Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2019 - 12/31/2019

PriorityHealth : **Holland Public Schools**
POS HSA Plan

Coverage for: Subscriber/Dependent | Plan Type: POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. Note: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage or to get a copy of the complete terms of coverage, visit us at PriorityHealth.com or call 1-800-446-5674. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-446-5674 to request a copy.

Important Questions	Answers	Why this Matters
What is the overall deductible?	For participating providers $1,350 person / $2,700 family For non-participating providers $2,700 person / $5,400 family The deductible for each benefit level is calculated separately.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes, the preferred benefits deductible doesn't apply to preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. For participating providers $2,300 person / $4,600 family For non-participating providers $4,600 person / $9,200 family The out-of-pocket limit for each benefit level is calculated separately.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, services that exceed an annual day/visit limit, and any co-pays and co-insurance you pay for any non-essential health benefit.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Does this plan use a network of providers?	Yes. See PriorityHealth.com or call 1-800-446-5674 for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do I need a referral to see a specialist?	No, you don't need a referral in order to receive the preferred benefit for services provided by a participating specialist. Yes, you do need a referral in order to receive the preferred benefit for services provided by a non-participating specialist.	You can see the in-network specialist you choose without a referral. This plan will pay some or all of the costs to see an out-of-network specialist for covered services but only if you have a referral before you see the specialist.

All co-payment and co-insurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance/ visit	40% co-insurance/ visit	Prescription drug co-pay may also apply when selected injectable drugs are provided. Prescription drugs for infertility treatment covered only with prescription drug addendum. Retail health clinic services are covered at reasonable and customary charges.
	Specialist visit	20% co-insurance/ visit	40% co-insurance/ visit	
	Other practitioner office visit	•20% co-insurance/ visit for evaluation/ management services only at retail health clinics •50% co-insurance/ visit for family planning/ infertility services •50% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery	•Evaluation/management services only at retail health clinics covered at the preferred benefit level •Family planning/ infertility services not covered •50% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery	
	Preventive care/screening/ immunization	No charge	40% co-insurance/ visit	Preventive care services are those listed in Priority Health's Preventive Health Care Guidelines, including women's preventive health care services. Preferred benefit level deductible does not apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	----------none----------
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	Prior Approval required for certain radiology examinations.

* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com.

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.priorityhealth.com/prog/pharmacy/pharmacy.cgi	Generic drugs	$10 co-pay/ retail prescription $20 co-pay/ mail order prescription	Not covered	Costs shown in the "Your Cost" columns apply to drugs on the approved drug list when obtained from a Participating Provider. Covers up to a 31-day supply (retail prescription); Covers up to a 90 day supply (mail order prescription) Up to a 90-day supply of medication (excluding Specialty Drugs) may be obtained at one time for three applicable Copayments at a retail Participating Pharmacy. 50% co-insurance/ prescription for infertility drugs.
	Preferred brand drugs	$20 co-pay/ retail prescription $40 co-pay/ mail prescription	Not covered	
	Non-preferred brand drugs	$40 co-pay/ retail prescription $80 co-pay/ mail prescription	Not covered	
	Preferred specialty drugs	$20 co-pay/ retail prescription	Not covered	----------none----------
	Non-Preferred specialty drugs	$40 co-pay/ retail prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance/ visit	40% co-insurance/ visit	Including outpatient care, observation care and ambulatory surgery center care. Prior approval may be required. Prior approval is required for bariatric surgery. Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not Covered, even if the first procedure occurred prior to joining this plan.
	Physician/surgeon fees	20% co-insurance/ visit	40% co-insurance/ visit	
If you need immediate medical attention	Emergency room services	20% co-insurance/ visit	Covered at the preferred benefit level	----------none----------
	Emergency medical transportation	20% co-insurance	Covered at the preferred benefit level	----------none----------
	Urgent care	20% co-insurance/ visit	40% co-insurance/ visit	Urgent Care services received from a Non-Participating Provider who is located outside of our Service Area are Covered at the Preferred Benefit level.

