



2022 GUIDE TO BENEFITS
Dental & Vision

Medical and Prescription Drug Options in 2022

- The DSRA-BT Medigap plans offered through the Hartford are now ALL available in ALL states.
- BCBSM Medicare Advantage Plans are available to DSRA-BT members through the Auto VEBA Trust at www.MyMedPlans.com
- Two BCBSM Prescription Drug plans, High and Low are available for DSRA-BT participants with the Hartford Medigap plans, BCBSM Medicare Advantage plans or as “standalone” plans.

Dental Benefits

We understand the importance of good dental health. Good oral hygiene is important to your overall health. Regular visits to the dentist can help detect problems like gingivitis and even oral cancer. Plan on visiting your dentist once every six months.

DSRA-BT offers dental coverage through Blue Cross Blue Shield of Michigan (BCBSM). The dental plans provide a wide variety of covered services – either covered in full or partially by the plans. Members will continue to have the choice to enroll in High or Low dental and/or vision which requires an application to be completed.

The table below provides an overview of the dental plan benefit. For specific details about the plans, please refer to the Benefits-at-a-Glance summary of benefits on the website at www.dsrabenfitrust.net.

LOW PLAN

Annual Dental Maximum per Person \$3,000

Class I Service

Includes but not limited to:
 Bitewing X-rays Full Mouth X-Rays
 Dental prophylaxis (Teeth Cleaning)
 Fluoride Treatment - Under 19y/o

\$0 = Your Deductible 0% = Your Coinsurance
 * 100% coverage for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.

Class II Service

Includes but not limited to:
 Fillings (for permanent & primary teeth)
 Root Canal Oral
 Surgery
 General anesthesia or IV sedation

\$50 = Your Deductible per member to a maximum of \$150 per family per calendar year
 20% = Your Coinsurance
 * 80% Coverage is for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.

Class III Service

Includes but not limited to:
 Dentures (complete & partial)
 Occlusal biteguards
 Endosteal Implants
 Onlays, crowns and veneer fillings- permanent teeth age 12 and older
 Bridge Installations

\$50 = Your Deductible 50% = Your Coinsurance
 * 50% Coverage is for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.

Class IV Service

Orthodontic services for dependents under age 19

Not Covered

HIGH PLAN

Annual Dental Maximum per Person

\$3,000

Class I Service

Includes but not limited to:

- Oral Exams
- Bitewing X-rays
- Full Mouth X-Rays
- Dental prophylaxis (Teeth Cleaning)
- Fluoride Treatment -Any age**

\$0 = Your Deductible
0% = Your Coinsurance

* 100% coverage for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.

Class II Service

Includes but not limited to:

- Fillings (for permanent & primary teeth)
- Onlays, Crowns, Veneers, Inlays - permanent teeth**
- Occlusal biteguards**
- Oral Surgery
- Root Canal

\$50 = Your Deductible per member to a maximum of \$150 per family per calendar year
20% = Your Coinsurance

* 80% Coverage is for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.

Class III Service

Includes but not limited to:
Dentures (complete & partial)
Endosteal Implants
Bridge Installations

\$50 = Your Deductible
50% = Your Coinsurance

* 50% Coverage is for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.

