Expatriate Insurance

Proposed Group Insurance Dental Plan

Tanisha Systems, Inc.

Effective Date: 12/01/2019

National PPO 30				Passive PPO Custom Plan
	NON-ORTHODONTICS		ORTHODONTICS	
	Out of U.S. and U.S. In-Network	U.S. Non-Network	Out of U.S. and U.S. In-Network	U.S. Non-Network
Individual Annual Calendar Year Deductible	$50	$50	$0	$0
Family Annual Calendar Year Deductible	$150	$150	$0	$0
Maximum (the sum of all Network and Non-Network benefits will not exceed annual maximum)	$1,000	$1,000	Not Covered	
New enrollee's waiting period:	No			
Annual deductible applies to preventive and diagnostic services	No			
Annual deductible applies to orthodontic services	Not applicable			
Orthodontic eligibility requirement	Not Covered			
COVERED SERVICES	**Out of U.S. and U.S. In-Network**	**U.S. Non-Network**	**BENEFIT GUIDELINES**	
Diagnostic Services				
Periodic Oral Evaluation	100%	100%	Limited to 2 times per consecutive 12 months.	
Radiographs	100%	100%	Bite-wing: Limited to 1 series of films per Plan Year. Complete/Panorex: Limited to 1 time per consecutive 36 months.	
Lab and Other Diagnostic Tests	100%	100%		
Preventative Services				
Prophylaxis (Cleanings)	80%	80%	Limited to 2 times per consecutive 12 months.	
Fluoride Treatment (Preventive)	80%	80%	Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.	
Sealants	80%	80%	Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	
Space Maintainers	80%	80%	For Covered Persons under the age of 16 years, limited to 1 per consecutive 60 months.	

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Basic Services			
Restorations (Amalgams or Anterior Composite)	50%	50%	Multiple restorations on one surface will be treated as a single filling.
General Services	50%	50%	General Anesthesia: When clinically necessary.
Simple Extractions	50%	50%	Limited to 1 time per tooth per lifetime.
Oral Surgery (includes surgical extractions)	50%	50%	
Periodontics	50%	50%	Perio Surgery: Limited to 1 quadrant or site per consecutive 36 months per surgical area. Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months. Periodontal Maintenance: Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement.
Endodontics	50%	50%	
Emergency Treatment	50%	50%	Palliative Treatment: Covered as a separate benefit only if no other service was done during the visit other than X-rays.
Major Services			
Inlays/Onlays/Crowns	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	50%	50%	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
Fixed Partial Dentures (Bridges)	50%	50%	Once per tooth per consecutive 60 months.
Orthodontic Services			
Diagnose or correct misalignment of the teeth or bite	0%	0%	Not Covered

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Dental Exclusions and Limitations		
General Limitations	**General Exclusions**	
	The following are not covered:	
PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.	Dental Services that are not necessary.	Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to one time per consecutive 36 months. Exception to this limit will be made for Paronex Radiograph if taken for diagnosis of molars, Cysts or neoplasm.	Hospitalization or other facility charges.	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 over dentures, 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.
BITEWING RADIOGRAPHS Limited to 1 series of films per Plan Year.	Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)	Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
EXTRA ORAL RADIOGRAPHS Limited to 2 films per Plan Year.	Reconstructive Surgery regardless of whether or not the surgery which 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.	Placement of dental implants, implants-supported abutments and prostheses. (Not applicable for plans with implants).
DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.	Any dental procedure not directly associated with dental disease.	Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
FLUORIDE TREATMENTS Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.	Any procedure not performed in a dental setting.	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.

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SEALANTS Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	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.	Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
SPACE MAINTAINERS Limited to Covered Persons under the age of 16 years. Limited to 1 per consecutive 60 months. Benefit includes all adjustment within 6 months of installation.	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.	Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jawbone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment or treatment for the temporomandibular joint. (Not Applicable for Plans with TMJ).
RESTORATIONS Multiple restorations on 1 surface will be treated as a single filling.	Expenses for dental procedures begun prior to the covered person becoming enrolled under the policy.	Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.	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.	Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

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INLAYS AND ONLAYS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.	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. Foreign services are not covered unless required as an Emergency.	Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
CROWNS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.	Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for twelve continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.	Occlusal guard used as safety items or to affect performance primarily in sports-related activities.
POST AND CORES Covered only for teeth that have had root canal therapy.	Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been covered under the policy for 12 continuous months.	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.
SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam were performed on the same tooth during the visit.	Replacement of complete dentures, 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.	Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

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SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.	REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS 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. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.	PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 per quadrant or site per consecutive 36 months per surgical area
FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.	OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.
PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.	GENERAL ANESTHESIA Covered only when clinically necessary.
RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	FULL MOUTH DEBRIDEMENT Limited to 1 time every consecutive 36 months.
REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 time per consecutive 6 months.	OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only if prescribe to control habitual grinding.
PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than exam and radiographs, were performed on the same tooth during the visit.	
This is a high level benefits overview. Refer to actual plan documents, including benefits summary, for more detailed benefit descriptions.	

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