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance/ visit	40% co-insurance/ visit	Prior Approval is required at least 5 working days in advance, except in emergencies or for Hospital stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section. Notification must be provided for all admissions following emergency room care. Prior approval is required for bariatric surgery. Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not Covered, even if the first procedure occurred prior to joining this plan.
	Physician/surgeon fee	20% co-insurance/ visit	40% co-insurance/ visit	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance/ visit	40% co-insurance/ visit	No charge for first three visits with participating provider within 90 days of discharge from a participating hospital for mental health inpatient care. Including medication management visits.
	Mental/Behavioral health inpatient services	20% co-insurance/ visit	40% co-insurance/ visit	Including Residential Treatment and partial hospitalization. Except in an emergency, prior approval required.
	Substance use disorder outpatient services	20% co-insurance/ visit	40% co-insurance/ visit	Prior Approval required for intensive outpatient treatment. Including medication management visits.
	Substance use disorder inpatient services	20% co-insurance/ visit	40% co-insurance/ visit	Including subacute Residential Treatment and partial hospitalization. Except in an emergency, prior approval required.
If you are pregnant	Routine prenatal and postnatal care	No charge	40% co-insurance/ visit	Routine prenatal and postnatal visits are covered under your Preventive Health Care Services benefit. Appropriate office visit charge (PCP or specialist) may apply for physician office services or home visits and consultations for complications of pregnancy.
	Delivery and all inpatient services	20% co-insurance/ visit	40% co-insurance/ visit	----------none----------

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% co-insurance/ visit	40% co-insurance/ visit	Including hospice care services; excluding rehabilitation and habilitation services. Prior approval required except for hospice care services in the home.
	Rehabilitation services *not* for the treatment of Autism Spectrum Disorder	20% co-insurance/ visit	40% co-insurance/ visit	Spinal manipulations are limited to a combined 30 visits per contract year. Physical and occupational therapy limited to a combined 50 visits per contract year. Speech therapy limited to a combined 50 visits per contract year. Cardiac rehabilitation & pulmonary rehabilitation limited to a combined 50 visits per contract year.
	Habilitation services for treatment of Autism Spectrum Disorder ***only***	20% co-insurance/ visit	40% co-insurance/ visit	Prior Approval required for Applied Behavior Analysis (ABA). Covered services include Physical, Occupational, Speech Therapy and Applied Behavior Analysis (ABA). Services are Covered for children and adolescents under age 19 only. Multiple charges may apply during one day of service.
	Habilitation services not for the treatment of Autism Spectrum Disorder	Not covered	Not covered	Not covered
	Skilled nursing care	20% co-insurance/ visit	40% co-insurance/ visit	Services received in a skilled nursing care facility, subacute facility, inpatient rehabilitation care facility or hospice care facility are limited to a combined 90 days per contract year. Prior approval required.
	Durable medical equipment (DME)	20% co-insurance/ visit	50% co-insurance/ visit	Including rental, purchase or repair. Prior Approval required for equipment over $1,000, all rentals and all shoe inserts.
	Prosthetics & orthotics	20% co-insurance/ visit	50% co-insurance/ visit	
	Hospice service	20% co-insurance/ visit	40% co-insurance/ visit	This benefit applies to hospice services provided in the home only. Any hospice services provided in a facility will be subject to the appropriate facility benefit.
If your child needs dental or eye care	Child eye exam	Not covered	Not covered	Not covered
	Child glasses	Not covered	Not covered	Not covered
	Child dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan documents for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Habilitation services not for the treatment of Autism Spectrum Disorder
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan documents.)

- Bariatric surgery
- Chiropractic care
- Emergency services provided outside the U.S.
- Infertility treatment - diagnostic, counseling and planning services for the underlying cause of infertility
- Weight loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Insurance and Financial Services (DIFS) at 1-877-999-6442 or difs-HICAP@michigan.gov; the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov; or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Priority Health at 1-800-446-5674 or www.priorityhealth.com; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Department of Insurance and Financial Services (DIFS) at 1-877-999-6442 or difs-HICAP@michigan.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) at 1-877-999-6442 or difs-HICAP@michigan.gov.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-446-5674.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-446-5674.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-446-5674.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-446-5674.

----------To see examples of how this plan might cover costs for a sample medical situation, see the next section----------

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, co-payments, and co-insurance) and excluded services under this plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,000
Specialist co-insurance	20%
Hospital (facility) co-insurance	20%
Other co-insurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Co-payments	$60
Co-insurance	$2,520
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$5,640

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,000
Specialist co-insurance	20%
Hospital (facility) co-insurance	20%
Other co-insurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,823
Co-payments	$1,115
Co-insurance	$1,104
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$4,096

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,000
Specialist co-insurance	20%
Hospital (facility) co-insurance	20%
Other co-insurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,504
Co-payments	$0
Co-insurance	$396
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,900

The plan would be responsible for the other costs of these EXAMPLE covered services.

