

**2021 Local 1784 Insurance Comparison**

	<b>Union Dental/Vision The Standard Ins Company</b>		<b>City Dental/Vision Blue Cross/Blue Shield</b>	
<b>Dental Benefits</b>	<b>In-Network</b>	<b>Out of Network</b>	<b>In-Network</b>	<b>Out of Network</b>
Deductible (On Basic & Major Services Only)	Individual: \$50 Family: \$150	Individual: \$50 Family: \$150	Individual: \$50 Family: \$150	Individual: \$50 Family: \$150
Annual Maximum Benefit	\$1,250.00		\$1,500.00	\$1,500.00
<b>Preventive Services</b>				
Exams, Cleanings, X-Rays	100%	100%	100%	80% Employees & Spouses eligible for a \$25 gift card after showing proof of one cleaning per year
<b>Basic Services</b>				
Fillings, General Anesthesia, Surgery, Simple Extractions	90%	80%	80%	60%
<b>Major Services</b>				
Crowns, Bridges, Dentures, Inlays, Veneers	60%	50%	50%	40%
Orthodontia	50% to a Lifetime Max of \$1,000		50% to a Lifetime Max of \$1,000	
Waiting Periods	No Waiting Period		No Waiting Period	
Network Name	Classic PPO		BCBS Dental	
<b>Vision Benefits</b>	<b>In-Network</b>	<b>Out of Network</b>	<b>In-Network</b>	<b>Out of Network</b>
<b>Exams</b>	Once Every 12 Months	Covers Up to \$35	\$15 Copay One every 12 months	Covers Up to \$45
Deductible	\$10	\$0	\$0	\$0
<b>Lenses</b>	Once Every Rolling 12 months		Once Within A 12 Month Period	
Single Vision	Covered in Full	Up to \$25	\$15 Copay	Up to \$40
Bifocal	Covered in Full	Up to \$40	\$15 Copay	Up to \$65
Trifocul	Covered in Full	Up to \$55	\$15 Copay	Up to \$75
Lenticular	20% Discount	Not Covered	\$15 Copay	Up to \$100
<b>Contact Lenses</b>	Once every rolling 12 months		Limited to one set of lenses every calendar year	
Conventional Contact Lenses	\$150 Allowance	Up to \$105	\$150 Allowance	Up to \$120
Disposable Contact Lenses	\$150 Allowance	Up to \$105	\$150 Allowance	Up to \$120
Medically Necessary Contacts	\$0 Copay	Up to \$225	Covered at 100%	Up to \$210
<b>Frames</b>	Up to \$150 Once Every Rolling 24 months	Up to \$75	\$0 copay up to \$150 Allowance	Up to \$82
Network Name	EyeMed		BCBS Vision	
<b>Dental/Vision Premium (Per Payday)</b>				
Single	\$16.51		\$12.18	
Member + One	\$32.53		\$24.79	
Family (Employee + Two Dependents)	\$49.68		\$37.40	

Basic/Group Life - \$10,000 Life Insurance to all Local 1784 Members free of charge, regardless of active or retired or age

Voluntary Life Insurance \$20,000 \$3.42 per pay period  
(Member Life Insurance) \$50,000 \$8.55 per pay period

Voluntary Life Insurance \$10,000 \$1.50 per pay period  
(Spousal Life Insurance) \$25,000 \$3.75 per pay period  
(Must purchase member life in order to purchase spousal life)