2023 Open Enrollment

May 1 – 17, 2023

NON-MEDICARE ELIGIBLE RETIREES

Open Enrollment will begin on **May 1, 2023,** and will end on **May 17, 2023,** for the plan year beginning July 1, 2023. This is your once-a-year opportunity to enroll, cancel or changes your health and dental benefits. During this time, you may also add or drop coverage for your eligible spouse and/or dependent children.

WHAT YOU NEED TO KNOW

The benefit plan premiums (or rates) for the health plan will increase approximately 9.4% for the upcoming plan year beginning July 1, 2023. Dental plan premiums will not change for the upcoming plan year beginning July 1, 2023.

For additional information about the health plans offered, please refer to the attached health plan comparison chart. Benefit summaries for each of the four plans was sent to you in the mail by the Statewide Benefits office. Additional information on each of the plans can be found on-line via the following links: www.cityofdover.com/retiree or https://dhr.delaware.gov/benefits/oe/groups.shtml. **All forms must be completed and returned to Human Resources by the close of business on Wednesday, May 17, 2023 (no exceptions).** Changes made during Open Enrollment will become effective on July 1, 2023.

Please take the time to read the information provided so that you are an active participant in this year's Open Enrollment process. **If you are not making any changes and wish to continue your current level of coverage, no action is needed, unless you insure a spouse on your plan.**

IMPORTANT NOTICE

IF YOU COVER YOUR SPOUSE ON YOUR HEALTH PLAN IT IS VERY IMPORTANT THAT YOU COMPLETE THE SPOUSAL COORDINATION OF BENEFITS FORM. A NEW FORM MUST BE COMPLETED EACH YEAR DURING OPEN ENROLLMENT OR YOUR SPOUSE'S COVERAGE WILL BEREDUCED.

The electronic Spousal Coordination of Benefits form can be found on the Statewide Benefits website at https://cob.ben.omb.delaware.gov. Be sure to fill out the form in its entirety. After completing the form online, click on "Printable Summary" to print a copy for your records. Please note that completing the spousal coordination of benefits form **DOES NOT** enroll your spouse or discontinue coverage for your spouse. You must complete and submit an enrollment application. If concerns arise regarding your spouse's coverage, Human Resources may request a copy of the Printable Summary mentioned above.

Premium tables and information for the health and dental plans year beginning July 1, 2023, are attached. If you would like to enroll, change or cancel coverage during this open enrollment period, please contact Human Resources for the appropriate forms or visit www.cityofdover.com/retiree. **All forms must be completed and returned to Human Resources by the close of business on Wednesday, May 17, 2022 (no exceptions).** Changes made during Open Enrollment will become effective on July 1, 2023.

All requested enrollment forms will be sent via email or USPS. Completed enrollment forms can be returned in the same fashion, either via email (humanresources@dover.de.us) or USPS (postmarked on or before May 17, 2023) or completed forms may be placed in the Human Resources Drop Box on the first floor of 5 E. Reed Street.

If you have any questions or concerns, please contact a member of the Human Resources Department via phone at (302) 736-7073 or email at humanresources@dover.de.us.

Health Premiums
Effective: July 1, 2023
25% Blended Rate

Plan Name	Coverage Type	Retiree Pays per Month	City Pays	Total Cost Monthly
Highmark Delaware First State Basic	Retiree Only	$ -	$ 870.72	$ 870.72
	Spouse of Retiree Only	$ 217.69	$ 653.03	$ 870.72
	Retiree & Child(ren)	$ 112.87	$ 1,209.32	$ 1,322.18
	Retiree & Spouse	$ 231.97	$ 1,566.63	$ 1,798.60
	Family	$ 344.23	$ 1,903.44	$ 2,247.66
Highmark Delaware Comprehensive PPO	Retiree Only	$ -	$ 836.26	$ 993.68
	Spouse of Retiree Only	$ 248.41	$ 745.26	$ 993.68
	Retiree & Child(ren)	$ 134.06	$ 1,395.90	$ 1,529.96
	Retiree & Spouse	$ 266.35	$ 1,792.72	$ 2,059.06
	Family	$ 394.93	$ 2,178.50	$ 2,573.44
Aetna HMO	Retiree Only	$ -	$ 908.90	$ 908.90
	Spouse of Retiree Only	$ 227.23	$ 681.67	$ 908.90
	Retiree & Child(ren)	$ 120.02	$ 1,268.94	$ 1,388.96
	Retiree & Spouse	$ 251.11	$ 1,662.22	$ 1,913.32
	Family	$ 369.46	$ 2,017.27	$ 2,386.74
Aetna CDH Gold	Retiree Only	$ -	$ 758.36	$ 901.08
	Spouse of Retiree Only	$ 225.26	$ 675.82	$ 901.08
	Retiree & Child(ren)	$ 118.55	$ 1,256.73	$ 1,375.28
	Retiree & Spouse	$ 241.09	$ 1,624.35	$ 1,865.44
	Family	$ 367.02	$ 2,002.14	$ 2,369.16

