide a variety of resources, information and tools to ensure that you receive the best care and live a healthy life.

Three medical plan options:

Delta Dental of California and Delta Dental Insurance Company

Anthem Blue Cross		Anthem Blue Cross		Kaiser Permanente
CDHP (Consumer Directed Health Plan) With Health Savings Account (HSA)	or	PPO (Preferred Provider Organization)	or	Kaiser HMO (Health Maintenance Organization) For CA and GA

Delta Dental of Pennsylvania and Delta Dental of New York

Anthem Blue Cross		Anthem Blue Cross		Anthem Blue Cross
CDHP (Consumer Driven Health Plan) With Health Savings Account (HSA)	or	EPO (Executive Provider Organization) (PA residents only)	or	PPO (Preferred Provider Organization)

Medical plan comparison at a glance

Plan Features	Anthem Blue Cross CDHP		Anthem Blue Cross PPO		Kaiser HMO (CA & GA)		Anthem Blue Cross EPO (PA)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Type of Account	Health Savings Account (HSA)		N/A		N/A		N/A	

If you enroll in the Anthem Blue Cross CDHP option, you automatically receive the Delta Dental contribution amount, listed below, on January 1 of each year. New hires with enrollment effective July 1 through December 1 will receive 50% of the Delta Dental contribution amount.

Employee Only	$500 annually		N/A		N/A		N/A	
Employee & Spouse/ Domestic Partner or Employee & Family	$1,000 annually		N/A		N/A		N/A	
Deductible	$1,500 person $3,000 family	$3,000 person $6,000 family	$500 person $1,000 family	$1,000 person $2,000 family	None None	N/A N/A	None None	N/A N/A
Coinsurance	10% after deductible	30% after deductible	20% after deductible	40% after deductible	Copays for most services	N/A	copays for most services	N/A
Out-of-Pocket Maximum	$3,000 person $6,000 family	$6,000 person $12,000 family	$2,000 person $4,000 family	$4,000 person $8,000 family	CA: $1,500 person $3,000 family	GA: $2,000 person $4,000 family	$2,000 person $4,000 family	N/A N/A
Preventive Care Visit	Fully covered	50% after deductible	Fully covered	40% after deductible	Fully covered	N/A	Fully covered	Not covered
Emergency Room	10% after deductible		20% after deductible		$150 copay (waived if admitted)		$150 copay (waived if admitted)	

*Under the Anthem Blue Cross CDHP option, if more than one individual is enrolled, the family deductible must be met. Once the family deductible has been met, the plan will pay each enrolled family member's covered expenses based on the co-insurance level. However, one individual may satisfy the per person out-of-pocket maximum.

Plan Features	Anthem Blue Cross CDHP		Anthem Blue Cross PPO		Kaiser HMO (CA & GA)		Anthem Blue Cross EPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Primary Care Physician Office Visit (General Practice, Family Practice, Internal Medicine, Pediatricians, Obstetrics/ Gynecologists)	10% after deductible	30% after deductible	20% after deductible	40% after deductible	$20 copay	Not Covered	$20 copay	Not Covered
Specialist Office Visit (Specialist such as Allergist, Cardiologist, Orthopedist, Physical Therapist)	10% after deductible	30% after deductible	20% after deductible	40% after deductible	$40 copay	Not Covered	$40 copay	Not Covered
Urgent Care	10% after deductible	30% after deductible	20% after deductible	40% after deductible	CA: $20 copay GA: $40 copay	Not Covered	$20 copay	Not Covered
Outpatient Surgery	10% after deductible	30% after deductible	20% after deductible	40% after deductible	$100 copay	Not Covered	$100 copay	Not Covered
Outpatient Lab & X-ray	10% after deductible	30% after deductible	20% after deductible	40% after deductible	Eligible expenses fully covered	Not Covered	Eligible expenses fully covered	Not Covered
X-Ray Scans (CT, PET, MRI)	10% after deductible	30% after deductible	20% after deductible	40% after deductible	Eligible expenses fully covered	Not Covered	Eligible expenses fully covered	Not Covered
Hospital Facility Charge	10% after deductible	30% after deductible	20% after deductible	40% after deductible	$250 per admission	Not Covered	$250 per admission	Not Covered
Physician Charge in Hospital	10% after deductible	30% after deductible	20% after deductible	40% after deductible	Eligible expenses fully covered	Not Covered	Eligible expenses fully covered	Not Covered
Outpatient Mental Health & Substance Abuse	10% after deductible	30% after deductible	20% after deductible	40% after deductible	$20 copay	Not Covered	$20 copay	Not Covered
Inpatient Mental Health & Substance Abuse	10% after deductible	30% after deductible	20% after deductible	40% after deductible	$150 per admission	Not Covered	$250 per admission	Not Covered

*Under the HSA Base Plan, if more than one individual is enrolled, the family deductible must be met. Once the family deductible has been met, the plan will pay each enrolled family member's covered expenses based on the co-insurance level. However, one individual may satisfy the per person out-of-pocket maximum.

