



Community Health Plan Insurance Company



P O Box 8510 * St. Louis, MO 63126
(314) 543-4900 * (800) 501-3471

ORIGINAL EFFECTIVE DATE: Jan 1, 2006

Benefit Summary

In-Network Benefit

Preventive 100%

Out-of-Network Benefit

Preventive 100%

Copay & Maximum

Annual Maximum In-Network Per Person: \$1000

Annual Maximum Out-of-Network Per Person: \$1000

Copay Per Person Per visit: \$25

Annual Maximum is on a Calendar Year Basis (Jan-Dec) and applies to Preventive Services

COVERED BENEFIT

Preventive Care

- Comprehensive oral examination: one (1) in any thirty-six (36) consecutive month period (00150)
- Periodic routine examinations: one (1) in any six (6) consecutive month period (00120)
- Bitewing x-rays: one (1) series of four (4) bitewing x-rays in any six (6) consecutive month period (00272) (00274)
- Full mouth/Panoramic x-rays: one (1) in any thirty-six (36) consecutive month period (00210) (00330)
- Prophylaxis: cleaning, scaling- one (1) in any six (6) consecutive month period (01110) (01120)
- Topical fluoride treatment: one (1) in any twelve (12) consecutive month period for dependent children under 16 years of age (01201) (01203)
- Space maintainers: one (1) in five (5) years to replace prematurely lost teeth for dependent children under 16 years of age (01510) (01515) (01520)(01525)
- Re-cementation of space maintainers: two (2) in any twenty-four (24) consecutive month period for dependent children under 16 years of age (01550)

NON-COVERED BENEFITS: Basic, Major, & Orthodontic Services

Out of Network Services – Claims are paid at a fee schedule. The provider will bill the insured for any charges that exceed the fee schedule.

Limitations

Certain services and procedures may be subject to limitations under your Essex Dental Benefits program, as follows:

- If dental care is received from more than one dentist for the same procedure, benefits will not exceed what would have been paid for one dentist for that procedure.
- Dependent child must be at least three (3) years of age to receive dental care benefits.

Exclusions

Certain services and procedures are excluded from your Essex Dental Benefits program, as follows:

- Services provided solely to improve appearance or to correct congenital malformations.
- Nitrous oxide
- Any services not specifically stated as covered dental services, i.e. hospital, medical, prescription and non-prescription drugs.
- Services or supplies not reasonably necessary for the care of the covered person or charges that exceed the usual, customary and reasonable or fee schedule limits.
- Care covered under, or subject to, any worker's compensation law or federal employer's compensation or liability acts.
- Services for which a covered person would normally incur no charge.
- Experimental services, procedures or supplies.
- Charges for hypnosis.
- Charges which were a direct or indirect result of any act of war.
- Charges for oral hygiene instruction, OSHA charges or sterilization fees, missed appointments, completing a claim form and duplication of x-rays or dental records.
- Charges for treatment that is already in progress prior to the covered person's effective date or charges incurred for the treatment provided after coverage terminates.