UnitedHealthcare Insurance Company

Dental Benefit Booklet

FOR: Cultural Mission of the Royal Embassy of Saudi Arabia Student Resources

DENTAL PLAN NUMBER: PI003

ENROLLING GROUP NUMBER: 201600196501

EFFECTIVE DATE: January 1, 2017

Administered by

UnitedHealthcare Insurance Company

Introduction to your Dental Benefit Booklet

You and any of your Enrolled Dependents are eligible for Coverage under the Policy if the required Premiums have been paid. The Policy is referred to in this DENTAL BENEFIT BOOKLET as the "Policy" and is designated on the identification ("ID") card.

Coverage is subject to the terms, conditions, exclusions, and limitations of the Policy. As a DENTAL BENEFIT BOOKLET, this document describes the provisions of Coverage under the Policy but does not constitute the Policy.

Network and Non-Network Benefits

This DENTAL BENEFIT BOOKLET describes both benefit levels available under the Policy.

Network Benefits - These benefits apply when you choose to obtain Dental Services from a Network Dentist. Section 9: Procedures for Obtaining Benefits describes the procedures for obtaining Covered Dental Services as Network Benefits. Unless otherwise noted in the Schedule of Covered Dental Services or Section 10: Covered Dental Services, Network Benefits generally require you to pay less to the provider than Non-Network Benefits. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network Dentist an amount for a Covered Dental Service in excess of the contracted fee.

Non-Network- Benefits do not apply when you obtain Dental Services from Non-Network Dentists.

Dental Services Covered Under the Policy

In order for Dental Services to be Covered as Network Benefits, you must obtain all Dental Services directly from or through a Network Dentist.

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling the Company and/or provider. If necessary, the Company can provide assistance in referring you to Network Dentists. If you use a provider that is not a participating provider, you will be required to pay the entire bill for the services you received.

Only Necessary Dental Services are Covered under the Policy. The fact that a Dentist has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment, for a dental disease does not mean that the procedure or treatment is Covered under the Policy.

The Company has the authority in interpreting the benefits Covered under the Policy and the other terms, conditions, limitations and exclusions set out in the Policy and in making factual determinations related to the Policy and its benefits. The Company may, from time to time, delegate authority to other persons or entities providing services in regard to the Policy.

Important Note About Services

The Company does not provide Dental Services or practice dentistry. Rather, the Company arranges for providers of Dental Services to participate in a Network. Network Dentists are independent practitioners and are not employees of the Company. The Company, therefore, makes payment to Network Dentists through various types of contractual arrangements. These arrangements may include financial incentives to promote the delivery of dental care in a cost efficient and effective manner. Such financial incentives are not intended to impact your access to Necessary Dental Services.

The payment methods used to pay any specific Network Dentist vary. The method may also change at the time providers renew their contracts with the Company. If you have questions about whether there are any financial incentives in your Network Dentist's contract with the Company, please contact the

Company at the telephone number on your ID card. The Company can advise you whether your Network Dentist is paid by any financial incentive, however, the specific terms, including rates of payment, are confidential and cannot be disclosed.

The Dentist-patient relationship is between you and your Dentist. This means that:

- You are responsible for choosing your own Dentist.
- You must decide if any Dentist treating you is right for you. This includes Network Dentists who you choose or providers to whom you have been referred.
- You must decide with your Dentist what care you should receive.
- Your Dentist is solely responsible for the quality of the care you receive.

The Company makes decisions about eligibility and if a benefit is a Covered benefit under the Policy. These decisions are administrative decisions. The Company is not liable for any act or omission of a provider of Dental Services.

Identification ("ID") Card

You must show your ID card every time you request Dental Services. If you do not show your card, the providers have no way of knowing that you are Covered under a Policy issued by the Company and you may receive a bill for Network Benefits.

Section 1: Procedures for Obtaining Benefits

Section 1.1 Dental Services

You are eligible for Coverage for Dental Services listed in the Schedule of Covered Dental Services if such Dental Services are Necessary and are provided by or under the direction of a Participating Network Dentist. All Coverage is subject to the terms, conditions, exclusions and limitations of the Policy.

