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

ELKTON-PIGEON-BAY PORT-LAKER SCHOOLS Vision Benefits Plan **Group # 42063**
Aides, Food Service, Transportation – Employee coverage only / Instructional, Mechanics, Supervisors

The Plan-at-a-Glance	**Benefit Period – January 1st through December 31st**
Vision Examination	Covered Up to $64
Spectacle Lenses (Pair):	
Single Vision	Covered Up to $84
Bifocal	Covered Up to $96
Trifocal	Covered Up to $120
Lenticular or Progressive	Covered Up to $144
Frames	Covered Up to $65
Contact Lenses (Pair)	Covered Up to $200

Extra Lens Features - None

Limits & Exclusions

1. Plan participants are limited to one vision examination during any benefit year period.
2. Plan participants are limited to one pair of corrective spectacle lenses and one frame or pair of contacts during any benefit year period.
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. Photochromic, Polarized and Polycarbonate Lenses.
10. Charges for contact lenses that exceed the one-time annual plan allowance

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

PO Box 610
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ELKTON-PIGEON-BAY PORT-LAKER SCHOOLS Vision Benefits Plan **Group # 42063**
Food Service-Family coverage

The Plan-at-a-Glance	Benefit Period – January 1st through December 31st
Vision Examination	Covered Up to $48
Spectacle Lenses (Pair):	
Single Vision	Covered Up to $63
Bifocal	Covered Up to $72
Trifocal	Covered Up to $90
Lenticular or Progressive	Covered Up to $108
Frames	Covered Up to $100
Contact Lenses (Pair)	Covered Up to $150

Extra Lens Features - None

Limits & Exclusions

1. Plan participants are limited to one vision examination during any benefit year period.
2. Plan participants are limited to one pair of corrective spectacle lenses and one frame or pair of contacts during any benefit year period.
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. Photochromic, Polarized and Polycarbonate Lenses.
10. Charges for contact lenses that exceed the one-time annual plan allowance

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

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ELKTON-PIGEON-BAY PORT-LAKER SCHOOLS Vision Benefits Plan **Group # 42063**
Clerical

The Plan-at-a-Glance	Benefit Period – January 1st through December 31st
Vision Examination	Covered Up to $64
Spectacle Lenses (Pair):	
Single Vision	Covered Up to $84
Bifocal	Covered Up to $96
Trifocal	Covered Up to $120
Lenticular or Progressive	Covered Up to $144
Frames	Covered Up to $65
Contact Lenses (Pair)	Covered Up to $200

Extra Lens Features - None

Limits & Exclusions

1. Plan participants are limited to one vision examination during any benefit year period.
2. Plan participants are limited to one pair of corrective spectacle lenses and one frame or pair of contacts during any benefit year period.
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. Photochromic, Polarized and Polycarbonate Lenses.
10. Charges for contact lenses that exceed the one-time annual plan allowance

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

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ELKTON-PIGEON-BAY PORT-LAKER SCHOOLS Vision Benefits Plan **Group # 42063**
Administrators

The Plan-at-a-Glance	Benefit Period – January 1st through December 31st
Vision Examination	Covered Up to $64
Spectacle Lenses (Pair):	
Single Vision	Covered Up to $84
Bifocal	Covered Up to $96
Trifocal	Covered Up to $120
Lenticular or Progressive	Covered Up to $144
Frames	Covered Up to $65
Contact Lenses (Pair)	Covered Up to $200

Extra Lens Features - None

Limits & Exclusions

1. Plan participants are limited to one vision examination during any benefit year period.
2. Plan participants are limited to one pair of corrective spectacle lenses and one frame or pair of contacts during any benefit year period.
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. Photochromic, Polarized and Polycarbonate Lenses.
10. Charges for contact lenses that exceed the one-time annual plan allowance

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

ADN ADMINISTRATORS

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

ELKTON-PIGEON-BAY PORT-LAKER SCHOOLS Vision Benefits Plan **Group # 42063**
Aides-Family coverage

The Plan-at-a-Glance	**Benefit Period – January 1st through December 31st**
Vision Examination	Covered Up to $40
Spectacle Lenses (Pair):	
Single Vision	Covered Up to $42
Bifocal	Covered Up to $48
Trifocal	Covered Up to $60
Lenticular or Progressive	Covered Up to $72
Frames	Covered Up to $90
Contact Lenses (Pair)	Covered Up to $100

