Alaska Standard 2-9 (non-voluntary) & 3-9 Voluntary

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Plan name	Option 1 Indemnity 1500	Option 2 PPO 1000	Option 3 PPO 1500	Option 4 PPO 2000	Option 5 PPO 500R	Option 6 PPO 1500R	Voluntary Option 1	Voluntary Opt 2 PPO 500R
	Indemnity 100/80/50	PPO 100/80/50	PPO 100/80/50	PPO 100/80/50	PPO 100/30/30	PPO 100/80/50	PPO 100/80/50	PPO 100/30/30
Annual deductible per member (does not apply to diagnostic & preventive services)	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum	$25; 3X Family Maximum	$25; 3X Family Maximum	$75; 3X Family Maximum	$25; 3X Family Maximum
Annual maximum benefit	$1,500	$1,000	$1,500	$2,000	$500	$1,500	$1,000	$500
Diagnostic services								
Oral exams								
Periodic oral exam	100%	100%	100%	100%	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%	100%	100%	100%	100%
X-rays								
Bitewing - single film	100%	100%	100%	100%	100%	100%	100%	100%
Complete series	100%	100%	100%	100%	100%	100%	100%	100%
Preventive services								
Cleaning	100%	100%	100%	100%	100%	100%	100%	100%
Sealants - per tooth	100%	100%	100%	100%	100%	100%	100%	100%
Fluoride application - child	100%	100%	100%	100%	100%	100%	100%	100%
Space maintainers	100%	100%	100%	100%	100%	100%	100%	100%
Basic services								
Amalgam fillings	80%	80%	80%	80%	30%	80%	80%	30%
Resin fillings, anterior	80%	80%	80%	80%	30%	80%	80%	30%
Oral surgery								
Extraction - exposed root or erupted tooth	80%	80%	80%	80%	30%	80%	80%	30%
Extraction of impacted tooth - soft tissue	80%	80%	80%	80%	30%	80%	80%	30%
***Major services: Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service. Does not apply to the 500R and 1500R plans.**								
Complete upper denture	50%	50%	50%	50%	30%	50%	50%	30%
Partial upper denture (resin base)	50%	50%	50%	50%	30%	50%	50%	30%
Crown - Porcelain with noble metal	50%	50%	50%	50%	30%	50%	50%	30%
Pontic - Porcelain with noble metal	50%	50%	50%	50%	30%	50%	50%	30%
Oral surgery								
Removal of impacted tooth - partially bony	50%	50%	50%	50%	30%	50%	50%	30%
Endodontic services								
Bicuspid root canal therapy	50%	50%	50%	80%	30%	80%	50%	30%
Molar root canal therapy	50%	50%	50%	50%	30%	80%	50%	30%
Periodontic services								
Scaling & root planing - per quadrant	50%	50%	50%	80%	30%	80%	50%	30%
Osseous surgery - per quadrant	50%	50%	50%	50%	30%	80%	50%	30%
Orthodontic services (lifetime max when covered)	Not covered	Not covered	Not covered	Not covered	Not covered	50% $1000	Not covered	Not covered

Dental insurance plans are offered and/or underwritten by Aetna Life Insurance Company (Aetna).

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Alaska Standard (non-voluntary) and voluntary dental (10+)

