Laurens County Cares Dental Schedule of Benefits Effective September 1, 2024

Dental Coverage				
Calendar Year Benefits Maximum (Per Member)	\$1,000			
Calendar Year Deductible:				
Individual-	\$50			
Family- The first three members of an enrolled family to satisfy their deductible will satisfy the Deductible for the entire family.	\$150			
Orthodontic Services Lifetime Maximum Benefits per member under age 19	\$1,500			
Benefit Highlights	Plan Pays	You Pay		
Type 1- Preventive & Diagnostic				
Oral Evaluation				
Prophylaxis: Routine Cleanings	100%			
Dental X-Rays	No Deductible			
Topical Fluoride		No Charge		
Diagnostic Casts		· ·		
Pulp Vitality Testing				
Sealants				
Space Maintainers				
Type 2- Basic				
Fillings				
Simple Extractions				
Oral Surgery				
Palliative Emergency Treatment	80%	20%		
Apicoectomy	After Deductible	After Deductible		
Occlusal Guards				
Impactions				
Endodontics				
Gingivectomy and Gingivoplasty				
Osseous Surgery				
Vestibuloplasty				
Periodontic Services				
Periodontal Prophylaxis				
Type 3- Major				
Inlays and Onlays		50%		
Crowns	50%	3070		
Dentures (Full and Partial)				
Bridges (Fixed & Removable)	After Deductible	After Deductible		
Denture Rebase or Reline				
Repair of Fixed Bridges	50%	50% After Deductible		
Repair of Removable Dentures	After Deductible	Aiter Deductible		
Re-cement Crowns and Bridges	After Deductible			

baby teeth) by means of a fixed or removable appliance designed to prevent adjacent and opposing teeth from moving. Adjustments are covered if required because of relative change in the condition of the mouth. Fixed and Removable EXCEPT THAT: the initial installation shall be limited to replacement of one or more natural teeth extracted while the member is covered under this Plan, and; the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while covered under this Plan and after the existing denture or bridge was installed; or if the existing denture or bridge cannot be made serviceable. Denture and Bridge Repairs	Type 4- Orthodontic	50%	50%		
Eletime Benefits Maximum: \$1,500 The plan will only pay for covered charges up to the yearty Benefits Maximum, when applicable. Benefit-specific Maximum in any also apply. Calendar Year Deductible The plan will only pay for covered charges up to the yearty Benefits Maximum, when applicable. Benefit-specific deductibles may also apply. Special Requirements For new dental plans (non-replacement), Type 3 and 4 Services will not be covered for the first 12 months. For any LATE entraints to the program, Type 3 and 4 Services will not be covered for the first 12 months. For any LATE entraints to the program, Type 3 and 4 Services will not be covered for the first 12 months. For any LATE entraints to the program, Type 3 and 4 Services will not be covered for the first 12 months. For any LATE entraints to the program, Type 3 and 4 Services will not be covered for the first 12 months. For any LATE entraints to the program, Type 3 and 4 Services will not be covered for the first 12 months. For the program, Type 3 and 4 Services will not be covered for the first 12 months. For the program, Type 3 and 4 Services will not be covered for the first 12 months. For the program, Type 3 and 4 Service will not be covered for the first 12 months. For the program, Type 3 and 4 Service will not be covered for the first 12 months. For the program of the progr		No Deductible	No Deductible		
The plan will only pay for covered charges up to the yearly Benefits Maximum. When applicable. Benefit-specific Maximum any also apply. Calendar Year Deductible This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefit-specific deductibles may also apply. Special Requirements For new dental plans (non-replacement), Type 3 Services will not be covered for the first 12 months. For any LATE entrants to the program, Type 3 services will not be covered for the first 12 months. Pretreatment Review Pretreatment Review Pretreatment review is available on a voluntary basis when dental work in excess of \$350 is proposed. Alternate Benefit Provision Provision when more than one covered Dental Service could provide suitable treatment based on common dental standards. Core will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. Timely Filing Out of network claims submitted to Core after 365 days from date of service will be denied Benefit Plan Provisions: Missing Tooth Limitation For feeth missing prior to coverage through Core, the amount payable is 50% of the amount otherwise payable until covered for 12 months; thereafter, considered a Class III expense. X-rays (non-routine) 2 per calendar year X-rays (non-routine) Radiographs, full mouth X-rays or pancramic X-rays (not more than once in any period of 36 consecutive months). It also includes not more than the wo supplementary blewing X-rays wide per calendar year and other dental X-rays as required in connection with the diagnosis of a specific condition requiring treatment. Payable only in conjunction with onthodonitic workup. Pulp Vitality Testing- one per calendar year. Cleanings 2 per calendar year, including periodontal maintenance procedures following active therapy. Fluoride Application 2 per calendar year for children under age 15. Sealants (per tooth) For permanent teeth (imited to covered dependent children between the age					
