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HAVE QUESTIONS?

BENEFITS CONTACT INFORMATION			
PROVIDER	**BENEFIT**	**PHONE #**	**WEBSITE**
Blue Cross Blue Shield of Michigan	PPO Medical	(800) 637-2227	www.bcbsm.com
Blue Care Network	HMO Medical	(800) 662-6667	www.bcbsm.com
Health Alliance Plan	HMO Medical	(313) 872-8100	www.hap.org
Consumerism Card	• Teladoc • Discounts	(800) 800-7616	www.MyMemberPortal.com
Delta Dental	Dental	(800) 524-0149	www.deltadentalmi.com
Superior Vision	Vision	(800) 507-3800	www.superiorvision.com
Discovery Benefits	Flexible Spending Accounts • Health Care • Dependent Care	(866) 451-3399	www.discoverybenefits.com
Health Equity	Health Savings Account	(866) 346-5800	www.healthequity.com
Unum	Long Term Care	(800) 227-4165	unuminfo.com/hfcc
Liberty Mutual	• Life Insurance • Short & Long Term Disability	For status on open claims: (800) 210-0268	www.mylibertyconnection.com Company Code: HenryFord
Liberty Mutual Work-Life Balance	Employee Assistance Program (EAP)	(877) 695-2789	bensingerdupont.com/MLA Password: MLASSIST
Liberty Mutual Travel Assistance Services	Worldwide Travel Assistance Program	Within US (410) 453-6330 Outside the US, please see the brochure	N/A
Public School Employees Retirement System Office of Retirement Services	Retirement	(800) 381-5111	www.michigan.gov/ors
Henry Ford College	General Benefits Questions Office of Human Resources	(313) 845-9692	hr.hfcc.edu/

YOUR BENEFIT GUIDE

Welcome! This guide is designed to provide you with an overview of your benefit options. You have the ability under the Henry Ford College benefit plan to customize your benefits to meet the needs of you and your family.

Which benefits are right for you and your family? The choice you make can impact your future. To help you with this important decision, we are providing this guide – you'll find information about our medical and dental plans, vision plan and more inside. This is important benefit information for you and your family. Please take the time to read this information carefully to ensure you are well acquainted with your benefit options.

ANNUAL ENROLLMENT

There is an annual enrollment period held each spring for the benefit programs that Henry Ford College offers. During this time, you can review and revise your elections as necessary to best meet the needs of your family.

Enrollment is conducted using BenXpress, Henry Ford College's online enrollment system.

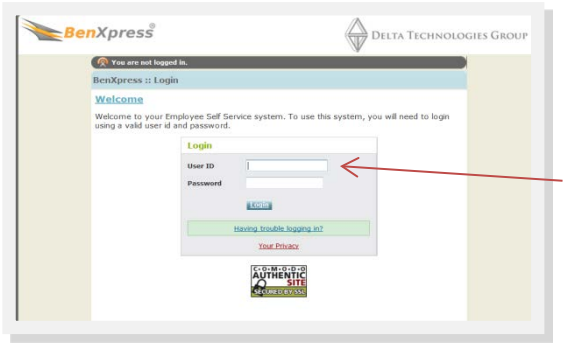
When you are ready to enroll, please go to www.benxpress.com/hfc. The first time that you login your User ID will be the initial letter of your first name and your entire last name. (For example, if your name is John Smith, your User ID is jsmith.) Your Password will be the last 6 digits of your social security number. You will have the opportunity to change your Password after your initial login.

BenXpress is available 24 hours a day, 7 days a week during the annual enrollment period. **Annual enrollment begins at 8:00 A.M. on Monday, November 13, 2017 and closes at 11:59 P.M. on Sunday, November 19, 2017**. You may log into the system and make changes as often as you choose during this time. The last changes you make before the end of the enrollment period will be your final elections.

INITIAL ELIGIBILITY PERIOD

Newly eligible employees will become a participant in the Plan on the first day of the month following your date of hire.

Enrollment is conducted using BenXpress. Henry Ford College will advise you of the specific period of time in which you must make your initial benefit elections.



Login to:
www.benxpress.com/hfc

User ID: First initial of your first name and last name
Password: Last 6 digits of your social security number

You may login to BenXpress anytime during the year to view your enrollment information and benefit plan documents, change your beneficiaries and more!

