Your Dental Summary

Advantage Premier 2000 Dental

Delta Dental Premier Network

	In-Network	Out-of-Network
Calendar Year Common Deductible (per person)	$50	
Calendar Year Common Deductible (per family)	$75	
Calendar Year Maximum Benefit (per person)	$2,000	

Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and login at myProvidence.com

- In-network and out-of-network services accumulate together to meet the calendar year deductible and maximum benefit.
- To get the most out of your benefits, use in-network providers within the Dental Premier Network. View a list of network providers at ProvidenceHealthPlan.com/FindADentist.
- If you choose to go outside the network, you may be subject to billing for charges that are above Maximum Plan Allowance (MPA). Benefits for out-of-network services are based on these MPA charges.
- Limitations and exclusions apply. See your dental handbook for details.
- For customer service, including dental claims and Predetermination of Benefits, call 833-212-5035.

	Below is the amount you pay after you have met your calendar year deductible. In-Network	Out-of-Network
Diagnostic & Preventive Services		
Routine exams (1 per 6 months, including a comprehensive evaluation)	Covered in full ✓	Covered in full ✓
Bitewing X-rays (1 set per 12 months)	Covered in full ✓	Covered in full ✓
Full mouth or panoramic X-ray (1 every 5 years)	Covered in full ✓	Covered in full ✓
Cleanings (1 every 6 months)	Covered in full ✓	Covered in full ✓
Topical fluoride (1 every 6 months for under age 19; 1 every 6 months for age 19 and over if recent periodontal surgery or risk of decay)	Covered in full ✓	Covered in full ✓
Sealants (1 per tooth in a 5-year period limited to occlusal surfaces of permanent molars)	Covered in full ✓	Covered in full ✓
Space maintainers (once per space)	Covered in full ✓	Covered in full ✓
Basic Services		
Restorative fillings	20%	20%
Oral surgery extractions and other minor surgical procedures	20%	20%
Endodontics and Periodontics	20%	20%
Stainless steel crowns (once per lifetime for primary teeth; once per 24 months for permanent teeth)	20%	20%
Major Services		
Porcelain & Gold crowns (once service per tooth in a 7-year period)	50%	50%
Cast restorations (once per tooth in a 7-year period)	50%	50%
Denture and bridge work (construction or repair of fixed bridges, partials and complete dentures; limited to once in every 7 years; not covered under age 16)	50%	50%
Implants (once per lifetime per tooth space)	50%	50%
Athletic mouthguards (once every 12 months for under age 16 and once every 24 months for ages 16 and over)	50%	50%
Occlusal guard (nightguard) covered up to $200 every five years	Covered in full ✓	Covered in full ✓

✓ Deductible does not apply

The following services are excluded. Please refer to your member handbook for a complete explanation of limitations and exclusions.

- Anesthetics, analgesics, hypnosis and most medications, including nitrous oxide
- Charges above the maximum plan allowance
- Charting (including periodontal, gnathologic)
- Congenital or developmental malformations
- Cosmetic services
- Duplication and interpretation of X-rays or records
- Experimental or investigational treatment
- Hospital costs or other fees for facility or home care
- Instructions or training (including plaque control and oral hygiene or dietary instruction)
- Medications
- Orthodontia, unless your plan includes the orthodontia Supplemental Benefit (see section 4.5 of your handbook)
- Over-the-counter night guards and athletic mouth guards
- Rebuilding or maintaining chewing surfaces (misalignment or malocclusion) or stabilizing teeth
- Self-treatment
- Services or supplies available under any city, county, state or federal law, except Medicaid
- Translation or sign language services are not covered as separate charges
- Temporomandibular joint syndrome (TMJ)
- Treatment before coverage begins or after coverage ends
- Treatment not dentally necessary

✓ Deductible does not apply

Explanation of terms and phrases

Coinsurance – The percentage of the cost that you may need to pay for covered services.

Common Deductible – The dollar amount that an individual or family pays for covered in-network and out-of-network services before the plan pays any benefits within a calendar year. In-network and out-of-network services accumulate together to meet the calendar year deductible. The following expenses do not apply to the individual or family deductible: services not covered by the plan; fees that exceed Maximum Plan Allowance (MPA) charges as established by the plan; copays and coinsurance for services that do not apply to the deductible.

In-network – Refers to services received from an extensive network of highly qualified dentists and providers contracted by the Plan. Generally, your out-of-pocket costs will be less when you receive covered services from in-network providers.

Limitations and Exclusions – All covered services are subject to the limitations and exclusions specified for your plan. Refer to your member handbook or contract for a complete list.

Maximum Plan Allowance (MPA) - The maximum amount that the Plan will reimburse providers. The MPA is based on a PPO Fee Schedule or a contracted rate. When using an Out-of-Network Dentist who does not have contracted rates with our dental network provider, the Plan will reimburse the provider at the MPA, and any amount above the MPA is your responsibility.