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Plan name	Option 1A PPO 80/80/50	Option 2A PPO 80/80/50 Plus	Option 3A PPO 1000	Option 4A PPO 1000 Plus	Option 5A PPO 1500	Option 6A PPO 1500 Plus	Option 7A PPO 2000
	PPO 80/80/50	PPO 80/80/50	PPO 100/80/50	PPO 100/80/50	PPO 100/80/50	PPO 100/80/50	PPO 100/80/50
Annual deductible per member (does not apply to diagnostic & preventive services)	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum	$50; 3X Family Maximum
Annual maximum benefit	$1,500	$1,500	$1,000	$1,000	$1,500	$1,500	$2,000
Diagnostic services							
Oral exams							
Periodic oral exam	80%	80%	100%	100%	100%	100%	100%
Comprehensive oral exam	80%	80%	100%	100%	100%	100%	100%
Problem-focused oral exam	80%	80%	100%	100%	100%	100%	100%
X-rays							
Bitewing - single film	80%	80%	100%	100%	100%	100%	100%
Complete series	80%	80%	100%	100%	100%	100%	100%
Preventive Services							
Cleaning	80%	80%	100%	100%	100%	100%	100%
Sealants - per tooth	80%	80%	100%	100%	100%	100%	100%
Fluoride application - child	80%	80%	100%	100%	100%	100%	100%
Space maintainers	80%	80%	100%	100%	100%	100%	100%
Basic services							
Amalgam filling - 2 surfaces	80%	80%	80%	80%	80%	80%	80%
Resin filling - 2 surfaces, anterior	80%	80%	80%	80%	80%	80%	80%
Endodontic Services							
Bicuspid root canal therapy	80%	80%	80%	80%	80%	80%	80%
Periodontic Services							
Scaling & root planing - per quadrant	80%	80%	80%	80%	80%	80%	80%
Oral Surgery							
Extraction - exposed root or erupted tooth	80%	80%	80%	80%	80%	80%	80%
Extraction of impacted tooth - soft tissue	80%	80%	80%	80%	80%	80%	80%
***Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major & Ortho Services. Does not apply to Options 10A and 11A.**							
Complete upper denture	50%	50%	50%	50%	50%	50%	50%
Partial upper denture (resin base)	50%	50%	50%	50%	50%	50%	50%
Crown - Porcelain with noble metal	50%	50%	50%	50%	50%	50%	50%
Pontic - Porcelain with noble metal	50%	50%	50%	50%	50%	50%	50%
Oral Surgery							
Removal of impacted tooth - partially bony	80%	80%	50%	80%	80%	80%	80%
Endodontic Services							
Molar root canal therapy	80%	80%	50%	80%	80%	80%	80%
Periodontic Services							
Osseous surgery - per quadrant	80%	80%	50%	80%	80%	80%	80%
***Orthodontic Services**	50%	50%	50%	50%	50%	50%	50%
Orthodontic Lifetime Maximum	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,500

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Alaska Standard (non-voluntary) and voluntary dental (10+)

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Plan name	Option 8A PPO 2000 Plus	Option 9A Indemnity 1500	Option 10A PPO 500R	Option 11A PPO 1500R
	PPO 100/80/50	Indemnity 100/80/50	PPO 100/30/30	PPO 100/80/50
Annual deductible per member (does not apply to diagnostic & preventive services)	$50; 3X Family Maximum	$50; 3X Family Maximum	$25; 3X Family Maximum	$25; 3X Family Maximum
Annual maximum benefit	$2,000	$1,500	$500	$1,500
Diagnostic services				
Oral exams				
Periodic oral exam	100%	100%	100%	100%
Comprehensive oral exam	100%	100%	100%	100%
Problem-focused oral exam	100%	100%	100%	100%
X-rays				
Bitewing - single film	100%	100%	100%	100%
Complete series	100%	100%	100%	100%
Preventive Services				
Cleaning	100%	100%	100%	100%
Sealants - per tooth	100%	100%	100%	100%
Fluoride application - child	100%	100%	100%	100%
Space maintainers	100%	100%	100%	100%
Basic services				
Amalgam filling - 2 surfaces	80%	80%	30%	80%
Resin filling - 2 surfaces, anterior	80%	80%	30%	80%
Endodontic Services				
Bicuspid root canal therapy	80%	80%	30%	80%
Periodontic Services				
Scaling & root planing - per quadrant	80%	80%	30%	80%
Oral Surgery				
Extraction - exposed root or erupted tooth	80%	80%	30%	80%
Extraction of impacted tooth - soft tissue	80%	80%	30%	80%
***Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major & Ortho Services. Does not apply to Options 10A and 11A.**				
Complete upper denture	50%	50%	30%	50%
Partial upper denture (resin base)	50%	50%	30%	50%
Crown - Porcelain with noble metal	50%	50%	30%	50%
Pontic - Porcelain with noble metal	50%	50%	30%	50%
Oral Surgery				
Removal of impacted tooth - partially bony	80%	80%	30%	80%
Endodontic Services				
Molar root canal therapy	80%	80%	30%	80%
Periodontic Services				
Osseous surgery - per quadrant	80%	80%	30%	80%
***Orthodontic Services**	50%	50%	Not covered	Always included 50%
Orthodontic Lifetime Maximum	$1,500	$1,000	Does not apply	Always included $1,000

Dental insurance plans are offered and/or underwritten by Aetna Life Insurance Company (Aetna).

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Limitations & Exclusions

Not every health service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are medically necessary and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What The Plan Covers* section or by amendment attached to this Booklet.

Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Plan Covers* section.

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet.

Charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider's license.

Charges submitted for services that are not rendered, or not rendered to a person not eligible for coverage under the plan.

Court ordered services, including those required as a condition of parole or release.

