



Chicago Transit Authority PPO Benefit Summary

PPO Schedule

This is a summary of dental services and the allowable levels of coverage. Benefits are eligible only when services are rendered by a participating preferred dental provider. Preferred dental providers have agreed to a specific fee schedule that will provide savings to you. Claim forms must be submitted to CompBenefits for payment

Percentage Coverage*

Preventive

- Oral Examination (two per benefit period) 100%*
- Prophylaxis (two per benefit period) 100%
- Topical Fluoride Application-under age 14 (one per benefit period) 100%
- Sealants-under age 14 100%
- Space Maintainers-under age 14, when not part of orthodontic treatment 100%
- Emergency oral examinations and palliative emergency treatment for the temporary relief of pain 100%

Primary Dental Services

- Dental X-rays
 - full mouth (one per 36 months) 90%
 - bitewings (one per 12 months) 90%
- Fillings-Silver, silicate, plastic, porcelain and composite 90%
- Extractions-for specific coverage refer to special limitations ** 90%
- Oral Surgery-for specific coverage refer to special limitations ** 90%
- Endodontics/Root Canal Treatment 90%
- Pulp Vitality Tests (once per 12 months) 90%
- Apicoectomies 90%
- Hemisection 90%
- Biopsies of Oral Tissue 90%
- Periodontics/Periodontal Therapy ** 90%
- General Anesthesia/Intravenous Sedation ** 90%
- Denture Adjustments, Rebasing and Relining ** 90%
- Recementing of Crowns, Inlays, Onlays, and Bridges 90%
- Fixed Bridge Repairs ** 90%
- Repair of Removable Dentures ** 90%

Major Dental Services

- Inlays, Onlays and Crowns ** 50%
- Full and Partial Dentures, Fixed Bridgework 50%
- Posterior Veneers 50%

* THE % OF COVERAGE WILL BE APPLIED TO THE REDUCED FEE SCHEDULE THAT PREFERRED PROVIDERS HAVE AGREED TO ACCEPT FOR THE PPO OPTION.

** FOR SPECIFICS ON LIMITATIONS PLEASE REFER TO “YOUR GROUP HEALTH AND DENTAL BENEFITS PROGRAM” BOOKLET.

Pre-Estimation of Benefits • For services that will cost more than \$125.00 a Pre-Estimation of benefits is recommended.

Benefit Maximum		\$2,000.00
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Yearly Deductible	Single	\$25.00
	Family	\$50.00

Below is a general outline of services and supplies that are excluded from coverage. Your CTA Group and Dental Benefit Program provides a more detailed listing of exclusions. Please refer to the Group and Dental Benefit Program for specific information about excluded services or supplies.

SPECIAL LIMITATIONS

No benefits will be provided under this Benefit Section for:

1. Dental services which are performed for cosmetic purposes.
2. Dental services or appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction and Related Disorders.
3. Oral Surgery for the following procedures:
 - surgical services related to a congenital malformation;
 - surgical removal of complete bony impacted teeth, unless covered by a Medical HMO plan;
 - excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth;
 - excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands, or ducts; reduction of dislocation, or excision of the temporomandibular joints.
4. Repair of natural teeth due to accidental injury.
5. Hospital and ancillary charges are not covered.
6. Any services, treatments or supplies included as an eligible benefit under any other Benefit Section of this booklet.
7. Any services, treatments or supplies included as an eligible benefit under other group hospital, medical and/or surgical coverage.

This summary of benefits is intended only to highlight benefits provided under the dental option of Chicago Transit Authority's Employee Health Benefit Plan and should not be relied upon to fully determine coverage. This plan may not cover all dental expenses.

PLAN ADMINISTERED BY:
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