FINDLAY CITY SCHOOLS
EMPLOYEE BENEFIT PLAN
(DENTAL AND VISION)

PLAN DOCUMENT

EBSO GROUP NUMBER: F-569

Effective: December 1, 1993

Revised and Restated: December 1, 2019

SECTION B

SCHEDULE OF COVERAGE

NOTE: THIS IS ONLY A SUMMARY, SPECIFIC SERVICES AND SUPPLIES MAY BE SUBJECT TO EXCLUSIONS AND LIMITATIONS.

NOTE: Benefits under this Plan will be paid only if the Plan Administrator decides in his/her discretion that the individual is entitled to them.

DENTAL BENEFITS

Calendar Year Deductible	
Individual	$25
Family	$50
Payment Percentages	
Class I Services – Diagnostic and Preventive Care (1)	100%
Class II Services - Basic Services	80%
Class III Services - Major Services	50%
Class IV Services – Orthodontics (2)	60%
Maximum Benefit Payment Amounts	
Per Calendar Year for Class I, II & III Services - Combined	$2,500
Per Lifetime for Class IV Services	$ 850

(1) Class I Services are ***NOT*** subject to the Calendar Year Deductible.
(2) Orthodontic Services are ***LIMITED*** to Dependent children less than 19 years of age.

VISION BENEFITS

Deductible	None
Payment Percentages	100%
Maximum Benefit Payment Amounts	
Examination – once every 12 months	$25
Frames – once every 24 months *	$20
Lenses - Maximum Payable per pair every 12 months	
Single Vision Lenses	$30
Bifocals Lenses	$40
Trifocal Lenses	$60
Lenticular Lenses	$100
Contact Lenses (soft, hard or gas permeable) **	
Medically Necessary Contact Lenses	$160
Cosmetic Contact Lenses	$80

* The frame allowance may be applied toward the cost of lenses, except for contact lenses.

** Contact lenses are not limited to one pair per 12 months, only to the Maximum Payable specified above. Contact lenses are further limited to either Medically Necessary Contact Lenses or Cosmetic Contact Lenses (not both). Benefits for Contact Lenses are payable in lieu of those payable for conventional lenses and frames.