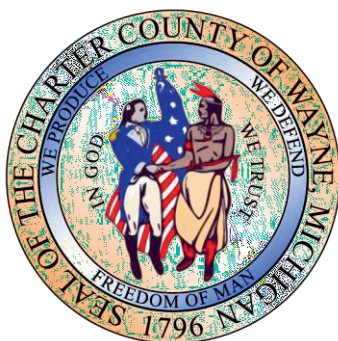


Wayne County Executive Retiree

Voluntary Dental and Vision Benefit Enrollment Information

Enrollment Period: October 3 - 20, 2025

For Coverage Effective: January 1 - December 31, 2026



Employees' Retirement System
Robert J. Grden, Executive Director



Warren C. Evans County Executive

October 3, 2025

To: All Wayne County Executive Retirees*

We have once again partnered with TMR & Associates, Inc. to provide you dental and vision plan offerings through reputable insurance carriers with convenient payment options. This 2026 Voluntary Dental & Vision Enrollment Booklet contains important information about the dental & vision plans being made available to you during an open enrollment period of October 3 through 20, 2025 for coverage beginning January 1, 2026.

This booklet contains information about the benefits and costs for plans being offered through:

Delta Dental Plans

Heritage Vision Plan

If you have not already done so, this is your opportunity to enroll you and your eligible dependents in a voluntary dental and/or vision plan. You will find specific benefit and provider information for each of the voluntary plans being offered in this booklet starting on page 3.

If you are electing to enroll for the first time, you must complete the 2026 Enrollment Form found on the back page of this booklet. Instructions for completing the form can be found on page 1. You will be responsible for the full cost of the plan(s) you select in the amount(s) indicated on the election form. Premium payments are payable through a deduction from your Wayne County Employees' Retirement System (WCERS) pension check or personal account through annual direct pay. Premium payment deductions made through your pension check will begin with the check to be issued on January 2, 2026, and be applied to the premium due for the month of January.

If you do not get a monthly pension check from WCERS, we offer direct billing through the Benefits Administration office as described on the enclosed enrollment form. Direct billing is arranged through your Benefit Enrollment Specialist at Wayne County.

If you are currently enrolled and do not wish to make a change at this time, no action is required – your coverage will remain in effect unless otherwise notified. If there has been a change in the monthly premium rate or coverage, the new rate or coverage will automatically become effective with the premium due for January 2026. The premium rates for 2026 are included on the 2026 Enrollment Form found on the back page of this booklet.

If you wish to cancel your current enrollment in a Voluntary Dental and/or Vision Plan, you may do so by completing Parts I and IV of the 2025 Enrollment Form (checking the last box in Part IV) and submitting it as directed on the form. Canceled coverage will end effective on December 31, 2025, unless you specify otherwise. Cancellation rules may apply.

Please take the time to read this booklet before completing the Enrollment Form; and then keep it so you can refer to it throughout the year. Should you have questions about the voluntary benefits offered you may contact the insurance carrier directly at the numbers listed below to speak with a representative. If you call, be sure to identify yourself as a Wayne County Retiree so that they can provide you with better assistance.

Delta Dental Plans
(800) 524-0149

Heritage Vision Plans
(800) 252-2053

Enrollment forms need to be submitted by October 20, 2025 for coverage to be effective January 1, 2026. If you need additional assistance, please contact our voluntary benefits program agency, TMR & Associates, Inc. at (313)-963-1135.

Sincerely,

Personnel/HR – Benefits Administration Division

**This offering does not apply to retirees of the Wayne County Airport Authority.*

**Wayne County Executive Retirees
Voluntary Dental and Vision
Benefit Plan Enrollment Booklet**

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ENROLLMENT INSTRUCTIONS

This booklet contains information about the plans offered by Delta Dental and Heritage Vision starting on page 3. Please review the materials provided in this booklet thoroughly. After making your selection, complete the Voluntary Dental and Vision Plan Benefits Enrollment Form found on the back page of the booklet. Instructions for completing the form can be found below.

Part I – Retiree Information

Please be sure to complete all the required information in this section, including providing your SSN and Retiree ID number, so that the insurance carrier will be able to issue coverage. Your Retiree ID number can be found on your pension check or direct deposit authorization statement (DDA).

