

# Holland Public Schools, G-768 Professional Support & HESPA (Full Time)

Benefit Description	Dental Plan
Beriefit Description	Limits
Benefit Year	January 1 through December 31
Benefit Percentage Type I - Preventive Dental Services	100% (0% coinsurance)
Type II - Minor Restorative Dental Services	90% (10% coinsurance)
Type III - Major Restorative Dental Services	70% (30% coinsurance)
Type IV - Orthodontic Services (for all Covered Persons)	70% (30% 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	\$1,000
persons under age 18 are not subject to the Benefit Year dollar maximum.	
<u>Lifetime Maximum Benefit Paid per Covered Person for Type IV Orthodontic Services</u>	\$1,500

#### Special Provision for Injuries Arising Out of Automobile Accidents

## Motor Vehicle Exclusion (Michigan Residents Only)

BENEFITS ARE NOT PAYABLE UNDER THIS PLAN FOR INJURIES RECEIVED IN AN ACCIDENT INVOLVING A MOTOR VEHICLE AS DEFINED IN THE PLAN. It is your responsibility to obtain proper motor vehicle insurance that will give you and your family benefits. If you fail to maintain your motor vehicle insurance, you will not have any coverage for auto-related injuries. This exclusion shall not apply to a covered person who is a Michigan resident involved in an accident outside the state of Michigan for which Michigan no-fault coverage is not legally available. However, this exclusion shall apply if a covered person is injured while in his or her own uninsured motor vehicle for which a Michigan no-fault policy is legally required and would have provided coverage, had such a policy been in effect.

Coordination with Other Coverage for Injuries Arising out of Automobile Accidents (Non-Michigan Residents Only)

If a Covered Person has automobile insurance (including, but not limited to no-fault) that provides benefits, this Plan shall be the primary plan and the automobile insurance shall be the secondary plan for purposes of paying benefits.

#### **Summary of Dental Procedures**

NOTE: Additional limitations may apply to the replacement of some items addressed below. See the subsection entitled "EXCLUSIONS AND LIMITATIONS" in the

Plan document for more details.		
Services:	Special Limitations:	
Type I: Preventive Dental Services		
A. Oral Examination	Covered Persons Under Age 18: No special limitations. Covered Persons Age 18 and Over: Limited to two times in any calendar year.	
B. Dental Prophylaxis (cleaning teeth)	Limited to two times in any calendar year.	
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 calendar year.	
F. Bacteriologic Cultures	None.	
G. Fluoride Treatment	Covered Persons Under Age 18: No special limitations. Covered Persons Age 18 and Over: 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 under age 16 only.	
K. Space Maintainers	None.	

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## **Summary of Dental Procedures**

NOTE: Additional limitations may apply to the replacement of some items addressed below. See the subsection entitled "EXCLUSIONS AND LIMITATIONS" in the

