This is only a summary. If you want more detail about dental coverage and costs under this plan, you can get the complete terms in the policy or plan document at **www.premera.com/ak** or by calling **800-809-9361.**

Important Questions	Answers	Why this Matters
What is the premium amount?	$40	The premium amount is a monthly fee you must pay to your insurance company to receive dental insurance.
What is the overall deductible?	$65	You must pay all the costs related to covered services up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Does the deductible apply to preventive services?	No	The deductible does **not** apply to preventive exams, cleanings, or other preventive services. See the chart starting on page 2 for how much you pay for covered preventive services.
What is the out–of–pocket limit on my expenses?	$450 for 1 child $900 for 2+ children	The out-of-pocket limit is the most you could pay during the coverage year for your share of the cost of covered services. This limit helps you plan for dental care expenses.
What is not included in the out-of-pocket limit?	Premiums, non-covered services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No	There is no overall annual limit on what the plan will pay. The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services for children. This plan does not cover benefits for adults.
Who is included in this plan's network of providers?	See www. wahbexchange.org or call 1-855-923-4633 for a list of participating providers.	If you use an in-network provider, this plan will pay some or all of the cost of the covered services. Be aware, your in-network dentist may use an out-of-network provider (e.g., a hospital) for some services. Plans use the term in-network, preferred, or participating for providers in their networks. See chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No	You can see the specialist you choose **without** permission from this plan.
Do I need preauthorization before receiving certain dental services?	Yes	You **do** need to call the plan at 1-855-923-4633 before receiving certain dental services. See your policy or plan document for additional information.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 3. See your policy or plan document for additional information about excluded services.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered dental care, usually at the time of the service.
- **Coinsurance**, which is different from copayments, is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for a restorative procedure (e.g., a crown) is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network dentist charges $1,500 for a crown and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

⚠ All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Dental Treatment	Services You May Need	What you will pay if you use:		Limitations, Exceptions & Other Important Information
		In-Network Provider	Out-of-Network Provider	
Routine Check-up	Exams	Covered in Full	30%	Routine, comprehensive and periodic oral evaluations are limited to 1 every 6 months
	Teeth Cleanings	Covered in Full	20%	Limited to 1 every 6 months
	Fluoride	Covered in Full	20%	Limited to 1 every 6 months
	Sealants	Covered in Full	20%	Unrestored permanent molars, under age 19, limited to 1 sealant per tooth every 36 months
	Full Mouth X-rays	20%	30%	Limited to 1 every 5 years
	Bitewing X-ray	Covered in Full	30%	Limited to 1 every 6 months
	Single Tooth X-rays	Covered in Full	30%	
	Space Maintainers	Covered in Full	20%	Limited to members age 12 years and younger
	Nitrous oxide	Not covered	Not covered	

Filling a Cavity	Amalgam (Silver Filings) Front Tooth	20%	40%	Limited to once every 24 months
	Amalgam (Silver Filings) Back Tooth	20%	40%	Limited to once every 24 months
	Composite Front Tooth	20%	40%	Limited to once every 24 months
	Composite Back Tooth	20%	40%	Limited to once every 24 months
	Nitrous oxide	Not covered	Not covered	
	Temporary Filings	20%	40%	
Restorative Care	Periodontal Maintenance Cleanings (Treatment of gums)	20%	40%	Periodontal maintenance limited to 4 per calendar year
	Periodontal Scaling and Root Planing	20%	40%	• Full mouth debridement is limited to once per lifetime • Periodontal scaling and root planning, four or more teeth per quadrant, limited to once every 24 months
	Crowns	20%	40%	Covered for members age 14 years old and younger. Limited to 1 per tooth every 5 years
	Replacement of a Crown	20%	40%	Limited to 1 per tooth every five years
	Onlays	50%	50%	Limited to 1 per tooth every five years
	Root canal (per tooth)	50%	50%	
	Pulpotomy	50%	50%	Limited to primary teeth
Tooth Extraction	Extraction (per tooth)	20%	40%	
	Surgical Extraction (per tooth)	50%	50%	