Benefits peolite Maximums may also apply. This is the amount you must pay before the plan begins to pay for covered charges, when applicable. Benefits specific deductibles may also apply. For new dental plans (non-replacement), Type 3 Services will not be covered for the first 12 months. For any LATE entrants to the program, Type 3 and 4 Services will not be covered for the first 12 months. Pretreatment Review Pretreatment Review Pretreatment review is available on a voluntary basis when dental work in excess of \$350 is proposed. Alternate Benefit Provision Provision when more than one covered Dental Service could provide suitable treatment based on common dental standards. Core will determine the covered themal Service on which payment will be based and the expenses that will be included as Covered Expenses. Timely Filing Out of network claims submitted to Core after 365 days from date of service will be denied Benefit Plan Provisions: Missing Tooth Limitation For teeth missing prior to coverage through Core, the amount payable is 50% of the amount otherwise payable until covered for 12 months; thereafter, considered a Class III expense. 2 per calendar year X-rays (non-routine) 2 per calendar year X-rays (non-routine) 2 per calendar year Alternate work in a conscious of the amount payable is 50% of the amount otherwise conscious months in a conscious months in the diagnosis of a specific condition requiring treatment. Pagnostic Casts Payable only in conjunction with orthodonic workup. Pulp Vitality Testing- one per calendar year. Cleanings 2 per calendar year and order dental X-rays as required in connection with the diagnosis of a specific condition requiring treatment. For permanent teeth (limited to covered dependent children between the ages of 6 and 18 years old, once per tooth every 36 months). Space Maintainers Pretreatment between the premature loss or extraction of deciduous teeth (primary or bably teeth) by means of a fixed or removable appliance designed to prevent adjacent	Benefit Plan Provisions:				
Benefits-pecific deductibles may also apply.	Calendar Year Benefits Maximum				
For any LATE entrants to the program, Type 3 and 4 Services will not be covered for the first 12 months. Pretreatment Review Pretreatment review is available on a voluntary basis when dental work in excess of \$350 is proposed. Alternate Benefit Provision Provision when more than one covered Dental Service could provide suitable treatment based on common dental standards. Core will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. Timely Filing Out of network claims submitted to Core after 365 days from date of service will be denied Benefit Plan Provisions: Missing Tooth Limitation For teelth missing prior to coverage through Core, the amount payable is 50% of the amount otherwise payable until covered for 12 months; thereafter, considered a Class III expense. Oral Evaluations 2 per calendar year X-rays (nothing) Bitewings: 2 per calendar year Radiographs, full mouth X-rays or panoramic X-rays (not more than once in any period of 36 consecutive months). It also includes not more than two supplementary bitewing X-rays twice per calendar year and other dental X-rays as required in connection with the diagnosis of a specific condition requiring treatment. Diagnostic Casts Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Cleanings 2 per calendar year including periodontal maintenance procedures following active therapy. Fluoride Application 2 per calendar year for children under age 15. Sealants (per tooth) 6 pro permanent teeth (limited to covered dependent children between the ages of 6 and 18 years old, once per tooth every 36 months). Services to maintain existing space from the premature loss or extraction of deciduous teeth (primary obaty teeth) by means of a fixed or removable appliance designed to prevent adjacent and opposing the mount in mouth. Bridges (Fixed & Removable) Covered if more than once. Denture and Bridge Repairs Covered if more than once.	Calendar Year Deductible				
Alternate Benefit Provision Provision when more than one covered Dental Service could provide suitable treatment based on common dental standards, Core will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. Timely Filing Out of network claims submitted to Core after 366 days from date of service will be denied Benefit Plan Provisions: Missing Tooth Limitation For teeth missing prior to coverage through Core, the amount payable is 50% of the amount otherwise payable until covered for 12 months; thereafter, considered a Class III expense. Oral Evaluations 2 per calendar year X-rays (routine) Bitewings: 2 per calendar year Radiographs, full mouth X-rays or panoramic X-rays (not more than once in any period of 36 consecutive months). It also includes not more than two supplementary bitewing X-rays twice per calendar year and other dental X-rays as required in connection with the diagnosis of a specific condition requiring freatment. Diagnostic Casts Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Cleanings 2 per calendar year for children under age 15. Sealants (per tooth) For permanent teeth (limited to covered dependent children between the ages of 6 and 18 years