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
Is there a waiting period before I can use my benefits?	**No**	Some insurance companies require customers to have coverage for a set number of months before their services can be used.
What is the premium amount?	**Adult: $**36 **Child:** 0-18 yr old: $40	The premium amount is a monthly fee you must pay to your insurance company to receive dental insurance.
What is the overall deductible?	**Adult: $0** **Child: $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 period starts (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** 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.
Is there an overall out-of-pocket limit on my share of dental costs?	**Adult: No** **Child: Yes** **$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?	**Adult: Yes, $1,100** **Child: No**	There is no overall annual limit on what the plan will pay for children. The chart starting on page 2 describes any limits on what the plan will pay for adult coverage and other *specific* covered services for children.
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-pocket 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.
Some services in this plan are not covered for adults. The plan does not cover the service if adult copayment and coinsurance costs are not shown.

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	Oral Exams	**Adult:** 20%	40%	Routine, comprehensive and periodic oral evaluations are limited to 1 every 6 months
		Child: Covered in full	30%	Routine, comprehensive and periodic oral evaluations are limited to 1 every 6 months
	Teeth Cleanings	**Adult:** 20%	40%	Limited to 1 every 6 months
		Child: Covered in full	20%	Limited to 1 every 6 months
	Fluoride	**Adult:** 20%	40%	Limited to 2 every 12 months age 21 and under
		Child: Covered in full	20%	Limited to 1 every 6 months
	Sealants	**Adult:** 20%	40%	Limited to once every 5 calendar years, age 19 and older
		Child: Covered in full	20%	Unrestored permanent molars, under age 19, limited to 1 sealant per tooth every 36 months
	Full mouth X-rays	**Adult:** 20%	40%	Limited to once every 5 years
		Child: 20%	30%	Limited to 1 every 6 months
	Bitewing X-rays	**Adult:** 20%	40%	Limited to once per calendar year
		Child: Covered in full	30%	Limited to 1 every 6 months
	Single Tooth X-rays	**Adult:** 20%	40%	
		Child: Covered in full	30%	

	Space Maintainers	**Adult:** Not covered	Not covered	
		Child: Covered in full	20%	Limited to members age 12 years and younger
	Nitrous oxide	**Adult:** Not covered	Not covered	
		Child Not covered	Not covered	
Filling a Cavity	Amalgam (Silver Fillings) Front Tooth	**Adult:** 40%	60%	Limited to once every 2 calendar years
		Child: 20%	40%	Limited to once every 24 months
	Amalgam (Silver Fillings) Back Tooth	**Adult:** 40%	60%	Limited to once every 2 calendar years
		Child: 20%	40%	Limited to once every 24 months
	Composite Front Tooth	**Adult:** 40%	60%	Limited to once every 2 calendar years
		Child: 20%	40%	Limited to once every 24 months
	Composite Back Tooth	**Adult:** 40%	60%	Limited to once every 2 calendar years
		Child: 20%	40%	Limited to once every 24 months
	Nitrous oxide	**Adult:** Not covered	Not covered	
		Child: Not covered	Not covered	
	Temporary Fillings	**Adult:** 40%	60%	
		Child: 20%	40%	
Restorative Care	Periodontal Maintenance / Cleaning (Treatment of gums)	**Adult:** 20%	40%	Periodontal maintenance limited to 4 visits per calendar year combined with prophylaxis after the completion of active periodontal therapy
		Child: 20%	40%	Periodontal maintenance limited to 4 per calendar year
	Periodontal Scaling and Root Planning	**Adult:** 40%	60%	Periodontal scaling and root planning, one to three teeth, per quadrant limited to 1 every 24 months
		Child: 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	**Adult:** Not covered	Not covered	
		Child: 20%	40%	Covered for members age 14 years old and younger Limited to 1 per tooth every 5 years
	Replacement of a Crown	**Adult:** Not covered	Not covered	
		Child: 20%	40%	Limited to 1 per tooth every five years

