

# Your Dental Summary

## Preventive Dental



	In-Network	Out-of-Network
Calendar Year Deductible (per person)		Not Applicable
Calendar Year Deductible (per family)		Not Applicable
Calendar Year Maximum Benefit (per person)		Not Applicable
Waiting Periods		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](http://myProvidence.com).

- This Plan provides Preventive Services only
- View a list of in-network providers at [ProvidenceHealthPlan.com/findaprovider](http://ProvidenceHealthPlan.com/findaprovider).
- 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 Maximum Allowable Charge (MAC). Benefits for Out-of-Network services are based on these MAC charges.
- Limitations and exclusions apply. See your dental handbook for details.
- 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

<b>✓ Deductible does not apply</b>	In-Network	Out-of-Network
<b>Diagnostic &amp; Preventive Services</b>		
Routine Exams (2 per calendar year, including a maximum of 1 comprehensive evaluation every 3 years)	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*
One full mouth or panoramic X-ray (every 5 years)	Covered in full	Covered in full*
One topical fluoride per calendar year, age 16 and under	Covered in full	Covered in full*
One sealant per tooth per lifetime, age 16 and under (limited to permanent 1st and 2nd molars)	Covered in full	Covered in full*
Space maintainers to preserve space between teeth for premature loss of a primary tooth (does not include use for orthodontic treatment)	Covered in full	Covered in full*

\*Out-of-Network services may be subject to charges above MAC

## **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.

Not covered

Not covered\*

- Two evaluations in total per calendar year including a maximum of 1 comprehensive evaluation per every 3 years and 2 limited oral evaluations per calendar year.
- Two prophylaxes (cleaning, scaling and polishing teeth) per Calendar Year.
- Bitewing x-rays, 2 per calendar year.
- Periapical x-rays.
- One full mouth or panoramic x-ray per every 5 years..
- 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).
- One interim caries arresting medicament application per primary tooth is covered per lifetime.
- 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: 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, congenital, 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 and/or congenital conditions.
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.

## 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 Allowable Cost (MAC) 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 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.

**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 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](http://ProvidenceHealthPlan.com/findaprovider).

**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.

**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

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