

## Highlights of your Dental Coverage

### Bartlett Regional Hospital

Group Number: 9001328

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

Effective Date: 07/01/2025

2025 DENTAL OPTIMA - DENTAL BUY UP - ORTHO 50% \$2500		
	IN-NETWORK	OUT-OF-NETWORK
<b>DENTAL PLAN</b>		
<b>Dental Cost Share</b>		
Individual Deductible	\$50 PPY/\$150 PPY, also applies to Orthodontia	\$50 PPY/\$150 PPY, also applies to Orthodontia
Family Deductible	\$50 PPY/\$150 PPY, also applies to Orthodontia	\$50 PPY/\$150 PPY, also applies to Orthodontia
Preventive Cost Share	Covered in Full	Covered in Full
Basic Cost Share	Deductible, then 20%	Deductible, then 20%
Major Cost Share	Deductible, then 20%	Deductible, then 20%
Dental Reimbursement (Dental Choice Network)	AK fee schedule	80th percentile (in-state) and 90th percentile (out-of-state)
Dental Annual Maximum	\$3,000 PPY applies to basic and major services	\$3,000 PPY applies to basic and major services
<b>Benefit Enhancement Rider</b>		
Benefit Enhancement Rider	Endodontics & Periodontal Treatment (In Basic)	Endodontics & Periodontal Treatment (In Basic)
<b>Office Visit</b>		
Routine Comprehensive / Periodic Oral Exams (2 PPY)	Covered in Full	Covered in Full
Problem Focused/Emergency Exam (2 PPY)	Covered in Full	Covered in Full
Office Visits, Prof Consults, Perio Evals (2 PPY (Shared with Routine))	Covered in Full	Covered in Full
<b>Preventive Services</b>		
Prophylaxis - Cleaning (2 PPY)	Covered in Full	Covered in Full
Fluoride Treatments (2 PPY; 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

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	IN-NETWORK	OUT-OF-NETWORK
<b>DENTAL PLAN</b>		
<b>Diagnostic Imaging</b>		
<b>Bitewings X-rays (Unlimited)</b>	Covered in Full	Covered in Full
<b>Panoramic X-ray or comparable Conebeam view (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)</b>	Covered in Full	Covered in Full
<b>Restorative</b>		
<b>Fillings (1 per surface every 24 consecutive months)</b>	Deductible, then 20%	Deductible, then 20%
<b>Installation of Inlays, Onlays and Crowns (1 every 5 calendar years)</b>	Deductible, then 20%	Deductible, then 20%
<b>Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement)</b>	Deductible, then 20%	Deductible, then 20%
<b>Repair Crown/Inlay/Onlay (When performed 6 or more months after placement)</b>	Deductible, then 20%	Deductible, then 20%
<b>Endodontics</b>		
<b>Endodontic Therapy - Root Canal (Once per tooth every 24 consecutive months)</b>	Deductible, then 20%	Deductible, then 20%
<b>Periodontics</b>		
<b>Periodontal Maintenance (4 PPY)</b>	Deductible, then 20%	Deductible, then 20%
<b>Full Mouth Debridement (Once every 36 consecutive months)</b>	Deductible, then 20%	Deductible, then 20%
<b>Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)</b>	Deductible, then 20%	Deductible, then 20%
<b>Periodontal Surgery (Once per quadrant every 36 consecutive months)</b>	Deductible, then 20%	Deductible, then 20%
<b>Periodontal Soft Tissue Grafts (Once per quadrant every 36 consecutive months)</b>	Deductible, then 20%	Deductible, then 20%
<b>Prosthodontics (Dentures/Bridges)</b>		
<b>Installation or Replacement of Dentures, Partials and Fixed Bridges (1 every 5 calendar years)</b>	Deductible, then 20%	Deductible, then 20%
<b>Repair or Re-cement Bridgework and Dentures (When performed 6 or more months after placement)</b>	Deductible, then 20%	Deductible, then 20%
<b>Implant Services</b>		

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DENTAL PLAN	IN-NETWORK	OUT-OF-NETWORK
<b>Implant Crowns/Bridge/Denture</b> (1 every 5 calendar years)	Deductible, then 20%	Deductible, then 20%
<b>Oral Surgery</b>		
<b>Simple Extractions</b> (Unlimited)	Deductible, then 20%	Deductible, then 20%
<b>Surgical Extractions</b> (Unlimited)	Deductible, then 20%	Deductible, then 20%
<b>Oral Surgery</b> (Unlimited)	Deductible, then 20%	Deductible, then 20%
<b>General Services</b>		
<b>Anesthesia - Intravenous or General</b> (Unlimited)	Deductible, then 20%	Deductible, then 20%
<b>Anesthesia - Nitrous Oxide</b> (Unlimited)	Deductible, then 20%	Deductible, then 20%
<b>Palliative (Emergency) Treatment of Dental Pain</b> (Unlimited)	Deductible, then 20%	Deductible, then 20%
<b>Orthodontia</b>		
<b>Orthodontia Cost Share</b>	Deductible then, 50% up to Lifetime max diag/banding	Deductible then, 50% up to Lifetime max diag/banding
<b>Age Limit</b>	No Age Limit	No Age Limit
<b>Lifetime Maximum Benefit</b>	\$2,500 Lifetime	\$2,500 Lifetime
<b>TMJ</b> (Not Covered)	Not Covered	Not Covered

Diagnostic and Preventive Care Services aren't subject to the plan year deductible. PPY = Per Plan Year. Balance billing may apply if a provider is not contracted with Premera 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.*

## 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](mailto: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 serbisyong tulong sa wika nang walang bayad. Tumawag sa 800-508-4722 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-508-4722 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-508-4722 (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 800-508-4722 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-508-4722 (телефон: 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 800-508-4722 (TTY : 711)。

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Samoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 800-508-4722 (TTY: 711).

ໃບດອກບາ: ຖ້າວ້າ ທ່ານວ້າເມື່ອການວ່າວ້າ, ການບໍລິການວ່າລູ້ອດັງການວ່າວ້າ, ໂດຍບໍ່ເວັ້ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທດ 800-508-4722 (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。800-508-4722 (TTY:711) まで、お電話にてご連絡ください。

PAKDAAR: Nu saitaem ti Ilocano, ti serbisyong para ti baddang ti lengguaheng nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 800-508-4722 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-508-4722 (TTY: 711).

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

Телефонуйте за номером 800-508-4722 (телефон: 711).

ເໜີຍປາ: ຄ້າຄຸນພູດພາກຊາໄທຢູ່ຄຸນສາມາດຮັບອຳນວຍແລ້ວທາງພາກຊາໄຕ້ພີ່ ໃຫ້ 800-508-4722 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-508-4722 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwój pod numer 800-508-4722 (TTY: 711).

ملحوظة: إذا كنت تتحدث انكى اللغة، فإن خدمات المساعدة اللغوية متوفراً لك بالمجان. اتصل برقم 800-508-4722 (رقم هاتف الصمم: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-508-4722 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-508-4722 (ATS : 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-508-4722 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-508-4722 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (711) 800-508-4722 تماس بگیرید.

037379 (07-01-2021)