Employee Costs for Medical Coverage

The costs listed below are pre-tax, per-pay-period deductions, based on 26 pay periods a year.

	FULL-TIME	PART-TIME
CHOICE PLUS		
Employee Only	$79.48	$119.22
Employee + Children	$133.68	$200.52
Employee + Spouse	$190.80	$286.20
Employee + Family	$244.82	$367.23
CHOICE		
Employee Only	$41.76	$62.64
Employee + Children	$76.22	$114.33
Employee + Spouse	$111.32	$166.98
Employee + Family	$146.43	$219.65

Note: Additional coverage costs may apply due to the Working-Spouse Surcharge and/or the Tobacco-User Surcharge.

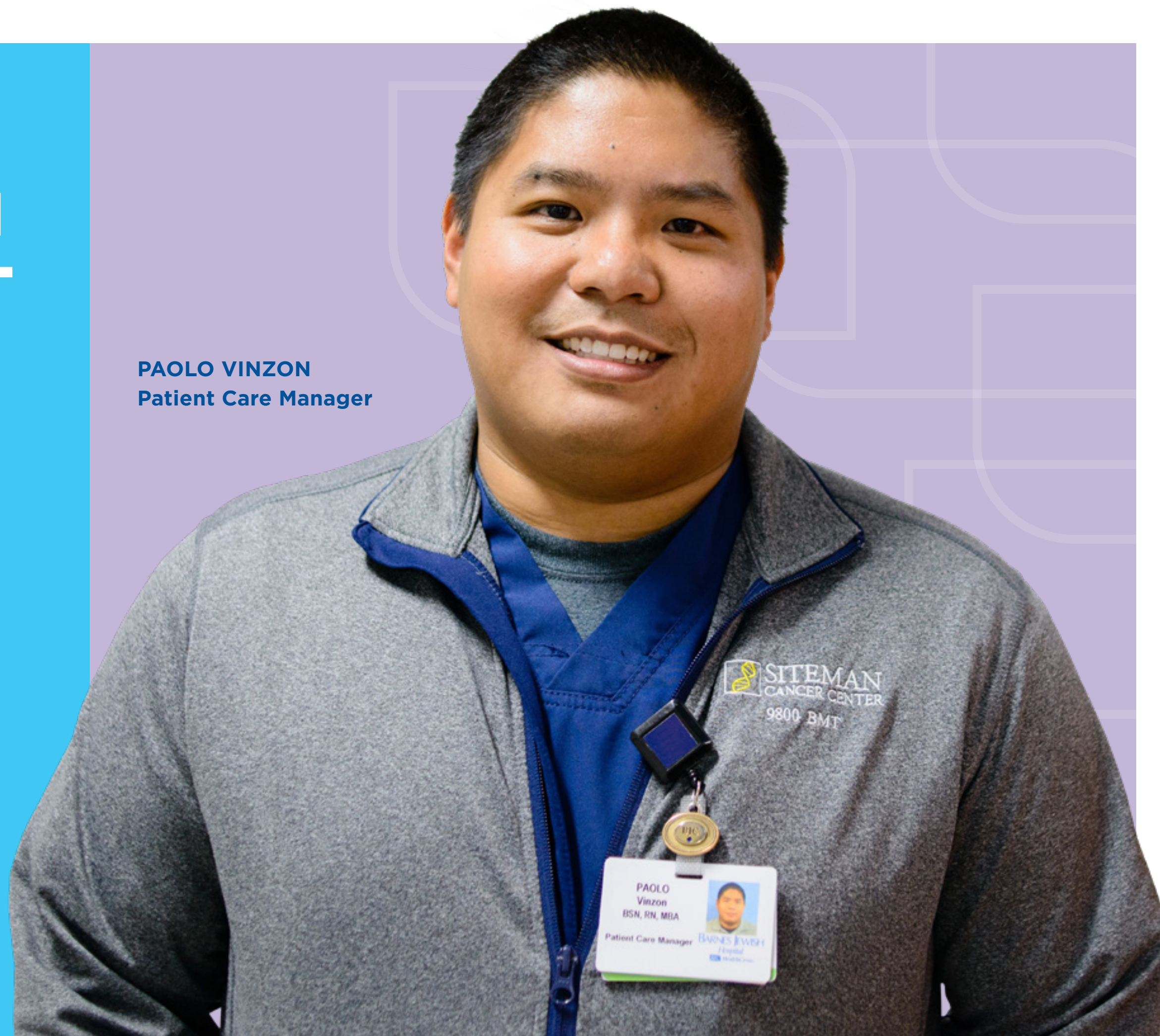
CHOOSE THE OPTION THAT'S BEST FOR YOU!

