GRAND RAPIDS COMMUNITY COLLEGE

DENTAL AND VISION REIMBURSEMENT PLAN

AMENDED EFFECTIVE SEPTEMBER 1, 2022

Prepared by:
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GRAND RAPIDS COMMUNITY COLLEGE

DENTAL AND VISION REIMBURSEMENT PLAN

Article 1

Establishment of the Plan

This document is intended to serve as the Plan document and Summary Plan Description for the Grand Rapids Community College Dental and Vision Reimbursement Plan sponsored by Grand Rapids Community College which is to provide eligible Employees with certain tax-free dental and vision reimbursement benefits. This document sets forth the terms of the Plan as of September 1, 2022. The Plan is intended to qualify as a Dental and Vision Reimbursement Plan under Section 105(h) of the Code and is to be interpreted in a manner consistent with the requirements of Section 105(h). It is also intended that the Plan is a limited-scope dental and/or vision benefit as described in Proposed Treasury regulation 54.9831-1(c)(3)(ii). As a result, it is intended that the market reforms of Health Care Reform shall not apply to the Plan.

Article 2

Definitions

The following terms used in the Plan shall have the meanings described in this Article unless the context clearly indicates another meaning.

2.1 Board of Directors

"Board of Directors" means the governing body of Employer.

2.2 Code

"Code" means the Internal Revenue Code of 1986, as amended.

2.3 Dependent

"Dependent" means a Participant's spouse (of the same and opposite gender) or an individual defined in Section 152 of the Code, but determined without regard to Sections 152(b)(1), (b)(2) and (d)(1)(B) of the Code or is a Participant's child within the meaning of Section 152(f)(1) of the Code who has not attained age 27 as of the end of the calendar year.

2.4 Employee

"Employee" means any person who, for tax purposes, is considered by Employer to be a common-law employee of Employer. A person who is treated by Employer as an independent contractor is not an Employee.

2.5 Employer

"Employer" means Grand Rapids Community College.

2.6 Health Care Reform

"Health Care Reform" means the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010.

2.7 HIPAA

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

2.8 Medical Expenses

"Medical Expenses" means any expenses incurred by a Participant or the Participant's Dependent for health care that would be deductible under Section 213 of the Code (without regard to the adjusted gross income limitation, which is generally 10%). Further, Medical Expenses are limited to expenses for the treatment of the mouth (including any organ or structure within the mouth) and eye.

2.9 Participant

"Participant" means an Employee who has satisfied the participation requirements under Article 3.

2.10 Plan

"Plan" means the Grand Rapids Community College Dental and Vision Reimbursement Plan.

2.11 Plan Administrator

"Plan Administrator" means the named fiduciary responsible for the operation and administration of the Plan. Employer shall be the Plan Administrator.

2.12 Plan Year

"Plan Year" means the 12-consecutive-month period beginning on January 1 and ending on the following December 31.

Article 3

Participation

3.1 Eligibility

Each Employee of Employer who is currently classified by Grand Rapids Community College as:

A. A full-time Employee and scheduled to work an average of 32.5 or more hours per week as regular Full Time Staff.

B. A full-time Employee who works 15 or more contract hours per week as Full Time Faculty

C. A full-time Employee who works 12 or more contract hours per week as a Full Time English Comp. Instructor.

An Individual will remain eligible for the Plan during any period when classes are not in session if the individual remains employed by Grand Rapids Community College for the duration of the break and also returns to Full Time Employment when the break has ended.

Retiree Coverage is unavailable.

An extension of Participation for long-term disability may be allowed as per the applicable employee handbook or collective bargaining agreement.

3.2 Participation

Each Employee eligible under Section 3.1 shall become a Participant during the Open Enrollment Period only.

3.3 Termination of Participation

An individual who terminates employment with Employer shall be considered to have terminated participation in the Plan as of the individual's employment termination date. The individual shall be ineligible to receive reimbursement under the Plan for Medical Expenses incurred after the date the individual's participation terminated.

If an individual terminates participation under this Section, the individual shall be ineligible to receive reimbursement under the Plan for Medical Expenses incurred after his participation termination date, except to the extent the individual continues to participate in the Plan as described in Section 3.4.

