

Delta Flex Travelers

2009 Benefits Enrollment Guide



FEATURES / COVERED SERVICES
Coinsurance
Annual Deductible
Coinsurance Limit
Office Visit (PCP and Specialist)
Routine Preventive Care
Inpatient Hospital Care
Outpatient Hospital Care/Surgery
ER Services
Urgent Care Services
Pharmacy - Retail (30 day supply)
Pharmacy - Mail (90 day supply)

UnitedHealthcare® Tier 3 Plan	
In-Network	Out-of-Network
80%	60%
\$250 Individual \$500 Family	\$500 Individual \$1,000 Family
\$2,250 Individual \$4,500 Family	\$4,000 Individual \$8,000 Family
\$20 copay	60% after deductible
\$20 copay	60% after deductible
80% after deductible	60% after deductible
80% after deductible	60% after deductible
\$100 copay	
\$50 copay	60% after deductible
\$10 - Generic \$35 - Brand \$60 - Non-Formulary	
\$25 - Generic \$87.50 - Brand \$150 - Non-Formulary	

UnitedHealthcare® Tier 2 Plan	
In-Network	Out-of-Network
80%	60%
\$1,500 Individual \$3,000 Family	\$3,000 Individual \$6,000 Family
\$5,000 Individual \$10,000 Family	\$11,000 Individual \$22,000 Family
\$25 copay	60% after deductible
\$25 copay	60% after deductible
80% after deductible	60% after deductible
80% after deductible	60% after deductible
\$150 copay	
\$50 copay	60% after deductible
\$10 - Generic \$35 - Brand \$60 - Non-Formulary	
\$25 - Generic \$87.50 - Brand \$150 - Non-Formulary	

UnitedHealthcare® Tier 1 Plan	
In-Network	Out-of-Network
80%	60%
\$3,000 Individual \$6,000 Family	\$6,000 Individual \$12,000 Family
\$6,000 Individual \$12,000 Family	\$12,000 Individual \$24,000 Family
\$35 copay	60% after deductible
\$35 copay	60% after deductible
80% after deductible	60% after deductible
80% after deductible	60% after deductible
\$200 copay	
\$75 copay	60% after deductible
\$10 - Generic \$35 - Brand \$60 - Non-Formulary	
\$25 - Generic \$87.50 - Brand \$150 - Non-Formulary	

Contributions per Paycheck			
	Tier 3	Tier 2	Tier 1
Employee Only	\$18.00	\$6.02	\$0.00
Employee + Spouse	\$99.62	\$75.66	\$63.61
Employee + Child(ren)	\$83.30	\$61.73	\$50.89
Employee + Family	\$181.24	\$145.29	\$127.21

COVERED SERVICE/PLAN COMPONENT	METLIFE DENTAL
DEDUCTIBLE (INDIVIDUAL/FAMILY)	\$50 / \$150
CALENDAR YEAR MAXIMUM	\$1,500 per Individual
PREVENTIVE / DIAGNOSTIC (DEDUCTIBLE WAIVED) ORAL EXAMINATIONS, CLEANINGS	100%
BASIC SERVICES FILLINGS, EXTRACTIONS, PERIODONTICS, ENDODONTICS	80%
MAJOR SERVICES CROWNS, INLAYS, ONLAYS, BRIDGEWORK, DENTURES	50%
ORTHODONTICS (FOR CHILDREN TO AGE 19)	50%
ORTHODONTIC LIFETIME MAXIMUM	\$1,500 per Individual

COVERED SERVICE/PLAN COMPONENT	UHC VISION
EXAMS	Once every 12 months
LENSES	Once every 12 months
FRAMES	Once every 24 months

Metlife Dental Plan

CONTRIBUTIONS PER PAYCHECK	
EMPLOYEE ONLY	\$7.55
EMPLOYEE + SPOUSE	\$15.28
EMPLOYEE + CHILD(REN)	\$16.99
EMPLOYEE + FAMILY	\$26.47

United Healthcare Vision Plan

CONTRIBUTIONS PER PAYCHECK	
EMPLOYEE ONLY	\$1.82
EMPLOYEE + SPOUSE	\$3.46
EMPLOYEE + CHILD(REN)	\$3.61
EMPLOYEE + FAMILY	\$5.57