	Onlays	**Adult:** Not covered	Not covered	
		Child: 50%	50%	Limited to 1 per tooth every five years
	Root canal (per tooth)	**Adult:** Not covered	Not covered	
		Child: 50%	50%	
	Pulpotomy	**Adult:** Not covered	Not covered	
		Child: 50%	50%	Limited to primary teeth
Tooth Extraction	Extraction (per tooth)	**Adult:** Not covered	Not covered	
		Child: 20%	40%	
	Surgical Extraction (per tooth)	**Adult:** 50%	50%	
		Child: 50%	50%	
Advanced Oral Surgery	Oral surgery	**Adult:** 50%	50%	
		Child: 50%	50%	
	Periodontal Surgery	**Adult:** 50%	50%	Limited to once every 36 months age 19 and over
		Child: 50%	50%	
	General Anesthesia	**Adult:** 50%	50%	
		Child: 50%	50%	
Orthodontia	Braces	**Adult:** Not covered	Not covered	
		Child: 50%	50%	Medically necessary up to age 19
	Removable appliances	**Adult:** Not covered	Not covered	
		Child: Not covered	Not covered	
Prosthetics	Implants	**Adult:** Not covered	Not covered	
		Child: Not covered	Not covered	
	Partial Dentures	**Adult:** Not covered	Not covered	
		Child: 50%	50%	
	Complete Dentures	**Adult:** Not covered	Not covered	
		Child: 50%	50%	

	Bridge or Denture Repair	**Adult:** 50%	50%	
		Child: 20%	40%	Limited to once in a 12 month period
	Rebase or Reline of Dentures	**Adult:** 50%	50%	Limited to once in a three year period when performed at least six-months after initial installation
		Child: 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.)

Adults:

- Pediatric dental care
- Pre-diagnostic services such as screening or assessments
- Oral pathology laboratory
- Cone beams, MRI and ultrasounds
- Tests and examinations such as genetic, caries, pulp vitality, diagnostic casts and risk assessment
- Lab collection, testing, processing and analysis
- Nutritional and tobacco counseling
- Oral hygiene instructions
- Preventive resin restorations or interim carries arresting medicament application
- Space maintainers, including recement or removal
- Resin infiltration and resin-based composite crowns
- Gold foils, inlay and onlay restorations
- Crowns and provisional crowns including re-cement, re-bond and repair of crowns
- Crown core buildups including any pins/posts
- Veneers
- Endodontic services including root canals, apexification/recalcification, pulpal regeneration, and apicoectomy/periradicular services
- Pulpotomies
- Periodontal surgery
- Provisional splinting
- Full mouth debridement
- Complete and partial dentures including adjustments, repairs, rebase, reline, and tissue conditioning. This includes inspection and removal
- Interim complete and partial dentures
- Overdentures
- Precision attachments
- Maxillofacial prosthetics including fluoride, medicament and radiation carriers

- Implant and implant related services
- Fixed partial dentures or bridges including re-cement and re-bond
- Temporary partial dentures or bridges
- Precision attachments
- Tooth extractions
- Oral and maxillofacial surgery including extraction and removal of teeth
- Alveoloplasty and vestibuloplasty
- Cast-metal framework, flexible base, and removable unilateral partial dentures
- Excision of lesions and bone tissue
- Surgical incisions
- Treatment of fractures
- Sutures and other repair procedures such as skin grafts
- Bone grafts
- Collection and application of blood
- Frenulectomy and frenuloplasty
- Salivary surgical procedures
- Tracheotomy/coronoidectomy
- Temporomandibular Joint (TMJ) Disorders including any dental services or supplies connected with the diagnosis or treatment of temporomandibular joint (TMJ) disorders, including any direct or indirect complications and aftereffects
- Orthognathic Surgery including procedures to lengthen or shorten the jaw (orthognathic surgery), regardless of the origin of the condition that makes the procedure necessary
- Orthodontia, regardless of condition, including casts, models, x-rays, photographs, examinations, appliances, braces, and retainers.
- Adjunctive general services such as anesthesia, drugs
- Application of desensitizing medicament
- Occlusal guard (nightguard) and athletic mouthguards, including repair and reline
- Occlusal analysis
- Occlusal adjustment (limited and complete)
- Enamel microabrasion, odontoplasty, and bleaching
- Prescription drugs

Children:

- 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.)

Children:

- 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 benefit.

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.

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