# Dental Plan Options
# for Medicare and Non-Medicare Eligible Retirees

| Benefits | Blue Cross Dental Plan | Delta Dental High Plan | Delta Dental Low Plan | DENCAP Dental (DHMO) |
|---|---|---|---|---|
| Maximum annual amount | $1,500 per member | $1,000 per member | $800 per member | $3,300 per member<br>$2,500 Primary Care Maximum<br>$800 Specialty Care Maximum |
| **Diagnostic** | | | | |
| Oral examinations | Twice per year: 100% In-network<br>50% Out-of-network | Twice per year<br>100% PPO Dentist<br>100% Premier Dentist<br>100% Out-of-network Dentist | Twice per year<br>100% PPO Dentist<br>100% Premier Dentist<br>75% Out-of-network Dentist | Twice Per Year 100%* |
| Emergency treatment for pain | 100% In-network<br>50% Out-of-network | 100% PPO Dentist<br>100% Premier Dentist<br>100% Out-of-network Dentist | 100% PPO Dentist<br>100% Premier Dentist<br>50% Out-of-network Dentist | 50%* up to $100 |
| X-rays | 100% In-network<br>50% Out-of-network<br>Limitations depending on type of x-ray | 100% PPO Dentist<br>100% Premier Dentist<br>100% Out-of-network<br>* Limitations depending on type of x-ray | 100% PPO Dentist<br>100% Premier Dentist<br>75% Out-of-network<br>* Limitations depending on type of x-ray | 100%8 |
| Prophylaxis – teeth cleaning | Twice per year:<br>100% In-network<br>50% Out-of-network | Twice per year<br>100% PPO Dentist<br>100% Premium Dentist<br>100% Out-of-network Dentist | Twice per year<br>100% PPO Dentist<br>100% Premium Dentist<br>75% Out-of-network Dentist | Twice Per 12 Months |
| Fluoride application | Twice per year:<br>100% In-network<br>50% Out-of-network | Twice per year<br>100% PPO Dentist<br>100% Premium Dentist<br>100% Out-of-network Dentist | Twice per year<br>100% PPO Dentist<br>100% Premium Dentist<br>75% Out-of-network Dentist | Twice Per 12 Months |
| Space maintainers | 18 and Younger:<br>Twice per quadrant:<br>100% In-network<br>50% Out-of-network | 100% PPO Dentist<br>100% Premier Dentist<br>100% Out-of-network Dentist | 100% PPO Dentist<br>100% Premier Dentist<br>100% Out-of-network Dentist | up to age 19: 100% |
| **Restorative** | | | | |
| Fillings: amalgam, composite | 80% In-network<br>50% Out-of-network | 80% PPO Dentist<br>50% Premier Dentist<br>50% Out-of-network Dentist | 50% PPO Dentist<br>50% Premier Dentist<br>50% Out-of-network Dentist | 85%* |
| Crowns: porcelains or metal | 50% In-network<br>50% Out-of-network | 50% PPO Dentist<br>50% Premier Dentist<br>50% Out-of-Network Dentist | 50% PPO Dentist<br>50% Premier Dentist<br>50% Out-of-Network Dentist | 80%* |
| Root canal therapy | 80% In-network<br>50% Out-of-network | 80% PPO Dentist<br>50% Premier Dentist<br>50% Out-of-network Dentist | 50% PPO Dentist<br>50% Premier Dentist<br>50% Out-of-network Dentist | 85%* |
| **Periodontics** | | | | |
| Treatment for gum disease of the mouth | 80% In-network<br>50% Out-of-network | 80% PPO Dentist<br>50% Premier Dentist<br>50% Out-of-network Dentist | 50% PPO Dentist<br>50% Premier Dentist<br>50% Out-of-network Dentist | 80%* if performed at a general dentist |

*PERCENTAGES are APPROXIMATE, see co-payments as listed on the Schedule of Benefits and Fixed Co-Pays.

