


Programs for State of Wisconsin

	Dental Wisconsin		
	<i>Preferred Provider Option</i>		<i>Select Option</i>
	In-Network	Out-of-Network	
Diagnostic/Preventative	100%	75%	No Coverage
Basic	75%	55%	75%
Major/Restore – includes implants	50%	25%	50%
Ortho – for children under age of 19	50%	50%	50%
Ortho Lifetime Maximum	\$1,000		\$1,000
Annual Deductible	\$25	\$50	\$50
Office Visit Copay	None		None
Annual Benefit Maximum	\$1,000		\$1,000
Endodontic & Periodontic	Both Under Major/Restore		Both Under Major/Restore
Waiting Period (if no prior dental insurance) Basic Services Major Services Ortho Credit	Prior coverage credited 3 Months 3 Months 12 Months		Prior coverage credited 3 Months 3 Months 12 Months
Network	Dental PPO Providers	Premier Providers - Out of network providers with a participating agreement.	Any Dentist - Utilization of a Participating Provider will eliminate any charges over the plan allowance.
WI Providers	1,417	2,344	3,761 Participating
Rates			
Employee	\$25.54		\$16.99
Employee + Spouse/ Domestic Partner	\$54.08		\$34.93
Employee + Child(ren)	\$60.47		\$40.30
Family	\$91.41		\$59.28

EPIC Benefits+ <i>Formerly the EPIC Plan</i>			
<i>Dental</i>	<i>Excess Medical</i>	<i>AD&D</i>	<i>New Vision Option</i>
No Coverage	Annual Deductible \$250/\$500 Family	\$10,000 Employee	See reverse side 
No Coverage		\$5,000 Spouse/Domestic Partner	
50%	Individual Lifetime Maximum \$250,000	\$2,000 Child	
50%			
\$1,200	In-patient Hospital/ Surgical Services Deductible, then 100%	\$2,000 Child	
\$75			
None			
1 st Year \$500 2 nd Year \$750 3 rd Year \$1,000			
Both Under Major/Restore			
Ortho: 12 or 24 months			
Any Dentist - Utilization of a Participating Provider will eliminate any charges over the plan allowance.			
3,761 Participating			

Rates	Without Vision	With Vision
Single	\$16.70	\$20.70
Insured/Spouse	\$33.40	\$40.47
Insured/Child	\$33.40	\$40.47
Family	\$50.10	\$60.49


EPIC
 LIFE INSURANCE
We Take Care of You

EPIC Supplemental Vision Plan
Available only when enrolled in Benefits+
Davis Vision Network

Plan	In-Network Benefits (member pays copayment)	Non-Network Benefits
Copays Routine Eye Exam Lenses (spectacle or contact)	N/A, covered under “Uniform Benefits” \$25	N/A, covered under “Uniform Benefits” Not applicable
Frame Collection Fashion Copay Designer Copay Premier Copay Non-Collection Allowance	\$0 \$20 \$40 EPIC pays \$100 & member receives 20% ¹ discount on charges over \$100	EPIC pays \$30 allowance EPIC pays \$30 allowance EPIC pays \$30 allowance EPIC pays \$30 allowance
Lens Allowance Single, Bifocal, Trifocal, Lenticular	Plastic lenses included	EPIC pays \$25-\$60
Contact Lenses (In Lieu of Eyeglasses) Materials Standard Fitting & Follow-up Medically Necessary	\$100 & 15% ¹ discount on charges over \$100 Included at no cost Materials, evaluation, fitting, and follow-up included at no cost	EPIC pays \$75 allowance EPIC pays \$75 allowance EPIC pays \$225 allowance
Lens Upgrade Glass, Oversize, Scratch Resistant Coating, Polycarbonate Lenses (children & special)	Included at no cost	Not covered
Fashion Tinting Plastic Lens, Gradient Tinting Plastic Lens, Ultraviolet Coating	\$15 copay	
Blended Lenses (invisible), Photochromic Glass Lenses	\$20 copay	
Polycarbonate Lenses (all other)	\$35 copay	
Standard Anti-reflective Coating	\$40 copay	
Premium Anti-reflective Coating	\$55 copay	
Ultra Anti-reflective Coating	\$69 copay	
Standard Progressive Lenses	\$65 copay	
Premium Progressive Lenses	\$105 copay	
Intermediate Vision Lenses	\$30 copay	
High Index Lenses	\$60 copay	
Polarized Lenses	\$75 copay	
Photosensitive Plastic Lenses	\$70 copay	
Scratch Protection		
Single Vision	\$20 copay	
Multifocal	\$40 copay	
Benefit Frequency		
Lenses	12 months	12 months
Frames	24 months	24 months

¹Members receive full allowance towards Walmart's everyday low prices. Additional discounts do not apply.