

# Your Dental Summary

## Providence Essential Access Dental



	In-Network	Out-of-Network
Calendar Year Common Deductible (per person)		\$50
Calendar Year Common Deductible (per family)		\$150
Calendar Year Common Maximum Benefit (per person)		\$1,000
Waiting Periods	None	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)

- Diagnostic and preventive services do not apply toward the calendar year maximum benefit.
- In-network and out-of-network services accumulate together to meet the calendar year deductible
- View a list of network providers at [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory)
- To get the most out of your benefits, use the providers within the network.
- 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 your dental handbook for details.
- Predetermination of Benefits is required for the following services: Basic and Major Services, except restorative fillings.
- For customer service, including dental claims and predetermination of benefits, call 800-878-4445.

Below is the amount you pay after you have met your calendar year deductible

	In-Network	Out-of-Network
<b>Diagnostic &amp; Preventive Services</b>		
Routine Exams (2 every calendar year, including a maximum of one comprehensive evaluation per 3 years)	Covered in full✓	10%✓
Bitewing X-rays (2 every calendar year)	Covered in full✓	10%✓
Cleanings (2 every calendar year)	Covered in full✓	10%✓
One Full mouth or panoramic X-ray (every 5 years)	Covered in full✓	10%✓
One topical fluoride every calendar year, age 16 and under	Covered in full✓	10%✓
One sealant per tooth per lifetime, age 16 and under (limited to permanent 1st and 2nd molars)	Covered in full✓	10%✓
Space maintainers to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment)	Covered in full✓	10%✓
<b>Basic Services (for All Members)</b>		
Restorative fillings, 1 per tooth, per surface every 2 years	20%	30%
Oral surgery extractions and other minor surgical procedures	20%	30%
Endodontics and Periodontics	20%	30%
<b>Major Services</b>		
Crowns	50%	50%
Cast restorations	50%	50%
Denture and bridge work (construction or repair of fixed bridges, partials and complete dentures)	50%	50%
Orthodontics/Orthodontia	Not Covered	Not Covered

✓ Deductible does not apply

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

1. Services which are covered under worker's compensation or employer's liability laws.
2. Services which are not necessary for the patient's dental health.
3. All Class IV Orthodontic services
4. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
5. Oral surgery requiring the setting of fractures and dislocations.
6. 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.
7. Dispensing of drugs.
8. Hospitalization for any dental procedure.
9. Implant removal or the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
10. Diagnosis or treatment of Temporomandibular Disorder (TMD) and/or occlusal disharmony.
11. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
12. Services not listed as covered.
13. Implants and related services
14. Replacement of lost, stolen or damaged prosthetic or orthodontic appliances.
15. Athletic mouth guards; precision or semi-precision attachments; denture duplication
16. Periodontal splinting of teeth.
17. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
18. 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
19. Treatment of cleft palate, malignancies or neoplasms.
20. 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.

✓ 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 usual, customary and reasonable (UCR) 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 Calendar Year Benefit** – Total dollar amount of benefits that you can receive per calendar year

**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 services 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 [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory)

**Predetermination of benefits** – A request to us or our authorizing agent by you or by your Dentist regarding a proposed course of treatment. Predetermination review will determine if the proposed service is eligible as a Covered Service or if an individual is a Member at the time of the proposed service.

**Usual, Customary & 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

Portland Metro Area: 503-574-7500

All other areas: 800-878-4445

TTY:711

[www.ProvidenceHealthPlan.com/contactus](http://www.ProvidenceHealthPlan.com/contactus)

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.

## Language Access Services

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).

✓ Deductible does not apply