PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

# Highlights of your Dental Coverage

## Alaska Public Broadcasting Health Trust

**Group Number: 4003399**

**Effective Date: 01/01/2027**

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

| DENTAL PLAN | 2027 DENTAL OPTIMA 0%/20%/50%/$1,500/ENHANCED + ANNUAL MAX WAIVER | |
|---|---|---|
| | **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 |



1090569-03 Independent Licensee of the Blue Cross Blue Shield Association

# Highlights of your Dental Coverage

## Alaska Public Broadcasting Health Trust

**Group Number: 4003399**

**Effective Date: 01/01/2027**

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

| DENTAL PLAN | 2027 DENTAL OPTIMA 0%/20%/50%/$1,500/ENHANCED + ANNUAL MAX WAIVER | |
|---|---|---|
| | 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 & Crowns** (Replacement once per tooth, 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** (Replacement once 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** (Replacement once per tooth, every 5 calendar years) | Deductible, then 50% | Deductible, then 50% |

# Highlights of your Dental Coverage

## Alaska Public Broadcasting Health Trust

**Group Number: 4003399**

**Effective Date: 01/01/2027**

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

| DENTAL PLAN | 2027 DENTAL OPTIMA 0%/20%/50%/$1,500/ENHANCED + ANNUAL MAX WAIVER | |
|---|---|---|
| | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Implant Bridge and Denture** (Replacement once 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% |
| **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% |

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 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.*

## 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.
Звертайтесь 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.

**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.

037398 (07-05-2024)