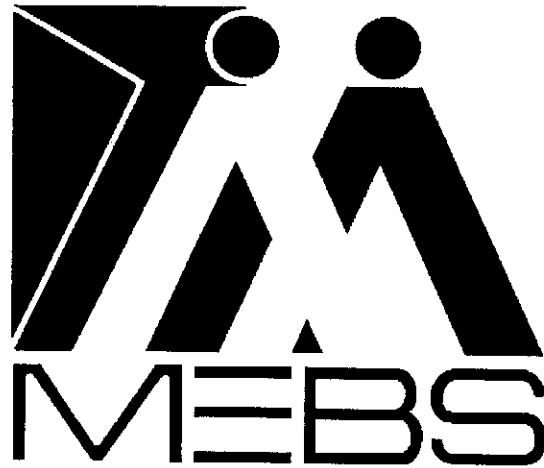


MICHIGAN EMPLOYEE BENEFIT SERVICES



SELF FUNDED DENTAL

FOR

**BAY ARENAC ISD**

Education Association

Effective November 1, 1997

**SELF FUNDED  
DENTAL BENEFIT COVERAGE SCHEDULE**

**Employer:** Bay Arenac ISD  
4228-2 Mile Rd.  
Bay City , Michigan 48706-2397  
(517)686-4410

**Group Number:** 04-0009  
**Effective:** November 1, 1997

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<b>Eligible Class(es):</b>	Bay Arenac Education Association
<b>Service Requirement:</b>	None
<b>Minimum Work Requirement:</b>	20 hours per week
<b>Employee Contributions:</b>	None
<b>Annual Open Enrollment Period:</b>	Month of September
<b>Coordination of Benefits:</b>	Standard
<b>Benefit Year:</b>	January 1 through December 31
<b>Plan Year:</b>	The records of the Plan are kept separately for each Plan Year. The Plan Year begins on July 1 and ends on June 30.

**Predetermination of Benefits:** Charges in excess of \$200.00 require predetermination of benefits.

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**Schedule of Dental Benefits**

Type I	Preventative Services	
	Percentage . . . . .	70%
	Annual Deductible Amount . . . . .	\$-0-
	Incentive Plan Increments . . . . .	10%*
Type II	Restorative and Replacement Services	
	Percentage . . . . .	70%
	Annual Deductible Amount . . . . .	\$-0-
Type III	Orthodontic Services (Applicable only for Covered Individuals under the age of 19)	
	Percentage . . . . .	70%
	Lifetime Deductible Amount . . . . .	\$-0-

\*10% each succeeding benefit year not to exceed 100%

**Plan Maximums**

Type I and II Services:	
	Maximum Annual Benefit per Covered Member . . . . . \$1,000.00
Type III Services:	
	Maximum Lifetime Benefit per Covered Member . . . . . \$1,500.00

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**Plan Modifications**

The following Plan Modifications have been included:

- Five Year Denture Waiver
- Missing Tooth Waiver
- Orthodontic Pre-Existing Exclusion Waiver

# **DENTAL CARE BENEFITS**

## **TABLE OF CONTENTS**

<b>ITEM</b>	<b>PAGE</b>
COVERAGE SCHEDULE	Inside Front Cover
INTRODUCTION TO THIS PLAN	1
GENERAL DEFINITIONS	2
WHO IS ELIGIBLE FOR COVERAGE	3
TERMINATION OF EMPLOYEE BENEFITS	5
COBRA CONTINUATION OF GROUP COVERAGE	6
BENEFIT SERVICES	9
MAXIMUM BENEFIT	11
EXCLUDED AND LIMITED CHARGES	11
EXTENSION OF BENEFITS	14
LIST OF DENTAL SERVICES	14
CLAIM PROVISIONS	19
COORDINATION OF BENEFITS	20
ADDITIONAL PLAN INFORMATION	21
PLAN ADMINISTRATION	23
SUBSCRIBER RESPONSIBILITIES	26

**IMPORTANT NOTICE:** Federal law requires employers to notify each covered Employee and dependent(s) of their continuation of coverage rights after termination of employment. Your rights regarding continuation of coverage can be found on page 6 of this booklet.

