

INTERPRETERS

Benefit Description	Employer-Funded Medical Reimbursement Plan
<p>The employer has established an Employer-Funded Medical Reimbursement Plan to cover eligible expenses not covered by the employer's group health plan or any other health care plan. A participant will file claims with the employer's group health plan and then with any other health care plan under which he or she may have elected coverage. After these plans have processed the claims, the participant's Employer-Funded Medical Reimbursement Plan will reimburse a participant for unpaid eligible expenses as follows:</p> <ul style="list-style-type: none"> In any Benefit Year, the Plan will reimburse a participant enrolled in employee-only coverage up to \$1,200 for amounts applied toward the satisfaction of the in- or out-of-network deductible. In any Benefit Year, the Plan will reimburse members of a family enrolled in family coverage up to \$2,400 for amounts applied toward the satisfaction of the in- or out-of-network deductible. 	
<p>A participant must follow these steps to file a claim under the Employer-Funded Medical Reimbursement Plan:</p> <ol style="list-style-type: none"> File a claim for health care expenses with the employer's group health plan. Obtain documentation from the employer's group health plan that eligible charges were applied toward that plan's deductible (e.g., an Explanation of Benefits [EOB]). NOTE: If the participant does not have other health plan coverage, the participant can proceed to step 5. If the participant has other coverage, he or she must continue with steps 3-6. File a claim for health care expenses with any other health plan under which coverage was elected. Obtain documentation from the other health plan that eligible charges were applied toward that plan's deductible (e.g., an EOB). Obtain an Employer-Funded Medical Reimbursement Plan Claim Form and complete it accurately and completely. The Employer-Funded Medical Reimbursement Plan Claim Form is available from the employer or from the Claim Administrator, ASR. You may contact ASR by writing to the address below, calling (616) 957-1751 or (800) 968-2449, or visiting www.asrhealthbenefits.com. Sign and date the claim form where indicated, attach the EOB from the employer's group health plan (and the EOB from the other health plan, if any), and mail all to ASR at the following address: <p style="text-align: center;">P.O. Box 6392 Grand Rapids, Michigan 49516-6392</p>	
<p>Complete and proper claims for benefits made by covered persons will be promptly processed. All information will be reviewed promptly. The employer or ASR may request missing or additional data if needed. The employer or ASR reserves the right to require an original claim form or billing statement.</p> <p>ASR shall examine each claim for reimbursement and determine whether the claim is for expenses covered by this plan. The Claim Administrator will automatically reimburse the approved portion directly to the participant. The Plan shall not recognize an assignment of benefits. The participant should keep a copy of the claim form and EOB statement(s) for each reimbursement request for his or her own records. Any questions can be directed to the employer or ASR.</p>	

Benefit Description	Dental Services
	Limits
<u>Benefit Percentage</u>	
Type I - Preventive Dental Services	90%
Type II - Minor Restorative Dental Services	50%
Type III - Major Restorative Dental Services	50%
Type IV - Orthodontic Services (for all Covered Persons)	50%
Maximum Benefit Paid per Covered Person per Calendar Year for Types I, II & III Dental Services	\$1,000
Lifetime Maximum Benefit Paid per Covered Person for Type IV Orthodontic Services	\$1,500

This summary represents only a summary of the Employer-Funded Medical Reimbursement Plan and the Dental Benefits Plan as it applies to all eligible employees and dependents. This summary is not the plan document or the summary plan description and shall not be relied upon to establish or determine eligibility, benefits, procedures, or the content or validity of any section or provision of the plan. Please refer to the plan document for specific information regarding plan provisions.



