Grand Haven Area Public Schools, WMP124

Local 517M Bargaining Unit Employees

Benefit Description	Vision Plan Limits
Benefit Year	July 1 through June 30
Benefit Percentage Vision Examinations	100% (0% coinsurance)
Maximum Benefit paid per covered person per Benefit Year	$65* *Benefits payable for vision examinations performed on covered persons under age 18 will not accrue toward the Benefit Year maximum stated above.
Eyeglass Frames	100% (0% coinsurance)
Maximum benefit paid per covered person per Benefit Year	$115
Eyeglass Lenses	100% (0% coinsurance)
Maximum benefit paid per covered person per Benefit Year for single-vision lenses	$80
Maximum benefit paid per covered person per Benefit Year for bifocal lenses	$90
Maximum benefit paid per covered person per Benefit Year for trifocal lenses	$110
Maximum benefit paid per covered person per Benefit Year for lenticular lenses	$125
Contact Lenses (All types, including hard, soft, gas permeable, and disposable)	100% (0% coinsurance)
Maximum benefit paid per covered person per Benefit Year	$185

Special Note about Vision Benefits: Subject to the dollar maximum stated above, the Plan will allow one exam* and **either** one pair of frames and eyeglass lenses **or** one pair of contact lenses** per covered person in any Benefit Year.

*This exam frequency limitation will not apply to covered persons under age 18.

**If disposable lenses are selected, the Plan will cover all contact lenses purchased up to the maximum benefit amount specified above.

Benefit Description	Dental Plan Limits
Benefit Year	July 1 through June 30
Benefit Percentage Type I - Preventive Dental Services	90%* (10% coinsurance) *Type I oral exams and fluoride treatment for covered persons under age 18 are paid at 100%.
Type II - Minor Restorative Dental Services	90% (10% coinsurance)
Type III - Major Restorative Dental Services	90% (10% coinsurance)
Type IV - Orthodontic Services (for dependent children under age 19 only)	90% (10% coinsurance)
Maximum Benefit Paid per Covered Person per Benefit Year for Types I, II, and III Dental Services Claims for Type I Preventive Dental Services incurred by covered persons under age 18 are not subject to the Benefit Year dollar maximum.	$1,200

Benefit Description	Dental Plan
	Limits
Lifetime Maximum Benefit Paid per Dependent Child for Type IV Orthodontic Services	$1,000

Special Provision for Injuries Arising Out of Automobile Accidents

Coordination with Other Coverage for Injuries Arising out of Automobile Accidents

In the event that a covered person is injured in an accident involving an automobile, this Plan shall be the primary plan for purposes of paying benefits and the covered person's automobile insurance shall pay as secondary.

Summary of Dental Procedures

NOTE: Additional limitations may apply to the replacement of some items addressed below. See the subsection entitled "EXCLUSIONS AND LIMITATIONS FOR DENTAL BENEFITS" in the Plan document for more details.

Services:	*Special Limitations:*
Type I: Preventive Dental Services	
A. Oral Examination	**Covered Persons Under Age 18:** None. **Covered Persons Age 18 or Older:** Limited to two times in any 12-consecutive-month period.
B. Dental Prophylaxis (cleaning teeth)	Limited to two times in any 12-consecutive-month period.
C. Complete Series or Panorex X-Rays	Limited to one time in any 36-consecutive-month period.
D. Occlusal, Extraoral, and Individual Periapical X-Rays	None.
E. Bite-Wing X-Rays	Limited to two times in any 12-consecutive-month period.
F. Bacteriologic Cultures	None.
G. Fluoride Treatment	**Covered Persons Under Age 18:** None. **Covered Persons Ages 18 or 19:** Limited to two times in any 12-consecutive-month period. **Covered Persons Age 20 or Older:** Not covered.
H. Palliative Treatment	Paid as a separate benefit only if no other service, except X-rays, was rendered during the visit.
I. Sedative Fillings	Paid as a separate benefit only if no other service, except X-rays, was rendered during the visit.
J. Sealants	Dependent children up to age 16 only.
K. Space Maintainers	None.
L. Emergency Treatment	Exams only.
Type II: Minor Restorative Dental Services	
A. Periodontal Exams	Limited to one time in any three-consecutive-month period.
B. Periodontal Prophylaxis	Limited to one time in any three-consecutive-month period.
C. Diagnostic Casts	Limited to one time in any 24-consecutive-month period.
D. Stainless Steel Crowns	None.
E. Re-cement Inlays, Onlays, Crowns, and Bridges	None.
F. Pulpotomy and Osseous Surgery	None.
G. Root Canal Therapy	None.
H. Apicoectomy and Retrograde Filling	None.
I. Scaling and Root Planing	Limited to two times per quadrant of the mouth in any 12-consecutive-month period.
J. Temporary Splinting	None.
K. Periodontal Appliance	Limited to one appliance in any 36-consecutive-month period.
L. Repairs to Full Dentures, Partial Dentures, and Bridges	Limited to repairs or adjustments done more than 12 months after the initial insertion.
M. Relining Dentures	Limited to relining done more than 12 months after the initial insertion and then not more than one time in any 24-consecutive-month period.
N. Simple Extraction	None.
O. Surgical Extraction of Impacted Teeth	None. The employer's medical plan may coordinate as the secondary payer on any unpaid balance.
P. Alveoplasty	None. The employer's medical plan may coordinate as the secondary payer on any unpaid balance.
Q. Gingivectomy	None. The employer's medical plan may coordinate as the secondary payer on any unpaid balance.
R. Vestibuloplasty	None. The employer's medical plan may coordinate as the secondary payer on any unpaid balance.
S. Root Recovery	None.

Summary of Dental Procedures

NOTE: Additional limitations may apply to the replacement of some items addressed below. See the subsection entitled "EXCLUSIONS AND LIMITATIONS FOR DENTAL BENEFITS" in the Plan document for more details.

Services:	***Special Limitations:***
Type II: Minor Restorative Dental Services, cont.	
T. Incision and Drainage	None.
U. Local and General Anesthesia	None.
V. Amalgam Restorations (fillings)	Multiple restorations on one surface will be treated as a single filling.
W. Silicate, Plastic, and Composite Restorations (fillings)	None.
X. Pin Retention	Limited to two pins per tooth.
Y. Gingival Curettage	None.
Z. Osseous Graft	None.
AA. Frenectomy	None.
BB. Occlusal Adjustment	None.
CC. Bite Splint Appliances	Limited to one appliance in any five-consecutive-year period.
Type III: Major Restorative Dental Services	
A. Gold Inlays and Onlays	Covered only when the tooth cannot be restored by silver fillings.
B. Porcelain Restorations	None.
C. Crowns	Covered only if the tooth cannot be restored by a filling or by other means.
D. Post and Core	None.
E. Replacement of Teeth to Bridges and Dentures	None.
F. Full or Partial Dentures	None.
G. Fixed Bridges	None.
H. Dental Implants	None.
Type IV: Orthodontic Services (Dependent Children Under Age 19 Only)	
Orthodontic Diagnostic Procedures, Surgical Therapy, and Appliance Therapy	None.