Network Benefits

Dental Services must be provided by a Network Dentist in order to be considered Network Benefits.

Enrolling for Coverage under the Policy does not guarantee Dental Services by a particular Network Dentist on the list of providers. The list of Network Dentists is subject to change. When a provider on the list no longer has a contract with the Company, you must choose among remaining Network Dentists. You are responsible for verifying the participation status of the Dentist, or other provider prior to receiving such Dental Services. You must show your ID card every time you request Dental Services.

If you fail to verify participation status or to show your ID card, and the failure results in non-compliance with required Company procedures, Coverage of Network Benefits may be denied.

Non-Network Benefits

Benefits do not apply when you obtain Dental Services from Non-Network Dentists.

Network Dentists

The Company has arranged with certain dental care providers to participate in a Network. These Network Dentists have agreed to discount their charges for Covered services and supplies.

Covered Persons are issued an identification card (ID card) showing they are eligible for Network discounts. A Covered Person must show this ID card every time Dental Services are given. This is how the provider knows that the patient is Covered under a Network plan. Otherwise, the person could be billed for the provider's normal charge.

A Directory of Network Dentists will be made available. A Covered Person can also call customer service to determine which providers participate in the Network. The telephone number for customer service is on the ID card.

Network Dentists are responsible for submitting a request for payment directly to the Company, however, a Covered Person is responsible for any Copayment at the time of service. If a Network Dentist bills a Covered Person, customer service should be called. A Covered Person does not need to submit claims for Network Dentist services or supplies.

Section 2: Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify the Company of such treatment before treatment begins and receive a Pre-Treatment Estimate. If you desire a Pre-Treatment Estimate, you or your Dentist should send a notice to the Company, via claim form, within 20 days of the exam. If requested the Dentist must provide the Company with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

The Company will determine if the proposed treatment is Covered under the Policy and estimate the amount of payment. The estimate of benefits payable will be sent to the Dentist and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

Pre-Treatment Estimate of benefits is not an agreement to pay for expenses. This procedure lets the Covered Person know in advance approximately what portion of the expenses will be considered for payment.

Section 3: Covered Dental Services

Dental Services described in this Section and in the Schedule of Covered Dental Services are Covered when such services are:

A. Necessary;

B. Provided by or under the direction of a Participating Network Dentist;

C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a benefit based on the least costly procedure; and

D. Not excluded as described in Section 4: General Exclusions.

Covered Dental Services are subject to satisfaction of the Deductible, Maximum Benefits and payment of any Copayments as described below and in the Schedule of Covered Dental Services.

This Section and the Schedule of Covered Dental Services: (1) describe the Covered Dental Services and any applicable limitations to those services; (2) outline the Copayments that you are required to pay for each Covered Dental Service; and (3) describe the Deductible and any Maximum Benefits that may apply.

Network Benefits:

When Network Copayments are charged as a percentage of Eligible Expenses, the amount you pay for Dental Services from Network providers is determined as a percentage of the negotiated contract fee between the Company and the provider rather than a percentage of the provider's billed charge. The Company's negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge a Covered Person or the Company for any service or supply that is not Necessary as determined by the Company. If a Covered Person agrees to receive a service or supply

that is not Necessary the Network provider may charge the Covered Person. However, these charges will not be considered Covered Dental Services and will not be payable by the Company.

Non-Network Benefits:

Benefits are not provided on your plan.

Maximum Benefits

Dental Services Maximum Benefit is $2,000 per Covered Person for Network Benefits per calendar year.

The sum of all Network benefits will not exceed a Maximum Benefit of $2,000 per Covered Person per calendar year.

Maximum Benefit applies to all Covered Dental Services.

Any required Copayment, Deductible, or Maximum Benefit is waived for a Covered Person in their 2nd or 3rd trimester of pregnancy for the following Covered Dental Services: prophylaxis, scaling and root planing, periodontal maintenance, full mouth debridement.

Orthodonic Maximum Benefit is $2,000 per Covered Person, per Lifetime, for Network Benefits up to age 19.