# ***DENTAL CARE BENEFITS***

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## **INTRODUCTION TO THIS PLAN DESCRIPTION**

To Covered Employees:

We are pleased to provide you with this summary description of your Dental Care Benefits. As you read through this booklet, keep in mind that it is intended to be a simple summary of the terms and conditions of benefits covered. Although this booklet describes in general terms the eligibility and coverage under this Dental Care Plan, it is not intended to cover every situation which might occur. Any reference in this booklet to a coverage or coverages not shown in the Coverage Schedule of Benefits shall not be applicable. The terms and conditions for eligibility and coverage are contained within this document and in the Coverage Schedule of Benefits located in the front of this booklet.

Provided further that under and subject to the terms and conditions of this Plan the Employee and his dependent(s), if any, whose name appears on the enrollment request and is recorded with the Plan Administrator is eligible for the coverage requested. Once all Plan provisions relating to eligibility and effective date of coverage have been fulfilled, the employee and dependents will be covered on the effective date as set forth in the enrollment request in accordance with the Coverage Schedule contained herein, provided he/she is actively at work on the proposed effective date, otherwise on the date he/she returns to active work.

The provisions set forth on the following pages hereof are hereby made a part of this Booklet.

You should read this material carefully and keep it for reference. It will help you to understand how the Plan works, what rights and benefits are provided for you and your family and how to obtain those benefits.

This Plan is being administered on our behalf by:

Michigan Employee Benefit Services, Inc.  
4301 Canal St., S.W.  
Grandville, Michigan 49418-2268

**Effective 11-1-97**  
25 Jefferson Ave.  
Jefferson Place  
Grand Rapids, Michigan 49503

**Treatment Plan:** A Dentist's report, on a form satisfactory to the Plan Administrator which (1) itemizes the dental services recommended by him for the necessary dental care of a person, (2) shows his charge(s) for each dental service(s) and (3) is accompanied by supporting pre-operative x-rays. Treatment Plans that exceed the amount specified on the Coverage Schedule (Predetermination of Benefits), need to be submitted by the Dentist to the Plan Administrator for prior approval of benefits payable.

**UC&R:** Usual, Customary and Reasonable; see "Reasonable Fees" above.

## **GENERAL INFORMATION**

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### **WHO IS ELIGIBLE FOR COVERAGE**

#### **Initial Employee Eligibility**

- (a) **In cases where the Employer pays the full cost of coverage (non-contributory)**, an employee shall be eligible for coverage under the Plan provided he/she meets all of the following conditions:
- (i) The Plan is in effect for the Employer; and
  - (ii) The employee is included in a class of employees which is eligible for coverage under the Plan; and
  - (iii) The employee is "Actively At Work" and meets any applicable minimum hours per week requirement; and
  - (iv) The employee has satisfied the applicable Service Requirement.

Coverage will be effective only when all of the above requirements have been met. For example, if an employee meets requirements (i), (ii), and (iv) he/she will not be covered under the Plan until he/she is Actively At Work (meets requirement (iii)).

- (b) **In cases where the employee contributes toward the cost of coverage**, an employee shall be eligible for coverage under the Plan provided he/she has met all of the requirements in paragraph (a) above (subparagraphs i, ii, iii, and iv), and he/she has completed an enrollment form and authorized his/her employer in writing to deduct the required contribution amount from his/her payroll checks.

**Employees who do not complete a written enrollment and authorization for payroll deduction within thirty-one (31) days after the date of initial eligibility (as defined in paragraph (a) above) may not enroll for coverage in the Plan until the following Open Enrollment or Open Enrollments Periods thereafter.**

- (c) The limiting age for Covered Members for the Orthodontic benefits is reached upon the Covered Member's 19th birthday.

