

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	ADULT DENTAL OPTIMA VOLUNTARY 1000	
	IN-NETWORK	OUT-OF-NETWORK
Dental Cost Share		
Individual/Family Deductible	\$50/\$150	Shared with In Network
Preventive Cost Share	Covered in Full	Covered in Full
Basic Cost Share	Deductible, then 30%	Deductible, then 30%
Major Cost Share	Deductible, then 50%	Deductible, then 50%
Dental Reimbursement (Dental Choice Network)	WA fee schedule	WA out of network reduced fee schedule (in-state) and FairHealth 80th percentile (out-of-state)
Dental Annual Maximum	\$1,000 PCY	Shared with In Network
Office Visit		
Routine Oral Exams (2 PCY)	Covered in Full	Covered in Full
Emergency Exams (Unlimited)	Deductible, then 30%	Deductible, then 30%
Preventive Services		
Cleanings (2 PCY)	Covered in Full	Covered in Full
Diagnostic Imaging		
Bitewings X-rays (1 set (up to 4) PCY)	Covered in Full	Covered in Full
Routine X-rays (1 complete series, 1 panoramic, or 1 comparable cone beam view in any 36 consecutive months)	Deductible, then 30%	Deductible, then 30%
Restorative		
Fillings (1 per surface every 24 consecutive months)	Deductible, then 30%	Deductible, then 30%
Installation of Crowns (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Re-cementing/Repair of Crowns (When performed 6 or more months after placement)	Deductible, then 50%	Deductible, then 50%

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ADULT DENTAL OPTIMA VOLUNTARY 1000		
	IN-NETWORK	OUT-OF-NETWORK
Build-Ups (Once every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Endodontics		
Endodontics (Once per tooth every 24 consecutive months)	Deductible, then 50%	Deductible, then 50%
Direct Pulp Cap (Unlimited)	Deductible, then 30%	Deductible, then 30%
Periodontics		
Periodontal Maintenance (4 PCY)	Deductible, then 30%	Deductible, then 30%
Full Mouth Debridement (Once every 36 consecutive months)	Deductible, then 30%	Deductible, then 30%
Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)	Deductible, then 30%	Deductible, then 30%
Prosthodontics (Dentures/Bridges)		
Installation or Replacement of Dentures, Partials and Fixed Bridges (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Repair or Re-cement Bridgework and Dentures (When performed 6 or more months after placement)	Deductible, then 50%	Deductible, then 50%
Oral Surgery		
Simple Extractions (Unlimited)	Deductible, then 30%	Deductible, then 30%
Surgical Extractions (Unlimited)	Deductible, then 50%	Deductible, then 50%
Oral Surgery (Unlimited)	Deductible, then 50%	Deductible, then 50%
General Services		
General Anesthesia (Unlimited)	Deductible, then 50%	Deductible, then 50%
Limited Occlusal Adjustment (1 every 12 consecutive months as dentally necessary)	Deductible, then 50%	Deductible, then 50%
Emergency Palliative Treatment (Unlimited)	Deductible, then 30%	Deductible, then 30%

Annual deductible waived for Diagnostic/Preventive services

A 12-month waiting period applies for Major services to members who have not had comparable dental coverage under the group's prior dental plan.

PCY = Per Calendar Year.

Out-of-network dental care providers will be reimbursed using the Washington out-of-network fee schedule. Balance billing may apply if a provider is not contracted with Premera Blue Cross Blue Shield of Alaska. 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.

Notice of availability and nondiscrimination 800-722-1471 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.

Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.

呼吁提供免费的语言援助服务和适当的辅助设备及服务。

呼籲提供免費的語言援助服務和適當的輔助設備及服務。

Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.

무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.

Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.

Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.

Звертайте за безкоштовною мовною підтримкою та відповідними додатковими послугами.

សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។

無料言語支援サービスと適切な補助器具及びサービスをお求めください。

ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ ማሳሰቢያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር

Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.

ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।

Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.

ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.

Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.

Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.

Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.

Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.

Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.

اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.

برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

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