Highlights of your Dental Coverage

MainVue Homes, LLC Group Number: 4024205

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

Individual Deductible S50 Shared with In Network Family Deductible S150 Shared with In Network Preventive Cost Share Covered in Full Covered in Full Basic Cost Share Deductible, then 20% Deductible, then 50% Deductible, then 20% Beductible, then 20% Beductible, then 20% Deductible, then 20% Beductible, then 20% Deductible,	DENTAL PLAN	PREMERA PREFERRED CHOICE: DENTAL OPTIMA - \$50/150 DED \$2,000 MAXIMUM WITH ORTHODONTIA	
Individual Deductible S50 Shared with In Network Family Deductible S150 Shared with In Network Preventive Cost Share Covered in Full Covered in Full Basic Cost Share Deductible, then 20% Deductible, then 50% Deductible, then 20% Beductible, then 20% Beductible, then 20% Deductible, then 20% Beductible, then 20% Deductible,		IN-NETWORK	OUT-OF-NETWORK
Family Deductible S150 Shared with In Network Preventive Cost Share Covered in Full Deductible, then 20% Deductible, then 20% Deductible, then 20% Deductible, then 50% Dental Annual Maximum S2,000 PCY applies to basic and major services Defunction Comprehensive / Periodic Oral Exams (2 PCY) Covered in Full Cove	Dental Cost Share	·	
Preventive Cost Share Basic Cost Share Deductible, then 20% Deductible, then 20% Deductible, then 50% Deductible, then 20%	Individual Deductible	\$50	Shared with In Network
Basic Cost Share Deductible, then 20% Deductible, then 50% Deductible, then 20% Deductible, then 20% Deductible, then 50% Deductible, then 20% Deductible, then 20% Deductible, then 50% Deductible, then 20%	Family Deductible	\$150	Shared with In Network
Major Cost Share Deductible, then 50% Deductible, then 50% Deductible, then 50% Stared with In Network Defice Visit Routine Comprehensive / Periodic Oral Exams (2 PCY) Problem Focused/Emergency Exam (Unlimited) Defice Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine)) Preventive Services Prophylaxis - Cleaning (2 PCY) Problem Tecused/Emergency Exam (Unlimited) Defice Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine)) Preventive Services Prophylaxis - Cleaning (2 PCY) Pluoride Treatments (2 PCY; under the age of 19) Sealants (Under age 19 limited to permanent molars only. Replacements limited to once every 24 consecutive months.) Space Maintainers (Members under age 19) Diagnostic Imaging Bittevings X-rays (1 set (up to 4) PCY) Panoramic X-ray or comparable Conebeam view in any 36 consecutive months) Restorative Fillings (1 per surface every 24 consecutive months) Restorative Fillings (1 per surface every 24 consecutive months) Deductible, then 20%	Preventive Cost Share	Covered in Full	Covered in Full
Dental Annual Maximum S2,000 PCY applies to basic and major services Shared with In Network Diffice Visit Routine Comprehensive / Periodic Oral Exams (2 PCY) Covered in Full Preventive Services Prophylaxis - Cleaning (2 PCY) Covered in Full Covered in	Basic Cost Share	Deductible, then 20%	Deductible, then 20%
Problem Focused / Exams (2 PCY) Covered in Full Covered in Ful	Major Cost Share	Deductible, then 50%	Deductible, then 50%
Routine Comprehensive / Periodic Oral Exams (2 PCY) Covered in Full Covered in	Dental Annual Maximum		Shared with In Network
Problem Focused/Emergency Exam (Unlimited) Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine)) Preventive Services Prophylaxis - Cleaning (2 PCY) Covered in Full Covere	Office Visit	·	
Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine)) Preventive Services Prophylaxis - Cleaning (2 PCY) Covered in Full	Routine Comprehensive / Periodic Oral Exams (2 PCY)	Covered in Full	Covered in Full
Preventive Services Prophylaxis - Cleaning (2 PCY) Covered in Full Covered in	Problem Focused/Emergency Exam (Unlimited)	Covered in Full	Covered in Full
Prophylaxis - Cleaning (2 PCY) Covered in Full	Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine))	Covered in Full	Covered in Full
Fluoride Treatments (2 PCY; under the age of 19) Sealants (Under age 19 limited to permanent molars only. Replacements limited to once every 24 consecutive months.) Space Maintainers (Members under age 19) Covered in Full	Preventive Services		
Sealants (Under age 19 limited to permanent molars only. Replacements limited to once every 24 consecutive months.) Space Maintainers (Members under age 19) Covered in Full	Prophylaxis - Cleaning (2 PCY)	Covered in Full	Covered in Full
to once every 24 consecutive months.) Space Maintainers (Members under age 19) Diagnostic Imaging Bitewings X-rays (1 set (up to 4) PCY) Panoramic X-ray or comparable Conebeam view (1 complete series, 1 conoramic or 1 comparable cone beam view in any 36 consecutive months) Restorative Fillings (1 per surface every 24 consecutive months) Installation of Inlays, Onlays and Crowns (1 every 5 calendar years) Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement) Covered in Full Covered in Full Covered in Full Covered in Full Deductible, then 20% Deductible, then 20% Deductible, then 20% Deductible, then 50% Deductible, then 20% Deductible, then 20% Deductible, then 20%	Fluoride Treatments (2 PCY; under the age of 19)	Covered in Full	Covered in Full
Diagnostic Imaging Bitewings X-rays (1 set (up to 4) PCY) Panoramic X-ray or comparable Conebeam view (1 complete series, 1 conoramic or 1 comparable cone beam view in any 36 consecutive months) Restorative Fillings (1 per surface every 24 consecutive months) Installation of Inlays, Onlays and Crowns (1 every 5 calendar years) Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement) Deductible, then 20%	Sealants (Under age 19 limited to permanent molars only. Replacements limited to once every 24 consecutive months.)	Covered in Full	Covered in Full
Bitewings X-rays (1 set (up to 4) PCY) Panoramic X-ray or comparable Conebeam view (1 complete series, 1 conoramic or 1 comparable cone beam view in any 36 consecutive months) Restorative Fillings (1 per surface every 24 consecutive months) Deductible, then 20% Installation of Inlays, Onlays and Crowns (1 every 5 calendar years) Deductible, then 50% Deductible, then 50% Deductible, then 20%	Space Maintainers (Members under age 19)	Covered in Full	Covered in Full
Panoramic X-ray or comparable Conebeam view (1 complete series, 1 conoramic or 1 comparable cone beam view in any 36 consecutive months) Restorative Fillings (1 per surface every 24 consecutive months) Installation of Inlays, Onlays and Crowns (1 every 5 calendar years) Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement) Deductible, then 20%	Diagnostic Imaging		
Restorative Fillings (1 per surface every 24 consecutive months) Deductible, then 20% Installation of Inlays, Onlays and Crowns (1 every 5 calendar years) Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement) Deductible, then 20% Deductible, then 20% Deductible, then 50% Deductible, then 20% Deductible, then 20%	Bitewings X-rays (1 set (up to 4) PCY)	Covered in Full	Covered in Full
Fillings (1 per surface every 24 consecutive months) Installation of Inlays, Onlays and Crowns (1 every 5 calendar years) Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement) Deductible, then 20% Deductible, then 20% Deductible, then 20%	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
Installation of Inlays, Onlays and Crowns (1 every 5 calendar years) Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement) Deductible, then 50% Deductible, then 20%	Restorative		
Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement) Deductible, then 20% Deductible, then 20%	Fillings (1 per surface every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%
after placement) Deductible, then 20% Deductible, then 20%	Installation of Inlays, Onlays and Crowns (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Repair Crown/Inlay/Onlay (When performed 6 or more months after placement) Deductible, then 20% Deductible, then 20%	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%

