APPENDIX B

CITY OF CANTON DENTAL & VISION

SCHEDULE OF BENEFITS

EFF 7/1/19 (AFSCME LOCALS 2937 AND 3449)

Network: DenteMax

Members receive same benefit whether Covered Services are provided by a Network or Non-Network Provider. Usual Customary and Reasonable (UCR) allowable applies.

DENTAL EXPENSE COVERAGE

Calendar year Maximum for Other than Orthodontic Services	$1,500
Orthodontic Lifetime Maximum (Dependent child under age 19)	$1,000
Calendar Year Deductible	
Individual	$25
Family	$50

The Deductible is waived for Preventive & Diagnostic Services.
Orthodontic Services are subject to a lifetime Deductible of $100 per Dependent child.

Coinsurance

Preventive & Diagnostic Services	100% Network rate or UCR
Basic Restorative Services	80% Network rate or UCR
Major Restorative Services	80% Network rate or UCR
Orthodontic Services	50% Network rate or UCR

VISION EXPENSE COVERAGE

Benefit Maximums

Vision Examination	$33.00
Lenses (per pair)	
Single Vision	$42.00
Bifocal	$69.00
Trifocal	$100.00
Lenticular	$125.00
Contact Lenses	$110.00
Frames	$50.00
Lasik Eye Surgery (Employee only)	$1,500 lifetime, 7/1/19 – 6/30/20

Benefit Period

Vision Examination	Once every calendar year
Frames and Lenses*	Once every 2 years, adults 18+
	Once every year, dependents under 18

* Benefits payable for contact lenses will be in lieu of all other frames and lenses benefits for the Benefit Period.

HEARING AID EXPENSE COVERAGE

Benefit Maximums

Hearing Aid, Ear Mold and Services of Audiologist for each ear for the Employee, Spouse and Dependent Children, payable once every 4 years	$1,500.00 per ear