



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 1 st through December 31 st
Annual Maximum Lifetime Maximum TMJ Services	\$1,500 per eligible individual for covered class I, II and III services \$1,500 per eligible individual for covered class IV 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 Prophylaxis (Cleaning), Periodontal Maintenance Topical Application of Fluoride Bitewing X-Rays Full-Mouth Series or Panoramic X-Rays All Other X-Rays	Twice per plan year Twice per plan year Twice per plan year to age 18 Twice per plan year Once per 36 months
Class II Restorative Services - 80%	***Incentive Plan Increases 10% per year to 100%
Composite and Amalgam fillings** Space Maintainers Root Canal Therapy Periodontal Root Planing Periodontal Surgery	Up to age 14
Oral Surgery and Extractions General Anesthesia or IV Sedation Occlusal Guards TMJ Appliances and Services	Medical plan primary for certain procedures With covered oral surgery or medically necessary For Bruxism Only

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 I\	/ Orthodontic	Servi	ces	80%
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Limited and Interceptive Treatment Comprehensive Treatment Removable and Fixed Appliance Therapy, up to age 19 Fixed Appliance Therapy, up to age 19

Not Covered

Sealants

Implants and Related Restorations

Cosmetic Treatment

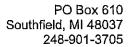
Deductible – None Missing Tooth Clause – None 12 Month Billing Limitation

**Composite and resins are not covered for posterior teeth, alternate benefit applies

Waiting Periods – None **Prosthetics are considered on delivery date COB – Standard ***Annual Routine Exam or Prophy required for

***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.





OKEMOS PUBLIC SCHOOLS Vision Benefits Plan

Group # 40457

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

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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.