3.4 COBRA Continuation Coverage

If an individual whose participation in the Plan terminates under Section 3.3 the participant will have the option of continuing to participate in the Plan to the extent required by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA").

3.5 FMLA

The FMLA provisions of the Plan apply during any Calendar Year when GRCC is subject to FMLA, which generally means GRCC employs 50 or more Employees (including part-time Employees) each working day during 20 or more calendar weeks in the current or preceding Calendar Year. Further, the FMLA provisions apply only to eligible Participants (i.e., Participants who have been employed by GRCC for at least 12 months and who have worked at least 1,250

hours in the 12-month period immediately preceding the taking of the FMLA leave). A Participant on leave under the FMLA may continue coverage during the leave on the same basis and at the same Participant contribution as if the Participant had continued in active employment continuously for the duration of the leave. The maximum period of an FMLA leave is generally 12 workweeks per 12-month period (as that 12-month period is defined by GRCC). However, if a Participant takes leave under the FMLA to care for a spouse, parent, child, or next of kin injured in the line of active military duty, the maximum period of FMLA leave is 26 workweeks per 12-month period. Other provisions regarding an FMLA leave are set forth in the FMLA and GRCC's policy regarding the FMLA. If the Participant fails to return from the FMLA leave for any reason other than the continuation, recurrence, or onset of a "serious health condition" as defined in the FMLA or other circumstance considered by the Plan Administrator as beyond the control of the Participant, GRCC may recover any Employer contribution paid to maintain coverage for the Participant during the leave. If a Participant fails to pay any required contribution for coverage during the FMLA leave within 30 days of the due date for the contribution, coverage shall be suspended upon 15 days advance written notification of the non- payment, subject to the right to reinstatement of coverage upon return to work from FMLA leave with no waiting period or other limitation normally applicable to a new Participant in the Plan.

3.6 Continuation of Coverage Upon Military Leave

If an Employee ceases to be eligible for coverage under the Plan owing to service in the U.S. military, the Plan shall comply with the requirements of the Uniformed Services Employment and Reemployment Rights Act (USERRA). These requirements include the following:

(a) The Employee and any Dependents may elect to continue coverage under the Plan. Such coverage will be available until the earliest of the following:

(1) The expiration of the 24-month period following the Employee's last day of work before beginning service in the U.S. Military.

(2) The end of the period allowed by the law for the Employee to apply for re-employment following the Employee's service in the U.S. military.

(b) USERRA continuation coverage shall run concurrently with an extension of coverage under COBRA.

(c) If the Employee gives GRCC advance notice of the Employee's service in the U.S. military, the Plan Administrator shall provide the Employee with a notice of the right to continue coverage pursuant to USERRA. If the Employee's service in the U.S. military exceeds 30 days and the Employee fails to return the completed election form to the Plan Administrator within 60 days of the date the election form was provided to the Employee, the Employee and Dependents shall cease to be eligible to continue coverage pursuant to USERRA as the Employee's last day of work before beginning service in the U.S. military.

(d) If the Employee fails to give GRCC advance notice of the Employee's service in the U.S. military, the coverage of the Employee and any Dependents shall be cancelled. However, the coverage of the Employee and any Dependents shall be

cancelled. However, the coverage of the Employee and any Dependents may be reinstated retroactively to the first day of the Employee was absent from work for service in the U.S. military under all of the following circumstances:

(1) The Employee is excused from providing advance notice of the Employee's service in the U.S. military as provided under USERRA regulations (e.g., it was impossible or unreasonable for the Employee to provide advance notice was precluded by military necessity).

(2) The Employee elects to reinstate the coverage.

(3) The Employee pays all unpaid premiums for the retroactive coverage.

(e) The Employee must pay for USERRA continuation coverage. Coverage continued pursuant to USERRA shall be cancelled if the Employee does not timely pay any required premiums for that coverage. The Employee's cost of coverage is determined as follows:

(1) If the period of military service is 30 days or less, the Employee's required contributions for coverage will equal the required contributions for identical coverage paid by similarly situated active Employees.

