

# 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.*

### Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email [AppealsDepartmentInquiries@Premera.com](mailto:AppealsDepartmentInquiries@Premera.com). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>.

### Language Assistance

**ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

**注意:** 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471 (TTY: 711)。

**CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

**주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

**ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

**PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

**УВАГА!** Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.

Телефонуйте за номером 800-722-1471 (телетайп: 711).

**ប្រយ័ត្ន:** បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

**注意事項:** 日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471 (TTY:711) まで、お電話にてご連絡ください。

**ማስታወሻ:** የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711)።

**XIYYEEFFANNAA:** Afaan dubbattu Oroomiffa, tajaajjila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

**ملحوظة:** إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

800-722-1471 (TTY: 711)

**ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

**ໄປດອຸບ:** ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ຄ່າສັງຄານ, ຄວນມີພ້ອມໃຫ້ທ່ານ. ໂທ 800-722-1471 (TTY: 711).

**ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

**ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

**UWAGA:** Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

**ATENÇÃO:** Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

**ATTENZIONE:** In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

**توجہ:** اگر بہ زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.