**IMPORTANT NOTE:** Employees must submit a completed enrollment form to the Employer within thirty-one (31) days of initial eligibility date for coverage. Prior to the payment of any claims, a completed enrollment form must be submitted to the Benefit Administrator. Contact your Bay Arenac ISD's Benefit Office for proper enrollment forms.

### **Change(s) In Coverage/Open Enrollment**

Employees may enroll and/or make subscriber changes (such as adding Dependents) during Open Enrollment, or at certain other times subject to the following conditions:

- (a) Family Status Changes, such as addition or deletion of a spouse or dependent(s) must be made within thirty-one (31) days of the date the change in family status occurred. Otherwise, Family Status changes may be made effective on the first day of the month following approval of the application. A change in family status should be reported to the Employer within 31 days.

Note: An ex-spouse may be continued beyond the date of the divorce if the divorce decree stipulates that the member must provide health coverage for his/her spouse. The member will be required to pay the sponsored dependent contribution in addition to his/her normal contribution. Coverage will terminate on either the date the ex-spouse remarries or the date which is 36 months following the date of the divorce, whichever is earlier.

- (b) If an employee's spouse or dependent is covered under another Plan, and that Other Plan coverage is subsequently canceled due to layoff, termination, leave of absence, etc., the employee's spouse, or dependent may be enrolled immediately in this Plan at the time the Other Plan coverage terminates, provided there is no lapse in coverage between the Other Plan and this Plan and proper application is made within thirty-one (31) days of such event. Otherwise, the spouse or other dependent may be enrolled effective on the first day of the month following approval of the application.
- (c) Employees who are required to contribute toward the cost of their coverage, and who have not completed enrollment and written authorization for payroll deduction within thirty-one (31) days after they initially become eligible for coverage, may enroll at the next Open Enrollment or succeeding Open Enrollments, with coverage to begin effective on the first day of the month following the Open Enrollment Period.

The Open Enrollment Period for your group is indicated on the Employer Data Schedule found on page (i) of this booklet.

## **WHEN COVERAGE TERMINATES**

### **Termination of Coverage**

Once an employee is initially eligible for coverage under the Plan, his/her coverage will continue until it is terminated. Termination of coverage will be effective on the first occurring of any of the following dates:

- (a) On the first day of the month for which the Employer's contributions are no longer current; provided that coverage shall be reinstated effective the first of the month for which contributions on the employee's behalf resume provided all other eligibility requirements are met; or,

(c) If you are a dependent child of a covered employee and are covered under the Plan, you have the right to Continuation Coverage if you lose coverage under the Plan for any of the following ~~reasons~~

- (i) The death of a parent who is a covered employee; or,
- (ii) The termination of your parent's employment, reduction in your parent's hours of employment with a contributing employer, layoff, disability, medical leave of absence or retirement; or,
- (iii) Your parent's divorce or legal separation; or,
- (iv) Your parent becomes entitled to Medicare and your parent's coverage under the Plan terminates; or,
- (v) You cease to be a "dependent child" as defined under this Plan.

(d) If you are a Sponsored Dependents of a covered member and are covered under the Plan, you have the right to Continuation Coverage if you lose coverage under the Plan for any of the following reasons;

- (i) they are over 19 years of age
- (ii) they are not eligible for coverage under Family Continuation
- (iii) the member provides more than half of the support for the dependent
- (iv) they are related to the member by blood, marriage, or legal adoption.
- (v) they are living in the members household.

(e) Newborn or Adopted Child

If you have a newborn child or have a child placed with you for adoption (for whom you have financial responsibilities) while your COBRA continuation coverage is in effect, you may add this child to your coverage by notifying the Fund Office in writing within 30 days after the birth or placement. A child born or placed for adoption while you are on COBRA will have the same COBRA rights as your spouse or dependents who were covered by the plan before the event that triggered COBRA coverage. Like all qualified beneficiaries with COBRA coverage, their continued coverage depends on the timely and uninterrupted payment of COBRA premiums.