old, once per tooth every 36 months). Space Maintainers Privad and Removable EXCEPT THAT: the initial installation shall be limited to replacement of one or more natural teeth extracted while the member is covered under this Plan, and plan the condition of the mouth. Fixed and Removable EXCEPT THAT: the initial installation shall be limited to replacement of one or more natural teeth extracted while covered under this Plan, the replacement of one or more natural teeth extracted while covered under this Plan, the replacement of one or more natural teeth extracted while the member is covered under this Plan, the replacement of one or more natural teeth extracted while covered under this Plan, the replacement o	Special Requirements	For any LATE entrants to the program, Type 3 and 4 Services will not be covered for the first 12			
Alternate Benefit Provision common dental standards, Core will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. Timely Filing Out of network claims submitted to Core after 365 days from date of service will be denied Benefit Plan Provisions: Missing Tooth Limitation For teeth missing prior to coverage through Core, the amount payable is 50% of the amount otherwise payable until covered for 12 months; thereafter, considered a Class III expense. Oral Evaluations 2 per calendar year X-rays (routine) Bitewings: 2 per calendar year Radiographs, full mouth X-rays or panoramic X-rays (not more than once in any period of 36 consecutive months). It also includes not more than two supplementary bitewing X-rays twice per calendar year and other dental X-rays as required in connection with the diagnosis of a specific condition requiring treatment. Diagnostic Casts Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Cleanings 2 per calendar year, including periodontal maintenance procedures following active therapy. Fluoride Application 2 per calendar year for children under age 15. Sealants (per tooth) For permanent teeth (limited to covered dependent children between the ages of 6 and 18 years old, once per tooth every 36 months). Services to maintain existing space from the premature loss or extraction of deciduous teeth (primary one baby teeth) by means of a fixed or removable appliance designed to prevent adjacent and opposing teeth from moving. Adjustments are covered if required because of relative change in the condition of the mouth. Fixed and Removable EXCEPT THAT: the initial installation shall be limited to replacement of addition of teeth is required to replace one or more additional natural teeth extracted while covered under this Plan, and, the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while covered under	Pretreatment Review	Pretreatment review is available on a voluntary basis when dental work in excess of \$350 is proposed.			
### Benefit Plan Provisions: ### For teeth missing prior to coverage through Core, the amount payable is 50% of the amount otherwise payable until covered for 12 months; thereafter, considered a Class III expense. ### Cl	Alternate Benefit Provision	common dental standards, Core will determine the covered Dental Service on which payment will be			
For teeth missing prior to coverage through Core, the amount payable is 50% of the amount otherwise payable until covered for 12 months; thereafter, considered a Class III expense. 2 per calendar year X-rays (routine) Bitewings: 2 per calendar year Radiographs, full mouth X-rays or panoramic X-rays (not more than once in any period of 36 consecutive months). It also includes not more than two supplementary bitewing X-rays twice per calendar year and other dental X-rays as required in connection with the diagnosis of a specific condition requiring treatment. Diagnostic Casts Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Cleanings 2 per calendar year, including periodontal maintenance procedures following active therapy. Fluoride Application 2 per calendar year for children under age 15. Sealants (per tooth) For permanent teeth (limited to covered dependent children between the ages of 6 and 18 years old, once per tooth every 36 months). Space Maintainers Services to maintain existing space from the premature loss or extraction of deciduous teeth (primary obaby teeth) by means of a fixed or removable appliance designed to prevent adjacent and opposing teeth from moving. Adjustments are covered if required because of relative change in the condition of the mouth. Fixed and Removable EXCEPT THAT: the initial installation shall be limited to replacement of one or more natural teeth extracted while the member is covered under this Plan, and; the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while covered under this Plan, and; the replacement or bridge was installed; or if the existing denture or bridge was installed; or if the existing denture or bridge was installed; or if the existing denture or bridge was installed; or if the existing denture or bridge was installed; or if the existing denture or bridge was installed; or if the existing denture or bridge was installed.	Timely Filing	Out of network claims submitted to Core after 365 days from date of service will be denied			
