

# Your Dental Benefit Summary

## Essential Access Plus

Calendar Year Common Maximum Benefit	Common Orthodontia Lifetime Maximum Benefit	Calendar Year Common Deductible	Waiting Period
\$1,000 per person	\$1,500 per person	\$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](http://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](http://www.ProvidenceHealthPlan.com/providerdirectory).
- If you choose to go outside the network, you may be subject to billing for charges that are above Usual, Customary and Reasonable charges (UCR). Benefits for out-of-network services are based on these UCR charges.
- Limitations and exclusions apply. See below or your Member Handbook for details.

#### Benefit Highlights

After you have paid your calendar year common deductible, you pay the following for covered services

✓ No deductible needs to be met prior to receiving this benefit.	In-Network	Out-of-Network
<b>Diagnostic &amp; Preventive Care</b>		
<b>These services do not apply to the calendar year maximum benefit</b>		
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 1 <sup>st</sup> and 2 <sup>nd</sup> Molars)	Covered in full ✓	10% ✓
Space Maintainers	Covered in full ✓	10% ✓
<b>Basic Care</b>		
Restorative Fillings	20%	30%
Oral Surgery	20%	30%
Endodontics (Root Canals)	20%	30%
Periodontics	20%	30%
<b>Major Restorative Care</b>		
Crowns	50%	50%
Dentures	50%	50%
Bridges	50%	50%
<b>Orthodontics</b>		
Adult	50%	50%
Children	50%	50%

## 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 in total per Calendar Year including a maximum of one comprehensive evaluation per 36 months and one limited oral evaluation per 12 months.
- 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.**
  - **Coronectomy, intentional partial tooth removal, one per lifetime.**
  - **Alveolectomy, alveoplasty, and frenectomy.**
  - **Excision of periocoronary gingiva, exostosis, or hyperplastic tissue, and excision of oral tissue for biopsy.**
  - **Tooth re-implantation and/or stabilization; tooth transplantation**
  - **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.**
  - **Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1110/D1120, limited to once per two years**
  - **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, one per 60 months.**
  - **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.**
  - **One scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure, per two years.**

### Class IV. Orthodontics:

- Diagnostic, active and retention treatment to include removable fixed appliance therapy and comprehensive therapy.

### EXCLUDED 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

### General Exclusions:

#### We do not cover Services and supplies which:

- Are not provided;
- 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 Usual, Customary and Reasonable (UCR) costs;
- “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 UCR.

**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 exceed usual, customary and reasonable UCR 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.

**Orthodontia lifetime maximum benefit**

The total dollar amount of benefits that you can receive, per lifetime, for covered orthodontia services.

**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](http://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

**Usual, Customary and Reasonable (UCR)**

Describes your plan's allowed charges for services that you receive from an out-of-network provider. When the cost of out-of-network services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums. See your Member Handbook.

**Waiting Period**

A period of time during which all specified treatments or services are excluded from coverage.

**Contact us**

Headquartered in Portland, our customer service professionals have been proudly serving our members since 1986.

Portland Metro Area: **503-574-7500**

All Other Areas: **800-878-4445**

TTY: **711**

Have questions about your benefits and want to contact us via email? Go to our website at:  
[www.ProvidenceHealthPlan.com/contactus](http://www.ProvidenceHealthPlan.com/contactus)