ADDENDUM 1
FOR
SOUTHERN LOCAL SCHOOL DISTRICT

SCHEDULE OF DENTAL BENEFITS

The following *Schedule of Benefits* is designed as a quick reference.

Deductible Per Calendar Year:	
Individual	$25
Family (Aggregate)	$50
The deductible is waived for diagnostic & preventive dental services and orthodontic services.	
Maximum Benefit Per Covered Person For:	
Preventive, Basic and Major Dental services per calendar year (other than Orthodontics)	$1,500
Orthodontic services while covered by this ***Plan***	$1,000
Covered Dental Expenses:	***Coinsurance***
Class I - Diagnostic & Preventive Dental Services	100%
Class II - Basic Dental Services	80%
Class III - Major Dental Services	60%
Class IV - Orthodontic Services	60%

Refer to *Dental Expense Benefit* for complete details.

DENTAL EXPENSE BENEFIT

Subject to all the terms of the ***Plan***, the ***Plan*** will pay a dental benefit for covered dental expenses. The dental benefit is a percentage of the ***customary and reasonable amount*** for ***nonpreferred providers*** or the ***negotiated rate*** for ***preferred providers*** for covered dental expenses, as shown on the *Schedule of Benefits*.

DEDUCTIBLE

Individual Deductible

The individual deductible is the dollar amount of ***covered expense*** which each ***covered person*** must incur during each calendar year before the ***Plan*** pays applicable benefits. The individual deductible amount is shown on the *Schedule of Benefits*.

Family Deductible

If, in any calendar year, covered members of a family incur ***covered expenses*** that are subject to the deductible that are equal to or greater than the dollar amount of the family deductible shown on the *Schedule of Benefits*, then the family deductible will be considered satisfied for all family members for that calendar year. Any number of family members may help to meet the family deductible amount, but no more than each person's individual deductible amount may be applied toward satisfaction of the family deductible by any family member.

Deductible Carry-Over

Amounts ***incurred*** during October, November and December and applied toward the individual deductible of any ***covered person***, will also be applied to the individual deductible of that ***covered person*** in the next calendar year.

COINSURANCE

For services, supplies and treatments of a ***preferred provider***, the ***Plan*** pays a specified percentage of the ***negotiated rate*** for ***covered expenses***. For services, supplies and treatments of a ***nonpreferred provider***, the ***Plan*** pays a specified percentage of the ***customary and reasonable amount***. Those percentages are listed on the *Schedule of Benefits*. The ***covered person*** is responsible for the difference between the ***Plan's*** payment and the ***negotiated rate*** for ***preferred providers***, and the difference between the ***Plan's*** payment and the amount billed for ***nonpreferred providers***.

MAXIMUM BENEFIT

The maximum calendar year benefit payable on behalf of a ***covered person*** for covered dental expense is stated on the *Schedule of Benefits*. If the ***covered person's*** coverage under the ***Plan*** terminates and he subsequently returns to coverage under the ***Plan*** during the calendar year, the ***maximum benefit*** will be calculated on the sum of benefits paid by the ***Plan***.

The ***maximum benefit*** for orthodontic treatment while a ***covered person*** is covered by this ***Plan*** is also specified on the *Schedule of Benefits*.

ALTERNATIVE TREATMENT

In the event the ***dentist*** recommends a particular course of treatment and a lower-cost alternative would be as effective, benefits shall be limited to the lower-cost alternative. Any balance remaining, as a result of the ***covered person's*** choice to obtain the higher-cost treatment will be the ***covered person's*** responsibility.

DENTAL INCURRED DATE

A dental procedure will be deemed to have commenced on the date the covered dental expense is ***incurred***, except as follows:

1. For installation of a prosthesis other than a bridge or crown, on the date the impression was made;

2. For a crown, bridge or gold restoration, on the date the tooth or teeth are first prepared;

3. For endodontic treatment, on the date the pulp chamber is opened.

There are times when one overall charge is made for all or part of a course of treatment. In this case the ***claims processor*** will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be ***incurred*** as each visit or treatment is completed.

COVERED DENTAL EXPENSES

Subject to the limitations and exclusions, covered dental expenses shall include the necessary services, supplies, or treatment listed below and on the following pages. No dental benefit will be paid for any dental service, supply or treatment which is not on the following list of covered dental expenses.

Class I Diagnostic and Preventive Dental Services

1. Routine oral examination: Initial or periodic, limited to twice in twelve (12) months.

2. Prophylaxis: Scaling and cleaning of teeth, limited to twice in twelve (12) months.

3. Dental x-rays as follows:

   a. Supplementary bite-wing x-rays.
   b. Panorex or full mouth series, limited to one (1) in thirty-six (36) months.
   c. Other dental x-rays necessary for the diagnosis of a specific condition requiring treatment.

