

Highlights of your Dental Coverage

Law Enforcement Officers and Firefighters Health and Welfare Trust

Group Number: 4000190

Effective Date: 01/01/2022

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

DENTAL PLAN	DENTAL PLAN 3A \$25/\$75 0%/0%/50% \$2,500 W/ORTHO \$2,500 50%*	
	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
Office Visit		
Routine Comprehensive / Periodic Oral Exams (2 PCY)	Covered in Full	Covered in Full
Problem Focused/Emergency Exam (Unlimited)	Covered in Full	Covered in Full
Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine))	Covered in Full	Covered in Full
Preventive Services		
Prophylaxis - Cleaning (2 PCY)	Covered in Full	Covered in Full
Fluoride Treatments (2 PCY; under the age of 19)	Covered in Full	Covered in Full
Sealants (Under age 19 limited to permanent molars only. Replacements limited to once every 24 consecutive months.)	Covered in Full	Covered in Full
Space Maintainers (Members under age 19)	Covered in Full	Covered in Full
Diagnostic Imaging		
Bitewings X-rays (1 set (up to 4) PCY)	Covered in Full	Covered in Full
Panoramic X-ray or comparable Conebeam view (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)	Covered in Full	Covered in Full
Restorative		
Fillings (1 per surface every 24 consecutive months)	Deductible, then Covered in Full	Deductible, then Covered in Full
Installation of Inlays, Onlays and Crowns (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%

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

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	IN-NETWORK	OUT-OF-NETWORK
Orthodontia Cost Share	\$2,500 Lifetime, 50% up to Lifetime Maximum diagnostic/banding	\$2,500 Lifetime, 50% up to Lifetime Maximum diagnostic/banding
Lifetime Maximum Benefit	\$2,500 Lifetime, 50% up to Lifetime Maximum diagnostic/banding	\$2,500 Lifetime, 50% up to Lifetime Maximum diagnostic/banding

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 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/online/services/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: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់លើក។ 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: በክፍለ ስራዎቻችን ተዘጋጅተዋል። ወደ ሚክሶሎ ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711)።

XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltidhaan 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).

ਪਿਆਰ 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. 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 به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.

037378 (07-01-2021)