

SCHEDULE OF COVERED SERVICES AND PROVISIONS

TOWNSHIP HIGH SCHOOL DISTRICT 214

I. DENTAL CARE BENEFITS

COVERED SERVICES AND PROVISIONS	
Coverage	
Calendar Year Deductible	\$25 per person \$75 per family
Calendar Year Periodontal Care and Denture Replacement Benefit Maximum	\$1,000 per person
Lifetime TMJ Services Benefit Maximum	\$1,000 per person
Calendar Year Implant Services Benefit Maximum	\$1,500 per person
Lifetime Orthodontic Benefit Maximum	\$1,000 per person
Deductible Carry-Over	Any Covered Services incurred during October, November, and/or December which are applied to the Covered Person's Deductible will also "carry-over" to the following year's Deductible.
Claims Filing Limit	All charges and corresponding requested documentation must be submitted within 1 year of the date incurred.
Coordination of Benefits	If it is determined that this Plan is the secondary payer, benefits will be adjusted and reduced (standard). Benefits payable from both plans shall not exceed 100% of the eligible U&C charges.
ALTERNATE TREATMENT If more than one method of treatment is possible, the Covered Dental Charges will be limited to the Usual and Customary charges appropriate for those services and supplies which are customarily employed nationwide in the treatment of such condition and which are recognized by the dental profession to be appropriate methods of treatment, taking into account the total oral condition of the family member.	
TREATMENT PLAN You may wish to have an estimate of benefits payable before beginning treatment for extensive dental work. To receive this estimate, please have Your Dentist submit a Treatment Plan to the Plan Administrator before beginning a course of treatment which can reasonably be expected to involve Covered Services of \$300 or more.	

II. PREVENTIVE CARE SERVICES

COVERED SERVICES AND PROVISIONS		
	In-Network	Out-of-Network
Preventive Care Waiting Period	0 months	0 months
Routine oral examinations and prophylaxis <i>Limited to 2 exams and cleanings per Calendar Year per Covered Person.</i>	100% <u>Deductible waived.</u>	100% <u>Deductible waived.</u>
Palliative emergency treatment <i>Limited to reduction of fractures, stopping of bleeding and providing relief from pain.</i>	100% <u>Deductible waived.</u>	100% <u>Deductible waived.</u>
Dental X-rays <ul style="list-style-type: none"> <i>Diagnostic X-rays - Full mouth X-rays limited to 1 set every 36 months per Covered Person.</i> 	100% <u>Deductible waived.</u>	100% <u>Deductible waived.</u>
Topical sodium or stannous fluoride applications <i>Limited to 1 treatment per 12 months for Covered Persons age 18 and under.</i>	100% <u>Deductible waived.</u>	100% <u>Deductible waived.</u>
Topical application of sealants <i>Limited to once per tooth per Calendar Year for Covered Persons age 18 and under.</i>	80% of first \$1,500, then 50% for remaining expenses during that Calendar Year.	80% of first \$1,500, then 50% for remaining expenses during that Calendar Year.
Space maintainers <i>Limited to missing deciduous teeth.</i>	80% of first \$1,500, then 50% for remaining expenses during that Calendar Year.	80% of first \$1,500, then 50% for remaining expenses during that Calendar Year.
Mouth guards (occlusal night guards) <i>Limited for treatment of bruxism.</i>	80% of first \$1,500, then 50% for remaining expenses during that Calendar Year.	80% of first \$1,500, then 50% for remaining expenses during that Calendar Year.
Expenses Deemed Incurred for Preventive Care Services	<i>Preventive Care Services expenses are deemed to be incurred: (1) By the person receiving the dental care and (2) as of the date dental care is performed.</i>	

