Regence BlueShield of Idaho: Expressions

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 11/01/2014 - 10/31/2015

Coverage for: Individual & Eligible Family

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myRegence.com or by calling 1 (888) 367-2117.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** member / **$0** family per Calendar year.	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out-of-pocket limit?	This plan has no **out-of-pocket limit**.	Not applicable because there's no **out-of-pocket limit** on your expenses.
Is there an overall annual limit on what the plan pays?	Yes. **$1,000**	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See **www.myRegence.com** or call **1 (888) 367-2117** for lists of in-network or out-of-netowrk **providers**.	If you use an in-network dental **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network dental **provider** may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for a crown is $500, your **coinsurance** payment of 50% would be $250. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network dentist charges $200 for an examination and the **allowed amount** is $150, you may have to pay the $50 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Dental Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have preventive dental services	Cleanings and examinations	No charge	No charge	Coverage is limited to 2 cleanings and 2 preventive oral examinations / year.
	X-rays	No charge	No charge	Coverage is limited to 2 bitewing x-ray series / year.
	Other preventive dental services	15% co-insurance	15% co-insurance	Coverage is limited to 1 complete intra-oral mouth and 1 panoramic mouth x-rays once in a 3 year period.Coverage is limited to members under age 18 for sealants (permanent bicuspids and molars only), members under age 12 for space maintainers, and members under age 18 and limited to 2 treatments / year for topical fluoride application.
If you need basic dental services	Periodontal services	15% co-insurance	15% co-insurance	Coverage is limited to 1 complete intra-oral mouth and 1 panoramic mouth x-rays once in a 3 year period. Coverage is limited to members under age 18 for sealants (permanent bicuspids and molars only), members under age 12 for space maintainers, and members under age 18 and limited to 2 treatments / year for topical fluoride application.
	Endodontic services	15% co-insurance	15% co-insurance	——————none——————
	Emergency and other basic dental services	15% co-insurance	15% co-insurance	——————none——————

Common Dental Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need major dental services	Bridges	15% co-insurance	15% co-insurance	Coverage is limited to replacement bridges once per 7 years after placement.
	Crowns, inlays and onlays	15% co-insurance	15% co-insurance	Coverage is limited to replacement crowns, inlays or onlays once per tooth, 7 years after placement.
	Dentures (full and partial)	15% co-insurance	15% co-insurance	Coverage is limited to replacement dentures 7 years after placement.
	Implants (endosteal)	15% co-insurance	15% co-insurance	Coverage is limited to 4 endosteal implants / lifetime.
If you need TMJ services	Temporomandibular joint (TMJ) disorder services	15% co-insurance	15% co-insurance	Coverage is limited to $5,000 / lifetime.

Excluded Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Aesthetic dental procedures • Cosmetic/reconstructive services and supplies, except congenital anomalies • Duplicate x-rays	• Facility charges • Gold-foil restorations • Implants (non–endosteal) • Nitrous Oxide	• Orthodontic services • Orthognathic surgery • Tooth transplantation • Veneers