EyeMed
VISION CARE®

HOLLAND PUBLIC SCHOOLS

Holland Public Schools has selected EyeMed as your vision wellness program effective 1/01/2010. This plan allows you to improve your health through a routine eye exam, while saving you money on your eye care purchases. The plan is available through thousands of provider locations participating on the EyeMed SELECT network.

To see a list of participating providers near you, go to www.enrollwitheyemed.com and choose SELECT from the provider locator dropdown box. You can also call 1-866-268-4063.

Enroll today to take advantage of an affordable way to help ensure a lifetime of healthy vision.

Vision Care Services	Member Cost	Out-of-Network Reimbursement
Exam with Dilation as Necessary	$10 Copay	Up to $35
Exam Options:		
Standard Contact Lens Fit and Follow-up	Up to $40	N/A
Premium Contact Lens Fit and Follow-up	10% off Retail	N/A
Frames	$140 Allowance; 20% off balance over $140	Up to $56
Standard Plastic Lenses:		
Single Vision	$10 Copay	Up to $25
Bifocal	$10 Copay	Up to $40
Trifocal	$10 Copay	Up to $60
Standard Progressive	$10 Copay	Up to $85
Premium Progressive	$10, 80% of charge less $120 Allowance	Up to $85
Lens Options (paid by the member and added to the base price of the lens):		
Tint (Solid and Gradient)	20% off retail	N/A
UV Treatment	20% off retail	N/A
Standard Plastic Scratch Coating	20% off retail	N/A
Standard Polycarbonate	$0	Up to $28
Standard Anti-Reflective Coating	20% off retail	N/A
Other Add-Ons and Services	20% off Retail Price	N/A
Contact Lenses (allowance covers materials only):		
Conventional	$155 Allowance; 15% off balance over $155	Up to $109
Disposables	$155 Allowance; balance over $155	Up to $109
Medically Necessary	$0 Copay, Paid in Full	Up to $200
LASIK and PRK Vision Correction Procedures:	15% off retail price OR 5% off promotional pricing	N/A

Additional Pairs Benefit
Members also receive a 40% discount off complete pair eyeglass purchase and 15% discount off conventional contact lenses once the funded benefit has been used.

Frequency:	
Exam	Once every 12 months
Frames	Once every 12 months
Standard Plastic Lenses or Contact Lenses	Once every 12 months

Additional Purchases and Out-of-Pocket Discount

Member will receive a 20% discount on remaining balance at Participating Providers beyond plan coverage; the discount does not apply to EyeMed' s Providers' professional services or disposable contact lenses.

Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.

Benefits are not provided for services or materials arising from: Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; Medical and/or surgical treatment of the eye, eyes or supporting structures; Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Plano (non-prescription) lenses and/or contact lenses; Non-prescription sunglasses; Two pair of glasses in lieu of bifocals; Services or materials provided by any other group benefit plan providing vision care; Certain brand name Vision Materials in which the manufacturer imposes a no-discount policy; or Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive Lens not covered - fund as a Bifocal Lens. Standard Progressive Lens covered - fund Premium Progressive as a Standard.

Underwriter Insured Plans are underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Fidelity Security Life Policy Number VC-73/VC-74, form number M-9059. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

LENSCRAFTERS
PEARLE VISION
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Value Added Features:
In addition to the health benefits your EyeMed program offers,members also enjoy additional, value-added features including:

- **Eye Care Supplies** - Receive 20% off retail price for eye care supplies like cleaning cloths and solutions purchased at network providers (not valid on doctor' s services or contact lenses).
- **Laser Vision Correction** - Save 15% off the retail price or 5% off the promotional price for LASIK or PRK procedures.
- **Replacement Contact Lens Purchases** - Visit www.eyemedcontacts.com to order replacement contact lenses for shipment to your home at less than retail price.

