

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 - 0%/20%/50%/\$1500 SHARED FAMILY + MAX WAIVER			
			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 Reimbursement (Dental Choice Network)			AK fee schedule		80th percentile (in-state) and 90th percentile (out-of-state)	
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	
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)			Covered in Full		Covered in Full	
Problem Focused/Emergency Exam (2 PCY)			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 20)			Covered in Full		Covered in Full	
Sealants (Under age 20 limited to permanent molars only, Replacements limited to once every 24 consecutive months)			Covered in Full		Covered in Full	
Space Maintainers (Members under age 20)			Covered in Full		Covered in Full	
Diagnostic Imaging						

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	IN-NETWORK	OUT-OF-NETWORK	
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%	
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 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 (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%	

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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%
Orthodontia					
Orthodontia Cost Share			Not Covered		Not Covered
Lifetime Maximum Benefit			Not Covered		Not Covered
TMJ Rider					
TMJ Rider (Not Covered)			Not Covered		Not Covered

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 Premiera 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.

Notice of availability and nondiscrimination 800-508-4722 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.

Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.

Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.

무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.

Hu thov kev pab txhais lus pub dawb thiab lwm yam khoom pab dawb thiab kev pab cuam ua tsim nyog.

Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.

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。

Vala'au mo auaunaga tau fesoasoani mo gagana e leai ni totogi ma fesoasoani fa'aopo'opo talafeagai ma auaunaga.

ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.

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。

Tumawag para kadagiti libre a serbisio iti tulong iti pagsasao ken dagiti nakanada nga aid ken serbisio iti komunikasion.

Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.

Звертайтеся за безкоштовною мовною підтримкою та відповідними додатковими послугами.

ติดต่อขอบริการช่วยเหลือด้านภาษาฟรีพร้อมความช่วยเหลือและบริการอื่นๆ เพิ่มเติม

Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.

Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.

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.

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.

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