PREMERA | BLUE CROSS

Highlights of your Dental Coverage

Effective Date: 01/01/2023

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

DENTAL PLAN	PREFERRED CHOICE - ESSENTIALS DENTAL 20%/40%/50%/1000	
	IN-NETWORK	**OUT-OF-NETWORK**
Dental Cost Share		
Individual Deductible	$50	Shared with In Network
Family Deductible	$150	Shared with In Network
Preventive Cost Share	Deductible, then 20%	Deductible, then 30%
Basic Cost Share	Deductible, then 40%	Deductible, then 50%
Major Cost Share	Deductible, then 50%	Deductible, then 50%
Dental Annual Maximum	$1,000 PCY	Shared with In Network
Office Visit		
Routine Comprehensive / Periodic Oral Exams (2 PCY)	Deductible, then 20%	Deductible, then 30%
Problem Focused/Emergency Exam (Unlimited)	Deductible, then 40%	Deductible, then 50%
Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine)	Deductible, then 20%	Deductible, then 30%
Preventive Services		
Prophylaxis - Cleaning (2 PCY)	Deductible, then 20%	Deductible, then 30%
Fluoride Treatments (1 PCY; under the age of 19)	Deductible, then 20%	Deductible, then 30%
Sealants (Under age 19 limited to permanent molars only, Replacements limited to once every 24 consecutive months)	Deductible, then 20%	Deductible, then 30%
Space Maintainers (Members under age 19)	Deductible, then 20%	Deductible, then 30%
Diagnostic Imaging		
Bitewings X-rays (1 set (up to 4) PCY)	Deductible, then 20%	Deductible, then 30%
Panoramic X-ray or comparable Conebeam view (1 panoramic x-ray or comparable cone beam view in any 60 consecutive months)	Deductible, then 40%	Deductible, then 50%
Restorative		
Fillings (1 per surface every 24 consecutive months)	Deductible, then 40%	Deductible, then 50%

Premera Blue Cross is an Independent Licensee of the Blue Cross Blue Shield Association

059724 (08-01-2022)

Highlights of your Dental Coverage

Effective Date: 01/01/2023

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

DENTAL PLAN	**PREFERRED CHOICE - ESSENTIALS DENTAL 20%/40%/50%/1000**	
	IN-NETWORK	**OUT-OF-NETWORK**
Installation of Inlays, Onlays and Crowns (Crowns only - 1 every 5 calendar years)	Crowns only - Deductible, then 50%, all other services not covered	Crowns only - Deductible, then 50%, all other services not covered
Re-cement or Rebond Crowns/Inlay/Onlay (Crowns only - 1 every 24 months, 6 months after placement)	Crowns only - Deductible, then 40%, all other services not covered	Crowns only - Deductible, then 50%, all other services not covered
Repair Crown/Inlay/Onlay (Crowns only - 1 every 24 months, 6 months after placement)	Crowns only - Deductible, then 40%, all other services not covered	Crowns only - Deductible, then 50%, all other services not covered
Endodontics		
Endodontic Therapy - Root Canal (Root Canal Therapy - Once per lifetime)	Deductible, then 40%	Deductible, then 50%
Periodontics		
Periodontal Maintenance (4 PCY)	Deductible, then 40%	Deductible, then 50%
Full Mouth Debridement (Once per lifetime)	Deductible, then 40%	Deductible, then 50%
Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)	Deductible, then 40%	Deductible, then 50%
Oral Surgery		
Simple Extractions (Unlimited)	Deductible, then 40%	Deductible, then 50%
Surgical Extractions (Unlimited)	Deductible, then 40%	Deductible, then 50%
General Services		
Anesthesia - Intravenous or General	Deductible, then 40%	Deductible, then 50%
Palliative (Emergency) Treatment of Dental Pain	Deductible, then 40%	Deductible, then 50%

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms of the plan.This benefit highlight is not a contract and may change. Please see your benefit booklet or call Customer Service for full coverage information including a description of waiting periods, limitations, and exclusions.

Premera Blue Cross is an Independent Licensee of the Blue Cross Blue Shield Association

PREMERA | BLUE CROSS

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. 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 ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ 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 ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila 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 ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 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 به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.