MAKING MID-YEAR CHANGES

We sponsor a program that allows you to pay for certain benefits using pre-tax dollars. With this program, contributions are deducted from your paycheck before federal, state, and Social Security taxes are withheld. As a result, you reduce your taxable income and take home more money. How much you save in taxes will vary depending on where you live and on your own personal tax situation.

These programs are regulated by the Internal Revenue Service (IRS). The IRS requires you to make your pre-tax elections before the start of the plan year (January 1 – December 31). The IRS permits you to change your pre-tax contribution amount mid-year only if you have a change in status, which includes the following:

- Birth, placement for adoption, or adoption of a child, or being subject to a Qualified Medical Child Support Order which orders you to provide medical coverage for a child
- Marriage, legal separation, annulment, or divorce
- Death of a dependent
- A change in your home address if it causes you to lose eligibility for coverage (this can happen when someone enrolls with an HMO, and then moves out of the HMO's service area)
- A change in employment status if it affects eligibility under the plan (i.e. full-time to part-time)
- A change in election that is on account of, and corresponds with, a change made under another employer plan
- A dependent satisfying, or ceasing to satisfy, eligibility requirements under the health care plan
- The employee or dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility or the employee or dependent becomes eligible for premium assistance subsidy under Medicaid or CHIP

The change you make must be consistent with the change in status. For example, if you get married, you may add your new spouse to your coverage. Or if your spouse's employment terminates and she/he loses medical coverage through their employer, you may elect coverage for yourself and your spouse under our program. Remember that you need to request the change through the Office of Human Resources within 30 days of the event or within 60 days for a loss of Medicaid or Children's Health Insurance Program (CHIP) coverage or when eligibility for premium assistance under Medicaid or CHIP is determined. If you do not notify the Office of Human Resources within the specified timeframe you must wait until the next annual benefit period to make a change.

These rules relate to the program allowing you to pay for certain benefits using pre-tax dollars. Please review the medical booklet and other vendor documents for information about when those programs allow you to add or drop coverage, add or drop dependents, and make other changes to your benefit coverage, as the rules for those programs may differ from the pre-tax program.

ELIGIBILITY

You are eligible to participate in the benefit programs if you are a regular full-time Local 71 Henry Ford College employee.

Your eligible **dependents** include:

- Your spouse through legal marriage
- Dependent children until the end of the month in which they reach age 26. They may remain covered to any age if they are totally and permanently disabled by either a physical or mental condition subject to certain criteria.
- Eligible children include:
    - Natural Children
    - Step-Children
    - Foster Children
    - Children for whom you are the Legal Guardian
    - Adopted Children
    - Children for whom you are required to provide coverage pursuant to a Court Order, including those subject to a Qualified Medical Child Support Order

DEPENDENT DOCUMENTATION

When you first enroll in or if you change coverage mid-year due to a qualified change in family status event, you are required to provide documentation substantiating the eligibility of any dependents within 30 days from the enrollment or change. Please refer to the list below for a list of acceptable forms of documentation. Copies should be submitted, not originals.

Approved dependent documentation includes:

- **Children under age 26:** Birth Certificate, Adoption Papers, Guardianship Document or Court Order.
- **Children over age 26 (disabled):** Contact the Office of Human Resources for required documentation.
- **Spouse:** Marriage Certificate and first page of IRS Income Tax Filing.

Also, if you or your dependents are enrolled in Medicare, please provide a copy of your Medicare card.

MEDICAL PLAN OPTIONS

Henry Ford College offers several medical plan options to eligible employees. Each of the options offers a comprehensive level of coverage that will protect you and your family from financial hardship should you incur substantial bills as a result of an illness or accident. If you and your family have medical plan coverage elsewhere, for example, through your spouse's employer, you can choose to waive out of the medical coverage.

You may choose among the following medical plan options:

MEDICAL PLAN OPTIONS

1. Blue Cross Blue Shield (BCBSM) Simply Blue PPO High Deductible Health Plan (HDHP)
2. Blue Care Network (BCN) HMO
3. Health Alliance Plan (HAP) HMO
4. No Coverage (waiver)

Below is an overview of the medical plan options. A detailed coverage comparison of the medical plan options is available in the back of this guide.