Maximum Calendar Year Benefit – Total dollar amount of benefits that you can receive per calendar year.

Out-of-network – Refers to services you receive from dentists who have not contracted in the Delta Dental Premier network. Your out-of-pocket costs are generally higher when you receive covered services outside of your plan's network. To find an in-network provider, go to ProvidenceHealthPlan.com/FindAProvider.

Predetermination of Benefits – For expensive treatment plans, a predetermination service is available. The dentist may submit a predetermination request to get an estimate of what the Plan would pay. The predetermination will be processed according to the member's current policy and returned to the dentist. You and your dentist should review the information before beginning treatment.

Contact

Dental Customer Service: 833-212-5035
TTY:711

✓ Deductible does not apply

Your Dental Summary

Orthodontia

	In-Network	Out-of-Network
Lifetime Maximum Benefit (per person)	$1,500	

Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and login at myProvidence.com.

- In-network and out-of-network services accumulate together to meet the calendar year maximum benefit.
- This orthodontia rider supplements your dental plan.
- To get the most out of your benefits, use in-network providers within the same network as your dental plan. View a list of network providers at ProvidenceHealthPlan.com/FindADentist.
- Limitations and exclusions apply. See your dental handbook for details.
- For customer service, including dental claims and Predetermination of Benefits, call 833-212-5035.

	In-Network	Out-of-Network
Orthodontia	50%	

Explanation of terms and phrases

Coinsurance – The percentage of the cost that you may need to pay for covered services.

Dentally Necessary – Services that:

- Are established as necessary for the treatment or prevention of a dental injury or disease otherwise covered under the Plan.
- Are appropriate with regards to standards of good dental practice in the service area.
- Have a good prognosis.
- Are the least costly of the alternative supplies or levels of service that can be safely provided. For example, coverage would not be allowed for a crown when a filling would be adequate to restore the tooth appropriately.

In-network – Refers to services received from an extensive network of highly qualified dentists and providers contracted by the Plan. Generally, your out-of-pocket costs will be less when you receive covered services from in-network providers.

Limitations and Exclusions – All covered services are subject to the limitations and exclusions specified for your plan. Refer to your member handbook or contract for a complete list.

Lifetime Maximum Benefit – Total dollar amount of benefits that you can receive per lifetime.

Out-of-network – Refers to services you receive from dentists not in your plan's network. Your out-of-pocket costs are generally higher when you receive covered services outside of your plan's network. To find an in-network provider, go to ProvidenceHealthPlan.com/FindAProvider.

Predetermination of Benefits – For expensive treatment plans, a predetermination service is available. The dentist may submit a predetermination request to get an estimate of what the Plan would pay. The predetermination will be processed according to the member's current policy and returned to the dentist. You and your dentist should review the information before beginning treatment.

Contact

Dental Customer Service: 833-212-5035
TTY:711

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex.

Providence Health Plan and Providence Health Assurance:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, you can call us at 503-574-7500 or 1-800-878-4445 (TTY: 711).

If you believe that Providence Health Plan and Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158
Email: PHPAppealsandGrievances@providence.org

If you need help filing a grievance, call us at 503-574-7500 or 1-800-878-4445 (TTY:711) for assistance.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Members of Oregon Plans may file a complaint with the Division of Financial Regulation at 1-888-877-4894 or visit https://dfr.oregon.gov/Pages/index.aspx.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

Russian: ВНИМАНИЕ: Если Вы говорите по-русски, то Вам доступны услуги бесплатной языковой поддержки. Звоните 1-800-878-4445 (телетайп: 711).

Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-800-878-4445 (TTY: 711).

Traditional Chinese: 注意：如果您說中文，您可以免費獲得語言支援服務。請致電 1-800-878-4445 (TTY: 711)。

Kushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

Farsi:

توجه: اگر به زبان فارسی صحبت می‌کنید، تسهیلات زبانی به صورت رایگان به شما ارائه می‌شود. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

Ukrainian: УВАГА! Якщо Ви розмовляєте українською мовою, для Вас доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

Japanese: お知らせ: 日本語での通話をご希望の場合、言語支援サービスを無料でご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंले निम्न भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छन् । 1-800-878-4445 (TTY: 711) मा फोन गर्नुहोस् ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. Sunați 1-800-878-4445 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

Hmong: LUS CEEB TOOM: Yog tias koj hais lus Hmoob, cov kev pab txhais lus, muaj kev pab dawb rau koj. Hu rau 1-800-878-4445 (TTY: 711).

Cambodian: កំណត់សម្គាល់៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ
អាចមានសេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃពីលោកអ្នក។ សូមហៅទូរស័ព្ទលេខ 1-800-878-4445 (TTY: 711)។

Laotian: ຊືນຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ຈະມີການຊ່ວຍເຫຼືອດ້ານພາສາ
ໂດຍບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ 1-800-878-4445 (TTY: 711).