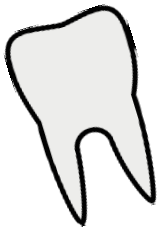

DENTAL/VISION REIMBURSEMENT

For many years the Board of Education has provided a Dental/Vision Care "Reimbursement" Plan to eligible employees. In 2018, the Board approved a proposal to increase the Vision Care portion of the combined Dental/Vision Care Plan. The allowances (for both Dental Care and Vision Care combined) are as follows:

1. The Plan will pay 100% of the first $100.00 of covered expenses per year. (July 1 – June 30)
2. The Plan will pay 50% of the next $400.00 of covered expenses per year. (July 1 – June 30)
3. Special Limitation: Under this Plan the maximum reimbursement for covered vision care Expenses will be ***$100.00*** per year. (This is an increase in the vision reimbursement)

All claims should be submitted using this ***Dental/Vision Benefit Claim Form along with a Detailed Statement that shows services received and amount***. If you have any questions, please do not hesitate to contact the benefits department at 885-4179.

DENTAL/VISION BENEFIT CLAIM FORM

Employee Name: _____ Last 4 digits of SS#_____

☐ Dental Claim ☐ Vision Claim

Is the patient covered under any other dental plan? __ Yes __ No

If Yes, list name, policy# of the other plan: _____

Claims Must Be Submitted Within 90 (Ninety) Day of Service

----------No Exceptions! ----------

In order to receive a reimbursement from Jessamine County Schools, you must file a claim with the School System's Benefit Department within 90 (Ninety) days of service, even if you have also filed with another Insurance plan and are awaiting a reply.

Date of Service: _____ $ Amount of Service: _____

Employee Signature: _____ Date Submitted: _____