(f) How Does the Election Take Place? In order to qualify for Continuation Coverage, the employee or a covered dependent has the responsibility to inform Bay Arenac ISD's Benefit Office (at the address found in the Introduction to this booklet) immediately after a divorce, legal separation, or if a child ceases to satisfy the definition of "dependent child" in the Plan. If you do not report one of these events to Bay Arenac ISD's Benefit Office within sixty (60) days after loss of coverage due to the Event, Continuation Coverage will not be available.

***It is the employee/subscriber's responsibility to notify Bay Arenac ISD's Benefit Office of family status change (called a Qualifying Event under COBRA). Failure, on the part of the employee, to notify the Benefit Office within 60 days of the Qualifying Event results in loss of COBRA qualification rights. You do not have to show that you are insurable to choose Continuation Coverage (COBRA).***

An employee, spouse, or dependent who is determined under Title II or Title XVI of the Social Security Act to have been disabled at the time of one of the qualifying events listed in (a), (b) or (c) must notify the Benefit Office of such determination within sixty (60) days after the determination; in addition, the Benefit Office must be notified within thirty (30) days of a final determination that the employee, spouse, or dependent is no longer disabled.

As with all COBRA coverage, eligibility for this extension depends on the timely and uninterrupted payment of premiums. If your dependents have COBRA coverage extending past 29 months (i.e., 36 months maximum coverage is granted certain qualifying events), then no further extension will be granted because of disability.

Regardless of which continuation period applies, an individual's Continuation Coverage may be cut short for any of the following four reasons:

- (i) This Plan no longer provides group coverage;
- (ii) You do not pay your contributions for Continuation Coverage on time;
- (iii) You or an eligible dependent become covered under another employer sponsored group plan as an employee, dependent or spouse, provided that continuation will not end for an individual for so long as the coverage under another employer sponsored group plan has an exclusion or limitation with respect to any pre-existing condition of that individual which is covered under this Plan; or
- (iv) You or an eligible dependent becomes entitled to Medicare.

Conversion of Coverage: Continuation Coverage is not the same as **conversion of coverage**. This group plan does not provide provisions for conversion of coverage.

If you have any additional questions regarding Continuation or Conversion of Coverage, please contact the Bay Arenac ISD's Benefit Office. Also, if you have changed marital status, you or your spouse has changed address, or you have acquired a new eligible dependent, please notify your Bay Arenac ISD's and MEBS within 30 days of the event.

**NOTE: This section does not apply if the employee has been terminated for Gross Misconduct or termination as part of the disciplinary sanctions described in board policy.**

## ***BENEFIT SERVICES***

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### **ELIGIBLE CHARGES**

These are the charges, subject to any limitations or exclusions provided in this Plan, actually made to the Employee for those services which are:

- A. included for payment in the applicable List of Dental Services (see Coverage Schedule); and
- B. part of a Treatment Plan which, prior to the performance of the services, has been (a) submitted to, and reviewed by, the Plan Administrator, and (b) returned to the Dentist showing estimated benefits, Submission of a Treatment Plan is not required. Failure to submit a Treatment Plan will not jeopardize or alter the amount of benefit payable.

## **TYPE II SERVICES**

**Payable Benefits:** Eligible Charges for Type II Services can be found in the List of Dental Services which are furnished for a person's dental care.

**Conditions for Benefits:** The charges incurred while the person is a Covered Individual, and during a Benefit Year (see Coverage Schedule).

**Amount Payable:** The Type II Benefits Percentage (see Coverage Schedule) of the charges are subject to the combined Plan Maximum annual benefit as stated on the Coverage Schedule.

## **TYPE III SERVICES**

**Payable Benefits:** The Eligible Charges incurred in connection with an orthodontic procedure performed on a covered individual.

**Conditions for Benefit:** The charges incurred during a three-month period, referred to in Section "Eligible Charges" which commences while the person is a Covered Individual.

