Effective 10/1/2020-9/30/2021	Expressions Incentive	
Dental - Administered by Regence BlueCross BlueShield of Oregon		
Benefit Category	**Preferred Providers***	**Out-of-Network Providers**
Annual Deductible		
Individual	$0	
Family	$0	
Annual Maximum	$1,500 per person	
Preventive Care: *Deductible waived. Includes :* *2 cleanings and 2 preventive oral examination* *2 bitewing x–ray series / year.* *1 complete intra–oral mouth and 1 panoramic mouth x–rays once in a 3 year period*	30%-0% Based on your incentive level Coverage Increases 10% per year until covered in full. If member receives no covered preventive care in contract year benefit will decrease 10% but will never be more than 30%	
Basic Services: *2 periodontal maintenance / year (in lieu of preventive cleanings).* *1 periodontal debridement in a 2 year period.* *Periodontal scaling and root planing 1 per quadrant in a 2 year period.* *Crowns replacements allowed every 5 years*	30%-0% Based on your incentive level Coverage Increases 10% per year until covered in full. If member receives no covered preventive care in contract year benefit will decrease 10% but will never be more than 30%	
Major services: *includes bridges, dentures and implants.* *5 year replacement*	50%	
Orthodontia: *Deductible waived* *$1,800 Lifetime Max*	20%	

% = co-insurance (amount you pay)

* Reduced out-of-pocket expense with use of Participating Provider

For more in-depth benefits please contact customer service or review your SPD