Your Dental Benefit Summary

Essential Dental

Calendar Year Common Maximum Benefit	Calendar Year Common Deductible	Waiting Period
In-Network: $1,000 per person Out-of-Network: $1,000 per person	In-Network: $50 per person $150 per family (3 or more) Out-of-Network: $50 per person $150 per family (3 or more)	None

Important information about your plan

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

- This benefit provides dental services for all enrolled family members.
- Your coinsurance does not apply to your medical plan deductible(s) or out-of-pocket maximum(s).
- Predetermination of Benefits for a proposed course of treatment is strongly recommended.
- To get the most out of your benefits, use in-network providers. View a list of network providers at www.ProvidenceHealthPlan.com/providerdirectory.
- If you choose to go outside the network, you may be subject to billing for charges that are above Maximum Allowable Cost (MAC). Benefits for out-of-network services are based on these MAC charges.
- Limitations and exclusions apply. See your Member Handbook for details.

Benefit Highlights ✓ No deductible needs to be met prior to receiving this benefit.	After you have paid your calendar year deductible, you pay the following for covered services In-Network	 Out-of-Network
Diagnostic & Preventive Care **These services do not apply to the calendar year maximum benefit**		
Routine Exams (2 per Calendar Year)	Covered in full ✓	10% ✓
Bitewing X-rays (2 per Calendar Year)	Covered in full ✓	10% ✓
Cleanings (2 per Calendar Year)	Covered in full ✓	10% ✓
Full mouth or Panoramic X-rays (1 per 60 months)	Covered in full ✓	10% ✓
Fluoride (1 per Calendar Year, age 16 and under)	Covered in full ✓	10% ✓
Sealants (1 per tooth per lifetime, age 16 and under. Limited to 1st and 2nd Molars)	Covered in full ✓	10% ✓
Space Maintainers	Covered in full ✓	10% ✓
Basic Care		
Restorative Fillings	20%	30%
Oral Surgery	20%	30%
Endodontics (Root Canals)	20%	30%
Periodontics	20%	30%
Major Restorative Care		
Crowns	50%	60%
Dentures	50%	60%
Bridges	50%	60%

CLASS I PREVENTIVE SERVICES

This Plan provides coverage for the preventive services listed below.

When those services are received from Network Dentists, coverage is provided in full. If you have coverage in full for these services under another Providence Health Plan medical or dental plan, this Plan will not duplicate that coverage.

If you receive these services from Out-of-Network Dentists, coverage is provided as shown in your benefit Summary.

- Two evaluations per Calendar Year including a maximum of one comprehensive evaluation per 36 months.
- One emergency or problem focused exam (D0140) per Calendar Year.
- Two prophylaxes (cleaning, scaling and polishing teeth) per Calendar Year.
- Bitewing x-rays, two per Calendar Year.
- Periapical x-rays.
- One full mouth or panoramic x-ray per 60 months.
- One topical fluoride per Calendar year, age 16 and under.
- One sealant per tooth per lifetime, age 16 and under (limited to permanent first and second molars).
- Space maintainers to preserve space between teeth for premature loss of primary tooth (does not include use for orthodontic treatment).
- Emergency palliative treatment (only if no services other than exam and x-rays were performed on the same date of service).

CLASS II BASIC SERVICES

Basic Services for all Members are listed below and covered as shown in the Benefit Summary.

