

# 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 VOLUNTARY- \$50/150 DED \$1,500 MAXIMUM	
	IN-NETWORK	OUT-OF-NETWORK
<b>Dental Cost Share</b>		
<b>Individual Deductible</b>	\$50	Shared with In Network
<b>Family Deductible</b>	\$150	Shared with In Network
<b>Preventive Cost Share</b>	Covered in Full	Covered in Full
<b>Basic Cost Share</b>	Deductible, then 20%	Deductible, then 20%
<b>Major Cost Share</b>	Deductible, then 50%	Deductible, then 50%
<b>Dental Annual Maximum</b>	\$1500 PCY	Shared with In Network
<b>Office Visit</b>		
<b>Routine Comprehensive / Periodic Oral Exams</b> (2 PCY)	Covered in Full	Covered in Full
<b>Problem Focused/Emergency Exam</b> (Unlimited)	Covered in Full	Covered in Full
<b>Office Visits, Prof Consults, Perio Evals</b> (2 PCY (Shared with Routine))	Covered in Full	Covered in Full
<b>Preventive Services</b>		
<b>Prophylaxis - Cleaning</b> (2 PCY)	Covered in Full	Covered in Full
<b>Fluoride Treatments</b> (2 PCY; under the age of 19)	Covered in Full	Covered in Full
<b>Sealants</b> (Under age 19 limited to permanent molars only, Replacements limited to once every 24 consecutive months)	Covered in Full	Covered in Full
<b>Space Maintainers</b> (Members under age 19)	Covered in Full	Covered in Full
<b>Diagnostic Imaging</b>		
<b>Bitewings X-rays</b> (Unlimited)	Covered in Full	Covered in Full
<b>Panoramic X-ray or comparable Conebeam view</b> (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)	Covered in Full	Covered in Full
<b>Restorative</b>		
<b>Fillings</b> (1 per surface every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%
<b>Installation of Inlays, Onlays and Crowns</b> (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%

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	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Re-cement or Rebond Crowns/Inlay/Onlay</b> (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%	
<b>Repair Crown/Inlay/Onlay</b> (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%	
<b>Endodontics</b>			
<b>Endodontic Therapy - Root Canal</b> (Once per tooth every 24 consecutive months)	Deductible, then 50%	Deductible, then 50%	
<b>Periodontics</b>			
<b>Periodontal Maintenance</b> (4 PCY)	Deductible, then 20%	Deductible, then 20%	
<b>Full Mouth Debridement</b> (Once every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%	
<b>Periodontal Scaling and Root Planing</b> (Once per quadrant every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%	
<b>Periodontal Surgery</b> (Once per quadrant every 36 consecutive months)	Deductible, then 50%	Deductible, then 50%	
<b>Periodontal Soft Tissue Grafts</b> (Once per quadrant every 36 consecutive months)	Deductible, then 50%	Deductible, then 50%	
<b>Prosthodontics (Dentures/Bridges)</b>			
<b>Installation or Replacement of Dentures, Partials and Fixed Bridges</b> (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%	
<b>Repair or Re-cement Bridgework and Dentures</b> (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%	
<b>Oral Surgery</b>			
<b>Simple Extractions</b> (Unlimited)	Deductible, then 20%	Deductible, then 20%	
<b>Surgical Extractions</b> (Unlimited)	Deductible, then 20%	Deductible, then 20%	
<b>Oral Surgery</b> (Unlimited)	Deductible, then 20%	Deductible, then 20%	
<b>General Services</b>			
<b>Anesthesia - Intravenous or General</b> (Unlimited)	Deductible, then 20%	Deductible, then 20%	
<b>Occlusal (Night) Guard</b> (Once every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%	
<b>Palliative (Emergency) Treatment of Dental Pain</b> (Unlimited)	Deductible, then 20%	Deductible, then 20%	

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.*

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