#1 BCBSM SIMPLY BLUE PPO (HDHP)

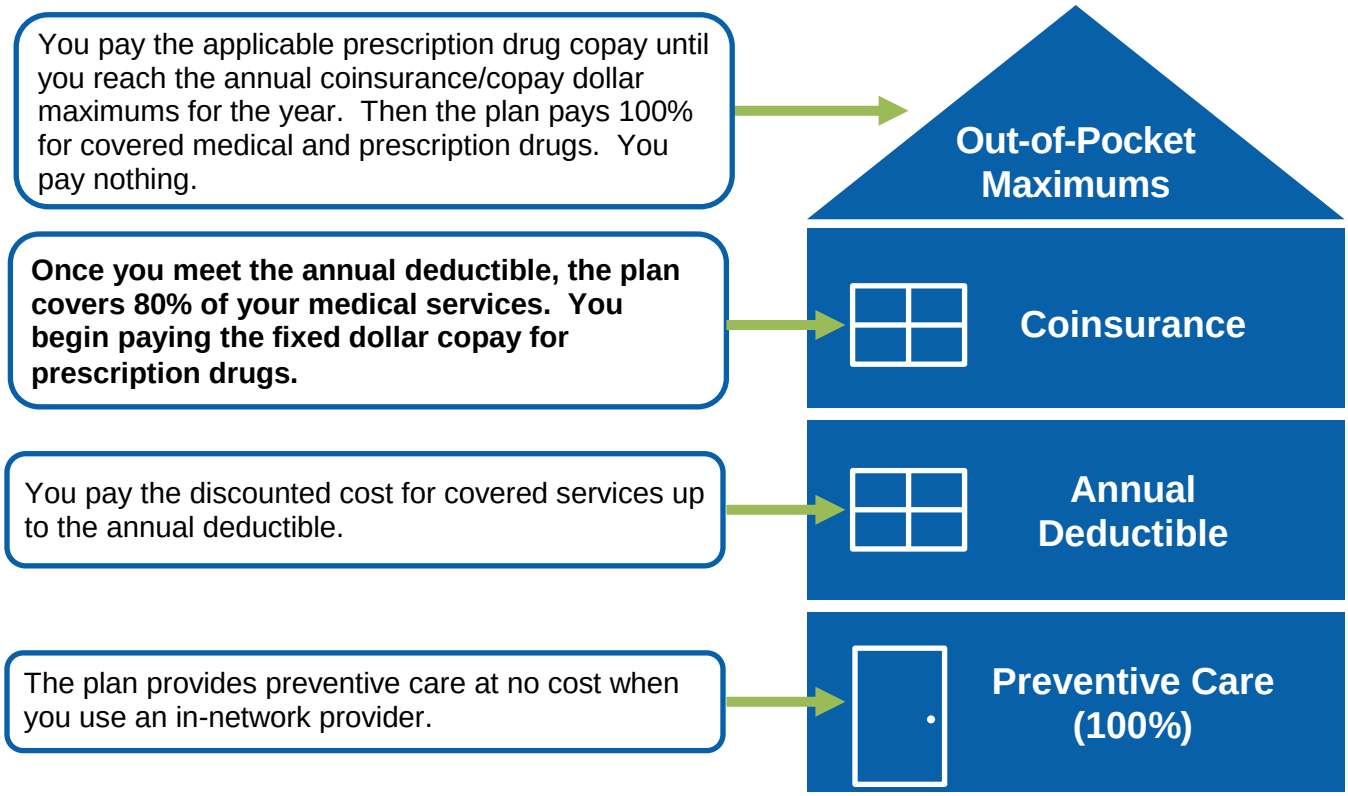
The "PPO" stands for Preferred Provider Organization. The Blue Cross Blue Shield (BCBSM) Simply Blue PPO (HDHP) option offers you comprehensive medical care coverage. You have the highest level of benefits and lowest out-of-pocket expenses when you receive care from BCBSM PPO physicians and facilities anywhere across the country. You don't need to select a Primary Care Physician (PCP) and you can see any BCBSM PPO provider you choose, even a specialist. There are no referrals for hospital, outpatient or ancillary services, and no claim forms when you receive care from BCBSM PPO providers. You can choose to see non-network providers for care, but your benefits will be reduced and your out-of-pocket costs will be higher. You may also be required to pay for services up front and file a claim for reimbursement.