Services:   Special Limitations:	Plan document for more details.		
Emergency Treatment   Exams only.	Services:	Special Limitations:	
Type II: Minor Restorative Dental Services	Type I: Preventive Dental Services, cont.		
A Periodontal Exams	L. Emergency Treatment	Exams only.	
B. Periodontal Prophysics   Limited to one time in any three-consecutive-month period.	Type II: Minor Restorative Dental Services		
B. Periodontal Prophysics   Limited to one time in any three-consecutive-month period.	A. Periodontal Exams	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.  G. Root Canal Therapy   None.  G. Root Canal Therapy   None.  H. Apicoactory and Retrograde Filling   None.  J. Saaling and Root Planing   Limited to low times per quadrant of the mouth in any calendar year.  J. Temporary Splinting   Limited to low times per quadrant of the mouth in any calendar year.  J. Temporary Splinting   Limited to repairs or adjustments done more than one calendar year after the initial insertion.  K. Periodontal Appliance   Limited to repairs or adjustments done more than one calendar year after the initial insertion.  M. Relining Dentures, Partial Dentures, and Bridges   Limited to repairs or adjustments done more than one time in any 24-consecutive-month period.  N. Simple Extraction   None.  Surgical Extraction of Impacted Teeth   None.  Q. Gingivectory   None.  Q. Gingivectory   None.  R. Vestibuloplasty   None.  Q. Gingivectory   None.  T. Incision and Drainage   None.  J. Amalgam Restorations (fillings)   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.  J. Pin Retention   Limited to two pins per tooth.  Type III: Major Restorations (fillings)   None.  C. Osseous Graft   None.  C. Osseous Graft   None.  D. Post and Core   None.  C. Crowns   Covered only when the tooth cannot be restored by a filling or by other means. An expense is considered incurred at the time the tooth or teeth are initially prepared.  D. Post and Core   None.  F. Full or Partial Dentures   None.  Type IV: Orthodontic Services (All Covered Persons)		·	
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O. Surgical Extraction of Impacted Teeth None. P. Alveoplasty None. Q. Gingivectomy None. R. Vestibuloplasty None. S. Root Recovery 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. V. Amalgam Restorations (fillings) None. V. Pin Retention Limited to two pins per tooth. V. Gingival Curettage None. V. Osseous Graft None. V. Osseous Gra	M. Relining Dentures		
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S. Root Recovery T. Incision and Drainage None. U. Local and General Anesthesia None. W. Amalgam Restorations (fillings) W. Silicate, Plastic, and Composite Restorations (fillings) X. Pin Retention Y. Gingival Curettage None. W. Soseous Graft None. X. Pin Retention Y. Gingival Curettage None. C. Osseous Graft None. AA. Frenectomy None. BB. Occlusal Adjustment 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. An expense is considered incurred at the time the tooth or teeth are initially prepared. D. Post and Core Replacement of Teeth to Bridges and Dentures F. Full or Partial Dentures None. Type IV: Orthodontic Services (All Covered Persons) Orthodontic Diagnostic Procedures, Surgical None.	Q. Gingivectomy	None.	
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Restorations (fillings)  X. Pin Retention  Y. Gingival Curettage  None.  AN. Frenectomy  BB. Occlusal Adjustment  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. An expense is considered incurred at the time the tooth or teeth are initially prepared.  B. Porcelain Restorations  None.  C. Crowns  Covered only if the tooth cannot be restored by a filling or by other means. An expense is considered incurred at the time the tooth or teeth are initially prepared.  D. Post and Core  Replacement of Teeth to Bridges and Dentures  F. Full or Partial Dentures  None.  G. Fixed Bridges  An expense is considered incurred at the time the tooth or teeth are initially prepared.  None.  G. Fixed Bridges  An expense is considered incurred at the time the tooth or teeth are initially prepared.  None.  Type IV: Orthodontic Services (All Covered Persons)  Orthodontic Diagnostic Procedures, Surgical  None.	V. Amalgam Restorations (fillings)	Multiple restorations on one surface will be treated as a single filling.	
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. An expense is considered incurred at the time the tooth or teeth are initially prepared.         B. Porcelain Restorations       None.         C. Crowns       Covered only if the tooth cannot be restored by a filling or by other means. An expense is considered incurred at the time the tooth or teeth are initially prepared.         D. Post and Core       None.         E. Replacement of Teeth to Bridges and Dentures       None.         F. Full or Partial Dentures       None.         G. Fixed Bridges       An expense is considered incurred at the time the tooth or teeth are initially prepared.         H. Dental Implants       None.         Type IV: Orthodontic Services (All Covered Persons)         Orthodontic Diagnostic Procedures, Surgical       None.		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. An expense is considered incurred at the time the tooth or teeth are initially prepared.  B. Porcelain Restorations None. C. Crowns Covered only if the tooth cannot be restored by a filling or by other means. An expense is considered incurred at the time the tooth or teeth are initially prepared.  D. Post and Core None.  E. Replacement of Teeth to Bridges and Dentures None.  F. Full or Partial Dentures None.  G. Fixed Bridges An expense is considered incurred at the time the tooth or teeth are initially prepared.  H. Dental Implants None.  Type IV: Orthodontic Services (All Covered Persons)  Orthodontic Diagnostic Procedures, Surgical None.	X. Pin Retention	Limited to two pins per tooth.	
AA. Frenectomy  BB. Occlusal Adjustment  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. An expense is considered incurred at the time the tooth or teeth are initially prepared.  B. Porcelain Restorations  None.  C. Crowns  Covered only if the tooth cannot be restored by a filling or by other means. An expense is considered incurred at the time the tooth or teeth are initially prepared.  D. Post and Core  E. Replacement of Teeth to Bridges and Dentures  F. Full or Partial Dentures  None.  G. Fixed Bridges  An expense is considered incurred at the time the tooth or teeth are initially prepared.  H. Dental Implants  None.  Orthodontic Diagnostic Procedures, Surgical  None.	Y. Gingival Curettage	None.	
