DPPO Plan - Elite Preferred 510 (with ortho)

HUMANA CompBenefits

Chicago Park District Summary of Benefits

PPO True Group+ High – Ortho

Partial Listing of Covered Services	In-Network Reimbursements	Out-of-Network Reimbursements
Type I Diagnostic & Preventive Oral Examination (once per six months) Prophylaxis (cleaning, once per six months) Topical Fluoride (children under 16,once per 12 months) X-Rays (limitations may apply) Sealants (once per 3 years for children under age 16, for non carious molars only) Space Maintainers (for children under age 16)	**100%**	**80%***
Type II Basic Services Simple Restorative (amalgam, synthetic,or composite fillings) Emergency Palliative Treatment Tooth Extraction Endodontics (root canals) Periodontics (includes treatment of diseases of the gums)	**80%**	**60%***
Type III Major Services (0 month waiting period**) Major Restorative (crowns/inlays/onlays) Bridge, Denture Repair Prosthetics (bridges and dentures)	**60%**	**40%***
Type IV Orthodontics (Optional) (0 month waiting period**) Dependent children 18 years of age or younger	**50%**	**50%***
Maximum Benefits		**Insured Individual and Dependents Lifetime**
Lifetime		
Type I, II, III	Unlimited	Unlimited
Type IV	$1,000	$1,000
Calendar Year		
Type I, II, III	$1,500	$1,500
Type IV	$1,000	$1,000
Deductible* **		
Type I	None	None
Type II, III, IV	$50	$50

➢ QUICK CLAIMS TURNAROUND

Humana CompBenefits' state of the art claims center provides fast reimbursement of your claims.

➢ ACCESS TO INFORMATION

Our toll-free customer service number at 1-800-837-2341 has Customer Care Representatives who can provide the answers you need quickly and thoroughly.

➢ TOTAL FREEDOM OF CHOICE

The plan provides you with total freedom of choice by allowing you to use any licensed dentist for treatment. The plan reimburses a percentage of eligible expenses based on the plan you have chosen.

This brochure contains a brief description of the plan. A complete description of the coverage, including limitations on certain procedures, is found in the Schedule of Benefits and Certificate of Group Dental Insurance.

*Out-of-Network coverage based on usual, customary and reasonable fees.

***Maximum of 3 per family.

Major Restorative Limitations

The charges for Major Restorative services will be Covered Dental Expenses subject to the following:

1. the denture or partial denture must replace a Natural Tooth extracted while insured for Dental Benefits under this policy;
2. the fixed bridge (including a resin bonded fixed bridge) must replace a Natural Tooth extracted while insured for Dental Benefits under this policy;
3. the replacement of a partial denture, full denture, or fixed partial denture (including a resin bonded bridge), or the addition of teeth to a partial denture if: (a) replacement occurs at least five years after the initial date of insertion of the current full or partial denture or resin bonded bridge; (b) replacement occurs at least five years after the initial date of insertion of an existing implant or fixed bridge; (c) replacement prosthesis or the addition of a tooth to a partial denture is required by the necessary extraction of a Functioning Natural Tooth while insured for Dental Benefits under this policy; or (d) replacement is made necessary by a Covered Dental Injury to a partial denture, full denture, or fixed partial denture (including a resin bonded bridge) provided the replacement is completed within 12 months of the injury;
4. the replacement of crowns, cast restorations, inlays, onlays or other laboratory prepared restorations if: (a) replacement occurs at least five years after the initial date of insertion; and (b) they are not serviceable and cannot be restored to function;
5. the replacement of an existing partial denture with fixed bridgework, only if upgrading to fixed bridgework is essential to the correction of the person's dental condition; and
6. the replacement of teeth up to the normal complement of 32.

EXCLUSIONS

Benefits will not be paid for:

1. procedures which are not included in the Schedule of Benefits;which are not medically necessary; which do not have uniform professional endorsement; are experimental or investigational in nature; for which the patient has no legal obligation to pay; or for which a charge would not have been made in the absence of insurance;
2. any procedure, service, or supply which may not reasonably be expected to successfully correct the patient's dental condition for a period of at least three years, as determined by CompBenefits Insurance Company;
3. crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling;
4. appliances, inlays, cast restorations or other laboratory prepared restorations used primarily for the purpose of splinting;
5. any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension; the alteration or restoration of occlusion including occlusal adjustment, bite registration, or bite analysis;
6. pulp caps, adult fluoride treatments, athletic mouthguards;myofunctional therapy; infection control; precision or semi-precision attachments; denture duplication; oral hygiene instruction; separate charges for acid etch; broken appointments; treatment of jaw fractures; orthognathic surgery;completion of claim forms; exams required by third party;personal supplies (e.g. water pik, toothbrush, floss holder, etc.); or replacement of lost or stolen appliances;
7. charges for travel time; transportation costs; or professional advice given on the phone;
8 procedures performed by a Dentist who is a member of Your immediate family;
9. any charges, including ancillary charges, made by a hospital,ambulatory surgical center, or similar facility;
10. charges for treatment rendered: (a) in a clinic, dental or medical facility sponsored or maintained by the employer of any member of Your family; or (b) by an employee of the employer of any member of Your family;
11. any procedure, service or supply required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures;
12. charges for treatment performed outside of the United States other than for emergency treatment. Benefits for emergency treatment which is performed outside of the United States are limited to a maximum of $100 (US dollars) per year;
13. the care or treatment of an injury or sickness due to war or an act of war, declared or undeclared;
14. treatment for cosmetic purposes. Facings on crowns or bridge units on molar teeth will always be considered cosmetic;
15. any services or supplies which do not meet the standards set by the American Dental Association or which are not reasonably necessary, or customarily used, for dental care;
16. procedures that are a covered expense under any other medical plan (established by the employer) which provides group hospital, surgical, or medical benefits whether or not on an insured basis;
17. a sickness for which the patient can receive benefits under a workers' compensation act or similar law;
18. an injury that arises out of or in the course of a job or employment for pay or profit;
19. charges to the extent that they are more than the Prevailing Fee. If the amount of the Prevailing Fee for a service cannot be determined due to the unusual nature of the service, CompBenefits Insurance Company will determine the amount. CompBenefits Insurance Company will take into account: (a) the complexity involved; (b) the degree of professional skill required; and (c) other pertinent factors; or
20. orthodontic plan benefits for persons 19 years of age or older.

PREDETERMINATION

If Covered Dental Expenses for a procedure are expected to be more than $200 it is recommended that you send a Dental Treatment Plan in prior to beginning treatment, send preauthorization to CompBenefits, P.O. Box 8236 Chicago, IL 60680–8236. You and/or your dentist will be notified of the benefits payable based upon the Dental Treatment Plan.

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