City Pays 100% of Employee Only Coverage;
Retiree Pays 25% of Dependent Coverage & City Pays 75% of Dependent Coverage as follows:

AFSCME Union employees who retired prior to June 30, 2015
DOE Union employees who retired prior to May 31, 2013
IBEW Union employees who retired prior to July 1, 2014
FOP Union employees who retired prior to July 1, 2012
Non-Bargaining employees who retired prior to July 1, 2012

Health Premiums
Effective: July 1, 20*23*
15% Employee Cost Sharing

Plan Name	Coverage Type	Biweekly Payroll Deduction	City Pays	Total Cost Monthly
Highmark Delaware First State Basic	Employee Only	$65.31	$740.11	$870.72
	Employee & Child(ren)	$99.17	$1,123.85	$1,322.18
	Employee & Spouse	$134.90	$1,528.81	$1,798.60
	Family	$168.58	$1,910.51	$2,247.66
Highmark Delaware Comprehensive PPO	Employee Only	$74.53	$844.63	$993.68
	Employee & Child(ren)	$114.75	$1,300.47	$1,529.96
	Employee & Spouse	$154.43	$1,750.20	$2,059.06
	Family	$193.01	$2,187.42	$2,573.44
Aetna HMO	Employee Only	$68.17	$772.57	$908.90
	Employee & Child(ren)	$104.17	$1,180.62	$1,388.96
	Employee & Spouse	$143.50	$1,626.32	$1,913.32
	Family	$179.01	$2,028.73	$2,386.74
Aetna CDH Gold	Employee Only	$67.58	$765.92	$901.08
	Employee & Child(ren)	$103.15	$1,168.99	$1,375.28
	Employee & Spouse	$139.91	$1,585.62	$1,865.44
	Family	$177.69	$2,013.79	$2,369.16

State of Delaware Health Plan Comparison Chart
(Effective July 1, 2023)

Plan Options	Highmark Delaware First State Basic Plan		Aetna CDH Gold Plan		Aetna HMO Plan		Highmark Delaware Comprehensive PPO Plan	
Plan Type	Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)		Health Maintenance Organization (HMO)		Preferred Provider Organization (PPO)	
Primary Care Provider (PCP) Selection	Recommended		Recommended		Required		Recommended	
Plan Feature	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventive Care/ Screening/Immunization (age, gender and risk parameters may apply)	100% covered, not subject to deductible	30% coinsurance, not subject to deductible	100% covered, not subject to deductible	30% coinsurance after deductible	100% covered	Not covered	100% covered	20% coinsurance after deductible
Deductible (per plan year)	$500 per individual/ $1,000 per family	$1,000 per individual/ $2,000 per family	$1,500 per individual/ $3,000 per family	$1,500 per individual/ $3,000 per family	N/A	N/A	N/A	$300 per individual/ $600 per family
Health Reimbursement Account (HRA)	N/A	N/A	$1,250 per individual/ $2,500 family	$1,250 per individual/ $2,500 family	N/A	N/A	N/A	N/A
Out-of-Pocket Maximum (including copays and deductibles)	$2,000 per individual/ $4,000 per family	$4,000 per individual/ $8,000 per family	$4,500 per individual/ $9,000 per family	$7,500 per individual/ $15,000 per family	$4,500 per individual/ $9,000 per family	N/A	$4,500 per individual/ $9,000 per family	$7,500 per individual/ $15,000 per family
Prenatal and Postnatal Care	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	100% covered after $25 initial copay (inpatient room and board copays do apply to hospital deliveries/ birthing centers)	Not covered	100% covered (inpatient room and board copays do apply to hospital deliveries/birthing centers)	20% coinsurance after deductible
24/7 Nurse Line	Yes, no cost		Yes, no cost		Yes, no cost		Yes, no cost	
Primary Care Visit to treat an injury or illness (in-person or virtual)	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	$15 copay per visit	Not covered	$20 copay per visit	20% coinsurance after deductible
Telemedicine (Virtual Doctor Visits)	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	$0 copay per visit	Not covered	$0 copay per visit	20% coinsurance after deductible