If you choose a non-network provider, there are two types of providers you may encounter: "participating" and "non-participating" providers. Participating providers have signed agreements with BCBSM to accept the BCBSM approved amount as payment in full for covered services. When you use participating providers, you limit your out-of-pocket costs to deductibles, copayments, coinsurances or non-covered services. Non-participating providers have not signed agreements with BCBSM. This means they may or may not choose to accept the BCBSM approved payment as payment in full. If you receive services from a non-participating provider, you may be responsible for the difference between the BCBSM payment and the provider's charges. For example, if your non-participating provider charges $100 for services and the BCBSM approved amount is $80, you will be responsible for the $20 difference, in addition to any deductible, copayment or coinsurance that applies.

To find a BCBSM PPO provider, go to **www.bcbsm.com** and select "Find a Doctor." When you are asked to choose a plan, select "PPO Plans." You can also call **BlueCard Access®** at **1-800-810-BLUE (2583)** for the names and addresses of doctors and hospitals near you.

How the High Deductible Health Plan Works

As the name implies, this plan carriers a high deductible and you need to meet the deductible before the plan begins paying benefits. This applies to all services, including prescription drugs and office visits. However, the deductible does not apply to in-network preventative care.

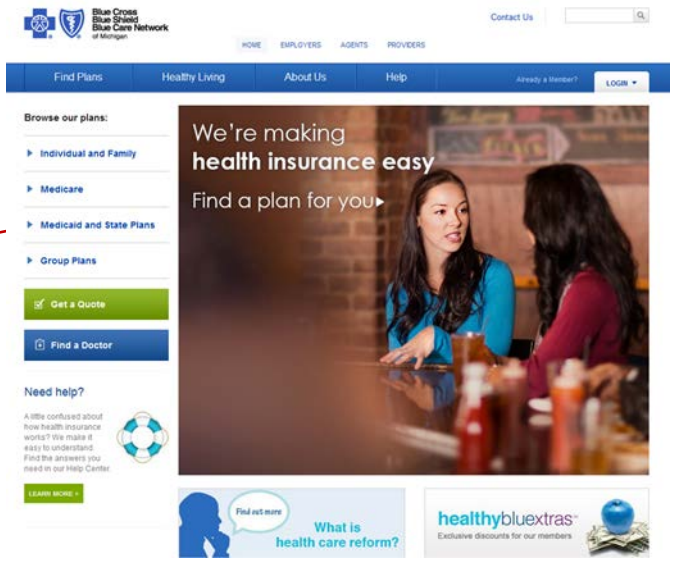


#2 BCN HMO

Blue Care Network (BCN) is an HMO plan that provides a high level of benefits through one of the largest networks in Southeast Michigan.

When you enroll in BCN, you need to select a Primary Care Physician (PCP) from BCN's list of providers; otherwise BCN will select one for you. You and each of your family members may choose a separate Primary Care Physician (PCP). Your Primary Care Physician (PCP) will be responsible for coordinating all of your medical care. The Primary Care Physician (PCP) will either perform the necessary service or refer you to a specialist. If you do not use your Primary Care Physician (PCP) or have his/her referral for the service, you will not have coverage under this plan (except for life threatening illnesses or injuries). For obstetric or gynecological care, you do not need prior authorization from BCN or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health professional in the network who specializes in obstetrics or gynecology.

TO FIND A BCN HMO PROVIDER:



To find a BCN HMO provider, go to **www.bcbsm.com** and select "Find a Doctor."

When you are asked to choose a plan, select "Blue Care Network (HMO)."

You can also call **BCN Member Services** at **1-800-662-6667** for the names and addresses of doctors and hospitals near you.

#3 HAP HMO

HMO stands for “Health Maintenance Organization”. This plan generally offers comprehensive medical care services. Most services are covered in full, although some care may require a copayment. There are no claim forms to complete.

When you enroll in HAP, you must select and use a Primary Care Physician (PCP), who is your first line of defense and the person to refer to in time of medical needs (except for an emergency). A PCP may be an internist, family practitioner, general practitioner, or pediatrician.

In some cases, your PCP may refer you to another provider in the network for treatment, which will be covered by your HMO. In order to see a specialist, you must receive a referral from your PCP. Please note, in most cases, your PCP will refer you to a specialist within the same hospital system as your PCP.

Females may obtain annual well-woman examinations and routine obstetrical and gynecological services from a network OB/GYN without a referral from their PCP.