Holland Public Schools, G-768

INSTRUCTIONAL ASS'TS & PARAPROS

Benefit Description	Employer-Funded Medical Reimbursement Plan
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<p>A participant must follow these steps to file a claim under the Employer-Funded Medical Reimbursement Plan:</p> <ol style="list-style-type: none"> File a claim for health care expenses with the employer's group health plan. Obtain documentation from the employer's group health plan that eligible charges were applied toward that plan's deductible (e.g., an Explanation of Benefits [EOB]). NOTE: If the participant does not have other health plan coverage, the participant can proceed to step 5. If the participant has other coverage, he or she must continue with steps 3-6. File a claim for health care expenses with any other health plan under which coverage was elected. Obtain documentation from the other health plan that eligible charges were applied toward that plan's deductible (e.g., an EOB). Obtain an Employer-Funded Medical Reimbursement Plan Claim Form and complete it accurately and completely. The Employer-Funded Medical Reimbursement Plan Claim Form is available from the employer or from the Claim Administrator, ASR. You may contact ASR by writing to the address below, calling (616) 957-1751 or (800) 968-2449, or visiting www.asrhealthbenefits.com. Sign and date the claim form where indicated, attach the EOB from the employer's group health plan (and the EOB from the other health plan, if any), and mail all to ASR at the following address: <p style="text-align: center;">P.O. Box 6392 Grand Rapids, Michigan 49516-6392</p> <p>Complete and proper claims for benefits made by covered persons will be promptly processed. All information will be reviewed promptly. The employer or ASR may request missing or additional data if needed. The employer or ASR reserves the right to require an original claim form or billing statement.</p> <p>ASR shall examine each claim for reimbursement and determine whether the claim is for expenses covered by this plan. The Claim Administrator will automatically reimburse the approved portion directly to the participant. The Plan shall not recognize an assignment of benefits. The participant should keep a copy of the claim form and EOB statement(s) for each reimbursement request for his or her own records. Any questions can be directed to the employer or ASR.</p>	

Benefit Description	Dental Plan
	Limits
<p>Benefit Percentage</p> <p>Type I - Preventive Dental Services</p> <p>Type II - Minor Restorative Dental Services</p> <p>Type III - Major Restorative Dental Services</p> <p>Type IV - Orthodontic Services (for all Covered Persons)</p>	<p>90%</p> <p>50%</p> <p>50%</p> <p>50%</p>
<p>Maximum Benefit Paid per Covered Person per Calendar Year for Types I, II & III Dental Services</p>	<p>\$1,000</p>
<p>Lifetime Maximum Benefit Paid per Covered Person for Type IV Orthodontic Services</p>	<p>\$1,500</p>

This summary represents only a summary of the Employer-Funded Medical Reimbursement Plan and the Dental Benefits Plan as it applies to all eligible employees and dependents. This summary is not the plan document or the summary plan description and shall not be relied upon to establish or determine eligibility, benefits, procedures, or the content or validity of any section or provision of the plan. Please refer to the plan document for specific information regarding plan provisions.



HESPA PART TIME

Benefit Description	Employer-Funded Medical Reimbursement Plan
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<p>A participant must follow these steps to file a claim under the Employer-Funded Medical Reimbursement Plan:</p> <ol style="list-style-type: none"> File a claim for health care expenses with the employer's group health plan. Obtain documentation from the employer's group health plan that eligible charges were applied toward that plan's deductible (e.g., an Explanation of Benefits (EOB)). NOTE: If the participant does not have other health plan coverage, the participant can proceed to step 5. If the participant has other coverage, he or she must continue with steps 3-6. File a claim for health care expenses with any other health plan under which coverage was elected. Obtain documentation from the other health plan that eligible charges were applied toward that plan's deductible (e.g., an EOB). Obtain an Employer-Funded Medical Reimbursement Plan Claim Form and complete it accurately and completely. The Employer-Funded Medical Reimbursement Plan Claim Form is available from the employer or from the Claim Administrator, ASR. You may contact ASR by writing to the address below, calling (616) 957-1751 or (800) 968-2449, or visiting www.asrhealthbenefits.com. Sign and date the claim form where indicated, attach the EOB from the employer's group health plan (and the EOB from the other health plan, if any), and mail all to ASR at the following address: <p style="text-align: center;">P.O. Box 6392 Grand Rapids, Michigan 49516-6392</p> <p>Complete and proper claims for benefits made by covered persons will be promptly processed. All information will be reviewed promptly. The employer or ASR may request missing or additional data if needed. The employer or ASR reserves the right to require an original claim form or billing statement.</p> <p>ASR shall examine each claim for reimbursement and determine whether the claim is for expenses covered by this plan. The Claim Administrator will automatically reimburse the approved portion directly to the participant. The Plan shall not recognize an assignment of benefits. The participant should keep a copy of the claim form and EOB statement(s) for each reimbursement request for his or her own records. Any questions can be directed to the employer or ASR.</p>	