CHOICE

Less per pay period but more out of pocket

CHOICE PLUS

More per pay period but less out of pocket



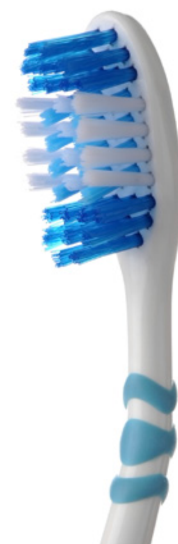
PAOLO VINZON
Patient Care Manager

Dental

You have two dental options: **High** and **Low,** both administered by Delta Dental of Missouri.

Both Options:

- Provide access to the **Delta Dental Premier Network,** which features more than 80 percent of dental care providers nationwide.
- Provide access to the **Delta Dental PPO Network** (preferred provider organization), which includes nearly 50 percent of all dentists nationwide.
- Cover **in-network preventive services** (e.g., two dental cleanings per year) with no deductible.
- Cover services for **basic care and major care** *(Low option plan participants pay more for these services).*



Dental Coverage Chart

	HIGH			LOW		
	PPO Network	Premier Network	Non-Network	PPO Network	Premier Network	Non-Network
ANNUAL DEDUCTIBLE						
• Per Individual	$50	$50	$50	$75	$75	$75
• Per Family	$100	No limit	No limit	$150	No limit	No limit
Preventive Care	0%; no deductible	0%; no deductible	20%; no deductible	0%; no deductible	0%; no deductible	40%; no deductible
Basic Care	20% after deductible	40% after deductible	40% after deductible	30% after deductible	40% after deductible	40% after deductible
Major Care	40% after deductible	60% after deductible	60% after deductible	50% after deductible	60% after deductible	60% after deductible
ORTHODONTIA BENEFIT						
• Services	40% after deductible	60% after deductible	60% after deductible	No coverage	No coverage	No coverage
• Lifetime Maximum	$2,000	$1,500	$1,500			
Annual Maximum Benefit	$2,000	$1,500	$1,500	$1,000	$750	$750

Copayments and coinsurance reflect member responsibility.

Employee Costs for Dental Coverage

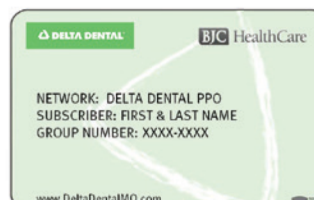
The costs listed below are pre-tax, per-pay-period deductions, based on 26 pay periods a year.

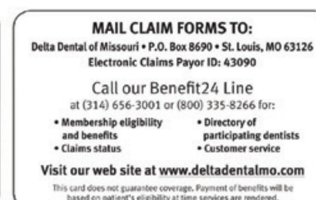
	FULL-TIME & PART-TIME
HIGH	
Employee Only	$4.57
Employee + Children	$18.27
Employee + Spouse	$16.94
Employee + Family	$22.00
LOW	
Employee Only	$2.91
Employee + Children	$10.52
Employee + Spouse	$10.61
Employee + Family	$12.42

ID Cards

Delta Dental issues your dental ID card. If you do not have your ID card, your provider can call Delta Dental to verify your eligibility and benefits.

For more information, or to find a provider, go to ***www.deltadentalmo.com*** or call **800-335-8266.**





Vision

Coverage from VSP Vision Care features a large national network of vision providers.

Key Features

- Covers a VSP Well Vision Exam® with a copayment for children up to age 18 twice a year and adults once a year
- Pays a portion of the cost for your contacts or eyeglass lenses once a calendar year
- Pays a portion of the cost for children's (up to age 18) frames once a calendar year and the cost of adult frames every other year
- Provides a discount on laser vision correction

To find a provider, visit ***www.vsp.com*** or call **800-877-7195.**

ID Cards

VSP does not issue ID cards. The VSP network provider needs only your social security number to verify your benefits and submit claims.

An annual preventive vision exam is covered at **100 percent** under the BJC Medical Plan. Present your Cigna ID card at the time of service.

Vision Coverage Chart

	VSP NETWORK	NON-NETWORK
VSP WellVision Exam® (twice every calendar year for children up to age 18; once every calendar year for adults)	$15 copayment	Up to $45 after $15 copayment
Contacts (once every calendar year instead of lenses and frames)	Up to $200	Up to $105
Contact Lens Exam, Fitting & Evaluation	$60 copayment	N/A
Lenses (once every calendar year) • Single Vision	$15 copayment	Up to $45 after $15 copayment
• Lined Bifocal	$15 copayment	Up to $65 after $15 copayment
• Lined Trifocal	$15 copayment	Up to $85 after $15 copayment
Frames (once every calendar year for children up to age 18; once every other calendar year for adults)	Up to $200 after $15 copayment	Up to $47 after $15 copayment
Laser Vision Correction	Average 15% discount	N/A

Employee Costs for Vision Coverage

The costs listed below are pre-tax, per-pay-period deductions, based on 26 pay periods a year.

	FULL-TIME & PART-TIME
Employee Only	$3.58
Employee + Children	$8.13
Employee + Spouse	$7.17
Employee + Family	$13.00