III. BASIC CARE SERVICES

COVERED SERVICES AND PROVISIONS		
	In-Network	Out-of-Network
Basic Care Waiting Period	0 months	0 months
Basic Primary Care Services limited to: <ul style="list-style-type: none"> • <i>Fillings (Restorations utilizing amalgam, acrylic or equivalent)</i> • <i>Endodontic treatment (root canals)</i> • <i>Inlays and onlays, crowns and repairs to crowns</i> • <i>Repair of bridges and dentures</i> • <i>Oral surgery, other than excision of full bony impactions (check Your medical coverage, if elected, for applicability).</i> • <i>Local anesthetics or general anesthesia administered in connection with oral surgery only if administered by an individual licensed to administer general anesthesia, other than the Dentist or Physician performing the service for which such anesthesia is administered.</i> • <i>Injection of antibiotic drugs by the attending Dentist</i> • <i>Consultations with a Dentist other than the Covered Person's primary care Dentist</i> • <i>Extractions</i> • <i>Partially impacted wisdom teeth</i> 	80% of first \$1,500, then 50% for remaining expenses during that Calendar Year.	80% of first \$1,500, then 50% for remaining expenses during that Calendar Year.
Periodontics limited to: <ul style="list-style-type: none"> • <i>Gingivectomy</i> • <i>Treatment of periodontal and other diseases of the gums and tissues of the mouth</i> 	50%	50%
Expenses Deemed Incurred for Basic Care Services	<p><i>Except as provided in (1) and (2) below, any expense or charge for Basic Care Services will be deemed to be incurred as of the date the particular procedure is performed.</i></p> <ol style="list-style-type: none"> <i>Expenses for restorations will be deemed incurred on the first date of preparation of the tooth or teeth involved provided You (or Your Dependent) remain continuously insured during the course of treatment;</i> <i>Expenses or charges for endodontic services shall be deemed incurred on the date the specific root canal procedure commenced provided You (or Your Dependent) remain continuously insured during the course of treatment.</i> 	

IV. MAJOR CARE SERVICES

COVERED SERVICES AND PROVISIONS		
	In-Network	Out-of-Network
Major Care Waiting Period	0 months	0 months
Treatment of temporomandibular joint (TMJ) dysfunction	50%	50%
Implant services	50% <u>Deductible waived.</u>	50% <u>Deductible waived.</u>
Initial dentures and bridges <i>Includes construction and insertion of bridges and dentures.</i>	80% of first \$1,500, then 50% for remaining expenses during that Calendar Year.	80% of first \$1,500, then 50% for remaining expenses during that Calendar Year.
Replacement of bridges or dentures to replace teeth previously replaced by an equivalent bridge or denture <i>Subject to the following: Replacement or alteration will be covered only if 5 years have elapsed since that previous bridge or denture was initially constructed and inserted. This 5-year restriction will not apply if the replacement is required because of the removal of additional natural teeth.</i>	50%	50%
Expenses Deemed Incurred for Major Care Services	<p><i>Except as provided in (1), (2) and (3) below, any expense or charge for Major Care Services will be deemed to be incurred as of the date the particular procedure is performed.</i></p> <ol style="list-style-type: none"> <i>Expenses for fixed bridgework, crowns, inlays or restorations will be deemed incurred on the first date of preparation of the tooth or teeth involved provided You (or Your Dependent) remain continuously insured during the course of treatment.</i> <i>Expenses for full or partial dentures will be deemed incurred on the date the final impression is taken provided You (or Your Dependent) remain continuously insured during the course of treatment.</i> <i>Expenses for rebase of an existing partial or complete denture will be deemed incurred on the first day of preparation of the rebase of such denture provided You (or Your Dependent) remain continuously insured during the course of treatment.</i> 	

V. ORTHODONTIC CARE SERVICES

COVERED SERVICES AND PROVISIONS		
	In-Network	Out-of-Network
Orthodontic Care Services - Consisting of installations of orthodontic appliances and all orthodontic treatments concerned with the reduction or elimination of an existing malocclusion and conditions resulting from that malocclusion through correction of abnormally positioned teeth.		
Orthodontic Care Waiting Period	0 months	0 months
Diagnostic services <i>Includes examination, study models, radiographs and all other diagnostic aids used to determine orthodontic needs.</i>	50% <u>Deductible waived.</u>	50% <u>Deductible waived.</u>
Active orthodontic treatment	50% <u>Deductible waived.</u>	50% <u>Deductible waived.</u>
Retention treatment	50% <u>Deductible waived.</u>	50% <u>Deductible waived.</u>
Expenses Deemed Incurred for Orthodontic Care Services	<i>Orthodontic Care Services expenses are deemed to have been incurred on a monthly basis, commencing for the initial appliances on the first day treatment is given and on an arrears basis for all other charges provided the person remains continuously covered during the Course of Orthodontic Treatment.</i>	

