

## BRIEF SUMMARY OF ODS DENTAL & VISION BENEFITS FOR CITY OF ALBANY EFFECTIVE JULY 1, 2008

### DENTAL BENEFITS

|  |                                       |                                 |
|--|---------------------------------------|---------------------------------|
| Maximum per person per calendar year.....          |                                       | \$1,750                         |
|  | PS Prime (HMO)<br><u>Participants</u> | PS (PPO)<br><u>Participants</u> |
| Calendar year deductible per person.....           | \$25 Individual                       | -0-                             |
| .....  | \$75 Family                           | -0-                             |
| Preventative/Diagnostic .....                      |                                       | Paid at 80%                     |
| For example: exam, cleaning, fluoride, x-ray, etc. |                                       |                                 |
| Restorative .....                                  |                                       | Paid at 80%                     |
| For example: filling, extraction, root canal, etc. |                                       |                                 |
| Prosthetic .....                                   |                                       | Paid at 50%                     |
| For example: dentures, bridges, crowns, etc.       |                                       |                                 |
| Gold Procedures .....                              |                                       | Paid at 50%                     |

**PREAUTHORIZATION:** Although it is not mandatory, it is **recommended** that you obtain a predetermination of benefits from ODS prior to having any major dental services done that exceed \$250.

### VISION CARE BENEFITS

|   |                                       |  |
|---|---------------------------------------|--|
| Maximum per person per calendar year..... |                                       | \$500  |
|   | PS Prime (HMO)<br><u>Participants</u> | PS (PPO)<br><u>Participants</u>  |
| Calendar year deductible per person.....  | \$25 Individual                       | -0-  |
| .....                                     | \$75 Family                           | -0-  |
| Percentage Paid .....                     |                                       | Paid at 80%  |
| Covered Expenses                          | Refraction (exam) .....               | Reasonable and customary charges; one exam/12 consecutive months.  |
|   | Lenses .....                          | Reasonable and customary charges; one pair/12 months.  |
|   | Frames.....                           | Up to \$100.00 a pair; limited to one pair/24 months.  |
|   | Contact Lens .....                    | In lieu of lenses and frames, contact lenses allowed every 12 months.  |
|   | .....                                 | Maximum amount payable is \$40.00 per lens.  |
|   | .....                                 | If visual acuity cannot be corrected to 20/70 in the better eye with standard lens, \$100.00 per lens/12 months. |

### REASONABLE AND CUSTOMARY CHARGES

Expenses incurred under dental and vision are subject to usual, customary, and reasonable costs. Charges in excess of R&C will be the responsibility of the insured person.