You may change your PCP at any time simply by calling the Member Services Department. HAP has a program called “Self Direct”. It allows HAP members assigned to a Henry Ford Medical Group (HFMG) PCP to self-refer to these HFMG specialists: Audiology, Dermatology, Cardiology (Adults), Gastroenterology (Adults), Ophthalmology, Obstetrics/ Gynecology, and Otorhinolaryngology (ENT). You may refer to the HAP website for more information.

SELECTING YOUR HAP PRIMARY CARE PHYSICIAN (PCP)

Your PCP is the HAP-affiliated physician you select to coordinate your medical care. A PCP may be a family practitioner, internist or pediatrician. As an HMO member, you must select a PCP. Once you select a PCP, you must see him or her for all routine care and any other specialty services for which you received direction from him/her.

The HAP delivery system has two models – this is important to understand if you want to utilize doctors at multiple affiliated hospital locations:

Integrated delivery system model: This model consists of employed or closely affiliated providers utilizing the Henry Ford Health System (HFHS), Genesis, and ACCESS integrated system of care. This refers to electronics records, e-prescribing and e-visits. An integrated delivery system may also have centralized scheduling. You cannot seek services outside of these four networks.

Open delivery system model: This model consists of physicians and providers that have admitting privileges at more than one facility. Within this model, providers may have multiple relationships for directing medically necessary care.

Both systems have benefits in terms of coordination of care and ease of seeing providers when you need medically necessary services. Your choice of primary care physician (PCP) determines which system model you will receive services through.

To Find a HAP HMO Provider, go to **www.hap.org** and select the “Find a Doctor/Facility” tab. You can also call **HAP Member Services** at **1-800-422-4641** for the names and addresses of doctors and hospitals near you.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

You have access to the comprehensive Employee Assistance Program through Liberty Mutual called MyLibertyAssist. The EAP is free, 100% confidential and available to help you and your family members manage work/life issues and so much more. You have unlimited access to consultants by telephone, resources and tools online and up to three face-to-face visits with counselors for help with a short-term problem. Here are just some of the services you may receive:

- **Dependent Care:** Assistance with child care, elder care, adoption and education
- **Financial Issues:** Information on credit, debt, educational material and one free telephonic advice session
- **Legal Issues:** Legal advice by telephone and assistance with document preparation, divorce and separation, real estate and civil matters
- **Other Work/Life Issues:** Assistance with marital and family, personal, alcohol and drug abuse and stress and anger issues

You may access a variety of services at the MyLibertyAssist EAP website. Or if you would like to talk to a consultant for assistance with a particular issue, you can call them anytime 24/7. Again, this service is free and completely confidential.

WORLDWIDE TRAVEL ASSISTANCE PROGRAM

You also have 24/7/365 access to travel assistance through UnitedHealthcare Global and Liberty Mutual. Assistance is available to you when you are 100 or more miles away from home. Below are the types of services available:

- **Worldwide destination intelligence:** Get weather, currency, culture, embassy, and immunization and vaccination information
- **Travel:** Receive assistance with lost passports and credit cards, ticket replacement, emergency messages, emergency travel arrangements, translation, legal referral, and emergency cash advances
- **Medical evacuation and repatriation:** Get assistance with emergency medical evacuation, transportation to join a patient, transportation home for unattended minor children, and repatriation of mortal remains
- **Security and political evacuation:** Obtain assistance with security intelligence and evacuation arrangements in the event of a threatening political or security situation

Travel assistance services are available via toll-free or collect call telephone numbers that connect directly to UnitedHealthcare Global's Emergency Response Center.

FLEXIBLE SPENDING ACCOUNT (FSA) PROGRAM

Want to stretch your income, reduce costs and pay less in taxes? How? By enrolling in the Flexible Spending Account (FSA) Program administered by Discovery Benefits. You may choose to participate in the Health Care Flexible Spending Account or the Dependent Care Flexible Spending Account, or both depending upon your individual needs.

HEALTH CARE FSA

This account allows you to set aside **pretax** money from each paycheck to pay for eligible out-of-pocket health care expenses (not covered by your medical, dental or vision insurance) that you and your dependents incur throughout the plan year. You may participate in the Health Care FSA even if you do not participate in our medical, dental and/or vision programs.

