



Effective 10/1/2022-9/30/2023

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: <i>Deductible waived. Includes :</i> 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: <i>includes bridges, dentures and implants.</i> 5 year replacement		50%
Orthodontia: <i>Deductible waived</i> \$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