Part II – Coverage Selection

Place an “X” in the box to indicate the plan and coverage type you wish to select.

Once you have chosen a dental plan and/or vision plan, you must select the coverage tier for each plan selection – single, two-person or family (3+). The monthly premium for each plan / coverage tier is displayed in this section.

Part III – Dependent Information

Please be sure to provide the requested information for each dependent to be enrolled in the dental/vision plan. Proof of relationship may be required.

Part IV – Authorization

This section must be signed and dated by the Retiree, and one of the boxes must be marked. Once you have completed and signed the form, use the attached self-addressed, postage-paid envelope to return this form to TMR & Associates, Inc. Alternatively, you may also fax this information to (313) 963-6947, or hand-deliver it to TMR's office located at 601 Abbott Street in Detroit 48226.

ENROLLMENT FORMS MUST BE RETURNED BY OCTOBER 20, 2025

Once You've Enrolled

Delta Dental and Heritage Vision do not provide ID cards. These may be printed from their websites (at www.deltadental.com and www.heritagevisionplans.com), or you may provide your information to the benefit provider directly to look up your eligibility.

If you have additional questions or need clarification regarding anything included in this booklet or on completing the Enrollment Form included herein, contact TMR & Associates, Inc. at (313) 963-1135 or by email to lowell@tmrandassoc.com.

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Delta Dental of Michigan is proud to be **your dental benefits provider.**



Have you scheduled your preventive dental visit?

Regular dental visits can prevent many oral health problems or help identify them earlier when treatment may be simpler and more affordable.

Get help when you need it.



Customer service 800-524-0149

Live help is available Monday–Friday,
8:30 a.m. to 8 p.m. ET.

An automated system is available at
all other times.

- Eligibility and benefit information
- Claim status
- Find a dentist near you



Your benefits 24/7 www.memberportal.com

Utilize our mobile-friendly Member Portal to:

- Review coverage and claims information
- Find a dentist near you
- Access online ID card
- Estimate dental care costs, and more!

Click the “Sign up!” link to register or
sign in with your username and password.

www.deltadentalmi.com | 800-524-0149

Delta Dental PPO™ Summary of Dental Plan Benefits For Group# 4600-8000 The Charter County of Wayne

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the Dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO™ Dentist Plan Pays	Delta Dental Premier® Dentist Plan Pays*	Nonparticipating Dentist Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services – fillings and crown repair	100%	100%	100%
Oral Surgery Services – extractions and dental surgery	100%	100%	100%
Major Restorative Services – crowns	100%	100%	100%
Major Services			
Endodontic Services – root canals	85%	85%	85%
Periodontic Services – to treat gum disease	85%	85%	85%
Other Basic Services – misc. services	85%	85%	85%
Relines and Repairs – to prosthetic appliances	85%	85%	85%
Prosthodontic Services – bridges, implants, dentures, and crowns over implants	85%	85%	85%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	No Age Limit		

* When you receive services from a Delta Dental Premier or Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's PPO Dentist Schedule that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her Dentist about treatment.
- Fluoride treatments are payable twice per calendar year with no age limit.
- Space maintainers are payable once per area per lifetime for people age 18 and under.
- Bitewing X-rays are payable twice per calendar year and full-mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any five-year period.
- Sealants are payable once per tooth per three-year period for first and second permanent molars for people age 19 and under. The surface must be free from decay and restorations.
- Veneers are payable on incisors, cuspids, and bicuspid once per tooth in any five-year period for people age 12 and older.

- Composite resin (white) restorations are payable on posterior teeth.
- Porcelain and resin facings on crowns are Covered Services on posterior teeth.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.
- Occlusal guards are payable once per 12-month period. Limited and complete occlusal adjustments are payable five times in any five-year period.
- People with special health care needs may be eligible for additional services including exams, hygiene visits, dental case management, and sedation/anesthesia. Special health care needs include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, healthcare intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of Dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our website or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – \$1,000 per Member total per Benefit Year on all services, except cephalometric films, photos, diagnostic casts and orthodontic services. \$1,000 per Member total per lifetime on cephalometric films, photos, diagnostic casts, and orthodontic services.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 50% of the per month fee charged by your Dentist based upon the agreed upon payment plan provided by Delta Dental to your Dentist.