(2) If the period of military service is more than 30 days, the Employee's required contributions will be 102% of the cost identical coverage for similarly situated active Employees.

(f) The initial premium is due within 45 days after the Employee elects to continue coverage, and subsequent premiums are due on the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after the Employee initially elects USERRA continuation coverage. Coverage shall be suspended if payment is not made by the first day of the month, but will be reinstated retroactively to the first of the month as long as payment for that month is made before the end of the grace period. Payment more than 30 days late will result in automatic termination of USERRA contribution coverage pursuant to this section with no right to reinstate.

(g) Upon re-employment, the coverage of the Employee and any Dependents shall be immediately reinstated under the Plan (i.e., no waiting period shall apply).

Article 4

Benefits

4.1 Expenses Covered

For each Plan Year, Employer shall reimburse a Participant for eligible Dental and Vision Expenses incurred on behalf of the Participant or the Participant's Dependent(s) during the

Plan Year. For purposes of the Plan, an Expense shall be incurred on the date the service or supply is provided. An Expense is eligible for reimbursement only if:

(a) The Expense has not been reimbursed by insurance or any other source. The claim must first be filed with any other medical, dental or vision plan (e.g., Grand Rapids Community College medical plan coverage or coverage under a spouse's employer's group health, dental or vision plan) before it can be filed under this plan.

(b) The Expense was incurred while the Employee or former Employee was a Participant.

(c) The Expense has been paid in full to the provider by the Employee.

Schedule of Benefits and General Plan Exclusions and Limitations listed in Appendix A.

4.2 Limit on Benefits

The Employer will reimburse 90% of eligible Expenses up to the maximum amount of $2575.00 during a Plan Year. This is an increase of $75.00 which is taking place effective September 1, 2022. Dates of service of claims can go back to January 1, 2022. However, preventative oral examinations, fluoride treatment and routine vision examinations rendered for Dependents under age 18 are covered at 100% and do not accrue towards the Plan Year Maximum.

4.3 Reimbursement

All claims for reimbursement must be filed with the Plan Administrator no later than 1 year after the end of the Plan Year. However, in the case of a Participant who terminates employment and participation in the Plan before the end of a plan year, all claims for reimbursement must be filed no later than 90 days after which his participation in the Plan terminated.

A Participant shall request reimbursement from Flex Administrators, Inc., in writing, on a form provided by Grand Rapids Community College, or request reimbursement from Flex Administrators, Inc. via the Employee's online portal or mobile app provided by Flex Administrators, Inc. Any bills or invoices documenting the dental or vision eexpense shall accompany the reimbursement request. The Plan Administrator may establish additional procedures for the submission of claims for reimbursement.

The Plan Administrator shall verify each claim for reimbursement and determine whether the claim is for expenses covered by the Plan. All reimbursement shall be made payable to the Participant. The Plan shall not recognize an assignment of benefits.

4.4 Nondiscrimination Rules

If the Plan Administrator determines at any time that the Plan may not satisfy a nondiscrimination rule in the Code, the Plan Administrator may take whatever action it deems appropriate to assure compliance with the rule. Any action shall be taken uniformly with respect to similarly-situated Participants.

4.5 Funding of Benefits

Each Participant's benefits under the Plan shall be paid from Employer's general assets. Nothing in the Plan shall be construed to require Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant.

4.6 HIPAA Privacy and Security Rules

The Plan shall be subject to the following HIPAA privacy and security rules:

(a) Permitted and Required Uses and Disclosure of Protected Health Information ("PHI"). Subject to Section (c), the Plan may disclose PHI to Employer, provided Employer does not use or disclose such PHI except for the following purposes:

(1) To perform Plan Administrative Functions which Employer does for the Plan;

(2) To obtain premium bids from insurance companies or other health plans for providing coverage under or on behalf of the Plan; or

(3) To modify, amend or terminate the Plan.

Notwithstanding the provisions of the Plan to the contrary, in no event shall Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR §164.504(f).

(b) Conditions of Disclosure. Employer agrees that with respect to any PHI, it shall:

(1) Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.

(2) Ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to Employer with respect to PHI.