| Benefits | Blue Cross Dental Plan | Delta Dental High Plan | Delta Dental Low Plan | DENCAP Dental (DHMO) |
|---|---|---|---|---|
| **Oral Surgery** | | | | |
| Extractions – simple and surgical | 80% In-network<br>50% Out-of-network | 80% PPO Dentist<br>50% Premier Dentist<br>50% Out-of-network Dentist | 50% PPO Dentist<br>50% Premier Dentist<br>50% Out-of-network Dentist | 85%* if performed at general dentist |
| **Prosthodontics** | | | | |
| Complete dentures | 50% In-network<br>50% Out-of-network | 50% PPO Dentist<br>50% Premier Dentist<br>50% Out-of-network Dentist | 50% PPO Dentist<br>50% Premier Dentist<br>50% Out-of-network Dentist | 85%* |
| Partial dentures – chrome acrylic | 50% In-network<br>50% Out-of-network | 50% PPO Dentist<br>50% Premier Dentist<br>50% Out-of-network Dentist | 50% PPO Dentist<br>50% Premier Dentist<br>50% Out-of-network Dentist | 80%* |
| Bridges | 50% In-network<br>50% Out-of-network | 50% PPO Dentist<br>50% Premier Dentist<br>50% Out-of-network Dentist | 50% PPO Dentist<br>50% Premier Dentist<br>50% Out-of-network Dentist | 75%* |
| **Orthodontics** | | | | |
| Orthodontics – teeth straightening | 50% In-network<br>50% Out-of-network | Up to age 19<br>50% PPO Dentist<br>50% Premier Dentist<br>50% Out-of-network Dentist | Up to age 19<br>50% PPO Dentist<br>50% Premier Dentist<br>50% Out-of-network Dentist | $1,800 up to age 19<br>$1,200 over age 19 per member |
| Orthodontics – lifetime maximum | $1,500 per member | $1,000 per member | $800 per member | $1,800 up to age 19<br>$1,200 over age 19 per member |
| **Specialty Care** | | | | |
| | | Special health care needs may be eligible for additional services | Special health care needs may be eligible for additional services | 50%* |
| **Service Provider** | | | | |
| | If you receive care from a nonparticipating dentist, you may be billed for the difference between the approved amount and the dentist charge. | If you receive care from a nonparticipating dentist, you may be billed for the difference between the approved amount and the dentist charge. | If you receive care from a nonparticipating dentist, you may be billed for the difference between the approved amount and the dentist charge. | Must use a provider in the DENCAP Dental Plan Network |
| Service area | Nationwide plan | Nationwide plan | Nationwide plan | Michigan |

*PERCENTAGES are APPROXIMATE, see co-payments as listed on the Schedule of benefits and Fixed Co-Pays.