Extra Lens Features - None

Limits & Exclusions

1. Plan participants are limited to one vision examination during any benefit year period.
2. Plan participants are limited to one pair of corrective spectacle lenses and one frame or pair of contacts during any benefit year period.
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. Photochromic, Polarized and Polycarbonate Lenses.
10. Charges for contact lenses that exceed the one-time annual plan allowance

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

PO Box 610
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ELKTON PIGEON BAY PORT LAKER Dental Benefits Plan — Group # 40202

Administrators

The Plan-at-a-Glance	PPO Networks: ADN Dental Network
Maximum Benefits	**January 1st through December 31st**
Annual Maximum	$1,300 per eligible individual for covered class I, II and III services
Lifetime Maximum	$1,550 per eligible individual for covered class IV services
TMJ Services	Applies to annual maximum, up to lifetime maximum of $1300
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
Inlays, Onlays and Crowns	
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
Occlusal Guards	For Bruxism Only
TMJ Appliances and Services	
Class III Major Services – 80%	**Annual deductible applies**
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 – $25 Individual Lifetime Class I & II, $25 Individual/$50 Family Annual Class III, $50 Individual Lifetime Class IV
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.**

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

ELKTON PIGEON BAY PORT LAKER Dental Benefits Plan Group # 40202
Administrators

The Plan-at-a-Glance	PPO Networks: ADN Dental Network
Maximum Benefits	**January 1st through December 31st**
Annual Maximum	$1,300 per eligible individual for covered class I, II and III services
Lifetime Maximum	$1,550 per eligible individual for covered class IV services
TMJ Services	Applies to annual maximum, up to lifetime maximum of $1300
Class I Preventive Services – 90%	*****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 – 90%	*****Incentive Plan Increases 10% per year to 100%**
Composite and Amalgam fillings**	
Space Maintainers	Up to age 14
Inlays, Onlays and Crowns	
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
Occlusal Guards	For Bruxism Only
TMJ Appliances and Services	
Class III Major Services – 80%	**Annual deductible applies**
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 – $25 Individual Lifetime Class I & II, $25 Individual/$50 Family Annual Class III, $50 Individual Lifetime Class IV
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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ELKTON PIGEON BAY PORT LAKER Dental Benefits Plan Group # 40202

Administrators

The Plan-at-a-Glance	PPO Networks: ADN Dental Network
Maximum Benefits	**January 1st through December 31st**
Annual Maximum	$1,300 per eligible individual for covered class I, II and III services
Lifetime Maximum	$1,550 per eligible individual for covered class IV services
TMJ Services	Applies to annual maximum, up to lifetime maximum of $1300
Class I Preventive Services – 100%	*****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 – 100%	*****Incentive Plan Increases 10% per year to 100%**
Composite and Amalgam fillings**	
Space Maintainers	Up to age 14
Inlays, Onlays and Crowns	
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
Occlusal Guards	For Bruxism Only
TMJ Appliances and Services	
Class III Major Services – 80%	**annual deductible applies**
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 – $25 Individual Lifetime Class I & II, $25 Individual/$50 Family Annual Class III, $50 Individual Lifetime Class IV
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 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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ELKTON PIGEON BAY PORT LAKER SCHOOLS Dental Benefits Plan — Group # 42063

Aides, Clerical, Food Service, Instructional, Mechanics, Supervisors

The Plan-at-a-Glance	PPO Networks: ADN Dental Network, DenteMax
Maximum Benefits	**January 1st through December 31st**
Annual Maximum	$1,000 per eligible individual for covered class I and II 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 – 70%	*****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 – 70%	*****Incentive Plan Increases 10% per year to 100%**
Composite and Amalgam fillings**	
Space Maintainers	Up to age 14
Sealants	Up to age 14
Inlays, Onlays and Crowns	Once per permanent tooth in 60 months
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
Occlusal Guards	For Bruxism Only
TMJ Appliances and Services	
Class III Major Services – 0%	
Class IV Orthodontic Services – 50%	
Limited and Interceptive Treatment	Removable and Fixed Appliance Therapy, up to age 19
Comprehensive Treatment	Fixed Appliance Therapy, up to age 19
Not Covered	

Major Prosthetics | 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.**