(3) Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Employer.

(4) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for which it becomes aware.

(5) Make available to an individual Participant who requests access, the Participant's PHI in accordance with 45 CFR §164.524.

(6) Make available to an individual Participant who requests an amendment, the Participant's PHI and incorporate any amendments to the Participant's PHI in accordance with 45 CFR §164.526.

(7) Make available to an individual Participant who requests an accounting of disclosures of the Participant's PHI, the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.

(8) Make its internal practices, books, and records, relating to the use and disclosures of PHI received from the Plan, available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA privacy rules.

(9) If feasible, return or destroy all PHI received from the Plan that Employer still maintains in any form, and do not retain copies of such information when no longer needed for the purpose for which the disclosure was made. If such return or destruction is not feasible, however, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(10) Ensure that the adequate separation between Plan and Employer, as required in 45 CFR §164.504(f)(2)(iii), is satisfied and that the terms set forth in Section (e) are followed.

(11) Employer further agrees that if it creates, receives, maintains or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, Employer shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI and Employer shall ensure that any agents (including Business Associates and subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. Employer shall report to the Plan any security incident of which it becomes aware.

(c) **Certification of Employer**. The Plan shall disclose PHI to Employer only upon the receipt of a Certification by Employer that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that Employer agrees to the conditions of disclosure set forth in Section (b).

(d) **Permitted Uses and Disclosure of Summary Health Information**. The Plan may disclose Summary Health Information to Employer, provided such Summary Health Information is only used by Employer for the purpose of obtaining premium bids from health plan providers for providing health coverage under the Plan, or modifying, amending or terminating the Plan.

(e) Adequate Separation Between Plan and Employer.

(1) The Employees, or classes of Employees, who shall be given access to PHI shall be set forth in Employer's HIPAA privacy policies and procedures for its group health plans.

(2) The access to and use of PHI by the individuals described in subsection (1) shall be restricted to the Plan Administrative Functions that Employer performs for the Plan.

(3) In the event any of the individuals described in subsection (1) do not comply with the provisions of the Plan relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further noncompliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

(4) To comply with the HIPAA security rules, Employer shall ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the authorized Employees or classes of Employees have access to electronic PHI.

(f) **Disclosure of Certain Enrollment Information to Employer**. Pursuant to 45 CFR §164.504(f)(1)(iii), the Plan may disclose to Employer information on whether an individual is participating in the Plan or is enrolled in, or has disenrolled from, any health insurance issuer or health maintenance organization offered by the Plan.

(g) **Other Disclosures and Uses of PHI**. With respect to all other uses and disclosures of PHI, the Plan shall comply with the HIPAA privacy rules.

(h) **Definitions**. For purposes of this subsection, the following terms shall have the meanings described in this subsection:

(1) "Business Associate" means a person or entity who:

(A) Performs or assists in performing a Plan function or activity involving the use and disclosure of PHI (including claims processing or administration, data analysis, underwriting, etc.); or

(B) Provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services, where the performance of such services involves giving the service provider access to PHI.

(2) "Plan Administrative Functions" mean activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan. Plan Administrative Functions include quality assurance, employee assistance, claims processing, auditing,

monitoring, and management of carve-out-plans such as vision and dental. PHI for these purposes may not be used by or between the Plan or Business Associates of the Plan in a manner inconsistent with the HIPAA privacy rules, absent an authorization from the individual. Plan Administrative Functions specifically do not include any employment-related functions.

(3) "Protected Health Information" or "PHI" means information that is created or received by the Plan, or a Business Associate of the Plan and relates to the past, present, or future physical or mental health or condition of a Participant; the provision of health care to a Participant; or the past, present, or future payment for the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant (whether living or deceased). The following components of a Participant's information are considered to enable identification:

(A) Names;

(B) Street address, city, county, precinct or zip code;

(C) Dates directly related to a Participant's receipt of health care treatment, including birth date, health facility admission and discharge dates, and date of death;

(D) Telephone numbers, fax numbers and electronic mail addresses;

(E) Social Security numbers;

(F) Medical record numbers;

(G) Health plan beneficiary numbers;

(H) Account numbers;

(I) Certificate/license numbers;

(J) Vehicle identifiers and serial numbers, including license plate numbers;

(K) Device identifiers and serial numbers;

(L) Web Universal Resource Locators (URLs);

(M) Biometric identifiers, including finger and voice prints;

(N) Full face photographic images and any comparable images; and

(O) Any other unique identifying number, characteristic or code.

