

CORVALLIS SCHOOL DISTRICT 509J – TPSC Group #45830

CLASSIFIED EMPLOYEES – VISION SUMMARY OF BENEFITS – CURRENT FOR OCTOBER 1, 2007

Note: All benefits are limited to one exam and one set of glasses (lenses & frames) or contacts per 12-month period.	ANY PROVIDER
Deductible	Vision care benefits are not subject to a Calendar Year Deductible
Exam	\$10 Copay, then Paid in full
Vision Hardware Frames Lenses - Single Vision - Bifocal - Trifocal - Lenticular Contacts - As an alternative to lenses, frames	Paid in full, up to \$85.00 per pair Paid in full, up to \$96.00 per pair Paid in full, up to \$134.00 per pair Paid in full, up to \$180.00 per pair Paid in full, up to \$250.00 per pair \$181.00 Allowance per pair

CLASSIFIED EMPLOYEES– DENTAL SUMMARY OF BENEFITS – CURRENT FOR OCTOBER 1, 2007

	Class I Preventive & Diagnostic Services	Class II Basic Services	Class III Major Services	Class IV Orthodontia
Deductible – The dollar amount of Covered Dental Expenses which must be Incurred during a Calendar Year before any other Covered Expenses can be considered for payment.	\$25 per Covered Person per Calendar Year \$75 per Family			
	Paid at 90%* <ul style="list-style-type: none"> • Exams • Cleanings • X-rays • Fluoride • Sealants 	Paid at 90%* <ul style="list-style-type: none"> • Fillings • Oral Surgery • Endodontics • Periodontics • Pathology • Anesthesia • Injectables • Space Maintainers • Repair of Dentures, Bridges • Palliative Emergency Treatment 	Paid at 90%* <ul style="list-style-type: none"> • Inlays, Onlays • Bridgework • Crowns • Dentures • Implants <p>NOTE: <i>Replacement of existing partials, dentures, or fixed dentures or bridges over 5 years old is covered at 50%, if initial placement was covered under this Plan.</i></p>	Paid at 50%* <ul style="list-style-type: none"> • Covered for Employees and Dependents
	\$1,500 Maximum per Calendar Year			\$1,000 Lifetime Maximum

* All services are limited to a Usual, Customary & Reasonable (UCR) allowance

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CLASSIFIED EMPLOYEES

VISION PLAN LIMITATIONS

- Eye examination is limited to one (1) every 12 months, subject to the Copayment shown in the Summary of Benefits.
- Vision hardware is limited to one set of eyeglass lenses and frames every 12 months.
- Contact lenses are covered as an alternative to eyeglass lenses and frames or if they are necessary after cataract surgery or if they are the only means to correct vision to 20/70 or better.
- Disposable contact lenses may be purchased on an as-needed basis.
- Coverage is limited to services provided by Optometrists, Ophthalmologists and Opticians to the extent that such services are within the scope of their license.

VISION PLAN EXCLUSIONS

1. Charges for special procedures, such as orthoptics or vision training.
2. Charges for fashion eyewear features such as flintglass, coated, tinted (except tints #1 and #2) or oversize lenses.
3. Additional charges for partially covered frames;
4. Charges for any eye examination required by an Employer as a condition of employment or which an Employer is required to provide under a labor agreement, or which is required by any law or government.
5. Charges for prisms, prism segs, slab-off, and other special purpose vision aids.
6. Replacement of lenses and frames, unless the Covered Person is otherwise eligible for benefits.
7. Drugs or medications of any kind.
8. Charges for services or supplies which are received while the individual is not covered.
9. Charges for any vision care services or supplies which are included as Covered Expenses under any other benefit section in this Plan.
10. Charges for vision care services or supplies for which benefits are provided under any Worker's Compensation law or any other law of similar purpose, whether benefits are payable as to all or only part of the charges.