Plan Options	Highmark Delaware First State Basic Plan		Aetna CDH Gold Plan		Aetna HMO Plan		Highmark Delaware Comprehensive PPO Plan	
Plan Feature	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Urgent Care Visit	100% covered after $25 copay per visit	100% covered after $25 copay per visit	10% coinsurance after deductible	30% coinsurance after deductible	$15 copay per visit	Not covered	$20 copay per visit	20% coinsurance after deductible
Emergency Room	10% coinsurance after deductible	10% coinsurance after deductible	10% coinsurance after deductible	10% coinsurance after deductible	$200 copay per visit (waived if admitted)	$200 copay per visit (waived if admitted)	$200 copay per visit (waived if admitted)	$200 copay per visit (waived if admitted)
Chiropractic Care (Requires medical necessity and excludes preventive/maintenance care) Note: No visit maximum for treatment of back pain	10% coinsurance after deductible for up to 30 visits per plan year	25% coinsurance after deductible for up to 30 visits per plan year	10% coinsurance after deductible for up to 30 visits per plan year	25% coinsurance after deductible for up to 30 visits per plan year	Lesser of $15 copay or 20% coinsurance (Referrals required through PCP)	Not covered	15% coinsurance for up to 30 visits per plan year	20% coinsurance after deductible for up to 30 visits per plan year
Physical Therapy (Requires medical necessity) Note: No visit maximum for treatment of back pain	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance for up to 45 visits per illness/injury (Referrals required through PCP)	Not covered	15% coinsurance	20% coinsurance after deductible
Specialist Visit (In-person or virtual)	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	$25 copay per visit (Referrals required for certain services through PCP)	Not covered	$30 copay per visit	20% coinsurance after deductible
Lab Work (Blood Work) Note: Lab Work at a non-preferred non-hospital affiliated lab may not be covered	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	LabCorp and Quest Diagnostics Lab (Preferred): $10 copay per visit Hospital/Other Lab Facility: $50 copay per visit	Not covered	In-Network Non-Hospital Affiliated Lab (Preferred): $10 copay per visit Hospital/Other Lab Facility: $50 copay per visit	20% coinsurance after deductible
Basic Imaging/Radiology (i.e., X-Ray, Ultrasound)	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	Non-Hospital Affiliated Freestanding Facility (Preferred): $0 copay per visit (Referrals required through PCP) Hospital Affiliated Facility: $50 copay per visit (Referrals required through PCP)	Not covered	Non-Hospital Affiliated Freestanding Facility (Preferred): $0 copay per visit Hospital Affiliated Facility: $50 copay per visit	20% coinsurance after deductible
High-Tech Imaging/Radiology (i.e., MRI, CT Scan) Note: Requires a prior authorization	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	Non-Hospital Affiliated Freestanding Facility (Preferred): $0 copay per visit Hospital Affiliated Facility: $100 copay per visit	Not covered	Non-Hospital Affiliated Freestanding Facility (Preferred): $0 copay per visit Hospital Affiliated Facility: $100 copay per visit	20% coinsurance after deductible

Plan Options		Highmark Delaware First State Basic Plan		Aetna CDH Gold Plan		Aetna HMO Plan		Highmark Delaware Comprehensive PPO Plan	
Plan Feature		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health, Behavioral Health, and Substance Abuse	**Outpatient Services**	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	$15 copay per visit	Not covered	$20 copay per visit Intensive Outpatient Care 100% covered	20% coinsurance after deductible
	Inpatient Services	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	$100 copay per day with max of $200 per admission	Not covered	$100 copay per day with max of $200 per admission	20% coinsurance after deductible
Outpatient Surgery		10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	Non-Hospital Affiliated Ambulatory Surgery Center (Preferred): $50 copay per visit Hospital Affiliated Facility: $150 copay per visit	Not covered	Non-Hospital Affiliated Ambulatory Surgery Center (Preferred): $50 copay per visit Hospital Affiliated Facility: $150 copay per visit	20% coinsurance after deductible
Hospital Admission		10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	$100 copay per day with max of $200 per admission	Not covered	$100 copay per day with max of $200 per admission	20% coinsurance after deductible
Center of Excellence (COE)*: Costs noted are for an inpatient stay. Note: Highmark refers to COE facilities as Blue Distinction Centers and Aetna refers to COE facilities as Institutes of Quality and Institutes of Excellence.									
Plan Feature		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Orthopedic (hip replacement/ knee replacement) **Note: Requires a prior authorization**		10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	COE Facility* (Preferred): $100 copay per day; $200 copay max per admission Non-COE Facility: $500 copay per admission	Not covered	COE Facility* (Preferred): $100 copay per day; $200 copay max per admission Non-COE Facility: $500 copay per admission	20% coinsurance after deductible
Spine (i.e., Cervical and lumbar fusion, cervical laminectomy, and lumbar laminectomy/ discectomy procedures) **Note: Requires a prior authorization**		10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible	30% coinsurance after deductible	COE Facility* (Preferred): $100 copay per day; $200 copay max per admission Non-COE Facility: $500 copay per admission	Not covered	COE Facility* (Preferred): $100 copay per day; $200 copay max per admission Non-COE Facility: $500 copay per admission	20% coinsurance after deductible