- Simple extraction of teeth.
- Amalgam and composite fillings excluding posterior composites (anterior restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface. restorations), per tooth, per surface every 24 months.
- Pin retention of fillings (multiple pins on the same tooth are allowable as one pin).
- Antibiotic injections administered by a Dentist.
- Oral surgery, including postoperative care for:
    - Removal of teeth, including impacted teeth.
    - Extraction of tooth root.
    - Alveolectomy, alveoplasty, and frenectomy.
    - Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy.
    - Reimplantation or transplantation of a natural tooth.
    - Excision of a tumor or cyst and incision and drainage of an abscess or cyst.
- Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
    - Root canal therapy (not covered if pulp chamber was opened before effective date of coverage).
    - Pulpotomy.
    - Apicoectomy.
    - Retrograde fillings, per root per lifetime.
- Periodontic services, limited to:
    - Two periodontal maintenance visits, following surgery per Calendar Year (D4341 is not considered surgery).
    - One scaling and root planing per quadrant (D4341 or D4342) per 24 months from age 21.
    - Occlusal adjustment performed with covered surgery.
    - Gingivectomy.
    - Osseous surgery including flap entry and closure.
    - One pedicle or free soft tissue graft per site per lifetime.
    - One appliance (night guards) per five years within six months of osseous surgery.
    - One full mouth debridement per lifetime.

CLASS III MAJOR RESTORATIVE SERVICES

Major Restorative Services for all Members are listed below and covered as shown in the Benefit Summary.

- One study model per 36 months.
- Crown build-up for non-vital teeth.
- Recementing bridges, inlays, onlays and crowns after 12 months of insertion and per 12 months per tooth thereafter.
- One repair of dentures or fixed bridgework per 24 months.
- General anesthesia and analgesia, including intravenous sedation, in conjunction with covered oral surgery or periodontal surgery.
- Restoration services, limited to:
    - Cast metal, stainless steel, porcelain/ceramic, all ceramic and resin-based composite inlay, onlay or crown for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling.
    - Replacement of existing inlay, onlay, or crown, after seven years of the restoration initially placed or last replaced.
    - Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally.
    - Stainless steel crowns.
- Prosthetic services, limited to:
    - Initial placement of removable dentures or fixed bridges.
    - Replacement of removable dentures or fixed bridges that cannot be repaired after seven years from the date of last placement.
    - Addition of teeth to existing partial denture.
    - One relining or rebasing of existing removable dentures per 24 months (only after 24 **months from date of last placement, unless an immediate prosthesis replacing at least three teeth.**

EXCLUDED SERVICES

- All Class IV Orthodontic services.
- Services which are not necessary for the patient's dental health.
- Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
- Oral surgery requiring the setting of fractures and dislocations.
- Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
- Dispensing of drugs.
- Hospitalization for any dental procedure.
- Implant removal or the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
- Diagnosis or treatment of Temporomandibular Disorder (TMD) and/or occlusal disharmony.
- Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
- Implants and related services;
- Replacement of lost, stolen or damaged prosthetic or orthodontic appliances;
- Athletic mouthguards; precision or semi-precision attachments; denture duplication;
- Periodontal splinting of teeth.
- Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
- Procedures that in the opinion of the Plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the Member's condition.
- Treatment of cleft palate, malignancies or neoplasms.
- Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of Member's continuous coverage under the plan.

GENERAL EXCLUSIONS

We do not cover Services and supplies which:

