

# COHO Plan 2012 Dental Benefit Summary

---

## Annual Deductibles

- INDIVIDUAL- \$50.00
- FAMILY- \$150.00

## Maximum Annual Benefit per Individual per year

- INDIVIDUAL - \$1500.00

- **Type I Benefit:** Preventive Dental Services. **No Deductible.**
- **Type II Benefit:** Basic Dental Services. 80% with \$50.00 Deductible. (Combined with Type III)
- **Type III Benefit:** Major Dental Services. 50% with \$50.00 Deductible. (Combined with Type II)
- **Type IV Benefit:** Orthodontic Services. 50% with **No Deductible** (patients under 19 years only)

## Late Entrant Penalties:

Members who **do not** enroll when they first become eligible will be considered late entrants, and are subject to the following limitations:

- Benefits for the first 12 months will be limited to Type I covered dental expenses and benefits.
- Benefits for the second 12 months will be limited to Types I and II covered dental expenses.
- Benefits after 24 months will be available for all Types of service.

The attached summary is a highlight of the most commonly used services of your COHO Benefits of CTSI plan (Dental). For more information on services not listed on the following pages, please refer to your Dental SPD which is available online at: [www.samhealth.org/Healthplans](http://www.samhealth.org/Healthplans) or call customer service at 800-832-4580.

The co insurance percentage shown in the charts on the following pages is the percentage the Plan will pay for allowable and or usual and customary amounts (after deductibles are satisfied). Coinsurance amounts vary by service.

## Maximum Annual Benefit per Individual per year = \$1,500.00

Preventive Care			Type I - Service	
Co Pay	Deductible	Co-Insurance	Type	Special Limitations
\$0	No	100%	Routine Oral Exam	1 every 6 months
\$0	No	100%	Full X-Ray Series or One Panorex	1 every 36 months
\$0	No	100%	Bite-Wing X-Rays	1 every 6 months
\$0	No	100%	Prophylaxis or Periodontal Cleaning	1 every 6 months
\$0	No	100%	Fluoride Treatments	1 every 6 months
\$0	No	100%	Sealants (Only covered for patients under 16 years of age)	1 every 36 months
\$0	No	100%	Palliative Treatment (emergency treatment at dental office for dental pain)	Emergency treatments only

Basic Care			Type II - Service	
Co Pay	Deductible	Co-Insurance	Type	Special Limitations
\$0	Yes	80%	Root Canal Therapy	N/A
\$0	Yes	80%	Scaling and Root Planing	One time per quadrant every 12 months
\$0	Yes	80%	Night Guard (for teeth grinding only)	N/A
\$0	Yes	80%	Repairing to Full or Partial Dentures, Bridges (only for repairs or adjustments)	12 months after initial insertion
\$0	Yes	80%	Relining Dentures	12 months after initial insertion. 1 time in 24 consecutive months.
\$0	Yes	80%	Tooth Extraction	N/A
\$0	Yes	80%	Tooth Restorations – Filings (amalgam and composite)	N/A

Major Care			Type III – Service	
Co Pay	Deductible	Co-Insurance	Type	Special Limitations
\$0	Yes	50%	Initial Full or Partial Dentures	Not covered if teeth are missing prior to effective date
\$0	Yes	50%	Initial Crowns	Covered only if the tooth cannot be restored by a filling or by other means. Not covered if placed for the purpose of periodontal splinting.
\$0	Yes	50%	Replacement Crowns, Dentures, or Bridges	(not covered if replacement is within 5 years of original)

Orthodontia Care			Type IV - Service	
Co Pay	Deductible	Co-Insurance	Type	Special Limitations
\$0	No	50%	Bands or appliance (not to exceed 30% of total benefit)	Lifetime Max of \$1,500.00
\$0	No	50%	Monthly adjustments paid on 3 month payment schedule	N/A