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 $1,500 SHARED FAMILY PLAN | |
|---|---|---|
| | **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** | $1500 SHARED PCY applies to basic and major services (Family shared PCY maximum limit – up to 3x Individual) | 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% |

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|---|---|---|
| | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Installation of Inlays, Onlays and Crowns** (1 every 5 calendar years) | Deductible, then 50% | Deductible, then 60% |
| **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.*