Advanced Oral Surgery	Oral surgery	50%	50%	
	Periodontal Surgery	50%	50%	
	General Anesthesia	50%	50%	
Orthodontia	Braces	50%	50%	Medically necessary up to age 19
	Removable appliances	Not covered	Not covered	
Prosthetics	Implants	Not covered	Not covered	
	Partial Dentures	50%	50%	
	Complete Dentures	50%	50%	
	Bridge or Denture Repair	20%	40%	
	Rebase or Reline of Dentures	50%	50%	Limited to once in a three year period when performed at least six-months after initial installation

Excluded Services & Other Covered Services

Services This Plan Does NOT Cover (This isn't a complete list. Check the policy or plan document for other excluded services.)

- Adult dental care
- Application of any type of desensitizing medicament
- Cast-metal framework, flexible base, and removable unilateral partial dentures
- Cleaning of appliances
- Connector bar or stress breaker
- Coping
- Diagnostic tests and examinations including collection, preparation, analysis, viral culture, genetic and caries susceptibility tests, and adjunctive pre-diagnostic tests.
- Diagnostic tomographic surveys, cone beam, MRI, ultrasound, 3-D imaging, and posterior-anterior or lateral skull and facial bone survey films
- Duplicate appliances
- Duplicate x-rays
- Extra dentures or other duplicate appliances, including replacements due to loss or theft
- Fabrication of an athletic mouthguard
- Facility charges (hospital and ambulatory surgical center) for dental procedures
- Gold foil restorations
- Home use products. Services and supplies that are normally intended for home use such as take-home fluoride, toothbrushes, floss and toothpaste
- Immediate dentures
- Implants and implant related services including but not limited to:
  - Surgical placement of implants including endosteal, eposteal, and transosteal;
  - Interim endosseous implants;
  - Endodontic endosseous implants;
  - Sinus augmentations or lift;
  - Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis;
  - Radiographic/surgical implant index;
  - Unspecified implant procedures.
- Indirect pulp caps
- Labial veneers
- Localized delivery of antimicrobial agents
- Medication and supply such as take-home drugs, pre-medications, therapeutic drug injections and supplies
- Occlusion analysis and limited and complete occlusal adjustments
- Oral pathology laboratory including collection of tissue samples, cultures and specimens
- Oral surgery treating fracture of the mandible (jaw)

- Pin retention in addition to restoration
- Plaque control programs (dietary instruction and home fluoride kits)
- Precision attachments, replacement of replaceable parts for semi-precision or precision attachments and personalization of appliances
- Provisional splinting
- Sedative fillings
- Surgical procedures including:
  - Exfoliative cytology sample collection or brush biopsy
  - Incision and drainage of abscess-extra oral soft tissue
  - Radical resection of maxilla or mandible
  - Removal of non-odontogenic cyst, tumor or lesion
  - Surgical stent
  - Surgical procedures for isolation of a tooth with rubber dam
- Temporary, interim or provisional services for crowns, bridges or dentures
- Tobacco cessation and nutritional counseling for control of dental disease
- Tooth preparation, acid etching, all adhesives, and liners
- Tooth transplantation including re-implantation from one site to another and splinting and/or stabilization
- Prescription drugs
- Treatment of temporomandibular joint (TMJ) disorder

Other Covered Services (This isn't a complete list. Check the policy or plan document for other covered services.)

- Endodontic services
- Surgical periodontic services
- Anesthesia services
- Treatment of accidental injuries

Grievance and Appeals Rights

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Customer Service at 800-809-9361.

Does this Coverage Provide Minimum Essential Coverage?

This plan or policy meets the Affordable Care Act's minimum value and benefits requirements for the pediatric dental essential health benefits.

Notice of availability and nondiscrimination 800-809-9361 | 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.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
ติดต่อขอบริการช่วยเหลือด้านภาษาฟรีพร้อมความช่วยเหลือและบริการอื่น ๆ 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.

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, 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, or sex. 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, or sex, 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.