(4) "Summary Health Information" means information that may be individually identifiable health information:

(A) That summarizes the claims history, claims expenses or type of claims experienced by individuals for whom Employer has provided health benefits under a health plan; and

(B) From which the information described at 45 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five-digit zip code.

(i) **Participant Notification**. Participants shall be notified of the provisions of this Article in the notice of privacy practices.

Article 5

Administration

5.1 Powers of Plan Administrator

The Plan Administrator shall have the discretionary authority and power necessary to administer and meet its obligations under the Plan, including, without limitation, the following:

(a) Interpret the terms and provisions of the Plan.

(b) Decide all questions of eligibility for participation in the Plan.

(c) Make and enforce rules and regulations it deems necessary for the efficient administration of the Plan.

(d) Establish procedures by which Participants may apply for reimbursement under the Plan.

(e) Determine the rights under the Plan of any Participant applying for or receiving reimbursement.

(f) Reimburse all Participants entitled to reimbursement under the Plan in a timely manner.

(g) Administer the claim procedures provided for in this Article.

(h) Delegate specific responsibilities for the operation and administration of the Plan to any Employees or agents as it deems advisable.

(i) Maintain records pertaining to the Plan.

5.2 Appeal Procedure

Any Participant whose claim for reimbursement under the Plan is not paid or is denied, in whole or in part, shall be given notice of the nonpayment or denial within 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan Administrator and notifies the Participant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary due to the failure of the Participant to submit the information required to decide the claim, the notice of extension shall describe the information still needed and the Participant shall be granted 45 days from the receipt of the notice within which to provide the additional information. The Plan's period for making the benefit determination shall be the 15-day period beginning on the date the Participant furnishes the additional information. If the Participant does not provide the additional information within 45 days from the receipt of the extension notice, the Plan Administrator may issue a denial of the claim within 15 days after the end of the 45-day period.

The Plan Administrator shall provide the Participant with a written or electronic notification of any adverse benefit determination. The notice shall set forth the specific reason or reasons for the adverse benefit determination, refer to the specific Plan provisions on which the determination is based, and describe any additional material or information necessary for the Participant to perfect the claim. The notice shall also describe the Plan's review procedures and related time limits.

If the adverse benefit determination was based upon an internal rule, guideline, protocol or other similar criterion, a copy shall be provided free of charge to the Participant upon request.

The Participant may request a review of any adverse benefit determination by submitting a written application to the Plan Administrator within 180 days following the denial of the claim. The Participant may submit written comments, documents, records and other information relating to the claim. The information shall be considered without regard to whether it was submitted or considered in the initial benefit determination. In filing the appeal, the Participant shall be provided, upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to the Participant's claim for benefits.

The appeal procedure shall provide for a review that does not afford deference to the initial adverse benefit determination. The appeal shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor a subordinate of that individual.

The Plan Administrator shall notify the Participant of the Plan's determination on review within 60 days after the Plan's receipt of the Participant's request for a review of an adverse benefit determination. The Plan Administrator shall provide a Participant with a written or electronic notification of the Plan's determination on review. The notice shall include the same information which must be included in the notification of the initial adverse benefit determination. The decision of the Plan Administrator on appeal shall be final and binding. No legal action may be brought with respect to a claim more than one year after the Plan Administrator has provided the Participant with a written notice denying the appeal.

5.3 Standard of Care

The Plan Administrator shall administer the Plan in accordance with the terms of the Plan solely in the interest of the Participants and for the exclusive purpose of providing benefits to Participants and defraying the reasonable expenses of administration of the Plan. The Plan Administrator shall administer the Plan with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person, acting in a like capacity and familiar with such matters, would use in the conduct of an enterprise of a like character and with like aims.

