Effective Date: July 1, 2019

Plans	Level of Coverage	Total Monthly Premium	Employer Pay Per Month	Employee Pays Per Month
OPEN ACCESS PLUS - with HSA Cigna (CDHP)	Employee	$669.00	$630.00	$39.00
	Dual	$1,229.00	$1,118.00	$111.00
	Family	$1,657.00	$1,509.00	$148.00
OPEN ACCESS PLUS Cigna (Traditional)	Employee	$735.00	$630.00	$105.00
	Dual	$1,410.00	$1,170.00	$240.00
	Family	$1,973.00	$1,588.00	$385.00
DELTA DENTAL PPO PPO Plus Premier Plan 1	Employee	$23.00	$21.00	$2.00
	Dual	$42.00	$37.00	$5.00
	Family	$67.00	$57.00	$10.00
DELTA DENTAL EPO New - Replaces DeltaCare DHMO	Employee	$27.00	$21.00	$6.00
	Dual	$52.00	$37.00	$15.00
	Family	$82.00	$57.00	$25.00
DELTA DENTAL PPO PPO Plus Premier - Plan 2	Employee	$39.00	$27.00	$12.00
	Dual	$69.00	$46.00	$23.00
	Family	$99.00	$69.00	$30.00

Effective Date: July 1, 2019

	Choice Fund Open Access Plus HSA Plan (No Referrals Needed to see Specialists)	
Benefits Highlights	***In Network***	***Out of Network***
	Both Medical and Pharmacy expenses are combined to satisfy the annual deductible.	
Pre-Existing Conditions Limitations	None	
Dependent Coverage to end of Calendar Year	Until age 26	
Out of Area Coverage	Cigna plans are provided through a national network. In-network coverage is provided in all states.	
Deductible	***Only in-network expenses count toward the in-network deductible. Only out-of-network expenses count toward the out-of-network deductible.***	
Collective Deductible	No. Deductible is satisfied on an individual basis.	No. Deductible is satisfied on an individual basis.
Single	$3,000	$3,000
Family	$6,000	$6,000
Coinsurance	100%	30%
Out-of-Pocket Limit	***Only in-network expenses count toward the in-network out-of-pocket maximum. Only out-of-network expenses count toward the out-of-network out-of-pocket maximum.***	
Collective Out of Pocket	No. OOP Maximum satisfied on an individual basis.	No. OOP Maximum satisfied on an individual basis.
Single	$4,000	$6,000
Family	$8,000	$12,000
Out-of-Pocket Maximum Includes:	Deductible, Coinsurance, Copays	
Lifetime Maximum	Unlimited	
Physician Services		
PCP Office Visits	100% after deductible	30% after deductible
Specialist Visits	100% after deductible	30% after deductible
Telehealth Visits	100% after deductible	Not Covered
Allergy Treatment / Injections	100% after deductible	30% after deductible
Preventive Care		
Well Child Care and Immunizations	$0	30% after deductible
Routine Adult Physical Exam and Immunizations	$0	30% after deductible
Well Woman/GYN Exam	$0	30% after deductible
Mammograms	$0	30% after deductible
Hospital Services		
Inpatient	100% after deductible	30% after deductible
Outpatient	100% after deductible	30% after deductible
Emergency Services		
Emergency Room	100% after deductible	100% after deductible
Urgent Care Center	100% after deductible	30% after deductible
Ambulance	100% after deductible	100% after deductible
Outpatient Diagnostic X-ray/Lab		
Diagnostic Lab Facility	100% after deductible	30% after deductible
Diagnostic X-ray Facility	100% after deductible	30% after deductible
Major Services - PET Scans, MRI, CT Scans	100% after deductible	30% after deductible
Maternity		
Outpatient and Inpatient Services	100% after deductible	30% after deductible
Mental Health & Substance Abuse		
Inpatient	100% after deductible	30% after deductible
Outpatient	100% after deductible	30% after deductible
Outpatient Therapy		
Physical, Occupational, Speech Therapies (30 days per Contract Year)	100% after deductible	30% after deductible
Spinal Manipulation (30 days per Contract Year)	100% after deductible	30% after deductible
Miscellaneous Services		
Vision Exam (Once per Contract Year)	Cigna Vision Network - $15 copay	Up to $45 reimbursement
Home Health Care (100 days per Contract Year)	100% after deductible	30% after deductible
Hospice	100% after deductible	30% after deductible
Skilled Nursing (100 days per Contract Year)	100% after deductible	30% after deductible
Durable Medical Equipment (Unlimited Maximum Per Contract Year)	100% after deductible	30% after deductible
Infertility Treatment	Not Covered	Not Covered
Organ Transplant (Travel: $10,000 Maximum Per Contract Year)	Included	Excluded
Bariatric Surgery	Not Covered	Not Covered
TMJ	Not Covered	Not Covered