**Amount Payable:** The Benefit Percentage (see Coverage Schedule) of the charges, but not to exceed the Maximum Orthodontic Benefit for all services and supplies furnished a person during his/her entire lifetime.

## **MAXIMUM BENEFIT**

**Type I and II Services:** The aggregate benefits payable under this Coverage for all charges incurred for a person's dental care in any one Benefit Year shall not exceed the Maximum Annual Dental Benefit (see Coverage Schedule).

**Type III Services:** The aggregate benefits payable under this Coverage for all charges incurred, but not to exceed the Type III Maximum Orthodontic Benefit (see Coverage Schedule) for all services and supplies furnished a person during his/her entire lifetime.

## ***EXCLUDED AND LIMITED CHARGES***

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### **CHARGE LIMITATION FOR CERTAIN DENTAL CARE BENEFITS**

- A. If, for any charge, a benefit amount would be provided both under this Coverage and any other coverage of the Employer's Plan (i.e. medical coverage), that charge will be eligible under this Coverage only to the extent necessary to provide a benefit equal to the excess, if any, of (a) the benefit that would be payable for such charge under this Coverage in the Absence of this limitation over (b) the aggregate benefit payable for that charge under all other coverages of this plan.

**B. Any charges incurred in connection with:**

1. Any service with respect to any person who (I) is required to contribute to the Cost of his plan, and (II) becomes a Covered Individual for the benefits of this Coverage after the end of the thirty-one day period immediately following the first day he is eligible to become such a Covered Individual, is furnished prior to the end of the twelve-month period commencing on the date he became such a Covered Individual, unless the service is necessitated as a result of accidental injuries sustained while the person was a Covered Individual.
2. A service furnished a person for (I) cosmetic purposes, unless necessitated as a result of accidental injuries sustained while the person was a Covered Individual, or (II) dental care of a congenital or developmental malformation. Facings on crowns, or pontics, posterior to the second bicuspid shall always be considered cosmetic.
3. Replacement of lost or stolen appliances or appliances or restoration necessary to increase vertical dimension, restore occlusion, or for implantology techniques.
4. Injury arising out of or in the course of any employment for wage or profit, or disease covered, with respect to such employment, by any Workers' Compensation law, occupational disease law or similar legislation.
5. A service rendered by a doctor, dentist, or dental hygienist who ordinarily resides in the same household with the Employee or who is a member of the Employee's immediate family (i.e. children or spouse) where charges are normally not made.

**C. Orthodontic Charges Not Covered: (Type III Services)**

1. Any "Charges not Covered" of the Dental Plan Type I, II and III Services, other than parts A(6), B(1), B(2), and B(3).
2. With respect to any person who (I) is required to contribute to the cost of his Plan, and (II) becomes a Covered Individual for the benefits of the Type III Coverage after the end of the thirty-one day period immediately following the first day he is eligible to become such a Covered Individual any orthodontic procedure in connection with which an active appliance has been installed prior to the end of the twelve month period commencing on the date he/she became such a Covered Individual.
3. The portion of any charge for any charge for any service in excess of the reasonable and customary dental charge. The reasonable and customary charge is the usual charge made by the provider for a like service in the absence of coverage, but not more than the prevailing charges, as determined by the Plan Administrator, for dental care of a comparable nature, made by providers of similar training and experience, within the area in which the service is actually provided. "Area" means the municipality (or in the case of a large city, the subdivision thereof) in which the service is actually provided or such greater area as is necessary to obtain a representative cross section of charges for a like service.
4. Replacement or repair of orthodontic appliances.

If two or more services included in this List are separately suitable for the dental care of a specific condition, according to customary dental practices, and if the charge is actually incurred for one of the such services, then a charge for only the least expensive of such services will be considered to have been incurred.