Deductible – None.

Eligible People – Eligible Persons who are eligible for dental benefits are covered on the first day of the month following the date of the Subscriber's first pension check or on date of pension check if dated the first of the month.

Also eligible are your Spouse and your Children to the end of the calendar year in which they turn 26, including your Children who are married, who no longer live with you, who are not your dependents for Federal income tax purposes, and/or who are not permanently disabled.

Enrollees and dependents choosing this plan are required to remain enrolled for a minimum of 12 months. Should an Enrollee or Dependent choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may only enroll if the Enrollee is enrolled (except under COBRA) and must be enrolled in the same plan as the Enrollee. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate Benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Enrollees under This Plan.

Benefits will cease on the last day of the month in which your employment is terminated.

Customer Service Toll-Free Number: 800-524-0149 (TTY users call 711)
<https://www.DeltaDentalMI.com>
 January 1, 202

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WAYNE COUNTY RETIREES

PLAN EFFECTIVE 01/01/2026

CLIENT #4140-01 | GROUP #1055 GENERAL

CLIENT #4143-00 | GROUP #4143-01 CASH PAY

SERVICES	NETWORK COVERAGE	OUT OF NETWORK ^{5,6}
EYE EXAM		
Comprehensive Eye Exam	100% Covered, \$5.00 Co-Pay	Reimbursed up to \$40.00
FRAME		
Frame	\$130.00 Retail Allowance Member pays retail frame costs over allowance, less 20% discount ² Walmart/Sam's EDLP Frames Level 3 \$75.00 Retail Allowance ³	Reimbursed up to \$45.00
STANDARD LENSES		
Single Vision	100% Covered, \$10.00 Co-Pay	Reimbursed up to \$45.00
Bifocal	100% Covered, \$10.00 Co-Pay	Reimbursed up to \$50.00
Trifocal	100% Covered, \$10.00 Co-Pay	Reimbursed up to \$60.00
Progressive, Standard	100% Covered, \$50.00 Co-Pay	Reimbursed up to \$60.00
Progressive, Premium	80% of the difference between the standard and premium, \$50.00 Co-Pay	Reimbursed up to \$60.00
Lens Options		
Anti-Reflective Coating	20% Discount	N/A
Hi-Index	20% Discount	N/A
Mirror Coating	20% Discount	N/A
Photochromic/Transition, Single Vision	20% Discount	N/A
Photochromic/Transition, Multi-Focal	20% Discount	N/A
Polycarbonate, Child	20% Discount	N/A
Polycarbonate, Adult	20% Discount	N/A
Polarization	20% Discount	N/A
Scratch Coating	20% Discount	N/A
Tint, Solid	20% Discount	N/A
Tint, Gradient	20% Discount	N/A
UV Coating	20% Discount	N/A
Other Lens Options	20% Discount	N/A
CONTACT LENS SERVICES		
Standard Contact Fitting	\$40.00 Max Co-Pay	Reimbursed up to \$20.00
Premium Contact Fitting	10% Discount ³	N/A
Contact Lenses ¹	\$130.00 Retail Allowance Member pays retail contact lens costs over allowance, less 10% discount ^{3,4}	Reimbursed up to \$105.00
Medically Necessary Prior Approval Required	Covered up to U&C Amount, \$10.00 Co-Pay	Reimbursed up to \$210.00

Plan Information

Network

National

Service Frequency

Exam	Every 12 months
Frames	Every 12 months
Lenses	Every 12 months
Contacts	Every 12 months

Dependent Children

Covered to age 26 (EOY)

¹ You are eligible for contact lenses or eyeglasses, not both, in any plan year.

² Preferred pricing discounts may not be available for certain frame brands as determined by the manufacturer or where prohibited by law.

³ At participating Walmart/Sam's Club locations, the "Everyday Low Price" (EDLP) frame benefit level differs from other providers in the network. Due to Walmart's heavily discounted prices, there are no added preferred pricing discounts on premium fitting fees, contact lenses, non-covered upgrades, options, additional prescription eyeglass or sunglass purchases at these locations.

