ADN ADMINISTRATORS

PO Box 610
Southfield, MI 48037
248-901-3705

OKEMOS PUBLIC SCHOOLS Dental Benefits Plan — Group # 40457

Administrators, Administrative Assistants, Aides, Clerical, Directors, Non-Instructional and Transportation with Medical

The Plan-at-a-Glance	PPO Networks: ADN Dental Network
Maximum Benefits	**January 1st through December 31st**
Annual Maximum	$1,500 per eligible individual for covered class I, II and III services
Lifetime Maximum	$1,500 per eligible individual for covered class IV services
TMJ Services	Applies to annual maximum, up to lifetime maximum of $1000
Class I Preventive Services – 80%	***Incentive Plan Increases 10% per year to 100%
Routine Oral Examinations	Twice per plan year
Prophylaxis (Cleaning), Periodontal Maintenance	Twice per plan year
Topical Application of Fluoride	Twice per plan year to age 18
Bitewing X-Rays	Twice per plan year
Full-Mouth Series or Panoramic X-Rays	Once per 36 months
All Other X-Rays	
Class II Restorative Services – 80%	***Incentive Plan Increases 10% per year to 100%
Composite and Amalgam fillings**	
Space Maintainers	Up to age 14
Root Canal Therapy	
Periodontal Root Planing	
Periodontal Surgery	
Oral Surgery and Extractions	Medical plan primary for certain procedures
General Anesthesia or IV Sedation	With covered oral surgery or medically necessary
Occlusal Guards	For Bruxism Only
TMJ Appliances and Services	
Class III Major Services – 80%	
Inlays, Onlays and Crowns	
Complete and Partial Removable Dentures	
Fixed Partial Dentures (Bridges)	
Denture Repair and Adjustment	
Denture Reline or Rebase	
Addition of Teeth to Partial Dentures	
Class IV Orthodontic Services – 80%	
Limited and Interceptive Treatment	Removable and Fixed Appliance Therapy, up to age 19
Comprehensive Treatment	Fixed Appliance Therapy, up to age 19

Not Covered

Sealants — Implants and Related Restorations — Cosmetic Treatment

Deductible – None
Missing Tooth Clause – None
12 Month Billing Limitation
Waiting Periods – None
COB – Standard

**Composite and resins are not covered for posterior teeth, alternate benefit applies
**Prosthetics are considered on delivery date
***Annual Routine Exam or Prophy required for increase or retention of higher benefit level

****Note – Quotes of benefits do not constitute a guarantee of payment. Eligibility is determined at time of service. Covered benefits may have limitations or exclusions affecting plan payment. Refer to plan document for additional coverage details and limitations. Predetermination is strongly encouraged for all non-emergency dental treatment exceeding $250.00 in charges. The treatment plan should be submitted to ADN prior to beginning any treatment.**

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OKEMOS PUBLIC SCHOOLS Vision Benefits Plan **Group # 40457**

Administrators, Administrative Assistants, Aides, Clerical, Custodians, Directors, Food Service, Non-Instructional, Transportation

The Plan-at-a-Glance	Benefit Period – Twenty-Four Months
Routine Vision Examination	Covered Up to $75
Second Vision Exam with Medical Necessity	Covered Up to $58
Spectacle Lenses (Pair):	
Single Vision	Covered Up to $180
Bifocal	Covered Up to $190
Trifocal	Covered Up to $200
Lenticular or Progressive	Covered Up to $190
Standard Frames	Covered Up to $80
Contact Lenses (Pair)	
Cosmetic/Elective	Covered Up to $160

Extra Lens Features – None

Limits & Exclusions

1. Plan participants are limited to one routine vision examination during any twenty-four month period (once in twelve months with medical necessity).
2. Plan participants are limited to one pair of corrective spectacle lenses and one frame during any twenty-four month period.
3. Plan participants may choose between eyeglasses and contact lenses, but not both.

No Payments will be made for the following:

1. Non-corrective eyeglass or contact lenses
2. Vision therapy or subnormal vision aids
3. Medical or surgical treatment of the eyes
4. Replacement of lost or broken lenses or frames if benefits applicable to the replacement were previously provided during the benefit year
5. Charges with respect to which benefits are provided under any Workers' Compensation or similar law
6. Vision examination, lenses or frames which would have been furnished without cost in the absence of this insurance or for which an insured person has no legal obligation to pay
7. The cost of frames that exceeds the plan allowance
8. Extra charges for any lens treatments and coatings not listed under Extra Lens Features
9. Photochromic and Polycarbonate Lenses.
10. Charges for cosmetic (elective) contact lenses that exceed the annual plan allowance

Note: For each benefit period, covered charges for contact lenses are in lieu of all other covered charges except examinations during the benefit period for each insured person.