Your Dental Summary

Individual & Family Dental

Delta Dental PPO Network

Deductible and Maximum Benefit	
Calendar Year Deductible (per person)	$0
Calendar Year Deductible (per family)	$0
Calendar Year Maximum Benefit (per person)	$1,000

Important information about your plan

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

- View a list of network providers at ProvidenceHealthPlan.com/FindADentist
- For members without 12 continuous months of prior dental coverage, there is a 6-month exclusion period for Basic Services and a 12-month exclusion period for Major Services.
- Limitations and exclusions apply. See your dental handbook for details.
- For Dental customer service, including dental claims and Predetermination of Benefits, call 833-212-5035.

Diagnostic & Preventive Services	In Network Only
Routine exams (1 per 6 months, including a comprehensive evaluation)	Covered in full
Bitewing X-rays (1 set per 12 months)	Covered in full
Full mouth or panoramic X-ray (1 every 5 years)	Covered in full
Cleanings (1 per 6 months)	Covered in full
Topical fluoride (1 per 6 months for under age 19; 1 every 12 months for age 19 and over if recent periodontal surgery or risk of decay)	Covered in full
Sealants (1 per tooth in a 5-year period limited to occlusal surfaces of permanent molars)	Covered in full
Basic Services	
Restorative fillings	30%
Space maintainers (once per space)	30%
Major Services	
Oral surgery extractions and other minor surgical procedures	50%
Endodontics and Periodontics	50%
Stainless steel crowns (once per lifetime for primary teeth; once per 24 months for permanent teeth)	50%
Porcelain and Gold crowns (once per tooth in a 7-year period)	50%
Cast restorations (once per tooth in a 7-year period)	50%
Denture and bridge work (construction or repair of fixed bridges, partials and complete dentures; limited to once every 7 years; not covered under age 16)	50%
Athletic mouthguards (once every 12 months for under age 16 and once every 24 months for ages 16 and over)	50%
Occlusal guard (nightguard) covered up to $200 every 5 years	50%

✓ Deductible does not apply

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

- Services provided out-of-network except for a problem focused exam or palliative care in the case of a dental emergency
- Anesthetics, analgesics, hypnosis and most medications, including nitrous oxide
- Charges above the maximum plan allowance
- Charting (including periodontal, gnathologic)
- Congenital or developmental malformations
- Cosmetic services
- Duplication and interpretation of X-rays or records
- Experimental or investigational treatment
- Hospital costs or other fees for facility or home care
- Implants
- Instructions or training (including plaque control and oral hygiene or dietary instruction)
- Medications
- Orthodontia
- Over-the-counter night guards and athletic mouth guards
- Rebuilding or maintaining chewing surfaces (misalignment or malocclusion) or stabilizing teeth
- Self-treatment
- Services or supplies available under any city, county, state or federal law, except Medicaid
- Translation or sign language services are not covered as separate charges
- Temporomandibular joint syndrome (TMJ)
- Treatment before coverage begins or after coverage ends
- Treatment not dentally necessary

Explanation of terms and phrases

Coinsurance – The percentage of the cost that you may need to pay for covered services.

Deductible – The dollar amount that an individual or family pays for covered in-network services before the plan pays any benefits within a calendar year. The following expenses do not apply to the individual or family deductible: services not covered by the plan and 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.

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.

Predetermination of Benefits – For expensive treatment plans, a predetermination service is available. The dentist may submit a predetermination request to get an estimate of what the Plan would pay. The predetermination will be processed according to the member's current policy and returned to the dentist. You and your dentist should review the information before beginning treatment.

Contact

Dental Customer Service: 833-212-5035
TTY:711

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