PREMERA | BLUE CROSS

Highlights of your Dental Coverage

Effective Date: 01/01/2025

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

DENTAL PLAN	PC: DENTAL OPTIMA - $25/75 DED $2,500 MAXIMUM	
	IN-NETWORK	**OUT-OF-NETWORK**
Dental Cost Share		
Individual Deductible	$25	Shared with In Network
Family Deductible	$75	Shared with In Network
Preventive Cost Share	Covered in Full	Covered in Full
Basic Cost Share	Deductible, then 10%	Deductible, then 10%
Major Cost Share	Deductible, then 40%	Deductible, then 40%
Dental Annual Maximum	$2,500 PCY applies to basic and major services	Shared with In Network
Office Visit		
Routine Comprehensive / Periodic Oral Exams (2 PCY)	Covered in Full	Covered in Full
Problem Focused/Emergency Exam (Unlimited)	Covered in Full	Covered in Full
Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine))	Covered in Full	Covered in Full
Preventive Services		
Prophylaxis - Cleaning (2 PCY)	Covered in Full	Covered in Full
Fluoride Treatments (2 PCY; under the age of 19)	Covered in Full	Covered in Full
Sealants (Under age 19 limited to permanent molars only, Replacements limited to once every 24 consecutive months)	Covered in Full	Covered in Full
Space Maintainers (Members under age 19)	Covered in Full	Covered in Full
Diagnostic Imaging		
Bitewings X-rays (Unlimited)	Covered in Full	Covered in Full
Panoramic X-ray or comparable Conebeam view (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)	Covered in Full	Covered in Full
Restorative		
Fillings (1 per surface every 24 consecutive months)	Deductible, then 10%	Deductible, then 10%
Installation of Inlays, Onlays and Crowns (1 every 5 calendar years)	Deductible, then 40%	Deductible, then 40%

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	IN-NETWORK	**OUT-OF-NETWORK**
Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 10%	Deductible, then 10%
Repair Crown/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 10%	Deductible, then 10%
Endodontics		
Endodontic Therapy - Root Canal (Once per tooth every 24 consecutive months)	Deductible, then 10%	Deductible, then 10%
Periodontics		
Periodontal Maintenance (4 PCY)	Deductible, then 10%	Deductible, then 10%
Full Mouth Debridement (Once every 36 consecutive months)	Deductible, then 10%	Deductible, then 10%
Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)	Deductible, then 10%	Deductible, then 10%
Periodontal Surgery (Once per quadrant every 36 consecutive months)	Deductible, then 10%	Deductible, then 10%
Periodontal Soft Tissue Grafts (Once per quadrant every 36 consecutive months)	Deductible, then 10%	Deductible, then 10%
Prosthodontics (Dentures/Bridges)		
Installation or Replacement of Dentures, Partials and Fixed Bridges (1 every 5 calendar years)	Deductible, then 40%	Deductible, then 40%
Repair or Re-cement Bridgework and Dentures (When performed 6 or more months after placement)	Deductible, then 10%	Deductible, then 10%
Implant Services		
Implant Crowns/Bridge/Denture (1 every 5 calendar years)	Deductible, then 40%	Deductible, then 40%
Oral Surgery		
Simple Extractions (Unlimited)	Deductible, then 10%	Deductible, then 10%
Surgical Extractions (Unlimited)	Deductible, then 10%	Deductible, then 10%
Oral Surgery (Unlimited)	Deductible, then 10%	Deductible, then 10%
General Services		
Anesthesia - Intravenous or General (Unlimited)	Deductible, then 10%	Deductible, then 10%
Occlusal (Night) Guard (Once every 36 consecutive months)	Deductible, then 10%	Deductible, then 10%
Palliative (Emergency) Treatment of Dental Pain (Unlimited)	Deductible, then 10%	Deductible, then 10%

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 of the plan.This benefit highlight is not a contract and may change. Please see your benefit booklet or call Customer Service for full coverage information including a description of waiting periods, limitations, and exclusions.