**Refer to Excluded and Limited Charges section for modification to this section.**

## **TYPE I SERVICES**

### **A. VISITS AND EXAMINATIONS:**

1. Office visits during regular office hours for treatment and observations of injuries to teeth and supporting structure (other than for routine operative procedures).
2. Office visits during regular office hours for the treatment and observation of teeth and supporting structure.
3. Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater).
4. Special consultation by a specialist for case presentation when diagnostic procedures have been performed by a general dentist.
5. Prophylaxis for children under age 14 (limited to two treatments each calendar year).
6. Prophylaxis for individuals age 14 or over, treatments to include scaling and polishing (limited to two treatments each calendar year).
7. Difficult prophylaxis requiring more than one visit (excess of 45 min.) (limited to once every five years).
8. Topical application of sodium fluoride, including prophylaxis (limited to single treatment and to children under age 14).
9. Topical application of stannous fluoride, including prophylaxis, per treatment (limited to one treatment per year for children under age 18).
10. Emergency palliative treatment, per visit.
11. Periodic oral examination and/or prophylaxis are limited to twice each calendar year.
12. Sealants for children under age 14.

### **B. X-RAY AND PATHOLOGY: Except for injuries, film fees include examination and diagnosis.**

1. Single film.
2. Additional films (up to 12), each.
3. Entire denture series consisting of at least 14 films, including bite wings if necessary (limited to once every three years).
4. Intra-oral, occlusal view, maxillary or mandibular, each.
5. Superior or inferior maxillary, extra-oral, one film.
6. Superior or inferior maxillary, extra-oral, two films.
7. Bite wing films, including examination (not more than twice each calendar year).
  - a. Two (2) films.
  - b. Four (4) films.(Adolescents with a history of dental decay will be covered at 6-12 month intervals and, adults 12-18 month intervals. Otherwise, adolescents with-out a history of dental decay will be covered at 12 month intervals only and adults at 24 month intervals only.)
8. Panoramic survey, maxillary and mandibular, single films (considered an entire denture series).
9. Biopsy and examination of oral tissue.
10. Microscopic examination.

- l. Frenectomy.
- m. Suture of soft tissue injury.
- n. Crown exposure for orthodontia.
- o. Injection of sclerosing agent into temporomandibular joint.
- p. Treatment of trigeminal neuralgia by injection into second and third divisions.

B. ANESTHESIA:

General, only when provided in conjunction with a surgical procedure.

C. PERIODONTICS:

1. Emergency treatment (periodontal abscess, acute periodontitis, etc.).
2. Subgingival curettage, root planing, per quadrant (not prophylaxis).
3. Correction of occlusion related to periodontal problems, per quadrant.
4. Gingivectomy (including post-surgical visits) per quadrant.
5. Gingivectomy, osseous or muco-gingival surgery (including post-surgical visits) per quadrant.
6. Gingivectomy, treatment per tooth (fewer than six teeth).

D. ENDODONTICS: Unless otherwise indicated, the limit shown is for one tooth.

1. Pulp capping.
2. Therapeutic pulpotomy (in addition to restoration).
3. Vital pulpotomy.
4. Re-mineralization (Calcium Hydroxide, temporary restoration) as a separate procedure only.
5. Root Canals including necessary X-rays and cultures but excluding final restoration.
  - a. Single rooted canal therapy.
  - b. Bi-rooted canal therapy.
  - c. Tri-rooted canal therapy.
  - d. Apicoectomy (including filling of root canal).
  - e. Apicoectomy (separate procedure).

E. RESTORATIVE: Excluding inlays, crowns (other than stainless steel) and bridges. (Multiple restoration in one surface will be considered as a single restoration.).

1. Amalgam Restorations-Primary Teeth.
  - a. Cavities involving one surface.
  - b. Cavities involving two surfaces.
  - c. Cavities involving three surfaces.
  - d. Cavities involving four or more surfaces.
2. Amalgam Restorations-Permanent Teeth.
  - a. Cavities involving one surface.
  - b. Cavities involving two surfaces.
  - c. Cavities involving three surfaces.
  - d. Cavities involving four or more surfaces.
3. Synthetic Restoration.
  - a. Silicate cement filling.
  - b. Plastic filling.
  - c. Composite filling.

