Your Dental Benefit Summary

Preventive Dental

Calendar Year Common Maximum Benefit	Calendar Year Common Deductible	Waiting Period
None	None	None

Important information about your plan

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

- This benefit provides Preventive services only.
- To get the most out of your benefits, use in-network providers within the Providence Dental Network. View a list of network providers at ProvidenceHealthPlan.com/findaprovider
- If you choose to go outside the network, you may be subject to billing for charges that are above Maximum Allowable Charge (MAC). Benefits for out-of-network services are based on these MAC charges.
- Limitations and exclusions apply. See below or your Member Handbook for details.

	In-Network	Out-of-Network
Diagnostic & Preventive Care		
Routine Exams (2 per Calendar Year)	Covered in full	Covered in full
Bitewing X-rays (2 per Calendar Year)	Covered in full	Covered in full
Cleanings (2 per Calendar Year)	Covered in full	Covered in full
Full mouth or Panoramic X-rays (1 per 60 months)	Covered in full	Covered in full
Fluoride (1 per Calendar Year, age 16 and under)	Covered in full	Covered in full
Sealants (1 per tooth per lifetime, age 16 and under. Limited to 1st and 2nd Molars)	Covered in full	Covered in full
Space Maintainers	Covered in full	Covered in full

CLASS I DIAGNOSSTIC & 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).
- One interim caries arresting medicament application per primary tooth is covered per lifetime.

CLASS II BASIC SERVICES: NOT COVERED

CLASS III MAJOR RESTORATIVE SERVICES: NOT COVERED

CLASS IV ORTHODONTICS: NOT COVERED

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

1. Additional preventive (routine) other than what is stated above.
2. Basic and Major dental services such as non-routine diagnostic x-ray, lab and examinations, fillings, crowns, dentures, oral hygiene instruction, nutritional and tobacco counseling, pre-diagnostic screening or assessments, endodontic, periodontic, oral surgery, implants, bridges and orthodontic care.
3. Services which are covered under worker's compensation or employer's liability laws.
4. Services which are not necessary for the patient's dental health.
5. All Class IV Orthodontic services
6. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
7. Oral surgery requiring the setting of fractures and dislocations.
8. Services with respect to malignancies, cysts or neoplasms, hereditary, mandibular prognathism or development malformations where such services should not be performed in a dental office.
9. Dispensing of drugs.
10. Hospitalization for any dental procedure.
11. Implant removal or the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
12. Diagnosis or treatment of Temporomandibular Disorder (TMD) and/or occlusal disharmony.
13. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
14. Services not listed as covered.
15. Implants and related services
16. Replacement of lost, stolen or damaged prosthetic or orthodontic appliances.
17. Athletic mouth guards; precision or semi-precision attachments; denture duplication
18. Periodontal splinting of teeth.
19. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations.
20. 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
21. Treatment of cleft palate, malignancies or neoplasms.
22. 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.

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.

Common 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 Maximum Allowable Charge (MAC) 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.

Maximum Allowable Charge (MAC)
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.

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 ProvidenceHealthPlan.com/findaprovider.

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**