Any dental examinations:
- required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
- required by any law of a government, securing insurance or school admissions, or professional or other licenses;
- required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
- any special medical reports not directly related to treatment except when provided as part of a covered service.

Experimental or investigational drugs, devices, treatments or procedures, except as described in the What the Plan Covers section.

Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

Miscellaneous charges for services or supplies including:
- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
- Care in charitable institutions;
- Care for conditions related to current or previous military service; or
- Care while in the custody of a governmental authority.

Non-medically necessary services, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary, as determined by Aetna, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.

Routine dental exams and other preventive services and supplies, except as specifically provided in the What the Plan Covers section.

Services rendered before the effective date or after the termination of coverage, unless coverage is continued under the Continuation of Coverage section of this Booklet.

Work related: Any illness or injury related to employment or self-employment including any injuries that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational" regardless of cause.

Exclusions That Apply to Basic Comprehensive Dental Insurance

Not every dental care service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section or by amendment attached to this Booklet-Certificate. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations. This includes services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services. These dental exclusions are in addition to the exclusions listed under your medical coverage.

Apicoectomy, (dental root resection), root canal treatment.

Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery; personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance, augmentation and vestibuloplasty; and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *What the Plan Covers* section. Facings on molar crowns and pontics will always be considered cosmetic. This exclusion does not apply to external bleaching.

- It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
- The tooth is an abutment to a covered partial denture or fixed bridge.

Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants.

Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider, provided in connection with treatment or care that is not covered under the plan.

Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

- Under any other part of this plan; or
- Under any other plan of group benefits provided by the policyholder.

Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion.

First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered.

Limitations & Exclusions

Any instruction for diet, plaque control and oral hygiene.
General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply.
Except as covered in the *What the Plan Covers* section, non-surgical and surgical treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.
Orthodontic treatment except as covered in the *What the Plan Covers* section.
Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium) except as covered in the *What the Plan Covers* section.
Prescribed drugs, pre-medication or analgesia.
Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.
Replacement of teeth beyond the normal complement of 32.
Removal of soft bony impactions.
Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services.

Surgical removal of impacted wisdom teeth when only for orthodontic reasons.
Topical application of fluoride.
Treatment by other than a dentist. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a dentist. These are:
- Scaling of teeth;
- Cleaning of teeth; and
- Topical application of fluoride.

Treatment of alveolectomy.
Treatment of periodontal disease.

Waiting periods, limitations and exclusions may not apply to all plans or all states.

Notes

2-9 non-voluntary and 3-9 voluntary

*Coverage Waiting Period: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service. Does not apply to the PPO 500R and 1500R plans.
Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services in Plan Option 4. General anesthesia along with all Oral Surgery, Endodontic and Periodontic services are covered as Basic Services on the PPO 500R and 1500R plans.

PPO plans: Out-of-Network plan payments are limited by geographic area to the prevailing fees at the 95th percentile

Indemnity Plan Option 1: Actual plan payments are limited by geographic area prevailing fees at the 95th percentile

Coverage for Implants is included as a Major Service on the PPO 500R and 1500R plans.

PPO 500R and 1500R plans: Orthodontic coverage is included for adults and dependent children.

10+ non-voluntary and voluntary

*Coverage Waiting Period applies to Voluntary Plans: Must be an enrolled member of the Plan for 12 months before becoming eligible for coverage of any Major Service including Orthodontic Services. Does not apply to Voluntary Options 10A and 11A

Most Oral Surgery, Endodontic and Periodontic services are covered as Basic Services in Plan Option 3A .All Oral Surgery, Endodontic and Periodontic services are covered as Basic Services in Plan Options 1A, 4A 5A, 7A & 9A. General anesthesia along with all Oral Surgery, Endodontic and Periodontic services are covered as Basic Services in Plan Options 2A, 6A, 8A, 10A and 11A.

Coverage for Implants is included as a Major Service in Plan Options 8A, 10A and 11A.

Out-of-Network plan payments are limited by geographic area to the prevailing fees at the 95th percentile

Actual plan payments on Indemnity Plan Option 9A are limited by geographic area prevailing fees at the 95th percentile.

Orthodontic coverage is optional for dependent children only. Option 11A includes coverage for adult and dependent children. Orthodontic coverage is excluded on Option 10A.

All plans:

PPO Deductible and Calendar Year Maximum cross-apply between In-Network and Out-of-Network.

Plan features and availability may vary by location and are subject to change. Information is believed to be accurate as of the production date; however, it is subject to change.

The list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate.

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