Eligible health care expenses may include:

- Office visit and prescription drug co-payments
- Deductibles
- Co-insurance
- Expenses not covered through your medical plan
- Out-of-pocket dental, vision or hearing related expenses

Ineligible health care expenses may include:

- Insurance premiums for employer-sponsored benefits deducted from your paycheck on a pre-tax basis
- If you itemize certain medical expenses on your income tax returns, those expenses cannot be submitted for reimbursement under this plan

Not a bad deal at all. By taking advantage of this benefit, you can stretch the money available for health care expenses and reduce your federal income and social security taxes — and depending on where you live, your state and local income taxes as well. The maximum annual election for the Health Care FSA is $2,650.

If you enroll in the Blue Cross Blue Shield (BCBSM) Simply Blue PPO (HDHP), you may enroll in the Limited Purpose Health Care FSA. You can reimburse yourself for out-of-pocket dental and vision expenses with the Limited Purpose Health Care FSA. Medical and prescription drug expenses aren't eligible under the Limited Purpose plan.

DEPENDENT CARE FSA

To decide whether a Dependent Care FSA is right for you, determine if you will incur eligible expenses. Generally, day care, nursery school, after-school care, elder care and companion service costs that allow you (and your spouse, if applicable) to work or attend school full-time are eligible expenses.

Your dependent care expenses must be for qualified individuals, including:

- Your dependent child under the age of 13 who lives with you for more than half the year
- Your spouse or other tax dependent who is physically or mentally incapable of self-care and lives with you for more than half the year

By contributing to a Dependent Care FSA through payroll deduction, you are able to pay for these eligible dependent care expenses with **pretax** dollars. The maximum annual election for the Dependent Care FSA is $5,000.

HEALTH SAVINGS ACCOUNT (HSA)

The Health Savings Account is available to employees enrolled in the Blue Cross Blue Shield (BCBSM) Simply Blue PPO (HDHP).

To be eligible to contribute to a Health Savings Account, you cannot be covered by another health plan. This includes a Health Care Flexible Spending Account (unless it is a Limited Health Care Flexible Spending Account) and any health plan that does not qualify as a "high deductible health plan."

What is a Health Savings Account?

A Health Savings Account is an interest bearing account that gives you a way to pay for current health care expenses (such as deductible and coinsurance) or to save for future health care expenses. A Health Savings Account is owned by you and is portable from employer to employer. The balance rolls over from year to year and may be used for future health care expenses during active employment or retirement.

You can use the money in your Health Savings Account to pay for medical expenses for yourself, your spouse and tax dependents. With a Health Savings Account, you do not have to submit a claim with receipts. You simply pay for eligible expenses with your HSA debit card or set up an online payment that is sent directly to the provider or as a reimbursement to you.

More About Health Savings Accounts

- The maximum annual contribution for 2018 is $3,450 Single/$6,900 Family
- Individuals age 55 or older (and not enrolled in Medicare) may contribute an additional amount referred to as a catch-up contribution. The maximum annual catch-up contribution is $1,000.
- The money in your Health Savings Account can be withdrawn on a taxable basis for reasons other than a medical expense. The distribution is considered taxable income and is subject to a 20% penalty. Once you turn 65, or become disabled and/or enroll in Medicare, any distribution from your Health Savings Account for non-qualified medical expenses is considered taxable income but will not be subject to the 20% penalty.
- Once you turn 65, or become disabled and/or enroll in Medicare, you can continue to use funds from your Health Savings Account. However, after age 65, you will no longer be able to contribute money to it.
- It is your responsibility to report Health Savings Account activity on your tax return, including contributions to and distributions from your Health Savings Account during the year. You will need to maintain records of medical expenses paid for with your HSA funds, so keep your receipts in a safe place.
- For more info on Health Savings Accounts, go to **healthequity.com.**

Top Reasons to Enroll in an HSA

- ✓ **HSAs triple your savings.** 1) Contributions aren't taxed; 2) Your earnings and growth aren't taxed and 3) Withdrawals to pay for medical care are tax free too.
- ✓ **The money in your account is accessible**. You get a debit card backed by Visa, and by swiping the card at your doctor's office or pharmacy, you withdraw money from your account. Or you can request a disbursement from your HSA. Either way, it's a breeze.

- ✓ **There's no "use it or lose it" rule.** HSAs are designed to follow you into retirement. So the money rolls over year after year.
- ✓ **Like your 401(k), HSAs grow with time**. You earn interest on the money in your HSA, and better yet, can invest amounts over $2,000 in mutual funds.
- ✓ **You own it. You control it.** No matter where you go or what you do, you can take your HSA with you.

