

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 - \$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	Covered in Full	
Basic Cost Share	Deductible, then 20%	Deductible, then 20%	
Major Cost Share	Deductible, then 50%	Deductible, then 50%	
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	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 20%	Deductible, then 20%	

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