- Are provided without charge or for which you would not be required to pay if you did not have this coverage;
- Are received before the Effective Date of Coverage;
- Are not listed as a Covered Service or relate to complications resulting from a Non-Covered Service;
- Are not furnished by a Qualified Dentist;
- Are provided by or payable under any plan or program established by a domestic or foreign government or political subdivision, unless such exclusion is prohibited by law;
- Are provided while you are confined in a Hospital or institution owned or operated by the United States Government or any of its agencies, except to the extent provided by 38 U. S. C. § 1729 as it relates to non-military Services provided at a Veterans Administration Hospital or facility;
- Are provided while you are in the custody of any law enforcement authorities or while incarcerated;
- Are self-administered, are prescribed by you for your own benefit, or are provided or prescribed by a person who resides in your home or is a member of your family. "Member of your family" for this purpose means any person who could possibly inherit from you under the intestate succession law of any state, plus any in-law, step relative, foster parent, or domestic partner of you or of any such person;
- Are provided for convenience, educational or vocational purposes including, but not limited to, videos and books, educational programs to which drivers are referred by the judicial system, and volunteer mutual support groups;
- Are performed in association with a Service that is not covered under this Plan;
- Are provided for any injury or illness that is sustained by any Member that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the Member. This exclusion also applies to injuries and illnesses that are the subject of a disputed claim settlement or claim disposition agreement under a Workers' Compensation Act or similar law. This exclusion does not apply to Members who are exempt under any Workers' Compensation Act or similar law;
- Are payable under any automobile medical, personal injury protection, automobile no-fault, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance makes benefits or Services available to you, whether or not you make application for such benefits or Services and whether or not you are refused payment for failure to satisfy any term of such coverage. If such coverage is required by law and you unlawfully fail to obtain it, benefits will be deemed to have been payable to the extent of that requirement. This exclusion also applies to charges applied to the deductible of such contract or insurance. Any benefits or Services provided under this Plan that are subject to this exclusion are provided solely to assist you and such assistance does not waive our right to reimbursement or subrogation as specified in section 5.3. This exclusion also applies to Services and supplies after you have received proceeds from a settlement as specified in section 5.3.3;
- Are provided for treatment or testing required by a third party or court of law which is not Dentally Necessary;
- Are Experimental/Investigational;
- Are determined by us not to be Dentally Necessary for diagnosis and treatment of a dental condition;
- Have not been Predetermined as required by this Plan;
- Relate to any condition sustained by a Member as a result of engagement in an illegal occupation or the commission or attempted commission of an assault or other illegal act by the Member, if such Member is convicted of a crime on account of such illegal engagement or act. For purposes of this exclusion, "illegal" means any engagement or act that would constitute a felony or misdemeanor punishable by up to a year's imprisonment under applicable law if such Member is convicted for the conduct. Nothing in this paragraph shall be construed to exclude Covered Services for a Member for injuries resulting from an act of domestic violence or a medical condition (i.e., a physical or mental health condition); and
- Relate to a civil revolution, riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.

We do not cover:

- Charges that are in excess of Maximum Allowable Costs (MAC);
- "Telephone visits" by a physician or "environment intervention" or "consultation" by telephone for which a charge is made to the patient;
- "Get acquainted" visits without physical assessment or diagnostic or therapeutic intervention provided and online treatment sessions;
- Missed appointments;
- Transportation or travel time, food, lodging accommodations and communication expenses;
- Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
- Any vitamins, dietary supplements, and other non-prescription supplements, except as required by federal or Oregon state law;
- Sales taxes, handling fees and similar surcharges, as explained in the definition of MAC.

Your guide to the words or phrases used to explain your benefits

Coinsurance
The percentage of the cost that you may need to pay for a covered service.

Deductible
The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. The deductible can be met by using in-network or out-of-network providers, or the combination of both. The following expenses do not apply to an individual or family deductible:

- Services not covered by your plan
- Fees that Maximum Allowable Cost (MAC) charges as established by your 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 made available to you by Providence Health Plan. Generally, your out-of-pocket costs will be less when you receive covered services from in-network providers.

Maximum calendar year benefit
The total dollar amount of benefits that you can receive, per calendar year.

Out-of-network
Refers to services you receive from a non-network provider. Your out-of-pocket costs are generally higher when you receive covered services from non-participating providers. To find a participating provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

Predetermination of Benefits
Predetermination of Benefits means a request to us, or our authorizing agent, by you or by your Dentist regarding a proposed course of treatment

Maximum Allowable Cost
A limitation on the billed charges as determined by Providence Health Plan or its authorizing agent by geographic area where the expenses are incurred and may not be less than the negotiated fee for the same service when provided by a Network Dental Provider.

MAC charges do not include sales taxes, handling fees and similar surcharges, and such taxes, fees and surcharges are not covered expenses.

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, 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, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide 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)
- Provide free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, 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

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 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*.

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).

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

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

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

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

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: (TTY: 711).

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

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

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

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می‌کنید، تسهیلات زبانی بصورت رایگان برای شما میباشد. با تماس 1-800-878-4445 (TTY: 711) می‌باشد.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)