CHRISTUS Health Plan

CHP Gold Pediatric Dental Benefits provided by DentaQuest

Covered Benefits	
Copayments, Coinsurance & Deductibles	**Gold Plans:** $0 co-payment and 0% coinsurance for preventative care $10 co-payment and 30% coinsurance all other covered services $700 deductible per child up to a $1,400 maximum deductible for and major services
Diagnostic & Preventative	• Initial exam; Once every 6 months (twice a year) • Diagnostic tests: Covered-including emergency oral exams. • Cleanings (Prophylaxis); once every six (6) months. • Bitewing x-rays (intraoral or panoramic) every 60 months (5 years); additional bitewing every 12 months (1 year) • Routine cleaning, scaling and polishing of teeth; once every six (6) months. • Fluoride treatment Topical Fluoride - Varnish - 1 every 6 months, Topical application of fluoride (excluding prophylaxis) - 1 every 6 months. • Space maintainers required due to the premature loss of teeth; not for the replacement of primary or permanent anterior teeth. • Sealants on unrestored permanent molars. One per 60 months (5 years). • Palliative Treatment
Restorative Services and Other Basic Services	• Fillings of amalgam, Resin-based Composite • Crowns- Resin-Based Composite; One per 60 months (5 years) when medically necessary. • Simple extractions • Sedation • Nitrous Oxide • Behavior Management

Complex Dental Services	• Pulpotomy for primary teeth; only when periapical lesion is present • Anterior Root Canal Treatment; only when medically necessary • Posterior Root Canal: bicuspid and molar root canal therapy; when medically necessary • Apicoectomy • Periodontal scaling and root planing; one per 24 months when medically necessary • Gingivectomy or gingivoplasty; One per 36 months when medically necessary • Osseous Surgey; One per 36 months when medically necessary • Bone Grafts; One per 36 months when medically necessary • Guided Tissue Regeneration; One per 36 months when medically necessary. • Maxillary denture- Complete; One per 60 months when medically necessary • Mandibular denture- Complete; One per 60 months when medically necessary • Maxilalry- Partial dentures; One per 60 months when medical necessary • Mandibular- Partial dentures: One per 60 months when medical necessary • Adjustment and Repair of dentures; One per 60 months when medical necessary • Reline-Maxillary and Mandibular dentures; One per 60 months when medical necessary • Overdentures-Maxillary and Mandible; One per 60 months when medical necessary • Aveoloplasty; Once per life time • Excision of benign and malignant cyst or tumor • Treatment of jaw joint problems (TMJ)
Dental Network Reimbursement	
Dental Network	We negotiate rates with dentists and other health care providers to help save you money. We refer to these providers as "In-Network providers". These negotiated rates are our Plan allowance for network providers. If you use in-network dentists to obtain covered care, benefits are paid at the in-network level. You are responsible for covered charges up to our negotiated plan allowance. You are not responsible for the difference between the plan payment and the amount billed. Services received from a provider that is not in-network are not a Covered Benefit.
Exclusions	

Plan Limitations	**The following items are excluded from coverage:** • Experimental care procedures that have not been sanctioned by the American Dental Association, or for which no procedure codes have been established. • A service or procedure that is not described as a benefit in this Policy. • Services that are rendered due to the requirements of a third party, such as an employer or school. • Travel time and related expenses. • An illness or injury that we determine arose out of and in the course of your employment. • A service for which you are not required to pay, or for which you would not be required to pay if you did not have coverage under this Policy. • A method of treatment more costly than is customarily provided. Benefits will be based on the least costly method of treatment. • A separate fee for services rendered by interns, residents, fellows or dentists who are salaried employees of a hospital or other facility. • Appointments with your dentist that you fail to keep. • A service rendered by someone other than a licensed dentist or a hygienist who is employed by a licensed dentist. • Prescription drugs. • A service to treat disorders of the joints of the jaw (temporomandibular joints), except for covered medically necessary orthodontics for individuals under age 19. • Services that are meant primarily to change or to improve your appearance. • Transplants. • Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss. • Lab exams. • Duplicate dentures and bridges. • Services related to congenital anomalies unless otherwise covered. However, this exclusion does not apply to covered orthodontic services. • Dietary advice and instructions in dental hygiene including proper methods of tooth brushing, the use of dental floss, plaque control programs and caries susceptibility tests. • Service, supply or procedure to increase the height of teeth (increase vertical dimension) or restore occlusion. • Services, supplies or appliances to stabilize teeth when required due to periodontal disease such as periodontal splinting. • Tooth bleach. • Computerized tomography (CT) scans, surgical stents, surgical guides for implants. • Transitional implants. • Sinus lifts. • Treatment of dental implant failures including surgical debridement and bone grafts to repair implant. • Cone Beam Imaging and Cone Beam MRI procedures. • Topical medicament center. • Orthodontia.

Additional Information

DentaQuest – Member Services
(855) 343-7402
8am-5pm MST, Mon-Fri
Interactive Voice Recognition Available 24x7

CHRISTUS Health Plan
www.christushealthplans.com
844-282-3100
8 am – 8 pm Mountain Time