Prescription drugs

Plan Features	Anthem Blue Cross CDHP		Anthem Blue Cross PPO and EPO		Kaiser HMO (CA & GA)	
	CVS Caremark Retail Pharmacy Network (up to a 30-day supply)	CVS Caremark Mail Service Pharmacy (up to a 90-day supply)	CVS Caremark Retail Pharmacy Network (up to a 30-day supply)	CVS Caremark Mail Service Pharmacy (up to a 90-day supply)	Kaiser Retail Pharmacy Network (up to a 30-day supply)	Kaiser Mail Service Pharmacy (up to a 90-day supply)
Preventive[1]	No copay	No copay	No copay	No copay	Applicable copay	Applicable copay
Generic Always ask your doctor if there's generic option available. It could save you money	$10 copay after deductible	$20 copay after deductible	$10 copay	$20 copay	$10 copay	$20 copay
Preferred Brand-Name If a generic is not available or appropriate, ask your doctor to prescribe from the preferred drug list	$30 copay after deductible	$60 copay after deductible	$30 copay	$60 copay	$30 copay	$60 copay
Non-Preferred Brand-Name Drugs that aren't on the preferred list will cost more	$60 copay after deductible	$120 copay after deductible	$60 copay	$120 copay	$30 copay, when approved (CA) $60 copay (GA)	$60 copay, when approved $120 copay (GA)
Refill Limits[2]	One fill plus two refills on long-term medications	None	One fill plus two refills on long-term medications	None	None	None
Specialty (limited to a 30-day supply)	$75 copay after deductible. Covered if filled at CVS specialty pharmacy		$75 copay. Covered if filled at CVS specialty pharmacy		$30 copay (CA) $100 copay (GA)	N/A

[1] You can purchase specific preventive prescription medications in-network at no cost. Visit the Delta Dental employee portal for a list of eligible preventive prescription medications.

[2] After your maximum number of fills, if you do not wish to fill 90-day supplies, you have the option of continuing to fill 30-day supplies of your long-term medications by calling CVS Caremark.

Tosee CVS Caremark covered drug list, go to www.caremark.com.

Dental

At a glance

Plan Features	Delta Dental PPO		DeltaCare USA (CA, FL, NV & TX)
	Delta Dental PPO Dentists**	Non-Delta Dental PPO Dentists**	Delta Care USA Dentists
Deductible (individual/family)	$0/$0	$0/$0	None
Annual Benefit Maximum (per person) Note: Diagnostic and Preventive services not counted toward maximum	$2,500	$2,500	N/A
Orthodontia Lifetime Maximum (per person)	$2,000	$2,000	$350 start-up fees $700 for dependents to age 19 $1,800 for adults
TMJ Lifetime Maximum (per person)	$1,000	$1,000	Not covered
Benefits and Covered Services*	**Plan Pays**		
Diagnostic & Preventive Services (D&P) Exams, cleanings, x-rays and sealants	100%	100%	No cost
Basic Services Fillings, posterior composites, endodontics (root canals), periodontics (gum treatment), oral surgery	100%	100%	No cost
Major Services Crowns, inlays, onlays and cast restorations	100%	100%	No cost
Prosthodontics Bridges and dentures	100%	100%	$0 to $50
Implant	50%	50%	Not covered
Temporomandibular Joint (TMJ)	50%	50%	Not covered
Orthodontic Adults and dependent children	60%	60%	See “Orthodontia Lifetime Maximum” above

* Limitations or waiting periods may apply by some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist’s submitted fees.
** Reimbursement is based on a PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and Premier contracted fees for non-Delta Dental dentist.

Vision

Vision

Delta Dental offers vision coverage through VSP to help you save money on eye exams and eyewear. You can see any vision provider you choose. The level of benefits you receive depends on whether you go in-network or out-of-network for services.

At a glance

Here's a look at what services are included in your coverage and the copay amount you will pay when you use the VSP network. When you go out of the VSP network for vision services, you will pay for your services up front and then be reimbursed for only a certain amount of each expense.

Service	Description	Frequency	Your Copay
Eye exams	Well Vision Exam focuses on your eye health and overall wellness covered in full	Every 12 months	$10
Lenses	Single vision, lined bifocal and lined trifocal. Polycarbonate lenses for dependent children.	Every 12 months	$20 (lenses & frames)
Frames	$115 allowance for a wide selection of frames. $135 allowance for featured frame brands. 20% savings on the amount over your allowance. $65 Costco frame allowance	Every 24 months	
Contact lenses (instead of glasses)	$105 allowance for contacts and contact lens exam (fitting and evaluation). 15% savings on a contact lens exam (fitting and evaluation)	Every 12 months	$0