

## BLUE CROSS BLUE SHIELD HEALTH BENEFIT OPTIONS

## METLIFE DENTAL

In-Network Benefits	PPO 1 - P62095	PPO 2 - P40309	HSA - P40236	In Network Benefits	Dental
Individual Deductible	\$1,000	\$1,500	\$2,800 *RVC Contributes \$1400	Individual Deductible	\$75 per calendar year
Family Deductible	\$2,000	\$3,000	\$5,600*** *RVC Contributes \$2800	Family Deductible	\$150 per calendar year
Individual OPX Limit (incl ded, co-pays & RX co-pays)	\$2,000	\$3,000	\$5,100	Maximum Benefit per person	\$1,250 per calendar year
Family OPX Limit (incl ded, co-pays & RX co-pays)	\$4,000	\$6,000	\$10,200	Diagnostic & Preventive Care	100% of Max Allowance
Coinsurance	80% in network 70% out of network	80% in network 70% out of network	**80% in network 70% out of network	Restorative Services	80% of Max Allowance after deductible
Office Visits-PCP	Deductible & Coinsurance	\$20 co-pay then 100%	Deductible & Coinsurance	General Services	80% of Max Allowance after deductible
Office Visits-Specialist	Deductible & Coinsurance	\$40 co-pay then 100%	Deductible & Coinsurance	Endodontic Services	80% of Max Allowance after deductible
Preventative Care	100%	100%	100%	Periodontic Services	80% of Max Allowance after deductible
Emergency Room	\$200 Co-Pay then 80% after deductible	\$200 Co-Pay then 80% after deductible	**\$200 Co-Pay then 80% after deductible	Oral Surgery Services	80% of Max Allowance after deductible
Prescriptions - Retail	\$25/\$50/\$75/\$150 up to 30 days	\$25/\$50/\$75/\$150 up to 30 days	**\$25/\$50/\$75/\$150 up to 30 days (after deductible)	Crowns, Inlays/Onlays	50% of Max Allowance after deductible
Prescriptions - Mail Order	\$20/\$30/\$50/\$100 up to 90 days	\$20/\$30/\$50/\$100 up to 90 days	**\$25/\$50/\$75/\$150 up to 90 days (after deductible)	Prosthetic, Implants	50% of Max Allowance after deductible
Vision	\$300 Cal Year Benefit & BCBS Discounts	\$300 Cal Year Benefit & BCBS Discounts	**\$300 Cal Year Benefit & BCBS Discounts (per federal guidelines)	Orthodontics	50% of Max Allowance after deductible

**HSA Plan- As subject to Federal Rules**

\* Rock Valley College contributes 50% of employee deductible

\*\*All parameters apply after deductible has been met

\*\*\*If a member and his/her dependents have family coverage, each calendar year they must satisfy the family coverage deductible before receiving benefits under this policy.

## Employee Monthly Contribution

	PPO1 - P62095		PPO2- P40309		HSA - P40236		MetLife Dental	
	EE – 20.50% SP,CH,FM - 22.50%	Non-wellness	Wellness Discount	Non-wellness	Wellness Discount	EE – 20.50% SP,CH,FM – 22.50%		
		EE – 21.50% SP,CH, FM – 22.50%	EE – 19% SP,CH,FM – 21%	EE – 21.50% SP,CH,FM – 22.50%	EE – 19% SP,CH,FM – 21%			
Employee Only	\$178.59	\$183.56	\$162.21	\$157.33	\$139.04	Employee Only	\$9.12	
Employee + Spouse	\$410.20	\$412.04	\$375.47	\$359.81	\$328.02	Employee + Spouse	\$18.46	
Employee + Child(ren)	\$392.94	\$395.07	\$359.63	\$345.00	\$314.19	Employee + Child(ren)	\$17.68	
Family	\$617.48	\$615.92	\$565.75	\$537.78	\$494.12	Family	\$27.84	