Plan Options	Highmark Delaware First State Basic Plan		Aetna CDH Gold Plan		Aetna HMO Plan		Highmark Delaware Comprehensive PPO Plan	
Plan Feature	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Bariatric **Note: Requires a prior authorization**	Not covered under Highmark Required through SurgeryPlus benefit	Not covered under Highmark Required through SurgeryPlus benefit	Not covered under Aetna Required through SurgeryPlus benefit	Not covered under Aetna Required through SurgeryPlus benefit	Not covered under Aetna Required through SurgeryPlus benefit	Not covered under Aetna Required through SurgeryPlus benefit	Not covered under Highmark Required through SurgeryPlus benefit	Not covered under Highmark Required through SurgeryPlus benefit
Transplants** **(For Highmark plans, does not apply to kidney and bone marrow/stem cell)** **Note: Requires a prior authorization**	COE Facility* (Preferred): 10% coinsurance after deductible	30% coinsurance after deductible	COE Facility* (Preferred): 10% coinsurance after deductible	30% coinsurance after deductible	COE Facility* (Preferred): $100 copay per day; $200 copay max per admission	Not covered	COE Facility* (Preferred): $100 copay per day; $200 copay max per admission	20% coinsurance after deductible

*Aetna and Highmark Delaware have designated certain healthcare facilities within their provider network as Centers of Excellence, or simply COE Facilities. COE Facilities have been identified as delivering high-quality services and superior outcomes for specific procedures or conditions. This means improved outcomes and reduced cost, which includes delivering surgery and post-operative care more efficiently and with lower risk of complications and readmissions.

**Members are encouraged to review the Highmark or Aetna plan documents for details regarding coverage.

Important Note on Allowable Charge and Coinsurance:

- **Allowable Charge is the price your health carrier (Highmark or Aetna) determines is reasonable for care or supplies. The amount the plan pays for covered services received in or out-of-network is based on the allowable charge and this may be different than the billed amount shown on your Explanation of Benefits (EOB). If an out-of-network provider bills more than the allowable charge, you may have to pay the difference.**

- **Coinsurance is the part of the allowable charge that you pay after you satisfy your deductible and is typically a percentage of the allowable charge for a service. For example, if the health plan covers 90% of the allowable charge for a specific service, you may be required to pay the remaining 10% as coinsurance. If your in-network allowable charge for covered medical services is $100 and your coinsurance is 10%, you would pay $10. The health plan would pay the remaining $90.**

Additional benefits automatically included with your Health Plan enrollment:				
SurgeryPlus (Surgeons of Excellence) Alternative benefits for non-emergency, planned procedures **(Joint Replacement & Revision, Spine, Cardiac, GYN, Bariatric, Hernia, Gallbladder, Thyroid, Orthopedics, ENT, Gastroenterology (i.e., Colonoscopy, Endoscopy), Pain Management, Other Minor/Misc. Procedures (i.e., Biopsy, Excision of Mass))**	All out-of-pocket costs (deductible, coinsurance, copay) are waived; Concierge service (Care Advocate) included; Eligible travel expenses covered; Financial incentives offered (receive a check for $500 up to $4,000 depending upon procedure) Bariatric surgery required under SurgeryPlus and not eligible for a financial incentive	All out-of-pocket costs (deductible, coinsurance, copay) are waived; Concierge service (Care Advocate) included; Eligible travel expenses covered; Financial incentives offered (receive a check for $500 up to $4,000 depending upon procedure) Bariatric surgery required under SurgeryPlus and not eligible for a financial incentive	All out-of-pocket costs (deductible, coinsurance, copay) are waived; Concierge service (Care Advocate) included; Eligible travel expenses covered; Financial incentives offered (receive a check for $500 up to $4,000 depending upon procedure) Bariatric surgery required under SurgeryPlus and not eligible for a financial incentive	All out-of-pocket costs (deductible, coinsurance, copay) are waived; Concierge service (Care Advocate) included; Eligible travel expenses covered; Financial incentives offered (receive a check for $500 up to $4,000 depending upon procedure) Bariatric surgery required under SurgeryPlus and not eligible for a financial incentive
Prescription Coverage (Administered by CVS Caremark)	Included	Included	Included	Included
Employee Assistance Program (Administered by ComPsych® GuidanceResources®) **Note: Members can obtain a maximum of 5 one-on-one professional counseling sessions annually**	Included	Included	Included	Included
Wellness and Condition Care Coordination (Provided through your health plan)	Included	Included	Included	Included