Benefit Description	Limits
<p><u>Benefit Percentage</u></p> <p>Type I - Preventive Dental Services</p> <p>Type II - Minor Restorative Dental Services</p> <p>Type III - Major Restorative Dental Services</p> <p>Type IV - Orthodontic Services (for all Covered Persons)</p>	<p>90%</p> <p>50%</p> <p>50%</p> <p>50%</p>
<p>Maximum Benefit Paid per Covered Person per Calendar Year for Types I, II & III Dental Services</p>	<p>\$1,000</p>
<p>Lifetime Maximum Benefit Paid per Covered Person for Type IV Orthodontic Services</p>	<p>\$1,500</p>

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Benefit Description	Employer-Funded Medical Reimbursement Plan
<p>The employer has established an Employer-Funded Medical Reimbursement Plan to cover eligible expenses not covered by the employer's group health plan or any other health care plan. A participant will file claims with the employer's group health plan and then with any other health care plan under which he or she may have elected coverage. After these plans have processed the claims, the participant's Employer-Funded Medical Reimbursement Plan will reimburse a participant for unpaid eligible expenses as follows:</p> <ul style="list-style-type: none"> In any Benefit Year, after a Participant enrolled in employee-only coverage has satisfied the first \$150 of the In- or Out-of-Network Deductible, the Plan shall reimburse the next \$1,000 of amounts applied toward the satisfaction of the In- or Out-of-Network Deductible. In any Benefit Year, after a family has satisfied the first \$300 of the In- or Out-of-Network Deductible, the Plan shall reimburse the next \$2,000 of amounts applied toward the satisfaction of the In- or Out-of-Network Deductible. 	
<p>A participant must follow these steps to file a claim under the Employer-Funded Medical Reimbursement Plan:</p> <ol style="list-style-type: none"> 1. File a claim for health care expenses with the employer's group health plan. 2. Obtain documentation from the employer's group health plan that eligible charges were applied toward that plan's deductible (e.g., an Explanation of Benefits [EOB]). NOTE: If the participant does not have other health plan coverage, the participant can proceed to step 5. If the participant has other coverage, he or she must continue with steps 3-6. 3. File a claim for health care expenses with any other health plan under which coverage was elected. 4. Obtain documentation from the other health plan that eligible charges were applied toward that plan's deductible (e.g., an EOB). 5. Obtain an Employer-Funded Medical Reimbursement Plan Claim Form and complete it accurately and completely. The Employer-Funded Medical Reimbursement Plan Claim Form is available from the employer or from the Claim Administrator, ASR. You may contact ASR by writing to the address below, calling (616) 957-1751 or (800) 968-2449, or visiting www.asrhealthbenefits.com. 6. Sign and date the claim form where indicated, attach the EOB from the employer's group health plan (and the EOB from the other health plan, if any), and mail all to ASR at the following address: <p style="text-align: center;">P.O. Box 6392 Grand Rapids, Michigan 49516-6392</p> <p>Complete and proper claims for benefits made by covered persons will be promptly processed. All information will be reviewed promptly. The employer or ASR may request missing or additional data if needed. The employer or ASR reserves the right to require an original claim form or billing statement.</p> <p>ASR shall examine each claim for reimbursement and determine whether the claim is for expenses covered by this plan. The Claim Administrator will automatically reimburse the approved portion directly to the participant. The Plan shall not recognize an assignment of benefits. The participant should keep a copy of the claim form and EOB statement(s) for each reimbursement request for his or her own records. Any questions can be directed to the employer or ASR.</p>	

Benefit Description	Dental Plan
	Limits
<u>Benefit Percentage</u>	
Type I - Preventive Dental Services	100%
Type II - Minor Restorative Dental Services	90%
Type III - Major Restorative Dental Services	70%
Type IV - Orthodontic Services (for all Covered Persons)	70%
Maximum Benefit Paid per Covered Person per Calendar Year for Types I, II & III Dental Services	\$1,000
Lifetime Maximum Benefit Paid per Covered Person for Type IV Orthodontic Services	\$1,500

Employer-Funded Medical Reimbursement Plan	
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**Holland Public Schools, G-768
Administration, Principals/HMMAA,
and Administrative Assistants**

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