Your Dental Summary

Advantage Access 2000 Dental

Delta Dental PPO™ Network

	In-Network	Out-of-Network
Calendar Year Common Deductible (per person)	$25	
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 PPO 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 the 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 Dental 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 ✓	10% ✓
Bitewing X-rays (1 set per 12 months)	Covered in full ✓	10% ✓
Full mouth or panoramic X-ray (1 every 5 years)	Covered in full ✓	10% ✓
Cleanings (1 every 6 months)	Covered in full ✓	10% ✓
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 ✓	10% ✓
Sealants (once per tooth in a 5-year period limited to occlusal surfaces of permanent molars)	Covered in full ✓	10% ✓
Space maintainers (once per space)	Covered in full ✓	10% ✓
Basic Services		
Restorative fillings	20%	30%
Oral surgery extractions and other minor surgical procedures	20%	30%
Endodontics and Periodontics	20%	30%
Stainless steel crowns (once per lifetime for primary teeth; once per 24 months for permanent teeth)	20%	30%
Major Services		
Porcelain and Gold crowns (once 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 a 7-year period; 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. If you go to an Out-of-Network Dentist who has contracted rates with the Delta Dental Premier network, you will not be balanced billed for charges above the MPA. 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 PPO 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