The Plan Administrator shall not be liable for any act or omission relating to its duties under the Plan, unless the act or omission violates the standard of care described in this Section. The Plan Administrator shall not be liable for any act or omission by another relating to the Plan.

Article 6

Amendment and Termination

6.1 Amendment of the Plan

Employer may amend the Plan at any time. No amendment shall reduce or eliminate a Participant's right to receive reimbursement in accordance with the provisions of the Plan for Medical Expenses incurred before the date of amendment. Further, any amendment may be made retroactively to the extent permitted by the Code.

6.2 Termination of the Plan

Although Employer intends to continue the Plan indefinitely, Employer reserves the right to terminate or partially terminate the Plan at any time by action of its Board of Directors. If the Plan is terminated or partially terminated for any reason, it shall not reduce or eliminate a Participant's right to receive reimbursement in accordance with the provisions of the Plan for Medical Expenses incurred prior to the date of termination.

Article 7

Miscellaneous Provisions

7.1 Uniformity of Treatment

Any discretionary action taken under the Plan by the Plan Administrator shall be uniform in its application to similarly-situated persons and shall be based upon the objective criteria set forth in the Plan.

7.2 Governing Law

The provisions of the Plan shall be governed by the laws of the state of Michigan.

Signature

Employer has adopted this document setting forth the terms of the Plan as of September 1, 2022.

Grand Rapids Community College

Christine Coon

Christine Coon (Sep 22, 2022 10:53 EDT)

Signature

Christine Coon - Executive Director of HR

Printed Name and Title

Other Basic Information About the Plan

Plan Name:	Grand Rapids Community College Dental and Vision Reimbursement Plan
Name, Address and Telephone Number of Employer:	Grand Rapids Community College 143 Bostwick NE Grand Rapids, MI 49503 (616) 234-4000
Employer's Taxpayer Identification Number:	38-2980195
Type of Plan:	Dental and Vision Reimbursement Plan
Plan Administrator:	Employer is the Plan Administrator.
Name and Address of Agent for Service of Legal Process:	Executive Director Human Resources Grand Rapids Community College 143 Bostwick NE Grand Rapids, MI 49503 Service of process may be made upon the Plan Administrator
Plan Year:	January 1 – December 31
Benefits Administrator:	Flex Administrators, Inc. 3980 Chicago Drive Suite 230 Grandville, MI 49418 (616) 456-7908

SCHEDULE OF DENTAL BENEFITS

BENEFITS	LIMITS
Type 1 – Preventative Dental Services *Eligible charges for preventive oral examinations and fluoride treatment rendered to Covered Dependents under age 18 may be paid by the Plan at 100% (0% Coinsurance). However, 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 GRCC's medical plan.	90% (10% Coinsurance)
Type II – Minor Restorative Dental Services *If the following services are covered under GRCC's medical plan, the medical plan will provide the primary coverage and the Dental Reimbursement Plan will coordinate as the secondary coverage for any unpaid balance: Surgical Extraction of Teeth (impacted wisdom teeth, partially impacted wisdom teeth and other extractions), Alveoplasty, Gingivectomy and Vestibuloplasty	90% (10% Coinsurance)

Type III – Major Restorative Dental Services	90% (10% Coinsurance)
Type IV – Orthodontic Services *****Reimbursement for orthodontics is only available on the initial payment for services and then for each additional monthly payment on the balances. The initial payment cannot exceed more than 25% of the total orthodontic cost. The plan will NOT reimburse a participant in one lump-sum payment at the end of the treatment period. When submitting reimbursement for orthodontic services, please provide Flex Administrators with 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.	90% (10% Coinsurance)*
Timing of Dental Expenses	For an appliance or modification of an appliance, an expense is considered incurred at the time the impression is made. For a crown, bridge, or gold restoration, an expense is considered incurred at the time the tooth or teeth are prepared. For root canal therapy, an expense is considered incurred at the time the pulp chamber is opened. All other expenses are considered incurred at the time a service is rendered or a supply is furnished. Expenses for appliances, dentures, fixed bridgework, crowns, or implants that were ordered before the termination date of a Covered Person, but that are installed or delivered more than 30 days after the date coverage terminates, are ineligible for payment under the Plan.

