GRCC
GRAND RAPIDS COMMUNITY COLLEGE

Grand Rapids Community College
Dental and Vision Reimbursement Plan

Benefit Description	Vision Plan Limits
Benefit Year	Dental/vision reimbursement benefit limit is $2,575. for the calendar year (January 1 -December 31) and each calendar year thereafter.
Benefit Percentage	
Vision Examinations for Covered Persons Under Age 18	100%
Vision Examinations for All Other Covered Persons	90%
Eyeglass Frames	90%
Eyeglass Lenses, Including Eyeglass Lens Add-Ons Such As Tinting, Ultraviolet Coatings, Scratch-Resistant Coatings, and Anti-Reflective Coatings	90%
Contact Lenses	90%
LASIK Surgery	90%
Maximum Benefit Paid per Family per Benefit Year for Types I, II, III, and IV Dental Services and All Eligible Vision Expenses Combined Claims for routine vision examinations incurred by covered persons under age 18 are not subject to the Benefit Year dollar maximum.	Dental/vision reimbursement benefit limit is $2,575 for the calendar year (January 1 -December 31) and each calendar year thereafter.

Benefit Description	Dental Plan Limits
Benefit Year	Dental/vision reimbursement benefit limit is $2,575 for the calendar year (January 1 -December 31) and each calendar year thereafter.
Benefit Percentage for All Other Covered Persons	
Type I - Preventive Dental Services	90%* *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	90%
Type III - Major Restorative Dental Services	90%
Type IV - Orthodontic Services (for all Covered Persons)	90%
Special Note for Covered Persons Under Age 18: Charges for oral examinations and fluoride treatment are not covered under the dental plan if the service is covered at 100% with the deductible waived under the Employer's medical plan. Please contact the Employer for additional information about available medical plan coverage.	
Maximum Benefit Paid per Family per Benefit Year for Types I, II, III, and IV Dental Services and All Eligible Vision Expenses Combined Claims for Type I Preventive Dental Services incurred by covered persons under age 18 are not subject to the Benefit Year dollar maximum.	

Summary of Dental Procedures	
Services:	***Special Limitations:***
Type I: Preventive Dental Services	
A. Oral Examination	**Covered Persons Under Age 18:** No special limitations. If services are covered under GRCC's medical plan, the medical plan will provide primary coverage and GRCC's dental plan will coordinate as the secondary coverage on any unpaid balance. **All Other Covered Persons:** No special limitations.
B. Complete Series or Panorex X-ray	No special limitations.
C. Occlusal, Extraoral, and Individual Periapical X-Rays	No special limitations.
D. Bite-Wing X-rays	No special limitations.
E. Bacteriologic Cultures	No special limitations.
F. Dental Prophylaxis (cleaning teeth)	No special limitations.
G. Fluoride Treatment	**Covered Persons Under Age 18:** No special limitations. If services are covered under GRCC's medical plan, the medical plan will provide primary coverage and GRCC's dental plan will coordinate as the secondary coverage on any unpaid balance. **All Other Covered Persons:** No special limitations.
H. Palliative Treatment	No special limitations.
I. Sedative Fillings	No special limitations.

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Summary of Dental Procedures	
Services:	***Special Limitations:***
Type I: Preventive Dental Services, cont.	
J. Sealants	No special limitations.
K. Space Maintainers	No special limitations.
L. Emergency Treatment	No special limitations.
Type II: Minor Restorative Dental Services	
A. Periodontal Exams	No special limitations.
B. Periodontal Prophylaxis	No special limitations.
C. Diagnostic Casts	No special limitations.
D. Stainless Steel Crowns	No special limitations.
E. Re-cement Inlays, Onlays, & Crowns	No special limitations.
F. Pulpotomy and Osseous Surgery	No special limitations.
G. Root Canal Therapy	No special limitations.
H. Apicoectomy and Retrograde Filling	No special limitations.
I. Scaling and Root Planing	No special limitations
J. Temporary Splinting	No special limitations.
K. Periodontal Appliance	No special limitations
L. Repairs to Full Dentures, Partial Dentures, Bridges	No special limitations
M. Relining Dentures	No special limitations
N. Re-cement Bridges	No special limitations.
O. Simple Extraction	No special limitations.
P. Surgical Extraction of Impacted/Partially Teeth, Alveoplasty, Gingivectomy, Vestibuloplasty, & Other Extractions	No special limitations. If services are covered under GRCC's medical plan, the medical plan will provide primary coverage and GRCC's dental plan will coordinate as the secondary coverage on any unpaid balance.
Q. Root Recovery	No special limitations.
R. Incision and Drainage	No special limitations.
S. Local and General Anesthesia	No special limitations.
T. Amalgam Restorations (fillings)	Multiple restorations on one surface will be treated as a single filling.
U. Silicate, Plastic, and Composite Restorations (fillings)	No special limitations.
V. Pin Retention	No special limitations.
W. Gingival Curettage	No special limitations.
X. Osseous Graft	No special limitations.
Y. Frenectomy	No special limitations.
Z. Occlusal Adjustment	No special limitations.
AA. Bite Splint Appliances	No special limitations.
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	No special limitations.
C. Crowns	Covered only if the tooth cannot be restored by a filling or by other means.
D. Post and Core	No special limitations.
E. Replacement of Teeth to Bridges and Dentures	No special limitations.
F. Full or Partial Dentures	No special limitations.
G. Fixed Bridges	No special limitations.
H. Dental Implants	No special limitations.
Type IV: Orthodontic Services	
****Orthodontic Diagnostic Procedures,** Surgical Therapy, and Appliance Therapy	No special limitations.

***Reimbursement for orthodontics** is only available on the initial payment for services *(*maximum initial down payment limit 25%), and then for each additional monthly payment on the balance. The plan will not reimburse a participant a one lump-sum payment at the end of the treatment period. When submitting a reimbursement request for orthodontic services, please provide a copy of the orthodontic contract, which details the total cost, the initial down payment, the monthly payment schedule, and the date on which the contract will be paid in full.

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