# Vision Plan Options
# for Medicare and Non-Medicare Eligible Retirees

| Benefits | Heritage Local Vision Plan | Heritage National Vision Plan | Vision Service Plan (VSP) |
|---|---|---|---|
| **Frequency** | | | |
| Applies to all listed benefits, unless otherwise noted. | Once every 24 months from date of last service | Once every 12 months from date of last service | Once every plan year |
| **Exams for Glasses** | | | |
| Comprehensive exam for eyeglasses (does not apply to contact lens exam) | In-network: 100%<br>Out-of-network: reimbursed up to $25.00 | In-network:100%, $5.00 copay<br>Out-of-network: reimbursed up to $45.00 | 100% with $5.00 copay |
| **Frames** | | | |
| Frames | In-network: $100.00 retail allowance<br>Out-of-network: reimbursed up to $30.00 | In-network: $130.00 retail allowance (Member pays retail frame costs over allowance, less 20% discount) Out-of-network: reimbursed up to $70.00 | Benefit renews once every two years:<br>$130 allowance for a wide selection of frames, $180 allowance for featured frame brands, 20% off amount over your allowance Out-of-network: reimbursed $70 |
| Frame warranty | In-network:100% no copay (6 month U & C manufacturer's warranty) Out-of-network: N/A | In-network:20% discount (where applicable)<br>Out-of-network: N/A | Warranty varies by manufacturer |
| **Lenses** | | | |
| Single vision | In-network:100%<br>Out-of-network: reimbursed up to $30.00 | In-network:100%, $10.00 copay<br>Out-of-network: reimbursed up to $30.00 | 100% (included in prescription glasses) |
| Lined bifocal | In-network:100%<br>Out-of-network: reimbursed up to $35.00 | In-network:100%, $10.00 copay<br>Out-of-network: reimbursed up to $50.00 | 100% (included in prescription glasses) |
| Lined trifocal | In-network:100%<br>Out-of-network: reimbursed up to $40.00 | In-network:100%, $10.00 copay<br>Out-of-network: reimbursed up to $65.00 | 100% (included in prescription glasses) |
| **Lens options** | | | |
| Tint (one solid color tint) | In-network:100%<br>Out-of-network: N/A | In-network:20% discount<br>Out-of-network: N/A | Average 20-25% discount<br>Out-of-network: NA |
| Scratch resistant coating | In-network:100%<br>Out-of-network: N/A | In-network:20% discount<br>Out-of-network: N/A | Average 20-25% discount<br>Out-of-network: NA |
| Progressive (standard) | In-network: 100%, $55.00 Copay<br>Out-of-network: reimbursed up to $40.00 | In-network:100%, $55.00 copay<br>Out-of-network: reimbursed up to $50.00 | In-network:100%<br>Out-of-network: NA |

| Benefits | Heritage Local Vision Plan | Heritage National Vision Plan | Vision Service Plan (VSP) |
|---|---|---|---|
| Prism | In-network:100%<br>Out-of-network: N/A | In-network: 20% discount<br>Out-of-network: N/A | Average 20-25% discount<br>Out-of-network: NA |
| **Contact lenses (instead of glasses)** | | | |
| Comprehensive eye exam for contact lenses (applies to contact lens exam and fitting) | Standard Contact Fitting In-network: 100%, $40.00 copay (10% discount on premium fitting)<br>Out-of-network: N/A | In-network:100%, $40.00 copay<br>(10% discount on premium fitting)<br>Out-of-network: N/A | In-network: 100%, up to $60 copay |
| Contact lenses elective (includes disposables) | In-network:$45.00 retail allowance<br>(Member pays retail contact costs over allowance, less 10% discount)<br>Out-of-network: reimbursed up to $40.00 | In-network:$130.00 retail allowance<br>(Member pays retail contact costs over allowance, less 10% discount)<br>Out-of-network: reimbursed up to $105.00 | In-network: $130 allowance<br>copay does not apply<br>Out-of-network: reimbursed up to $105 |
| Contact lenses medically necessary | In-network:$45.00 retail allowance<br>Out-of-network: reimbursed up to $40.00 | In-network:100%, $10.00 copay<br>Out-of-network: reimbursed up to $210.00 | In network: 100%, $10 copay<br>Out-of-network: reimbursed up to $210<br>($105 per eye) |
| **Progressive myopic** | | | |
| Progressive myopic – rapidly changing near-sighted vision | Children (under age 19) may receive an annual exam and new lenses with a prescription change of plus or minus .50 diopters or more. | NA – annual services available to all members. | No interim benefit |
| **Hearing Aids** | | | |
| Discount Programs | Amplifon Hearing – Average of 62% off retail cost, wide choice of products, risk-free trial, follow-up care | Amplifon Hearing – Average of 62% off retail cost, wide choice of products, risk-free trial, follow-up care | TruHearing – Average 60% discount, 45-day free trial, free batteries, network of 6,000 providers |
| **Service area** | | | |
| | Select network (Southeastern Michigan region). | National network (includes locations in Hawaii and Puerto Rico). | National network |
| **Note:** Vision plans are two year plans. | | | |