Section 4: General Exclusions

Section 4.1 Exclusions

Except as may be specifically provided in the Schedule of Covered Dental Services or through a Rider to the Policy, the following are not Covered:

A. Dental Services that are not Necessary.

B. Hospitalization or other facility charges.

C. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)

D. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.

E. Any Dental Procedure not directly associated with dental disease.

F. Any Dental Procedure not performed in a dental setting.

G. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

H. Placement of dental implants, implant-supported abutments and prostheses.

I. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

J. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or

other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

K. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

L. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.

M. Replacement of complete dentures, and fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.

N. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.

O. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

P. Expenses for Dental Procedures begun prior to the Covered Person becoming covered under the Policy.

Q. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

R. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.

S. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

T. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

U. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

V. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.

W. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.

X. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

Y. Foreign Services are not Covered unless required as an Emergency.

Z. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

AA. Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.

SCHEDULE OF COVERED DENTAL SERVICES

BENEFIT DESCRIPTION & LIMITATION	**NETWORK** **COPAYMENT** is shown as a percentage of Eligible Expenses after applicable Deductible is satisfied **DEDUCTIBLE**- Please note, there is no deductible applicable on any services.	**NON-NETWORK*** **COPAYMENT** *N/A- no non-network benefit applicable
DIAGNOSTIC SERVICES		
Bacteriologic Cultures	100%	0%
Viral Cultures	100%	0%
Intraoral Bitewing Radiographs Limited to 1 series of films per calendar year.	100%	0%
Panorex Radiographs Limited to 1 time per consecutive 36 months.	100%	0%
Oral/Facial Photographic Images Limited to 1 time per consecutive 36 months.	100%	0%
Diagnostic Casts Limited to 1 time per consecutive 24 months.	100%	0%
Extraoral Radiographs Limited to 2 films per calendar year.	100%	0%
Intraoral - Complete Series (including bitewings) Limited to 1 time per consecutive 36 months. Vertical bitewings cannot be billed in conjunction with a complete series.	100%	0%
Intraoral Periapical Radiographs	100%	0%
Pulp Vitality Tests Limited to 1 charge per visit, regardless of how many teeth are tested.	100%	0%

BENEFIT DESCRIPTION & LIMITATION	**NETWORK** **COPAYMENT** is shown as a percentage of Eligible Expenses after applicable Deductible is satisfied **DEDUCTIBLE**- Please note, there is no deductible applicable on any services.	**NON-NETWORK*** **COPAYMENT** *N/A- no non-network benefit applicable
Intraoral Occlusal Film	100%	0%
Periodic Oral Evaluation Limited to 2 times per consecutive 12 months.	100%	0%
Comprehensive Oral Evaluation Limited to 2 times per consecutive 12 months. Not Covered if done in conjunction with other exams.	100%	0%
Limited or Detailed Oral Evaluation Limited to 2 times per consecutive 12 months. Only 1 exam is Covered per date of service.	100%	0%
Comprehensive Periodontal Evaluation - new or established patient Limited to 2 times per consecutive 12 months.	100%	0%
Adjunctive Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures Limited to 1 time per consecutive 12 months.	100%	0%
PREVENTIVE SERVICES		
Dental Prophylaxis Limited to 2 times per consecutive 12 months.	100%	0%
Fluoride Treatments - child Limited to Covered Persons	100%	0%

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under the age of 16 years, and limited to 2 times per consecutive 12 months.		
Sealants Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	100%	0%
Space Maintainers Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.	100%	0%
Re-Cement Space Maintainers Limited to 1 per consecutive 6 months after initial insertion.	100%	0%
MINOR RESTORATIVE SERVICES		
Amalgam Restorations Multiple restorations on one surface will be treated as a single filling.	100%	0%
Composite Resin Restorations - Anterior Multiple restorations on one surface will be treated as a single filling.	100%	0%
Gold Foil Restorations Multiple restorations on one surface will be treated as a single filling.	100%	0%
ENDODONTICS		
Apexification	100%	0%