LIST OF DENTAL PROCEDURES

The following is a list of dental procedures for which benefits are payable. These benefits are subject to the limitations listed below and the maximums stated in the Schedule of Benefits:

TYPE I: PREVENTIVE DENTAL SERVICES

Services	***Special Limitations***
Oral Examination	**Covered persons under Age 18:** Not covered as a dental expense if covered under GRCC's medical plan. **All Other Covered Persons:** No special limitations
Complete Series or Panorex X-ray	No Special Limitations
Individual Periapical X-rays	No Special Limitations
Occlusal X-rays	No Special Limitations
Extraoral X-rays	No Special Limitations
Bite-Wing X-rays	No Special Limitations
Bacteriologic Culturs	No Special Limitations
Dental Prophylaxis	No Special Limitations
Fluoride Treatment	**Covered persons under Age 18:** Not covered as a dental expense if covered under GRCC's medical plan. **All Other Covered Persons:** No special limitations
Palliative Treatment	No Special Limitations
Sedative Fillings	No Special Limitations
Sealants	No Special Limitations
Space Maintainers	No Special Limitations
Emergency Treatment	No Special Limitations

TYPE II: Minor Restorative Dental Services

Services	*Special Limitations*
Periodontal Exams	No Special Limitations
Periodontal Prophylaxis	No Special Limitations
Diagnostic Casts	No Special Limitations
Stainless Steel Crowns	No Special Limitations
Re-cement Inlays	No Special Limitations
Re-cement Onlays	No Special Limitations
Re-cement Crowns	No Special Limitations
Pulpotomy	No Special Limitations
Root Canal Therapy	No Special Limitations
Apicoectomy and Retrograde Filling	No Special Limitations
Osseous Surgery	No Special Limitations
Scaling and Root Planing	No Special Limitations
Temporary Splinting	No Special Limitations
Periodontal Appliance	No Special Limitations
Repairs to full Dentures, Partial Dentures, Bridges	No Special Limitations
Relining Dentures	No Special Limitations
Re-cement Bridges	No Special Limitations
Simple Extraction	No Special Limitations
Surgical Extraction of Impacted Teeth	Not covered as a dental expense if covered under GRCC's medical plan.
Root Recovery	No Special Limitations
Alveoplasty	No Special Limitations
Incision and Drainage	No Special Limitations

Local Anesthesia	No Special Limitations
General Anesthesia	No Special Limitations
Amalgam Restorations (fillings)	Multiple restorations on one surface will be treated as a single filling
Silicate Restorations	No Special Limitations
Plastic Restorations (fillings)	No Special Limitations
Composite Restorations (fillings)	No Special Limitations
Pin Retention	Limited to two pins per tooth
Gingivectomy	Not covered as a dental expense if covered under GRCC's medical plan
Vestibuloplasty	Not covered as a dental expense if covered under GRCC's medical plan
Gingival Currettage	No Special Limitations
Osseous Graft	No Special Limitations
Frenectomy	No Special Limitations
Occlusal Adjustment	No Special Limitations
Bite Splint Appliances	No Special Limitations

TYPE III: Major Restorative Dental Services

Services	***Special Limitations***
Gold Inlays and Onlays	Covered only when the tooth cannot be restored by silver fillings
Porcelain Restorations	No Special Limitations
Crowns	Covered only if tooth cannot be restored by a filling or by other means
Post and Core	No Special Limitations
Replacement of Teeth to Bridges and Dentures	No Special Limitations

Full Dentures	No Special Limitations
Partial Dentures	No Special Limitations
Fixed Bridges	No Special Limitations
Dental Implants	No Special Limitations

TYPE IV: Orthodontic Services

Services	***Special Limitations***
Orthodontic Diagnostic Procedures	No Special Limitations
Surgical Therapy	No Special Limitations
Appliance Therapy	No Special Limitations

EXLUSIONS AND LIMITATIONS FOR DENTAL BENEFITS

The following exclusions and limitations apply to dental expenses incurred by all Covered Persons. No benefits will be payable for the following:

A. Instruction on Oral Hygiene, Plaque Control or Diet

B. Prescription Drugs

C. Vertical Dimension; Occlusion: Expenses incurred for appliances, restorations or procedures for the purpose of altering vertical dimension or restoring or maintaining occlusion.

