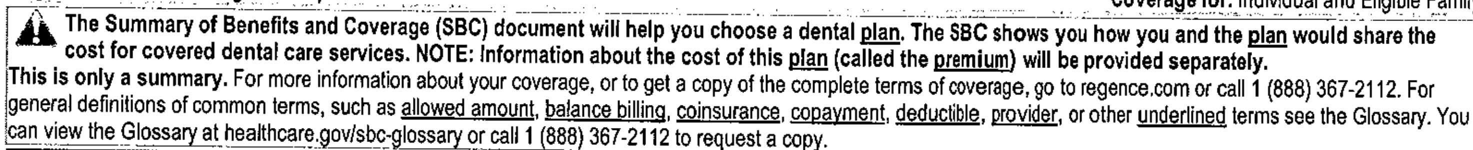
Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Regence BlueShield: Regence Expressions℠

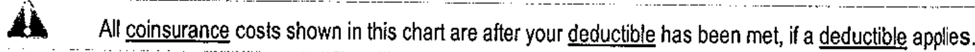
Coverage Period: 12/1/2020 – 11/30/2021
Coverage for: Individual and Eligible Family



The Summary of Benefits and Coverage (SBC) document will help you choose a dental plan. The SBC shows you how you and the plan would share the cost for covered dental care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to regence.com or call 1 (888) 367-2112. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1 (888) 367-2112 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$50 individual / $150 family per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive dental services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Not applicable.	You don't have to meet deductibles for specific services, but see the chart below for other costs for services this plan covers.
Is there an overall annual limit on what the plan pays?	Yes. $1,000 / individual per calendar year.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart below describes *specific* coverage limits.
What is not included in the out-of-pocket limit?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See regence.com/go/WW/RegenceDental or call 1 (888) 367-2112 for a list of network providers.	This plan uses a participating dental provider network. You pay less if you use a participating dental provider. You will pay the most if you use a nonparticipating dental provider, and you might receive a bill from a nonparticipating dental provider for the difference between the provider's charge and what your plan pays (balance billing).
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



All coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Dental Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Nonparticipating Provider (You will pay the most)	
If you have preventive dental services	Cleanings and examinations	No charge	No charge	Limited to 2 cleanings and 2 preventive oral examinations / year.
	X-rays	No charge	No charge	Limited to 2 bitewing x-ray sets / year. Limited to 1 complete intra-oral mouth and 1 panoramic mouth x-rays once in a 3-year period.
	Other preventive dental services	No charge	No charge	Limited to individuals under age 18 for sealants (permanent bicuspids and molars only), individuals under age 12 for space maintainers, and individuals under age 18 and limited to 2 treatments / year for topical fluoride application.
If you need basic dental services	Periodontal services	20% coinsurance	20% coinsurance	Limited to 2 periodontal maintenance / year (in lieu of preventive cleanings). Limited to 1 periodontal debridement in a 3-year period. Limited to 1 per quadrant in a 2-year period for periodontal scaling and root planing.
	Endodontic services	20% coinsurance	20% coinsurance	None
	Emergency and other basic dental services	20% coinsurance	20% coinsurance	None
If you need major dental services	Bridges	50% coinsurance	50% coinsurance	Limited to replacement bridges once per 7 years after placement.
	Crowns, inlays and onlays	50% coinsurance	50% coinsurance	Limited to replacement crowns, inlays or onlays once per tooth, 7 years after placement.
	Dentures (full and partial)	50% coinsurance	50% coinsurance	Limited to replacement dentures 7 years after placement.
	Implants (endosteal)	50% coinsurance	50% coinsurance	Limited to 4 endosteal implants / lifetime.

Common Dental Event	Services You May Need	What You Will Pay: Participating Provider (You will pay the least)	What You Will Pay: Nonparticipating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need TMJ services	Temporomandibular joint (TMJ) disorder services	Coverage is based on type of dental service provided.	Coverage is based on type of dental service provided.	Limited to $1,000 / year.

Excluded Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Aesthetic dental procedures
- Cosmetic/reconstructive services and supplies, except congenital anomalies
- Duplicate x-rays
- Facility charges
- Gold-foil restorations
- Implants (non-endosteal)
- Nitrous oxide
- Occlusal treatment
- Orthodontic services
- Orthognathic surgery
- Tooth transplantation
- Veneers