

## 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 ENHANCED+MAX<br>WAIVER+ORTHO |  |
|--------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|--------------------------------------------------------------------------------|--|
|                                                                                                                    | 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                                                                                              | \$1,500 PCY applies to basic and major services | Shared with In Network                                                         |  |
| Benefit Enhancement Rider                                                                                          |                                                 |                                                                                |  |
| Benefit Enhancement Rider                                                                                          | Endodontics & Periodontal Treatment (In Basic)  | Endodontics & Periodontal Treatment (In Basic)                                 |  |
| 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                                                                                                 |                                                 |                                                                                |  |
| Bitewings X-rays (Unlimited)                                                                                       | Covered in Full                                 | Covered in Full                                                                |  |

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|------------------------------------------------------------------------------------------------------------------------------------------|----------------------|--------------------------------------------------------------------------------|--|
|                                                                                                                                          | IN-NETWORK           | OUT-OF-NETWORK                                                                 |  |
| 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 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)                                                                                 | 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%                                                           |  |
| Oral Surgery (Unlimited)                                                                                                                 | Deductible, then 20% | Deductible, then 20%                                                           |  |

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|-------------------------------------------------------------|--|-------------------------|--------------------------------------------------------------------------------|-------------------------|--|
|                                                             |  | IN-NETWORK              |                                                                                | OUT-OF-NETWORK          |  |
| 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                                      |  | 100% up to Lifetime Max |                                                                                | 100% up to Lifetime Max |  |
| Lifetime Maximum Benefit                                    |  | \$1,500 Lifetime        |                                                                                | \$1,500 Lifetime        |  |
| 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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