Class IV Service

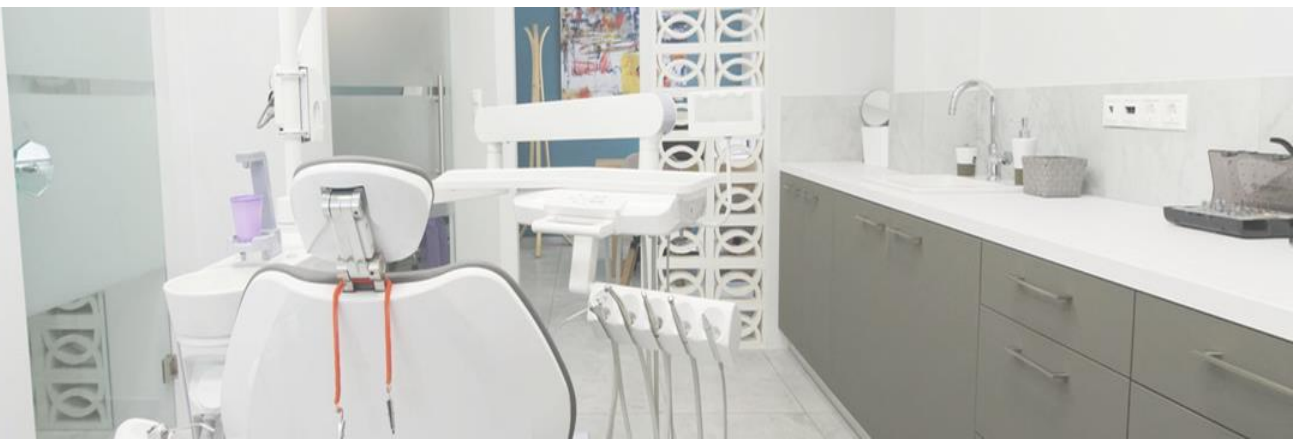
Orthodontic services for dependents under age 19**

50% = Your Coinsurance
\$2,500

Class IV Lifetime Maximum per Individual

*Before getting any major procedure, make sure to check with your provider for complete rates and coverage information.

**Consider these upgraded benefits when selecting the High Plan vs. Low Plan.



Vision Benefits

Your eyes are your windows to wellness. Routine eye exams each year allows your eye doctor to detect symptoms of serious eye disease – such as cataracts, glaucoma, and macular degeneration – and health conditions – such as diabetes, cardiovascular disease, and high blood pressure. Caught early, many of these diseases are treatable. However, left undetected and untreated, these conditions can result in vision loss, a lower quality of life, and higher overall health care costs.

DSRA-BT will continue to offer vision benefits through Blue Cross Blue Shield of Michigan (BCBSM). The vision plan offers you comprehensive coverage – including eye exams and materials – through VSP, the nation’s largest vision care network, with 27,000 doctors and 41,000 locations. Members will continue to have the choice to enroll in vision and/or dental which requires an application to be completed.

The table below provides an overview of the vision plan benefit. For specific details about the plan, please refer to the Benefits-at-a-Glance summary of benefits on the website at www.dsrabenefittrust.net. To find a VSP doctor, call 1-800-877-7195 or log on to the VSP website at www.vsp.com.

Members Responsibility (copays)

Benefits	VSP Network Doctor	Non-VSP Provider
Eye Exam	\$10	\$10 copay applies to charge
Prescription glasses (lenses and/or frames)	Combined \$15 copay	Member responsible for difference between approved amount and provider’s charge, after \$15 copay
Medically necessary contact lenses	\$15 copay	Member responsible for difference between approved amount and provider’s charge, after \$15 copay

Note: No copay is required for prescribed contact lenses that are not medically necessary

Eye Exam

Benefits	VSP Network Doctor	Non-VSP Provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	\$10 copay	Reimbursement up to \$45 less \$10 copay (member responsible for any difference)

One eye exam in any period of 12 consecutive months

Lenses and Frames

Benefits	VSP Network Doctor	Non-VSP Provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary.	\$15 copay (one copay applies to both lenses and frames)	Reimbursement up to approved amount based on lens type less \$15 copay (member responsible for any difference)
<ul style="list-style-type: none"> Progressive Lenses - Covered when rendered by a VSP network doctor 	One pair of lenses, with or without frames, in any period of 12 consecutive months	
Standard frames	\$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance)	Reimbursement up to \$70 less \$15 copay (member responsible for any difference)
Note: All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	One frame in any period of 24 consecutive months	