5. Dentures and Partial Dentures (fee for dentures, partial dentures and relining include adjustments within six months after installation. Specialized techniques and characterizations are not eligible.).
  - a. Complete maxillary denture.
  - b. Complete mandibular denture.
  - c. Partial acrylic upper or lower with gold or chrome cobalt alloy clasps, base.
  - d. Teeth and clasps, extra per unit.
  - e. Simple stress breakers, extra.
  - f. Stay-plate, base.
  - g. Teeth and clasps, extra per unit.
  - h. Office reline, cold cure, acrylic.
  - i. Denture reline.
  - j. Special tissue conditioning, per denture.
  - k. Denture duplication (jump case), per denture.
  - l. Adjustments to denture more than six months after installation.
6. Adding Teeth to Partial Denture to Replace Extracted Natural Teeth.
  - a. First tooth.
  - b. First tooth with clasp.
  - c. Each additional tooth and clasp.
7. Full and Partial Denture Repairs (Metal).
  - a. Broken dentures, no teeth involved.
  - b. Replacing missing or broken teeth, each tooth.

**TYPE III SERVICES: (ORTHODONTIC CARE)** (applicable only for Covered Individuals under age 19).

**A. ORTHODONTIC SERVICES:**

1. Habit breaking appliances
2. Minor tooth guidance appliances
3. Appliance construction and installation
4. Full banding treatment
5. Monthly, active treatment visits

## ***CLAIM PROVISIONS***

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These provisions apply to each coverage under this Plan which contains a specific provision subjecting the payment of benefits under this Coverage to this Plan's Claim Provisions.

Written proof of loss under a coverage upon which claim may be based must be furnished to the Plan Administrator on an approved claim form within ninety days after:

- A. The end of each month or lesser period for which the Employer is liable for coverage, if coverage provides for the payment at such periodic intervals;
- B. The end of each Benefit Determination Period for which the Employer is liable, if coverage is one under which payment is made for charges incurred during a "Benefit Determination Period" as defined in such coverage; and

- (c) When neither (a) nor (b) nor (c) is determinative, primary coverage for a dependent child is with the plan covering the parent whose birthday occurs earlier in the calendar year. If both parents have the same birthday, the benefits of the plan which has covered the covered member claiming benefits longer are determined before those of the plan which covered the covered member for a shorter period of time. If the Other Plan does not have this rule, coordination is determined under the rules of the Other Plan.

However, when the parents of a dependent child are legally separated or divorced, the following order of benefit determination applies: The Plan covering the child as a dependent of a parent who has been given financial responsibility for the medical, dental, or other health care expenses of the child under a court order or decree is primary. Otherwise, the plan covering the custodial parent is primary; where the custodial parent has remarried, coverage of the custodial parent will be primary, followed by the plan covering the child as a dependent of the custodial parent's spouse, followed by the plan of the non-custodial parent.

- (d) The Benefits of a plan which covers a Covered Member as an employee who is neither laid off nor retired (or as that employed Member's Dependent) are determined before those of a plan which covers that Covered Member as a laid off or retired employed Member (or as that Member's Dependent). If the Other Plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
- (e) If the above rules do not establish an order of benefit determination, primary liability rests with the plan which has covered the Covered Member or Dependent continuously for the longer period.
- (f) Where a Covered Member is subject to certain cost containment provisions under the primary plan, any cost containment sanction(s) imposed by the primary plan will not be payable as a benefit, or a secondary balance, by any of the other secondary plan(s).

## **STANDARD, INTERNAL, AND EXTERNAL COORDINATION OF BENEFITS**

Should a dependent spouse or child who is also covered as an employee, and is also considered a dependent under the Plan, and standard Coordination of Benefits provisions are applied, the plan is **Standard**. This plan has a **Standard** Coordination of Benefits.

