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

CITY OF BERKLEY Vision Benefits Plan — Group #9479

Public Safety Command

The Plan-at-a-Glance	Benefit Period – Twenty-four Months
Maximum Benefit Allowance	**$500 per Benefit Period**
Vision Examination	Covered at 100% of Reasonable & Customary (R&C)
Eyeglass Lenses (Pair):	
Single Vision	Covered at 100% of R&C
Bifocal	According to Limits & Exclusions
Trifocal	
Lenticular	
Progressive	
Frames	Covered at 100% of R&C
Contact Lenses (Pair)	Covered at 100% of R&C
Laser Surgery	Active employees only, once per eye in lifetime Maximum benefit allowance applies

Extra Lens Features – Polycarbonate, Photochromic (Transition), Polarized, Oversize Lenses, Anti-Reflective, UV and Scratch Coatings

Limits & Exclusions

1. Plan participants are limited to covered vision services listed above up to the maximum benefit allowance per benefit period.

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 (including diagnostic procedures) except as indicated above
4. Charges with respect to which benefits are provided under any Workers' Compensation or similar law
5. 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
6. Extra charges for any lens treatments and coatings not listed under Extra Lens Features
7. Charges that exceed the Maximum Benefit Allowance amount during a benefit period

Note: For each benefit period, covered charges for eyeglasses, contact lenses, optional eyeglass lens treatments and laser surgery are payable up to the Maximum Benefit Allowance for each insured person.

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CITY OF BERKLEY Dental Benefit Plan — Group #9479

Public Safety Command Officers and Retirees

The Plan-at-a-Glance	PPO Networks: ADN Dental Network, DenteMax
Maximum Benefits	**Plan year November 1 through October 31**
Annual Maximum	$1500 per eligible individual for covered class I, II and III services.
Lifetime Maximum	$ 600 per eligible individual for covered class IV services
Class I Preventive Services – 100%	
Oral Examinations	Twice per plan year
Prophylaxis (Cleaning)	Twice per plan year (include first and second periodontal maintenance)
Topical Application of Fluoride	Once per plan year to age 19
Bitewing X-Rays	Twice per plan year
Full-Mouth Series or Panoramic X-Rays	Once per 60 months
All Other X-Rays	
Sealants	Once per permanent molar per 36 months to age 14
Space Maintainers	Once per area per lifetime, up to age 19
Class II Restorative Services – 80%	
Composite and Amalgam fillings**	Once per tooth surface per 12 months
Root Canal Therapy	
Periodontal Maintenance	Third and fourth occurrence, twice per plan year
Periodontal Root Planing	Once per quadrant per 24 months
Periodontal Surgery	Once per quadrant per 36 months
Oral Surgery and Extractions	
General Anesthesia or IV Sedation	With covered oral surgery or medically necessary
Inlays, Onlays and Crowns**	Once per permanent tooth in 60 months
Occlusal Guard	Once per lifetime
Denture Repair and Adjustment	
Denture Reline or Rebase	Once per 36 months, per arch
Class III Major Services – 50%	
Complete and Partial Removable Dentures**	Once per arch per 60 months
Fixed Partial Dentures (Bridges)**	Once per arch per 60 months
Addition of Teeth to Partial Dentures	
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	

Implants and Restorations over Implants TMJ/TMD Treatment Cosmetic Treatment

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

**Composite, 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. Benefits are payable at the applicable percentage level of the Usual and Customary or PPO Fee Schedule allowed amount for the procedure rendered. 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.**