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Limited to 1 time per tooth per lifetime.		
Apicoectomy and Retrograde Filling Limited to 1 time per tooth per lifetime.	100%	0%
Hemisection Limited to 1 time per tooth per lifetime.	100%	0%
Root Canal Therapy Limited to 1 time per tooth per lifetime. Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	100%	0%
Retreatment of Previous Root Canal Therapy Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	100%	0%
Root Resection/Amputation Limited to 1 time per tooth per lifetime.	100%	0%
Therapeutic Pulpotomy Limited to 1 time per primary or secondary tooth per lifetime.	100%	0%
Pulpal Therapy (resorbable filling) - Anterior or Posterior, Primary Tooth (excluding final restoration) Limited to 1 time per tooth per lifetime. Covered for anterior or	100%	0%

BENEFIT DESCRIPTION & LIMITATION	**NETWORK** **COPAYMENT** is shown as a percentage of Eligible Expenses after applicable Deductible is satisfied **DEDUCTIBLE**- Please note, there is no deductible applicable on any services.	**NON-NETWORK*** **COPAYMENT** *N/A- no non-network benefit applicable
posterior teeth only.		
Pulp Caps - Direct/Indirect – excluding final restoration Not covered if utilized solely as a liner or base underneath a restoration.	100%	0%
Pulpal Debridement, Primary and Permanent Teeth Limited to 1 time per tooth per lifetime. This procedure is not to be used when endodontic services are done on same date of service.	100%	0%
PERIODONTICS		
Crown Lengthening Limited to 1 per quadrant or site per consecutive 36 months.	100%	0%
Gingivectomy/Gingivoplasty Limited to 1 per quadrant or site per consecutive 36 months.	100%	0%
Gingival Flap Procedure Limited to 1 per quadrant or site per consecutive 36 months.	100%	0%
Osseous Graft Limited to 1 per quadrant or site per consecutive 36 months.	100%	0%
Osseous Surgery Limited to 1 per quadrant or site per consecutive 36 months.	100%	0%
Guided Tissue Regeneration Limited to 1 per quadrant or site per consecutive 36 months.	100%	0%

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Soft Tissue Surgery Limited to 1 per quadrant or site per consecutive 36 months.	100%	0%
Periodontal Maintenance Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.	100%	0%
Full Mouth Debridement Limited to once per consecutive 36 months.	100%	0%
Provisional Splinting Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory based crowns and/or fixed partial dentures (bridges). Exclusion of laboratory based crowns or bridges for the purposes of provisional splinting.	100%	0%
Scaling and Root Planing Limited to 1 time per quadrant per consecutive 24 months.	100%	0%
Localized Delivery of Antimicrobial Agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report Limited to 3 sites per quadrant, or 12 sites total, for refractory pockets, or in conjunction with scaling or root planing, by report.	100%	0%
ORAL SURGERY		

BENEFIT DESCRIPTION & LIMITATION	**NETWORK** **COPAYMENT** is shown as a percentage of Eligible Expenses after applicable Deductible is satisfied **DEDUCTIBLE**- Please note, there is no deductible applicable on any services.	**NON-NETWORK*** **COPAYMENT** *N/A- no non-network benefit applicable
Alveoloplasty	100%	0%
Biopsy Limited to 1 biopsy per site per visit.	100%	0%
Frenectomy/Frenuloplasty	100%	0%
Surgical Incision Limited to 1 per site per visit.	100%	0%
Removal of a Benign Cyst/Lesions Limited to 1 per site per visit.	100%	0%
Removal of Torus Limited to 1 per site per visit.	100%	0%
Root Removal, Surgical Limited to 1 time per tooth per lifetime.	100%	0%
Simple Extractions Limited to 1 time per tooth per lifetime.	100%	0%
Surgical Extraction of Erupted Teeth or Roots Limited to 1 time per tooth per lifetime.	100%	0%
Surgical Extraction of Impacted Teeth Limited to 1 time per tooth per lifetime.	100%	0%
Surgical Access, Surgical Exposure, or Immobilization of Unerupted Teeth Limited to 1 per site per lifetime.	100%	0%

