SUMMARY OF BENEFITS

LINCOLN COUNTY SCHOOL DISTRICT
VISION & DENTAL CARE BENEFITS

EFFECTIVE OCTOBER 1, 2016

TPSC GROUP # 45833

DENTAL SUMMARY OF BENEFITS

BENEFIT PERIOD	Calendar Year
BENEFIT LIMITATION	All Dental Services are limited to a Usual & Customary and/or Reasonable (UCR) allowance.
ANNUAL MAXIMUM BENEFIT	**$1,750** per Individual per Calendar Year

DENTAL BENEFITS

Class I **Preventive & Diagnostic Services**	**Class II** **Restorative Services**	**Class III** **Major Services**
Exams	Extractions	Inlays and Onlays
Cleanings	Fillings	Crowns
X-rays	Palliative Emergency Treatment	Implants
Fluoride	Space Maintainers	Bridges
Sealants	Repair of Dentures and Bridges	Dentures
	Oral Surgery	Bruxism Splints and Nightguards
	Apicoectomy	Periodontal Splints
	Endodontics	
	Periodontics	

Percentage Paid for Class I, Class II and Class III Services

	Class I	**Class II**	**Class III**
1st Year	70%	70%	70%
2nd Year	80%	80%	80%
3rd Year	90%	90%	90%
4th Year	100%	100%	100%

In the first Calendar Year a Covered Person receives covered dental services, the Plan will pay 70 percent of Covered Expenses. For each succeeding Calendar Year in a row that a Covered Person receives covered dental services, the percentage will increase by 10 percentage points, up to a maximum of 100 percent. This means that in the 2nd year in a row that a Covered Person receives covered dental services, the Plan will pay 80 percent of Covered Expenses. In the 3rd year in a row, the Plan will pay 90 percent, and in the 4th year, 100 percent of Covered Expenses.

If in any Calendar Year a Covered Person fails to receive covered dental services, the percentage payable will remain at the same level. For each succeeding year in which a Covered Person fails to receive covered dental services, the percentage of Covered Expenses the Plan pays will decrease 10 percentage points, but never below 70 percent.

NOTE: The percentage the Plan pays for a Covered Person who becomes enrolled after July 1 in any Calendar Year will be increased by 10 percentage points at the beginning of the following Calendar Year whether or not covered dental services were received. However, the percentage the Plan pays in subsequent Calendar Years will either increase or decrease as described in previous paragraphs.

VISION SUMMARY OF BENEFITS FOR AGES EIGHTEEN (18) & YOUNGER

BENEFIT PERIOD	12 Months[1]
VISION BENEFITS	**ANY PROVIDER**
VISION EXAM **VISION HARDWARE**— Eyeglass Lenses, Fitting Fee, Frames & Special Features *(tinting, scratch resistant coating, etc)* Contact Lenses & Fitting Fee	Limited to **$600** for all services combined per Benefit Period.

VISION SUMMARY OF BENEFITS FOR AGES NINETEEN (19) & OLDER

BENEFIT PERIOD	24 Months[2]
VISION BENEFITS	**ANY PROVIDER**
VISION EXAM **VISION HARDWARE**— Eyeglass Lenses, Fitting Fee, Frames & Special Features *(tinting, scratch resistant coating, etc)* Contact Lenses & Fitting Fee	Limited to **$600** for all services combined per Benefit Period.

NOTE: Your new Vision Benefit is effective on October 1, 2016, and the full $600 benefit will be available to you regardless of any use of your vision benefits in the prior 12- or 24-month Benefit Period.

[1]12-Month Benefit Period. Your Vision Benefit Period begins on your Initial Date of Service. For example, if you purchase eyeglasses on October 15, the 12-month benefit period is from October 15 to October 14 of the following year. You may use your full $600 benefit during that 12-month Benefit Period. Any benefit remaining at the end of your Benefit Period is lost.

After one Benefit Period ends, your next Benefit Period does not start until you receive a new Vision Service, which now becomes your Initial Date of Service. For example, if you then had an eye exam on December 5, the 12-month benefit period would then be from December 5 to December 4 of the following year.

[2]24-Month Benefit Period. Your Vision Benefit Period begins on your Initial Date of Service. For example, if you purchase eyeglasses on October 15, the 24-month benefit period is from October 15 to October 14 of the second year. You may use your full $600 benefit during that 24-month Benefit Period. Any benefit remaining at the end of your Benefit Period is lost.

After one Benefit Period ends, your next Benefit Period does not start until you receive a new Vision Service, which now becomes your Initial Date of Service. For example, if you then had an eye exam on December 5, the 24-month benefit period would now be from December 5 to December 4 of the second year.

If you have any questions about how your Vision Benefit works, please call or email Customer Service as provided below.

ADMINISTRATOR CONTACT INFORMATION	
TRUSTEED PLANS SERVICE CORPORATION	
Customer Service Phone	(253) 564-5611 or Toll Free (800) 426-9786
Customer Service Email	BenefitSupport@TrusteedPlans.com
Web Address	www.trusteedplans.com