PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Highlights of your Dental Coverage

Effective Date: 01/01/2027

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

DENTAL PLAN	**PC - DENTAL OPTIMA 20%/20%/50%/$1000**	
	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	Waive Deductible, then 20%	Waive Deductible, then 20%
Basic Cost Share	Deductible, then 20%	Deductible, then 20%
Major Cost Share	Deductible, then 50%	Deductible, then 50%
Dental Reimbursement (Dental Choice Network)	AK fee schedule	80th percentile (in-state) and 90th percentile (out-of-state)
Dental Annual Maximum	$1,000 PCY	Shared with In Network
Benefit Enhancement Rider		
Benefit Enhancement Rider	Endodontics & Periodontal Treatment (In Major)	Endodontics & Periodontal Treatment (In Major)
Office Visit		
Routine Comprehensive / Periodic Oral Exams (2 PCY)	Waive Deductible, then 20%	Waive Deductible, then 20%
Problem Focused/Emergency Exam (2 PCY)	Waive Deductible, then 20%	Waive Deductible, then 20%
Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine))	Waive Deductible, then 20%	Waive Deductible, then 20%
Preventive Services		
Prophylaxis - Cleaning (2 PCY)	Waive Deductible, then 20%	Waive Deductible, then 20%
Fluoride Treatments (2 PCY; under the age of 20)	Waive Deductible, then 20%	Waive Deductible, then 20%
Sealants (Under age 20 limited to permanent molars only, Replacements limited to once every 24 consecutive months)	Waive Deductible, then 20%	Waive Deductible, then 20%
Space Maintainers (Members under age 20)	Waive Deductible, then 20%	Waive Deductible, then 20%
Diagnostic Imaging		
Bitewings X-rays (Unlimited)	Waive Deductible, then 20%	Waive Deductible, then 20%

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Panoramic X-ray or comparable Conebeam view (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)	Waive Deductible, then 20%	Waive Deductible, then 20%
Restorative		
Fillings (1 per surface every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%
Installation of Inlays, Onlays & Crowns (Replacement once per tooth, 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 50%	Deductible, then 50%
Periodontics		
Periodontal Maintenance (4 PCY)	Deductible, then 20%	Deductible, then 20%
Full Mouth Debridement (Once every 36 consecutive months)	Deductible, then 50%	Deductible, then 50%
Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)	Deductible, then 50%	Deductible, then 50%
Periodontal Surgery (Once per quadrant every 36 consecutive months)	Deductible, then 50%	Deductible, then 50%
Periodontal Soft Tissue Grafts (Once per quadrant every 36 consecutive months)	Deductible, then 50%	Deductible, then 50%
Prosthodontics (Dentures/Bridges)		
Installation or Replacement of Dentures, Partials and Fixed Bridges (Replacement once 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 (Replacement once per tooth, every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Implant Bridge and Denture (Replacement once 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%

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	IN-NETWORK	**OUT-OF-NETWORK**
Oral Surgery (Unlimited)	Deductible, then 20%	Deductible, then 20%
General Services		
Anesthesia - Intravenous or General (Unlimited)	Deductible, then 20%	Deductible, then 20%
Anesthesia - Nitrous Oxide (Unlimited)	Deductible, then 20%	Deductible, then 20%
Palliative (Emergency) Treatment of Dental Pain (Unlimited)	Deductible, then 20%	Deductible, then 20%

Diagnostic and Preventive Care Services aren't subject to the calendar year deductible. PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross Blue Shield of Alaska. 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.