The Summary of Benefits and Coverage (SBC) document will help you choose a dental plan. The SBC shows you how you and the plan would share the cost for covered dental care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to https://regence.com or call 1 (888) 370-6159. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1 (888) 370-6159 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$50 individual / $150 family per calendar year.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive dental services.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services, but see the Common Dental Event chart below for other costs for services this plan covers.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>Yes. $1,000 / individual per calendar year.</td>
<td>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 Common Dental Event chart below describes specific coverage limits.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>Not applicable.</td>
<td>This plan does not have an out-of-pocket limit on your expenses.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="https://regence.com/go/UT/VCDental">https://regence.com/go/UT/VCDental</a> or call 1 (888) 370-6159 for a list of network providers.</td>
<td>This plan uses a dental provider network. You will pay less if you use a dental provider in the plan’s network. You will pay the most if you use an out-of-network dental provider, and you might receive a bill from a dental provider for the difference between the provider’s charge and what your plan pays (balance billing).</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Dental Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Dentist</td>
<td>Out-of-Network Dentist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
</tbody>
</table>
| If you have preventive dental services | Cleanings and examinations | 20% coinsurance | 20% coinsurance | 2 cleanings* / year  
2 preventive oral examinations / year  
*Coverage may include another cleaning, refer to your plan for further information. |
|                     | X-rays | 20% coinsurance | 20% coinsurance | 2 bitewing x-ray sets / year  
1 complete intra-oral mouth x-ray in a 3-year period  
1 panoramic mouth x-ray in a 3-year period |
|                     | Other preventive dental services | 20% coinsurance | 20% coinsurance | Sealants limited to individuals under age 18 and for permanent bicuspid and molars only.  
Space maintainers limited to individuals under age 12.  
2 topical fluoride treatments / year for individuals under age 18 |
| If you need basic dental services | Periodontal services | 20% coinsurance | 20% coinsurance | 2 periodontal maintenance cleanings* / year (in lieu of preventive cleanings)  
1 periodontal debridement in a 3-year period  
Gingivectomy and gingivoplasty limited to 1 / quadrant in a 3-year period.  
Periodontal scaling and root planing limited to 1 / quadrant in a 2-year period.  
*Coverage may include another periodontal maintenance cleaning, refer to your plan for further information. |
|                     | Endodontic services | 20% coinsurance | 20% coinsurance | None |
|                     | Emergency and other basic dental services | 20% coinsurance | 20% coinsurance | None |
| If you need major dental services | Bridges | 50% coinsurance | 50% coinsurance | 1 bridge implant and abutment / tooth in a 7-year period  
1 bridge implant and abutment repair / tooth in a lifetime  
1 replacement bridge / 7 years after placement  
Adjustments and repairs not covered until 1 year after placement. |
<table>
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</table>
|                     |                       | In-Network Dentist | Out-of-Network Dentist | 1 crown repair / tooth in a lifetime  
|                     |                       | (You will pay the least) | (You will pay the most) | 1 crown implant and abutment / tooth in a 7-year period  
|                     |                       | 50% coinsurance | 50% coinsurance | 1 crown implant and abutment repair / tooth in a lifetime  
|                     | Crowns, inlays and onlays | | | 1 replacement crown / 7 years after placement (or subsequent replacement)  
|                     |                       | | | 1 replacement inlay / 7 years after placement (or subsequent replacement)  
|                     |                       | | | 1 replacement onlay / 7 years after placement (or subsequent replacement)  
|                     | Dentures (full and partial) | 50% coinsurance | 50% coinsurance | 1 rebase / per arch in a 3-year period  
|                     |                       | | | 1 reline / per arch in a 3-year period  
|                     |                       | | | 1 partial denture implant and abutment / tooth in a 7-year period  
|                     |                       | | | 1 replacement denture / 7 years after placement  
|                     |                       | | | Adjustments and repairs not covered until 1 year after placement.  
|                     | Implants (endosteal) | 50% coinsurance | 50% coinsurance | 4 implants / lifetime  
|                     |                       | | | 1 implant supported prosthesis or abutment repair / tooth in a lifetime  

**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  
- Non-direct patient care  
- Occlusal treatment  
- Orthodontic services  
- Orthognathic surgery  
- Temporomandibular joint (TMJ) disorder treatment  
- Tooth transplantation  
- Veneers  

*Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)*
NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Regence:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service
1-800-541-8981 (TTY: 711)

Customer Service for all other plans
1-888-344-6347 (TTY: 711)

If you believe that Regence 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 our civil rights coordinator below:

Medicare Customer Service
Civil Rights Coordinator
MS: B32AG, PO Box 1827
Medford, OR 97501
1-866-749-0355, (TTY: 711)
Fax: 1-888-309-8784
medicareappeals@regence.com

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 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 Avenue SW,
Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD).


Customer Service for all other plans
Civil Rights Coordinator
MS CS B32B, P.O. Box 1271
Portland, OR 97207-1271
1-888-344-6347, (TTY: 711)
CS@regence.com
Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (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 1-888-344-6347 (TTY: 711)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.


ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS: 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。1-888-344-6347 (TTY:711) まで、お電話にてご連絡ください。

Dii baa akó ninizin: Dii saad bee yànilti’go Diné Bizaad, saad bee aká’ánida’áwo’déé’, t’áá jíik’eh, éi ná hóló, kojí’ hódiiliñih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA’I: Kapau ‘oku ke Lea-Fakatonga, ko e kau tokoni fakatono lea ‘oku nau fai atu ha tokoni ta’etotangi, pea te ke lava ‘o ma’u ia. ha’o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

TOŽEHE: Ange foy biyana farisi caa bii kendir too, oshoroo jiboo bii astraay bii kai bii shama.Tevaa mi badda. (TTY: 711) 888-344-6347

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (teliettain: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaa wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรแกรม: อากูปุกภาษาไทย คุณสามารถใช้บริการข้อความทางภาษาได้فريق ไทย 1-888-344-6347 (TTY: 711)

Afkan dubbattan Oroomiffaa tiif, tajajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.