For more information, visit the Statewide Benefits Office (SBO) website at de.gov/statewidebenefits.

Delta Dental
Plan Premiums
Effective: July 1, 2023

Plan Type	Coverage Level	Monthly Cost*
Delta Dental High Plan	Employee Only	$ 40.35
	Employee & One Dependent	$ 75.70
	Family	$ 119.65
Delta Dental Low Plan	Employee Only	$ 27.24
	Employee & One Dependent	$ 52.33
	Family	$ 98.07

** Deducted 2nd paycheck of each month*

DELTA DENTAL

Keep Smiling

Delta Dental PPO™

Save with PPO

Visit a dentist in the PPO[1] network to maximize your savings.[2] These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.[3] Find a PPO dentist at **deltadentalins.com**.

Set up an online account

Get information about your plan, check benefits and eligibility information, find a network dentist and more. Sign up for an online account at **deltadentalins.com**.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or Social Security number. If your family members are covered under your plan, they'll need your information. Prefer to have an ID card? Simply log in to your account to view or print your card.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim — we'll handle the rest.

Understand transition of care

Generally, multi-stage procedures are covered under your current plan only if treatment began after your plan's effective date of coverage.[4] Log in to your online account to find this date.

Get LASIK and hearing aid discounts

With access to QualSight and Amplifon Hearing Health Care[5], you can save as much as 50% on LASIK procedures and more than 60% on hearing aids. To take advantage of these discounts, call QualSight at **855-248-2020** and Amplifon at **888-779-1429**.

Save with a PPO dentist

PPO

NON-PPO

[1] In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

[2] You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

[3] You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

[4] Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

[5] Vision corrective services and Amplifon's hearing health care services are not insured benefits. Delta Dental makes the vision corrective services program and hearing health care services program available to you to provide access to the preferred pricing for LASIK surgery and for hearing aids and other hearing health services.

HL_PPO #129455W (rev. 10/20)

Plan Benefit Highlights for: City of Dover
Group No: 15426

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).			
Deductibles	$50 per person / $150 per family each plan year Separate $50 Orthodontics lifetime deductible per person			
Deductibles waived for Diagnostic & Preventive (D & P)?	Yes			
Maximums	**Low Plan:** $1,000 per person each plan year **High Plan:** $1,500 per person each plan year			
D & P counts toward maximum?	Yes			
Waiting Period(s)	Basic Services None	Major Services None	Prosthodontics None	Orthodontics None

	Low Plan		High Plan	
Benefits and Covered Services*	**Delta Dental PPO dentists†**	**Non-Delta Dental PPO dentists†**	**Delta Dental PPO dentists†**	**Non-Delta Dental PPO dentists†**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100 %	100 %	100 %	100 %
Basic Services Fillings and simple extractions	80 %	80 %	80 %	80 %
Endodontics (root canals)	0 %	0 %	80 %	80 %
Surgical Periodontics	0 %	0 %	50 %	50 %
Non-Surgical Periodontics (gum treatment)	80 %	80 %	50 %	50 %
Oral Surgery	0 %	0 %	50 %	50 %
Major Services Crowns, inlays, onlays and cast restorations	0 %	0 %	50 %	50 %
Prosthodontics Bridges, dentures and implants	0 %	0 %	50 %	50 %
Orthodontic Benefits Adults and dependent children	0 %	0 %	50 %	50 %
Orthodontic Maximums	N/A	N/A	$1,000 Lifetime	$1,000 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees.

† Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of Delaware
One Delta Drive
Mechanicsburg, PA 17055

Customer Service
800-932-0783

Claims Address
P.O. Box 2105
Mechanicsburg, PA 17055-6999

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.