BENEFIT SUMMARIES

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MEDICAL PLAN COMPARISON

	BCBSM Simply Blue PPO (HDHP) **IN-NETWORK** **(Please see the BCBSM Benefits-At-A-Glance for OUT-NETWORK Benefits)**	BCN HMO	HAP HMO
CALENDAR-YEAR DEDUCTIBLE	$2,000 Single / $4,000 Family Notes: (1) Deductible combines amounts paid under the medical and prescription drug coverage. (2) The full family deductible must be met under a 2-person or family contract before benefits are paid for any person on the contract.	None	None
COINSURANCE %	80% Coverage	100% Coverage	100% Coverage
CALENDAR-YEAR OUT-OF-POCKET MAXIMUM (Includes deductible, coinsurance & copays)	$3,000 Single / $6,000 Family	$6,350 Single / $12,700 Family	$6,600 Single / $13,200 Family
LIFETIME MAXIMUM BENEFIT	None		
PREVENTATIVE SERVICES			
ROUTINE PHYSICALS WELL-CHILD CARE PAP SMEAR SCREENING MAMMOGRAPHY SCREENING PROSTATE SPECIFIC ANTIGEN (PSA) SCREENING IMMUNIZATIONS	100% Coverage (Not subject to copay, deductible or coinsurance)	100% Coverage	100% Coverage
PHYSICIAN OFFICE SERVICES (NON-PREVENTATIVE)			
PRIMARY CARE OFFICE VISIT	80% after in-network deductible	$20 Copay	$20 Copay
SPECIALIST OFFICE VISIT	80% after in-network deductible	$30 Copay	$20 Copay
CHIROPRACTIC OFFICE VISIT	80% after in-network deductible	$30 Copay	$20 Copay
URGENT CARE FACILITY	80% after in-network deductible	$35 Copay	$20 Copay
LAB AND X-RAY	80% after in-network deductible	100% Coverage	100% Coverage

MEDICAL PLAN COMPARISON Continued

	BCBSM Simply Blue PPO (HDHP) IN-NETWORK (Please see the BCBSM Benefits-At-A-Glance for OUT-NETWORK Benefits)	BCN HMO	HAP HMO
MATERNITY SERVICES			
PRENATAL AND POSTNATAL CARE	Prenatal: 100% after in-network deductible Postnatal: 80% after in-network deductible	$20 Copay	$20 Copay
LABOR, DELIVERY AND NEWBORN CARE	80% after in-network deductible	100% Coverage	100% Coverage
EMERGENCY CARE			
AMBULANCE	80% after in-network deductible	100% Coverage	100% Coverage
HOSPITAL EMERGENCY ROOM	80% after in-network deductible	$100 Copay	$150 Copay
INPATIENT HOSPITAL SERVICES			
SEMI-PRIVATE ROOM, SPECIALITY UNITS, PHYSICIAN SERVICES, SURGERY, THERAPY, LABORATORY, RADIOLOGY, HOSPITAL SERVICES AND SUPPLIES	80% after in-network deductible	100% Coverage	100% Coverage
ALTERNATIVES TO HOSPITAL CARE			
HOSPICE CARE	80% after in-network deductible	100% Coverage	100% Coverage
SKILLED NURSING CARE	80% after in-network deductible	100% Coverage	100% Coverage
HOME HEALTH CARE	80% after in-network deductible	$30 Copay	100% Coverage
MENTAL HEALTH AND SUBSTANCE ABUSE CARE			
INPATIENT TREATMENT	80% after in-network deductible	100% Coverage	100% Coverage
OUTPATIENT TREATMENT	80% after in-network deductible	100% Coverage	$20 Copay

MEDICAL PLAN COMPARISON Continued

	BCBSM Simply Blue PPO (HDHP) IN-NETWORK (Please see the BCBSM Benefits-At-A-Glance for OUT-NETWORK Benefits)	BCN HMO	HAP HMO
OTHER SERVICES			
ALLERGY TREATMENT AND INJECTIONS	80% after in-network deductible	100% Coverage	100% Coverage
PHYSICAL, OCCUPATIONAL OR SPEECH THERAPY	80% after in-network deductible	$30 Copay	100% Coverage
VOLUNTARY STERLIZATION	80% after in-network deductible	100% Coverage	100% Coverage
PRESCRIPTION DRUGS			
RETAIL	$10 Copay Generic $40 Copay Preferred Brand $80 Non-Preferred Brand	$10 Copay Generic $40 Copay Brand	$5 Copay Generic $25 Copay Preferred Brand $50 Non-Preferred Brand
MAIL ORDER	2 X Retail Copay	1 X Retail Copay	2 X Retail Copay