## ***ADDITIONAL PLAN INFORMATION***

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### **APPEAL OF DENIED CLAIMS**

Should an eligible employee/subscriber disagree with a decision of the Plan regarding benefits, the subscriber may file an Appeal of Denied Claims. To file an Appeal of Denied Claims, an employee/subscriber or his/her authorized representative should:

- (a) Write to the Plan listing the reasons for the appeal, and
- (b) Provide any and all facts upon which are relied on for the appeal, and

## **REASONABLE FEES**

This Plan does not pay the portion of any charge for any service in excess of the reasonable and customary dental charge. The reasonable fee is the usual charge made by the provider for a like service in the absence of coverage, but not more than the prevailing charges, as determined by the Plan Administrator, for dental care of a comparable nature, made by providers of similar training and experience, within the area in which the service is actually provided. "Area" means the municipality (or in the case of a large city, the subdivision thereof) in which the service is actually provided or such greater area as is necessary to obtain a representative cross section of charges for a like service.

## **RELEASE OF INFORMATION**

Each eligible employee/subscriber covered under this Plan hereby authorizes dentists, physicians, hospitals, and other providers of service to furnish the Plan's designee, Michigan Employee Benefit Services, Inc. (MEBS), upon request, information relating to services which the covered family member is or may be entitled to coverage for under this Plan.

Dentists, physicians, hospitals and other providers of services are hereby authorized to permit MEBS to examine their records with respect to such services. All information related to treatment of an eligible family member will remain confidential and shall be used solely for the purpose of determining rights and liabilities arising under this Plan.

## **ASSIGNMENT LIMITATIONS**

This Plan's coverage is "Assignable", no responsibility for the validity or sufficiency of any assignment is assumed by the Employer. The Benefit Administrator shall not be considered to have knowledge of any assignment unless the original or a duplicate is filed with the Benefit Administrator through the Employer.

## **FAVORABLE RESULT OF TREATMENT**

Benefits will be considered only for treatment that the Plan Administrator determines has a reasonably favorable prognosis.

## ***PLAN ADMINISTRATION***

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### **GENERAL INFORMATION**

The Employer has established this Plan exclusively to provide dental care and other related benefits to its eligible employees. The Plan is established, funded, maintained, and sponsored by the Employer. The Employer has contracted with Michigan Employee Benefit Services, Incorporated (MEBS), to provide billing, benefit, and claims administration services. The following is important information concerning this Plan:

- (a) **Name of Plan:** Bay Arenac ISD

(f) **Agent for Service of Legal Process:**

The agent for service of legal process is:

Dr Jon Whan, Superintendent  
Bay-Arenac Intermediate School District  
4228 - 2 Mile Rd.  
Bay City, Michigan 48706

## **SOURCE OF CONTRIBUTION**

This Plan is funded by the Employer and is established and maintained for the sole purpose of providing benefits to eligible employees and their eligible dependents. Should the Plan ultimately not pay benefit expenses which are eligible for payment under this Plan for any reason, the employees covered by this plan may be liable for those expenses.

## **LEGAL ACTION**

No legal action shall be made against the Plan prior to the expiration of thirty (30) days of receipt of claim. No such action shall be brought after the expiration of two (2) years of receipt of claim.

## **QUESTIONS REGARDING THIS PLAN**

The benefit administration of this Plan is handled by the staff of MEBS. Only employees of MEBS are qualified to answer questions regarding benefits, eligibility, and other terms and conditions of the Plan. Any questions about benefits may be directed to them at the following location:

Michigan Employee Benefit Services, Inc. (MEBS)  
4301 Canal, S.W.  
Grandville, Michigan 49418

**Effective 11-1-97**  
25 Jefferson Ave.  
Jefferson Place  
Grand Rapids, Michigan 49503

Telephone number(s): (800) 968-6327  
(616) 538-6327

Should an employee desire to inspect or receive copies of additional documents relating to this Plan, contact MEBS, the Benefit Administrator, at the address or phone number shown. The employee/subscriber will be charged a reasonable fee to cover the cost of reproducing any materials he/she wishes to receive.