Highlights of your Dental Coverage

Law Enforcement Officers and Firefighters Health and Welfare Trust

Group Number: 4000190

Effective Date: 01/01/2021

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

DENTAL PLAN	DENTAL PLAN 3 $25/$75 0%/0%/50% $2,500**	
	IN-NETWORK	OUT-OF-NETWORK
Dental Cost Share		
Individual Deductible	$25	Shared with In Network
Family Deductible	$75	Shared with In Network
Preventive Cost Share	Covered in Full	Covered in Full
Basic Cost Share	Deductible, then Covered in Full	Deductible, then Covered in Full
Major Cost Share	Deductible, then 50%	Deductible, then 50%
Dental Annual Maximum	$2,500 PCY applies to basic and major services	Shared with In Network
Benefit Enhancement Rider		
Benefit Enhancement Rider	Endodontics & Periodontal Treatment (In Basic)	Endodontics & Periodontal Treatment (In Basic)
Office Visit		
Routine Comprehensive / Periodic Oral Exams (2 PCY)	Preventive Cost Share	Preventive Cost Share
Limited Problem Focused (Emergency Exams) (Unlimited)	Preventive Cost Share	Preventive Cost Share
Non Routine Exams (Non Emergency) (2 PCY)	Preventive Cost Share	Preventive Cost Share
Preventive Services		
Prophylaxis - Cleaning (2 PCY)	Preventive Cost Share	Preventive Cost Share
Fluoride Treatments (2 PCY; under the age of 19)	Preventive Cost Share	Preventive Cost Share
Sealants (Under age 19 limited to permanent first and second molars only. Replacements limited to once every 2 calendar years.)	Preventive Cost Share	Preventive Cost Share
Space Maintainers (Members under age 19)	Preventive Cost Share	Preventive Cost Share
Diagnostic Imaging		
Bitewings X-rays (Unlimited)	Preventive Cost Share	Preventive Cost Share
Panoramic X-ray or comparable Conebeam view (1 complete series, 1 panoramic or 1 cone beam view in any 36 consecutive months)	Preventive Cost Share	Preventive Cost Share
Restorative		
Fillings (1 per surface every 24 consecutive months)	Basic Cost Share	Basic Cost Share
Installation of Inlays, Onlays and Crowns (1 every 5 calendar years)	Major Cost Share	Major Cost Share

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DENTAL PLAN	DENTAL PLAN 3 $25/$75 0%/0%/50% $2,500**	
	IN-NETWORK	OUT-OF-NETWORK
Re-cement or Rebond Crowns/Inlay/Onlay (Unlimited)	Basic Cost Share	Basic Cost Share
Repair Crown/Inlay/Onlay (Unlimited)	Basic Cost Share	Basic Cost Share
Endodontics		
Endodontic Therapy - Root Canal (Unlimited)	See Benefit Enhancement Rider	See Benefit Enhancement Rider
Endodontic Retreatment - Root Canal (Unlimited)	See Benefit Enhancement Rider	See Benefit Enhancement Rider
Periodontics		
Periodontal Maintenance (4 PCY)	Basic Cost Share	Basic Cost Share
Full Mouth Debridement (Unlimited)	Basic Cost Share	Basic Cost Share
Periodontal Scaling and Root Planing (Once per quadrant every 2 calendar years)	Basic Cost Share	Basic Cost Share
Periodontal Surgery (Unlimited)	See Benefit Enhancement Rider	See Benefit Enhancement Rider
Prosthodontics (Dentures/Bridges)		
Installation or Replacement of Dentures, Partials and Fixed Bridges (1 every 5 calendar years)	Major Cost Share	Major Cost Share
Repair or Re-cement Bridgework and Dentures (Unlimited)	Major Cost Share	Major Cost Share
Implant Services		
Implant Crowns/Bridge/Denture (1 every 5 calendar years for surgical implants, implant abutments, and/or implant prosthetics)	Major Cost Share	Major Cost Share
Oral Surgery		
Simple Extractions	Basic Cost Share	Basic Cost Share
Surgical Extractions (Unlimited)	Basic Cost Share	Basic Cost Share
Oral Surgery (Unlimited)	Basic Cost Share	Basic Cost Share
General Services		
Anesthesia - Intravenous or General	Basic Cost Share	Basic Cost Share
Palliative (Emergency) Treatment of Dental Pain	Basic Cost Share	Basic Cost Share

Annual deductible waived for Diagnostic/Preventive services

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross. Members are responsible for amounts in excess of the allowable charge.

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 civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. 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, or sex, 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.

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 ኣማርኛ 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, ໂດຍບໍ່ເສັຽຄ່າ, 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 (TTY: 711) 800-722-1471 تماس بگیرید.