

Adult Dental Optima™ Plan

FOR WASHINGTON GROUPS WITH 5–50 EMPLOYEES | Premera DentalBlue™

With Adult Dental Optima plans, employers can choose from an array of deductible and coinsurance cost-share options.

With **Adult Dental Optima**, employers can offer:

- Employees maximum flexibility because they can choose any licensed or certified dental-care provider
- Cost savings to their employees when utilizing our network providers

- Diagnostic and preventive services including routine exams, cleanings, fluoride, X-rays and sealants
- Basic services including fillings, extractions, periodontal services including up to four periodontal maintenance cleanings per year and endodontic (root canal) treatments
- Major services including crowns, inlays, dentures and implants without a 12-month waiting period.

Benefits apply after calendar year deductible is met, unless otherwise noted.

PCY = Per Calendar Year

Deductible & Coinsurance represent member's cost share	Choose one of the Adult Dental Optima plans below									
Annual Deductible PCY	Indvl: \$25 Fam: \$75	\$50 \$150	Indvl: \$0 Fam: \$0	\$25 \$75	\$50 \$150	Indvl: \$500* Fam: \$1,500*	Indvl: \$25 Fam: \$75	\$50 \$150		
Maximum Allowance per person, PCY	\$1,500 or \$2,000		\$1,000, \$1,500 or \$2,000			\$1,000 or \$1,500	\$1,000			

COVERED SERVICES				
ROUTINE DIAGNOSTIC AND PREVENTIVE†				
Cleanings limited to 2 PCY				
Emergency Exams (unlimited)				
Fluoride Treatments limited to 2 applications PCY for members under the age of 20				
Routine Oral Exams limited to 2 PCY	0%	0%	0%	20%
Routine X-rays complete series or panoramic X-ray once per 36 consecutive months				
Space Maintainers for members under age 20				
BASIC				
Emergency Palliative Treatment				
Endodontic (Root Canal) Treatment limited to 2 per arch when performed in conjunction with overdentures				
Fillings limited to once per tooth surface every 24 consecutive months				
Full-mouth Debridement				
General Anesthesia limited to covered dental procedures at a dental-care provider's office when dentally necessary	10%	20%	20%	20%
Oral Surgery including simple and surgical extractions				
Periodontal Maintenance limited to 4 visits per calendar year				
Periodontal Scaling limited to once per quadrant every 2 calendar years				
Repair & Recementing of Crowns, Inlays, Bridgework & Dentures				
MAJOR				
Implants, Dentures, Partials & Fixed Bridges replacements for dentures, partials & fixed bridges limited to once every 5 calendar years	40%	50%	50%	50%
Inlays, Onlays & Crowns replacements limited to once per tooth every 5 years				

Note: Coinsurance amounts based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.

* Deductible applies only to major services.

† Annual deductible waived for diagnostic and preventive services.

Adult Dental Optima Plan (cont.)

Enhancements and other options for all Premera DentalBlue plans

Our optional dental coverage offers employers extra flexibility in designing their benefit coverage.

OPTIONAL BENEFITS

DENTAL PREFERENCE: BENEFIT RIDER ENHANCEMENT (for groups of 26 or more employees)

Endodontic (Root Canal) & Surgical Periodontal Treatment	Cover under Basic instead of Major Services
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ORTHODONTIA (for groups with 26 or more employees)

Diagnostic Services and Active/Retention Treatment including Appliances	Covered in full ¹ up to Lifetime Maximum
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Monthly Orthodontic Adjustments including Retention Treatment	Covered in full ¹ up to Lifetime Maximum
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Lifetime Maximum per person (choose one)	\$1,000, \$1,500 or \$2,000
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Age Limit (choose one)	No Age Limit
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TMJ DENTAL SERVICES²

TMJ Exams & X-rays, Occlusal Guards & TMJ Surgical Procedures, Manipulations under Anesthesia	Deductible and Basic Coinsurance apply
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Annual Benefit Maximum	\$1,000
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Lifetime Maximum per person	\$5,000
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¹ Benefits provided at 100% of allowable charges; not subject to deductible or coinsurance.

² Balance billing may apply if a provider is not contracting with Premera Blue Cross.

This is not a contract. It is only a summary of the major benefits provided by this plan. For full coverage provisions, including a description of waiting periods, limitations and exclusions, please contact your producer.



BLUE CROSS

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