

# Highlights of your Dental Coverage

**Effective Date: 01/01/2022**

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

DENTAL PLAN	PREMERA PREFERRED CHOICE: DENTAL PREFERENCE FLEX - \$1,000 MAXIMUM	
	IN-NETWORK	OUT-OF-NETWORK
<b>Dental Cost Share</b>		
<b>Individual Deductible</b>	\$50	Shared with In Network
<b>Family Deductible</b>	\$150	Shared with In Network
<b>Preventive Cost Share</b>	Covered in Full	Waive Deductible, then 20%
<b>Basic Cost Share</b>	Deductible, then 20%	Deductible, then 40%
<b>Major Cost Share</b>	Deductible, then 50%	Deductible, then 60%
<b>Dental Annual Maximum</b>	\$1,000 PCY	Shared with In Network
<b>Office Visit</b>		
<b>Routine Comprehensive / Periodic Oral Exams (2 PCY)</b>	Covered in Full	Waive Deductible, then 20%
<b>Problem Focused/Emergency Exam (Unlimited)</b>	Deductible, then 20%	Deductible, then 40%
<b>Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine))</b>	Covered in Full	Waive Deductible, then 20%
<b>Preventive Services</b>		
<b>Prophylaxis - Cleaning (2 PCY)</b>	Covered in Full	Waive Deductible, then 20%
<b>Fluoride Treatments (2 PCY; under the age of 19)</b>	Covered in Full	Waive Deductible, then 20%
<b>Sealants (Under age 19 limited to permanent molars only. Replacements limited to once every 24 consecutive months.)</b>	Covered in Full	Waive Deductible, then 20%
<b>Space Maintainers (Members under age 19)</b>	Deductible, then 20%	Deductible, then 40%
<b>Diagnostic Imaging</b>		
<b>Bitewings X-rays (1 set (up to 4) PCY)</b>	Covered in Full	Waive Deductible, then 20%
<b>Panoramic X-ray or comparable Conebeam view (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)</b>	Covered in Full	Waive Deductible, then 20%
<b>Restorative</b>		
<b>Fillings (1 per surface every 24 consecutive months)</b>	Deductible, then 20%	Deductible, then 40%
<b>Installation of Inlays, Onlays and Crowns (1 every 5 calendar years)</b>	Deductible, then 50%	Deductible, then 60%

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	IN-NETWORK	OUT-OF-NETWORK
<b>Re-cement or Rebond Crowns/Inlay/Onlay</b> (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 40%
<b>Repair Crown/Inlay/Onlay</b> (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 40%
<b>Endodontics</b>		
<b>Endodontic Therapy - Root Canal</b> (Once per tooth every 24 consecutive months)	Deductible, then 20%	Deductible, then 40%
<b>Periodontics</b>		
<b>Periodontal Maintenance</b> (4 PCY)	Deductible, then 20%	Deductible, then 40%
<b>Full Mouth Debridement</b> (Once every 36 consecutive months)	Deductible, then 20%	Deductible, then 40%
<b>Periodontal Scaling and Root Planing</b> (Once per quadrant every 24 consecutive months)	Deductible, then 20%	Deductible, then 40%
<b>Periodontal Surgery</b> (Once per quadrant every 36 consecutive months)	Deductible, then 20%	Deductible, then 40%
<b>Periodontal Soft Tissue Grafts</b> (Once per quadrant every 36 consecutive months)	Deductible, then 20%	Deductible, then 40%
<b>Prosthodontics (Dentures/Bridges)</b>		
<b>Installation or Replacement of Dentures, Partials and Fixed Bridges</b> (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 60%
<b>Repair or Re-cement Bridgework and Dentures</b> (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 40%
<b>Implant Services</b>		
<b>Implant Crowns/Bridge/Denture</b> (1 every 5 calendar years for surgical implants, implant abutments, and/or implant prosthetics)	Deductible, then 50%	Deductible, then 60%
<b>Oral Surgery</b>		
<b>Simple Extractions</b>	Deductible, then 20%	Deductible, then 40%
<b>Surgical Extractions</b> (Unlimited)	Deductible, then 20%	Deductible, then 40%
<b>Oral Surgery</b> (Unlimited)	Deductible, then 50%	Deductible, then 60%
<b>General Services</b>		
<b>Anesthesia - Intravenous or General</b>	Deductible, then 50%	Deductible, then 60%
<b>Palliative (Emergency) Treatment of Dental Pain</b>	Deductible, then 20%	Deductible, then 40%

*This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms under which the program may be continued in force. This benefit highlight is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.*

### Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email [AppealsDepartmentInquiries@Premera.com](mailto:AppealsDepartmentInquiries@Premera.com). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>.

### Language Assistance

- ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).
- 注意:** 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471 (TTY: 711)。
- CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).
- 주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.
- ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).
- PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).
- УВАГА!** Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-722-1471 (телетайп: 711).
- ប្រយ័ត្ន:** បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល្អ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។
- 注意事項:** 日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471 (TTY:711) まで、お電話にてご連絡ください。
- ማስታወሻ:** የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711)።
- XIYYEEFFANNA:** Afaan dubbattu Oroomiffa, tajaajjila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).  
*ملحوظة:* إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).
- ਧਿਆਨ ਦਿਓ:** ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।
- ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).
- ໂປດຊາບ:** ຖ້າວ່າ ທ່ານວ່າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ຄ່າສິ່ງຄ່າ, ຄວນມີພ້ອມໃຫ້ທ່ານ. ໂທ 800-722-1471 (TTY: 711).
- ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).
- ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).
- UWAGA:** Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).
- ATENÇÃO:** Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).
- ATTENZIONE:** In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).
- توجه:** اگر بہ زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.