DENTAL PLAN LIMITATIONS AND EXCLUSIONS

ADDITIONAL LIMITATIONS AND EXCLUSION DO APPLY; REFER TO EACH DENTAL BENEFIT SECTION FOR SPECIFICS

1. Services for Injuries or conditions which are compensable under Worker's Compensation or Employers' Liability laws, or arising out of, or in the course of, any work for wage or profit; or services which are provided to the eligible person by any federal, state or provincial government agency or provided without cost to the eligible person by any municipality, county or other political subdivision;
2. Dentistry for Cosmetic reasons including, but not limited to, laminates or bleaching of teeth;
3. Customized dental procedures;
4. Restorations or appliances Necessary to correct vertical dimension or to restore the occlusion. Such procedures include restoration of tooth structure lost from attrition and restorations for malalignment of teeth;
5. Application of desensitizing medicaments;
6. Replacement of dental appliances or prosthetic devices which have been lost, mislaid or stolen;
7. Dental care that does not have ADA endorsement;
8. Treatment of Myofascial Pain Dysfunction or Temporomandibular Joint Dysfunction (TMJ);
9. Experimental services or supplies. Experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, this Plan, in conjunction with the American Dental Association, will consider if: (1) the services are in general use in the dental community in the State of Oregon; (2) the services are under continued scientific testing and research; (3) the services show a demonstrable benefit for a particular dental condition; and (4) they are proven to be safe and effective. Any individual whose claim is denied due to the experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request;
10. Analgesics (such as nitrous oxide) or any other euphoric drugs;
11. Hospitalization charges and any additional fees charged by the Dentist for Hospital treatment, except as needed for disabled dependents;
12. Dental services started prior to the date the person became eligible for services under this Plan, or the Company-sponsored plan this Plan replaces;
13. Dental services completed after the person is no longer covered under this Plan;
14. Charges for completion of claim forms and broken appointments;
15. Patient management problems;
16. Orthognathic surgery (augmentation or reduction of the upper or lower jaw);
17. Services and supplies that are not Necessary for treatment of a dental Injury or disease or that are not recommended and approved by the licensed Dentist attending the patient;
18. Charges by any person other than a licensed Denturist or a licensed Dental Hygienist and whose services are included in that Dentist's charge;
19. Charges for precision or other elaborate attachments for any appliance;
20. Charges for congenital malformation;
21. Charges for services rendered by any provider that is a Close Relative of the Covered Person, or that resides in the same household of the Covered Person;

22. Charges in excess of the Usual, Customary and Reasonable (UCR) charge for the services or supplies provided, or which exceed the UCR charges for the least costly plan of treatment when there is more than one accepted method of treatment for the dental condition;
23. Charges resulting from changing from one Dentist to another while receiving treatment, or from receiving care from more than one Dentist for one dental procedure, to the extent that the total charges billed exceed the amount that would have been billed if one Dentist had performed all the required dental services;
24. Prescription drugs, or any drug or supply distributed by a Dentist to be taken or used outside the Dentist's office; these include but are not limited to Fluoride rinses and mouthwash;
25. Services and supplies for which payment could be obtained in whole or in part if the Covered Person had applied for payment under any city, county, state or federal law except for Medicaid coverage;
26. Care rendered by any medical facility that is owned or operated by a government agency;
27. Charges Incurred for which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage;
28. Charges Incurred as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country. An act of terrorism will not be considered an act of war, declared or undeclared;
29. Services and supplies a Covered Person receives while in the custody or any state or federal law enforcement authorities or while in jail or prison;
30. Replacement and/or repair of orthodontic appliances prescribed under a treatment plan;
31. Recording of jaw movements and positions;
32. Models of teeth and surrounding tissue for purposes of study and treatment planning, except as provided under Class IV benefits.
33. Charges Incurred outside the United States if the Covered Person traveled to such a location for the sole purpose of obtaining dental services, drugs, or supplies;
34. All other services not specifically included in this Plan as covered dental benefits.