BB. Occlusal Adjustment  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. An expense is considered incurred at the time the tooth or teeth are initially prepared.  B. Porcelain Restorations  None.  C. Crowns  Covered only if the tooth cannot be restored by a filling or by other means. An expense is considered incurred at the time the tooth or teeth are initially prepared.  D. Post and Core  None.  E. Replacement of Teeth to Bridges and Dentures  F. Full or Partial Dentures  None.  G. Fixed Bridges  An expense is considered incurred at the time the tooth or teeth are initially prepared.  None.  Type IV: Orthodontic Services (All Covered Persons)  Orthodontic Diagnostic Procedures, Surgical  None.	Z. Osseous Graft	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. An expense is considered incurred at the time the tooth or teeth are initially prepared.  B. Porcelain Restorations  None.  C. Crowns  Covered only if the tooth cannot be restored by a filling or by other means. An expense is considered incurred at the time the tooth or teeth are initially prepared.  D. Post and Core  None.  E. Replacement of Teeth to Bridges and Dentures  F. Full or Partial Dentures  None.  G. Fixed Bridges  An expense is considered incurred at the time the tooth or teeth are initially prepared.  H. Dental Implants  None.  Type IV: Orthodontic Services (All Covered Persons)  Orthodontic Diagnostic Procedures, Surgical  None.	AA. Frenectomy	None.	
Type III: Major Restorative Dental Services  A. Gold Inlays and Onlays  Covered only when the tooth cannot be restored by silver fillings. An expense is considered incurred at the time the tooth or teeth are initially prepared.  B. Porcelain Restorations  None.  C. Crowns  Covered only if the tooth cannot be restored by a filling or by other means. An expense is considered incurred at the time the tooth or teeth are initially prepared.  D. Post and Core  E. Replacement of Teeth to Bridges and Dentures  F. Full or Partial Dentures  None.  F. Full or Partial Dentures  An expense is considered incurred at the time the tooth or teeth are initially prepared.  H. Dental Implants  None.  Type IV: Orthodontic Services (All Covered Persons)  Orthodontic Diagnostic Procedures, Surgical  None.	BB. Occlusal Adjustment	None.	
A. Gold Inlays and Onlays  Covered only when the tooth cannot be restored by silver fillings. An expense is considered incurred at the time the tooth or teeth are initially prepared.  None.  C. Crowns  Covered only if the tooth cannot be restored by a filling or by other means. An expense is considered incurred at the time the tooth or teeth are initially prepared.  None.  E. Replacement of Teeth to Bridges and Dentures  F. Full or Partial Dentures  None.  G. Fixed Bridges  An expense is considered incurred at the time the tooth or teeth are initially prepared.  None.  Type IV: Orthodontic Services (All Covered Persons)  Orthodontic Diagnostic Procedures, Surgical  None.	CC. Bite Splint Appliances	Limited to one appliance in any five-consecutive-year period.	
incurred at the time the tooth or teeth are initially prepared.  B. Porcelain Restorations  C. Crowns  Covered only if the tooth cannot be restored by a filling or by other means. An expense is considered incurred at the time the tooth or teeth are initially prepared.  D. Post and Core  E. Replacement of Teeth to Bridges and Dentures  F. Full or Partial Dentures  None.  G. Fixed Bridges  An expense is considered incurred at the time the tooth or teeth are initially prepared.  H. Dental Implants  None.  Type IV: Orthodontic Services (All Covered Persons)  Orthodontic Diagnostic Procedures, Surgical  None.	Type III: Major Restorative Dental Services		
C. Crowns  Covered only if the tooth cannot be restored by a filling or by other means. An expense is considered incurred at the time the tooth or teeth are initially prepared.  D. Post and Core  Replacement of Teeth to Bridges and Dentures  F. Full or Partial Dentures  None.  G. Fixed Bridges  An expense is considered incurred at the time the tooth or teeth are initially prepared.  H. Dental Implants  None.  Type IV: Orthodontic Services (All Covered Persons)  Orthodontic Diagnostic Procedures, Surgical  None.	A. Gold Inlays and Onlays		
considered incurred at the time the tooth or teeth are initially prepared.  D. Post and Core None.  E. Replacement of Teeth to Bridges and Dentures None.  F. Full or Partial Dentures None.  G. Fixed Bridges An expense is considered incurred at the time the tooth or teeth are initially prepared.  H. Dental Implants None.  Type IV: Orthodontic Services (All Covered Persons)  Orthodontic Diagnostic Procedures, Surgical None.	B. Porcelain Restorations	None.	
E. Replacement of Teeth to Bridges and Dentures  F. Full or Partial Dentures  None.  G. Fixed Bridges  An expense is considered incurred at the time the tooth or teeth are initially prepared.  H. Dental Implants  None.  Type IV: Orthodontic Services (All Covered Persons)  Orthodontic Diagnostic Procedures, Surgical  None.	C. Crowns		
F. Full or Partial Dentures  G. Fixed Bridges An expense is considered incurred at the time the tooth or teeth are initially prepared.  H. Dental Implants None.  Type IV: Orthodontic Services (All Covered Persons)  Orthodontic Diagnostic Procedures, Surgical None.	D. Post and Core	None.	
G. Fixed Bridges An expense is considered incurred at the time the tooth or teeth are initially prepared.  H. Dental Implants None.  Type IV: Orthodontic Services (All Covered Persons)  Orthodontic Diagnostic Procedures, Surgical None.		None.	
H. Dental Implants None.  Type IV: Orthodontic Services (All Covered Persons)  Orthodontic Diagnostic Procedures, Surgical None.	F. Full or Partial Dentures	None.	
Type IV: Orthodontic Services (All Covered Persons)  Orthodontic Diagnostic Procedures, Surgical None.	G. Fixed Bridges	An expense is considered incurred at the time the tooth or teeth are initially prepared.	
Orthodontic Diagnostic Procedures, Surgical None.	H. Dental Implants	None.	
	Type IV: Orthodontic Services (All Covered Persons)		