ADN ADMINISTRATORS

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

CLIO AREA SCHOOLS Dental Benefits Plan

Group #40100

Custodial Staff and Mechanics

The Plan-at-a-Glance	PPO Networks: ADN Dental Network, DenteMax
Maximum Benefits	**July 1st through June 30th**
Annual Maximum	$1,000 per eligible individual for covered class I, II and III services.
Lifetime Maximum	$1,300 per eligible individual for covered class IV services
Class I Preventive Services – 80%	
Routine Oral Examinations	Twice per plan year
Prophylaxis (Cleaning) **100% benefit**	Twice per plan year
Topical Application of Fluoride	Twice per plan year to age 19
Bitewing X-Rays	Once per plan year
Full-Mouth Series or Panoramic X-Rays	Once per 60 months
All Other X-Rays	
Space Maintainers	Up to age 14
Class II Restorative Services – 80%	
Composite and Amalgam fillings	
Onlays and Crowns**	Once per permanent tooth per 60 months
Root Canal Therapy	
Periodontal Maintenance	Following active treatment
Periodontal Root Planing	Once per quadrant per 24 months
Periodontal Surgery	Once per quadrant per 36 months
Oral Surgery and Extractions	Medical plan primary for certain procedures
General Anesthesia or IV Sedation	With covered oral surgery or medically necessary
Occlusal Guards	Once per lifetime
Denture Repair and Adjustment	
Denture Reline or Rebase	Once per 36 months, per arch
Class III Major Services – 80%	
Complete and Partial Removable Dentures	Once per arch per 60 months
Fixed Partial Dentures (Bridges)	Once per area per 60 months
Addition of Teeth to Partial Dentures	
Implants	Once per permanent tooth per 60 months
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 TMJ/TMD Treatment Cosmetic Treatment

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

**Porcelain and ceramic not covered for posterior teeth, alternate benefit applies
**Prosthetics are considered on delivery date

****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 booklet for additional coverage details and limitation. 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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CLIO AREA SCHOOLS Vision Benefits Plan — Group #40100

The Plan-at-a-Glance	Benefit Year – July 1st through June 30th
Vision Examination	Covered up to $85
Spectacle Lenses (Pair):	
Single Vision	Covered Up to $100
Bifocal	Covered Up to $130
Trifocal	Covered Up to $160
Progressive	Covered Up to $160
Lenticular	Covered Up to $175
Frames	Covered Up to $130
Contact Lenses (Pair)	
Cosmetic/Elective (Includes Exam and Fitting Fees)	Covered Up to $115

Extra Lens Features	
All Tints including Photochromic and Solid Tints	Covered Up to $125
Polarization	Covered Up to $105
Polycarbonate Lenses for Children under age 18	Covered Up to $75
Polycarbonate Lenses for Adults	Covered Up to $45
Rimless Drill and Mounting	Covered Up to $30

Limits & Exclusions

1. Plan participants are limited to one vision examination during a benefit year
2. Plan participants are limited to one pair of corrective spectacle lenses and one frame during a benefit year
3. Plan participants may choose between eyeglasses or 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. Charges for cosmetic (elective) contact lenses, including the exam, prescription and fitting fee, that exceed the annual plan allowance

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