SCHEDULE OF VISION BENEFITS

BENEFITS	LIMITS
Vision Examinations *Eligible charges for Routine vision examinations rendered to Covered Dependents under age 18 will be paid by the Plan at 100% (0% Coinsurance)	90% (10% Coinsurance)
Eyeglass Frames for prescription glasses	90% (10% Coinsurance)
Prescription Eyeglass Lenses	90% (10% Coinsurance)
Contact Lenses (all kinds including hard, soft, gas permeable, and disposable) to the extent that they are optically required.	90% (10% Coinsurance)
Lasik Surgery	90% (10% Coinsurance)

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to expenses incurred by all Covered Persons and to all benefits provided by this Plan. No benefits shall be payable by the Plan for the following items:

A. Completion of Claim Forms

Charges incurred for completion of insurance or benefit payment claim forms

B. Correctional Institutions

Charges resulting from, or in connection with, a Covered Person while the Covered Person was confined in a penal or correctional institution.

C. Corrective Vision Surgery

Charges incurred for or related to radial keratotomy, radial keratectomy or similar procedures, unless specifically stated as a Covered Expense elsewhere in the Plan.

D. Cosmetic Procedures

Charges incurred in connection with the care, treatment, or surgery performed for a Cosmetic Procedure. This exclusion shall not apply to procedures necessary to lessen or correct a deformity arising from , or directly related to, a congenital abnormality, a person injury resulting from an accident or trauma, or a disfiguring disease for a Covered Person.

E. Effective Date of Coverage

Charges incurred before a Covered Person's effective date of coverage under the Plan, or after the Covered Person's termination of participation in the plan.

F. Failure to Follow Generally Accepted Billing Practices

Charges that are not in compliance with generally accepted billing practices.

G. Fees and Taxes

Charges for sales tax, processing fees, fees for attainment of patient records and the like

H. Illegal Acts

Charges incurred for an illness or injury resulting from or occurring during the commission of a violation of law by the Covered Person, including but not limited to, the engaging of an illegal occupation or act, the commission of an assault or battery, or the operation of a motorized vehicle while the covered person is under the influence of illegal use of alcohol or illegal drugs, but excluding minor, non-criminal traffic violations and similar civil infractions.

I. Legal Obligation to Pay Charges

Charges incurred for which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.

J. Lost or Stolen

Charges for the replacement of lost or stolen items, including eyeglasses, contact lenses, and dental appliances.

K. Missed Appointments

Charges for failure to keep an appointment.

L. Non-Accepted Treatment and Procedures

Charges for services or supplies that meet any of the following criteria:

1. Constitute personal comfort or beautification items.
2. Are for education or training purposes
3. Are not recognized by the dental or vision communities (such as ADA, AOA, etc.) as generally accepted card.
4. Are specifically listed by those communicated as having no recognized value.

M. Orthoptics; Vision Therapy

Charges for Orthoptics or Vision Therapy

N. Over-the-Counter Products

a. Charges for all over-the-counter products, even though prescribed by a Physician

O. Services provided by the U.S. Government

Unless required by federal laws, charges for services, treatments, or supplies furnished by the United States Government or any of its agencies.

P. War or Armed Forces Service

Charges caused as a result of war o any act of war, whether declared or undeclared, if incurred during service (including part-time service and national guard service) in the armed forces of any country.

Q. Work-Related

Charges for the treatment of an injury or illness that arose out of or in the course of employment or occupation for wage or profit for which the Covered Person is eligible for benefits or claims or has claimed to be eligible for benefits under any worker's compensation or occupational disease law, or any similar law, whether or not he or she has applied for these benerfits.

NOTE: These exclusions will not apply to the extent they would violate the Americans with Disabilities Act or any other applicable law. Further, these exclusions will not apply to the extent a court or other judicial body requires the Plan to provide coverage.