



# Group Plan Comparison

PLAN	Grand	Hallmark	DCD
<b>GROUP SIZE</b>	5 or more Subscribers	3 or more Subscribers	2 or more Subscribers
<b>PLAN DETAILS</b>	<p>Class I - Preventive: 100%*</p> <p>Class II - Basic: 90%*</p> <p>Class III - Major: 70%*</p> <p>Class IV - Orthodontics: 35%*</p> <p>Specialty: 50%</p> <p>Deductible: None</p> <p><b>Vision Services Frequencies</b></p> <p>Exam: 12 months</p> <p>Frame: 24 months</p> <p>Lenses: 12 months</p> <p>Vision Co-Pays</p> <p>Exam: \$10   Materials: \$25</p>	<p>Class I - Preventive: 100%*</p> <p>Class II - Basic: 80%*</p> <p>Class III - Major: 60%*</p> <p>Class IV - Orthodontics: 35%*</p> <p>Specialty: 50%</p> <p>Deductible: None</p> <p><b>Vision Services Frequencies</b></p> <p>Exam: 12 months</p> <p>Frame: 24 months</p> <p>Lenses: 12 months</p> <p>Vision Co-Pays</p> <p>Exam: \$10   Materials: \$25</p>	<p>Class I - Preventive: 100%*</p> <p>Class II - Basic: 80%*</p> <p>Class III - Major: 60%*</p> <p>Class IV - Orthodontics: 35%*</p> <p>Specialty: 50%</p> <p>Deductible: None</p> <p><b>Vision Services Frequencies</b></p> <p>Exam: 12 months</p> <p>Frame: 24 months</p> <p>Lenses: 12 months</p> <p>Vision Co-Pays</p> <p>Exam: \$10   Materials: \$25</p>
<b>MONTHLY PLAN COSTS</b>	<p><b>Dental Only</b></p> <p>Single: \$21</p> <p>Two Persons: \$40</p> <p>Family: \$62</p> <p><b>With Superior Vision</b></p> <p>Single: \$27.50</p> <p>Two Persons: \$51.35</p> <p>Family: \$80.80</p>	<p><b>Dental Only</b></p> <p>Single: \$19</p> <p>Two Persons: \$34</p> <p>Family: \$55</p> <p><b>With Superior Vision</b></p> <p>Single: \$25.50</p> <p>Two Persons: \$45.35</p> <p>Family: \$73.80</p>	<p><b>Dental Only</b></p> <p>Single: \$22</p> <p>Two Persons: \$41</p> <p>Family: \$61</p> <p><b>With Superior Vision</b></p> <p>Single: \$28.50</p> <p>Two Persons: \$52.35</p> <p>Family: \$79.80</p>
<b>ANNUAL MAXIMUMS</b>	<p>Primary Care: \$2500</p> <p>Specialty Care: \$800</p> <p>Vision: N/A</p>	<p>Primary Care: \$2500</p> <p>Specialty Care: \$800</p> <p>Vision: N/A</p>	<p>Primary Care: \$2500</p> <p>Specialty Care: \$500</p> <p>Vision: N/A</p>
<b>WAITING PERIOD</b>	<p>Primary Care: None</p> <p>Specialty Care: None</p> <p>Vision: None</p>	<p>Primary Care: None</p> <p>Specialty Care: None</p> <p>Vision: None</p>	<p>Primary Care: None</p> <p>Specialty Care: 6 Months</p> <p>Vision: None</p>

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See Superior Vision Group Plan Benefits for optional vision coverage details.  
 DENCAP and Superior Vision are network based plans; out-of-network benefits are not covered.  
 \*PERCENTAGES are APPROXIMATE, based on member co-payments as listed on the Schedule of Benefits and Fixed Co-Pays

