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 FLEX - $50/150 DED $1,000 MAXIMUM**	
	IN-NETWORK	**OUT-OF-NETWORK**
Dental Cost Share		
Individual Deductible	$50	Shared with In Network
Family Deductible	$150	Shared with In Network
Preventive Cost Share	Covered in Full	Waive Deductible, then 10%
Basic Cost Share	Deductible, then 20%	Deductible, then 30%
Major Cost Share	Deductible, then 50%	Deductible, then 60%
Dental Annual Maximum	$1,000 PCY applies to basic and major services	Shared with In Network
Office Visit		
Routine Comprehensive / Periodic Oral Exams (2 PCY)	Covered in Full	Waive Deductible, then 10%
Problem Focused/Emergency Exam (Unlimited)	Covered in Full	Waive Deductible, then 10%
Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine))	Covered in Full	Waive Deductible, then 10%
Preventive Services		
Prophylaxis - Cleaning (2 PCY)	Covered in Full	Waive Deductible, then 10%
Fluoride Treatments (2 PCY; under the age of 19)	Covered in Full	Waive Deductible, then 10%
Sealants (Under age 19 limited to permanent molars only, Replacements limited to once every 24 consecutive months)	Covered in Full	Waive Deductible, then 10%
Space Maintainers (Members under age 19)	Covered in Full	Waive Deductible, then 10%
Diagnostic Imaging		
Bitewings X-rays (Unlimited)	Covered in Full	Waive Deductible, then 10%
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	Waive Deductible, then 10%
Restorative		
Fillings (1 per surface every 24 consecutive months)	Deductible, then 20%	Deductible, then 30%
Installation of Inlays, Onlays and Crowns (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 60%

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 FLEX - $50/150 DED $1,000 MAXIMUM**	
	IN-NETWORK	**OUT-OF-NETWORK**
Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 30%
Repair Crown/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 30%
Endodontics		
Endodontic Therapy - Root Canal (Once per tooth every 24 consecutive months)	Deductible, then 20%	Deductible, then 30%
Periodontics		
Periodontal Maintenance (4 PCY)	Deductible, then 20%	Deductible, then 30%
Full Mouth Debridement (Once every 36 consecutive months)	Deductible, then 20%	Deductible, then 30%
Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)	Deductible, then 20%	Deductible, then 30%
Periodontal Surgery (Once per quadrant every 36 consecutive months)	Deductible, then 20%	Deductible, then 30%
Periodontal Soft Tissue Grafts (Once per quadrant every 36 consecutive months)	Deductible, then 20%	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 60%
Repair or Re-cement Bridgework and Dentures (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 30%
Implant Services		
Implant Crowns/Bridge/Denture (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 60%
Oral Surgery		
Simple Extractions (Unlimited)	Deductible, then 20%	Deductible, then 30%
Surgical Extractions (Unlimited)	Deductible, then 20%	Deductible, then 30%
Oral Surgery (Unlimited)	Deductible, then 20%	Deductible, then 30%
General Services		
Anesthesia - Intravenous or General (Unlimited)	Deductible, then 20%	Deductible, then 30%
Occlusal (Night) Guard (Once every 36 consecutive months)	Deductible, then 20%	Deductible, then 30%
Palliative (Emergency) Treatment of Dental Pain (Unlimited)	Deductible, then 20%	Deductible, then 30%

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.