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Effective Date: 10/01/2022

Highlights of your Dental Coverage

MainVue Homes, LLC Group Number: 4024205

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

DENTAL PLAN	PREMERA PREFERRED CHOICE: DENTAL OPTIMA - \$50/150 DED \$2,000 MAXIMUM WITH ORTHODONTIA	
	IN-NETWORK	OUT-OF-NETWORK
Endodontic Therapy - Root Canal (Once per tooth every 24 consecutive months)	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%
Periodontal Soft Tissue Grafts (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 (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 for surgical implants, implant abutments, and/or implant prosthetics)	Deductible, then 50%	Deductible, then 50%
Oral Surgery		
Simple Extractions	Deductible, then 20%	Deductible, then 20%
Surgical Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%
Oral Surgery (Unlimited)	Deductible, then 20%	Deductible, then 20%
General Services	-	-
Anesthesia - Intravenous or General	Deductible, then 20%	Deductible, then 20%
Palliative (Emergency) Treatment of Dental Pain	Deductible, then 20%	Deductible, then 20%
Orthodontia		
Orthodontia Cost Share	100% up to lifetime max	100% up to Lifetime Max
Lifetime Maximum Benefit	\$1,500 Lifetime	\$1,500 Lifetime

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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 under which the program may be continued in force. This benefit highlight is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.