

Alaska Dental, Vision, and Hearing Plan

1-YEAR TERM OR 3-YEAR TERM STARTING JANUARY 1, 2023

Premera Blue Cross Blue Shield of Alaska offers a Dental, Vision, and Hearing Plan that you may purchase as standalone coverage. A description of benefit coverage is as follows:

Dental Benefit Highlights

You are responsible for all charges over the allowed charge set by Premera.

Benefits	Type A Diagnostic and Preventive Care	Type B Basic Care	Type C Major Services
Deductible	Waived	\$25 (total between both types)	
Coinsurance	0%	15%	Up to 50%
Benefit maximum	\$1,500		
Services provided by a dentist	<ul style="list-style-type: none"> • Oral examinations • Prophylaxis (cleaning) • Topical fluoride application • Dental x-rays • Sealants 	<ul style="list-style-type: none"> • Palliative emergency treatment • Space maintainers • Amalgam and resin-based fillings • Repair and recementing of crowns, inlays, bridgework, and dentures • Endodontics • Periodontic services • Simple extraction • Oral surgery 	<ul style="list-style-type: none"> • Inlays and onlays • Crowns • Bridges, fixed and removable • Dentures, full and partial

Orthodontia Benefit Highlights

Benefits are limited to an Individual Lifetime Maximum of \$1,000 and 50% coinsurance.

Orthodontia Services	
Orthodontia monthly adjustments/treatment (\$1,000 lifetime maximum)	50% coinsurance up to lifetime maximum for diagnostics/banding

Vision Benefit Highlights

Your plan provides benefits for covered services when provided by an ophthalmologist, optometrist, or optician. You are responsible for any charges over Premera's allowed charge.

Routine Vision Services	
Routine vision examinations Limited to one exam per benefit year	\$10 copay
Lenses Limited to one pair per benefit year	\$25 copay
Frames Limited to \$130 retail value every two benefit years	\$25 copay
Contact lenses in lieu of glasses Limited to \$130 per benefit year	0%

Ten-day right to return

Please read your contract when you receive it. If you are not satisfied for any reason, you may return the contract within 10 days after you receive it, and any health plan charges paid will be refunded. The contract will then be void and considered as never effective.

Eligibility, enrollment, and payment

Any Alaska resident may enroll in the Dental, Vision, and Hearing Plan. There is no health statement to complete and you cannot be declined as long as you are a resident at the time you enroll. When applying, you can choose either a 3-year or a 1-year (annual) contract. The full health plan bill must be paid at the time of application, and once coverage begins, the payment is non-refundable.

Each family member applying for coverage must complete a separate application. They should calculate their subscription charge either on the 3-year rate contract term or the 1-year rate contract term using the rate table above. Applications should be returned along with the appropriate payment in the envelope provided. Coverage will begin on the start date specified on the application. Or if there is no date indicated, coverage will begin on the first day of the month following receipt and acceptance by Premera. You will be notified when the contract term is about to end. You may reapply at that time if a new contract is desired. You can reapply as often as you wish, with an unlimited number of consecutive contract terms. The prior contract term must have ended before a new term can begin.

Hearing Benefit Highlights

Your plan pays 80% of the allowed amount up to a maximum benefit of \$3,000 per 3 benefit years. You are responsible for the remaining 20% and any charges over Premera's allowed charge amount or over the \$3,000 per 3 benefit years.

Hearing Services	
Exam by physician One per two benefit years	20%
Exam by audiologist One per contract period	20%
Hearing aid One per 3 benefit years	20%

The maximum benefit for each person is \$3,000 per 3 benefit years. You must provide Premera with written certification from the examining physician, explaining a hearing loss exists and that the hearing loss may be lessened by the use of a hearing aid.

Per Member		
Alaska Dental, Vision, Hearing Plan Contract		
AGE RANGE	1-YEAR CONTRACT TERM	3-YEAR CONTRACT TERM
Under 18	\$966	\$2,608
18-20	\$914	\$2,468
21-24	\$1,010	\$2,727
25-29	\$1,118	\$3,019
30-34	\$1,235	\$3,335
35-39	\$1,331	\$3,594
40-44	\$1,486	\$4,012
45-49	\$1,521	\$4,107
50-54	\$1,540	\$4,158
55-59	\$1,615	\$4,361
60-64	\$1,682	\$4,541
65-69	\$1,825	\$4,928
70-74	\$1,763	\$4,760
75-79	\$1,763	\$4,760

The state of Alaska requires that all Alaska health plan members are informed of the availability of the Dental, Vision, and Hearing plans. This is only a brief outline of the benefits provided by this plan. It is not a contract and does not include all of the benefit limitations or exclusion provisions. The complete terms of the coverage will be determined by the contract.

Discrimination is Against the Law

Premera Blue Cross Blue Shield of Alaska (Premera) complies with applicable Federal 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. 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>.

Language Assistance

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-809-9361 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-809-9361 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-809-9361 (TTY: 711) 번으로 전화해 주십시오.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 800-809-9361 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-809-9361 (телетайп: 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 800-809-9361 (TTY: 711)。

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se togoti, mo oe, Telefoni mai: 800-809-9361 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 800-809-9361 (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。800-809-9361 (TTY:711) まで、お電話にてご連絡ください。

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 800-809-9361 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-809-9361 (TTY: 711).

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

Телефонуйте за номером 800-809-9361 (телетайп: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-809-9361 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-809-9361 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-809-9361 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-809-9361 (رقم هاتف الصم والبكم: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-809-9361 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-809-9361 (ATS: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-809-9361 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-809-9361 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-809-9361 (TTY: 711) تماس بگیرید.