At participating US Vision, Nationwide Vision and Luxottica owned/operated locations, there are no discounts on premium fitting fees or contact lenses.

⁴ Discount may not apply to disposable contact lenses.

⁵ If you use the services of an in network provider but take advantage of a sale, coupon, or other in-store special, the provider may require that you pay in full and submit your itemized receipt for reimbursement at the out of network reimbursement rates.

⁶ Claims for out of network reimbursement must be filed within six months of service date.

EXTRA SAVINGS

20%

savings on additional glasses from your Heritage provider, with initial purchase
⁷In Network Only

15% off LASIK

available through LasikPlus®

HEARING AIDS UP TO 60% OFF RETAIL!

amplifon® Hearing Health Care

This is intended as an easy-to-read summary and provides a general overview of your benefits. It is not a contract.

To find a Heritage provider, visit www.heritagevisionplans.com, no login required.

Choose "NATIONAL NETWORK" from the dropdown.

Questions? Call **800.252.2053**.

Eligibility

Your eligibility to participate in this plan is determined by your employer, group or trust. Contact your benefit manager for eligibility rules.

Limitations

This plan is designed to cover eye examinations and corrective eyewear. It is also designed to cover visual needs rather than cosmetic options. Should you select options that are not covered under your plan, as shown in the vision benefits at a glance, you will pay a discounted fee to the participating provider, when applicable. Benefits are payable only for services received while your coverage is in force.

Exclusions:

- Non-Prescription Lenses
- Medical or surgical treatment of the eyes, including drugs and/or medications
- Replacement of lost or broken lenses or frames
- Vision training
- Services provided as a result of any workers' comp law, or similar legislation, or required by any governmental agency or program whether federal or state
- Two pairs of glasses instead of bifocals
- Parts or repair of frame not covered under manufacturers' warranty
- Services not visually necessary
- Corrective vision services, treatments and materials of an experimental nature
- Safety lenses (3mm) and/or frame with side shields
- Services not specified in scope of coverage
- Services or materials provided by any other group plan providing vision care
- Services rendered after the date an insured person ceases to be covered under the policy, except when materials ordered before coverage ended are delivered
- Benefits cannot be combined with any discount or promotional offering
- Fees charged for non-covered services and materials must be paid in full to the provider

Termination Provisions

Coverage will end on the earliest of: the date the policy ends, or the date you are no longer eligible.

Notes and Disclaimers

- The contact lens allowance may be used all at once, or throughout the plan year as needed, and may be applied toward contact lenses only
- Refractive Laser Surgery is considered an elective procedure, and may involve potential risks to patients. Heritage is not responsible for the outcome of any refractive surgery
- Discounts are not insured benefits
- ID cards are not required for services
- Other disclaimers may apply

Using an Out of Network Provider

If you choose to use an out of network provider or on-line vendor, here are the steps to take:

1. Verify your eligibility by logging in to the Member Web Portal <https://hvmwp.wonderboxsystem.com> to view your Benefits Summary. Or, call Customer Service toll free at 800.252.2053.
2. Make an appointment with the provider of your choice.
3. When the examination is complete and you have been fitted for necessary eyeglasses or contact lenses, pay the charges in full.
4. Request an itemized receipt.
5. Submit the completed Heritage Reimbursement Claim Form along with your itemized receipt(s) using one of these methods:

Electronic Submission:

<https://www.heritagevisionplans.com/Submit-A-Claim>

Manual Submission:

<https://www.heritagevisionplans.com/Reimbursement-Claim-Form>

Out of network benefits are subject to the same eligibility, frequency, limitation and exclusion provisions of the plan, and are in lieu of in network services.



