Regence Expressions℠

Effective December 1, 2022 through November 30, 2023

Regence

Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the Blue Cross and Blue Shield Association

This plan includes preventive and diagnostic services, as well as restorative and major services. After satisfaction of the deductible, this plan will provide payment for the services at the percentages listed below up to the Calendar Year maximum. Payment of benefits is based on a percentage of the Allowed Amount. Participating providers have agreed to accept the Allowed Amounts as payment for services. Services of a Nonparticipating provider are based on a percentage of the Allowed Amount. The Member will be responsible for any additional charges over the Allowed Amount.

Cost Share Details		Participating	Nonparticipating
Annual Deductible	The total deductible you pay per calendar year	$50 Individual $150 Family	
Annual Limit	The combined total for your deductible, coinsurance and copays per calendar year	$1,000 Individual	

Preventive and Diagnostic Dental Services (unless stated otherwise, a deductible applies)		What You Pay
Cleanings and Examinations	Cleanings - 2 per calendar year with a 3rd being covered with qualifying diagnosis Preventive oral examinations - 2 per calendar year	Covered in full
X-rays	Bitewing x-rays - 2 sets per calendar year Complete intra-oral mouth x-ray - Once in a 3-year period Panoramic mouth x-ray - Once in a 3-year period	Covered in full
Other Preventive Dental Services	Sealants (permanent bicuspids and molars only) for members under 18 years of age Space maintainers for members under 12 years of age Topical fluoride application - 2 per calendar year for members under 18 years of age	Covered in full

Basic Dental Services (unless stated otherwise, a deductible applies)		What You Pay
Complex Oral Surgery	Including surgical extraction of teeth	20%
Emergency and Other Basic Dental Services	Emergency treatment for pain relief	20%
Endodontic Services	Services including root canal treatment, pulpotomy and apicoectomy	20%
Periodontal Services	Periodontal maintenance - 2 per calendar year (in lieu of preventive cleanings) with a 3rd being covered with qualifying diagnosis Debridement - Once in a 3-year period Scaling and root planing - 1 in a 2 year period per quadrant	20%

Major Dental Services (unless stated otherwise, a deductible applies)		What You Pay
Bridges (fixed partial dentures)	Replacement once per 7 years after placement	50%
Crowns, Inlays and Onlays	Replacement once (per tooth) 7 years after placement	50%
Dentures (full and partial)	Replacement 7 years after placement	50%
Implants (endosteal)	4 implants per lifetime	50%

Temporomandibular Joint (TMJ) Disorders		What You Pay
Temporomandibular Joint (TMJ) Disorders	$1,000 per calendar year	Coverage is based on type of service provided (see Preventive, Basic, and Major Dental Services above)

This benefit summary provides a brief description of your plan benefits, limitations and/or exclusions under your plan and is not a guarantee of payment. Once enrolled, you can view your benefits booklet online at regence.com. **PLEASE REFER TO YOUR BENEFITS BOOKLET OR SUMMARY PLAN DESCRIPTION FOR A COMPLETE LIST OF BENEFITS, THE LIMITATIONS AND/OR EXCLUSIONS THAT APPLY, AND A DEFINITION OF MEDICAL NECESSITY**. Regence is providing this benefit summary for illustrative purposes only. Regence makes no warranties or representations regarding compliance with applicable federal, state, or local laws, or the accuracy of the benefit summary. This document is not the legally required Summary of Benefits and Coverage that an employer is required to provide to employees and members under Federal law, and the group must provide a legally compliant Summary of Benefits and Coverage to its employees and members.

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