DELTA DENTAL PLAN

MAXIMUM BENEFIT AMOUNT FOR CLASS I, II AND III SERVICES PER PERSON PER CALENDAR YEAR	$1,700	
MAXIMUM BENEFIT AMOUNT FOR CLASS IV - ORTHODONIA LIFETIME MAXIMUM PER PERSON	$3,000	
SERVICE	**DELTA PPO OR PREMIER DENTIST**	**NON-PARTICIPATING DENTIST***
CLASS I BENEFITS		
DIAGNOSTIC AND PREVENTIVE SERVICES INCLUDES EXAMS, CLEANINGS, FLUORIDE, AND SPACE MAINTAINERS	Covered-100%	Covered-100%
EMERGENCY PALLIATIVE TREATMENT TO TEMPORARILY RELIEVE PAIN	Covered-100%	Covered-100%
RADIOGRAPHS X-RAYS	Covered-100%	Covered-100%
SEALANTS TO PREVENT DECAY OF PERMANENT MOLARS	Covered-100%	Covered-100%
BRUSH BIOPSY TO DETECT ORAL CANCER	Covered-100%	Covered-100%
CLASS II BENEFITS		
ORAL SURGERY SERVICES EXTRACTIONS AND DENTAL SURGERY	Covered-90%	Covered-90%
ENDODONTIC SERVICES ROOT CANALS	Covered-90%	Covered-90%
PERIODONTIC SERVICES USED TO TREAT DISEASES OF THE GUMS	Covered-90%	Covered-90%
RELINES AND REPAIRS TO BRIDGES AND DENTURES	Covered-90%	Covered-90%
MINOR RESTORATIVE SERVICES FILLINGS AND CROWN REPAIR	Covered-90%	Covered-90%
MAJOR RESTORATIVE SERVICES CROWNS	Covered-90%	Covered-90%
CLASS III BENEFITS		
PROSTHODONTIC SERVICES INCLUDES BRIDGES, IMPLANTS, AND DENTURES	Covered-90%	Covered-90%
CLASS IV BENEFITS		
ORTHODONTIC SERVICES **ORTHODONTIC AGE LIMIT**	Covered-90% None	Covered-90% None

- ***When services are received from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This Nonparticipating Dentist Fee may be less than what the dentist charges, which means that the patient will be responsible for the difference.**
- **Oral exams and cleanings are payable twice per calendar year**
- **Bitewing x-rays are payable once per calendar year and full mouth x-rays are payable once in any five-year period**
- **You are encouraged, but not required, to seek predetermination of benefits so that you will know before the dental service is provided how much, if any, of the cost of that service is not covered under the plan**
- **Other benefit limitations and exclusions apply. Please see the Delta Dental coverage booklet for more details.**

SUPERIOR VISION PLAN

COVERED SERVICES BENEFIT YEAR: ROLLING 12 MONTHS FROM DATE OF SERVICE		IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
EXAMINATIONS	Limited to one examination per benefit period	Covered in full	Plan pays up to $37 for Ophthalmologist; $28 for Optometrist
FRAMES	Limited to one frame per benefit period	Plan pays up to $175	Plan pays up to $86
LENSES	Limited to one set of lenses per benefit period		
	Single Vision	Covered in full	Plan pays up to $35
	Bifocal		Plan pays up to $50
	Trifocal		Plan pays up to $60
	Progressive	Covered at lined trifocal level	Plan pays up to $60
	Polycarbonate (for children up to age 18)	Covered in full	No coverage
	Photochromic	Plan pays up to $80	No coverage
	Tints, solid or gradient	Covered in full	No coverage
CONTACT LENSES	Limited to once per benefit period in lieu of eyeglass lenses and frames benefit		
	Elective	Plan pays up to $200	Plan pays up to $100
	Medically Necessary	Covered in full	Plan pays up to $210
LASER VISION CORRECTION		Superior Vision has a nationwide network of refractive surgeons who offer members a discount on services.	No coverage