YOU DESERVE

Benefits that fit **your lifestyle.**

WHY ENROLL

- **Eye exams are an important part of overall health.** Eyes are windows to the soul. Many pathologies can be detected through an eye exam, making regular appointments an essential component of overall physical health.
- **Eye care is for the whole family.** Your vision may be perfect—but what about your spouse's or your children's? Vision benefits ensure that your whole family is provided for.
- **Vision insurance can save you hundreds of dollars a year.** From reduced costs when seeing an eye doctor to discounts on glasses and contacts, vision is one benefit that can prove its worth.
- **Changes in eye health can be hard to spot!** Do you notice yourself squinting? Are you experiencing headaches? Do your eyes feel tired at the end of the day? Time to get your eyes checked!
- **Express your personal style!** You have more than one pair of shoes. Why one pair of glasses? You don't have to choose between versatile everyday frames and a bold statement look.



For more info:

Visit us online: www.heritagevisionplans.com

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**Wayne County Executive Retirees
VOLUNTARY DENTAL & VISION PLAN BENEFITS
2026 Enrollment Form**

Rates effective Jan. 1, 2026 through Dec. 31, 2026

Part I. RETIREE INFORMATION: *Please print*

Last Name			First Name			M.I.			Social Security Number (REQUIRED) ____ - ____ - ____		
Street Address			Apt. No.			Date of Birth (mm/dd/yyyy) ____ / ____ / ____			Retiree ID Number (Located on pension check or DDA) ____		
City			State			Zip Code			Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Area Code & Telephone Number (____) ____ - ____			Email Address ____ @ ____								

Part II. COVERAGE SELECTION: *Place an "X" in ONE box to indicate the plan and coverage tier for your dental and/or vision selection.*

Dental Plan Option	Provider or Facility No.*	One Person	Two Person	Family	Premium Payment Options
Delta Dental Plan PPO	N/A	<input type="checkbox"/> \$37.59/ mo	<input type="checkbox"/> \$73.40 / mo	<input type="checkbox"/> \$129.78/ mo	- Pension payroll deduction - Direct-pay – annual only
Heritage Vision Plan	N/A	<input type="checkbox"/> \$8.25 / mo	<input type="checkbox"/> \$13.76 / mo	<input type="checkbox"/> \$21.17/ mo	- Pension payroll deduction - Direct-pay – annual only

Part III. DEPENDENT INFORMATION: *Provide requested information for each dependent to be enrolled in the selected dental / vision plan.*

Rel. to Retiree	Dependent			Date of Birth (mm/dd/yyyy)	Sex	Last 4 Digits of Soc. Sec. No.
	Last Name	First Name	M.I.			
Spouse				____/____/____		____
Child				____/____/____		____
Child				____/____/____		____
Child				____/____/____		____

☐ Additional dependents included on the back of this form

Part IV. AUTHORIZATION: *Read the section below completely, check the appropriate boxes and sign and date the form before submitting.*

- ☐ I have elected to enroll myself and my eligible dependents in the above Voluntary Dental and/or Vision Plan. I understand that these plans are NOT sponsored by Wayne County and I understand that Wayne County will not contribute to the costs of the plan I have selected. Accordingly, I understand and agree that I am solely responsible for all costs and expenses associated with the plans.
- ☐ I hereby authorize the Wayne County Employees' Retirement System (WCERS) or its paying agent to deduct or recover the cost of the above selected voluntary dental and /or vision plan from my monthly retirement pension check from WCERS.
- ☐ I DO NOT receive a pension check from the WCERS, or do not wish to have my premium payments deducted from my pension check but wish to enroll via direct pay, if available. Contact your Wayne County Enrollment Specialist at 313-224-5157 or benefits@waynecountymi.gov for payment instructions. Coverage will not start until payment has been received.
- ☐ I wish to terminate part/all current voluntary dental and/or vision plan coverage for myself and/or any covered spouse and dependents. Effective Jan. 1, 2026, stop coverage for the following plan(s): ☐ Dental ☐ Vision ☐ Dental and Vision

Retiree Signature: _____ Date: _____

Return the completed form by fax or by mail in the enclosed, self-addressed envelope by October 20, 2025.

Return to: TMR & Associates, Inc. • 601 Abbott Street • Detroit, MI 48226
Phone: (313) 963-1135 • Fax: (313) 963-6947 • Email: lowell@tmrandassoc.com

Part III. DEPENDENT INFORMATION continued

[illegible]