MENDON COMMUNITY SCHOOLS DENTAL BENEFIT PLAN **Effective July 1, 2014**
Dental Summary of Benefits

DENTAL BENEFITS	BENEFIT PAYMENT	MAXIMUM BENEFIT
Benefit Year Deductible (January 1st – December 31st)	**Waived.** Dental Plan benefits are not subject to a Calendar Year Deductible.	Calendar Year maximum benefit of $1,500 per individual for Type 1, 2 & 3 Dental Services.
Type 1 - Preventive Dental Services 1. Oral Examinations and Office Visits (twice in any period of 12 consecutive months) 2. Routine Cleanings (twice in any period of 12 consecutive months) 3. Fluoride Treatments (twice in any period of 12 consecutive months for members up to age 19) 4. Bitewing Films (once in any period of 12 consecutive months) 5. Full-Mouth X-rays (once in any five-year period; 60 months) 6. Emergency Treatment	100% of covered expenses.	
Type 2 - Basic Dental Services 1. Amalgam and Synthetic Fillings 2. Tooth Extractions; simple or surgical. 3. Periodontal Services 4. Endodontic Services; including root canals. 5. Oral Surgery 6. Relines and Repairs; bridges and dentures.	50% Coinsurance.	
Type 3 - Major Dental Services Prosthodontic Services: caps, crowns, bridges, dentures, and implants. Implants and implant related services are covered once per tooth in any five-year period.	50% Coinsurance.	
Type 4 - Orthodontic Services Includes examination and braces, for individuals up to age 19.	50% Coinsurance.	Lifetime maximum orthodontic benefit of $1,000 per individual.

MENDON COMMUNITY SCHOOLS VISION BENEFIT PLAN **Effective July 1, 2014**
Vision Summary of Benefits

VISION BENEFITS	BENEFIT PAYMENT	MAXIMUM BENEFIT
Benefit Year Deductible (January 1st – December 31st)	**Waived.** Vision Plan benefits are not subject to a Calendar Year Deductible.	No Annual Maximum Benefit; No Lifetime Maximum Benefit. Participants may elect to receive benefits for one pair of glasses OR one pair of contact lenses during any 12 month period.
Vision Examination: Limited to 1 examination every 12 months.	$6.50 Member Co-payment	
Frames: Limited to one pair of frames every 12 months.	$175 maximum allowance	
Lenses: Single Vision, Lined Bifocal, Lined Trifocal & Lenticular. Limited to one set of lenses every 12 months.	$18 Member Co-payment	
Extra Lens Features: Photochromic, Sun or Gradient Tints and Tinted or Color-coated Single Vision, Lined Bifocal Lenses, Lined Trifocal Lenses & Lenticular. **Polaroid:** Single Vision, Lined Bifocal, Lined Trifocal & Lenticular **Oversize & Rimless**	Covered in Full	
Contact Lenses: Includes Contact lenses, exam and fitting fees. Limited to one set of lenses every 12 months.	$110 maximum allowance	

- **Questions regarding Coverage and/or Benefits should be directed to:**

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