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Primary Closure of a Sinus Perforation Limited to 1 per tooth per lifetime.	100%	0%
Placement of Device to Facilitate Eruption of Impacted Tooth Limited to 1 time per tooth per lifetime.	100%	0%
Transseptal Fiberotomy/Supra Crestal Fiberotomy, by report Limited to 1 time per tooth per lifetime.	100%	0%
Vestibuloplasty Limited to 1 time per site per consecutive 60 months.	100%	0%
Bone Replacement Graft for Ridge Preservation - per site Limited to 1 per site per lifetime Not Covered if done in conjunction with other bone graft replacement procedures.	100%	0%
Excision of Hyperplastic Tissue or Pericoronal Gingiva Limited to 1 per site per consecutive 36 months.	100%	0%
Appliance Removal (not by dentist who placed appliance) includes removal of arch bar Limited to once per appliance per lifetime.	100%	0%
Tooth Reimplantation and/or Transplantation Services Limited to 1 per site per lifetime.	100%	0%

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Oroantral Fistula Closure Limited to 1 per site per visit.	100%	0%
ADJUNCTIVE SERVICES		
Analgesia Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.	100%	0%
Desensitizing Medicament	100%	0%
General Anesthesia Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.	100%	0%
Local Anesthesia Not Covered in conjunction with operative or surgical procedure.	100%	0%
Intravenous Sedation and Analgesia Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is	100%	0%

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clinically Necessary.		
Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report Limited to 1 per visit.	100%	0%
Occlusal Adjustment	100%	0%
Occlusal Guards Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.	100%	0%
Occlusal Guard Reline and Repair Limited to relining and repair performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	100%	0%
Occlusion Analysis - Mounted Case Limited to 1 time per consecutive 60 months.	100%	0%
Palliative Treatment Covered as a separate benefit only if no other services, other than exam and radiographs, were done on the same tooth during the visit.	100%	0%
Consultation (diagnostic service provided by dentists or physician other than practitioner providing treatment.) Not Covered if done with exams or professional visit.	100%	0%
MAJOR RESTORATIVE SERVICES		

BENEFIT DESCRIPTION & LIMITATION	**NETWORK** **COPAYMENT** is shown as a percentage of Eligible Expenses after applicable Deductible is satisfied **DEDUCTIBLE**- Please note, there is no deductible applicable on any services.	**NON-NETWORK*** **COPAYMENT** *N/A- no non-network benefit applicable
Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.		
Coping Limited to 1 per tooth per consecutive 60 months. Not Covered if done at the same time as a crown on same tooth.	100%	0%
Crowns – Retainers/Abutments Limited to 1 time per tooth per consecutive 60 months. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	100%	0%
Crowns - Restorations Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	100%	0%
Temporary Crowns - Restorations Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	100%	0%
Inlays/Onlays – Retainers/Abutments Limited to 1 time per tooth per 60 consecutive months. Not Covered if done in conjunction with any other inlay, onlay and	100%	0%

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crown codes except post and core buildup codes.		
Inlays/Onlays - Restorations Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	100%	0%
Pontics Limited to 1 time per tooth per consecutive 60 months.	100%	0%
Retainer-Cast Metal for Resin Bonded Fixed Prosthesis Limited to 1 time per tooth per consecutive 60 months.	100%	0%
Pin Retention Limited to 2 pins per tooth; not covered in addition to cast restoration.	100%	0%
Post and Cores Covered only for teeth that have had root canal therapy.	100%	0%
Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core Limited to those performed more than 12 months after the initial insertion.	100%	0%
Sedative Filling Covered as a separate benefit only if no other service, other than x-rays and exam, were done on the same tooth during the	100%	0%

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visit.		
Stainless Steel Crowns Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.	100%	0%
FIXED PROSTHETICS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.		
Fixed Partial Dentures (Bridges) Limited to 1 time per tooth per consecutive 60 months.	100%	0%
REMOVABLE PROSTHETICS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement.		
Full Dentures Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	100%	0%
Partial Dentures Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	100%	0%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12	100%	0%

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months.		
Tissue Conditioning - Maxillary or Mandibular Limited to 1 time per consecutive 12 months.	100%	0%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	100%	0%