PREMERA BLUE CROSS

# 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 | ADULT DENTAL OPTIMA 1500 ENHANCED ORTHODONTIA | |
|---|---|---|
| | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Dental Cost Share** | | |
| **Individual/Family Deductible** | $50/$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 Reimbursement** (Dental Choice Network) | WA fee schedule | FairHealth 90th percentile (in state and out-of-state) |
| **Dental Annual Maximum** | $1500 PCY | Shared with In Network |
| **Office Visit** | | |
| **Routine Oral Exams** (2 PCY) | Covered in Full | Covered in Full |
| **Emergency Exams** (Unlimited) | Covered in Full | Covered in Full |
| **Preventive Services** | | |
| **Cleanings** (2 PCY) | Covered in Full | Covered in Full |
| **Diagnostic Imaging** | | |
| **Bitewings X-rays** (1 set (up to 4) PCY) | Covered in Full | Covered in Full |
| **Routine X-rays** (1 complete series, 1 panoramic, or 1 comparable cone beam view in any 36 consecutive months) | Deductible, then 20% | Deductible, then 20% |
| **Restorative** | | |
| **Fillings** (1 per surface every 24 consecutive months) | Deductible, then 20% | Deductible, then 20% |
| **Installation of Crowns** (Replacement once per tooth, every 5 calendar years) | Deductible, then 50% | Deductible, then 50% |
| **Re-cementing/Repair of Crowns** (When performed 6 or more months after placement) | Deductible, then 50% | Deductible, then 50% |


059735 (08-01-2026)
Independent Licensee of the Blue Cross Blue Shield Association

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|---|---|---|
| | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Build-Ups** (Replacement once per tooth, every 5 calendar years) | Deductible, then 50% | Deductible, then 50% |
| **Endodontics** | | |
| **Endodontics** (Once per tooth every 24 consecutive months) | Deductible, then 20% | Deductible, then 20% |
| **Direct Pulp Cap** (Unlimited) | 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% |
| **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 50% | Deductible, then 50% |
| **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 50% | Deductible, then 50% |
| **Oral Surgery** (Unlimited) | Deductible, then 50% | Deductible, then 50% |
| **General Services** | | |
| **General Anesthesia** (Unlimited) | Deductible, then 50% | Deductible, then 50% |
| **Limited Occlusal Adjustment** (1 every 12 consecutive months as dentally necessary) | Deductible, then 50% | Deductible, then 50% |
| **Emergency Palliative Treatment** (Unlimited) | Deductible, then 20% | Deductible, then 20% |
| **Orthodontia** | | |
| **Orthodontia Cost Share** | 50% up to lifetime max | 50% up to lifetime max |

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|---|---|---|
| | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Age Limit** | None | None |
| **Lifetime Maximum Benefit** | $1,500 | $1,500 |

*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.*

## Notice of availability and nondiscrimination 800-722-1471 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរស័ព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

**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, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our 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, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 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.



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