4. Topical application of fluoride for ***dependent*** children, limited to one (1) treatment in twelve (12) months.

5. Space maintainers, fixed appliance (not made of precious metals), designed to preserve the space between teeth caused by the premature loss of a primary tooth (also called a baby tooth) including all adjustments within six (6) months of installation, limited to ***dependent*** children. This does not include space maintainers used in orthodontics to create a space between teeth.

6. Topical application of sealant to permanent posterior teeth, for ***dependent*** children through the age of thirteen (13), limited to one (1) treatment per tooth every thirty-six (36) months.

7. Emergency palliative treatment primarily for relief of dental pain, not cure. Only paid as a separate benefit when no other treatment (except x-rays) is rendered during the visit.

Class II Basic Dental Services

1. Sedative fillings, covered as a separate procedure only if no other service (except x-rays) is rendered during the visit.

2. Restorations (fillings) to restore teeth to normal function, using amalgam, silicate, acrylic, synthetic, and composite filling materials to restore teeth broken down by decay or ***injury***.

3. Pin retention when part of the restoration instead of gold or crown retention.

4. Periodontics as follows:

   a. Gingivectomy/gingivoplasty, gingival curettage, gingival flap procedure or mucogingival surgery.
   b. Scaling and root planing.
   c. Pedicle and free soft tissue grafts, and vestibuloplasty.
   d. Occlusal adjustment, excluding charges for TMJ.
   e. Excision of pericoronal gingiva.
   f. Periodontal prophylaxis limited to twice in twelve (12) months with proof of previous periodontal treatment.
   g. Osseous surgery.

5. Endodontics as follows:

   a. Direct pulp capping.
   b. Pulpotomy.
   c. Root canal therapy on permanent teeth only.
   d. Apicoectomy.
   e. Hemisection.
   f. Retrograde fillings.

6. Oral surgery, including customary postoperative treatment furnished in connection with oral surgery, as follows:

   a. Simple extraction of one (1) or more teeth.
   b. Surgical extraction of erupted teeth and of soft tissue, partially bony, and completely bony impacted teeth.
   c. Extraction of tooth root.
   d. Incision and drainage of a tumor or a cyst.
   e. Alveolectomy, alveoloplasty, and frenectomy.
   f. Exostosis or hyperplastic tissue and excision of oral tissue for biopsy.
   g. Re-implantation or transplantation of a natural tooth.
   h. General anesthesia, only when provided in conjunction with a surgical procedure.

7. Therapeutic injections of antibiotics administered by a ***dentist***.

8. Repairs and adjustments to full or partial dentures.

9. Relining of present dentures, but only if they were installed more than six (6) months earlier and if they have not been relined during the past twelve (12) months.

10. Rebasing of present dentures, but only if they were installed more than six (6) months earlier and if they have not been rebased during the past thirty-six (36) months.

11. Denture adjustment, only if done more than six (6) months after the initial insertion of the denture.

12. Repair or recementing of crowns, inlays, onlays or bridgework.

13. Specialist consultations and specialty examinations provided the ***covered person*** has been referred by a general ***dentist***. These consultations and examinations are not restricted to the limitations for routine oral exams.

Class III Major Dental Services

1. Post and core on permanent teeth only.

2. Plastic or stainless steel crowns will be covered for primary teeth only and the five (5) year limitation, as noted below will not be applied.

3. Gold Inlays and Onlays: Covered only when the tooth cannot be restored by basic restorations, and then only if at least five (5) consecutive years have elapsed since the last placement.

4. Porcelain Restorations: Covered only when the tooth cannot be restored by basic restorations, and then only if at least five (5) consecutive years have elapsed since the last placement.

5. Crowns: Covered only when the tooth cannot be restored by basic restorations, and then only if at least five (5) consecutive years have lapsed since the last placement. Crowns used to treat temporomandibular joint dysfunction will not be covered.

6. Initial installation of fixed bridge (including abutments) to replace one (1) or more natural teeth.

7. Removable bridge, partial or complete dentures to replace one (1) or more natural teeth.

8. Replacement of an existing partial or full removable denture or fixed bridge, or the addition of teeth to existing bridgework to replace extracted natural teeth. However, only replacement or additions that meet the "Prosthesis Replacement Rule" below will be covered.

9. Complete dentures.

Prosthesis Replacement Rule

The Prosthesis Replacement Rule requires that replacements for or additions to existing dentures or bridgework will be covered only if satisfactory evidence is furnished that one of the following services applies:

1. The replacement or addition of teeth is required to replace one (1) or more teeth extracted after the existing denture or bridgework was installed.

2. The existing denture or bridge cannot be made serviceable and was installed at least five (5) years prior to its replacement.