Diagnostic Casts Payable until covered for 12 months; thereafter, considered a Class III expense. Z-per calendar year X-rays (non-routine) Bitewings: Payable until covered for 12 months; thereafter, considered a Class III expense. Radiographs, full mouth X-rays or panoramic X-rays (not more than once in any period of 36 consecutive months). It also includes not more than two supplementary bitewing X-rays twice per calendar year and other dental X-rays as required in connection with the diagnosis of a specific condition requiring treatment. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Cleanings Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Fluoride Application Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. For permanent teeth (limited to covered dependent children between the ages of 6 and 18 years old, once per tooth every 36 months). Sealants (per tooth) For permanent teeth (limited to covered dependent children between the ages of 6 and 18 years old, once per tooth every 36 months). Services to maintain existing space from the premature loss or extraction of deciduous teeth (primary obaby teeth) by means of a fixed or removable appliance designed to prevent adjacent and opposing teeth from moving. Adjustments are covered if required because of relative change in the condition of the mouth. Fixed and Removable EXCEPT THAT: the initial installation shall be limited to replacement or addition of teeth is required to replace one or more additional natural teeth extracted while the member is covered under this Plan, and; the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while covered under this Plan and after the existing denture or bridge was installed, or if the existing denture or bridge cannot be made serviceable. Penture Relines, Rebases and Adjustments Covered if more than 6 months af	Benefit Plan Provisions:				
X-rays (routine) Bitewings: 2 per calendar year Radiographs, full mouth X-rays or panoramic X-rays (not more than once in any period of 36 consecutive months). It also includes not more than two supplementary bitewing X-rays twice per calendar year and other dental X-rays as required in connection with the diagnosis of a specific condition requiring treatment. Diagnostic Casts Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Cleanings 2 per calendar year, including periodontal maintenance procedures following active therapy. Fluoride Application 2 per calendar year for children under age 15. Sealants (per tooth) For permanent teeth (limited to covered dependent children between the ages of 6 and 18 years old, once per tooth every 36 months). Services to maintain existing space from the premature loss or extraction of deciduous teeth (primary obaby teeth) by means of a fixed or removable appliance designed to prevent adjacent and opposing teeth from moving. Adjustments are covered if required because of relative change in the condition of the mouth. Fixed and Removable EXCEPT THAT: the initial installation shall be limited to replacement or addition of teeth is required to replace one or more additional natural teeth extracted while the member is covered under this Plan, and; the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while the member is covered under this Plan, and; the replacement or under this Plan and after the existing denture or bridge was installed; or if the existing denture or bridge cannot be made serviceable. Denture Relines, Rebases and Adjustments Covered if more than 6 months after installation.	Missing Tooth Limitation				
Radiographs, full mouth X-rays or panoramic X-rays (not more than once in any period of 36 consecutive months). It also includes not more than two supplementary bitewing X-rays twice per calendar year and other dental X-rays as required in connection with the diagnosis of a specific condition requiring treatment. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendary year. Payable only in conjunction w	Oral Evaluations	2 per calendar year			
consecutive months). It also includes not more than two supplementary bitewing X-rays twice per calendar year and other dental X-rays as required in connection with the diagnosis of a specific condition requiring treatment. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year. Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendary per calendary. Payable only in conjunction with orthodontic workup. Payable only in conjunction testing periodontal maintenan	X-rays (routine) Bitewings:	2 per calendar year			
Cleanings 2 per calendar year, including periodontal maintenance procedures following active therapy. Fluoride Application 2 per calendar year for children under age 15. For permanent teeth (limited to covered dependent children between the ages of 6 and 18 years old, once per tooth every 36 months). Services to maintain existing space from the premature loss or extraction of deciduous teeth (primary ob baby teeth) by means of a fixed or removable appliance designed to prevent adjacent and opposing teeth from moving. Adjustments are covered if required because of relative change in the condition of the mouth. Fixed and Removable EXCEPT THAT: the initial installation shall be limited to replacement of one or more natural teeth extracted while the member is covered under this Plan, and; the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while covered under this Plan and after the existing denture or bridge was installed; or if the existing denture or bridge cannot be made serviceable. Denture and Bridge Repairs Reviewed if more than once. Covered if more than 6 months after installation.	X-rays (non-routine)	consecutive months). It also includes not more than two supplementary bitewing X-rays twice per calendar year and other dental X-rays as required in connection with the diagnosis of a specific			
