Your Dental Summary

Advantage Premier 2000 Dental

Delta Dental Premier® 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 Delta 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 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.

✓ Deductible does not apply	Below is the amount you pay after you have met your calendar year Deductible In-Network	Out-of-Network
Diagnostic and Preventive Services		
Routine exams (2 every calendar year, including a comprehensive evaluation)	Covered in full ✓	Covered in full ✓
Bitewing X-rays (1 set every 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 (2 every calendar year)	Covered in full ✓	Covered in full ✓
Topical fluoride (2 every calendar year for under age 19; 1 every calendar year for age 19 and over if recent periodontal surgery or risk of decay)	Covered in full ✓	Covered in full ✓
Sealants (1 per tooth every 5 years; limited to unrestored occlusal surfaces of permanent molars)	Covered in full ✓	Covered in full ✓
Space maintainers (1 per quadrant)	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 (1 per tooth for lifetime of primary teeth; 1 per tooth every 24 months for permanent teeth)	20%	20%
Major Services		
Porcelain and gold crowns (1 per tooth in a 7-year period)	50%	50%
Cast restorations (1 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 every 7 years; not covered under age 16)	50%	50%

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✓ Deductible does not apply	Below is the amount you pay after you have met your calendar year Deductible In-Network	Out-of-Network
Major Services		
Implants (1 per lifetime per tooth space)	50%	50%
Athletic mouthguards (1 every 12 months for under age 16 and 1 every 24 months for ages 16 and over)	50%	50%
Occlusal guards (nightguard) covered up to $200 every 5 years	Covered in full ✓	Covered in full ✓

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, orthognathologic)
- 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
- 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

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 Service 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 Calendar Year Benefit – Total dollar amount of benefits that you can receive per Calendar Year

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 dental provider who has contracted rates with our dental network provider, you will not be balanced billed for charges above the MPA. When using an Out-of-Network dental provider 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.

Out-of-Network - Refers to services you receive from providers not in your plan's network. Your out-of-pocket costs are generally higher when you receive Covered Service outside of your plan's network. An Out-of-Network Provider does not have contracted rates with Providence Health Plan and so balance billing may apply. 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 us

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

ProvidenceHealthPlan.com/contactus

Non-Discrimination Statement

Discrimination is against the law. Providence Health Plan ("PHP") does not discriminate or treat people unfairly based on:

- Age
- Color
- Disability
- National origin
- Gender identity
- Language proficiency
- Race
- Sexual orientation
- Religion
- Sex
- Pregnancy

You have the following rights:

- To get free help from a qualified language interpreter.
- To get written information in the language you speak.
- To get information in a way you understand, including:
  - free help from a qualified sign language interpreter,
  - written information in large print, audio, Braille, or other formats, or
  - other reasonable modifications.

Contact the Civil Rights Coordinator at PHP if you:

- Need reasonable modifications, appropriate auxiliary aids and services, or language assistance services,
- Believe PHP failed to provide services and discriminated against you, or
- Want to file a grievance.

Please contact our Civil Rights Coordinator in one of these ways:

1) **You can call us.**
   Toll-Free: 1-800-878-4445 **Oregon: 1-503-574-7500**
   Hearing Impaired members may call our TTY line at 711.
2) **You can mail or email us.**
   Providence Health Plan Attn: Civil Rights Coordinator
   PO Box 4158 Portland, OR 97208-4158
   Email: PHPAppealsandGrievances@providence.org
3) **You also have a right to file a complaint with the following:**
   U.S. Department of Health and Human Services, Office for Civil Rights
   Web portal: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsfWA
   Email: OCRComplaint@hhs.gov
   Phone: 1-800-368-1019, 1-800-537-7697 (TTY: 711)
   Mail: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Bldg., Washington, DC 20201

   Oregon Division of Financial Regulation
   Web: https://dfr.oregon.gov/Pages/index.aspx
   Email: DFR.InsuranceHelp@dcbs.oregon.gov
   Phone: 1-888-877-4894

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 नि:शुल्क 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: កំណត់សម្គាល់ៈ បើសិនជាអ្នកនិយាយភាសាខ្មែរ អាចមានសេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃពីលោកអ្នក។ សូមហៅទូរស័ព្ទលេខ 1-800-878-4445 (TTY: 711)។

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