EXCLUSIONS

No payment will be made under this Plan for expenses incurred by a Covered Person based on the below exclusions *(unless specifically stated within the Schedule of Covered Services and Provisions)*:

1. for services and treatment unless they were prescribed by a Dentist or Physician, except for scaling or cleaning of teeth and topical application by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the Dentist or Physician;
2. for or in connection with an Injury for which the Employee or Dependent is entitled to benefits under any Workers' Compensation or similar law;
3. for care and treatment of an Injury arising out of, or in the course of, any employment for wage or profit;
4. for charges incurred on account of services received from a dental or medical department maintained by an employer, a mutual benefit association, labor union, trustee or similar type of group;
5. for charges payable under any federal, state or local government program (unless legally required);
6. for services, supplies or treatment received in any government owned facility (unless legally required or when due to an emergency);
7. for charges which the Covered Person is not legally required to pay, or for charges which would not have been made if no coverage had existed;
8. for services, supplies or treatment for which no charge is applied or under this Plan is prohibited by any law to which the Covered Person is subject at the time expenses are incurred;
9. which are not Reasonable and/or in excess of Usual and Customary Charges;
10. for services or treatment which do not meet the standard of dental practice accepted by the American Dental Association;
11. which are for care or treatment which is experimental or investigational, according to accepted standards of dental practice;
12. which are for care or treatment which is not Dentally Necessary;
13. due to accidental Injury resulting from participation in the commission of an assault or felony;
14. for training, educational instructions or materials, even if they are performed or prescribed by a Dentist or Physician;
15. for charges in connection with dentistry for cosmetic purposes, including the alteration or extraction and replacement of sound teeth to change appearance;
16. for charges incurred on account of war, declared or undeclared, including armed aggression;
17. for expenses incurred on account of loss or theft of dentures, bridgework or appliances;
18. for installation, replacement or alteration of, or additions to, dentures or fixed bridgework, except as provided in the Schedule of Covered Services and Provisions;

19. for charges incurred for:
 - a. myofunctional therapy;
 - b. mouth guards, except as provided in the Schedule of Covered Services and Provisions;
 - c. oral hygiene, dietary or plaque control programs or other educational programs;
 - d. duplicate prosthetic devices or appliances;
 - e. porcelain veneered crowns or pontics placed on or replacing a tooth posterior to the second bicuspid, to the extent the charges exceed the charge that would have been covered under the Schedule of Covered Services and Provisions for acrylic veneered crowns or pontics; or
 - f. crowns, appliances or restorations for the primary purpose of periodontal splinting, altering vertical dimension, or restoring occlusion (except as covered under orthodontic treatment);
20. for services, supplies or treatment which were ordered or started before coverage began, or after coverage ended;
21. for charges incurred by telephone consultation, failing to keep a scheduled visit, failing to complete a claim form or failing to provide medical records;
22. for supplies or appliances of the type normally intended for sport use;
23. for treatment of Temporomandibular Joint (TMJ) disorders;
24. for charges incurred for:
 - a. completion of claim forms; or
 - b. prescription drugs and medicines;
25. for dental care which is provided under a Health or Dental Maintenance Organization or similar organization;
26. for services or supplies furnished by a hospital owned or operated by the United States Government or agency thereof, or furnished by a physician employed by the United States Government or agency thereof, except that services provided and billed by a Veterans' Administration facility or by a Military Hospital for non-service related disabilities will be eligible;
27. for charges for any service or supply not included within the Schedule of Covered Services and Provisions;
28. for supplies or appliances of the type normally intended for home use;
29. for any service covered under the medical plan.