	Choice Fund Open Access Plus HSA Plan (No Referrals Needed to see Specialists)	
Abortion	100% after deductible	30% after deductible
Acupuncture	Not Covered	Not Covered
Prescription Drugs		
Pharmacy Out of Pocket Maximum	Combined with Medical	Not Applicable
Non-Specialty Drugs - Day Supply Limit Retail	90	Not Applicable
Non-Specialty Drugs - Day Supply Limit Home	90	Not Applicable
Specialty Drugs - Day Supply Limit Retail	30	Not Applicable
Specialty Drugs - Day Supply Limit Home	30	Not Applicable
Preventive Drugs (Refer to Cigna List)	No cost - Deductible and Copays do not apply	Not Applicable
Retail - 30 day supply:	***Prescription copayments or coinsurance apply after the Annual Deductible has been satisfied.***	
Tier 1	$15	Not Applicable
Tier 2	$40	Not Applicable
Tier 3	$75	Not Applicable
Tier 4	20% Coinsurance up to $200 Maximum	Not Applicable
Mail Order - 90-day Supply (Tiers 1, 2 and 3 Only)	$38/ $100/ $188	Not Applicable
Retail - 90 day supply (Tiers 1, 2 and 3 Only)	$45 / $120 / $225	Not Applicable
Mail Order - 30 day supply (Tier 4 - Specialty)	20% up to $200 Maximum	Not Applicable

Additional Information Available at www.cigna.com; Cigna Customer Service: 1-800-997-1654; or Cigna One Ouide: 1-888-806-5042

Effective Date: July 1, 2019

	Open Access Plus Traditional Plan (No Referrals Needed to see Specialists)	
Benefits Highlights	***In Network***	***Out of Network***
	Both Medical and Pharmacy expenses are combined to satisfy the annual deductible.	
Pre-Existing Conditions Limitations	None	
Dependent Coverage to end of Calendar Year	Until age 26	
Out of Area Coverage	Cigna plans are provided through a national network. In-network coverage is provided in all states.	
Deductible	***Only in-network expenses count toward the in-network deductible. Only out-of-network expenses count toward the out-of-network deductible.***	
Collective Deductible	No. Deductible is satisfied on an individual basis.	No. Deductible is satisfied on an individual basis.
Single	$500	$800
Family	$1,000	$1,600
Coinsurance	20%	30%
Out-of-Pocket Limit	***Only in-network expenses count toward the in-network out-of-pocket maximum. Only out-of-network expenses count toward the out-of-network out-of-pocket maximum.***	
Collective Out of Pocket	No. OOP Maximum satisfied on an individual basis.	No. OOP Maximum satisfied on an individual basis.
Single	$3,750	$4,750
Family	$7,500	$9,500
Out-of-Pocket Maximum Includes:	Deductible, Coinsurance, Copays	
Lifetime Maximum	Unlimited	
Physician Services		
PCP Office Visits	$15 Copay	30% after deductible
Specialist Visits	$35 Copay	30% after deductible
Telehealth Visits	$15 Copay	Not Covered
Allergy Treatment / Injections	Covered the same as PCP or Specialist Copay	30% after deductible
Preventive Care		
Well Child Care and Immunizations	$0	Not covered
Routine Adult Physical Exam and Immunizations	$0	Not covered
Well Woman/GYN Exam	$0	Not covered
Mammograms	$0	Not covered
Hospital Services		
Inpatient	20% after deductible	30% after deductible
Outpatient	20% after deductible	30% after deductible
Emergency Services		
Emergency Room	20% after deductible	20% after deductible
Urgent Care Center	$35 Copay	30% after deductible
Ambulance	20% after deductible	20% after deductible
Outpatient Diagnostic X-ray/Lab		
Diagnostic Lab Facility	20% after deductible	30% after deductible
Diagnostic X-ray Facility	20% after deductible	30% after deductible
Major Services - PET Scans, MRI, CT Scans	20% after deductible	30% after deductible
Maternity		
Outpatient and Inpatient Services	Office Copay for initial visit. Global Fee: Plan pays 20% after annual deductible for all additional pre- and post-natal visits, inpatient services and delivery charges. Office Copay will apply to visits outside the Global Maternity Fee.	30% after deductible
Mental Health & Substance Abuse		
Inpatient	20% after deductible	30% after deductible
Outpatient	$15 Copay	30% after deductible
Outpatient Therapy		
Physical, Occupational, Speech Therapy (30 days per Contract Year)	$25 Copay	30% after deductible
Spinal Manipulation (30 days per Contract Year)	$25 Copay	30% after deductible
Miscellaneous Services		
Vision Exam (Once per Contract Year)	Cigna Vision Network - $15 copay	Up to $45 reimbursement
Home Health Care (100 days per Contract Year)	20% after deductible	30% after deductible