Fluoride Application 2 per calendar year for children under age 15. For permanent teeth (limited to covered dependent children between the ages of 6 and 18 years old, once per tooth every 36 months). Services to maintain existing space from the premature loss or extraction of deciduous teeth (primary obaby teeth) by means of a fixed or removable appliance designed to prevent adjacent and opposing teeth from moving. Adjustments are covered if required because of relative change in the condition of the mouth. Fixed and Removable EXCEPT THAT: the initial installation shall be limited to replacement of one or more natural teeth extracted while the member is covered under this Plan, and; the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while covered under this Plan and after the existing denture or bridge was installed; or if the existing denture or bridge cannot be made serviceable. Penture and Bridge Repairs Reviewed if more than once. Covered if more than 6 months after installation.	Diagnostic Casts	Payable only in conjunction with orthodontic workup. Pulp Vitality Testing- one per calendar year.			
Sealants (per tooth) For permanent teeth (limited to covered dependent children between the ages of 6 and 18 years old, once per tooth every 36 months). Services to maintain existing space from the premature loss or extraction of deciduous teeth (primary of baby teeth) by means of a fixed or removable appliance designed to prevent adjacent and opposing teeth from moving. Adjustments are covered if required because of relative change in the condition of the mouth. Fixed and Removable EXCEPT THAT: the initial installation shall be limited to replacement of one or more natural teeth extracted while the member is covered under this Plan, and; the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while covered under this Plan and after the existing denture or bridge was installed; or if the existing denture or bridge cannot be made serviceable. Penture and Bridge Repairs Reviewed if more than once. Covered if more than 6 months after installation.	Cleanings	2 per calendar year, including periodontal maintenance procedures following active therapy.			
Space Maintainers Services to maintain existing space from the premature loss or extraction of deciduous teeth (primary of baby teeth) by means of a fixed or removable appliance designed to prevent adjacent and opposing teeth from moving. Adjustments are covered if required because of relative change in the condition of the mouth. Fixed and Removable EXCEPT THAT: the initial installation shall be limited to replacement of one or more natural teeth extracted while the member is covered under this Plan, and; the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while covered under this Plan and after the existing denture or bridge was installed; or if the existing denture or bridge cannot be made serviceable. Denture and Bridge Repairs Reviewed if more than once. Covered if more than 6 months after installation.	Fluoride Application	2 per calendar year for children under age 15.			
baby teeth) by means of a fixed or removable appliance designed to prevent adjacent and opposing teeth from moving. Adjustments are covered if required because of relative change in the condition of the mouth. Fixed and Removable EXCEPT THAT: the initial installation shall be limited to replacement of one or more natural teeth extracted while the member is covered under this Plan, and; the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while covered under this Plan and after the existing denture or bridge was installed; or if the existing denture or bridge cannot be made serviceable. Denture and Bridge Repairs	Sealants (per tooth)				
more natural teeth extracted while the member is covered under this Plan, and; the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while covered under this Plan and after the existing denture or bridge was installed; or if the existing denture or bridge cannot be made serviceable. Denture and Bridge Repairs Reviewed if more than once. Covered if more than 6 months after installation.	Space Maintainers	teeth from moving. Adjustments are covered if required because of relative change in the condition of			
Denture Relines, Rebases and Adjustments Covered if more than 6 months after installation.	Bridges (Fixed & Removable)	more natural teeth extracted while the member is covered under this Plan, and; the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while covered under this Plan and after the existing denture or bridge was installed; or if the existing denture or bridge			
Adjustments Covered if more than 6 months after installation.	Denture and Bridge Repairs	Reviewed if more than once.			
CET DENITAL COD FOR DETAILED EVALUE ON		Covered if more than 6 months after installation.			
SEE DENTAL SPD FOR DETAILED EXCLUSIONS					