Covered expenses for both a temporary and permanent prosthesis will be limited to the charge for the permanent prosthesis.

Class IV Orthodontic Services

1. Any dental expense furnished in connection with the orthodontic treatment.

2. Surgical exposure of impacted or unerupted teeth in connection with orthodontic treatment, including routine x-rays, local anesthetics, and post-surgical care.

3. Active appliances, including diagnostic services, the treatment plan, the fitting, making and placing of the active appliance, and all related office visits including post-treatment stabilization.

4. Comprehensive full-banded and bracketed orthodontic treatment.

5. Fixed or cemented appliance to control harmful habits.

DENTAL EXCLUSIONS

In addition to the *Plan Exclusions*, no benefit will be provided under this ***Plan*** for dental expenses ***incurred*** by a ***covered person*** for the following:

1. Charges for any device ordered while the individual was covered under this Plan and not delivered or installed until after termination of coverage.

2. Replacement of lost, missing or stolen appliances or prosthetic devices or duplicate appliances or prosthetic devices.

3. Charges for dental implants only.

4. Charges for any expense incurred in connection with a dental service that is completed after an individual's coverage is terminated unless:

    a. For fixed bridgework and full or partial dentures, the first impressions were taken and/or abutment teeth fully prepared while the individual was covered and the device is installed or delivered to him within three (3) calendar months after coverage ceases.

    b. For a crown, inlay or onlay, the tooth was prepared while the individual was covered and the crown, inlay or onlay is installed within three (3) calendar months after coverage ceases.

    c. For root canal therapy, the pulp chamber of the tooth was opened while the individual was covered and the treatment is completed within three (3) calendar months after coverage ceases.

    X-rays and prophylaxis shall not be deemed to start a dental procedure.

5. Services, supplies or treatment that is cosmetic in nature, including charges for personalization or characterization of dentures. Veneers or coverings placed on teeth except when used to return the tooth to normal form and function are considered cosmetic in nature.

6. Surgical services with respect to congenital or developmental malformations. These conditions include: cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis, and anodontia.

7. Appliances, restoration or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, or replacing tooth structure lost as a result of abrasion or attrition, except as provided under *Orthodontic Services*.

8. A service not furnished by a ***dentist***, except:

   a. Services performed by a licensed dental hygienist under a ***dentist's*** supervision;
   b. X-rays ordered by a ***dentist***; and
   c. Denturist.

9. Replacement of a prosthetic which in the ***dentist's*** opinion can be repaired or does not need replacement.

10. Fixed prosthetics and/or partials for children through the age of fifteen (15). An allowance will be made for a temporary acrylic partial.

11. A posterior fixed prosthetic appliance when done in connection with a removable appliance in the same arch.

12. Charges in excess of the least costly plan of treatment when there is more than one accepted method of treatment for a dental condition.

13. Charges resulting from changing from one ***dentist*** to another while receiving treatment, or resulting from receiving care from more than one ***dentist*** for one dental procedure, to the extent that the total charges billed exceed the amount that would have been billed if one ***dentist*** had performed all the required dental services.

14. Porcelain, gold, porcelain veneer, acrylic veneer, and precious metal crowns over primary teeth for children through the age of fifteen (15). An allowance will be made for an acrylic crown.

15. Charges for precision attachments, semi-precision attachments.

16. Charges for instruction in dental plaque control, dental hygienics, or nutritional counseling.

17. Charges for services or supplies related to diagnosis of, or treatment of temporomandibular joint syndrome, by whatever name called.

18. Charges for adjustments of new dentures within six (6) months of installation.

19. Charges for infection control (OSHA fees).

20. Charges for local anesthetic or analgesia including gas (nitrous oxide).

21. Charges for behavior management.

22. Any procedure not listed under *Covered Dental Expense*.

ADDITIONAL SOUTHERN LOCAL SCHOOL DISTRICT ELIGIBILITY AND TERMINATION INFORMATION

DEPENDENT(S) ELIGIBILITY

For Southern Local School District, every eligible ***employee*** may enroll eligible ***dependents***. However, if both the husband and wife are ***employees***, they may choose to have one covered as the ***employee***, and the spouse covered as the ***dependent*** of the ***employee***, or they may choose to have both covered as ***employees***. Eligible children may be enrolled as ***dependents*** of one or both spouses.

TERMINATION OF EMPLOYEE COVERAGE

1. The date the ***employer*** terminates the ***Plan*** and offers no other group health plan.

2. The date the ***employee*** ceases to meet the eligibility requirements of the ***Plan***.

3. The date employment terminates, as defined by the ***employer's*** personnel policies.

4. The date the ***employee*** becomes a full-time, active member of the armed forces of any country.

5. The date the ***employee*** ceases to make any required contributions.