Holland Public Schools, G-768

Operational Assistants and Professional Support

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

The following special coordination rule applies regarding automobile insurance. 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:** None. **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:** None. **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.

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, cont.	
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 calendar year.
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 one calendar year 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.
P. Alveoplasty	None.
Q. Gingivectomy	None.
R. Vestibuloplasty	None.
S. Root Recovery	None.
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. 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 Therapy, and Appliance Therapy	None.