

## Highlights of your Dental Coverage

### WA TECHNOLOGY INDUSTRY ASSOCIATION EMPLOYEE BENEFIT TRUST

Effective Date: 12/01/2021

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

DENTAL PLAN		
2021 WTIA D \$2000		
Dental Network - Choice	IN-NETWORK	OUT-OF-NETWORK
<b>Dental Cost Share</b>		
Individual Deductible	\$25	Shared with In Network
Family Deductible	\$75	Shared with In Network
Preventive Cost Share	Covered in Full	Waive Deductible, then 20%
Basic Cost Share	Deductible, then 10%	Deductible, then 20%
Major Cost Share	Deductible, then 40%	Deductible, then 60%
Dental Annual Maximum	\$2,000 PCY applies to basic and major services	Shared with In Network
<b>Benefit Enhancement Rider</b>		
Benefit Enhancement Rider	Endodontics & Periodontal Surgical Treatment (In Basic)	Endodontics & Periodontal Surgical Treatment (In Basic)
<b>Office Visit</b>		

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Dental Network - Choice	IN-NETWORK	OUT-OF-NETWORK
<b>Routine Comprehensive / Periodic Oral Exams</b> (2 PCY)	Preventive Cost Share	Preventive Cost Share
<b>Limited Problem Focused (Emergency Exams)</b> (Unlimited)	Preventive Cost Share	Preventive Cost Share
<b>Non Routine Exams (Non Emergency)</b> (1 PCY)	Basic Cost Share	Basic Cost Share
<b>Preventive Services</b>		
<b>Prophylaxis - Cleaning</b> (2 PCY)	Preventive Cost Share	Preventive Cost Share
<b>Fluoride Treatments</b> (2 PCY; under the age of 19)	Preventive Cost Share	Preventive Cost Share
<b>Sealants</b> (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
<b>Space Maintainers</b> (Members under age 19)	Basic Cost Share	Basic Cost Share
<b>Diagnostic Imaging</b>		
<b>Bitewings X-rays</b> (Unlimited)	Preventive Cost Share	Preventive Cost Share
<b>Panoramic X-ray or comparable Conebeam view</b> (1 complete series, 1 panoramic or 1 cone beam view in any 36 consecutive months)	Preventive Cost Share	Preventive Cost Share
<b>Restorative</b>		
<b>Fillings</b> (1 per surface every 24 consecutive months)	Basic Cost Share	Basic Cost Share
<b>Installation of Inlays, Onlays and Crowns</b> (1 every 5 calendar years)	Major Cost Share	Major Cost Share
<b>Re-cement or Rebond Crowns/Inlay/Onlay</b> (Unlimited)	Basic Cost Share	Basic Cost Share
<b>Repair Crown/Inlay/Onlay</b> (Unlimited)	Basic Cost Share	Basic Cost Share
<b>Endodontics</b>		
<b>Endodontic Therapy - Root Canal</b> (Once per tooth every 2 calendar years)	See Benefit Enhancement Rider	See Benefit Enhancement Rider
<b>Endodontic Retreatment - Root Canal</b> (Once per tooth every 2 calendar years)	See Benefit Enhancement Rider	See Benefit Enhancement Rider
<b>Periodontics</b>		
<b>Periodontal Maintenance</b> (4 PCY)	Basic Cost Share	Basic Cost Share
<b>Full Mouth Debridement</b> (Once every 3 calendar years)	Basic Cost Share	Basic Cost Share
<b>Periodontal Scaling and Root Planing</b> (Once per quadrant every 2 calendar year)	Basic Cost Share	Basic Cost Share

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Dental Network - Choice	IN-NETWORK	OUT-OF-NETWORK
<b>Periodontal Surgery</b> (Once per quadrant every 3 calendar years)	See Benefit Enhancement Rider	See Benefit Enhancement Rider
<b>Prosthodontics (Dentures/Bridges)</b>		
<b>Installation or Replacement of Dentures, Partials and Fixed Bridges</b> (1 every 5 calendar years)	Major Cost Share	Major Cost Share
<b>Repair or Re-cement Bridgework and Dentures</b> (Unlimited)	Basic Cost Share	Basic Cost Share
<b>Implant Services</b>		
<b>Implant Crowns/Bridge/Denture</b> (1 every 5 calendar years for surgical implants, implant abutments, and/or implant prosthetics)	Major Cost Share	Major Cost Share
<b>Oral Surgery</b>		
<b>Simple Extractions</b>	Basic Cost Share	Basic Cost Share
<b>Surgical Extractions</b> (Unlimited)	Basic Cost Share	Basic Cost Share
<b>Oral Surgery</b> (Unlimited)	Basic Cost Share	Basic Cost Share
<b>General Services</b>		
<b>Anesthesia - Intravenous or General</b>	Basic Cost Share	Basic Cost Share
<b>Palliative (Emergency) Treatment of Dental Pain</b>	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](mailto: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:** បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃល្អ  
គឺអាចមានសំរាប់អ្នក។ ចូរទូរស័ព្ទ 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፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚክተለው 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 انكر 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).

**ប្រៃសណីយ៍:** បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃល្អ  
គឺអាចមានសំរាប់អ្នក។ ចូរទូរស័ព្ទ 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.