Dental Plan Schedule for HESPA (Part Time; Location 11; Plans MR768J & MR768JF)

Benefit Description	Dental Plan Limits
Benefit Year	January 1 through December 31
Benefit Percentage Type I - Preventive Dental Services	90%* (covered person pays 10%) *Eligible charges for preventive oral examinations and fluoride treatment rendered to covered persons under age 18 will be paid at 100%.
Type II - Minor Restorative Dental Services	50% (covered person pays 50%)
Type III - Major Restorative Dental Services	50% (covered person pays 50%)
Type IV - Orthodontic Services (for all Covered Persons)	50% (covered person pays 1,500%)
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

Dental Plan Schedule for HESPA (Full Time; Location 12; Plans MR768L & MR768LF)

Benefit Description	Dental Plan Limits
Benefit Year	January 1 through December 31
Benefit Percentage Type I - Preventive Dental Services	100% (covered person pays 0%)
Type II - Minor Restorative Dental Services	90% (covered person pays 10%)
Type III - Major Restorative Dental Services	70% (covered person pays 30%)
Type IV - Orthodontic Services (for all Covered Persons)	70% (covered person pays 30%)
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

Summary of Dental Procedures for All Plans

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.
Type I: Preventive Dental Services, cont.	
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 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 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.
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 **NOTE: For replacement of items A., C., E., F., G., and H. below, see the subsection entitled "EXCLUSIONS AND LIMITATIONS" in the Plan document.**	
A. Gold Inlays and On lays	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.

Services:	***Special Limitations:***
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.

SCHEDULE OF BENEFITS

Employer(s):	Holland Public Schools
Plan Number:	7298
Original Plan Effective Date:	May 1, 2012
Benefits Revised Date:	January 1, 2019
Eligible Class: Class 03:	HESPA Employees
Employer Premium Contribution:	100%
Elimination Period:	120 days
Minimum Hourly Work Requirement:	20 hours per week
Waiting Period:	None
Evidence of Insurability:	Required for Late Enrollees, Increases & amounts exceeding the Guarantee Issue
Employee Eligibility Date:	Upon completion of the Waiting Period
Minimum Participation Requirement:	100%
Leaves and Sabbaticals:	Coverage with premium payment while on FMLA leave; Coverage with premium payment for up to 12 months while on Paid Leave
Definition of Disability:	Zero Day
Own Occupation Period: Elimination Period	24 months following the end of the
Any Occupation Period:	From the end of the Own Occupation Period to the end of the Maximum Benefit Period
Cumulative Elimination Period:	10 Working Days
Recurrent Disability:	6 months
Pre-disability Earnings:	Base pay only
Maximum Monthly Covered Salary:	$3,750
LTD Benefit Percentage:	66-2/3%
Maximum Monthly Benefit:	$2,500
Guarantee Issue:	$2,500
Minimum Monthly Benefit:	$100

SCHEDULE OF BENEFITS

A. Administrative

1. Employer:	Holland Public Schools
2. Plan Number:	3997
3. Initial Plan Effective Date:	May 1, 2012
4. Benefits Revised Date:	January 1, 2019
5. Evidence of Insurability Requirements:	Applies to Late Enrollees, Increases in Benefits and Amounts over Guarantee Issue Amounts
6. Eligible Class:	06 HESPA Employees
7. Minimum Hourly Work Requirement:	20 hours per week
8. Waiting Period for Insurance Coverage:	None
9. New Employee Eligibility Date:	Upon completion of the Waiting Period
10. Leaves / Layoffs:	Coverage with premium payment while on FMLA leave; Coverage with premium payment for up to 12 months while on Paid Leave
11. Employee Premium Contribution	
Employee Basic Insurance:	0%
12. Participation Requirements	
Employee Basic Insurance:	100%
13. Insurance Reduction Schedule	
Employee Basic Insurance:	Basic Life and Basic AD&D Insurance reduces to 65% at age 65, reduces to 50% of the original amount at age 70 and will terminate at retirement.

B. Basic Life Insurance

Employee Basic Life:	$20,000
Guarantee Issue:	$20,000

C. Additional Benefits

1. Conversion of Insurance Benefit:	Included
2. Waiver of Premium Benefit:	Included
3. Living Benefit:	Included

D. Accidental Death and Dismemberment (AD&D) Insurance

1. Basic AD&D Insurance	
Employee Basic AD&D Insurance:	$20,000
Guarantee Issue:	$20,000

E. Additional AD&D Benefits

1. Seat Belt Benefit:	Included