Contact Lenses

Benefits	VSP Network Doctor	Non-VSP Provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	\$15 copay	Reimbursement up to \$210 less \$15 copay (member responsible for any difference)
Contact lenses up to the allowance in any period of 12 consecutive months		
Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	\$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	\$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
Contact lenses up to the allowance in any period of 12 consecutive months		

Dental & Vision Rates (Stand Alone no Medical)

Retirees Under Age 65 -

LOW PLAN

	Dental /Vision	Dental Only	Vision Only
Single	\$72.23	\$64.75	\$7.48
Two Person	\$140.22	\$125.25	\$14.97
Family	\$240.85	\$216.00	\$24.85

The BCBSM Dental & Vision Standalone rates above **INCLUDE** the admin fee of \$4.25

HIGH PLAN

	Dental /Vision	Dental Only	Vision Only
Single	\$79.82	\$72.34	\$7.48
Two Person	\$155.41	\$140.44	\$14.97
Family	\$267.43	\$242.58	\$24.85

The BCBSM Dental & Vision Standalone rates above **INCLUDE** the admin fee of \$4.25

Medicare Disabled Retirees or Eligible Dependents Under Age 65 Retirees Post 65 -

LOW PLAN

	Dental /Vision	Dental Only	Vision Only
Single	\$70.82	\$64.75	\$6.07
Two Person	\$137.39	\$125.25	\$12.14
Family	\$203.96	\$185.75	\$18.21

The BCBSM Dental & Vision Standalone rates above **INCLUDE** the admin fee of \$4.25

HIGH PLAN

	Dental /Vision	Dental Only	Vision Only
Single	\$74.90	\$68.83	\$6.07
Two Person	\$145.55	\$133.41	\$12.14
Family	\$216.20	\$197.99	\$18.21

The BCBSM Dental & Vision Standalone rates above **INCLUDE** the admin fee of \$4.25

Dental & Vision Rates (with Hartford or Medicare Advantage Medical)

Medicare Disabled Retirees or Eligible Dependents Under Age 65

LOW PLAN

	Dental /Vision	Dental Only	Vision Only
Single	\$70.82	\$64.75	\$6.07
Two Person	\$137.39	\$125.25	\$12.14
Family	\$203.96	\$185.75	\$18.21

The BCBSM Dental & Vision Standalone rates above **INCLUDE** the admin fee of \$4.25

HIGH PLAN

	Dental /Vision	Dental Only	Vision Only
Single	\$74.90	\$68.83	\$6.07
Two Person	\$145.55	\$133.41	\$12.14
Family	\$216.20	\$197.99	\$18.21

The BCBSM Dental & Vision Standalone rates above **INCLUDE** the admin fee of \$4.25

No admin fee is added to the BCBSM Dental & Vision rates when enrolling in a bundled medical, dental and/or vision.

If you are over 65 and covered by Medicare, you must provide your Medicare ID number and Part A and/or Part B effective Date in Section I of the Benefit Enrollment and Change of Status Form or call Benistar, our plan administrator, at 1-888-588-6682 to receive the reduced rate.

Billing & Payments

Billing

Our plan administrator is Benistar Admin Services. If you elect any of the benefit plans offered through BCBSM – dental or vision – you will be billed monthly by Benistar, our plan administrator. Contact Benistar with any questions regarding the enrollment in these plans at **1-888-588-6682**.

It is essential that your premium payments be made on time. As such, members are **highly encouraged** to set up an automatic electronic-funds transfer with Benistar to make premium payments.

Payments Received After the Due Date

If you do not pay your monthly premium by the 1st of the month for which coverage is provided, you run the risk of your coverage being **terminated**.

If premiums are not paid by the due date, **coverage will be terminated as of the last day of the preceding month**. All benefits will cease, and no claims will be paid.

If you are not making any changes to your Dental /Vision coverage, **no action** is required however, if you use Automatic Electronic Fund Transfers, they will need to be established with Benistar for 2022.