	Open Access Plus Traditional Plan (No Referrals Needed to see Specialists)	
Hospice	20% after deductible	30% after deductible
Skilled Nursing (100 days per Contract Year)	20% after deductible	30% after deductible
Durable Medical Equipment (Unlimited Maximum per Contract Year)	20% after deductible	30% after deductible
Infertility Treatment	Not Covered	Not Covered
Organ Transplant (Travel: $10,000 Maximum Per Contract Year)	Included	Excluded
Bariatric Surgery	Not Covered	Not Covered
TMJ	Not Covered	Not Covered
Abortion	20% after deductible	30% after deductible
Acupuncture	Not Covered	Not Covered
Prescription Drugs		
Pharmacy Out of Pocket Maximum	Combined with Medical	Not Applicable
Non-Speciality Drugs - Day Supply Limit Retail	90	Not Applicable
Non-Specialty Drugs - Day Supply Limit Home	90	Not Applicable
Specialty Drugs - Day Supply Limit Retail	30	Not Applicable
Specialty Drugs - Day Supply Limit Home	30	Not Applicable
Preventive Drugs (Per ACA Guidelines)	No Cost	Not Applicable
Retail - 30 day supply:		
Tier 1	$15	Not Applicable
Tier 2	$40	Not Applicable
Tier 3	$75	Not Applicable
Tier 4	20% Coinsurance up to $200 Maximum	Not Applicable
Mail Order - 90-day Supply (Tiers 1, 2 and 3 Only)	$38/ $100/ $188	Not Applicable
Retail - 90 day supply (Tiers 1, 2 and 3 Only)	$45 / $120 / $225	Not Applicable
Mail Order - 30 day supply (Tier 4 - Specialty)	20% up to $200 Maximum	Not Applicable

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UCR = Usual, Customary and Reasonable Charge	New EPO (Replaces DeltaCare DHMO)	PPO Plus Premier Plan 1	PPO Plus Premier Plan 2
Type	Managed Care	Fee for Service	Fee for Service
Dentist Choice	From Delta PPO Network Only	Any provider; Maximum benefit if participating PPO or Premier network dentist	
Deductible Per Contract Year	None	$25 per patient; $75 per family Diagnostic/Preventive services exempt	$75 per patient; $225 per family Diagnostic/Preventive services exempt
Maximum Benefit Per Contract Year	$2,000 per person	$1,000 per person	$1,250 per person (Diagnostic/Preventive services do not count toward annual maximum.)
Diagnostic and Preventive Services			
Oral exam and cleaning (2 x per year)	100%	100% UCR	100% UCR
X-rays (bitewings 1 x/year; full mouth 1 x /3 years)	100%	100% UCR	100% UCR
Sealants (to age 16)	See fee schedule for copay	100% UCR	100% UCR
Basic Services			
Fillings (Composite and white)	See fee schedule for copay	PPO Dentist: 10% after deductible Premier Dentist: 20% UCR after deductible	PPO Dentist: 10% after deductible Premier Dentist: 20% UCR after deductible
Oral surgery and extractions	See fee schedule for copay	PPO Dentist: 10% after deductible Premier Dentist: 20% UCR after deductible	PPO Dentist: 10% after deductible Premier Dentist: 20% UCR after deductible
Endodontics and Periodontics	See fee schedule for copay	PPO Dentist: 10% after deductible Premier Dentist: 20% UCR after deductible	PPO Dentist: 10% after deductible Premier Dentist: 20% UCR after deductible
Denture Repair/Recementation	See fee schedule for copay	PPO Dentist: 10% after deductible Premier Dentist: 20% UCR after deductible	PPO Dentist: 10% after deductible Premier Dentist: 20% UCR after deductible
Major Services			
Crowns	See fee schedule for copay	No coverage	PPO Dentist: 40% after deductible Premier Dentist: 50% UCR after deductible Every 5 years
Prosthetic Coverage	See fee schedule for copay	No coverage	PPO Dentist: 40% after deductible Premier Dentist: 50% UCR after deductible Every 5 years
Orthodontics	50% PPO allowance $2,000 lifetime maximum (adults and dependent children)	No coverage	50% UCR (under age 19) $1,000 lifetime maximum
Implants	No coverage	No coverage	PPO Dentist: 40% after deductible Premier Dentist: 50% UCR after deductible Once per Lifetime site

Additional Information Available at www.deltadentalva.com; Delta Dental Customer Service: 1-800-237-6060